Tennessee

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/26/2021 9.26.08 AM)

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

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State DUNS Number

Number 878890425

Expiration Date

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

Agency Name Avis Easley

Organizational Unit Division of Research, Planning, Policy & 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	8/26/2021 9:21:17 AM
Revision Date	8/26/2021 9:21:30 AM

VI. Contact Person Responsible for Application Submission

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

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

Footnotes:

State Information

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

Fiscal Year 2022

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 nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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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).

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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[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.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

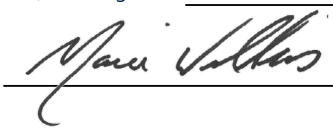
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or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

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

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

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

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

Signature of CEO or Designee[1]: 

Title: TDMHSAS Commissioner

Date Signed: 07/23/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:

BILL LEE
GOVERNOR
STATE OF TENNESSEE

August 21, 2019

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

Dear Ms. Crocker:

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

Contact information for Commissioner Williams is as follows:

Marie Williams
Commissioner
Tennessee Department of Mental Health and Substance Abuse Services
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

ARPA Funding Plan 2021 (MH) – Tennessee

Required proposal information:

1. Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.

We are grateful for the opportunity to respond to this question, as these dollars will most certainly go a long way in helping the Tennessee Department of Mental Health & Substance Abuse Services (TDMHSAS) meet our community-specific needs and gaps. Please note that our Department works in tandem with our State and Regional Planning and Policy Councils who identify needs and gaps by region. To that end, our proposal seeks to allocate funds to our local providers focused on those activities allowed by this block grant to make the most meaningful impact to address the effects of the COVID-19 pandemic for individuals with mental illness.

A similar approach to allocating funds directly to community behavioral health agencies has helped inform TDMHSAS regarding needs when implementing the first installment of COVID Relief MHBG funds. This information was adjunct to the input of the needs assessment done by the TDMHSAS Planning and Policy Council. Those projects range from 12-21 months in length and are uniquely based on community needs. The projects are summarized by category of impact and include a focus whereby:

- 66% of projects support standard goals and objectives of the MHBG to support a continuum of prevention, intervention, treatment, and recovery services
- 47% of projects support evidence-based crisis services
- 62% of projects support increase access to evidence-based treatment and coordinated recovery support
- 29% of projects operate of an "access line," "crisis phone line," or "warm lines" to address any mental health issues for individuals
- 38% of projects train staff in topics related to enhanced mental health crisis response and services
- 15% of projects support Mental Health Awareness training for first responders and others
- 38% of projects support hire of outreach and/or peer support workers for regular check-ins for people with SMI/SED
- 9% of projects support prison and jail re-entry and enhanced discharge from inpatient settings to reduce risks of COVID-19 transmission
- 9% of projects support COVID-19 related expenses for those with SMI/SED, including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE)
- 47% of projects support services that address the needs of children
- 29% of projects support services that address the needs of children regarding school re-entry and related crises for children and adolescents

When identifying local needs for ARPA MHBG support, agencies will be encouraged to consult with their Regional Planning and Policy Councils to prepare proposals and factor in needs outlined in recent annual needs assessments.

2. Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.

The TDMHSAS is fortunate to have a strong established partnership with our Medicaid agency which administers TennCare, as both of our funds directly support and oversee the Tennessee Statewide Crisis Services System. This robust crisis continuum, which provides access to Tennesseans in all of Tennessee's ninety-five counties, 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 existing Crisis Services Continuum is a broad and coordinated array of services available to eligible individuals who are in need of crisis services to meet their needs in the least restrictive and most appropriate setting, to alleviate or stabilize their symptoms as well as strengthen or develop their support system and coping skills, and to allow each individual to remain in his or her community during and after a behavioral health crisis period.

TDMHSAS partners and contracts with thirteen community behavioral health providers who provide mobile crisis and crisis hotline services. Tennessee has a vast statewide crisis system, with 24-hour crisis line and services, reaching over 123,900 individuals in state fiscal year 2020. Approximately 10,200 of the calls were received by the statewide hotline. Each contracted agency operates a local crisis hotline and there is a Tennessee 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.

Adult Mobile Crisis Services are provided to adults who are eighteen (18) years of age and over. There are twelve (12) adult-serving Mobile Crisis Response teams. During state fiscal year 2020, over 45,000 adult mobile assessments were completed. Of that total, over 20,000 assessments were technology assisted using telehealth. The mobile crisis teams provide data to TDMHSAS regarding the location of face-to-face assessments completed by mobile crisis teams. Children and Youth Mobile Crisis Services are provided to children and youth who are seventeen (17) years of age or younger. There are four (4) Children and Youth serving Mobile Crisis Response Teams. During state fiscal year 2020, over 10,800 total youth mobile assessments were completed. Of that total, over 3,600 assessments were technology assisted using telehealth.

Tennessee's National Suicide Prevention Lifeline Center (NSPL) Network is comprised of six (6) crisis call centers across the state. Three include state-contracted crisis service providers, and the remaining providers are not crisis services providers. TDMHSAS is proudly in the second year of a two-year capacity building grant from NSPL aimed at enhancing Lifeline call capacity and increasing answer rates to further ensure all Tennesseans across the state have easy access to crisis care. The standard formula MHBG 5% set aside supports Tennessee's NSPL Center Networks as they prepare for the 9-8-8 go-live in July 2022 by contracting with all six call centers to increase staffing capacity to answer the line.

Tennessee invaluable crisis providers operate eight (8) crisis Walk-In Centers that are non-hospital, facility-based services, affiliated with each of the State-licensed Crisis Stabilization Units, offering

services twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365). Crisis Walk-in Triage Services include assessment and evaluation; early intervention; prevention; stabilization; referral(s) to needed behavioral health services; and follow-up services for symptoms of a behavioral health illness or crisis. In state FY20 there were over 19,200 assessments completed at one of the Walk-In Centers.

The Tennessee Crisis Stabilization Units are licensed by TDMHSAS 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 involuntarily commitment to a psychiatric hospital or other treatment resource and who cannot be appropriately and/or safely managed in a less restrictive environment. There are eight (8) Crisis Stabilization Units across the state, a total of one hundred and fifteen (115) beds. In state FY20 there were over 9,100 admissions to a Crisis Stabilization Units. TDMHSAS, TennCare, and the TennCare Managed Care Organizations (MCOs) worked in collaboration and explored the option of expanding services to include children and youth Crisis Stabilization Units (CSUs). This included engaging providers, stakeholders, and other community partners across the state in an effort to assess children and youth service needs. At this time, and based on the information gathered, the volume of clinically appropriate TennCare member admissions is not significant enough to support or sustain a child and adolescent CSU.

TDMHSAS is utilizing the crisis set-aside funds from the first MHBG COVID Relief award to supplement the work of the adult and youth mobile crisis services statewide. Additionally, SAMHSA COVID-19 Behavioral Health Care Response funding is supporting services in Crisis Walk-In Centers and CSUs. It is anticipated that ARPA MHBG funds would be used for similar purpose as those grants conclude.

3. Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.

The spending plan is multi-tiered and aimed at providing the most equitable distribution of funds to current providers while allowing the local agencies to propose how funds will be utilized across Tennessee's 95 counties. A high-level breakout of the spending plan is included in the table below by state fiscal year with the expectation that the majority of funds would be used during a 45-months timeframe.

ARPA MHBG Funds Breakout by State FY (est 45 months to spend)	SFY2022 Oct 2021 - June 2022 (9months)	SFY2023 July 2022 - June 2023 (12 months)	SFY2024 July 2023 - June 2024 (12 months)	SFY2025 July 2024 - June 2025 (12 months)	TOTAL APRA AWARD
SERVICES	$4,377,965	$5,837,287	$5,837,287	$5,837,287	**$21,889,827**
FEPI 10%	$545,609	$727,478	$727,478	$727,478	**$2,728,044**
CRISIS 5%*	$272,804	$363,739	$363,739	$363,739	**$1,364,022**
ADMIN 4.76%	$259,710	$346,280	$346,280	$346,280	**$1,298,549**
TOTAL AWARD (09/21/2021 – 09/30/2025)	$5,456,089	$7,274,785	$7,274,785	$7,274,785	**$27,280,443**

**This is the minimum set-aside budgeted but will likely be higher.*

- **Continue existing COVID Relief Efforts**- Community providers previously proposed funding needs for COVID Relief for a period of 12-21 months. Funds from ARPA MHBG will allow for

TDMHSAS to review continued needs for those projects and extend project terms if needed. Provider project data and outcomes will be used to evaluate the continued needs for using ARPA MHBG funds. ***Estimated $10m-$13.5m***

- **Crisis continuum supplemental** – Based on provider financial feedback, TDMHSAS has increased focus on investing federal grant dollars into the robust crisis continuum that includes all crisis components, to support operations of the mobile crisis, crisis walk in center, crisis stabilization units, and NSPL call centers. In FY20, more than half of the crisis continuum providers estimated a loss of approximately $4.6m. TDMHSAS has focused grants to support mobile crisis face to face assessments (est $2.2m thru March 2023), and the walk in centers and crisis stabilization units (est $1.4m thru May 2022). Based on the outcomes of those grants, it's likely that ARPA funds will allow for continued support of crisis services supplemental funds to support uninsured Tennesseans needing those services after those awards have ended. Tennessee is currently engaged in a 988 planning grant and there is potential that ARPA MHBG funds may be needed to support that infrastructure enhancement. ***Estimated $1.4 – $7.2m***

- **First Episode Psychosis Initiative (FEPI) –** TDMHSAS is currently working with community mental health agencies to expand the current FEPI program into additional counties using COVID Relief MHBG funds. Tennessee's FEPI utilizes the evidence-based OnTrack model to provide Coordinated Specialty Care to youth and young adults ages fifteen (15) to thirty (30) years old who experience a first episode of psychosis. The purpose of this program is to increase access, quality, and utilization of services and supports for these youth and young adults and their families. The program is required to be person-centered, be delivered by a multi-disciplinary team, and be able to work with the youth and young adults for up to two years. The program is also required to initiate services at onset for the target population and to design referral, recruitment, and community education components to reduce treatment delays. ARPA MHBG funds will allow this expansion to continue for an additional two years. ***Estimated $2.8m***

- **Provider input to improve and enhance the mental health service array –** TDMHSAS plans to offer a funding announcement to community behavioral health agencies to allow for their proposals related to how these ARPA funds can improve and enhance the mental health service array that serves their community. Projects would likely be setup for a two-year state fiscal year period of FY23 – FY24 with the ability to be extended for FY25 based on project performance. **Estimated $11m – $15m**

  Like the COVID Relief funding approach, TDMHSAS would provide SAMHSA recommendations for APRA MHBG funding when seeking proposals including:

  - Standard goals and objectives of the MHBG to support a continuum of prevention*, intervention, treatment, and recovery services related to impact/effects of the COVID-19 pandemic for Americans with mental illness. *Any prevention efforts funded with ARP will target the SMI/SED population.

- Develop partnerships with the emerging Suicide Lifeline (9-8-8) systems, Law Enforcement, EMS, health care providers, housing authorities, Housing and Urban Development (HUD) Continuum of Care, hospital systems, peer-based recovery organizations, and substance use specific treatment providers, all of whom have a critical role in the crisis continuum.
- A comprehensive 24/7 crisis continuum for children including screening and assessment; mobile crisis response and stabilization; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination.
- Provide increased outpatient access, including same-day or next-day appointments, for those in crisis.
- Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural areas; use of GPS, to expedite response times, and to remotely meet with the individual in crisis.
- The adoption and use of health information technology, such as electronic health records, to improve access to and coordination of behavioral health services and care delivery.
- Advance telehealth opportunities to expand crisis services for hard to reach locations, especially rural areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: MHBG funds cannot be used to purchase any items for consumers/clients.
- Support for crisis and school-based services that promote access to care for children with SED.

4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.

Tennessee's plan for advancing services aims to give local behavioral health agencies a strong voice to propose how funds will be utilized across Tennessee's 95 counties to support the coordinated continuum of prevention*, intervention, treatment, and recovery services which Tennessee is fortunate to have in place. *Any prevention efforts funded with ARP will target the SMI/SED population.

The response to question #1 provides a high-level breakout of how TN behavioral health providers chose to allocate new federal funds to support COVID relief. Their projects cover a wide variety of topics including: direct services related to client support, funds to sustain adequate workforce, outreach and awareness, therapy, peer support, employment, FEPI, behavioral health training for staff and first responders, support lines, suicide prevention and crisis services. Significantly more than the 5% setaside was allocated to support mobile crisis services and many of the providers requested additional funds be allocated to crisis related initiatives such as crisis discharge planning, emergency department diversion services, and crisis co-responders. Tennessee is excited to see how these projects will be implemented over the coming months and expects that a portion of ARPA MHBG funds would sustain many of these projects.

TDMHSAS plans to offer a funding announcement to community behavioral health agencies to allow for their proposals related to how these ARPA MHBG funds can improve and enhance the mental health service array in their community. Projects would have the option to focus on the SAMHSA recommendations for ARPA MHBG, many of which were for crisis services.

5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

TDMHSAS will continue to collaborate with the array of community mental health providers to support this work. There are approximately 35 – 40 providers that will be supported by ARPA MHBG funds statewide. Crisis Services are implemented through TDMHSAS state appropriations and TennCare (stated Medicaid authority) funding across the state. TDMHSAS will continue to partner with TennCare as the funding to support crisis services is a shared expense model to ensure that funding can sustained, as needed.

6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.

TDMHSAS is currently working with community mental health agencies to expand the current FEPI program using COVID Relief MHBG funds. Tennessee's FEPI utilizes the OnTrack model to provide Coordinated Specialty Care to youth and young adults ages fifteen (15) to thirty (30) years old who experience a first episode of psychosis. The purpose of this program is to increase access, quality, and utilization of services and supports for these youth and young adults and their families. The program is required to be person-centered, be delivered by a multi-disciplinary team, and be able to work with the youth and young adults for up to two years. The program is also required to initiate services at onset for the target population and to design referral, recruitment, and community education components to reduce treatment delays. ARPA funds will allow this expansion to continue for an additional two years.

7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.

When identifying local needs for ARPA support, agencies will be encouraged to consult with their regional planning and policy councils to prepare proposals and factor in needs outlined in annual needs assessments. Each Spring, Tennessee's seven Regional Planning and Policy Councils as well as the Statewide Planning and Policy Council's Committees (Adult, Children's, and Consumer Advisory Board) work independently to identify and prioritize mental health and substance abuse needs. Tennessee recently finalized the annual 2021 Needs Assessment and we expect this will be an important tool when agencies consider how to use APRA MHBG funds.

8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

At this time there is no plan in place to use the ARPA funds for health IT infrastructure. Should this plan change, TDMHSAS will reach out to SAMHSA project officer for this grant.

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

Commissioner

Organization

Tennessee Department of Mental Health and Substance Services

Signature: Date:

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

Footnotes:

This form is not applicable.

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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Footnotes:

Assess the strengths and organizational capacity of the service system to address the specific populations

TDMHSAS is responsible for planning and promoting a comprehensive array of services and supports for individuals of all ages, living with mental illness, co-occurring disorders, and/or serious emotional disturbances. Initiatives include: treatment services for uninsured; 24-hour crisis services; affordable housing programs; homelessness prevention services; wellness and recovery services; peer recovery services; suicide prevention services; older adult services; disaster emergency services; and comprehensive System of Care-based child, youth, and family supports services.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The TN Behavioral Health 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.

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. 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. Certified Peer Recovery Specialists (CPRSs) provide CSU Peer Link program designed to reduce repeat use of crisis services, increase continuity of care, and help individuals move forward in their recovery.

Additional services that strengthen the adult system of care include: Supportive housing programs that provide opportunities for permanent housing in residential settings with access to support services, such as peer recovery, supported employment, and support staffing. 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. TDMHSAS supports Peer Support Centers statewide for adults diagnosed with mental illness or co-occurring disorders, offering a a place to supplement existing mental health services and support their own recovery process. Individual Placement and Support (IPS) supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. This is an evidence-based partnership between TDMHSAS, Department of Human Services, and the Division of Vocational Rehabilitation. Peer Wellness Coach teams promote healthier behaviors for Tennesseans with Mental Health and/or Substance Use Disorder conditions by providing evidence-based self-management workshops along with one-on-one wellness coaching.

Criterion 2: Mental Health Systems Epidemiology

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

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

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

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

Criterion 3: Children's Services

Tennessee's Council on Children's Mental Health (CCMH), codified in T.C.A. 37-3-110–115, was established by the General Assembly in 2008 as a Tennessee Commission on Children and Youth (TCCY) and TDMHSAS partnership. Tennessee has a twenty-year history of providing System of Care programs focusing on intensive care coordination services that bring together a continuum of services and supports that allow for children, youth, and young adults to function in their homes and communities outside of inpatient and residential facilities.

Services focused on strengthen the child system of care include: The Regional Intervention Program (RIP) is a parent-implemented, professionally supported program for families with young children experiencing challenging behaviors. The program equips parents with tools to manage their child's behavior so that early appearing behavior problems are less likely to put the child at risk of aggression and delinquency later in life. TDMHSAS supports and array of school-based services in Tennessee focused on providing prevention services for children who have or are at-risk for Serious Emotional Disturbance (SED), behavior problems, or substance use disorders. These programs focus on education about behavioral health, supporting early identification of children at risk of serious emotional disorders, and connecting and referring children and families to treatment. The First Episode Psychosis Initiative (FEPI) and other SAMHSA federal grant programs provide a continuum of care for youth and young adults who are experiencing or at-risk of experiencing early onset psychosis. TDMHSAS oversees the Statewide Young Adult Leadership Council consisting of youth and young adults who have lived experience with mental health conditions, substance abuse, and/or involvement with child and adult systems.

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

Tennessee works in collaboration with other state departments to support programs with focus on rural development. The Projects for Assistance in Transition from Homelessness (PATH) and the Children and Youth Homeless Outreach Project (CYHOP) have the primary objective of conducting quality outreach efforts to individuals who are homeless or at risk for homelessness and facilitate opportunities for mental health, substance abuse, care coordination, and housing support services. The Older Adults Program provides care management to individuals over 50 who are not eligible for these services through any other funding source. Care management services include outreach, screening, assessment, linkage, in-home therapy, and other supportive services. 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.

Criterion 5: Management Systems

TDMHSAS offers multiple opportunities annually to behavioral health workforce to educate and receive continuing education. TDMHSAS offers multiple peer workforce certification programs including: Certified Peer Recovery Specialists, Certified Family Support Specialist, and Certified Young Adult Peer Support Specialist. Additionally, a Statewide Peer Wellness Coach and Trainer provides health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. The Department also oversees the Training and Technical Assistance Center (TTAC) (https://socacrosstn.org/resources-trainings/) promoting system of care values and principles through providing quality resources, training, and consultation to youth and young adults with behavioral health needs, their families, and those who serve them.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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Footnotes:

Identify Unmet Service Needs and Critical Gaps within the Current System

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

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

Needs Assessment Process

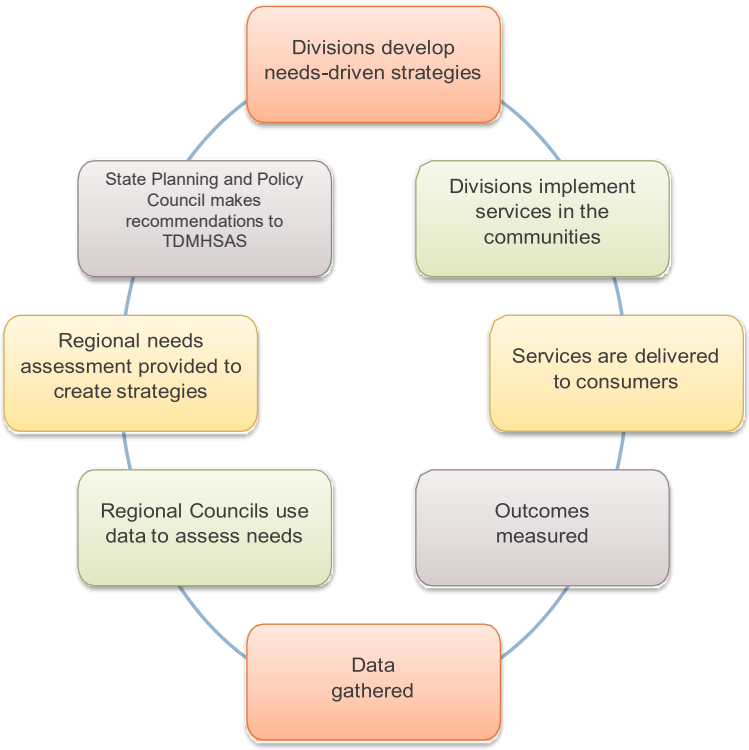
Service needs are identified through an annual needs assessment process with input from TDMHSAS Statewide Planning and Policy Council (Council), the Regional Council system, and TDMHSAS staff. Regional needs are identified, reviewed, and prioritized by the Planning and Budget Committee of the Council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

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

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

Exhibit 1.2

TDMHSAS Needs Assessment Model



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

Data Sources

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

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

- Behavioral Health Safety Net of Tennessee (BHSNTN)
- Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS) with the Centers for Disease Control and Prevention
- Kids Count website (http://datacenter.kidscount.org)
- National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

- SAMHSA: National Survey on Drug Use and Health (NSDUH)
- SAMHSA Uniform Reporting System tables
- SAMHSA: Treatment Episode Data Set
- Tennessee Department of Health
- Tennessee Health Care Financing Administration: TennCare (state Medicaid program)
- Tennessee Outcome Measurement System (TOMS)
- U.S. Census

In addition to the data products which are provided to the Statewide and Regional Councils, the Office of Research provided a Needs Assessment Data Report to provide program specific data to councils about needs identified in the statewide needs assessment. The Report is posted on the department's website at https://www.tn.gov/behavioral-health/planning1/needs-assessment.html. A Data Resources webpage was also provided: https://www.tn.gov/behavioral-health/research/data--research--and-planning/data-resources-.html

The 2021 Need Assessment Summary includes needs and critical gaps identified by the Regional Councils, Statewide Children and Adult Committee, and the Consumer Advisory Board (CAB). The multiple needs identified by regions include: crisis stabilization units (CSUs) and crisis respite centers (CRCs) for children and youth and/or adults; behavioral health workforce development; and increasing school-based mental health education, services, and screenings.

The Summary is posted on the on the department's website at: https://www.tn.gov/content/dam/tn/mentalhealth/documents/planning/FINAL%202021%20NA%20Summary.pdf.

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

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and TennCare, the State Medicaid Authority, believe that there has never been a better nor more critical time to work in the field of mental health and substance abuse services. Based on an anticipated greater need for mental health and substance use services, the Department believes it is imperative the public behavioral health community begin to assess for ways to further enrich and grow the public behavioral health workforce in our state. To that end, TDMHSAS and TennCare (Tennessee's Medicaid Authority) have initiated the Tennessee Public Behavioral Health Workforce Workgroup. The goals of the workgroup will be to: 1. Clearly identify gaps and needs related to the public behavioral health workforce using relevant national data and data specific to the state of Tennessee; 2. Assess for strategies to address identified gaps, including proven actions to support the effective recruitment and retention of public behavioral health professionals in the state of Tennessee; and 3. Develop a report for key decision makers which will highlight identified gaps, but more importantly, will offer effective short-term and long-term

strategies to address public behavioral health workforce challenges in the state of Tennessee. TDMHSAS and TennCare anticipate the workgroup will meet three (3) times between June and August 2021. TDMHSAS and TennCare identified participants in the workgroup based on their statewide purview and unique position in addressing the recruitment and retention of future and present public behavioral health professionals. The Chair and Vice-Chair of the Statewide Planning and Policy Council will be participating in the workgroup. TDMHSAS and TennCare recognizes the valuable insight that Planning and Policy Council members from across the state have on this topic, and their voice will be heard through the Statewide Planning and Policy Council leadership.

TDMHSAS continues to make valiant efforts, with the support of the Lee Administration, the Tennessee General Assembly, and through the acquisition of new federal grants, to increase school-based mental health education, services, and screenings. During the 2012 legislative session of the Tennessee General Assembly, the legislature, with the support of the Lee Administration, created the K-12 Mental Health Trust Fund and allocated $250 million dollars as an initial investment. The new trust fund will be managed by the Tennessee State Treasurer and interest earned from the trust fund will be used to execute an analysis of needs in each individual Tennessee school district and distributed based on the results of that analysis in order to establish treatment and supports for Tennessee K-12 students.

In FY 21, TDMHSAS received notable funding with new, re-occurring state appropriations to expand school-based efforts. Most notably, the department received $3,014,300 to expand its School-Based Behavioral Health Liaison (SBBHL) initiative. With these new resources, TDMHSAS contracted with providers to ensure a SBBHL was available for each of Tennessee's 95 counties. SBBHLs provide a multi-tiered system of support for K-12 students, faculty, and staff. SBBHLs provide face-to-face consultation with classroom teachers who will enhance learning environments for children who have or are at-risk for Serious Emotional Disturbance (SED), behavior problems, and/or substance use disorders (SUDs). SBBHLs also provide training and education for the classroom teacher and serve as a link between the school and the child's family. In addition to teacher trainings and consultations, the SBBHLs provide individual consultations and psycho-educational groups to students as well as clinical services through individual, group, and family therapy sessions.

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

SEOW

SAMHSA funds the Tennessee's State Epidemiological Outcomes Workgroup (SEOW) to bring together stakeholders to identify substance use data and analyze the consequences of substance use. SEOW data guides substance use prevention, treatment, and recovery policy and programs. The Tennessee SEOW 1. facilitates collaboration across state and local agencies by creating a common language about substance use disorders, sharing information with a variety of audiences, and building the capacity for stakeholders

to use data; 2. evaluates the causes and consequences of substance use disorders by organizing data from state and local sources, using data to identify priority populations, and using data to identify emerging trends; and supports data-driven planning and decision making by using data to inform planning and policy, promoting interagency substance use prevention, and promoting effective and efficient treatment and recovery strategies.

The Tennessee SEOW consists of the Tennessee Department of Mental Health and Substance Abuse Services, the Bureau of TennCare (Tennessee's Medicaid Authority), Tennessee Bureau of Investigation, Tennessee Department of Children's Services, Tennessee Department of Correction, Tennessee Department of Education, Tennessee Department of Health, Tennessee National Guard, Tennessee Department of Safety and Homeland Security, Metro Nashville Crime Laboratory, East Tennessee State University, the Oasis Center, and the Allies for Substance Abuse Prevention of Anderson County.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Maintain and improve services

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Maintain and improve effectiveness of community mental health services.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of calls to the statewide crisis hotline (855-CRISIS-1) and provider local crisis lines (all ages) providing access and referral to crisis services to individuals experiencing a mental health crisis

Baseline Measurement: In state FY2021, there were 128,136 total crisis calls across all crisis providers, including calls to the statewide crisis hotline.

First-year target/outcome measurement: Maintain or increase the total number of calls to the statewide crisis hotline during state FY2021.

Second-year target/outcome measurement: Maintain or increase the total number of calls to the statewide crisis hotline during state FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted

Indicator #: 2

Indicator: Number of Tennesseans (all ages) receiving emergency psychiatric crisis services assessment (face to face or telephonically) from a mobile crisis responder or at a crisis walk-in center thereby saving the state additional dollars for more expensive inpatient hospital care and ensuring that Tennesseans receive the right care at the right time in the right place.

Baseline Measurement: In state FY2021, there were 72,039 individuals that received a face to face crisis assessment.

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

Second-year target/outcome measurement: Maintain or increase the total number of individuals receiving face to face crisis assessments during state FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

Other outcomes reviewed will include the percentage of individuals receiving a crisis assessment who were diverted from a higher level of care; percentage individuals seen by mobile crisis within two hours of the request for assessment; and percentage of assessments that were completed using telehealth.

Indicator #: 3

Indicator: Number of admissions to the eight Crisis Stabilization Units (adults) 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: In state FY2021, there were 6,348 individuals admitted to a state supported Crisis Stabilization Unit (CSU) for treatment services.

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

Second-year target/outcome measurement: Maintain or increase the total number of individuals receiving treatment services at a CSU during state FY2022

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 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 FY2021, there are seven CSU in operation. A new CSU will be opening in the coming months to serve Hamblen and surrounding counties that was awarded by TDMHSAS as a result of a competitive funding announcement.

Indicator #: 4

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

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

Baseline Measurement: In state FY2021, there were 39,840 served by the Behavioral Health Safety Net for Adults.

First-year target/outcome measurement: Serve as many uninsured individuals as are eligible and apply to the Behavioral Health Safety Net for Adults during state FY2021 with a goal of serving 41,000 individuals.

Second-year target/outcome measurement: Serve as many uninsured individuals as are eligible and apply to the Behavioral Health Safety Net for Adults during state FY2022 with a goal of serving 41,000 individuals.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted

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: In state FY2021, there were 545 served by the older adult program.

First-year target/outcome measurement: Maintain or increase the total number of older adults receiving care management services during state FY2021.

Second-year target/outcome measurement: Maintain or increase the total number of older adults receiving care management services during state FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 6

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

Baseline Measurement: In state FY2021, 154 youth and young adults experiencing first episode psychosis received evidence-based treatment and recovery support services

First-year target/outcome measurement: Increase the total number of youth and young adults receiving treatment and recovery support services from state FY2021 with a goal of serving at least 165 individuals.

Second-year target/outcome measurement: Maintain or increase the total number of youth and young adults receiving treatment and recovery support services during state FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

In FY22, the program expands to three new sites to expand the OnTrack model for youth and young adults ages 15 to 30 years old who experience a first episode of psychosis, residing in Anderson, Montgomery, or Rutherford County, Tennessee.

Indicator #:	7
Indicator:	Number of individuals (adults) experiencing mental illness or co-occurring disorders who receive short term-financial support for services such as rental assistance, utilities, medical support, and other costs associated with living independently and maintaining stable housing.
Baseline Measurement:	In state FY2021, 5,666 individuals experiencing mental illness or co-occurring disorders received short term-financial support for services aimed at living independently and maintaining stable housing.
First-year target/outcome measurement:	Maintain or increase the total number of individuals able to live independently and/or maintain stable housing with short-term financial support during state FY2021.
Second-year target/outcome measurement:	Maintain or increase the total number of individuals able to live independently and/or maintain stable housing with short-term financial support during state FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Indicator #:	8
Indicator:	Number of safe, affordable mental health and/or recovery housing opportunities that are created, improved, or preserved for people with a history of mental illness or co-occurring disorders as a result of the Regional Housing Facilitators and Consumer Housing Specialists supporting the Creating Homes Initiative
Baseline Measurement:	In state FY2021, there were 3,012 housing or opportunities available statewide through the Creating Homes Initiative (CHI).
First-year target/outcome measurement:	Increase the total number of housing opportunities available through CHI from state FY2021 with a goal of 3,200 housing opportunities.
Second-year target/outcome measurement:	Maintain or increase the total number of housing opportunities available through CHI during state FY2020

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

In FY22, state funding for the Creating Homes Initiative will be increased to include “CHI 3.0”, to create new safe, quality, and affordable permanent housing opportunities with effective support services to Tennesseans experiencing mental illness and/or substance use disorder who re-enter the community from prisons and jails or have been previously incarcerated.

Indicator #:	9
Indicator:	Number of individuals (adults) experiencing mental illness or co-occurring disorders who reside in community-based TDMHSAS provider housing facilities (independent living, group homes, supportive housing) and/or receive services and supports to maintain long-term supportive housing.
Baseline Measurement:	In state FY2021, there were 1,667 individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and supports to maintain long-term supportive housing.
First-year target/outcome measurement:	Maintain or increase the total number of individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and supports to maintain long-term supportive housing during state FY2021.
Second-year target/outcome measurement:	Maintain or increase the total number of individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and supports to maintain long-term supportive housing during state FY2022.

Data Source:

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

Description of Data:

Community Supportive Housing provides flexible funding to agencies to provide supported housing for adults diagnosed with mental illness and co-occurring disorders. Staff is hired by contract agencies to provide on-site supervision for residents and as-needed supervision to non-supervised group homes and apartments; coordinate outside activities for the residents; and work one-on-one to develop a housing plan that identifies the consumer’s ideal housing goal and more independent living. This program includes housing developed through the Creating Homes Initiative (CHI), a strategic plan to partner with local communities on a grassroots level to create permanent housing options for Tennesseans with mental illness. The Emerging Adults program in Nashville, TN provides a comprehensive array of supportive housing and habilitation services for youth ages 18 to 25 living with serious emotional disturbances (SED) who have recently graduated out of the State's foster care system and/or adolescent residential recovery for mental illness or co-occurring disorder; includes mental health and substance abuse treatment, recovery and resiliency skills training; education and employment training and support; and life skills training such as financial management, wellness and nutrition, personal grooming and hygiene, leisure and community engagement, relationship building, and household management. 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.

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 10

Indicator: Number of eligible individuals will become certified as peer workforce annually from programs including: Certified Peer Recovery Specialists (CPRS), Certified Family Support Specialist (CFSS), and Certified Young Adult Peer Support Specialist (CYAPSS).

Baseline Measurement: In state FY21, 213 peer specialists were certified.

First-year target/outcome measurement: Maintain or increase the number of peer specialists certified during FY2021.

Second-year target/outcome measurement: Maintain or increase the number of peer specialists certified during FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

No in-person CPRS Trainings were provided during FY21 due to COVID-19 pandemic, all were virtual. Not all trainees on the waitlist were able to do a virtual training, so the number trained and then the number certified was subsequently lower. In summer 2021 TDMHSAS released its Certified Young Adult Peer Support Specialist (CYAPSS) program which will allow for young adults to become certified to provide support to other young adults on their recovery journey.

Indicator #: 11

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

Baseline Measurement: In state FY2021, 1,096 individuals were served through the evidence-based Individual Placement and Support Supported Employment initiative and 46% were employed in competitive and integrated work for at least one day.

First-year target/outcome measurement: Maintain or increase the percentage of the individuals served through the evidence-based Individual Placement and Support Supported Employment initiative will be employed in competitive and integrated work for at least one day during state FY20201.

Second-year target/outcome measurement: Maintain or increase the percentage of the individuals served through the Individual Placement and Support Supported Employment initiative employed in competitive and integrated work for at least one day during state FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 12

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

Baseline Measurement: In state FY2021, 1,254 individuals participated in self-management workshops or received

one-on-one peer wellness coaching.

First-year target/outcome measurement: Maintain or increase the total number of individuals participating in self-management workshops or receiving one-on-one peer wellness coaching during state FY2021.

Second-year target/outcome measurement: Maintain or increase the total number of individuals participating in self-management workshops or receiving one-on-one peer wellness coaching during state FY2022.

Data Source:

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

Description of Data:

Peer Wellness Initiative program is a component of the statewide, peer-led health and wellness initiative, which promotes chronic disease prevention and self-management programming for individuals with mental illness, substance use disorders, and co-occurring disorders. Statewide Peer Wellness Coaches and Trainer provide mental health and co-occurring treatment and recovery services providers with health and wellness training, technical assistance, and ongoing support in implementing health and wellness programming. Peer Wellness Coaches promote healthier behaviors for Tennesseans with Mental Health and/or Substance Use Disorder conditions. They do this by facilitating holistic, evidence-based curriculums such as Chronic Disease, Diabetes, and Chronic Pain Self-Management Workshops, Whole Health Action Management (WHAM), Nutrition Education Wellness and Recovery (NEW-R), Tobacco Free Workshops, and one-on-one Peer Wellness Coaching to help participants achieve their wellness goals, all of which are based around the Eight Dimensions of Wellness.

Data issues/caveats that affect outcome measures:

None noted.

Priority #: 2

Priority Area: Promote early intervention

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Provide effective early intervention, education and prevention services.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of uninsured or underinsured Tennessee children having a serious mental illness, able to access outpatient mental health care from Behavioral Health Safety Net for Children that otherwise would not have the ability to receive core behavioral health services

Baseline Measurement: In state FY2021, there were 475 served by the Behavioral Health Safety Net for Children.

First-year target/outcome measurement: Serve as many uninsured or underinsured children as are eligible and apply to the Behavioral Health Safety Net for Children during state FY2022 with a goal of serving 500 individuals.

Second-year target/outcome measurement: Maintain or increase the number of uninsured or underinsured children served by the Behavioral Health Safety Net for Children during state FY2022.

Data Source:

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

Description of Data:

The Behavioral Health Safety Net (BHSN) for Children provides essential outpatient mental health services to Tennesseans ages three to 17 who don't have insurance coverage or lack full behavioral health coverage. There are no limits on family income for eligibility. The BHSN for Children is administered through contracts with Community Mental Health Agencies across the state, and each provider agency has an Outreach Coordinator who can assist families. These services are community-based, so inpatient care is not covered. The program also helps to connect/refer to other behavioral health payor sources.

Data issues/caveats that affect outcome measures:

The BHSN for Children program began in FY2021.

Indicator #: 2

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

Baseline Measurement: In state FY2021, 113,880 individuals received mental health awareness in Tennessee, through the provision of mental health and suicide prevention training, and/or public awareness activities.

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

Second-year target/outcome measurement: Maintain or increase the total number of individuals receiving mental health awareness in Tennessee, through the provision of mental health and suicide prevention training, and/or public awareness activities during state FY2022.

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.

Description of Data:

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.

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 3

Indicator: Number of students to receive targeted behavioral health services and supports (including both in person and virtual) such as screening, individualized classroom consultation, or therapeutic interventions in schools through school based programming.

Baseline Measurement: In state FY2021, 14,439 students received mental health screening, services, or supports in schools.

First-year target/outcome measurement: Increase the total number of students receiving mental health screening, services, or supports in schools from state FY2021 with a goal of 15,000 students served.

Second-year target/outcome measurement: Maintain or increase the total number of students receiving mental health screening, services, or supports in schools during state FY2022.

Data Source:

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

Description of Data:

School Based Behavioral Health Liaisons use the Multi-Tiered Systems of Supports (MTSS) framework to provide face-to-face consultation with classroom teachers to enhance trauma-informed learning environments for children and youth who have or are at-risk for SED, behavior problems, or substance use disorders. Liaisons provide training and education for the classroom teachers regarding mental health and substance abuse topics, as well as behavioral interventions. Liaisons provide a connection between the child's family and school to ensure collaboration and proper communication; assists with transitions between alternative school/classroom placements; supports school staff/families in navigating mental health transitions between alternative school/classroom placements; supports school staff/families in navigating mental health and other needed services; and provides mental health screenings and brief therapy for the child or youth as needed. Project B.A.S.I.C. (Better Attitudes and Skills in Children) is a school-based, mental health prevention and early intervention service that focuses on the promotion of mental health in children in the earliest school grades (K-3rd grade). A child development specialist (CDS), employed by a community mental health agency, works full-time in an elementary school to promote Pyramid Model practices and implementation. The program includes: identification and referral of children with serious emotional disturbance (SED), teacher consultation, student consultation, positive school climate activities, and classroom mental health promotion presentations, all guided by the Pyramid Model framework. Violence prevention and resiliency for youth in grades 4-8; uses the Second Step curriculum, an evidence-based practice that teaches empathy, impulse control, decision-making skills and anger management. The School & Communities Youth Screen Program uses a scientifically-based screening tool designed to identify at-risk youth; provide effective interventions to assist with their treatment. Youth Screen is a national mental health and suicide risk-screening program for youth.

Data issues/caveats that affect outcome measures:

School-based programming overcame the unprecedented challenges posed by the pandemic and exceeded goals for FY21 allowing students to receive targeted behavioral health services and supports. TDMHSAS will continue to expand these successful programs in FY22 with state funding as part of the Tennessee Resiliency Project Grant focusing on expansion/creation of early childhood mental health programs, school-based mental health services, and enhanced coordination of care for youth experiencing behavioral health crisis.

Indicator #: 4

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

Baseline Measurement: In FY2021, 292 children under the age of 6 and their families received prevention and early intervention services and supports through Regional Intervention Program (RIP) to ensure that young children and their families experiencing challenging behaviors receive services and support.

First-year target/outcome measurement: Increase the number of children under the age of 6 and their families receiving prevention and early intervention services and supports from state FY2021 with a goal of 375 children served.

Second-year target/outcome measurement: Maintain or increase the number of children under the age of 6 and their families receiving prevention and early intervention services and supports during state FY2022.

Data Source:

Maintain or increase the number of children under the age of 6 and their families receiving prevention and early intervention services and supports during state FY2022.

Description of Data:

The Regional Intervention Program is a parent-implemented, professionally-supported program for young children (2-6 years old) and their families experiencing challenging behaviors. RIP has been serving families with young children since 1969. This unique, internationally recognized program guides parents in learning the skills necessary to work with their own children, while they receive training and support from other RIP families. There are 11 program sites across Tennessee. For the entirety of FY21, like many other programs, RIP maintained programming in a virtual world with little in-person service delivery. All programs continued to run & serve families virtually. Programs have slowly opened to in-person services, based on their community's guidelines, and several programs anticipate opening in early FY22. Programs that have already opened described significant increases in referrals as children re-enroll in school/childcare settings.

Data issues/caveats that affect outcome measures:

None noted.

Indicator #:	5
Indicator:	Number of children, youth and young adults with SED at-risk of out of home placement who receive evidence-based High Fidelity Wraparound support to support, stabilize, and keep them with their families and in their communities
Baseline Measurement:	In FY2021, 82 children, youth and young adults will receive evidence based high-fidelity wraparound support.
First-year target/outcome measurement:	Increase the number of children, youth and young adults served from state FY2021 with a goal of serving 200 families with High Fidelity Wraparound
Second-year target/outcome measurement:	Maintain or increase the number of children, youth and young adults served during state FY2022.

Data Source:

Providers report data monthly on High Fidelity Wraparound outcomes to DMHS Office of Children, Young Adults, and Families.

Description of Data:

System of Care programs provide intensive care coordination services, using High Fidelity Wraparound to families of children with an SED/SMI with the intent of reducing out-of-home placements, including hospitalizations.

Data issues/caveats that affect outcome measures:

The FY21 baseline is based on only the Federal SOCAT total served. The SOCAT TANF began in FY21 and that is why the total target for FY22 is higher.

Indicator #:	6
Indicator:	Number of juvenile justice involved youth diverted to evidence-based, community-based services and completing the treatment program
Baseline Measurement:	In FY2021, 724 juvenile justice involved youth were discharged from services. 17% of those discharges can be attributed to engagement issues and the youth did not complete the program.
First-year target/outcome measurement:	Decrease the number of juvenile justice involved youth exiting services before program completion due to engagement compared to state FY2021.
Second-year target/outcome measurement:	Maintain or decrease the number of juvenile justice involved youth exiting services before program completion due to engagement compared to state FY2022.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
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: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[c]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$2,748,584.00			$380,000.00			$1,579,394.00		$1,273,087.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$26,057,800.00	$5,681,400.00	$265,453,400.00	$23,424,200.00	$2,332,000.00			
7. Other 24-Hour Care		$7,800,578.00			$40,846,198.00			$2,799,895.00		$2,553,813.00
8. Ambulatory/Community Non-24 Hour Care		$14,253,533.00		$16,330,238.00	$162,542,116.00			$8,399,685.00		$7,661,439.00
9. Administration (excluding program/provider level)[e] MHBG and SABG must be reported separately		$1,308,849.00	$626,000.00	$2,912,516.00	$28,616,000.00	$3,761,000.00	$1,571,100.00	$752,092.00		$577,375.00
10. Crisis Services (5 percent set-aside)[f]		$1,374,292.00			$44,806,934.00			$2,262,875.00		$636,543.00
11. Total	**$0.00**	**$27,485,836.00**	**$26,683,800.00**	**$24,924,154.00**	**$542,644,648.00**	**$27,185,200.00**	**$3,903,100.00**	**$15,793,941.00**	**$0.00**	**$12,702,257.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[c] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[f] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:
Tennessee's plan is to utilize all of the COVID 19 Relief funds (MHBG) in FY22 and FY23. For the ARP MHBG funds Tennessee's plan is to utilize the funds over the 4 year grant period and this table shows only funds used during FY22 and FY23.

Planning Tables

Table 6 Non-Direct Services/System Development

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems						
2. Infrastructure Support	$687,146.00	$470,296.00	$311,674.00	$687,146.00	$470,296.00	$415,565.00
3. Partnerships, community outreach, and needs assessment						
4. Planning Council Activities (MHBG required, SABG optional)	$309,400.00			$318,700.00		
5. Quality Assurance and Improvement	$590,000.00			$590,000.00		
6. Research and Evaluation						
7. Training and Education	$1,501,675.00	$413,040.00	$64,687.00	$1,282,609.00	$413,040.00	$86,250.00
8. Total	**$3,088,221.00**	**$883,336.00**	**$376,361.00**	**$2,878,455.00**	**$883,336.00**	**$501,815.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

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

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

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

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

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

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

TDMHSAS, as well as Tennessee's State Medicaid Agency, TennCare, continue to support integrated care and expanded co-occurring competent services through its respective treatment provider networks. As outlined in the highlighted activities below, TDMHSAS understands the reciprocal relationship between physical health and mental health, as well as the prevalence of co-occurring serious mental illnesses and substance use disorders.

TDMHSAS launched the Project Rural Recovery program in December 2020. Funded through a five-year SAMHSA grant, Project Rural Recovery brings integrated behavioral and physical health mobile care services to 10 rural counties in two recreational vehicles (RVs). The RVs park at various sites in the communities, including grocery stores, shopping centers, libraries, health departments, and parks. The multidisciplinary mobile health team, comprised of a program director, nurse practitioners, behavioral health clinicians, integrated care community specialists/certified peer recovery specialists, and mobile office managers provides an array of services, including individual/group counseling, suicide risk screening, psychotropic medication dispensing, tobacco/nicotine cessation, primary health screenings, and access to nutrition and housing services, all at no cost to the patient. The mobile health team refers patients to community providers for specialty services that cannot be provided on the mobile bus.

The Office of Crisis Services within TDMHSAS has contracts with Mobile Crisis Providers across the state, to ensure access to emergency mental health evaluations are available for all in need. Mobile Crisis Providers establish relationships with providers of all types, including Primary Care Providers, in their regions. These connections serve as a point of entry for consumers in the Crisis Continuum, and Mobile Crisis Staff often respond to requests for evaluations at a Primary Care office. Mobile Crisis staff often consult with Primary Care Providers when gathering information for the crisis assessment. Additionally, Mobile Crisis staff include Primary Care Provider information in the crisis assessment. When a consumer is referred to a higher level of care, such as CSU, Detox Facility, or Inpatient Hospitalization, these providers have access to the Primary Care Provider via the information in the crisis assessment. This information is useful for communication during the discharge process.

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) with the National Alliance for Mental Illness (NAMI) Tennessee and the Tennessee Association of Mental Health Organizations (TAMHO) jointly created the Tennessee Co-Occurring Disorders Collaborative (TNCODC) in 2011. The TNCODC mission is to create a common understanding of the impact and treatment of co-occurring disorders in our communities, to share knowledge about the conditions and available resources, reduce stigma, and accurately direct people to timely and effective prevention, treatment, and support for co-occurring mental health and substance use disorders.

At the onset of the COVID-19 pandemic, telehealth services became a significant venue for delivering services through the TN Behavioral Health Safety Net (BHSN). Prior to March 2020, only selected BHSN services were made allowable via telehealth. Beginning in March 2020, most BHSN services were made and continue to be allowable via telehealth in alignment with TennCare's telehealth guidance during COVID-19. Between February 2020 and March 2020, the volume of BHSN services provided via telehealth increased 500%. Throughout FY21, 79% of BHSN enrollees received at least one service via telehealth and 30% of all BHSN services delivered were via telehealth. The embrace of 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. The Behavioral Health Safety Net is eligible to individuals with Medicare but without TennCare to receive Case Management services. BHSN Case Management provides assessment and linkage to other community resources and on-going monitoring of care plans and service arrangements.

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

Older Adults Program, eligible to individuals 50 years and older who may have Medicare but do not have TennCare or Behavioral Health Safety Net, provides a care coordination component that may include outreach, screening, assessment, in-home therapy, and other supportive services as needed. Care coordination may include linkage to other support and services from other providers, including primary care services. In response to COVID-19, telehealth is being widely leveraged to provide care coordination services in the Older Adult program.

TDMHSAS has a significant partnership with NAMI (National Alliance on Mental Illness) Tennessee, which provided leadership in developing and maintaining the Tennessee Parity Project website, which includes access to an online complaint form with the Tennessee Department of Commerce and Insurance and serves to educate the public about parity in Tennessee.

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

TDMHSAS supports its Certified Peer Recovery Specialist program, which currently has over 600 CPRS's trained in co-occurring peer support. CPRS's have lived experience of mental illness or substance use disorder. TDMHSAS also supports the Certified Family Support Specialist (CFSS) program which draws on the lived experience of parents and caregivers who can provide support and advocacy to parents/caregivers who have a child, youth, or young adult who are experiencing a mental health concern. The CFSS program currently has 124 CFSS trained. In summer 2021 TDMHSAS released its Certified Young Adult Peer Support Specialist (CYAPSS) program which will allow for young adults to become certified to provide support to other young adults on their recovery journey.

TDMHSAS continues to provide leadership for advancing integrated systems of care for individuals with co-occurring disorders. Encouraging co-occurring competent and co-occurring friendly programs is key value present in all grant contracts administered by the Division of Mental Health Services. This evident through the department's support of the Tennessee Co-Occurring Disorders Collaborative (TNCODC). This multi-agency effort aims to create a common understanding of the impact and treatment of co-occurring disorders in Tennessee communities. The primary goals of TNCODC include (1) to share knowledge about the conditions and available resources, (2) reduce stigma, and (3) accurately direct people to timely and effective prevention, treatment, and support. The TNCODC provides training and technical assistance to improve co-occurring capability of M/SUD providers across the state.

A program example of supporting integrated systems of care is through the Statewide Peer Wellness Coach and Trainer program. This program provides and coordinates health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and supports assists providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

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

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

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

The SMI/SED focused services covered under Tennessee's Block Grant funding are ancillary and fill gaps by providing services not covered by insurance. While TDMHSAS monitors access issues through various data sets (e.g. HRSA healthcare shortage areas, TDOH professional licensure databases, etc.) and from feedback generated by the state's planning and policy councils, there is presently no formal initiative yet developed that will monitor access to all behavioral health services in Tennessee. TennCare and TDMHSAS did launch, however, a Public Behavioral Health Workforce Workgroup in June 2021 which has studied workforce recruitment and retention issues, and associated impacts on access to care.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii) heart disease (●) Yes ( ) No

iii) hypertension (●) Yes ( ) No

iv) high cholesterol (●) Yes ( ) No

v) diabetes (●) Yes ( ) No

c) Recovery supports (●) Yes ( ) No

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

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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

In 2021, the Tennessee General Assembly passed and Governor Bill signed into law SB151/HB360/Public Chapter 244 re: behavioral health parity. Under the aforementioned legislation, by January 31, 2022, and each year thereafter, the Tennessee Department of Commerce (TDCI) and Insurance must 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.

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

The Division of Mental Health, Office of Wellness and Employment, supports the implementation of six evidence-based health and wellness programs by providing ongoing training and up to date licensing of curriculum for: Chronic Disease Self-Management Program, Diabetes Self-Management Program, Chronic Pain Self-Management Program, Tobacco Free Program, Nutrition and Exercise for Wellness and Recovery Program, and Whole Health Action Management Program. These curricula are provided by trained peers in the state's 45 Peer Support Centers and through one-on-one evidence informed peer wellness coaching in some areas of the state where there are no Peer Support Centers.

TDMHSAS has a significant partnership with NAMI (National Alliance on Mental Illness) Tennessee, which provided leadership in developing and maintaining the Tennessee Parity Project website, which includes access to an online complaint form with the Tennessee Department of Commerce and Insurance, and serves to educate the public about parity in Tennessee

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

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

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	(•) Yes ( ) No
e) Gender identity	(•) Yes ( ) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

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

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

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

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

The Projects for Assistance in Transition from Homelessness (PATH) program connects/reconnects individuals experiencing homelessness with mainstream mental health, substance abuse, or co-occurring services that otherwise would be difficult to access. To address health disparities, the PATH program implements an individualized, person-centered approach to meet the need of all persons within the targeted population who engage with the service via outreach as well as enrollment. Tennessee's PATH program provider agencies implement and ensure training for cultural awareness and humility for all program service delivery staff and utilizes resources such as language interpreter telecommunication for non-English speaking individuals. Given that social, demographic, geographic and environmental factors are important contextual contributors to disparities in health, a continuous and quality improvement approach will be used to analyze, assess and monitor key data points on the PATH Quarterly Progress Reports. Outcomes for services and supports will be monitored across race and ethnicity to determine the grant's impact on behavioral health disparities. All results will be tracked and sorted by race, ethnicity, gender, sexual orientation, and/or age to ensure that any disparities in service delivery or outcome can be identified and addressed.

The Community Supportive Housing, and Intensive Long-term Support are permanent supportive housing programs that assists with maintaining access to supportive services (mental health, co-occurring, case management, etc.) for service recipients in over 100 quality affordable housing sites across the state. Additionally, in SFY 2022, the Office of Housing and Homeless Services began its Supportive Recovery Housing program, which provides access to supportive recovery-based services at quality affordable permanent housing sites for individuals in recovery from substance use disorders. The Community Targeted Transitional Support (CTTS) program provides temporary financial assistance to support service recipients' ability to sustain community living, and avert homelessness or reduce the risk of homelessness. The Inpatient Targeted Transitional Support (ITTS) program assists service recipients exiting the Regional Mental Health Institutes, 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. Both the CTTS and ITTS programs provide 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 are vital for those who lack these resources to successfully obtain housing at such a critical time of need.

The Office of Children, Young Adults, & Families oversees multiple SAMHSA-funded federal discretionary grants that provide services to all ages including transition-age youth and young adults, including System of Care Across Tennessee (SOCAT), Healthy Transitions (HT), Clinical High Risk for Psychosis (CHR-P), and First Episode Psychosis Initiative/Early Serious Mental Illness (FEPI/ESMI). Each initiative includes the development and implementation of a Disparity Impact Statement. These statements

address following: Proposed number of individuals to be served by subpopulations in the grant service area; A quality improvement plan using our data; and Adherence to the CLAS standards. The Regional Intervention Program (RIP) has a policy for Limited English Proficiency (LEP) that meets Title VI requirements and addresses language services for clients. The LEP policy also includes a 4 Factor Analysis that is completed annually and addresses: Number or proportion of LEP persons eligible to be served or likely to be encountered by the program; Frequency with which LEP individuals come in contact with the program; Nature and importance of the program, activity, or service provided by the program to people's lives; and Resources available to the LEP grantee/recipient and the cost.

The Office of Crisis Services oversees grant contracts with providers that offer crisis services to every county in the state. These services are available, at no cost, to all in need. These services include access to a statewide crisis phone line 24/7/365. These hotline services are staffed to assist consumers in need with crisis management, offer resources and connection with a wide range of community providers, as well as connection with other services within the crisis continuum. Mobile Crisis Services are also available to anyone experiencing a mental health emergency, at no cost, 24/7/365. These services are available to assess the individual and assist with facilitating connection with services that meet the current need of the client. These crisis providers ensure that the full continuum of crisis services is available across the state. The State has contracts with 6 Crisis Stabilization Unit (CSU) providers across the state. These CSU facilities are utilized as an alternative to hospitalization, where the consumer is able to receive therapeutic treatment, including medication management, without being admitted to an inpatient psychiatric facility. These CSU facilities take referrals from crisis providers across the state, which allows consumers state-wide to have access to the appropriate level of care. The use of telehealth services for crisis assessments has provided even more efficient connection with a provider, thereby more quickly addressing the needs of the consumer. Telehealth services in an expanded capacity during the pandemic, ensuring that services were continuing to be provided, when a face to face assessment was not available. Mobile crisis providers have established relationships with other agencies in their regions, including law enforcement, as well as other transportation services. These relationships ensure a collaborative approach when determining the best treatment outcomes, as well as the most appropriate mode of transportation, for the consumer.

The TDMHSAS Training and Technical Assistance Center (TTAC) includes a trainer in Cultural Competency in Health and Human Services by the Cross-Cultural Health Care Program. The trainings provided are focused on CLAS standards and cultural and linguistic responsiveness. Trainings are provided to contracted providers and by request from community partners.

Individual Placement and Support (IPS) Supported Employment Trainers offer training, support, and guidance to supported employment providers across the state. The training is provided to behavioral health direct support staff, agency leadership, mental health providers, and Vocational Rehabilitation staff who support clients in the search for competitive integrated jobs.

The Director for the Office of Wellness and Employment serves as the chair for the Employment First Task Force – Mental Health Workgroup. The goals of the workgroup are to increase access to IPS, determine methods to reach clients who are dually diagnosed with a mental illness and intellectual development disability, and create methods to support clients who wish to work in competitive jobs, but do not have access to IPS.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

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

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

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

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

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

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

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

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

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

In partnership with Governor Lee's office and Tennessee's executive agencies, the Office of Evidence and Impact (OEI) was established in September 2019 to support agencies in using data to invest in programs produce positive outcomes for Tennesseans. TDMHSAS has worked on many projects with OEI to create program inventory of current funded programming and develop internal evaluation plans focused on outcomes for current and expanded programs. TDMHSAS promotes the use of evidence-based practices and services in funding announcements.

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

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Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

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

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

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

Certified Peer Recovery Specialists /Certified Young Adult Peer Support Specialists. Carey Counseling Center, Inc. provides services in the rural northwest Tennessee counties of Carroll, Gibson, Henry, Lake, Obion, and Weakley Counties. Mental Health Cooperative provides services in Davidson County. Alliance Healthcare Services provides services in Shelby County. Helen Ross McNabb Center provides services in Knox and Hamilton Counties. In addition, an funding announcement is in process to add three additional county sites in SFY2022, which will allow for an increased number of youth and young adults to be served.

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

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

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

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

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

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

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

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

In FY2022 and 2023, TDHMSAS will continue to provide services through the First Episode Psychosis Initiative (FEPI), the Clinical High Risk for Psychosis (CHR-P) program, and Healthy Transitions (HT) program. TDMHSAS as part of the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260] and the American Rescue Plan Act (ARPA), 2021 [P.L. 117-2] will utilize supplemental funding to address the effects of the COVID -19 pandemic for Americans with mental illness. The MHBG allocation requires states to set aside ten percent (10%) of their total allocation for first-episode psychosis or early SMI programs. Tennessee intends to use these set aside funds to expand the First Episode Psychosis Initiative (FEPI) for an estimated four years into three (3) new county service areas.

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

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

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

Diagnostic categories identified in Tennessee's ESMI programs include:
• 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, or Hamilton Counties; and
• Currently have, or anytime in the past twenty four (24) months had, a diagnosable psychosis spectrum condition including schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, or other serious mental illness that warrants psychosis interventions such as depression with psychosis, bipolar disorder with psychosis, or others that meet diagnostic criteria in the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5), or more current edition.

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

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

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

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

N/A

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

If a person experiencing a mental health crisis has a developed plan, such as a Declaration of Mental Health Treatment, crisis providers make every effort to locate the plan, and connect with the identified support system documented in the plan, to assist with evaluating treatment options, utilizing the least restrictive setting possible to meet the clinical needs of the consumer. Mobile Crisis providers work with the consumers, and these supports, to ensure that consumers are an essential part of their treatment plan. Consumers are able to voice their feelings about services on the full continuum of crisis services, and work with the Mobile Crisis staff to ensure that the appropriate level of care is being pursued. Caregivers are consulted to assist with treatment planning, which includes crisis management and safeguarding the home environment. Mobile Crisis staff use this communication to assist the caregivers and consumers in navigating the crisis and ensuring they have the resources necessary to access crisis services, should a crisis situation occur in the future.

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

The state has a Certified Family Support Specialist certification program in which parents can become certified to provide peer-to-peer support services to parents or caregivers of a child with a Social Emotional Disturbance (SED). The State also has a Certified Peer Recovery Specialist program and has recently launched a CPRS Transition Age designation for youth and young adults ages 18-30 with lived experience of mental illness or substance use disorder, the Certified Young Adult Peer Support Specialist program (CYAPSS). Within the Office of Children, Young Adults, and Families,, the System of Care Across Tennessee lab sites employ Family Support Specialists, and the Clinical Risk for Psychosis (CHR-P), On Track TN (FEPI) and Healthy Transitions lab sites employ Peer Support/Recovery Specialists who collaborate with the consumer's Care Coordinator and Therapist to ensure person-centered planning.

Through the System of Care Across Tennessee (SOCAT) children, youth, young adults, and their families receive Intensive Care Coordination services utilizing a wraparound approach which allows for full partnership between those being served and the service providers.

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

Through the state's Older Adult Program, six community mental health provider agencies offer care coordination that may include outreach, screening, assessment, in-home therapy, and other supportive services as needed. Through person-centered planning at the Community Mental Health Provider level, individuals enrolled in the Older Adult Program determine along with their support people, caregivers, and their providers, which services and treatment options are best for the individual.

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

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

Tennessee's crisis continuum works closely with consumers, as well as identified support systems, to ensure that treatment/crisis planning is focused on the individual. Crisis planning includes, when appropriate, communicating with the consumer to ensure that identified triggers, support systems, steps necessary to safeguard the home environment, as well as ways to access the crisis continuum at any point in the future if needed. This person-centered approach ensures that the treatment and crisis planning is tailored to the needs of the individual, recognizing that each consumer experiences a crisis situation in a unique manner. In the event that the consumer is unable to participate in this planning, Mobile Crisis staff work closely with identified support persons to ensure that treatment options are communicated as well as actions to be taken to keep the consumer safe and to access crisis services in the future.

The Community Supportive Housing program and the new Supportive Recovery Housing program require 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. Plans can include a wide variety of areas, including daily living skills, educational and/or employment goals, health and wellness, socialization skill development, and budget management, among others. Provider agencies ensure each resident is directly involved in the development and modifications of their plan, and that plans are achievable. Plans are centered around the resident's self-identified goals and explore means to achieve greater recovery, resiliency and independence in community living and engagement. The Intensive Long-term Support (ILS) program serves individuals who have discharged from the state's Regional Mental Health Institutes after an extensive length of stay, and who need enhanced-level support services to live in the community. Residents of the ILS program benefit from a person-centered, whole-person approach, as treatment and support plans are tailored to meet the needs of each individual, and each plan serves to optimize the respective resident's quality of community living. The Emerging Adult Services program requires the provider agency to conduct an assessment for each service recipient to identify their individual strengths and needs, and subsequently develop a transitional plan to guide services and supportive practices toward effective transition to sustainable independence in adulthood.

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

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6. Program Integrity - Required

Narrative Question

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

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

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

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

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 TDMHSAS Grantee Manual is located on the Grants Management section of the TDMHSAS web site which 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, for Providers, the Grants Management section of the web site includes extensive information and guidance for sub-recipients around the sue of federal funds including Uniform Guidance, Allowable Vs. Non-Allowable Costs, FFATA, and more. Web site link: https://www.tn.gov/behavioral-health/for-providers/grants-management.html

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 Office of Contracts, within the TDMHSAS Division of General Counsel, includes prohibitions within sub-recipient grant contracts. The State Procurement Commission has incorporated the sections into the pro forma statewide grant contract template as optional language. Sub-recipient contracts that are supported with Mental Health Block Grant funds include the following language within Section E. Special Terms and Conditions. E.#) Prohibitions on Use of Federal Mental Health Block Grant (MHBG) Funds. Pursuant to federal laws and regulations, the Grantee shall not use any federal Community Mental Health Services Block Grant (now MHBG, formerly CMHS BG) funds made available under this Grant Contract for any of the following purposes: a. to provide inpatient services; b. to make cash payments to intended recipients of

health services; c. to purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or to purchase major medical equipment; d. to satisfy any requirement for the expenditure of non-federal funds for the receipt of federal funds; e. to provide financial assistance to any entity other than a public or non-profit private entity. And E.#) Prohibition on Supplantation of Federal Mental Health Block Grant (MHBG) Funds. Pursuant to federal laws and regulations, the Grantee shall not use any funds paid or services rendered under the federal Community Mental Health Services Block Grant (now MHBG, formerly CMHS BG) to supplant any other funds available for the services provided under this Grant Contract. Additionally, the scope of services and deliverables for all programs within Division of Mental health services include a section within the program structure that speaks states, "Grantees are strongly encouraged to seek compensation from third party payers, such as Medicaid, when possible for reimbursable services and supports delivered under this contract therefore allowing this contract to help offset the activities and expenses that are non-reimbursable by third party payers."

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

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

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

N/A

2. What specific concerns were raised during the consultation session(s) noted above?

N/A

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

N/A

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

N/A

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

Footnotes:

This is not applicable to Tennessee.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

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

The Intensive Long-term Support (ILS) program serves individuals who have 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 include 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.

The Inpatient Targeted Transitional Support (ITTS) program assists service recipients exiting the Regional Mental Health Institutes, 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 are 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.

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

Peer Wellness Coaching (PWC) is offered statewide. Adults living with serious mental illness die on average 25 years earlier than other Americans largely due to treatable medical conditions. The My Health, My Choice, My Life (MHMCML) Initiative, led by PWCs, includes evidence-based, self-management workshops along with one-on-one wellness coaching. Peer Wellness Coaches promote healthier behaviors for Tennesseans with Mental Health and/or Substance Use Disorder conditions. They do this by facilitating holistic, evidence-based curriculums such as Chronic Disease, Diabetes, and Chronic Pain Self-Management Workshops, Whole Health Action Management (WHAM), Nutrition Education Wellness and Recovery (NEW-R), Tobacco Free Workshops, and one-on-one Peer Wellness Coaching to help participants achieve their wellness goals, all of which are based around the Eight Dimensions of Wellness. MHMCML also trains agency staff in health and wellness curriculum and provides technical assistance and support in promoting health and wellness within mental health and substance use services.

The 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 eleven (11) counties, expanding

to fourteen (14) in FFY2021. These programs ensure that individuals receive care coordination, peer services, IPS, education services, medication management and therapy.

The System of Care Across Tennessee Network (SOCAT-N) and TANF (SOCAT-TANF) provide intensive care coordination services that bring together a continuum of services and supports that allow for children, youth, and young adults to function in their homes and communities outside of inpatient and residential facilities. Stepdown services are provided to children, youth, and young adults who are being discharged from inpatient, residential, and detention facilities.

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 TDMHSAS Mental Health Institutes. The purpose of the initiative is to transition the individuals to the least restrictive and most integrated setting appropriate based on the individual need.

The TN Behavioral Health Safety Net provides essential outpatient mental health services to adult Tennesseans 18 years and older who lack insurance coverage and Tennessee children ages 3-17 years 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 BHSN is administered through contracts with 14 Community Mental Health Agencies across the state.

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

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

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

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.

The Behavioral Health Safety Net, which consists of co-occurring competent providers, delivers core, essential, outpatient, behavioral health services to an estimated 40,000 uninsured Tennesseans annually who meet program eligibility criteria through a network of community mental health centers. This includes: 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. Many of the services offered within the Behavioral Health Safety Net are evidence-based practices. Some of those services include:

Case Management: https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/case-management
Certified Peer Recovery Specialists: https://www.wsipp.wa.gov/BenefitCost/Program/336
Cognitive Behavioral Therapy: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/240/Collaborative-primary-care-for-anxiety-general-adult-population
Dialectical Behavioral Therapy:
https://web.archive.org/web/20180625174409/https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=36
Illness Management and Recovery: http://www.wsipp.wa.gov/BenefitCost/Program/288
Medication Management: http://store.samhsa.gov/product/MedTEAM-Medication-Treatment-Evaluation-and-Management-Evidence-Based-Practices-EBP-KIT/SMA10-4549

Motivational Interviewing for Individuals with SMI: https://www.wsipp.wa.gov/BenefitCost/Program/670
Wellness Recovery Action Plan (WRAP): http://www.wsipp.wa.gov/BenefitCost/Program/495

3. Describe your state's case management services

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

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

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

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

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

The Inpatient Targeted Transitional Support program provides the opportunity for individuals discharging from the Regional Mental Health Institutes, Crisis Stabilization Units, and State-Contracted Facilities to secure safe, affordable, permanent supportive housing with access to temporary financial assistance to obtain and maintain residence and related supports as they transition to community living. The Community Supportive Housing program provides flexible funding to provider agencies to offer supported housing for adults with mental illness or co-occurring disorders, while the new Supportive Recovery Housing provides similar services in supportive housing for individuals in recovery from substance use disorder. 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. The Intensive Long-term Support program provides supportive housing for individuals discharging from the Regional Mental Health Institutes, who need enhanced supportive services while living in the community. These enhanced services include on-site access to mental health care personnel, and access for opportunities in skill-building, educational, and life skills trainings and activities, to increase the functionality of each service recipient outside of the institutional setting.

Crisis 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. The State-wide crisis hotline is able to assist consumers in connecting with resources in their communities, if there is not an identified need for a mobile crisis assessment. 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.

The Behavioral Health Safety Net of TN is a state funded program that provides vital mental health services to uninsured adult Tennesseans and uninsured/underinsured Tennessee children who are eligible. The services provided through the BHSN of TN are intended to reduce hospitalizations and the recidivism rate. The services consist of: assessment and evaluation, therapy, case management, peer support services, psychosocial rehabilitation services, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination. Individuals actively enrolled in BHSN are less likely to require inpatient psychiatric care. In FY20, approximately 2.4% of individuals enrolled in BHSN were admitted to a Regional Mental Health Institute (RMHI) within 90 days of a BHSN service.

Through the First Episode Psychosis Initiative, four OnTrackTN teams provide individualized services to youth and young adults

experiencing a first episode of psychosis. Youth and young adults involved in these programs experience a large reduction in number and length of hospital stays. System of Care Across Tennessee provides intensive care coordination services, using High Fidelity Wraparound to families of children with an SED/SMI with the intent of reducing out-of-home placements, including hospitalizations. The Healthy Transitions(2)-Improving Life Trajectories initiative will utilize a young adult peer stabilizer that will be partnering with the child and adult mobile crisis teams at a local lab site, with the goal of reducing hospitalizations and increasing engagement in community-based services. The Clinical High Risk for Psychosis (CHR-P) program seeks to prevent or delay the onset of psychosis for youth and young adults who are at clinical risk for developing psychosis through a continuum approach to services.

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

TDMHSAS supports the Tennessee Mental Health Consumers' Association (TMHCA) in the Peer Intensive Care program, which places Certified Peer Recovery Specialists at the state's four Regional Mental Health Institutes to provide peer support services that include aftercare services in community to prevent recurring use of inpatient psychiatric services.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	376,195	192,292
2.Children with SED	100,249	90,136

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.

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.
(A) The Target population is adults with Severe Mental Illness (SMI) and children with Severe Emotional Disturbance (SED).
(C) Tennessee uses the URS tables for FY2020 to estimate the incidence of SMI and SED, because the URS tables contain aggregate data provided by the State Medicaid Authority, in addition to individuals served by the Tennessee Department of Mental Health and Substance Abuse Services.

If your state does not calculate these rates, but obtains them from another source, please describe.
(B) Tennessee uses the upper limit of 2019 NRI statewide prevalence estimates of adults with SMI.
Tennessee also uses the upper limit of 2019 NRI statewide prevalence estimates for the Level of Functioning score <=60 for ages 9 -17 as an estimate of children with SED.

If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.
N/A

Criterion 3: Children's Services

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

Criterion 3

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

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

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

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

Criterion 4

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

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

The Community Supportive Housing program and the Supportive Recovery Housing program provides opportunities for permanent housing in residential settings that are supplemented with access to support services, such as peer recovery, supported employment, and support staffing. Several of these residences are located in rural counties. The Targeted Transitional Support programs are designed to provide temporary financial assistance to individuals to obtain housing or related supports; this helps to avert homelessness during a time in which an individual is in the process of acquiring permanent financial means to sustain housing. Targeted Transitional Support services are delivered by a total of 16 community-based mental health services providers across the state to ensure accessibility to each county in the state. The Creating Homes Initiative seeks to assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable, and permanent housing options for people with mental illness, substance use disorders and co-occurring disorders. For this initiative, Regional Housing Facilitators and Regional Substance Use Housing Facilitators work in collaboration with the state's Continua of Care and many community stakeholders to create and develop these quality, safe, affordable and permanent housing opportunities. The Regional Housing Facilitators are geographically stationed in each of the Department's 7 Planning and Policy Council regions, and each are made accessible to all stakeholders and community members in each region, including all rural communities and counties across Tennessee for the purpose of pursuing and achieving the creation of new affordable housing opportunities.

Individual Placement and Support (IPS) Supported Employment is a model of employment with research indicating that it is a successful model for rural communities. Currently, IPS is offered in 37 counties, 27 of which are IPS Providers in rural communities. IPS is delivered in 22 programs across the state. There are seven Peer Wellness Coaches and one Statewide Peer Wellness Coach and Trainer in TN and programming is offered to clients regardless of their housing status throughout the state.

The Behavioral Health Safety Net of TN is available to eligible uninsured adult Tennesseans and uninsured/underinsured Tennessee children who live in rural areas of the state. There are 146 sites across the state in 71 counties, with 54 of those counties considered rural. In FY20, transportation became a permanent reimbursable BHSN service to help with transportation needs, especially in rural communities, to behavioral health services for individuals enrolled in BHSN. In FY20, in response to COVID-19, all BHSN services remain available via telehealth, which greatly improves access for those in rural communities.

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 amongst community stakeholders to meet the needs of rural consumers. Crisis services are available to all age groups and to individuals including those that present in rural county emergency departments, county, jails, consumer's residence, and/or are homeless. Crisis providers often partner with local law enforcement and ED personnel to trouble shoot technology assisted assessments to reduce response times ensure timely response to community locations, reducing average length of stay in emergency rooms and improving overall efficiency of limited crisis resources.

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

The Juvenile Justice Reform Diversion Grant Programs (JJR) provide community-based services and training to increase treatment options for juvenile courts to utilize across the state, specifically services and training that 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 targeted services to the homeless population.

Homeless populations within the State of Tennessee who are experiencing mental illness, substance abuse, or co-occurring disorders have a variety of programs available to provide permanent supportive housing and other financial services to facilitate independence in the community and increased access to behavioral health care. Most of these programs geographically span a wide array of communities in our state, including many of our rural counties. Two programs, the Projects for Assistance in Transition from Homelessness (PATH) and the Children and Youth Homeless Outreach Project (CYHOP), has the primary objective of conducting quality outreach efforts to individuals who are homeless or at risk for homelessness and facilitate opportunities for mental health, substance abuse, care coordination, and housing support services. Outreach efforts and services include active engagement with qualifying individuals, establishing positive working partnerships with area shelters, strengthening relationships with the local HUD Continuums of Care, collaborating with faith-based communities, fostering engagement with community organizations and institutions, partnering with local social services agencies and organizations, building collaborative relationships with homeless outreach workers outside of the program, advocacy efforts within the community, and disseminating information related to available mental health services. Additionally, limited, one-time financial support is available for immediate needs that can avert homelessness or imminent risk of homelessness, e.g., rent deposit, emergency food or essential items.

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

Tennessee's crisis continuum service is available to all Tennesseans experiencing mental illness, substance abuse, or co-occurring disorders in various settings. Crisis continuum providers can facilitate and assist with providing housing and homeless resources to those experiencing homelessness by referring persons to housing and homelessness programs at their community mental health center. The Office of Crisis Services and Suicide Prevention assists persons who are experiencing homelessness by cross-collaborating with the Office of Housing by meeting persons where they are at in the community to initiate stabilization and referring persons to Projects for Assistance in Transition from Homelessness (PATH) and SSI/SSDI Outreach, Access, and Recovery (SOAR) as needed.

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

The Older Adult Program provides care management to individuals over 50 who would not otherwise be eligible for these services. Services may include assessment, outreach, linkage, in home therapy and other supportive resources. In addition, community mental health education is provided to promote awareness regarding older adult and healthy aging issues. These services are provided to improve quality of life and to develop skills to enable the older adult to continue to live independently in the community and age in place. In FY19, the Older Adult Program was expanded to meet the growing need of Tennessee's aging population. Funding for the Older Adult Program increased 70% and allowed for two more community mental health centers to provide services. The expansion also allowed for coverage of more counties to be served, specifically in rural southwest and northeast Tennessee. In response to COVID-19, telehealth is being widely leveraged to provide care coordination services in the Older Adult program, which greatly improves access for rural communities.

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

Criterion 5: Management Systems

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

Criterion 5

Describe your state's management systems.

An important ingredient to maintaining high-quality behavioral health services is offer training and technical assistance opportunities for its workforce. Some of the recent trainings and ongoing workforce development initiatives are included in this section.

The Individual Placement and Support Statewide Virtual Conference hosted over 150 participants in September 2020. The conference is a collaborative effort between DMHSAS and DHS-VR and provides opportunity for direct service staff, VR counselors, IPS statewide leadership, and IPS community affiliates to celebrate progress made in serving individuals who pursue competitive work opportunities through the IPS Supported Employment initiative. Additionally, TDMHSAS supports a Statewide Peer Wellness Coach and Trainer to provide and coordinate health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and support assists providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

Each agency serving Older Adults has a designated allotment of funds to train staff in behavioral health issues facing Older Adults, in addition to systemic issues. These are to be used in a manner which will best fit their agency's operations and their regional population needs. In 2021, the annual Older Adult conference, entitled "Understanding Behavioral Health Care and Aging Needs" was held virtually with over 480 attendees with topics that included Alzheimer's disease treatment advances, older adults with substance abuse issues, impact of hearing loss on mental decline, and impact of chronic loneliness during COVID-19. The conference was approved for continuing education credits for several mental health-related professions.

Approximately 200 eligible individuals become certified as peer workforce annually from TDMHSAS certified programs including: Certified Peer Recovery Specialists (CPRS), Certified Family Support Specialist (CFSS) , and Certified Young Adult Peer Support Specialist (CYAPSS). Certified Family Support Specialists are afforded the opportunity to attend a spring, summer, and fall Peer Leadership Academy focused on ensuring the skills needed to provide quality peer services. Beginning in September 2021 young adults will have an opportunity to become certified as a Young Adult Peer Support Specialist aligning with the CPRS program.

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

TDMHSAS utilized new technical assistance funds from the PATH (Projects for Assistance in Transition from Homelessness) formula grant to hold its very first statewide Housing and Homeless Services conference in Spring 2021. Entitled "On Our Way Home: The PATH to Resiliency, Recovery, and Independence," the conference was held via virtual platform to optimize access and opportunity for stakeholders across the state to attend, regardless of scheduling challenges and/or inability to cover registration, travel and lodging costs. The conference provided education, information and awareness for a variety of topics impacting housing and homeless services and those who work within them; topics included evidence-based solutions and best practices in addressing homelessness; providing supportive housing for individuals with Serious and Persistent Mental Illness (SPMI); Peer Recovery Support; the Tennessee Creating Homes Initiative; and others. The conference featured a keynote speaker from the National Health Care for the Homeless Council to discuss the relationship between mental illness, health care and homelessness. A total of 364 people registered for the conference statewide, and the conference earned a 79% turnout rate, which was 2% higher than the calculated industry average.

In FY20, TDMHSAS launched a media campaign to promote the Behavioral Health Safety Net for Children. The statewide media campaign targeted parents and other people with roles in the lives of Tennessee children (teachers, coaches, pastors, etc.) as well as raising general awareness of supports for children and families. A statewide buy was placed on social media and spots on broadcast television were bought in Nashville, Memphis, Knoxville, Chattanooga, and northeast Tennessee media markets.

Statewide Crisis Phone Line receives more than 128,000 calls annually from Tennessee adults and youth. To increase awareness of the crisis line and increase call volume, we developed the Crisis Services Media Campaign. The Crisis Services media campaign of early 2019 was a statewide effort to increase awareness of Tennessee's Statewide Crisis Line and promote more positive outcomes in psychiatric emergencies. The messages of the campaign were carried through: 30 and :15 second video commercials that were displayed on television and social media. To date, the campaign received more than 9.4 million impressions statewide in television

and social media. The crisis continuum also assures that all crisis responders are adequately trained in all skills required for successful crisis intervention that also increases awareness and utilization of the most clinically appropriate and least restrictive services available. Crisis responders are required to successfully complete a self-study, web based crisis training and complete a booster training every three years. Additionally, a six hour specialized training is provided to qualified mental health professional that in part, qualifies them as Mandatory Pre-screening Agents (MPA), certified to write the first "Certificate of Need" after conducting the first assessment for involuntary psychiatric hospitalization. "Suicide Prevention in the Emergency Department" is a free online interactive training developed by the TDMHSAS, Mental Health America of Middle Tennessee, and the Tennessee Suicide Prevention Network to increase education for hospital emergency department staff about mental health and suicide, the screening, assessment, and referral process of patients at risk for suicide, environmental risk factors for suicide in the hospital setting, means reduction, and referral materials to provide to patients upon discharge.

The Fifth Annual Statewide Crisis Services Conference titled "Making A Difference: Celebrating the Heroes of Today" was virtually held on August 27, 2020. Celebrating the Crisis Services Heroes of Today which featured sessions ranging from community partnerships, providing crisis response to consumers with dual diagnoses, staying connected, and self-care for responders from TDMHSAS leadership, community providers/partners, and various dynamic practitioners/presenters. The tribute to TN's crisis service heroes led to discussions about barriers in rural and urban communities, lessons learned, and successes while learning to shift and pivot to meet vulnerable persons where they are at in the midst of the COVID-19 Global Pandemic

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? (●) Yes ( ) No

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

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

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

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

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

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

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

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

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

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

TDMHSAS has over 600 Certified Peer Recovery Specialists (CPRS's) throughout the state providing trauma-informed peer support services. Trauma-informed care is a key part of the required training to become a CPRS and on-going continuing education in trauma-informed care is encouraged.

TDMHSAS supports the Tennessee Mental Health Consumers' Association (TMHCA) in the Peer Intensive Care program, which places Certified Peer Recovery Specialists at the state's four Regional Mental Health Institutes to provide peer support services that include aftercare services in community to prevent recurring use of inpatient psychiatric services. This program is largely funded

through a partnership with Tennessee's Office of Criminal Justice Programs using VOCA (Victims of Crime Act) funding.

The School Based Behavioral Health Liaisons program expanded to all 95 counties. The grant contract language highlights using a trauma-informed approach to services in schools and aligns with Tennessee Department of Education's Multi-Tiered Systems of Supports school-based mental health model.

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

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Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

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

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

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

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

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

In an effort to divert youth and families from further juvenile court and DCS involvement, TDMHSAS, in collaboration with Department of Children's Services, Administrative Office of the Courts, Tennessee Commissioner on Children & Youth, juvenile courts, and grantee service providers, has implemented the Juvenile Justice Reform Local Diversion Grant (JJR Grant) program. The primary purpose of this program is to expand community-based services and training to provide treatment options for juvenile courts to utilize across the state, specifically services and training that are evidence-based and outcomes oriented. In addition, the JJR Grant aims to support Building Strong Brains (Tennessee's ACEs Initiative) by supporting youth served by the JJR Grant in building resiliency and educating professionals on responding in a trauma-informed manner.

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

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

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

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

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

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

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

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

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☑ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

Crisis Services are implemented through TDMHSAS state appropriations and TennCare (stated Medicaid authority) funding across the state. TDMHSAS partners with TennCare as the funding to support crisis services is a shared expense model to ensure that funding can sustained, as needed.

Funding from the 5% block grant set-aside is being utilized for the National Suicide Prevention Lifeline 988 Infrastructure Enhancements Program. The program provides support in increasing capacity of Tennessee's current National Suicide Prevention Lifeline (NSPL) crisis call centers as the state prepares for the implementation of the national 988 mental health crisis number. NSPL grantees utilize funds to enhance functionality and capacity to increase current in-state answer rate to meet the national standard of 90% or higher answer rate.

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

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

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

Please respond to the following:

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

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

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

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

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

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

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

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 recently launched 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. In addition, several programs within the Office of Children & Youth employ peers to provide recovery-focused services, including: Clinical High Risk for Psychosis (CHR-P), On Track TN (FEPI) and Healthy Transitions, which utilize Peer Recovery/Support Specialists, and System of Care Across Tennessee which utilizes Family Support Specialists.

TDMHSAS provides certification for Certified Peer Recovery Specialists in Tennessee.

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

Tennessee offers an array of recovery support services for individuals with substance use disorders. Recovery Services promotes client engagement in the recovery process and provides needed supports for continued recovery. Its structure has three service components to address the needs of individuals, communities, and the state – provider network, faith-based congregations/organizations, and Lifeline peer coordinators.

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

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

The Office of Housing and Homeless Services expanded housing solutions for Tennesseans with mental illness and/or substance abuse disorders with Creating Homes Initiative 2.0 (CHI 2.0), which increases the opportunity for further attention to rural communities in Tennessee, while also placing more emphasis on recovery housing. In SFY 2021, in response to a CHI 2.0 grant announcement of funding, a total of 110 new housing opportunities were created to provide quality residence to Tennesseans in recovery from substance use disorder. As a result of a renewed partnership, the Tennessee Housing Development Agency (THDA) committed to a one-time funding match for CHI 2.0, which resulted in an additional 74 new housing opportunities for Tennesseans in recovery from substance use disorder, in particular opioid use disorder. With continual efforts led by the CHI 2.0 Regional Substance Use Housing Facilitators, this initiative may expand the use of Oxford Housing, which are self-run, self-supporting homes for individuals in recovery from drug and alcohol addiction. In the coming year, the Office intends to further expand this initiative to include particular focus on the creation of new housing for Tennesseans experiencing mental illness and/or substance use disorder who re-enter the community from prisons and jails or have been previously incarcerated.

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

Fully co-occurring since 2013, Tennessee's Certified Peer Recovery Specialist trains and certifies individuals with lived experience of mental illness and/or substance use disorder. Currently, 604 CPRS serve as a role model for recovery and hope every day in Tennessee.

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

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

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

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Footnotes:

WebBGAS limits the ability to edit Yes/No responses. TDMHSAS provides all services/activities mentioned above.

Environmental Factors and Plan

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

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. 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.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

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

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

[64]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.

[65]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.

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

[67]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**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

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

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

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

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

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

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

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

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

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

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

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

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

The State of Tennessee provides integrated services through partnerships that have been developed throughout the state since the adoption of system of care in 1999. The system of care in Tennessee is governed by the legislatively mandated Council on Children's Mental Health (CCMH), which brings together individuals from across the state to discuss systems, projects, and programs that touch the lives of children and youth with mental health concerns. CCMH provides a venue, five times annually, for child serving agencies to discuss current trends within the state as well as potential barriers to service. The council has various ad hoc committees that identify and problem-solve issues around financing, policy, community readiness, marketing, and other areas related to the promotion of system of care across Tennessee. In addition to CCMH, there are numerous advisory boards, councils, and committees that system of care is represented to work toward improving the lives of young children, children, youth, young adults, and families across the state including: the Youth Transition Advisory Council, Healthy Transitions State Transition Team, Young Child Wellness Council, Association for Infant Mental Health in Tennessee, and the Tennessee Council on Autism Spectrum Disorder. System of care in Tennessee provides training on the use of high-fidelity wraparound which will further integrate services by providing wraparound services to children and families by bringing together systems to work toward a single treatment plan among child-serving agencies. Several of the department's children and youth programs offer integrated services at the local level by working with schools, the juvenile justice system, and child welfare services. Through the work of System of Care Across Tennessee TDMHSAS was able to secure $21 million in funding to expand the System of Care until 2024, $12 million in federal SAMHSA funding and $9 million interagency funding with the Department of Human Services Temporary Assistance for

Needy Families (TANF) program.

TDMHSAS partners with Tennessee Department of Education on a 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.

In the most recent legislative session Governor Lee announced a $250 million mental health trust fund to be used to expand mental health services across the state.

In August, an Announcement of Funding (AOF) is set to be released for the Tennessee Resiliency Project (TRP) to provide an additional $6.5 million in funding to increase resiliency in early childhood, school based, and crisis continuum settings.

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

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

The Children and Youth Homeless Outreach Project aims to identify and provide outreach services for the purpose of linking children with Serious Emotional Disturbance (SED) or children at risk of SED who are experiencing homelessness or at risk of homelessness, and their caregivers to mental health and housing services. The program provides services that help to prevent homelessness or positively affect the quality of life for the service recipients and their families/caregivers and help to keep the family unit intact. Outreach efforts and services include active engagement with qualifying children and families/caregivers, establishing positive working partnerships with area shelters, strengthening relationships with the local HUD Continuums of Care, collaborating with faith-based communities, fostering strong communication with schools, partnering with local social services agencies and organizations, building collaborative relationships with homeless outreach workers outside of the program, advocacy efforts within the community, and disseminating information related to available mental health services. Additionally, this program can provide limited, one-time financial support for immediate needs that can avert homelessness or imminent risk of homelessness, e.g., rent deposit, emergency food or household items.

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

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

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

Please respond to the following items:

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

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

The Tennessee Suicide Prevention Network (TSPN) is a public private network to address suicide in the state. The TN State Suicide Prevention Plan developed by TSPN with oversight by TDMHSAS is a comprehensive plan with a focus on Universal, Selective, and indicated interventions. TSPN is overseen by a Governor appointed Advisory Council. TSPN provides/coordinates with the state to provide gatekeeper training and postvention activities. The state also increased efforts to focus on interventions at the community level using evidence-based practices such as supporting screening with the Mental Health America (MHA) online screening tools for both MHA Tennessee affiliates and Youth/Teen Screen with TN Voices.

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

TDMHSAS continues to develop and promote an initiative to reduce suicide in working age adults called the Be The One Campaign: Suicide Prevention in the Workforce. The Be The One Campaign is a component of Tennessee's Zero Suicide Initiative and specifically designed for public and private sectors. The campaign is based on the premise that staff, collectively, can build a supportive workforce which values and affirms life. Be The One includes suicide prevention training, suicide awareness, social marketing strategies, and postvention guidance. As statewide engagement had increased new gatekeeper scenarios have been added, veteran and work from home specific scenarios, to better reach those at risk working aged adults.

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

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Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

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

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

Please respond to the following items:

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

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

If yes, with whom?

TDMHSAS continues to add new partners and/or enhance existing partnerships that help support the mission of the department. Examples include:

TDMHSAS continues to strengthen its partnership with the other primary funder of the state's public behavioral health system, TennCare (State Medicaid agency). This relationship continues to grow, specifically within the context of the state's crisis continuum, children's services, and substance use treatment. Additional key state agency partnerships include the TN Department of Intellectual and Development Disabilities, the Tennessee Department of Correction, the Tennessee Department of Children Services, the Tennessee Department of Human Services, and in wake of the COVID-19 pandemic, the Tennessee Department of Health. Tennessee is very fortunate to have an administration that stresses the importance of enterprise dependences, which in return, ensures for a more effective system of care for individuals living with behavioral health challenges.

TDMHSAS participates on monthly Tennessee Homeless Services calls, led by the Tennessee Department of Health and includes the Tennessee Housing Development Agency (THDA), the Tennessee Department of Human Services, the Tennessee Emergency Management Agency (TEMA), and the Tennessee HUD Continuums of Care, to provide agency and area updates, share information and resources, and discuss issues impacting efforts to serve individuals experiencing homelessness or are at risk of homelessness.

TDMHSAS has partnered with the Tennessee Housing Development Agency (THDA) in its expansion of the Tennessee Creating Homes Initiative (CHI) to increase focus on the creation of new, quality, affordable and permanent housing opportunities for individual in recovery from substance use disorders; this is known as Creating Homes Initiative 2.0 (CHI 2.0). This partnership is highlighted by THDA's commitment to a one-time $3 million match for the release of a grant funding opportunity to create new

affordable housing for this population; the match dollars resulted in new grant contracts with housing providers to create 74 new permanent housing opportunities in Tennessee. In the coming year, TDMHSAS intends to further expand the Creating Homes Initiative to include a specific focus on the creation of new housing for Tennesseans experiencing mental illness and/or substance use disorder who re-enter the community from prisons and jails or have been previously incarcerated. The Office of Housing and Homeless Services intends to establish a new partnership with the Tennessee Department of Correction to fortify this expansion with collaboration on strategic planning, insight, technical support and guidance, and resource alignment. Additionally, TDMHSAS will enhance its partnership with THDA towards this latest expansion of CHI. This multi-agency collaborative effort will serve to ensure a solid strategic infrastructure that promises to optimize the success of this latest expansion, both near-term and long-term. Through the Creating Homes Initiative and its expansions, Tennessee's Regional Housing Facilitators and CHI 2.0 Regional Substance Use Housing Facilitators will continue to utilize their expertise and skills in leveraging partnerships and resources to develop safe, quality, affordable, and permanent housing.

TDMHSAS has recently established a partnership with the Tennessee Department of Economic and Community Development (ECD) to provide insight, technical guidance and ancillary support in their leadership and management of their Recovery Housing Program, a HUD-funded Community Development Block Grant that is intended to fund transitional recovery housing for individuals with substance use disorders. Recent collaborative efforts involved the drafting of a proposed action plan, in preparation for release for public comment. Collaboration will continue through the grant process as needed.

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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

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

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

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

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

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

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

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

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

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

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

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

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Footnotes:

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

ALBERT RICHARDSON
CHAIR

RIKKI HARRIS
VICE-CHAIR

August 11, 2021

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

RE: FY 2022 Mental Health Block Grant Application

Dear Commissioner Williams:

The Tennessee Department of Mental Health and Substance Abuse Planning and Policy Council (TDMHSAS P&PC) is proud to support the Department in its work to serve people of all ages who have mental illness, serious emotional disturbance, and substance abuse disorders through an application for the FY 2022 Mental Health Block Grant.

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

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

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

Best regards,

Albert Richardson

Albert Richardson
Acting, 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 Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Bartholomew Allen	Providers	Lowenstein House	6590 Kirby Center Cove Memphis TN, 38115 PH: 901-334-3200	bartholomew.allen@lowensteinhouse.com
Richard Barber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Aspell Recovery Center	331 North Highland Avenue Jackson TN, 38301 PH: 731-694-0252	rbarber@aspellrecovery.com
Shara Biggs	Providers	Mental Health Cooperative	108 Hickory Way N Hendersonville TN, 37075 PH: 615-815-8894	sbiggs@mhc-tn.org
Renee Bouchillon	State Employees	Dept. of Human Services (Social Service Agency)	1400 College Park Drive Columbia TN, 38401 PH: 931-380-4636	renee.bouchillon@tn.gov
Jan Cagle	Providers	Ridgeview Behavioral Health Services	240 Tyrone Road Oak Ridge TN, 37830 PH: 865-482-1076	caglejg@ridgeview.com
Jim Casey	State Employees	Tennessee Department of Correction	320 6th Avenue North Nashville TN, 37243 PH: 615-253-8163	jim.casey@tn.gov
Jeff Fladen	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI	1101 Kermit Drive Nashville TN, 37221 PH: 603-785-7110	jfladen@namitn.org
Jessyca Foster	Youth/adolescent representative (or member from an organization serving young people)		6830 Conner Lane Chattanooga TN, 37421 PH: 423-508-7057	Jessycafoster1110@gmail.com
Paul Fuchcar	Persons in recovery from or providing treatment for or advocating for SUD services	CADAS	207 Spears Avenue Chattanooga TN, 37405 PH: 423-667-3311	paul.fuchcar@cadas.org
Amber Hampton	Providers	Mental Health America of Middle TN	446 Metroplex Drive Nashville TN, 37211 PH: 615-312-3113	ahampton@mhamt.org

Ben Harrington	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Mental Health Association of East TN	PO Box 32731 Knoxville TN, 37930 PH: 865-584-9125	ben@mhaet.com
Rikki Harris	Others (Advocates who are not State employees or providers)	Tennessee Voices for Children	500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-269-7751	rharris@tnvoices.org
Clarkton Harrison	Others (Advocates who are not State employees or providers)	U.S. Department of Veterans Affairs	1310 24th Avenue South Nashville TN, 37212 PH: 615-427-5207	clarkton.harrison@va.gov
Debbie Hillin	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Buffalo Valley, Inc	5465 Village Way Nashville TN, 37211 PH: 615-975-0196	debbiehillin@buffalovalley.org
Kayla Jackson	Parents of children with SED/SUD	Mental Health Cooperative	7004 Brittney Circle Baxter TN, 38544 PH: 931-319-7876	kayla.jackson@mhc-tn.org
Amanda Johnson	State Employees	Vocational Rehabilitation	400 Deaderick Street Nashville TN, 37243 PH: 615-770-5496	mandy.1.johnson@tn.gov
Elizabeth Jones	State Employees	Tennessee Department of Health	710 James Robertson Parkway Nashville TN, 37243 PH: 615-253-8483	elizabeth.jones@tn.gov
Jennifer Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		6000 Westfork Drive Smyrna TN, 37167 PH: 615-995-6069	celtic_path@comcast.net
Lynn Julian	Family Members of Individuals in Recovery (to include family members of adults with SMI)		110 Bon Air Circle Jackson TN, 38305 PH: 731-695-2276	virginia.julian@crestwynbh.com
Deanna King	Providers	Youth Villages	6236 Airpark Drive Chattanooga TN, 37421 PH: 423-954-8844	deanna.king@youthvillages.org
Wayne King	Family Members of Individuals in Recovery (to include family members of adults with SMI)		18752 Alberta Street Oneida TN, 37841 PH: 423-215-2607	trulight@live.com
Linda Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 474 McKenzie TN, 38201 PH: 731-418-9307	llewis38201@yahoo.com
Rebekah Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2716 Brenda Street Thompson's Station TN, 37179 PH: 615-330-7312	rebekah.l.lewis@vanderbilt.edu
Gayle Lodato	Providers	Helen Ross McNabb Center	9862 Baker Boy Drive Ooltewah TN, 37363 PH: 423-664-2849	gayle.lodato@mcnabb.org
Emma Long	Family Members of Individuals in Recovery (to include family		94 Labelle Street Jackson TN, 38301	emmalong@aol.com

	members of adults with SMI)		PH: 731-326-2041	
Senator Becky Massey	Others (Advocates who are not State employees or providers)		425 5th Avenue North TN, 37243 PH: 615-741-1648	sen.becky.massey@capitol.tn.gov
Debbie Miller	State Employees	Tennessee Department of Children's Services	315 Deaderick Street Nashville TN, 37243 PH: 615-741-9206	debbie.miller@tn.gov
Dawn Mitchell	Parents of children with SED/SUD		1010 Drummond Drive Nashville TN, 37211 PH: 615-293-0676	dawnmmitchell@yahoo.com
Brenna Morse	State Employees	Tennessee Department of Education	710 James Robertson Parkway Nashville TN, 37243 PH: 615-532-4774	brenna.morse@tn.gov
Michael Myszka	State Employees	Tennessee Bureau of TennCare (Medicaid)	310 Great Circle Road Nashville TN, 37243 PH: 615-507-6630	michael.myszka@tn.gov
Mary Neal	Providers	Connections Counseling	297 Mary Ann Drive Memphis TN, 38117 PH: 901-674-1728	maryneal.lpc@gmail.com
Robin Nobling	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI Davidson County	329 Harding Place Nashville TN, 37211 PH: 615-891-4724	rnobling@namidavidson.org
Mary Nelle Osborne	Providers	Peninsula Sevier Clinic	1104 Foxwood Drive Sevierville TN, 37862 PH: 865-970-9800	mosborn1@CovHlth.com
Kim Parker	Providers	Pathways	238 Summar Drive Jackson TN, 38301 PH: 731-541-8988	kim.parker@wth.org
Tim Perry	Providers	Frontier Health	2106 Moccasin Street South Kingsport TN, 37660 PH: 423-245-4263	tperry@frontierhealth.org
Representative Bob Ramsey	Others (Advocates who are not State employees or providers)		425 5th Avenue North Nashville TN, 37243 PH: 615-741-3560	rep.bob.ramsey@capitol.tn.gov
Albert Richardson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	C.A.A.P.	4041 Knight Arnold Road Memphis TN, 38118 PH: 901-360-0442	arichardson@caapincorporated.com
Constandina Savvenas	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	TAMHO	42 Rutledge Street Nashville TN, 37210 PH: 615-707-0257	csavvenas@tamho.org
Susan Seabourn	Providers	Centerstone	2400 White Avenue Nashville TN, 37204 PH: 615-460-4451	susan.seabourn@centerstone.org
Pamela Sessions	Providers	Renewal House	3410 Clarksville Pike Nashville TN, 37218 PH: 615-255-5222	psessions@renewalhouse.org

Samantha Slagle	Providers	Frontier Health	26 Midway Street Bristol TN, 37620 PH: 423-989-4500	sslagle@frontierhealth.org
Patrick Starnes	Family Members of Individuals in Recovery (to include family members of adults with SMI)		4325 Shady Dale Road Nashville TN, 37218 PH: 615-330-1832	trucare10@yahoo.com
Angie Thompson	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Metro Public Health Department	2500 Charlotte Avenue Nashville TN, 37209 PH: 615-340-8602	angie.thompson@nashville.gov
Don Watt	State Employees	Tennessee Housing Development Agency	502 Deaderick Street Nashville TN, 37243 PH: 615-815-2032	dwatt@thda.org
Eula Whittaker	Parents of children with SED/SUD		3323 Foxwood Drive Memphis TN, 38115 PH: 901-949-0661	e.l.whittaker@att.net
Marie Williams	State Employees	Tennessee Department of Mental Health and Substance Abuse Services	500 Deaderick Street Nashville TN, 37243 PH: 615-532-6500 FX: 615-532-6514	marie.williams@tn.gov
Rebecca Woods	Others (Advocates who are not State employees or providers)	Tennessee Primary Care Association	710 Spence Lane Nashville TN, 37217 PH: 615-425-5848	rebecca.woods@tnpca.org
Evelyn Yeargin	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health Cooperative	275 Cumberland Bend Nashville TN, 37228 PH: 615-743-1467	eryeargin@mhc-tn.org

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Footnotes:

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

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**47**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	9	
Parents of children with SED/SUD*	3	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	5	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**25**	**53.19%**
State Employees	9	
Providers	13	
Vacancies	0	
Total State Employees & Providers	**22**	**46.81%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Comments, changes, and questions were invited via email to the Director of Planning (author of the plan). The draft Plan was also sent to Statewide and Regional Council members to review and comment. No recommendations were made to modify the application.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

a) Public meetings or hearings? (●) Yes ( ) No

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

If yes, provide URL:

The draft plan was posted on the Tennessee Department of Mental Health and Substance Abuse Services website in the Planning and Policy Council area and on the home page at the following link: https://www.tn.gov/behavioral-health/planning1/mental-health-block-grant.html

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

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Footnotes: