

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2016

State DUNS Number

Number

878890425

Expiration Date

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

Agency Name

Tennessee Department of Mental Health and Substance Abuse Services

Organizational Unit

Division of Planning, Research and Forensics

Mailing Address

601 Mainstream Drive

City

Nashville

Zip Code

37243

II. Contact Person for the Grantee of the Block Grant

First Name

Suzanne

Last Name

Weed

Agency Name

Tennessee Department of Mental Health and Substance Abuse Services

Mailing Address

601 Mainstream Drive

City

Nashville

Zip Code

37243

Telephone

615-253-6396

Fax

615-253-1846

Email Address

suzanne.weed@tn.gov

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

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

8/29/2013 3:05:45 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Suzanne

Last Name

Weed

Telephone

615-253-6396

Fax

615-253-1846

Email Address

suzanne.weed@tn.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

The signed uploaded document can be found in the attachments for Tennessee's MHBG.

I: State Information

Assurance - Non-Construction Programs

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

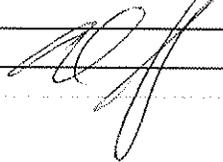
1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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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.

Name: E. Douglas Varney
Title: Commissioner
Organization: Tennessee Department of Mental Health and Substance Abuse

Signature: _____

Date: _____



8/14/13

Footnotes:

The signed uploaded document can be found in the attachments for Tennessee's MHBG.

I: State Information

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 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 by:

- 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).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

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

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)

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.

Name	E. Douglas Varney
Title	Commissioner
Organization	Tennessee Department of Mental Health and Substance Abuse

Signature: _____ Date: _____

Footnotes:

The signed uploaded document can be found in the attachments for

I: State Information

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 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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 45 CFR Part 76 by:

- 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;
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 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), (d), (e), and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
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3. Certifications Regarding Lobbying

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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.)
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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.

Name E. Douglas Varney
Title Commissioner
Organization Tennessee Department of Mental Health and Substance Abuse

Signature:  Date: 8/14/13

Footnotes:

The signed uploaded document can be found in the attachments for

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

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 I and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I 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.

Name of Chief Executive Officer (CEO) or Designee

E. Douglas Varney

Title

Commissioner

Signature of CEO or Designee¹: _____ Date: _____

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

Footnotes:

The signed uploaded document can be found in the attachments for Tennessee's MHBG.

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
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 as required by
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Name of Chief Executive Officer (CEO) or Designee

E. Douglas Varney

Title

Commissioner

Signature of CEO or Designee¹:



Date:

8/14/13

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

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I: 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	<input type="text" value="E. Douglas Varney"/>
Title	<input type="text" value="Commissioner"/>
Organization	<input type="text" value="Tennessee Department of Mental Health and Substance Ab"/>

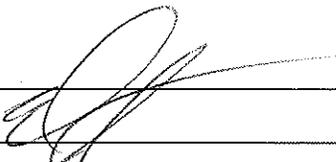
Signature: _____ Date: _____

Footnotes:

The signed uploaded document can be found in the attachments for Tennessee's MHBG.

DISCLOSURE OF LOBBYING ACTIVITIES

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

1. Type of Federal Action: <input checked="" type="checkbox"/> B a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance		2. Status of Federal Action <input checked="" type="checkbox"/> A a. bid/offer/application b. initial award c. post-award		3. Report Type: <input checked="" type="checkbox"/> A a. initial filing b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____	
4. Name and Address of Reporting Entity: <input checked="" type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ TX DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES. 601 MAINSTREAM DRIVE NASHVILLE, TN 37243 Congressional District, if known: 5			5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: <p style="text-align: center;">N/A</p> Congressional District, if known: _____		
6. Federal Department/Agency: HEALTH + HUMAN SERVICES SAMHSA			7. Federal Program Name/Description: MENTAL HEALTH BLOCIC GRANT CFDA Number, if applicable: _____		
8. Federal Action Number, if known:			9. Award Amount, if known: \$ _____		
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i> <p style="text-align: center;">NONE</p>			b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i> <p style="text-align: center;">NONE</p>		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.			Signature: 		
			Print Name: E. DOUGLAS VARNEY		
			Title: COMMISSIONER		
			Telephone No.: 741/1413 Date: 8/14/13		
Federal Use Only:			Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)		

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**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

N/A

Page

of

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Standard Form – LLL-A

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

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

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

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

II: Planning Steps

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

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

Section II, Step 1
Service Delivery Strengths and Needs

Strengths and Needs of the Service Delivery System

History of the Tennessee Department of Mental Health and Substance Abuse Services

In 1953, the Tennessee General Assembly created the Department of Mental Health and Mental Retardation to provide for better treatment and improved welfare of persons with mental illness or intellectual disability (then called mental retardation). In 2000, the General Assembly recreated the agency, changed its name to the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD), and passed a comprehensive revision of the mental health and developmental disability law, Title 33 of the Tennessee Code Annotated (TCA).

In 1973, under the Comprehensive Alcohol and Drug Treatment Act, the General Assembly gave the Department responsibility for developing programs for treating and preventing alcohol and drug abuse.

In 1975, the department was renamed the Tennessee Department of Mental Health and Mental Retardation to reflect services to individuals with intellectual disabilities (then called mental retardation). In July 1991, the Division of Alcohol and Drug Abuse Services was transferred to the Department of Health.

In 2000, the General Assembly recreated the agency, changed its name to the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD), and passed a comprehensive revision of the mental health and developmental disability law, Title 33 of the Tennessee Code Annotated (TCA). In 2007, the Bureau of Alcohol and Drug Abuse Services (BADAS) was transferred to TDMHDD from the Department of Health by executive order and codified in 2009. This transfer expanded the Department's authority for the provision of services and supports for persons with substance use disorders (SUD). In 2010, legislation was passed that created a Department of Intellectual and Developmental Disabilities (DIDD). The 2010 Legislature also changed the name of TDMHDD to the Tennessee Department of Mental Health (TDMH) effective January 15, 2011. Effective July 1, 2012, the Legislature changed the name of the Department of Mental Health to the Department of Mental Health and Substance Abuse Services (TDMHSAS) to more accurately reflect the mission of the agency.

Responsibility for services related to developmental disabilities and/or intellectual disabilities was transferred to the new Department of Intellectual and Developmental Disabilities. DIDD now serves as the state's developmental disability authority with responsibility to coordinate, set standards for, plan, monitor, and promote the development and provision of services and supports to meet the needs of persons with intellectual and developmental disabilities.

Purpose, Scope and Activities of the Department of Mental Health and Substance Abuse Services (TDMHSAS)

TDMHSAS serves as the State's mental health, substance use disorders, and opioid authority. The Department is responsible for system planning; setting policy and quality standards; licensing personal support services agencies, mental health and substance abuse services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who live with serious mental illness (SMI), serious emotional disturbance (SED), and substance

use disorder (SUD). Through the operation of four fully accredited Regional Mental Health Institutes (RMHIs), TDMHSAS also provides inpatient psychiatric services for adults, including acute, sub-acute, and secure forensic beds. TDMHSAS is headed by a Commissioner, a cabinet level appointee who has direct access to the Governor. Organizationally, the Commissioner oversees the Deputy Commissioner and Assistant Commissioners of the following Divisions: General Counsel; Planning, Research, and Forensics; Hospital Services; Mental Health Services; Substance Abuse Services; Clinical Leadership; and Administrative Services. These officials collectively comprise the Executive Staff.

TCA Title 33, the mental health and substance abuse law, requires TDMHSAS to establish a system of care that provides a comprehensive array of quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports based on the needs and choices of individuals living with mental illness, SED, and/or SUD. TDMHSAS leadership and staff could not fulfill this mission, however, were it not for the involvement of multiple stakeholders, including current and former consumers, their families, advocates, service providers, and other state agencies. In fact, Tennessee statute specifies that the aforementioned stakeholders advise the Department regarding policy, budget requests, and developing and evaluating services and supports. The statute also recognizes that the needs of this service population cannot be met by the Department in isolation but rather in conjunction with other human service agencies and programs. Therefore, there are ongoing and growing partnerships that exist between TDMHSAS and other state agencies such as the Department of Health, Department of Children's Services, Department of Education, Department of Correction and the Bureau of TennCare (Medicaid). This service delivery approach ensures a well-rounded systemic plan for identifying and meeting the needs of Tennessee's citizens.

The mental health and substance abuse law requires active citizen participation in service system planning through its statewide Planning and Policy Council (Council). The Council advises the Department in planning, policy development, legislative and budget proposals, and oversight of the State's comprehensive mental health service system. It also mandates that a majority of Council members be former or current consumers and family members (see TCA 33-1-401). Other members include consumer advocates for children, adults, and the elderly; representatives from state agencies; providers; and other affected persons and organizations. TDMHSAS has worked hard to not only recruit minorities, caregivers of children with SED, and Tennessee residents from rural areas, but also to ensure a balance of constituencies from both the mental health and substance abuse communities. At the time of the submission of this plan, the Councils (including seven regional and one state level) are fully integrated and highly functioning with leadership and membership from both the mental health and substance abuse organizations and communities, and consumer representation. The regional councils supply local membership representation and needs-based information to the state Council through spoken report at state Council meetings and written assessment when requested. In this way, Tennessee encourages, and the TDMHSAS Office of Planning facilitates, grassroots citizen participation in service delivery system planning.

TDMHSAS leadership collaborates with other state agencies to provide integrated service and support initiatives for shared service populations. For example, service integration for children is accomplished via multiple linkages and interactions between the primary child-serving Departments and the network of provider agencies. The Departments of Health, Education, Children's Services, and Mental Health and Substance Abuse Services each have complementary responsibilities for meeting the needs of children and youth. In addition, TDMHSAS has participated in collaborative federal grant projects with child welfare agencies, education, and the Administrative Office of the

Courts (AOC). The interface between juvenile justice and mental health systems has been particularly successful. The Department is also involved in two subcabinets, the Safety Subcabinet and the Children's Subcabinet, which focus on specific topics common to all state agencies. The Commissioners of each related agency are involved in the Children's Subcabinet and support the efforts for change and increased efficiency across agencies to safeguard the interests of children and youth in Tennessee and ensure the highest quality continuum of early identification and treatment available. The Public Safety Subcabinet seeks to implement a public safety action plan to significantly reduce drug abuse and drug trafficking, curb violent crime, and lower the rate of repeat offenders.

The majority of publicly funded mental health treatment and support services are provided by a network of community mental health agencies (CMHAs), various community organizations, and specialty providers through direct contract with TDMHSAS and TennCare, the State's Medicaid authority. Treatment services provide an extensive range of care from psychotherapy and medication management to crisis services and inpatient psychiatric care. Support services recognize the value of holistic wellness, and thus include a variety of consumer-led education, peer support, adult recovery services, prevention, early identification, and early intervention services for children and youth. TDMHSAS also contracts with individual community-based agencies for substance abuse treatment and prevention services.

TDMHSAS is also the recipient of the infrastructure expansion grant for Systems of Care (SOC), a treatment delivery modality that brings a specific and multi-systemic approach to children's services. Having operated several successful pilot programs in selected counties in recent years, the Office of Children and Youth Services (OC&Y) is preparing to implement a statewide SOC service delivery method over the next four years. By implementing SOC principles and addressing required changes in the delivery system culture, OC&Y will focus on the increased advancement of prevention, public awareness, trauma-informed care, recovery support, and data availability. This implementation will reveal gaps which may exist in the delivery of programming; bring together those organizations/agencies that work on behalf of children and their families; illuminate overlapping services which may help to increase efficiency; and ensure that children and their families receive the services needed. The SOC expansion is described in more detail under item two, Children and Youth Services, later in this document.

TennCare's Impact on the Service System

CMHAs and other nonprofit corporations that provide behavioral health services have historically met the needs of individuals with mental illness from all age groups and socioeconomic levels. Notably, these agencies have been the collective cornerstone of the community-based behavioral health system throughout the State since the 1950s and today serve as the primary provider network for the TennCare program.

Due to deinstitutionalization and the creation of Medicare and Medicaid programs in the 1960s, Tennessee, along with most other States, developed a parallel system to serve persons who were uninsured. State-owned and operated Regional Mental Health Institutes (RMHIs) and newly created CMHAs, both of which provided a continuum of outpatient community-based services funded through State contracts, began to operate concurrently. The CMHAs were required to offer services to all persons, regardless of ability to pay, through a sliding fee scale based on the person's income.

Those persons needing a deeper level of care could be referred to the RMHIs for evaluation and admission.

TDMHSAS's general revenue mental health dollars provided population-based grant funding to CMHAs to provide services to non-Medicaid and other uninsured or low-income residents within the CMHAs' designated service areas. Despite a shift in the late 1980s when persons with SMI were identified as the priority focus for Tennessee's public mental health system, this combination of financial resources allowed providers to cost shift from high revenue generating programs to cover the provision of reduced cost or free care to uninsured individuals.

The TennCare program, initiated in 1994 and administered by the Department of Finance and Administration (F&A), sought to create a comprehensive health budget in Tennessee using various funding sources, including those of TDMHSAS. The intent was to maximize federal matching dollars through the Medicaid match and provide a more seamless service delivery system while containing rising State expenditures. The TennCare program's coverage of persons who were uninsured and uninsurable, along with those who were Medicaid eligible, utilized a third party payer insurance model and placed all enrollees in managed care plans. The complexity of the public mental health system, however, led to the development of a "carve-out" of mental health and substance abuse benefits. Implemented in 1996, the TennCare Partners program was intended to protect funding for behavioral health benefits by providing a specialized focus that ensured services were provided by specialty providers and that behavioral health funding was not shifted to higher cost physical health services.

By 2003, the TennCare Partners program, managed by TDMHSAS, provided roughly 75% of the funding for public mental health services. Despite expectations to the contrary, not all uninsured persons with SMI were TennCare eligible. The State historically earmarked TDMHSAS funding to cover the costs of treating uninsured persons living with SMI. This funding was rolled into the State's share of the TennCare program creating a funding gap. Many community providers determined that they would no longer be able to carry the financial burden of serving the uninsured population with fees based on a sliding scale. For those agencies that struggled to continue serving this population (as a result of the commitment to the original mission), the challenges of doing so became increasingly difficult.

In 2005, major TennCare reforms presented the mental health system with the new challenge of serving a large influx of uninsured persons when the funding previously used had been incorporated into the TennCare global budget. The Department's solution to this dilemma was the program called the Behavioral Health Safety Net of Tennessee (BHSNTN) which was funded by the State to provide a limited range of core vital services to persons with SMI who were removed from TennCare eligibility. TDMHSAS partnered with CMHAs to provide these "safety net" services. The BHSNTN addressed a critical need successfully, although gaps grew for an increasing number of Tennesseans without insurance coverage experiencing mild to severe mental illness. Today, the program's budget has doubled and serves more than 32,000 individuals per year. In the absence of BHSNTN outpatient services, the remaining service access point for non-TennCare eligible persons would become inpatient services at the state operated RMHIs at a greater cost to funders.

In 2008, TennCare converted the separately managed (carved out) behavioral health arrangement to a fully integrated physical and behavioral health managed care system. As a result of this shift, TennCare assumed primary responsibility for and control of the Medicaid-funded behavioral health

service delivery system. The Department of Commerce and Insurance assumed some oversight functions for the Managed Care Organizations contracted to administer and fund the delivery system. The funding arrangement between TDMHSAS and TennCare changed substantially and, with the change, the budget of TDMHSAS was altered.

TDMHSAS maintains direct contracts for specific community mental health services (designed to ensure that service gaps are filled for those who are uninsured or underinsured) with CMHAs and which also contract with one or more of three Managed Care Organizations (MCOs) for the provision of TennCare reimbursed services. As a result of this bifurcated funding methodology, and the separate systems managed by each respective funding entity (TDMHSAS and TennCare), the Department continues to maintain a collaborative and consultative relationship with TennCare leadership and staff to ensure that the two separate agencies act in concert. In this way, TDMHSAS acts diligently to fulfill its mission to plan for and promote the availability of a comprehensive array of services and supports for those living with mental illness, SED, and SUD.

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

The Commissioner of the Tennessee Department of Mental Health and Substance Abuse Services has identified five priority areas to be addressed by programming statewide which are noted below. Many programs fit under multiple priority headings since most programming fits in more than one priority area. For the purposes of this Step (1), the description of each program will correspond with the priority area under which it is noted in Table 1-Step 3.

As the Affordable Care Act (ACA) is implemented in Tennessee, TDMHSAS is moving to ensure that programs and services fall wholly into the gaps in services provided by TennCare and other third-party payor coverage. The TDMHSAS remains committed to the provision and authority of a continuum of quality mental health services across the lifespan for Tennesseans both insured and uninsured. The mission of TDMHSAS is to continue to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation and rehabilitation services and supports based on the needs and choices of individuals and families served. To this array of services and supports, TDMHSAS adds the implementation of the ACA in that the services and supports provided fill the need created by implementation and transformation of the pre-ACA service delivery system.

Five Identified Priority Areas:

1. Uninsured Individuals
2. Children & Youth Services
3. Prevention
4. Recovery
5. Performance & Outcome Data

Many of the programs listed below could, because of the complexities of the programs funded, fall under different headings. In the Narrative Summary section, they may be noted under headings other than the ones under which they are listed in this document.

1. Uninsured Individuals

This priority addresses the needs of individuals who are currently neither eligible for Medicaid nor insured by Medicare or another third party payor. This priority also addresses those who may be between jobs or in the probationary period of a new job during which benefits have not yet been activated.

Programs addressing the uninsured population include:

Behavioral Health Safety Net of Tennessee (BHSNTN) offers community-based, core, vital services that people living with serious mental illness need to continue leading functional, productive lives. This includes assessment, evaluation, diagnostic, therapeutic intervention, case management, psychiatric medication management, psychosocial education, peer support services, labs related to medication management and pharmacy assistance and coordination.

The BHSNTN partners with 15 community mental health providers across Tennessee. The BHSNTN continues to provide core behavioral health services to more than 34,000 indigent individuals living with serious mental illness. As the state implements the Affordable Care Act, the plan for the future of the BHSNTN includes a shift to gap services for those who are uninsured who are not eligible for Medicaid and for those needing assistance in between periods of employment.

Beginning February 2013, the TDMHSAS added psychosocial rehabilitation and peer support services to services covered by the BHSNTN. The inclusion of psychosocial services assists individuals whose coverage does not address recovery-related services such as employment assistance or homelessness assistance. Psychosocial rehabilitation adds the recovery element to services covered by the BHSNTN.

Older Adult Services will provide services to the older adult SMI populations to assist with developing skills that will allow recipients to live independently in the community as long as possible. TDMHSAS contracts with four mental health services agencies across the state to provide in-home therapy, outreach services, screening, assessment and linkage services to individuals over the age of 50 who have mental health needs and who are not eligible for Medicaid. Older Adult Services programming helps to ensure that uninsured older adults receive the services that are needed to help maintain independence later in life.

Preadmission Screening and Resident Review (PASRR) evaluations were created in accordance with the Omnibus Budget Reconciliation Act of 1987, legislation which mandates that all individuals diagnosed with a mental illness, developmental or intellectual disability, or a related condition are to be screened before entering a nursing home.

This screening determines whether the individual's mental health and/or disability-related needs can be met by the services provided in the nursing home. Clinicians certified to conduct the screening assessments make recommendations on existing needs and whether or not the nursing home can meet the needs. In the event that needs cannot be met, and there is a need for specialized services other than that provided in the nursing home, recommendations appropriate to the need are made.

Evaluation after admission to a nursing home may also be a part of the PASRR process. The purpose of the program is to ensure that the needs of older adults are met. A goal impact of the

PASRR program is that nursing homes intake and/or attempt to serve fewer older adults with unmet mental health needs.

2. Children and Youth Services

Mental Health 101 provides educational programming for youth in middle and high schools in 18 eastern and middle Tennessee counties. The purpose of the programming is to offer support and educational materials to youth regarding mental health issues to help reduce stigma and to increase the number of at-risk persons who seek services.

Erasing the Stigma (I.C. HOPE®) offers mental health awareness curriculum for youth to promote understanding of mental illness and to reduce the stigma associated with mental illness.

The Child and Family Education Program is based on the With Hope in Mind program, providing free classes for caregivers about brain biology and specific brain disorders such as attention deficit disorder (ADD)/hyperactivity disorder (ADHD). Participants also learn coping skills, such as communication, self-care, problem management, advocacy, and organization and record keeping.

Violence and Bullying Prevention curriculum contains a violence prevention and resiliency enhancement program designed for youth in grades four through eight (4-8).

Family Support and Advocacy Program funds Tennessee Voices for Children's (TVC is an organization that acts as an active advocate for the emotional and behavioral well-being of children and their families by providing training, support, referral, prevention, and early intervention services) Statewide Family Support Network, a comprehensive family advocacy, outreach, support, and referral service provided statewide. This service also provides information and training to lay and professional groups.

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 plus the identification, assessment, and referral of children with Serious Emotional Disturbance (SED). The purpose of this program is to produce more socially/emotionally competent children which ultimately will lead to more productive citizens. The population served is all K-3 grade children and teachers in each elementary school served by the program. The goal of the program is to increase the number of children referred to necessary and appropriate mental health services. Consumer needs associated with Project B.A.S.I.C include teachers who need help dealing with problem behaviors, children who need mental health wellness education and help with normative developmental crises, and children at risk who may need to be referred to mental health treatment.

Renewal House offers services via three primary programs to women: Licensed Intensive Outpatient Program (12-15 weeks), Family Residential Recovery Program (up to 2 years), and Independent Recovery Apartments (Permanent/Unlimited). Renewal House's mission recognizes that women and children enter into recovery together when they arrive together at the facility. Block Grant dollars help to fund a regular program for both resident mothers and resident and off-site

children, addressing such issues as children's developmental needs, communication skills, discipline and consistency, and above all, alcohol and drug abuse primary prevention.

The Regional Intervention Program (RIP), an internationally recognized parent implemented program in which parents learn to work directly with their own children, is designed for early intervention for children up to age six years who have moderate to severe behavior disorders. Experienced RIP parents provide training and support to newly enrolled families. RIP is a parent-implemented program supported by a small professional and paraprofessional staff. Parents serve as primary teachers and behavior change agents for their own child as well as facilitators of the program for other parents. The goal and objective of this program is a reduction in the number of problem behaviors of RIP enrolled children after having participated in services.

Consumer needs met by RIP consist of parenting skills for parents who have a need and a desire to produce socially/emotionally competent children and to learn how to interact effectively with their children. The RIP program is open to all socio-economic levels, ethnicities and age groups. However, the targeted population is parents who need to learn effective child-interaction techniques.

Child care consultation programs will provide training and technical assistance coaching on the Pyramid Model (CSEFEL) strategies to Project B.A.S.I.C. staff, with a focus on 10 selected Project B.A.S.I.C. implementation sites, and to a few selected early childhood education centers across the state.

The System of Care (SOC) initiatives and expansion: TDMHSAS oversees and administers three federally funded SOC demonstration initiatives currently in seven counties. Each grant provides funding and technical assistance to local communities to build and sustain Systems of Care for children and youth diagnosed with serious emotional disturbance (SED) and their families. SOC are grounded in a values based framework, which includes being family-driven, youth-guided, community-based, and culturally and linguistically competent. SOC values and principles place the child and family at the center of this values-based approach to service delivery and system collaboration and assemble a network of effective formal and informal supports around the family. TDMHSAS partners with child serving departments, agencies, service providers, youth, families, and other stakeholders in developing comprehensive and coordinated Systems of Care and the infrastructure to support and sustain effective and appropriate services for children and youth with intensive mental health needs.

The Statewide System of Care Expansion Initiative (SOC-EXP) implementation grant was awarded to the TDMHSAS in October 2012. Implementation of the grant will fundamentally change the way mental health services are provided to children in Tennessee.

The focus of the expansion grant is infrastructure and workforce development through the creation of a statewide sustainable SOC Technical Assistance Center. In addition TDMHSAS will be developing a strategic financing plan for long-term sustainability of the SOC approach in Tennessee.

TDMHSAS has established four overarching goals and objectives for the SOC Expansion Implementation Grant:

- 1) Implement state-level policy, administrative and regulatory changes promoting and sustaining a statewide SOC infrastructure, including a strategic financing plan;

- 2) Facilitate increased access to and expand or enhance the coordinated system of services, supports, and individualized care management for children and youth with serious emotional disturbances and their families;
- 3) Create and implement sustainable training and technical assistance strategies that facilitate ongoing learning, coaching and practice improvement, and supports fidelity to SOC values and principles; and
- 4) Expand the existing support and advocacy base for a statewide System of Care.

The SOC expansion is a grant funded initiative.

Planned Respite and Respite Voucher programs are contracted with local agencies statewide to provide a break for caregivers of a child who is diagnosed with SED. Almost 400 families annually receive respite services either on an emergent basis or on a planned basis. The purpose of the program is to preserve the family and protect the mental health of the child and the parent. Respite also helps to prevent child abuse.

Homeless Outreach Project (HOP) identifies children, youth, and their families in which there is a diagnosis of SED who are homeless or at risk of homelessness. HOP provides short-term services that link children, youth, and their families to more permanent housing as well as provides mainstream case management, mental health treatment and/or other social services to help remove the threat of homelessness.

Office of Consumer Affairs (OCA) Ombudsman Program offers direct assistance to individuals and families who are experiencing problems accessing mental health services and supports through Consumer Advocates.

Family Support Specialist Certification Program provides state certification for individuals who provide direct caregiver-to-caregiver support services to families of children and youth with emotional, behavioral, substance abuse, or co-occurring disorders.

Therapeutic Intervention, Education, and Skills (TIES) features programming for children age 17 and younger who are either in out-of-home placement or at risk of removal due to parent/caretaker substance abuse. The TIES program will create a collection of outreach, treatment, education, counseling, and supportive services for children and families affected by substance abuse and trauma. The program will be operated in conjunction with the Seeking Safety curriculum for victims of trauma and the evidence-based Homebuilders model, which is an intensive, in-home crisis program that has already been used successfully around the nation to help keep children in their homes. TIES is a grant funded program.

Building Strong Families in Rural Tennessee (BSF) consists of a grant-funded intensive in-home service (Intensive Family Preservation Services program using an evidence-based model) to families of children, ages birth to eighteen, who are currently in or at-risk of out-of-home placement. Risk may result from a parent's or caregiver's substance use. This program is offered in eight counties in rural Middle Tennessee.

The Tennessee Integrated Court Screening and Referral Project involves a collaboration between the Office of Forensic and Juvenile Court Services and the Administrative Office of the

Courts (see Forensic Services, below). The program includes placing certified Family Support Providers in four juvenile courts to assist youth in legal trouble and their families in gaining access to mental health, substance abuse and family services.

Forensic Services and the Office of Forensic and Juvenile Court Services provides comprehensive mental health evaluations on forensic issues ordered by juvenile courts on youth alleged to be delinquent. The program collaborates with the Administrative Office of the Courts, Vanderbilt University Center of Excellence, Tennessee Commission on Children and Youth, Department of Children's Services and Tennessee Voices for Children on a federal grant to train youth service officers to complete mental health and substance abuse screening for youth in juvenile courts. Referrals to appropriate services are made if needed based on screening results.

Mobile Crisis Services offers 24/7 toll-free telephone triage and intervention, face-to-face services to citizens of Tennessee. Services include:

- prevention, triage, and intervention;
- community screenings by a mandatory prescreening agent;
- evaluation and referral for additional services and treatment;
- stabilization of symptoms;
- mobile services to wherever crisis is occurring in the community whenever possible;
- follow-up services to wherever the crisis is occurring in the community whenever possible; and
- follow-up services for behavioral health illness, a crisis situation, or a perception of a crisis situation.

Crisis Respite Services is a voluntary admission service that offers 24/7 support with behavioral health treatment, including medication management, illness management and recovery services with a focus on short-term stabilization to youth 18 years of age or younger.

Professional Services (Support for Mental Health Professionals): The Tennessee Department of Mental Health and Substance Abuse Services, in cooperation with the TDMHSAS Advisory Panel on Best Practice Guidelines, has developed guidelines for use by psychiatrists, primary care physicians, psychologists, health service providers, nurses, nurse clinicians, physician extenders, social workers and other health care professionals to:

- Promote high quality of care for adults and children served by Tennessee's public health system;
- Aid in identification, evaluation, and provision of effective treatment for persons with severe mental illness and severe emotional disorders;
- To promote continuity of care through establishment of uniform treatment options and the best use of multidisciplinary treatment resources; and
- In February 2013, TDMHSAS published the updated and expanded Behavioral Health Guidelines for Children and Adolescents: Birth through 17 Years of Age. Behavioral Health Guidelines for Children and Adolescents is published on the TDMHSAS website for use by any and all parties at <http://tn.gov/mental/omd/omdbpg.html>.

Youth Screen consists of a national mental health and suicide risk-screening program for youth. The purpose of the program is to ensure that all parents are offered the opportunity for their teens to receive a voluntary mental health check-up at their school.

3. Prevention

The Emotional Fitness Centers program consists of a faith-based initiative in Memphis and Shelby County that provides funding for Peer Advocate Liaisons (PALS) in churches in underserved African-American communities. The Liaisons assist parishioners in identifying behavioral health needs and help to successfully navigate the behavioral health system with the goal of increasing utilization of mental health and substance abuse services. Desoto and Hardeman Counties offer satellite sites for residents outside Shelby county.

Suicide Prevention. The state of Tennessee provides funding for Tennessee Lives Count, the Tennessee Suicide Prevention Network, and Project Tennessee/Jason Foundation, to supply comprehensive suicide prevention across the lifespan.

The Jason Foundation's Suicide Peer Awareness program, entitled A Promise for Tomorrow, is comprised of an intensive two-hour curriculum that incorporates education for teachers, students and parents about the signs of suicide. The curriculum teach tools and resources needed to identify at-risk youth.

The Tennessee Lives Count (TLC) youth suicide early prevention/intervention project is funded through a federal Garrett Lee Smith grant made possible by the Garrett Lee Smith Memorial Act through SAMHSA. TLC serves youth ages 10 to 24. Prevention/intervention services are provided through suicide gatekeeper training to adults who work with youth. TLC uses best practice approaches in gatekeeper training.

The Tennessee Suicide Prevention Network (TSPN) is a statewide public-private organization and association of agencies, advocates, consumers, professionals, physicians, clergy, journalists, social workers, law enforcement as well as survivors and attempters. TSPN develops and oversees the implementation of the Tennessee Strategy for Suicide Prevention to do the following:

- eliminate and reduce the incidence of suicide across the lifespan,
- reduce the stigma of seeking help for mental health problems that lead to suicide, and
- educate Tennesseans about suicide prevention and intervention.

TSPN adheres to the public health model to help reduce the incidence of suicide. Through its membership and directly, TSPN provides Question, Persuade, Refer (QPR) suicide prevention gatekeeper training, social marketing/awareness, TIP 50 and 101 training to substance use/abuse providers. TSPN is autonomous but has administrative oversight provided by Mental Health America of Middle Tennessee. TDMHSAS has adopted as its own the statewide suicide prevention strategy developed and published by TSPN. The prevention strategy is presented in its entirety in this Block Grant application, specifically item S of the Narrative Plan section entitled Suicide Prevention.

The most important objective of the suicide prevention programs is to raise awareness among Tennesseans that suicide is common and preventable. Another important aspect of suicide prevention in Tennessee is that programs cover the life spans of humans and address gender-specific needs. Specific populations have been targeted and include the African-American community, LGBTQ, college-aged persons and older adults. TDMHSAS' Division of Clinical Leadership implements evidence-based practices and provides Civil Rights Compliance and suicide prevention activities which include Suicide Prevention and the African-American Faith Communities Conferences and activities related to suicide prevention in the faith communities/places of worship. SAMHSA strategic initiatives addressed by this programming are prevention and special consideration for military personnel and their families.

The ***Shield of Care*** component of the state's suicide prevention strategy comprises the progressive emerging approach to prevention. The Shield of Care is ground-breaking suicide prevention curriculum designed specifically for persons who work in juvenile justice facilities. The culmination of three years of development, the curriculum is based on studies of suicide in juvenile justice settings, best practice literature, lived experience providing community general suicide gatekeeper training in Tennessee's juvenile justice facilities, and input from a workgroup with broad membership of juvenile justice and child-serving stakeholders. Focus-group style input from juvenile justice facilities staff that included clinical, security and educational disciplines helped assure that the content would be relevant and useful to those working in the field. The curriculum combines didactic material, group activities and dramatized scenarios in video clips to help participants develop skills to *See* suicide risk, *Protect* the physical and emotional safety of youth, *Listen* to youth express their feelings, *Assess* the severity of risk, and *Network* with other staff to prevent suicide, forming the Shield of Care S-PLAN. All training materials, including trainer and participant workbooks, PowerPoint with embedded video clips and wallet cards are posted on the TDMHSAS website. The Shield of Care program was recently accepted to the Suicide Prevention Resource Center's (SPRC's) Best Practice Registry (BPR), which is a collaborative effort with the American Foundation for Suicide Prevention and SAMHSA.

Suicide is a major public health problem and the most preventable type of death. Tennessee has been a national leader in suicide prevention and has contributed to the knowledge base regarding suicideology, including the development of the Shield of Care curriculum for juvenile justice, a first of its kind. Tennessee has more vendors answering the *Lifeline*, the suicide warmline, and is often cited as having one of the best suicide prevention networks nationally. In January, February, and March of 2012, *Lifeline* answered 3700 calls from those needing help or support. In the same time period of 2013, *Lifeline* answered 4295 calls, an increase of almost 16%. Suicide rates for youth have decreased in Tennessee in recent years, a clear demonstration of the effectiveness of Tennessee's prevention programming.

Disaster Mental Health Response is a presently unfunded program because there are no recent or active federal disaster areas declared in Tennessee (at the time of this application). A workgroup operated through the Division of Mental Health Services will develop infrastructure to respond to mental health needs in the event of a disaster. Infrastructure will include a provider network, satisfaction surveys and a strategy for monitoring. In the event of a disaster, the program will be ready to activate and serve those affected Tennesseans.

Crisis Continuum programming is designed to improve access to timely mental health care for individuals in crisis, reduce costs associated with inpatient hospitalization, reduce the rate of suicide,

and reduce inappropriate incarceration. The populations served by Tennessee's crisis continuum are adults and children with mental health and/or substance abuse issues experiencing a crisis, of all minorities, ages, genders, and payer sources. Consumer needs associated with this program are 24/7 access to mental health and/or substance abuse assessment and referral within two hours from the time the [crisis] call is received. The continuum ensures the appropriate and least restrictive level of care necessary to promote the stabilization and recovery of individuals in need.

Desired outcomes for Crisis Continuum programming are as follows:

- through the use of telehealth technology, reduce the number of transports to an RMHI that result in a non-admit decision;
- increase access to community services for children and youth with special needs;
- prevention of inappropriate psychiatric hospitalization;
- reduce the number of occurrences that a youth is unable to access needed services;
- decrease amount of time from request for services to time services are accessed; and
- reduce wait times when psychiatric hospitalization is indicated.

Programs offered within the crisis continuum (focused solely on prevention):

1-855-CRISIS-1 or (1-855-274-7471) is available 24/7/365 for individuals within the state of Tennessee who are experiencing a behavioral health crisis. The service provides, via the Crisis Hotline, as well as the default responder line, "live" answering by qualified and trained crisis triage personnel within three (3) minutes. Responders conduct telephonic crisis assessment, intervention, and triage until the individual can be linked to the crisis provider serving the area from which the telephone call originated and/or the area where the individual is physically present. This program ensures individuals experiencing a mental health crisis receive immediate and appropriate intervention.

Mobile Crisis Services offer 24/7 toll-free telephone triage and intervention, face-to-face services. Services include:

- prevention, triage, and intervention;
- community screenings by a mandatory prescreening agent;
- evaluation and referral for additional services and treatment;
- stabilization of symptoms;
- mobile services to wherever crisis is occurring in the community whenever possible;
- follow-up services to wherever the crisis is occurring in the community whenever possible; and
- follow-up services for behavioral health illness, a crisis situation, or a perception of a crisis situation.

Crisis Respite Services is a facility-based, voluntary service that offers 24/7 support with behavioral health treatment, including medication management, illness management and recovery services with a focus on short-term stabilization to adults 18 years of age or older.

Crisis Stabilization Unit (CSU)/Walk-In Services is a non-hospital, facility-based voluntary service that offers 24/7 intensive, short term stabilization and behavioral health treatment for persons 18 years of age and older. Those individuals utilizing CSU services must have a

behavioral health condition that does not meet the criteria for involuntary commitment to a psychiatric hospital or other treatment resource. Services provided by a CSU are limited to ninety-six (96) hours. CSUs provide assessment and evaluation, early intervention, prevention, stabilization, referral, and follow-up services. Individuals receiving CSU services generally seek assistance in obtaining appropriate behavioral health services or linkage of services to achieve or improve a prior level of functioning following a crisis situation.

Child and Youth Mobile Crisis Services consists of community-based services that offer: 24/7 toll-free telephone triage and intervention as needed;

- face-to-face services including prevention, triage, and intervention;
- community screenings by a mandatory prescreening agent;
- evaluation and referral for additional services and treatment;
- stabilization of symptoms;
- mobile services to wherever the crisis is occurring in the community whenever possible, and;
- follow-up services for individuals under the age of eighteen (18) who are experiencing a crisis secondary to a behavioral health illness or serious emotional disturbance.

4. Recovery

Creating Homes Initiative (CHI) puts forward an overarching purpose of creating affordable permanent housing with supports as needed accessible to people living with mental illness or co-occurring disorders. Since the year 2001 and effective February 2013, CHI Tennessee has leveraged \$373 million to help provide stable housing for those who are living with mental illness or co-occurring disorders. The objectives of CHI are to assist local communities with maintaining existing housing opportunities while creating 500 new or improved affordable, appropriate and integrated permanent housing opportunities. Goals are as follows: avoid psychiatric hospitalization; avoid criminal justice involvement and other social problems; enhance the ability to recover; and help individuals become productive contributing members of the community. Housing options fall along a continuum from 24/7 supportive living facilities (most restrictive) to achieving home ownership (least restrictive) for people with mental illness or co-occurring disorders. Individuals may access available affordable housing opportunities through assistance in accessing housing websites and community education.

Global priorities met by CHI include: tertiary prevention of future hospitalization by population at highest risk; health care reform by increasing access to appropriate high-quality recovery services; support of integrated, coordinated care, especially for people with behavioral health conditions; and recovery support by ensuring that permanent housing and supportive services are available for individuals living with or in recovery from mental illness and substance abuse disorders. Consumer needs associated with this program include the need to access and maintain safe, affordable, integrated permanent supportive housing to advance their recovery. The population served by CHI is adults with a history of mental illness or co-occurring substance abuse disorders who have very low income.

Community Supportive Housing provides flexible funding to agencies that offer supported housing for adults diagnosed with mental illness and co-occurring disorders. Staff members also coordinate outside activities for residents and work one-on-one to develop a housing plan that

identifies the consumer's ideal housing goal and the steps needed to achieve more independent living.

Emerging Adult Services (formerly Transitional Youth Program) provides supportive housing with individualized treatment and support for young adults ages 18-25 living with a mental illness, substance use disorder, or co-occurring disorders; and who are transitioning out of foster care or out of treatment for these conditions. The program goal is to guide youth from adolescence into adulthood as productive citizens who are in recovery and to help recipients to contribute positively to society up to their maximum individual potential. In addition to residential services, youth receive mental health and substance abuse treatment, education and employment training and life skills training such as wellness, financial management, relationship building and household management. Supervision and support activities meet the needs of the individual youth and decreases in intensity as the service recipient gains more independence.

Consumer Family Support provides funding to mental health advocacy organizations in Tennessee including Tennessee Mental Health Consumers Association (TMHCA), National Alliance for Mental Illness (NAMI) Tennessee and Frontier Health. TMHCA, a statewide organization, represents mental health consumers and offers support through advocacy, peer support, and education. Consumer Family Support funding is allocated to the infrastructure of the TMHCA, its advocacy activities, and the BRIDGES education program. BRIDGES stands for Building Recovery of Individual Dreams and Goals through Educations and Support. BRIDGES is a peer-taught psychoeducational course on mental illness, mental health treatment, and self-help skills. NAMI Davidson County receives funding to support infrastructure, parent support groups, and the "With Hope in Mind" educational course. NAMI Tennessee receives funding to support infrastructure, affiliate groups, and the "With Hope in Mind" educational course. Frontier Health receives a small grant to support consumer support groups.

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

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

My Health, My Choice, My Life delivers services in Peer Support Centers, Addictions Disorder Peer Recovery Support Centers, Psychosocial Facilities, and Intensive Long-term Support Programs.

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

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

The recommended length and timeframe of CDSMP and DSMP is 2.5 hours per week for 6 weeks. Recommended class size is 10-16 people.

Each individual who participates in the CDSMP and Peer Wellness Coaching will need to participate in a pre-, post-, and re-assessment. The assessment includes the NOMS, Recovery Assessment Scale, Health and Self-Management Questionnaire, and Additional Health Behaviors Questionnaire and is completed by a My Health, My Choice, My Life regional peer wellness coach.

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) grant is used in Tennessee to expand the state certification for peer specialists to include individuals who have lived experience with substance use disorders by transforming the current model into a co-occurring peer recovery specialist model. BRSS TACS also includes a statewide strategy to educate community behavioral health providers about peer recovery specialists. BRSS TACS identifies and develops the initial training required for peer recovery specialists and addresses the training needs of supervisors. This growing program has the potential to impact the lives of thousands of people who live with mental illness, substance use disorders, or both. This program focuses on recovery.

Adults who are diagnosed with mental illness, substance use disorders or co-occurring disorders who train to become certified peer recovery specialists may be served by BRSS TACS. Community and consumer needs for peer support and recovery education are supported by the program.

Outcomes that address recovery needs for the BRSS TACS program are as follows:

- A well-trained workforce of certified peer recovery specialists throughout the state with lived experience of mental illness, substance use disorders, or both;
- A specially-trained workforce of mental health professionals who supervise peer recovery specialists;
- Medicaid reimbursement for peer support provided by certified peer recovery specialists who have lived experience of substance use disorders;
- A minimum of thirteen (13) individuals who complete each peer recovery specialist certification training;
- A minimum of forty-five (45) graduates of the peer recovery specialist certification training per quarter;
- Ongoing infrastructure for certification trainings, including Wellness Recovery Action Plan (WRAP) trainings;
- Clear communication to stakeholders statewide to help potential peer recovery specialists achieve certification;
- Relationships with educational institutions to provide peer recovery specialists as speakers for students in behavioral health fields;
- An integrated, statewide consumers' organization with membership of people with lived experience with substance use disorders or mental illness;
- Connections with community colleges and other academic institutions to explore possibilities for college credit for certification training, and;
- Grassroots progress toward further integrating mental health and substance use disorder systems.

Consumer-operated Peer Support Centers are spaces where adults diagnosed with mental illness or co-occurring disorders develop their own programs to supplement existing mental health services and support services. Peer Support Center staff members promote the involvement of individuals in treatment and recovery and assist them in acquiring the necessary skills for the utilization of resources within the community. This is accomplished by providing education, support and socialization. Consumer needs associated with the PSC program include recovery, education, support, and opportunities for social interactions. The current Peer Support Center program is operated through contracted mental health agencies serving as host agencies for the Peer Support Centers.

Peer Support Center participation reduces reliance upon more costly professional services and programs. Adults ages 18 and over who have serious and persistent mental illness may receive services at the Peer Support Centers. All staff members of each center are mental health consumers who have completed training as a peer specialist. The director of each Peer Support Center must be certified as a peer specialist. The Peer Support Center's activities are directed and planned by the member participants.

Goals and objectives of the Peer Support Centers are:

- create educational opportunities on implementing recovery principles and practices at the local level;
- identify, plan for, and prioritize transportation issues;
- assist individuals to develop a Wellness Recovery Action Plan (WRAP);

- improve the advertising of Peer Support Center services and to invite members of the Behavioral Health Safety Net of Tennessee (BHSNTN) to take advantage of the recovery opportunities available at Peer Support Centers; and
- develop a strategy for reaching out to youth in transition and invite them to participate in recovery opportunities.

5. Performance and Outcome Data

The TDMHSAS Commissioner created the Office of Research in 2011. The purpose for the Office of Research is to provide data to the Commissioner, Governor, providers, stakeholders and staff that informs the delivery system planning process. The Office of Research develops data regarding policy, programs, and state standing on the national stage via a variety of statistics collected from various sources. The Research Team and the Office of Planning work collaboratively with TDMHSAS staff to ensure that Tennessee's resources for mental health and substance abuse services are efficiently and effectively utilized and that decisions made are data-informed and data-driven. The Research Team supports policy makers by providing the information, data, and research necessary to make informed decisions and measure the effectiveness and efficiency of projects and programs.

In collaboration with the Division of Clinical Leadership, and in addition to the core purposes for the Office of Research, the data and information produced by the Research Team helps to produce best practice guidelines for use by psychiatrists, primary care physicians, psychologists, health service providers, nurses, nurse clinicians, physician extenders, social workers and other health care professionals. Guidelines are published for use with adult and children's services and will later add specialized guidelines for substance abuse and senior services. The Division of Clinical Leadership also manages the Institutional Review Board (IRB) which publishes requirements and guidelines for original research. The IRB may also review proposals for original research projects to ensure that the guidelines for ethical research are followed by researchers.

Through funding from SAMHSA's Data Infrastructure Grant, TDMHSAS has collaborated to form a partnership with the Tennessee Association of Mental Health Organizations (TAMHO) to build on an already-existing data warehouse utilized by many of the TAMHO member organizations. The Department is hopeful that the **Behavioral Statistics System for Tennessee (BeSST)** will be finished in the winter of 2014 and ready for use by all Tennessee service organizations providing behavioral health services in 2015. The purpose of the BeSST is to ensure that services provided are beneficial to recipients and to discover trends and practice information in Tennessee at large.

As a part of the data-informed effort in Tennessee, the development of useful and accurate outcome measures has stepped front and center in the planning and research operations of TDMHSAS. The Department's Three-Year Plan, a plan required by state law, includes measurable outcomes for all programs that are described in this grant document. Each program manager develops strategies for ensuring that measures of success are readily available for each program. Those strategies and the applicable outcomes are reported annually to the Commissioner and the Governor. The Three-Year Plan is updated annually to ensure that all priorities, goals and strategies for reaching the goals are applicable to current needs, trends and data. Item 2 in the Planning Steps section provides more information regarding Tennessee's data and information trends.

To confirm that state and federal dollars are spent responsibly and that money is expended to fund programs that are needed and that benefit recipients, each program is monitored by the program manager. In addition, language is added to the contracts of each provider to bind the purchased service to the applicable law and to the best practice or curriculum associated with the program. Each contract includes appropriate language related to state and federal law and each provider is accountable for complying with all state and federal law including, but not limited to, requirements for audited financials, compliance with non-discrimination laws, background checks and credentialing for employees, etc. The current draft of the TDMHSAS Quality Assurance Quality Improvement Plan (QAQIP) is submitted with this grant document in item R of the Narrative Plan.

II: Planning Steps

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

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

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

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Section II Planning Steps
Step 2
Identify Unmet Needs and Service Gaps

Identify Unmet Needs and Critical Gaps

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

- Goal 1: Streamline and restructure TDMHSAS central operations
- Goal 2: Increase the efficiency and effectiveness of state regional mental health institutes (RMHIs)
- Goal 3: Strengthen and improve community mental health and substance abuse services
- Goal 4: Expand and improve mental health services to children
- Goal 5: Encourage consumer recovery, resiliency and personal achievement
- Goal 6: Decrease abuse of prescription drugs

Mental Health Block Grant (MHBG) funds provide essential dollars needed for strengthening community mental health services, expanding and improving mental health services to children, and encouraging consumer recovery, resiliency and personal achievement.

To determine the unmet service needs and critical gaps within the current service system, TDMHSAS (1) analyzes multiple state and federal data sources and (2) conducts a data-driven needs assessment. Service needs are identified through an annual needs assessment process with input from TDMHSAS's statewide Planning and Policy Council (TDMHSASPPC), regional councils, and TDMHSAS staff. TDMHSAS developed a number of data books comparing state-specific and national data as well as providing regional planning and policy councils with regional and county-level data. These data books are also posted on the TDMHSAS website. Information about the TDMHSAS needs assessment process and the data used to determine regional and state needs is posted on the department's website at http://tn.gov/mental/policy/tdmhsas_data_rpt.shtml

Regional needs are identified, reviewed, and prioritized by the Planning and Budget Committee of the TDMHSASPPC 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.

For the 2012 needs assessment, the TDMHSAS collected data from a statewide needs assessment survey and compiled regional behavioral health information on a wide variety of indicators including demographics, behavioral health, and services available in each region. Information from the statewide needs assessment was provided to the TDMHSASPPC and the regional data book informed the 2012 regional needs assessment process. The 2013 needs assessment survey was revised, analyzed and provided to each regional council. In addition, the regional data book was expanded to include county-level data for each mental health planning region. TDMHSAS utilized various data sources to inform the regional and county data books including, but not limited to:

- Kids Count

- U.S. County Health Rankings
- U.S. Census
- National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)
- National Institute of Mental Health
- SAMHSA /National Survey on Drug Use and Health
- Behavioral Risk Factor Surveillance System (BRFSS) and the Youth BRFSS with the Centers for Disease Control and Prevention
- Tennessee Department of Health
- TennCare
- Behavioral Health Safety Net of Tennessee (BHSNTN)
- Tennessee Outcome Measurement System (TOMS)
- SAMHA Uniform Reporting System

Data collection is fundamental to assessing the need, access, utilization, and quality of services delivered. As such, TDMHSAS is evaluating the feasibility of purchasing or developing a Department-wide integrated system to manage mental health and substance abuse services and outcomes collection across programs. Through funding from SAMHSA's Data Infrastructure Grant, TDMHSAS has collaborated to form a partnership with the Tennessee Association of Mental Health Organizations (TAMHO) to build on an already-existing data warehouse utilized by many of the TAMHO member organizations. The Department is hopeful that the **Behavioral Statistics System for Tennessee (BeSST)** will be finished in the winter of 2014 and ready for use by all Tennessee service organizations providing behavioral health services in 2015. The purpose of the BeSST is to ensure that services provided are beneficial to recipients and to discover trends and practice information in Tennessee at large.

Currently, Tennessee relies on several surveys to collect information about the use of best practices by service providers and about national outcome measures for people receiving mental health services. The Tennessee Outcome Measurement System (TOMS) Survey and Mental Health Statistical Improvement Program (MHSIP) survey are used to collect NOMs information. In 2012, approximately 54,000 of the 240,000 people received mental health services in community-based settings from agency members of the Tennessee Association of Mental Health Organizations (TAMHO) completed the TOMS survey.

Tennessee's Data Infrastructure Grant (DIG) allowed TDMHSAS to partner with the TAMHO to merge client-level data contained in the TOMS survey with data from the TAMHO data warehouse, and with state hospital data for the purpose of submitting client-level data to SAMHSA. Over time, TDMHSAS plans to build on this effort to collect NOMs data on additional people receiving behavioral health services through TAMHO member agencies, people receiving Behavioral Health Safety Net and crisis services as well as Medicaid-reimbursed behavioral health services. Tennessee was one of 32 states that submitted FY 2012 client-level data to SAMHSA.

Estimates of the annual prevalence of SMI in Tennessee are taken from the 2010-2011 National Survey on Drug Use and Health (NSDUH) by SAMSHA. An estimated 23.43% of Tennessee adults (or 1,120,000 adults) over the age of 18 had a mental illness in the past year and 5.87% adults (or 280,000 adults) live with a serious mental illness (SMI) such as schizophrenia, major depression, or bipolar disorder. An estimated 7.11% of Tennessee adults (or about 340,000 adults) "had at least

one major depressive episode in the past year”, compared to 6.70% nationwide.¹ An estimated 90,993 or 12% of Tennessee children, ages 9 to 17, had a serious emotional disturbance (SED).² An estimated 8.27% (or 41,000) youth, ages 12-17, had a least one major depressive episode in the past year.³

Service-related priorities

Priority 1: Uninsured individuals

In Tennessee, about 20.7% (or about 813,800) of nonelderly adults, ages 18 to 64, are uninsured, while only 5.3% (or about 79,244) children are uninsured.⁴ An estimated 4,800 children, ages 9-17, have a diagnosis of serious emotional disturbance (SED) and are uninsured⁵. Conservatively, over 46,000 adults living with SMI have no health insurance and would potentially be eligible for Medicaid expansion or an assisted purchase of coverage via the Health Insurance Marketplace. In addition, it is likely that many individuals living with SMI are underinsured for mental health benefits since most private insurance plans and Medicare do not include the types of wrap-around and rehabilitative services routinely needed by those individuals.

The most vulnerable of uninsured individuals with SMI (those at 100% FPL and below) are eligible for the state-funded Behavioral Health Safety Net of Tennessee (BHSNTN). The BHSNTN is a program offering a package of core, vital mental health outpatient clinical services, labs, and case management to people who are not eligible for Medicaid through TennCare, the state’s Medicaid program. Services such as psychosocial rehabilitation have been added to the milieu of services for the coming fiscal year. During FY 2012, the BHSNTN provided paid services to 32,667 individuals with SMI. In the absence of the BHSNTN, enrollees would have access to only the more expensive inpatient services provided at the State-operated RMHIs.

The TennCare program includes a wide variety of rehabilitative mental health services, including case management, crisis services, psychosocial rehabilitation, and illness management and recovery. Like the BHSNTN, TennCare offers insurance to eligible people with incomes up to 100% of the federal poverty level.

In FY 2012, approximately 169,173 TennCare members received behavioral health services. Of these, 63.6% (or 107,661) people had an SMI/SED diagnosis only; 2.1% (3,575 people) had a substance use disorder diagnosis only; and 6.4% (10,748 people) had a co-occurring SMI/SED and SUD diagnosis.

An estimated 46,700 people who are currently eligible for but not enrolled in TennCare could seek enrollment during FY 2014 due to increased publicity, outreach and the requirement that people be screened for TennCare before purchasing insurance in the Health Insurance Marketplace. SAMHSA⁶ estimates that 16.2% of the adult Medicaid-eligible population has a SMI and 10.7% has a substance use disorder (SUD).

A group of 115,600 adults with incomes below 100% of the federal poverty level (FPL) will remain uninsured if Medicaid is not expanded in Tennessee. This group does not meet current Tennessee Medicaid eligibility requirements and will not be eligible to receive federal subsidies to purchase

insurance through the Health Insurance Marketplace. SAMHSA estimated 16.2% of adults with incomes below 100% of FPL have a SMI diagnosis and 10.7% have a SUD diagnosis.

If Tennessee opts for Medicaid expansion, SAMHSA estimates an estimated 110,000 adults with SMI (about 30,000) or with SUD (about 80,000) will become eligible for Medicaid. Another 93,500 adults with SMI (about 16,500) or with SUD (77,000) will become eligible for insurance through the Health Insurance Marketplace in FY 2014.

Priority 2: Prevention

TDMHSAS supports the primary, secondary and tertiary prevention of mental illness using a variety of strategies.

The focus of primary prevention is decreasing stigma and increasing public awareness about mental illness. Increasing public understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention will help people recognize mental and substance use disorders and seek assistance with the same urgency as any other condition, and make recovery the expectation.

In a 2009 survey⁷ 75% of Tennesseans strongly agreed that treatment can help people with mental illness lead normal lives, and only 1.3 percent strongly disagreed. Over 50 percent of Tennesseans strongly or slightly agreed that people are generally caring and sympathetic to people with mental illness. However, a SAMHSA report found that one in five Americans feel that persons with mental illness are a danger to others. The same report found that 20 percent of Americans would think less of a friend or relative if they discovered that person is in recovery from an addiction.

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

Evidence of the need for children's mental health services is provided by TennCare data. TennCare reported that 75% (40,021 of 52,978) of the children receiving Medicaid-reimbursed behavioral health services in FY 2012 had diagnoses of serious emotional disturbance.

Crisis services are critical to prevent the inappropriate use of criminal justice, hospital emergency room, and inpatient hospitalization of people in crisis. According to a 2006 study of 36 county jails conducted for TDMHSAS (Ducote and DeWitt, 2006), 15.6% (or 1,950) inmates in the State's local jails have a diagnosis of serious mental illness. Another 34.7% of the inmates exhibited behaviors suggesting undiagnosed mental illness.⁸ There is little mental health treatment that occurs in jails. In a 2007 study conducted by TDMHSAS (no citation), it was found that individuals with mental health diagnoses who had spent time in jails often were unable to receive psychiatric medications while incarcerated. Also, many jails include substance use disorders as part of an SMI diagnosis.

Those in psychiatric crisis even more frequently end up in hospital emergency rooms. These individuals often spend long periods of time in ERs whose staff frequently have little training in the needs of those living with mental illness. According to Tennessee Department of Health, mental

disorders as a primary diagnosis for emergency department visits for inpatient discharges or for outpatient visits accounted for 3,282,564 visits or 2.2% of all conditions in 2010.⁹

According to the TOMS Survey for FY 2011-2012, of 65,810 respondents receiving treatment at community mental health centers, 14% reported that they had stayed overnight in a hospital, psychiatric hospital, or substance abuse treatment center. Furthermore, 23% of the 51,212 respondents reported they had gone to the ER at least one time in the past month. Anecdotal opinion would suggest that it is far preferable for individuals living with mental illness (who are in crisis) to have access to specialized crisis services, rather than to seek treatment in ERs or to be arrested and taken to jail.

The focus of TDMHSAS tertiary prevention activities is providing the supports needed to encourage disease management and recovery. The need for these services is described in the next section.

Priority 3: Recovery-oriented services for adults with SMI or COD

Tennessee has made recovery-oriented services for the uninsured SMI population one of its block grant priority areas. The most commonly received services include outpatient therapy and prescription drugs, or a combination of the two. People with SMI often require non-medical services, such as income support, vocational training, or housing assistance, to help them manage day-to-day activities.

The State's recovery-oriented services include housing and supported employment. According to the TOMS Survey for FY 2011-2012, 3.3% adult respondents receiving treatment at community mental health centers, said they were living in homeless shelters, on the street, or in jail. In addition, large numbers (84%) reported that they were not working. The TOMS survey found that only 5.5% of the respondents were working full-time, while another 10.3% worked part-time. About 31% of the respondents reported that they were unemployed but "looking for paid work."

The survey also found large numbers of individuals that would like to participate in their own recovery, but appeared to face barriers in doing so. Many respondents (61%) said they "often" or "almost always" felt responsible for their own recovery with an additional 25% saying "sometimes." Yet, 61% percent of respondents said sometimes, often, or almost always their physical health kept them from doing things and 32% said they rarely or never knew what to do to control the symptoms of their mental illness. There were 47% of the respondents that reported that they often or almost always "have goals". In order to give these individuals tools to make recovery possible, services like peer support, health coaching, and WRAP® training are emphasized in Tennessee's recovery programs.

Priority 4: Children and Youth Services

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

U.S. Census data indicates that 23.6% of the State's population (or 1,496,001 children and youth) is under age 18. According to Kids Count¹⁰, almost one in four children (25.9%) in Tennessee live in poverty in 2010. An estimated 90,993 Tennessee children have a serious emotional disturbance (SED).

Emotional well-being is a critical component of children's health. It has a complex interactive relationship with physical health and the ability to succeed in school and ultimately at work and in society. One in five children nationally has diagnosable mental health problems and a high rate of physical health problems. For children with diagnosable mental health problems, there is a higher potential for drug and alcohol dependence increased interactions with the juvenile justice system and increased challenges at school. In the Youth Behavior Risk Surveillance Survey 2011, 26% of Tennessee youth in grades 9 to 12 reported feeling sad or lonely (almost every day for two or more weeks in a row so that usual activities were stopped in some way during the 12 months prior to the survey). Tennessee ranks in the middle 22 states for percentage of youth feeling sad or lonely.

Unless addressed, many children's mental health issues persist into adulthood. Researchers (Kessler et al, 2005) supported by the National Institute of Mental Health (NIMH) have found that half of all lifetime cases of mental illness begin by age 14 and three fourths by age 24 years, and that despite effective treatments, there are long delays between first onset of symptoms and when people seek and receive treatment.¹¹

As many as 70% of children diagnosed with depression will have a relapse by adulthood. According to a study that looked at the World Health Organization's 2004 Global Burden of Disease Report, neuropsychiatric disorders such as depression, substance abuse, and schizophrenia account for nearly half (45%) of disability in young people between ages 10 and 24.

¹ SAMSHA, Center for Behavioral Statistics and Quality. (2012). National Survey on Drug Use and Health: 2010-2011.

² Number of children with serious emotional disturbances, age 9 to 17, by state, 2011. NASMHPD Research Institute, Inc. Accessed on 3/10/2013 from http://www.nri-inc.org/projects/SDICC/urs_forms.cfm.

³ SAMSHA, Center for Behavioral Statistics and Quality. (2012). National Survey on Drug Use and Health: 2010-2011.

⁴ U.S. Census Bureau (2010). Health insurance coverage status, 2010 American Community Survey 1-year estimates.

Accessed on 8/8/2013 from

<http://factfinder2.census.gov/faces/tableservices/jsf/pages/prodcutview.xhtml?pid=ACS10...>

⁵ National Association of State Mental Health Program Directors Research Institute. (2012) [2011 SMI and SED Prevalence Estimates](#).

⁶ Substance Abuse and Mental Health Services Administration. Enrollment under the Medicaid expansion and health insurance exchanges: A focus on those with behavioral health conditions in Tennessee.

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

⁸ Ducote, D., and DeWitt, P. (2006). County Jails in Tennessee: Third Survey Report. Tennessee Department of Mental Health and Developmental Disabilities.

⁹ Tennessee Department of Health, Office of Health Statistics (2011). Hospital discharge data system. Available from <http://health.state.tn.us/statistics/specialprojects.htm#hdds>

¹⁰ Annie E. Casey Foundation. Kids Count Data Center. Accessed from <http://datacenter.kidscount.org/>

¹¹ Ronald C. Kessler, PhD; Patricia Berglund, MBA; Olga Demler, MA, MS; Robert Jin, MA; Kathleen R. Merikangas, PhD; Ellen E. Walters, MS. (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.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Covering Uninsured Individuals
Priority Type:	MHP, MHS
Population (s):	SMI, SED
Goal of the priority area:	<p>TDMHSAS provides programming that covers citizens who are uninsured, underinsured, and/or who are indigent. Programming also covers those services not covered by Medicaid and ancillary services that are necessary but may not be available under insurance coverage.</p>
Strategies to attain the goal:	<p>This priority addresses the needs of individuals who are currently neither eligible for Medicaid nor insured by Medicare and/or another third-party payor. This priority also addresses those who may be in between jobs or in the probationary period of a new job during which benefits have not yet been activated. The State of Tennessee has investigated gaps in services and implemented "bridge" services that can assist those who need care in excess of their ability to pay or who are not covered under any third-party payor program.</p>
Annual Performance Indicators to measure goal success	
Indicator #:	1
Indicator:	The Behavioral Health Safety Net will provide mental health services for uninsured Tennesseans including those services that are essential for maintaining mental health and those services not covered by insurance.
Baseline Measurement:	Number of persons served in 2012 (32,667).
First-year target/outcome measurement:	Number of persons served in 2014 (32,727).
Second-year target/outcome measurement:	Number of persons served in 2015 (32,777).

Data Source:

Behavioral Health Safety Net database

Description of Data:

Number of persons served at each community provider, other client-level and demographic data

Data issues/caveats that affect outcome measures::

None noted

Indicator #:

2

Indicator:

Older Adult Services will provide services to the older adult SMI populations to assist with developing skills that will allow recipients to live independently in the community as long as possible.

Baseline Measurement:

Number of persons served in 2012 (120).

First-year target/outcome measurement:

Number of persons served in 2014 (120).

Second-year target/outcome measurement:

Number of persons served in 2015 (120).

Data Source:

Provider records and reports.

Description of Data:

Care management tracking.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:

3

Indicator:

Preadmission Screening and Resident Review (PASRR) will provide screening and evaluation services to older adults applying for admission and residing in Medicaid Certified Nursing

Facilities. These screenings will determine if (a) nursing facility is an appropriate placement or if an inpatient psychiatric placement is necessary and (b) if nursing facility placement is appropriate what psychiatric treatment is necessary.

Baseline Measurement: Number of persons served in FY 2012 and percentage of assessments processed according to guidelines of federal government (goal is 100%) numbering in excess of 200 referrals a month.

First-year target/outcome measurement: 100% of the number of referrals per month. 2013 referrals exceeded 500.

Second-year target/outcome measurement: 100% of the number of referrals per month. 2013 referrals exceeded 500.

Data Source:

Daily monitoring of contracted agencies/individuals.

Description of Data:

Number of referrals and assessments.

Data issues/caveats that affect outcome measures::

None noted.

Priority #: 2

Priority Area: Children and Youth Services

Priority Type: MHP, MHS

Population SED

(s):

Goal of the priority area:

TDMHSAS' Office of Children and Youth Services provides a progressive and ongoing effort toward the development of the System of Care model for the service delivery system in Tennessee.

Strategies to attain the goal:

The Office of Children and Youth Services administers a milieu of services across the state to ensure that all children and their families have

access to excellent care including prevention, intervention and recovery-oriented services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Erase the Stigma and Mental Health 101 will increase awareness regarding mental health and the importance of screening.

Baseline Measurement: All groups requesting a presentation or educational materials receive those materials.

First-year target/outcome measurement: 235 events, including schools presentations, civic group presentations and events with advocacy groups.

Second-year target/outcome measurement: 240 events, including schools presentations, civic group presentations and events with advocacy groups.

Data Source:

Contracted agency/provider annual report, satisfaction surveys, pre and post-tests, training sign-in sheets.

Description of Data:

Contracted data collection including demographic data and records of information and materials provided.

Data issues/caveats that affect outcome measures::

All participants may not be included in the data. The data may be incomplete.

Indicator #: 2

Indicator: Child and Family Mental Health Education will increase support groups for parents of children diagnosed with SED.

Baseline Measurement: Number of individuals served by the program.

First-year target/outcome measurement: 4,000 individuals participating in support groups.

Second-year target/outcome measurement: 4,500 individuals participating in support groups.

Data Source:

Contracted agency/provider annual report, satisfaction surveys, pre and post-tests, training sign-in sheets.

Description of Data:

Data includes description of participants in support groups funded through the contract.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:

3

Indicator:

Violence and Bullying Prevention in Schools will decrease the number of discipline referrals in the classroom for school and youth participants.

Baseline Measurement:

Number of discipline referrals in participating schools.

First-year target/outcome measurement:

Decreased number of discipline referrals compared to prior year.

Second-year target/outcome measurement:

Decreased number of discipline referrals compared to prior year.

Data Source:

Contracted agency records of discipline referrals in participating schools.

Description of Data:

Contracted agency collects the data that shows demographic data for the children and schools participating in and affected by the program.

Data issues/caveats that affect outcome measures::

Indicator #:

4

Indicator:

Family Support and Advocacy will provide support and advocacy groups for families with a child diagnosed SED.

Baseline Measurement:

Number of participants attending support groups.

First-year target/outcome measurement: Eight support groups, indicating an increase in number of participants attending support groups compared to the prior year.

Second-year target/outcome measurement: Nine support groups, indicating that the program maintained the number of participants attending support groups compared to the prior year.

Data Source:

Contracted agency/Provider annual report, satisfaction survey, pre- and post-tests, training sign-in sheets.

Description of Data:

Number of participants attending the support groups.

Data issues/caveats that affect outcome measures::

The Office of Children and Youth Programs is reviewing the data to determine if there is any additional information that would be useful to capture.

Indicator #:

5

Indicator:

School Based Liaison programming seeks to increase the number of families and/or youth referred to necessary and appropriate mental health services.

Baseline Measurement:

The number of discipline referrals in school; the number of referrals for mental health services; the number of children remaining in community-based setting; and school satisfaction ratings.

First-year target/outcome measurement:

Decrease the number of discipline referrals in school. Increase the number of referrals for mental health services. Increase the number of children remaining in community-based setting. Increase school satisfaction ratings compared to the baseline year.

Second-year target/outcome measurement:

Decrease the number of discipline referrals in school. Increase the number of referrals for mental health services. Increase the number of children remaining in community-based setting. Increase school satisfaction ratings compared to the baseline year.

Data Source:

Contracted agencies.

Description of Data:

Contracted agencies collect detailed information regarding child ethnicity, age, gender, referral, and other information.

Data issues/caveats that affect outcome measures::

The Office of Children and Youth Programs seeks to collect as much useful data as possible to ensure that the efficacy of the program is well described.

Indicator #: 6

Indicator: Renewal House Early Intervention program will serve the children of addicted mothers.

Baseline Measurement: Number of children served during the year.

First-year target/outcome measurement: Maintain service to 40-60 children.

Second-year target/outcome measurement: Maintain service to 40-60 children.

Data Source:

Contracted agency will collect demographic and treatment information for children served.

Description of Data:

Contracted agency will collect demographic and treatment information for children served.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #: 7

Indicator: Child care consultation programming will provide training and technical assistance coaching on the Pyramid Model (CSEFEL) strategies to Project B.A.S.I.C. staff, with a focus on 10 selected Project B.A.S.I.C. implementation sites, and to a few selected early childhood education centers across the state.

Baseline Measurement: The number of staff, schools, and centers served.

First-year target/outcome measurement: Maintain or increase the number of schools, centers and staff served in comparison with the prior year. In FY 2013, technical assistance was provided to staff at 5 selected

elementary schools as well as providing training and some technical assistance coaching to all Project B.A.S.I.C. staff, and selected early childhood centers.

Second-year target/outcome measurement:

Maintain or increase the number of schools, centers and staff served in comparison with the prior year. In FY 2014, increase targeted elementary school Pyramid Model technical assistance coaching to 10 selected elementary schools, as well as providing continued training on Pyramid Model strategies to all Project B.A.S.I.C. staff.

Data Source:

Child Care Consultation staff of Contracted agency provide semi-annual and annual reports.

Description of Data:

Name and location of school/center, number of staff trained or provided with technical assistance coaching, number of children impacted.

Data issues/caveats that affect outcome measures::

This is not routinely gathered data. It could be retrieved through the DOE or LEA.

Indicator #:

8

Indicator:

Systems of Care Expansion (SOC-EXP) will increase the number of SOC sites statewide to build and sustain Systems of Care for children and youth diagnosed with SED and their families. SOC services are family driven, youth-guided, community-based, and culturally and linguistically competent.

Baseline Measurement:

SOC sites will expand from the three present to an undetermined number statewide

First-year target/outcome measurement:

Four or more increase in SOC sites as compared with the prior year.

Second-year target/outcome measurement:

Increase the number of SOC sites as compared to the year before.

Data Source:

Contracted agencies will gather data and provide the data to Office of System of Care Initiatives during monthly check-in meetings and annual monitoring.

Description of Data:

Data will include number of agencies that adopt SOC values and principles statewide.

Data issues/caveats that affect outcome measures::

Indicator #:

9

Indicator:

Systems of Care (SOC) contracted agencies will build and sustain Systems of Care for children and youth diagnosed with SED and their families. SOC services are family driven, youth-guided, community-based, and culturally and linguistically competent.

Baseline Measurement:

Number out of home placements, number of school disciplinary actions, number of ages 0-5 children diagnosed with SED who receive appropriate mental health services, awareness of SED and SOC through statewide outreach activities.

First-year target/outcome measurement:

Number out of home placements, decrease number of school disciplinary actions, increase number of ages 0-5 children diagnosed with SED who receive appropriate mental health services, increase awareness of SED and SOC through statewide outreach activities as compared to the year before.

Second-year target/outcome measurement:

Number out of home placements, decrease number of school disciplinary actions, increase number of ages 0-5 children diagnosed with SED who receive appropriate mental health services, increase awareness of SED and SOC through statewide outreach activities as compared to the year before.

Data Source:

Contracted agency tracking and data gathering.

Description of Data:

Number out of home placements, number of school disciplinary actions, number of ages 0-5 children diagnosed with SED who receive appropriate mental health services, awareness of SED and SOC through statewide outreach activities.

Data issues/caveats that affect outcome measures::

Indicator #:

10

Indicator:

Respite and Planned Respite programming will provide respite for parents or caregivers for

their child with an SED diagnosis.

Baseline Measurement:

Number of families receiving respite services in a year.

First-year target/outcome measurement:

160 families will receive Respite services, 200 families will receive Planned Respite services.

Second-year target/outcome measurement:

Increase of number of families from the prior year by 5%: 168 families will receive Respite services, 210 families will receive Planned Respite services.

Data Source:

Contracted provider will collect data.

Description of Data:

Number of families who receive Respite services and the number of families who receive Planned Respite services. Contracted agency may also collect demographic information.

Data issues/caveats that affect outcome measures::

Indicator #:

11

Indicator:

Homeless Outreach Project which identifies children and youth under 18 with serious emotional disturbances (SED) who are homeless or at risk of homelessness and links them to needed mental health and housing services

Baseline Measurement:

Number of eligible children and youth under 18 with identified/risk of SED who are homeless or at risk of homelessness and family members who receive support services, specific assistance and linkage and referral to avoid homelessness or maintain stable housing

First-year target/outcome measurement:

At least 150 enrolled families served and discharged during the year. 80% of youth and children identified with an SED will receive initial mental health service by time of discharge. 80% of adult family members identified with mental illness will receive an appointment for mental health services by time of discharge. 80% or more of families enrolled will have maintained stable housing, secured more stable housing or completed an application for more permanent housing by time of discharge.

Second-year target/outcome measurement:

150 families served and discharged.

Data Source:

Semi-annual reports from contract agencies.

Description of Data:

Composite number of service recipients, number of family members, services received, housing status change from enrollment to discharge from each contract agency.

Data issues/caveats that affect outcome measures::

Data collected in aggregate.

Priority #: 3

Priority Area: Prevention

Priority Type: MHP

Population SMI, SED

(s):

Goal of the priority area:

Prevention programming is designed to stop the progression of negative trends either before they begin or in beginning phases.

Strategies to attain the goal:

TDMHSAS provides a statewide sweep of services targeting suicide prevention, general health education and prevention, bullying prevention and awareness programming.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Emotional Fitness Centers increase mental health screenings in the African American community in Memphis to ensure that individuals in need are appropriately referred for services.

Baseline Measurement:

Number of individuals screened in a year.

First-year target/outcome

500 individuals screened, demonstrating an increased number of individuals screened

measurement: compared to the prior year.

Second-year target/outcome measurement: 525 individuals screened, demonstrating an increased number of individuals screened compared to the prior year.

Data Source:

Contracted agency/Provider annual report, satisfaction surveys, pre and post-tests, and training sign-in sheets.

Description of Data:

Contractor agency records demographic data for those who visit the Counseling Center.

Data issues/caveats that affect outcome measures::

Office of Children and Youth Programs seeks to increase the accuracy and usefulness of data gathered.

Indicator #: 2

Indicator: Suicide prevention programming activities will reduce the incidents of suicide in Tennessee by increasing the ability of individuals to recognize the warning signs of suicide and then to intervene, providing enhanced follow-up services for at risk youth and by decreasing stigma.

Baseline Measurement: The rate of suicides in Tennessee; the ability of crucial persons to recognize the warning signs.

First-year target/outcome measurement: Reduction in the rate of suicide by .5% from the prior year, 200 teachers will receive suicide awareness training, 1000 youth will receive peer suicide awareness training, and 50 Tennesseans will be trained as gatekeepers for suicide prevention.

Second-year target/outcome measurement: Maintain or increase the numbers from the year prior.

Data Source:

Contracted and partnered agencies will submit data and evaluation information on a quarterly basis.

Description of Data:

Number of youth served, number of teachers trained, number of gatekeepers trained, suicide rate for the year, evaluation outcomes and demographic data.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Project Better Attitudes and Skills in Children (B.A.S.I.C.) programming will increase the number of children referred to necessary and appropriate mental health services.

Baseline Measurement: Service to K-3 children and teachers in contracted schools.

First-year target/outcome measurement: Number of children and teachers served in the school year.

Second-year target/outcome measurement: Maintain or increase the number of children and teachers served in comparison with the prior year.

Data Source:

Technical assistants will collect data on the number served and the evaluation information.

Description of Data:

Number of persons served, evaluation data.

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Regional Intervention Program (RIP) will serve families with a child diagnosed with SED at all sites.

Baseline Measurement: Number of families served, number of parents/guardians/caregivers providing supports

First-year target/outcome measurement: Number of families served, number of parents/guardians/caregivers providing supports

Second-year target/outcome measurement: Maintain or increase numbers from the year before.

Data Source:

RIP centers and staff will collect data.

Description of Data:

Number of families served, number of parents/guardians/caregivers providing supports,demographic information, evaluation information

Data issues/caveats that affect outcome measures::

Indicator #:

5

Indicator:

Disaster Mental Health Response is presently unfunded since there are no federal disaster areas declared in Tennessee at the time of this application. The workgroup will develop infrastructure to respond to mental health needs in the event of a disaster.

Baseline Measurement:

Development of infrastructure.

First-year target/outcome measurement:

Development of a provider network, development of satisfaction surveys, development of monitoring strategy.

Second-year target/outcome measurement:

After development of infrastructure, the number of Tennesseans served, and numbers of referral of survivors of a disaster needing additional services

Data Source:

Contracted agencies will submit data and demographic information.

Description of Data:

Under development.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:

6

Indicator:

Crisis continuum programming will provide crisis intervention services to the citizens of Tennessee.Through 13 contracted agencies, crisis programming will provide assessment, referral, crisis intervention and follow-up services in the least restrictive environment available regardless of ability to pay 24 hours a day, 7 days a week.

Baseline Measurement: Number of individuals who request assistance receive it within two hours of the request, number of individuals served, number hospitalized after receiving services, number of individuals reporting services were helpful, number of successful follow-up attempts.

First-year target/outcome measurement: 90% of individuals requesting service receive it within two hours of the request, and the total number of individuals making a request, number hospitalized after receiving services will reduce from 7.84% of those who contacted Crisis Services to 7%, 75% of individuals receiving crisis services will participate in a follow-up contact.

Second-year target/outcome measurement: 90% of individuals requesting service receive it within two hours of the request, and the total number of individuals making a request as compared to the prior year.

Data Source:

Contracted agency will collect and report data on a quarterly basis.

Description of Data:

: Number of individuals served, percentage that are served within two hours of making a request, decrease in the number of hospitalizations, increased percentage reporting services were helpful.

Data issues/caveats that affect outcome measures::

None noted.

Priority #: 4

Priority Area: Recovery

Priority Type: MHP, MHS

Population SMI, SED

(s):

Goal of the priority area:

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

Strategies to attain the goal:

TDMHSAS administers programming and services that help individuals living with mental illness or substance use disorders to embrace recovery as a way of life.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Supportive Housing, Emerging Adults and Intensive Long-term Support will provide supportive housing to reduce hospitalization needs.

Baseline Measurement: Number of adults (18+) who meet eligibility requirements served by receiving safe, affordable, quality housing and supports as needed to prevent psychiatric hospitalization and optimize resident's recovery potential.

First-year target/outcome measurement: Provide housing and supports for 780 people and reduce hospitalization needs by at least 85%.

Second-year target/outcome measurement: Provide housing and supports for 780 people and reduce hospitalization needs by at least 85%.

Data Source:

Annual contracts with vendors include requirements for reporting the number of hospitalization days, number of supported housing days and positive effects of programming of life domains of recipients.

Description of Data:

Annual contracts with vendors include requirements for reporting the number of hospitalization days, number of supported housing days and positive effects of programming of life domains of recipients.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #: 2

Indicator: Consumer Family Support will increase recovery by serving adults diagnosed with serious mental illness and co-occurring disorders.

Baseline Measurement: Number of individuals who participate in programming provided.

First-year target/outcome: Maintain the outcomes achieved the year prior pertaining to number of individuals

measurement: completing the BRIDGES Teacher and Facilitator Training, number of individuals completing the Peer Counseling training, and the number of individuals who complete the Mental Health First Aid training, results of evaluations for the With Hope in Mind program, and the results of evaluations for selected trainings.

Second-year target/outcome measurement: Maintain the outcomes achieved the year prior pertaining to number of individuals completing the BRIDGES Teacher and Facilitator Training, number of individuals completing the Peer Counseling training, and the number of individuals who complete the Mental Health First Aid training, results of evaluations for the With Hope in Mind program, and the results of evaluations for selected trainings.

Data Source:

Contracted vendors will provide outcome data and other information as prescribed by contract.

Description of Data:

Contracted vendors will provide outcome data and other information as prescribed by contract.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: My Health, My Choice, My Life programming will improve the well-being and recovery of individuals living with mental illness and substance abuse disorders by increasing physical health behaviors and decreasing symptoms.

Baseline Measurement: In the first year of implementation, proper staff will be hired and training provided statewide.

First-year target/outcome measurement: 20 staff hired, 10 workshops held, 151 consumers attended workshops

Second-year target/outcome measurement: 20 staff hired, 15 workshops held, 200 consumers attended workshops

Data Source:

Staff will complete evaluation and enter data via iPad interface.

Description of Data:

Number of workshops held, participants at each workshop, and evaluation of each participant, demographic data for each participant.

Data issues/caveats that affect outcome measures::

My Health, My Choice, My Life Peer Wellness Coaches collect data on demographics, health behaviors, and symptom management that is analyzed through Centerstone Research Institute. My Health, My Choice, My Life TDMHSAS staff collects data on agency staff trained, workshops health, and consumers who attended workshops.

Indicator #: 4

Indicator: Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) will train certified peer recovery specialist in Tennessee

Baseline Measurement: Number of peer recovery specialists trained

First-year target/outcome measurement: 13 peer recovery specialists trained in year one

Second-year target/outcome measurement: 13 peer recovery specialists trained in year two

Data Source:

Contracted providers for the training modules will report number of participants in training sessions and the number who complete the training program.

Description of Data:

Number of peer recovery specialists trained by BRSS TACS in Tennessee.

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: Peer Support Centers will serve citizens of Tennessee living with mental illness and substance abuse disorders by providing recovery and education supports and opportunities for socialization.

Baseline Measurement: Number attending peer support center programming and evaluation results for those who

attend who complete evaluations.

First-year target/outcome measurement:

Maintain or increase attendance (2000 participants statewide each month) and positive evaluation outcomes compared to the year prior.

Second-year target/outcome measurement:

Maintain or increase attendance (2000 participants statewide each month) and positive evaluation outcomes compared to the year prior.

Data Source:

Peer support center staff (of contracted agencies and organizations) will collect monthly information regarding attendance and evaluation results.

Description of Data:

Evaluations include information concerning participant socialization, feelings of loneliness, ability to ask for help, report of feeling more independent, feeling less likely to need hospitalization, and have experienced fewer hospitalizations as the result of attending.

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Performance and Outcome Data

Priority Type: MHP, MHS

Population SMI, SED

(s):

Goal of the priority area:

Improve the accuracy and availability of data in order to support decision making and inform delivery system planning. Increase client level data available for the purpose of improving the representation of actual clients receiving services statewide.

Strategies to attain the goal:

Complete implementation of the Behavioral Statistics System for Tennessee and complete and implement the plan for best practices statewide.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator: The Behavioral Statistics System for Tennessee (BeSST) including the necessary logistics, training and hardware needed for implementation with state-contracted agencies.

Baseline Measurement: Those pieces of the BeSST already in place effective August 31, 2013.

First-year target/outcome measurement: Development of the final plan for implementation of the BeSST and statewide implementation of the plan.

Second-year target/outcome measurement: Implementation of the completed plan including any needed contracts, logistics, training and hardware.

Data Source:

Office of Research records, Division of Mental Health Services records, and data entry by contracted agencies.

Description of Data:

System in place, software developed and operational, number of providers trained.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #:

2

Indicator: TDMHSAS Office of Research and Division of Mental Health Services will collaborate to identify best practice approaches for contracted providers, funded through Mental Health Block Grant and state dollars, and develop logistics and training for implementation of best practice approaches statewide.

Baseline Measurement: Number of contracted providers utilizing best practices on August 31, 2013.

First-year target/outcome measurement: Development of the plan for implementation including logistics, training and tracking information.

Second-year target/outcome measurement: Implementation of the plan in full including logistics, training and tracking information.

Data Source:

Office of Research records, Division of Mental Health Services records, and data entry by contracted agencies.

Description of Data:

Number trained per best practice area.

Data issues/caveats that affect outcome measures::

None noted.

Indicator #: 3

Indicator: TDMHSAS Division of Mental Health Services will collaborate to identify efficient and effective approaches to assist recipients and providers will ensuring enrollment of recipients for eligible benefits, awareness of effective business practices, and increased ability of providers to bill for services provided.

Baseline Measurement: Development of a plan to begin August 31, 2013.

First-year target/outcome measurement: Implementation including contracting, logistics, training and tracking information.

Second-year target/outcome measurement: Implementation of the plan in full including logistics, training and tracking information.

Data Source:

Office of Research records, Division of Mental Health Services records, and data entry by contracted agencies.

Description of Data:

Number of contracted providers, and information about implementation received from those providers.

Data issues/caveats that affect outcome measures::

None noted.

Footnotes:

Priorities and indicators may be in a different order in this Planning Step than they appear in other parts of the document. Some indicators may appear in more than one Priority area. Some programs described in the narrative text of Steps one and two may not appear in this Planning Step.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
6. Other 24 Hour Care		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
7. Ambulatory/Community Non -24 Hour Care		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
8. Mental Health Primary Prevention		\$ 1,810,500	\$ <input type="text"/>	\$ <input type="text"/>	\$ 228,000	\$ <input type="text"/>	\$ <input type="text"/>
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$ 1,308,952	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
10. Administration (Excluding Program and Provider Level)		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
11. Total	\$	\$ 3,119,452	\$	\$	\$ 228,000	\$	\$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$
Specialized Outpatient Medical Services	0	0.00	\$
Acute Primary Care	0	0.00	\$
General Health Screens, Tests and Immunizations	0	0.00	\$
Comprehensive Care Management	0	0.00	\$
Care coordination and Health Promotion	0	0.00	\$
Comprehensive Transitional Care	0	0.00	\$
Individual and Family Support	0	0.00	\$
Referral to Community Services Dissemination	0	0.00	\$
Prevention (Including Promotion)			\$642,500
Screening, Brief Intervention and Referral to Treatment			\$

Brief Motivational Interviews			\$
Screening and Brief Intervention for Tobacco Cessation			\$
Parent Training			\$
Facilitated Referrals			\$
Relapse Prevention/Wellness Recovery Support			\$642,500
Warm Line			\$
Substance Abuse (Primary Prevention)			\$1,810,500
Classroom and/or small group sessions (Education)			\$
Media campaigns (Information Dissemination)			\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$
Parenting and family management (Education)			\$
Education programs for youth groups (Education)			\$
Community Service Activities (Alternatives)			\$
Student Assistance Programs (Problem Identification and Referral)			\$1,810,500
Employee Assistance programs (Problem Identification and Referral)			\$

Community Team Building (Community Based Process)			\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$
Engagement Services			\$122,600
Assessment			\$
Specialized Evaluations (Psychological and Neurological)			\$122,600
Service Planning (including crisis planning)			\$
Consumer/Family Education			\$
Outreach			\$
Outpatient Services			\$
Evidenced-based Therapies			\$
Group Therapy			\$
Family Therapy			\$
Multi-family Therapy			\$
Consultation to Caregivers			\$
Medication Services			\$

Medication Management			\$
Pharmacotherapy (including MAT)			\$
Laboratory services			\$
Community Support (Rehabilitative)			\$3,628,117
Parent/Caregiver Support			\$1,186,352
Skill Building (social, daily living, cognitive)			\$280,000
Case Management			\$
Behavior Management			\$
Supported Employment			\$
Permanent Supported Housing			\$
Recovery Housing			\$2,161,765
Therapeutic Mentoring			\$
Traditional Healing Services			\$
Recovery Supports			\$597,382
Peer Support			\$597,382
Recovery Support Coaching			\$

Recovery Support Center Services			\$
Supports for Self-directed Care			\$
Other Supports (Habilitative)			\$866,310
Personal Care			\$
Homemaker			\$
Respite			\$866,310
Supported Education			\$
Transportation			\$
Assisted Living Services			\$
Recreational Services			\$
Trained Behavioral Health Interpreters			\$
Interactive Communication Technology Devices			\$
Intensive Support Services			\$
Substance Abuse Intensive Outpatient (IOP)			\$
Partial Hospital			\$

Assertive Community Treatment				\$
Intensive Home-based Services				\$
Multi-systemic Therapy				\$
Intensive Case Management				\$
Out-of-Home Residential Services				\$
Children's Mental Health Residential Services				\$
Crisis Residential/Stabilization				\$
Clinically Managed 24 Hour Care (SA)				\$
Clinically Managed Medium Intensity Care (SA)				\$
Adult Mental Health Residential				\$
Youth Substance Abuse Residential Services				\$
Therapeutic Foster Care				\$
Acute Intensive Services				\$
Mobile Crisis				\$
Peer-based Crisis Services				\$

Urgent Care				\$
23-hour Observation Bed				\$
Medically Monitored Intensive Inpatient (SA)				\$
24/7 Crisis Hotline Services				\$
Other (please list)				\$

Footnotes:

This table contain projections for FY 2014, 7/1/2013 through 6/30/2014 based on information available at the time of submission of this application.

Programs, in order from top to bottom of the table are as follows: Community Targeted Transitional Support, B.A.S.I.C, Child Care Consultation, TeenScreen, Regional Intervention Program, Older Adult Services, Community Supportive Housing, Peer-to-peer Support and Education, and Planned Respite and Respite Voucher Programs. Detailed descriptions of these programs are located in the Section II, Planning Steps documents.

Tennessee continues to update and recategorize programs according to new and changing category definitions. Some programs may fit into more than one category.

For a different view, please see attached document entitled "Description of Block Grant Expenditures."

Tennessee Department of Mental Health and Substance Abuse Services, Division of Mental Health Services, Total projected expenditures FFY 2014 for the Mental Health Services Block Grant

Contracted Agency	BLOCK	BLOCK	BLOCK	BLOCK	BLOCK
	Community Supportive Housing	Community Targeted Transitional Support	Peer to Peer Support & Education	Regional Intervention Programs	B.A.S.I.C. Programs
1	\$2,161,765	\$642,500	\$599,673	\$1,186,352	\$1,620,500
2					
3		7,500			
4					
5					
6					
7	1,114,200				
8					
9		22,000			120,008
10		50,000			
11					
12		110,000		291,162	263,887
13					
14		22,000			70,068
15					
16					
17					
18		0			
19	332,165	55,500	0	145,000	296,557
20					
21					
22		30,500		115,000	40,016
23					
24					
25					
26	35,000	32,000			

Tennessee Department of Mental Health and Substance Abuse Services, Division of Mental Health Services, Total projected expenditures FFY 2014 for the Mental Health Services Block Grant

27					
28					
29					
30					
31					
32			229,382		
33					
34					
35					
36		30,000			
37		25,000			
38		36,000			120,047
39		22,000			160,064
40		15,000			229,727
41					
42					
43		22,000			40,016
44					
45					
46	680,400	58,000			
47					
48					
49					
50					
51					
52					
53					
54					
55			368,000		
56					
57					
58				115,000	
59					

Tennessee Department of Mental Health and Substance Abuse Services, Division of Mental Health Services, Total projected expenditures FFY 2014 for the Mental Health Services Block Grant

60					
61		105,000		520,190	280,110
62					
63					
64					
65					
66	0	0	2,291	0	0
Total	\$2,161,765	\$642,500	\$597,382	\$1,186,352	\$1,620,500

Tennessee Department of Mental Health and Substance Abuse Services, Division of Mental Health Services, Total projected expenditures FFY 2014 for the Mental Health Services Block Grant

BLOCK	BLOCK	BLOCK	BLOCK	BLOCK	
Planned Respite Services	Youth Screen	Child Care Consultation	Respite Voucher Program	Older Adults Program	TOTAL BLOCK
\$647,600	\$122,600	\$190,000	\$218,710	\$280,000	\$7,669,700

					7,500
					0
					0
					0
					1,114,200
					0
					142,008
					50,000
					0
81,112				70,000	816,161
					0
					92,068
					0
					0
					0
					0
81,112				70,000	980,334
					0
					0
					185,516
					0
					0
					0
					67,000

Tennessee Department of Mental Health and Substance Abuse Services, Division of Mental Health Services, Total projected expenditures FFY 2014 for the
Mental Health Services Block Grant

					0
242,040				70,000	1,217,340
					0
					0
					0
					0
0	0	0	0	0	2,291
\$647,600	\$122,600	\$190,000	\$218,710	\$280,000	\$7,667,409

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ <input type="text"/>
MHA Planning Council Activities	\$ <input type="text" value="4,500"/>
MHA Administration	\$ <input type="text"/>
MHA Data Collection/Reporting	\$ <input type="text"/>
Enrollment and Provider Business Practices (3 percent of total award)	\$ <input type="text"/>
MHA Activities Other Than Those Above	\$ <input type="text"/>
Total Non-Direct Services	\$4500
<p>Comments on Data:</p> <p>The dollar amount listed for Planning and Policy Council (Council) activities includes mileage, lodging and lunches for Statewide quarterly Council meetings. The actual Block Grant dollar amount expended in FY 2012 for the Council was \$3840.21.</p>	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

Item C: Coverage of M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Narrative Answer:

Introduction to the system of services via Tennessee's State Government

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as the single state mental health authority (SSA) and is a separate, cabinet-level agency. TDMHSAS acts in tandem and partnership with other state agencies to achieve the following:

1. Monitoring Tennessee's implementation of the Affordable Care Act (ACA).
2. Identifying how Tennessee assesses improved access to behavioral health care and health care in general.
3. Identifying how QHP's and TennCare meet the requirements for parity as it relates to behavioral health care benefits.

TDMHSAS acts in a consultative and collaborative role to the bureau of TennCare, the state's Medicaid agency, to ensure that recipients have access to a broad range of behavioral health care services. The Bureau of TennCare is held under the auspices of the Tennessee Department of Finance and Administration (TDFA). The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) in the United States Department of Health and Human Services. TennCare is a demonstration program. The principle being demonstrated by TennCare is that a state can organize its Medicaid program under a managed care

model and generate sufficient savings to extend coverage to additional populations (who would not otherwise be Medicaid eligible) without compromising quality of care.

The Tennessee Department of Commerce and Insurance (TDCI) retained responsibility for selecting the Qualified Health Plan (as required under the ACA), ultimately selecting the Blue Cross Blue Shield PPO Plan after a period of public meetings and comment. TDCI also provides a measure of oversight of the Medicaid program and its contracted Managed Care Organizations (MCO's). TDCI examines the affairs of any health maintenance organization as often as is reasonably necessary for the protection of the interests of the people of Tennessee.

The Tennessee Department of Health (TDOH) is the public health agency for the state of Tennessee. TDOH is charged with addressing such issues as prevention as it relates to problems that contribute to disease and injury, immunizing children against childhood diseases, recruiting doctors to practice in rural medically underserved areas of Tennessee, offering early prenatal care and proper nutrition to pregnant women, ensuring that restaurants meet standards of cleanliness, and performing laboratory tests to ensure safe drinking water. The TDOH provides some laboratory services under the auspices of TDMHSAS's Behavioral Health Safety Net of Tennessee and provides screening for mental health and substance abuse in TDOH clinics. In addition, TDOH licenses and regulates health care professionals, maintains vital records and provides mobile dental services to underserved populations and areas.

The Tennessee Department of Human Services (TDHS) presently processes initial applications for eligibility for benefits including Families First, the state's Temporary Assistance for Needy Families (TANF) program, Food Stamps (now known as the Supplemental Nutrition Assistance Program or SNAP), Medicaid/TennCare, Child Support, Child Care Licensing, Child Care Assistance, Adult Protective Services, and Rehabilitation Services. TDHS provides the workforce necessary for establishing benefits available to eligible citizens.

The TennCare benefit array for behavioral health covers outpatient counseling and psychiatric care, medication management, inpatient care and other clinical services. TennCare publishes the eligibility criteria and the covered services list. A copy of the most recent benefit list is included as an attachment with this application. For services not covered by TennCare for eligible populations/persons, or for those persons who are part of the "churn" of eligible citizenry who may, for various reasons, move in and out of eligibility, TDMHSAS's Behavioral Health Safety Net of Tennessee (BHSNTN) covers ancillary and direct services. Services listed on Table 3 are identified on various choices of the TennCare benefit list as published by the MCO's in accordance with state and federal law and contractual arrangement.

The BHSNTN offers community-based, core, vital services that people living with serious mental illness must access to continue leading functional, productive lives. This includes assessment, evaluation, diagnostic, therapeutic intervention, case management, psychiatric medication management, labs related to medication management and pharmacy assistance and coordination. Beginning February 2013, the TDMHSAS has added peer support services and psychosocial rehabilitation to services covered by the BHSNTN. The BHSNTN partners with 15 community mental health providers across Tennessee to continue providing core behavioral health services to more than 32,500 indigent individuals living with serious mental illness. As the state implements the Affordable Care Act, the plan for the future of the BHSNTN includes ongoing evaluation for need in Tennessee and increasing "gap" services for those who are uninsured who are not eligible for

Medicaid, and for those needing assistance in between periods of employment. The Behavioral Health Safety Net of Tennessee is funded by State dollars and does not receive Block Grant funding.

The Behavioral Health Safety Net of Tennessee database is an eligibility, service delivery tracking, and payment system for the BHSNTN program and is an internally developed web-based application. Providers may send electronic claims or enter services through the Web-based system. The BHSNTN system utilizes national standard codes including ICD-9, HCSPCS, and NPI numbers.

Through the use of independent eligibility verifications completed by the Bureau of TennCare, the TDMHSAS's Behavioral Health Safety Net of Tennessee and the Tennessee Department of Commerce and Insurance, individuals in Tennessee are enrolled in the appropriate service delivery mechanism for physical and behavioral health services. For uninsured individuals in Tennessee, TennCare eligibility would be determined. If the individual is ineligible for TennCare and unable to purchase a Qualified Health Plan (QHP) through the Health Insurance Marketplace, the individual may then be eligible for the BHSNTN in the event eligibility requirements are met. Tennessee uses a multifaceted approach to ensure that the highest quality mental health and substance abuse services are provided to citizens through the appropriate coverage mechanism. The comprehensive approach exemplified by the three entities completing eligibility verifications further demonstrate Tennessee's commitment to serving citizens in a responsible way.

Presently, initial eligibility for TennCare (Medicaid) is established through the Tennessee Department of Human Services (TDHS). A new system for determining eligibility is under development that will serve the Health Insurance Marketplace and will process applications for TennCare, Medicare, and other types of insurance. There exist eligibility determinants and a significant provider network for BHSNTN and TennCare that seek to ensure that the core of services that are needed to establish good health are available to all citizens. Through partnership and collaboration, weekly eligibility checks are shared between agencies to ensure that no citizen is without those core benefits and services.

Qualified Health Plan (QHP) owners must arrange for the approval of each QHP through the Health Insurance Marketplace by means of submission of an application. Tennessee's Health Insurance Marketplace will be operated by the federal government. EHB requirements provide for mental health and substance abuse services to be provided by the QHPs.

The exact process of implementation is under development as the various Departments work together to establish a system of care. Currently, citizens may register a complaint with TDMHSAS or with the Tennessee Department of Finance and Administration (TDFA), Division of Health Care Financing. The TDCI also provides a measure of oversight for Tennessee's Medicaid program and its contracted MCOs to ensure that citizens are served according to state and federal law requirements.

To a large extent, Tennessee's Mental Health Block Grant (MHBG) service array is already positioned to cover the uninsured and underinsured and to establish services for those citizens moving in and out of eligibility. As the Health Insurance Marketplace is operationalized, Tennessee will be vigilant to ensure that coverage is consistent with established essential health benefits required by the ACA.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

Item D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. State Mental Health Authorities and State Substance Abuse Services Authorities (SMHAs and SSAs) should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Narrative Answer:

Individual recipients of Medicaid initially may apply for benefits via the application process administered by the Tennessee Department of Human Services (TDHS). Subsequent determinations of eligibility (for TennCare/Medicaid) will take place independent of the TDHS process via a to-be-established procedure. However, the existing process establishes the “churn” of eligibility changes that may occur as recipients become employed, become unemployed, change jobs, add family members, have children, etc. Unduplicated and repeated recipients of Medicaid and Behavioral Health Safety Net of Tennessee (BHSNTN) services are tracked through the TennCare information system and the BHSNTN database. Those persons who lose TennCare eligibility may be picked up by BHSNTN and then may reestablish eligibility for TennCare benefits if possible through a re-application process.

Through community mental health providers, Tennessee has established positions called eligibility assisters that will assist service recipients with accessing services and building a successful future. The assisters positions are separate from the funding mentioned below and, in a different format, existed prior to the Navigator program included as part of the ACA. The positions exist as part of the BHSNTN program for the purpose of helping those who have a need for medication or some other benefit and are unable to get that need through other means.

In addition, TDMHSAS is working to establish the Behavioral Statistics System of Tennessee (BeSST) that will ultimately track all enrollment, treatment, eligibility and demographic data of Tennesseans receiving behavioral health services. In the meantime, TDMHSAS has assembled data from different sources to track enrollment and other information to ensure that all eligible persons are enrolled for the appropriate coverage and that those enrolled have access to core and needed services. Data is assembled from all possible sources including TennCare, BHSNTN database, Tennessee Web-based Information Technology System (TN-WITS), the Tennessee Association of Mental Health Organizations (TAMHO) data warehouse, the Regional Mental Health Institute database called AVATAR, and other sources.

TDMHSAS, in collaboration with other Departments and service providers, is addressing the Navigator and assister possibilities and philosophy to ensure that it meets the needs of citizens. Tennessee’s \$1.48M share of the dollars available for Navigator funding is being discussed among agencies eligible to add the positions that serve the role of eligibility assister. At the time of this application, this program is under development although many Tennessee providers already assist patients and consumers with establishing benefits. Early indications are that several TDMHSAS contractors will add eligibility assister responsibilities to the job duties of staff that already provide non-clinical benefit-related assistance services to Tennesseans.

As stated before, Tennessee’s Behavioral Health Safety Net of Tennessee (BHSNTN) offers community-based, core, vital services that people living with serious mental illness need to continue leading functional, productive lives. This includes assessment, evaluation, diagnostic, therapeutic intervention, case management, psychiatric medication management, psychosocial education, peer support services, labs related to medication management and pharmacy assistance and coordination. The BHSNTN partners with 15 community mental health providers across Tennessee. Many of these same providers also offer Medicaid covered services to those recipients who are a part of the eligible group of citizens.

There are technical and financial eligibility requirements that must be met by individuals before they can qualify for BHSNTN assistance. Individuals who are eligible for the BHSNTN must meet the following requirements:

1. Be determined ineligible for TennCare or, if not ineligible, have completed a Tennessee Department of Human Services (TDHS) TennCare application;
2. Do not have private health insurance, or the private health insurance lacks mental health coverage or all mental health benefits under private health insurance have been exhausted as determined by the provider in consultation with the service recipient. NOTE: Individuals with private health insurance providing mental health benefits with high deductibles are considered to possess private health coverage, even if the deductible is financially difficult for the individual to meet. Therefore, said individual would not be eligible for BHSNTN assistance.
3. Do not have Medicare Part B coverage with the exception of the Daniels Class Dis-enrollees with Medicare Part B; MHSN/CTR 2005 Dis-enrollees with Medicare Part B; and applicants residing in TDMHSAS Planning Council Regions 1 or 2 of the state with Medicare Part B.
4. Do not have behavioral health benefits through the Veteran's Administration;
5. Be a U.S. Citizen, or legal resident alien;
6. Be a resident of Tennessee;
7. Be diagnosed with a qualifying mental health diagnosis which indicates serious primary mental illness (ICD-9 diagnosis code list is provided as an attachment in the attachment list);
8. Have a household income at or below 100% of the Federal Poverty Level (FPL);
9. Be nineteen to sixty-four (19-64) years of age with the exception of the Daniels Class Dis-enrollees; MHSN/CTR dis-enrollees with Medicare Part B; and applicants residing in TDMHSAS Planning Council Regions 1 or 2 of the State with Medicare Part B.
10. Not be in an inpatient facility; and
11. Not be an inmate or not be incarcerated.

Tennessee's marketplace will be operated by the federal government. At the time of this application, the Healthcare.gov website states that the Centers for Medicaid and Medicare Services will ensure that providers are paneled with those QHP owners offered through the Health Insurance Marketplace.

The programs that utilize dollars that serve MHBG recipients are not direct service programs (psychiatric care, therapy, medication management, etc.). Most programming funded by MHBG dollars is ancillary programming that covers services not covered by third-party payor coverage or by Medicaid or Medicare. MHBG funds are used in Tennessee to support, not supplant, the services covered by the TennCare (Medicaid) program.

In addition to the array of supportive ancillary services provided via MHBG funds, the State of Tennessee provides the BHSNTN program that does supply individuals with core and necessary services in the absence of a third-party payor either by the individual being uninsured or the service not being covered. BHSNTN recipients are 100% uninsured or underinsured and are 100% or less of the FPL in income. Please see the eligibility criteria for the BHSNTN listed above, this item.

Providers named on the Statewide Entity Inventory and the evidence-based practice survey were polled on May 22, 2013. 100% of providers in that group offering programming consistent with TennCare-covered services are enrolled as panel providers in the TennCare program.

Providers named on the Statewide Entity Inventory and the evidence-based practice survey were polled on May 22, 2013. 100% of providers in that group offering programming consistent with TennCare covered services will remain enrolled as panel providers in the TennCare program for the foreseeable future. Some providers may add service capacity in 2015 as the result of a possible increase in the number of covered recipients due to a possible Medicaid expansion or increased need.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

Item E: Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc. States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG.

State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Narrative Answer

Forward: In the application approved in late May 2013, guidance around this question focuses on SAMHSA's program integrity efforts to: (1) promote the proper expenditure of Block Grant funds, (2) improve Block Grant program compliance nationally, and (3) demonstrate the effective use of Block Grant funds. The guidance states that SAMHSA is "strongly recommending that states use the MHBG and SABG resources to support, not supplant, individuals and services that will be covered through QHPs and Medicaid." The guidance goes on to state that the program integrity efforts at SAMHSA are under discussion and development (paraphrasing).

TDMHSAS carries out an annual contracting process, a rigorous review process, and monitoring of programs that includes on-site review, written reporting, data management and fiscal audit for all Block Grant funded programs. Both TDMHSAS contracting and monitoring procedures were recently the subjects of Tennessee's LEAN review. LEAN is a philosophy and a set of tools that focus on business processes to maximize value while minimizing roadblocks. As funders of the TDMHSAS focus more on efficiency and outcomes, TDMHSAS is committed to self-review and quality improvement practices.

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

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

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

Providers' contracts require that other sources of funding are used prior to drawing of dollars from Block Grant funding (see Item C, Coverage for M/SUD Services for eligibility information). Contract language includes a requirement that eligibility for Medicaid and other funding is verified before utilizing Block Grant dollars. In addition, providers' contracts include language pertaining to compliance with the law, compliance with the reporting of outcomes, and the specifics of program operations and payment requirements. Department staff monitors contract compliance and is responsible for audit, compliance check-ins, and communicating quality and safety standards

including credentialing and selection of staff associated with the program (see question 2 this item). Staffing credentials including background checks and certification or licensing needs are also included in the contract language.

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

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

Tennessee provides “gap” programming for those services or individuals not covered by Medicaid. With the exception of the Behavioral Health Safety Net of Tennessee services, there are no direct-service programs synonymous with those covered under Tennessee’s Medicaid programs or other third-party payor coverage. Further, the Behavioral Health Safety Net of Tennessee is funded by state dollars and does not receive MHBG funding. MHBG dollars cover those services that are not covered by Medicaid, Medicare, employer-sponsored insurance or other third-party payor coverage.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

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

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

Item F: Use of evidence in purchasing decisions

Narrative Question:

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

- 1) Does your state have specific staff that are [sic] responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Narrative Answer:

In collaboration with the Division of Clinical Leadership (DCL), and in addition to the core purposes for the Office of Research, the data and information produced by the Office of Research helps to produce best practice guidelines for use by psychiatrists, primary care physicians, psychologists, health service providers, nurses, nurse clinicians, physician extenders, social workers and other health care professionals. Guidelines are published for use with adult and children's services and will later add specialized guidelines for substance abuse, senior services, trauma-informed care, and system of care.

To accomplish the production of the best practice guidelines, the DCL staff developed statewide workgroups comprised of professionals with expertise in each area named in the guidelines. The workgroups then met, developed a set of principles and practices based on empirical data, and then published those items as part of the peer-reviewed guidelines. The documents are available on the TDMHSAS website at <http://tn.gov/mental/omd/omdbpg.html>. Best practice guidelines that encompass substance abuse services and treatment will be available before July 2014.

TDMHSAS created the Office of Research in 2011 to ensure that the use of data and evidence-based practices became a priority as part of the mission of the Department. The purpose for the Office of Research is to provide information to the Commissioner, Governor, providers, stakeholders and staff that inform the delivery system planning process. The Office of Research develops data regarding policy, programs, and state standing on the national stage via a number of statistics collected from various sources. Sources include, but are not limited to, the following:

- Kids Count
- U.S. County Health Rankings
- National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)
- National Institute of Mental Health

- SAMHSA /National Survey on Drug Use and Health
- Behavioral Risk Factor Surveillance System (BRFSS) and the Youth BRFSS with the Centers for Disease Control and Prevention
- Tennessee Department of Health
- TennCare (Medicaid Tennessee)
- Behavioral Health Safety Net of Tennessee (BHSNTN)
- Tennessee Outcome Measurement System (TOMS)
- SAMHSA Uniform Reporting System
- Agency for Healthcare Research & Quality (AHRQ), U.S. Department of Health & Human Services (HHS)
- Center for Evaluation and Program Improvement (CEPI)
- Department of Psychiatry, University of Pittsburgh School of Medicine
- Children’s Hospital Boston
- Georgia State University, Department of Psychology
- Modified Checklist for Autism in Toddlers (instrument and scoring directions)
- Vanderbilt ADHD Diagnostic Parent Rating Scale (VADPRS) and Vanderbilt ADHD Diagnostic
- Teacher Rating Scale (VADTRS)
- SAMHSA national consensus statement on mental health recovery

The Office of Research works collaboratively with TDMHSAS staff, providers and other state agencies and employees to ensure that Tennessee’s resources for mental health and substance abuse services are efficiently and effectively utilized. The Office of Research supports policy makers by providing the information, data, and research necessary to make data-driven decisions and conduct evaluation activities that measure the effectiveness and efficiency of projects and programs.

As SAMHSA establishes good, modern and contemporary best practices for all areas of service covered by Block Grant dollars, TDMHSAS will build best practice language into contracts with providers funded by Block Grant dollars. Contracting language, then, leads to the ability of TDMHSAS to monitor for compliance.

Programs that presently are funded with Mental Health Block Grant dollars that are evidence-based, best practice and/or research supported include the Regional Intervention Program, the Shield of Care program, Youth Screen, and the Child Care Consultation program.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

Item G: Quality

Narrative Question

In addition to the measures noted by SAMHSA:

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Tennessee will focus on two main measures in the areas of prevention and recovery. The prevention priority will be suicide prevention with a focus on at-risk groups. The recovery priority will be the continuing effort to integrate medical and behavioral health through the My Health My Choice My Life program which teaches and advocates for overall wellness and recovery.

Narrative Answer:

Tennessee will focus on two main measures in the areas of prevention and recovery. The prevention priority will be suicide prevention with a focus on at-risk groups. The recovery priority will be the continuing effort to integrate medical and behavioral health through the My Health My Choice My Life program which teaches and advocates for overall wellness and recovery.

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

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

According to the TSPN, “in 2011...Tennessee’s age-adjusted suicide rate was 14.6 per 100,000 people, translating into 938 reported suicide deaths. This rate and number are down from previous years but are still above the national average of 12.4 per 100,000 as reported for the year 2010 by the Centers for Disease Control (CDC).” (Status of Suicide in Tennessee, 2013). According to the TSPN, suicide claims more lives in Tennessee “than homicide, drunk driving, or HIV infection.” (Tennessee’s Older Adult Suicide Prevention Plan, 2013).

Suicide can result when an individual finds him or herself experiencing a variety of stressors or difficulties in the various domains of everyday life such as interpersonal relationships, communities, institutions, and society. The suicide of youth can be lately attributed to bullying or like issues related

to school. The suicide of older adults may be attributed to depression, isolation, poor health, and an ageist society that devalues older persons. (Older Adults, 2013).

The TDMHSAS, in partnership with TSPN, seeks to raise awareness and educate the public regarding the warning signs of suicide and how to react to prevent possible suicidal behavior. Tennessee's new best practice program, the Shield of Care, is being implemented statewide with quality outcomes evidenced by a further decrease of the suicide rate in Tennessee to below the national average.

The Shield of Care is a ground-breaking grant-funded suicide prevention curriculum developed in Tennessee specifically for staffs that work in juvenile justice facilities in which youth can be at a higher risk for suicide than in the general population. This curriculum is the culmination of three years of studies of suicide in juvenile justice settings, best practice literature, experience providing community general suicide gatekeeper training in Tennessee's juvenile justice facilities, and input from a workgroup with broad membership of juvenile justice and child-serving stakeholders. Focus-group style input from juvenile justice facility staff that included clinical, security and educational disciplines helped assure that the content would be relevant and useful to those working in the field. The curriculum combines didactic material, group activities and dramatized scenarios in video clips to help participants develop skills forming the Shield of Care S-PLAN:

- See suicide risk;
- Protect the physical and emotional safety of youth;
- Listen to youth express their feelings;
- Assess the severity of risk, and;
- Network with other staff to prevent suicide.

All training materials, including trainer and participant workbooks, PowerPoint with embedded video clips and wallet cards are posted on the TDMHSAS website. The Shield of Care has been accepted and registered as a best practice by the Suicide Prevention Resource Center, a project of the Education Development Center of Massachusetts.

Activities and metrics: 200 teachers will receive suicide awareness training, 1000 youth will receive peer suicide awareness training, and 50 Tennesseans will be trained as gatekeepers for suicide prevention. 50 emergency departments will be provided suicide prevention training. Second-year target/outcome measurement: Maintain or increase the numbers from the year prior. Data source: National Vital Statistics System–Mortality (NVSS–M), CDC, NCHS. from the prior year; 200 teachers will receive suicide awareness training, 1000 youth will receive peer suicide awareness training, and 50 Tennesseans will be trained as gatekeepers for suicide prevention. 50 emergency departments will be provided suicide prevention training. Second-year target/outcome measurement: Maintain or increase the numbers from the year prior.

Outcome measure: Reduction in the rate of suicide by 10% with the goal of reaching the Healthy People 2020 target of 10.2 suicides per 100,000 population: 2011 baseline: 14.6 suicides per 100,000 population.

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

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

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

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

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

The recommended length and timeframe of CDSMP and DSMP is 2.5 hours per week for 6 weeks. Recommended class size is 10-16 people.

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

Activities and metrics: 15 agency staff trained in CDSMP and DSMP workshops, 20 workshops held, 200 consumers attended workshops in FY 2014. Second-year target/outcome measurement: 11 agency staff trained in CDSMP and DSMP workshops, 6 workshops held, 60 consumers attended workshops in FY 2015.

Outcome measures: (1) An increased number of people receiving mental health services who show improved physical health as measured by responses to the question: “In past 30 days, how much of the time has your physical health interfered with your daily life? All of the time; Most of the time; Some of the time; A Little of the time; None of the time.”

And/or

(2) An increase in recovery from mental illness reported by people receiving mental health services as measured by scores on the Recovery Assessment Scale.

Status of Suicide in Tennessee. (2013). Tennessee Suicide Prevention Network.

Tennessee’s Older Adult Suicide Prevention Plan. (2013). Tennessee Suicide Prevention Network.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

Item H: Trauma-informed Care

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Narrative Answer:

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

The TDMHSAS's Crisis Continuum is currently moving toward a more trauma-informed philosophy. This is evidenced by a specialized training requirement for staff who conduct assessments for consideration of a history of trauma. Consideration will be made for those with a history of military service and children who may have involvement with child welfare agencies.

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

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

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

To that end, TDMHSAS has agreed to partner with the Tennessee Centers of Excellence for Children in State Custody (COE) to integrate statewide SOC efforts into their existing infrastructure and expand their efforts where appropriate to accomplish TDMHSAS' SOC expansion goals. "The mission of the Centers of Excellence is to improve the quality of physical and behavioral health services provided to children in or at-risk of entering Tennessee state custody by providing direct clinical services, disseminating evidence-based practices, and implementing quality improvement projects" (Vanderbilt University, 2013).

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

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

making and monitor outcomes in child-serving systems. The Vanderbilt COE maintains a statewide infrastructure to train and certify TDCS staff to reliably use the CANS, and deploys a staff of Master's-level consultants in each TDCS region to support use of the information for services planning.

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

IV: Narrative Plan

I. Justice

Narrative Question:

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

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

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

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

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

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

Footnotes:

Item I – Justice

Narrative Question:

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5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Narrative Answer:

TDMHSAS operates 31 **Drug/Recovery Courts** across the state. A total of 37 Drug/Recovery Courts exist, six of which are funded by other means. Within the auspices of the Drug-Recovery

Court operation, TDMHSAS operates four DUI Courts, three Mental Health Courts, and three Veteran's Courts.

TDMHSAS Drug/Recovery Courts are funded with state appropriations and drug court fees. The drug courts are specialized courts or court dockets that incorporate the following for the target population: intensive judicial supervision; treatment services; sanctions; and incentives to address the needs of addicted non-violent offenders. The target population includes juvenile and adult male or female offenders who meet the criteria of the Drug Court Program and voluntarily participate in the Drug Court Program. Each drug court is comprised of a team that includes judge, prosecutor, defense attorney, drug court coordinator, probation officer, treatment providers, and other program staff. The team works in concert to ensure that defendants have the support of the justice system and access to treatment services that will address their substance abuse problems and needs. Every drug court receiving state funding must follow the ten key components for Drug Courts adopted by the Bureau of Justice, Justice Assistance Programs and receive certification from Tennessee Department of Mental Health and Substance Abuse Services.

The ten key components for operation of drug/recovery courts are as follows:

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Drug courts use a non-adversarial approach, promote public safety while protecting participants' due process rights.
3. Drug courts identify eligible participants early and promptly place them in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Drug courts monitor abstinence by frequent alcohol and other drug testing.
6. Drug Courts use a coordinated strategy to govern responses to participants' compliance.
7. Drug Courts use ongoing judicial intervention with each drug court participant as an essential component of the program.
8. Drug Courts utilize monitoring and evaluation to measure the achievement of program goals and gauge effectiveness.
9. Drug courts employ continuing interdisciplinary education to promote effective drug court planning, implementation, and operations.
10. Drug courts forge partnerships among the court, public agencies, and community-based organizations to generate local support and enhance drug court effectiveness.

Statewide Recovery Court--Effective August 1, 2013, TDMHSAS and the Tennessee Department of Correction (TDOC) opened the first state-wide residential Recovery Court in the nation. The court is located in the Tennessee Morgan County city of Wartburg, which is about 45 miles west of Knoxville. The 100-bed program has been established to allow the state to divert people in need of substance abuse treatment or mental health services from prison beds to effective treatment programs that evidence-based and proven to have a larger impact on reducing recidivism. The Recovery Court will also allow prison beds to be reserved for those violent offenders who are in most need of them and who have a more noticeable effect on public safety.

TDMHSAS and the Tennessee Department of Corrections (TDOC) maintain a collaborative relationship for mental health and substance abuse service availability for inmates. TDOC and TDMHSAS offer several programs that address the needs of individuals involved in the criminal and juvenile justice systems both prior to and following adjudication. TDOC Office of Mental Health Services sets the policy standards for the delivery of inmate mental health services and evaluates the care provided throughout the department's system. Mental Health Services performs mental health screenings, extensive mental health appraisals and evaluations. Tennessee's correctional system provides inmates with access to a continuum of treatment services including medication management, psychotherapy and case management.

The TDOC strives to improve quality of life for inmates by ensuring access to quality mental health care that reduces the debilitating effects of serious mental illness which, in turn, helps to ensure the safety of prison staff, inmates, volunteers, prison visitors, and the community. Mental health services (associated with the TDOC) is initiating a major effort to provide the best possible care by initiating Centers of Excellence based on Levels of Care. (Scope, 2013).

In Tennessee, the Department of Corrections ensures that mental health and substance abuse issues and disorders are addressed by way of a service system that is consistent with a community mental health model as a part of Inmate Health Care within Tennessee's prisons. Inmates are able to access mental health services at any time during their incarceration. Referrals for mental health services are often from inmate family members or cohorts, line or medical staff, or family members. Inmates also self-refer for mental health services. According to TDOC policy or ACA guidelines, special populations are screened or assessed for mental health services upon referral. During incarceration, mental health team staff regularly visits all segregation areas to make certain no inmate is placed in a segregated area because of their mental illness and to ensure inmates get the mental health services they need.

TDOC identifies the scope of services and care as follows:

- Mental health programming for each level of care, including individual and group therapy and other pro-social life skills
- Partial hospitalization
- Crisis intervention
- Pharmacy
- Labs related to medication management
- Psychiatric medication management
- Multi-disciplinary mental health treatment teams
- Psychological testing
- Residential sex offender treatment
- Tele-psychiatry
- Sheltered living for Seriously and Persistently Mentally Ill (SPMI) inmates in acute care supportive and in chronic care supportive living units (Scope, 2013).

Additionally, within TDOC, mental health services are included as a component of the system of care, which includes transition and reentry. Tennessee also has Correctional Release Centers, which provide evidence-based services to meet the offender's needs as identified by the Level of

Service/Case Management Inventory (LS/CMI), which is a validated risk/needs assessment tool (<http://www.tn.gov/correction/rehabilitative/reentry.shtml>).

The Criminal Justice/Behavioral Health Liaison Program (CJ/BH LP) is a community project to facilitate communication and coordination among the community, criminal justice and the behavioral health systems to achieve the following common goals:

- decriminalizing mental illnesses, co-occurring disorders (COD) and substance abuse disorders;
- supporting the establishment of services that would promote diversion activities for persons with serious mental illness (SMI), mental illness (MI), COD or substance abuse disorders (SUD) who come in contact with the criminal justice system due to an arrest; and
- providing liaison and case management services to adults with SMI, MI, COD or substance abuse disorders who are incarcerated or at risk of incarceration and who would benefit from referral and linkage to behavioral health, and other recovery and supportive services.

The Shield of Care component of the state's suicide prevention strategy comprises the progressive emerging approach to prevention. The Shield of Care is ground breaking suicide prevention curriculum specifically for persons who work in juvenile justice facilities. The culmination of three years of development, the curriculum is based on studies of suicide in juvenile justice settings, best practice literature, our experience providing community general suicide gatekeeper training in Tennessee's juvenile justice facilities, and input from a workgroup with broad membership of juvenile justice and child-serving stakeholders. Focus-group style input from juvenile justice facilities staff that included clinical, security and educational disciplines helped assure that the content would be relevant and useful to those working in the field.

The curriculum combines didactic material, group activities and dramatized scenarios in video clips to help participants develop skills to utilize the Shield of Care S-PLAN:

- See suicide risk,
- Protect the physical and emotional safety of youth,
- Listen to youth express their feelings,
- Assess the severity of risk, and
- Network with other staff to prevent suicide.

All training materials, including trainer and participant workbooks, PowerPoint with embedded video clips and wallet cards are posted on the TDMHSAS website. The Shield of Care program was recently accepted to the Suicide Prevention Resource Center's (SPRC's) Best Practice Registry (BPR), which is a collaborative effort with the American Foundation for Suicide Prevention and SAMHSA.

The Tennessee Integrated Court Screening and Referral Project (TICSRP) employs mental health and substance abuse screening of youth at the earliest point of entry into a juvenile court as an early intervention/prevention strategy to divert youth from the justice system when appropriate and support resiliency toward independent functioning. TICSRP is supported by a multi-agency collaboration including the Administrative Office of the Courts (AOC), the Tennessee Department

of Children's Services (TDCS), the Vanderbilt University Center of Excellence (VUCOE), the Tennessee Commission on Children and Youth (TCCY) and Tennessee Voices for Children (TVC).

TICSRP trains Youth Service Officers to complete a 33-item juvenile justice screening version of the Child and Adolescent Needs and Strengths (CANS) survey. Screenings are conducted as a part of the court intake process for all youth alleged to be unruly or delinquent. Any mental health, substance abuse or family support needs identified by the screening result in a referral by the TDCS court liaison to locally available evidence-based services. A previous Transfer Transformation Initiative (TTI) grant allowed for the establishment of family service providers (FSP) in some of the pilot counties. FSPs are self-identified parents/caregivers of a youth who have required mental health and/or substance abuse treatment. FSPs complete a TDMHSAS certification process which is similar to a peer support counselor. Their role is primarily to assist youth and families to follow up on referrals and overcome barriers to treatment.

In the first phase of the project, 43 youth service officers in 12 pilot juvenile courts were certified as CANS screeners. Over 2,500 screenings have been conducted resulting in over 1,800 service referrals since October of 2010. More than 90 families have received direct individual assistance from FSPs. A new TTI grant will allow for expansion of this project to additional courts and provide family peer support services to additional families.

Board of Parole Risk Assessment Evaluations: The Office of Forensic and Juvenile Court Services contracts with the Vanderbilt University Department of Psychiatry for a variety of forensic mental health evaluations, including risk assessments of parole-eligible inmates in the (TDOC). Tennessee law requires mental health evaluations of offenders convicted of certain sex offenses prior to consideration for parole, and the Board of Parole also makes discretionary requests for evaluation of violent offenders, often convicted of murder. The TDOC coordinates with the Vanderbilt University evaluators to make the inmates and their records available in a secure setting appropriate for mental health evaluations. Between 30 and 40 such evaluations are completed each year for the Board of Parole.

The Safe and Respectful School Decision-Maker course is a train-the-trainer workplace violence prevention curriculum presented in collaboration between TDMHSAS Office of Forensic and Juvenile Court Services and Tennessee Department of Education (TDOE) to school district administrators, supervisors and security directors of local school districts.

Other programs that address the justice needs and programs of those who live with mental illness, substance abuse disorders and co-occurring disorders will be described in the Substance Abuse Block Grant plan.

Scope of Mental Health Services. (2013). Retrieved on March 1, 2013 from
Reti<http://www.tn.gov/correction/clinical/mentalhealthservices.html>.

IV: Narrative Plan

J. Parity Education

Narrative Question:

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

Item J: Parity Education Possibilities in Tennessee

Narrative Question:

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Narrative Answer:

Tennessee's Mental Health Block Grant (MHBG) dollars provide funding to the Tennessee Mental Health Consumers' Association (TMHCA) to provide training and educational activities for consumers across the state. The TDMHSAS Office of Consumer Affairs and Peer Support Services will provide technical assistance to TMHCA to develop a parity communication strategy for consumers statewide. The parity communication strategy will include such communication tools as an easy-to-understand PowerPoint presentation and associated fact sheets that TMHCA Peer Recovery Specialists will deliver in person to the state's 45 Peer Support Centers.

TDMHSAS is developing a plan to work with statewide healthcare providers and other state agencies, such as the TDOH, to create parity educational materials for primary care physicians throughout Tennessee to provide to their patients.

TDMHSAS will begin the parity education process by developing a workgroup comprised of consumers, consumer and family organizations, mental health providers, and other stakeholders, etc. to come together to ensure that outreach is both broad and strategic and that the appropriate and relevant audiences are targeted.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

Item K: Primary and Behavioral Health Care Integration

Narrative Question:

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

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6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Narrative Answer:

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

MHMCML focuses on wellness and good general health promotion for Tennesseans who live with mental health and substance use disorders. The holistic health initiative integrates a medical model that emphasizes recovery and resiliency resulting in an initiative that centers on overcoming physical and mental health symptoms through strengths and personal empowerment. The program is facilitated by individuals who have first hand, lived experience with psychiatric and/or co-occurring

disorders. MHMCML is comprised of three specific services: Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program (DSMP) and Peer Wellness Coaching (PWC). MHMCML provides individuals with self-directed tools, empowerment by means of acquiring the knowledge, skills and resources to improve overall well-being and resiliency to make it possible for individuals to live healthy and purposeful lives.

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

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

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

The recommended length and timeframe of CDSMP and DSMP is 2.5 hours per week for 6 weeks. Recommended class size is 10-16 people.

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

Other Tennessee Organizations Understanding the Value of Integration

On April 15, 2013, **Centerstone Health Partners** joined forces with Physician Health Partners to develop integrated healthcare clinics. The new clinics will serve both the medical and behavioral health needs of all patients. The underpinning design of the clinics allows patients to address primary care concerns that may also affect behavioral health and behavioral health concerns that may affect medical health. Services are presently offered for children only in Maury, Davidson and Montgomery Counties.

Cherokee Health Systems, based in East Tennessee, offers a unique training opportunity for clinicians and other professionals to learn about healthcare integration. Cherokee provides the Primary/Behavioral Health Integrated Training Academy that teaches the constructs of integrated care ranging from services to administrative functions. Cherokee also offers integrated care models of services in several of the 13 counties of east Tennessee in which Cherokee offers services.

Other mental health providers are in the early stages of planning for ways to integrate care including but not limited to co-location of primary care and behavioral health, provision of behavioral health services in Federally Qualified Health Centers (FQHC), and FQHC look-alikes, and the provision of behavioral health services in clinics operated by the TDOH.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

Item L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities. While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Narrative Answer:

As TDMHSAS develops and creates the BeSST data collection system, the collection of demographic information by gender, race, ethnicity and age is included in the data elements. Presently, TDMHSAS does not track the LGBTQ population at the client level due to the issues surrounding the complexities of inquiring after such information and the distinct possibility that the numbers would be skewed due to the unwillingness of recipients to reveal sexual orientation information. However, information on the availability of services for this specific population was requested in TDMHSAS's annual needs assessment survey. Items incorporating requests for service availability sensitive to the needs of this and other minority and ethnic populations were included for all those surveyed namely consumers, caregivers, providers and stakeholders. TDMHSAS is in the process of finalizing common data elements for behavioral health service availability in Tennessee

including data for populations that could possibly experience difficulty in locating services specific to their needs.

The TDMHSAS, as of January 2013, completed *Best Practice Guidelines for Children and Youth*. These Best Practices guidelines specifically address children and adolescents who identify as lesbian, gay, bisexual, transsexual, transgendered and gender nonconforming, or questioning. There are nine (9) practice principles outlined in the Best Practices which indicate the importance of individual factors and their interplay in the life of the individual receiving services. For example, principle four (4) states that “Clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk (listed are: bullying, suicide, high-risk behaviors, substance abuse, HIV/AIDS and other sexually transmitted diseases). The documents are available on the TDMHSAS website at <http://tn.gov/mental/omd/omdbpg.html>.

Additionally, suicide prevention efforts in Tennessee cover the life span and both genders with a major emphasis on youth. Specific populations have been targeted, specifically the African American community, LGBTQ, college-aged young persons and the elderly. Mental Health Block Grant monies are used to fund contracted vendors who implement Tennessee’s mental health service continuum across the life span and are included within disparity-vulnerable subpopulations.

TDMHSAS staff joins the Cultural and Linguistics Competency Coordinators monthly conference calls. This call is coordinated by staff at the National Center for Cultural Competence and National Technical Assistance. The mission of the group focuses on integrating cultural and linguistic competency throughout mental health treatment for all individuals.

The System of Care (SOC-EXP) Expansion Initiative includes a principle that addresses the need for “culturally and linguistically competent, with agencies, programs, and services that are responsive to the cultural, racial, ethnic, and language differences of the populations.” (see http://www.tn.gov/mental/mentalhealthservices/sp_SysCare_core.html). As Tennessee implements the SOC-EXP expansion statewide, this principle, along with the others associated with and unique to the SOC operational paradigm, will become a part of the service delivery model.

TDMHSAS Division of Clinical Leadership (DCL) staff takes part in special projects with the TDOH Office of Minority Health to address disparities in both mental health and physical health.

In terms of addressing the needs of underserved populations, all organizations contracting with TDMHSAS for funding for services must comply with Title VI of the Civil Rights Act of 1964. Recipients of services funded through the State of Tennessee are eligible for language assistance, interpreter services for the deaf and hard of hearing, and may receive reasonable accommodations for disabilities which might otherwise prevent them from receiving services. The TDMHSAS provides the Family Support and Advocacy program designed to provide support and advocacy for those families with a child who is diagnosed with SED.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

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

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

Item M: Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the widescale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has [sic] developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

YES: Tennessee has adopted a definition of recovery and a set of recovery values and principles described below.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

YES: The State of Tennessee and its contractors hire those who are in recovery for all roles, including leadership roles.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

YES: The Department of Mental Health and Substance Abuse Services uses person-centered language, planning and self-direction, and moves forward to recipient-driven care in all corners of the state.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

YES: Tennessee provides every type of program and service named in this question with many available throughout the state rather than locally or regionally.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

YES: As peer-driven and recipient-driven programming proceeds, the aforementioned special populations' needs are addressed first in the training of peer workers and then in practice.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

YES: Tennessee's programming is described below, this item.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

YES: Tennessee's programming is described below, this item.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

See below.

Involvement of Individuals and Families

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

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Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

Narrative Answer:

The Concept of Recovery

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

- Recovery emerges from hope;

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

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

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

The State’s Definition of Recovery

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

The State’s Certification Program for Peer Specialists

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

A Tennessee Certified Peer Specialist has self-identified as a person with a mental illness or co-occurring disorder and has successfully navigated the service system to access treatment and resources necessary to build personal recovery and success with his or her life goals. This individual undergoes training recognized by the department on how to assist other persons with mental illness

in fostering their own wellness, based on the principles of self-directed recovery. Tennessee Certified Peer Specialists deliver unique services in the mental health system, provide Medicaid-billable services through provider agencies, assist service recipients by promoting self-directed recovery goals, and function as role models, advocates, teachers and group facilitators. To date, Tennessee has certified 222 Peer Specialists and continues to expand the professional employment opportunities for peers statewide.

Tennessee Peer Support Centers

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

Tennessee also promotes recovery through three peer recovery centers for people who have lived experience with substance use disorders.

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) grant is used in Tennessee to expand the state certification for peer specialists to include individuals who have lived experience with substance use disorders by transforming the current model into a co-occurring peer recovery specialist model. BRSS TACS also includes a statewide strategy to educate community behavioral health providers about peer recovery specialists. BRSS TACS identifies and develops the initial training required for peer recovery specialists and addresses the training needs of supervisors. This growing program has the potential to impact the lives of thousands of people who live with SMI, SUD, or both. This program focuses on recovery.

Adults who are diagnosed with mental illness, substance use disorders or co-occurring disorders who train to become certified peer recovery specialists may be served by BRSS TACS. Community and consumer needs for peer support and recovery education are supported by the program.

Outcomes that address recovery needs for the BRSS TACS program are as follows:

- A well-trained workforce of certified peer recovery specialists throughout the state with lived experience of mental illness, substance use disorders, or both.
- A specially-trained workforce of mental health professionals who supervise peer recovery specialists.
- Medicaid reimbursement for peer support provided by certified peer recovery specialists who have lived experience of substance use disorders.

- A minimum of thirteen (13) individuals who complete each peer recovery specialist certification training.
- A minimum of forty-five (45) graduates of the peer recovery specialist certification training per quarter.
- Ongoing infrastructure for certification trainings, including Wellness Recovery Action Plan (WRAP) trainings.
- Clear communication to stakeholders statewide to help potential peer recovery specialists achieve certification.
- Relationships with educational institutions to provide peer recovery specialists as speakers for students in behavioral health fields.
- An integrated, statewide consumers' organization with membership of people with lived experience with substance use disorders or mental illness.
- Connections with community colleges and other academic institutions to explore possibilities for college credit for certification training.
- Grassroots progress toward further integrating mental health and substance use disorder systems.

Peer and Family Support Programs

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

TDMHSAS Consumer Advisory Board (CAB)

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

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

The Consumer Advisory Board serves two roles:

1. Advise the Office of Consumer Affairs (OCA) and Peer Support Services Director

- Gathers input from consumers statewide on issues of concern
- Provides input to OCA with an annual report
- Develops policy position papers on consumer issues

2. Represent consumers on the statewide Departmental Planning and Policy Council and each of the seven regional councils.

- Identifies and reports to the Councils issues of concern to consumers
- Makes recommendations on actions to be taken to address issues
- Ensures increased consumer participation on the Planning Councils

The Consumer Advisory Board's major achievement over the last three years includes two annual Peer Specialist Conferences. The Conferences were instrumental in promoting peer specialist work throughout the state and has helped to educate stakeholders regarding the value of hiring trained Peer Specialists in their agencies. As the direct result, the TDMHSAS continues to help reduce stigma associated with those who live with mental health and substance abuse disorders, and create better community mental health services.

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

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

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

The **Creating Homes Initiative (CHI)** puts forward an overarching purpose of creating affordable permanent housing with needed supports accessible to people living with mental illness or co-occurring disorders. Since the year 2001 and effective until February 2013, CHI Tennessee has leveraged \$373 million to help provide stable housing for those who are living with mental illness or co-occurring disorders. Goals are: avoid psychiatric hospitalization; avoid criminal justice involvement and other social problems; enhance the ability to recover; and help individuals become productive contributing members of the community. Other objectives of CHI are to assist local communities with maintaining existing housing opportunities while creating 500 new or improved affordable, appropriate and integrated permanent housing opportunities. Housing will follow along a continuum from 24/7 supportive living facilities to achieving home ownership for people with mental illness or co-occurring disorders. Individuals may access available affordable housing opportunities through assistance in accessing housing websites and community education.

Global priorities met by CHI include: tertiary prevention of future hospitalization by population at highest risk; health care reform by increasing access to appropriate high-quality recovery services; support of integrated, coordinated care, especially for people with behavioral health conditions; and recovery support by ensuring that permanent housing and supportive services are available for

individuals with or in recovery from mental illness and SUDs. Consumer needs associated with this program include the need to access and maintain safe, affordable, integrated permanent supportive housing to advance their recovery. The population served by CHI is adults with a history of mental illness or co-occurring SUDs who have very low income.

Therapeutic Intervention, Education, and Skills (TIES) features programming for children age 17 and younger who are either in out-of-home placement or at risk of removal due to parent/caretaker substance abuse. The TIES program will create a collection of outreach, treatment, education, counseling, and supportive services for children and families affected by substance abuse and trauma. It will be operated in conjunction with the Seeking Safety curriculum for victims of trauma and the evidence-based Homebuilders model, which is an intensive, in-home crisis program that has already been used successfully around the nation to help keep children in their homes.

Community Supportive Housing provides flexible funding to agencies that offer supported housing for adults diagnosed with mental illness and co-occurring disorders. Staff members also coordinate outside activities for residents and work one-on-one to develop a housing plan that identifies the consumer's ideal housing goal and the steps needed to achieve more independent living. In this way, TDMHSAS facilitates recovery for those who might need extra support to further their recovery experience.

IV: Narrative Plan

N. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

N. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Narrative Answer

The TDMHSAS operates an array of prevention and intervention programs focused in the Division of Substance Abuse Services (DSAS), in psycho-educational programming and in the Division of Mental Health Services (DMHS) prevention-focused and early intervention programs. Some of these programs are funded with Mental Health Block Grant dollars, some with state dollars, some with grant dollars, and some with funding that comes from more than one source. The programs named in this item are those operated through the Division of Mental Health Services. The Mental Health Block Grant funding for these programs far exceeds 5% of the total amount of the Block Grant allocated to Tennessee. Tennessee has long recognized the importance of prevention programming and embraces the idea that the occurrence and severity of disease can be ameliorated through prevention and early intervention.

TDMHSAS will spend \$1,810,500, a full 22% of Tennessee's Mental Health Block Grant initial allocation for 2014, on primary prevention activities and programs. In addition to this expenditure, TDMHSAS spends a minimum of \$228,000 state dollars on programs that focus on prevention and screening activities for at-risk and underserved populations.

Prevention is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute of Mental Health (NIMH) as follows:

- a. Primary prevention: To protect individuals in order to avoid problems prior to signs or symptoms of problems. Includes those activities, programs, and practices that operate on a fundamentally non-personal basis and alter the set of opportunities, risks, and expectations surrounding individuals.
- b. Secondary prevention: Identifies persons in the early stages of problem behaviors and attempts to avert the ensuing negative consequences by inducing them to cease their problem behavior through counseling or treatment. It is often referred to as early intervention.
- c. Tertiary prevention: Strives to end problem behavior and/or to ameliorate their negative effects through treatment and rehabilitation. This is most often referred to as treatment but also includes rehabilitation and relapse prevention.

The Emotional Fitness Centers program consists of a faith-based initiative in Memphis and Shelby County that provides funding for peer advocate liaisons (PALS) in churches in underserved African-American communities. The liaisons assist parishioners in identifying behavioral health needs through pre-screening and referral, and then help to successfully navigate the behavioral health system with the goal of increasing utilization of mental health and substance abuse services. Desoto and Hardeman Counties offer satellite sites for residents outside Shelby County.

Emotional Fitness Centers assist those who present at the sites to break through emotional barriers to achieve wholeness. The process for the Emotional Fitness Centers, in the main, take the following path:

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

Suicide Prevention. The state of Tennessee provides funding for Tennessee Lives Count (TLC), the Tennessee Suicide Prevention Network (TSPN), and Project Tennessee/Jason Foundation, to supply comprehensive suicide prevention across the lifespan. The Jason Foundation's Suicide Peer Awareness program, entitled A Promise for Tomorrow, is comprised of an intensive two-hour curriculum that incorporates education for teachers, students and parents about the signs of suicide. The curricula teach tools and resources needed to identify at-risk youth. The TLC youth suicide early prevention/intervention project is funded through a federal Garrett Lee Smith grant made possible by the Garrett Lee Smith Memorial Act through SAMHSA. TLC serves youth ages 10 to 24. Prevention/intervention services are provided through suicide gatekeeper training to adults who work with youth. TLC uses best practice approaches in gatekeeper training.

The TSPN is a statewide public-private organization and association of agencies, advocates, consumers, professionals, physicians, clergy, journalists, social workers, law enforcement as well as survivors and attempters. TSPN develops and oversees the implementation of the Tennessee Strategy for Suicide Prevention to do the following:

- eliminate and reduce the incidence of suicide across the lifespan,
- reduce the stigma of seeking help for mental health problems that lead to suicide, and
- educate Tennesseans about suicide prevention and intervention.

TSPN adheres to the public health model to help reduce the incidence of suicide. Through its membership and directly, TSPN provides Question, Persuade, Refer (QPR) suicide prevention gatekeeper training, social marketing/awareness, TIP 50 and 101 training to substance use/abuse providers. TSPN is autonomous but has administrative oversight provided by Mental Health America of Middle Tennessee. TDMHSAS has adopted as its own the statewide suicide prevention strategy developed and published by TSPN. That strategy is presented in its entirety in this Block Grant application, item S of the Narrative Plan section entitled Suicide Prevention.

The most important objective of the suicide prevention programs is to raise awareness among Tennesseans that suicide is common and preventable. Another important aspect of suicide prevention in Tennessee is that programs cover the life span and address the needs of all genders. Specific populations have been targeted and include the African-American community, LGBTQ, college-aged persons and older adults. TDMHSAS' Division of Clinical Leadership (DCL) implements evidence-based practices and provides Civil Rights Compliance and suicide prevention activities which include Suicide Prevention and the African-American Faith Communities

Conferences and activities related to suicide prevention in the faith communities/places of worship. SAMHSA strategic initiatives addressed by this programming are prevention and special consideration for military personnel and their families.

The Shield of Care component of the state's suicide prevention strategy comprises the progressive emerging approach to prevention. The Shield of Care is ground breaking suicide prevention curriculum specifically for persons who work in juvenile justice facilities. The culmination of three years of development, the curriculum is based on studies of suicide in juvenile justice settings, best practice literature, our experience providing community general suicide gatekeeper training in Tennessee's juvenile justice facilities, and input from a workgroup with broad membership of juvenile justice and child-serving stakeholders. Focus-group style input from juvenile justice facilities staff that included clinical, security and educational disciplines helped assure that the content would be relevant and useful to those working in the field.

The curriculum combines didactic material, group activities and dramatized scenarios in video clips to help participants develop skills to utilize the Shield of Care S-PLAN:

- See suicide risk,
- Protect the physical and emotional safety of youth,
- Listen to youth express their feelings,
- Assess the severity of risk, and
- Network with other staff to prevent suicide.

All training materials, including trainer and participant workbooks, PowerPoint with embedded video clips and wallet cards are posted on the TDMHSAS website. The Shield of Care program was recently accepted to the Suicide Prevention Resource Center's (SPRC's) Best Practice Registry (BPR), which is a collaborative effort with the American Foundation for Suicide Prevention and SAMHSA.

Suicide is a major public health problem and the most preventable type of death. Tennessee has been a national leader in suicide prevention and has contributed to the knowledge base regarding suicideology, including the development of a groundbreaking curriculum for juvenile justice, a first of its kind. Tennessee operates the *Lifeline*, the suicide warmline, and is often cited as having one of the best suicide prevention networks nationally. In January, February, and March of 2012, Lifeline answered 3700 calls from those needing help or support. In the same time period of 2013, Lifeline answered 4295 calls, an increase of almost 16%. Tennessee is home to a major national suicide prevention corporation, the Jason Foundation. Suicide rates for youth have decreased in Tennessee in recent years, a clear demonstration of the effectiveness of Tennessee's prevention programming.

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 plus the identification, assessment, and referral of children with serious emotional disturbances (SED). The purpose of this program is to produce more socially/emotionally competent children which ultimately will lead to more productive citizens. The population served is all K-3 grade children and teachers in each elementary school served by the program. The goal of the program is to increase the number of children referred to necessary and

appropriate mental health services. Consumer needs associated with Project B.A.S.I.Cc include teachers who need help dealing with problem behaviors, children who need mental health wellness education and help with normative developmental crises, and children at risk who may need to be referred to mental health treatment.

Renewal House offers services via three primary programs to women: Licensed intensive outpatient program (12-15 weeks), family residential recovery program (up to 2 years), and independent recovery apartments (permanent/unlimited). Renewal House's mission recognizes that women and children enter into recovery together when they arrive together at the facility. Block Grant dollars help to fund a regular program for both resident mothers and resident and off-site children, addressing such issues as children's developmental needs, communication skills, discipline and consistency, and above all, alcohol and drug abuse primary prevention.

Child care consultation programming will provide training and technical assistance coaching on the Pyramid Model (CSEFEL) strategies to Project B.A.S.I.C. staff, with a focus on 10 selected Project B.A.S.I.C. implementation sites, and to a few selected early childhood education centers across the state.

In addition to primary research programming funded by Mental Health Block Grant dollars, the TDMHSAS uses Block Grant monies to fund evidence-based and early intervention programs. \$1,308,952 of Block Grant dollars (16% of the Tennessee total Block Grant) funds the following two evidence-based, research-supported early intervention and screening programs in the State of Tennessee.

Regional Intervention Program (RIP) is a research-supported program in which parents who have learned behavior management skills consolidate that learning by teaching other parents. Parents, supported by a small professional staff, serve as primary teachers and behavior change agents for their own child, and as daily operators of the overall program. Requirements for parents entering the RIP program are that parents have a troubled child under age six with a behavior disorder and participate in the program with their child. Parents receive parenting education, skills and support in managing the behavior of the child. The RIP program is contracted with five non-profit mental health agencies and operates in urban areas statewide. It is funded through Mental Health Block Grant dollars.

Youth Screen consists of a national mental health and suicide risk-screening program for youth. The purpose of the program is to ensure that all parents are offered the opportunity for their teens to receive a voluntary mental health check-up at their school.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

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 over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

Item 0: Children and Youth Services

Narrative Question:

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 over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates evidence-based treatment for youth with substance use disorders. SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Narrative Answer:

System of Care (SOC) Expansion in Tennessee--TDMHSAS oversees and administers three federally funded SOC demonstration initiatives currently in seven counties. Each grant provides funding and technical assistance to local communities to build and sustain Systems of Care for children and youth diagnosed with serious emotional disturbance (SED) and their families. SOC are grounded in a values-based framework, which includes being family driven, youth-guided, community-based, and culturally and linguistically competent. SOC values and principles place the child and family at the center of this values-based approach to service delivery and system collaboration and assemble a network of effective formal and informal supports around the family. TDMHSAS partners with child-serving departments, agencies, service providers, youth, families, and other stakeholders in developing comprehensive and coordinated Systems of Care and the

infrastructure to support and sustain effective and appropriate services for children and youth with intensive mental health needs.

The Statewide System of Care Expansion Initiative (SOC-EXP) implementation grant was awarded to the TDMHSAS in October 2012. Implementation of the grant will fundamentally change the way mental health services are provided to children in Tennessee.

The focus of the expansion grant is infrastructure and workforce development through the creation of a statewide sustainable SOC Technical Assistance Center. In addition TDMHSAS will be developing a strategic financing plan for long-term sustainability of the SOC approach in Tennessee.

TDMHSAS has established four overarching goals and objectives for the SOC Expansion Implementation Grant:

- 1) Implement state-level policy, administrative and regulatory changes promoting and sustaining a statewide SOC infrastructure, including a strategic financing plan;
- 2) Facilitate increased access to and expand or enhance the coordinated system of services, supports, and individualized care management for children and youth with serious emotional disturbances and their families;
- 3) Create and implement sustainable training and technical assistance strategies that facilitate ongoing learning, coaching and practice improvement, and supports fidelity to SOC values and principles; and
- 4) Expand the existing support and advocacy base for a statewide System of Care.

The SOC expansion is a grant funded initiative.

The Milieu of Children's Services in Tennessee

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

1. Project B.A.S.I.C. contracts with ten non-profit mental health agencies that provide behavioral health professionals to schools to provide mental health education and to assist teachers with managing behavior issues in students. The program's focus is to promote mental health in K-3 children, and to identify and refer children at risk of SED to mental health services. Project B.A.S.I.C. seeks to produce socially and emotionally competent children who then become productive adults. Project B.A.S.I.C. is a Mental Health Block Grant funded program.
2. Mental Health 101 and Erasing the Stigma allow Mental Health America of Middle Tennessee and Mental Health America of East Tennessee to offer support and educational materials to any group making a request for such support or materials. Groups served include professional groups, schools, civic groups, churches and any group serving middle and high school students. Materials and presentations are designed to help reduce the stigma

associated with mental illness and to increase awareness of mental health concerns. Erase the Stigma is a state funded program.

3. Child and Family Mental Health Education allows the National Alliance on Mental Illness of Tennessee (NAMI) to provide support groups for parents or caregivers of children who are diagnosed with SED. Groups help parents and caregivers by offering parenting skills, communication skills and diagnostic information. Curriculum and materials are furnished by NAMI. Child and Family Mental Health Education is a state funded program.
4. Violence and Bullying Prevention allows Centerstone, Inc. to offer elementary and middle school children in Middle Tennessee programming that will help to decrease the number of disciplinary referrals in the classroom including in-school suspensions and expulsions for students who participate. The ultimate goal is to reduce the incidence of violent behavior and bullying in schools and increase the graduation rates for middle Tennessee schools. Violence and Bullying Prevention is a state funded program.
5. Emotional Fitness Center is a faith-based program that allows the Healing Word Counseling Center to provide mental health screenings for African American children and families. The screenings are ethnicity-sensitive and are provided in a warm and welcoming environment. The purpose of the program is to improve access to mental health services to African Americans in the Memphis area. Emotional Fitness Center is a state funded program.
6. The Juvenile Court Screening Program permits youth services officers and workers from the Tennessee Department of Children's Services (TDSCS) to be trained to administer the juvenile justice screening version of the Child and Adolescent Needs and Strengths (CANS) survey to those juveniles who present at the juvenile courts with evidence of a mental health concern. The program is a collaborative effort between the TDMHSAS, the Administrative Office of the Courts, DCS, the juvenile court system, Tennessee Voices for Children (TVC), and the Vanderbilt University Center of Excellence (COE) to ensure that juveniles are referred for needed treatment. This program is grant funded and recently renewed for the upcoming fiscal year.
7. Child Care Consultation is a contracted program that allows TVC staff to provide coaching and training on Pyramid Model social-emotional development strategies to Project B.A.S.I.C. staff, and to K and 1st grade teachers in schools served by Project B.A.S.I.C. The purpose is to encourage socially and emotionally competent children who become good students as they progress through school. Child Care Consultation is funded with state dollars.
8. Renewal House of Nashville provides early intervention and prevention services for the children of mothers who are residing in the facility for treatment for addiction. Mental health services not otherwise funded for these children are provided. Services are funded with state dollars.
9. Regional Intervention Program (RIP) is a contracted program in which parents who have learned behavior management skills consolidate that learning by teaching other parents. Parents, supported by a small professional staff, serve as primary teachers and behavior change agents for their own child, and as daily operators of the overall program. Requirements for parents entering the RIP program are that parents have a troubled child under age six with a behavior disorder and participate in the program with their child. Parents receive parenting education, skills and support in managing the behavior of the

child. The RIP program is contracted with five non-profit mental health agencies and operates in urban areas statewide. It is funded through Mental Health Block Grant dollars.

10. Respite Voucher and Planned Respite programs are contracted with local agencies statewide to provide a break for caregivers of a child who is diagnosed SED. Almost 400 families annually receive respite services either to help them pay for respite or to help them learn to find and train a respite provider for planned respite. The purpose of the program is to preserve the family and protect the mental health of the child and the parent. Respite also helps to prevent child abuse. The Respite programs are funded with Mental Health Block Grant dollars.
11. The School-based Liaison program contracts with local mental health providers to assist teachers with managing students with emotional or behavioral problems. The purpose is to reduce discipline referrals, increase the likelihood that children will remain in school and in a community-based setting and decrease classroom behavior problems. School-based Liaison program is funded through interdepartmental dollars including funding from TDOE, Division of Substance Abuse Services, Division of Mental Health Services, and some federal dollars.
12. The Family Support and Advocacy program is designed to provide support and advocacy for those families with a child who is diagnosed with SED. Tennessee Voices for Children (TVC) contracts to provide the services statewide and the program is state funded.
13. Suicide prevention services include Tennessee Lives Count (TLC), the Tennessee Suicide Prevention Network (TSPN), Project Tennessee, and Youth Screen. All four programs are designed to address the needs of children and youth and are conducted in school for the children or for the teachers. The purpose of the programming is to reduce the number of suicides among Tennessee's children and to increase the ability of the adults to recognize the warning signs of suicide and intervene on behalf of a child. Several evidence-based curricula are used including the Shield of Care curriculum. Suicide prevention services are funded through state dollars and grant dollars.
14. Building Strong Families specifically targets parents with substance abuse issues, particularly methamphetamine, by providing in-home education and services with the desired outcome to prevent children from being removed from the home. The program presently exists in eight central Tennessee counties. Contracted with Centerstone, Inc., Building Strong Families is a grant funded program.
15. Therapeutic Intervention, Education, and Skills (TIES) features programming for children age 17 and younger who are either in out-of-home placement or at risk of removal due to parent/caretaker substance abuse. The TIES program will create a collection of outreach, treatment, education, counseling, and supportive services for children and families affected by substance abuse and trauma. It will be operated in conjunction with the Seeking Safety curriculum for victims of trauma and the evidence-based Homebuilders model, which is an intensive, in-home crisis program that has already been used successfully around the nation to help keep children in their homes. TIES is a grant funded program.
16. Crisis continuum programming allows community mental health centers across the state to assist children and their families when a crisis situation arises. Mobile crisis providers travel directly to the home and provide intervention for children in crisis. The purpose of the program is to assist families during a crisis, prevent the need for more restrictive services,

preserve the family, prevent child abuse, and improve access to care for children in crisis. Crisis Continuum programming is funded through Mental Health Block Grant dollars.

Collaborative Relationships with other Child-Serving Agencies and Groups

Governor's Children's Cabinet

The mission of Governor's Children's Cabinet is "to create a comprehensive strategy focused on Tennessee children's well-being." The Cabinet consists of representatives of the Tennessee Departments of Health, Children's Services, Mental Health and Substance Abuse Services, Education and TennCare (Tennessee's Medicaid program). The Governor's Children's Cabinet will "work to coordinate, streamline and enhance the state's efforts in providing resources and services" to children in Tennessee (Governor, 2013).

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

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

Council on Children's Mental Health

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

The plan created by the Council must:

- Provide a service delivery system that focuses on the principles of care for a system of care and enumerates those principles;
- Include a core set of services and supports that appropriately and effectively address the mental health needs of children and families;
- Develop a financial resource map and cost analysis of all federal and state funded programs for children's mental health, updated on an annual basis, to guide and support the plan. (Delk, 2013).

Various

TDMHSAS also collaborates with the TDOE, the Coordinated School Health program, the Center of Social and Emotional Foundations for Early Learning (CSEFEL), and other related groups to increase awareness of the crucial importance of early identification and treatment of children and youth with mental health problems.

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

Delk, F. (2013). Council on Children's Mental Health. Retrieved March 1, 2013 from (<http://www.tn.gov/tccy/ccmh-home.shtml>).

Governor, First Lady to Co-Chair Children's Cabinet. (2013). Retrieved March 1, 2013 from (<https://news.tn.gov/node/8339>).

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation 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.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between 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.

For the context of the Block Grants 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. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order 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. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Item Q: Data, Information and Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Narrative Answer:

FY 2012 marked the first year that TDMHSAS was able to submit client-level data to the National Research Institute for the purpose of reporting outcomes for the previous year's Mental Health Block Grant (FY2012). Efforts toward development of a state behavioral health electronic database (The Behavioral Statistics System of Tennessee or BeSST) continue as TDMHSAS works toward completion of the task funded both by state dollars and by the Data Infrastructure Grant. This effort is expected to evolve into a collaborative structure that gathers data from across Tennessee regarding services offered and outcomes achieved.

The TDMHSAS Commissioner created the Office of Research in 2011. The purpose for the Office of Research is to provide data to the Commissioner, Governor, providers, stakeholders and staff that inform the delivery system planning and evaluation process. The Office of Research develops data regarding policy, programs, and state standing on the national stage via a variety of statistics collected from a number of sources. The Office of Research works collaboratively with TDMHSAS staff to ensure that Tennessee's resources for mental health and substance abuse services are efficiently and effectively utilized. The Office of Research supports policy makers by providing the information, data, and research necessary to make data-driven decisions and measure the effectiveness and efficiency of projects and programs.

The data and information produced by the Research Team, in collaboration with the Division of Clinical Leadership, includes best practice guidelines for use by psychiatrists, primary care physicians, psychologists, health service providers, nurses, nurse clinicians, physician extenders, social workers and other health care professionals. Guidelines are published for use with adult and children's services and will later add specialized guidelines for substance abuse and senior services.

Through funding from SAMHSA's Data Infrastructure Grant, TDMHSAS has developed a partnership with the Tennessee Association of Mental Health Organizations (TAMHO) to build on an already-existing data warehouse utilized by the TAMHO member organizations. The purpose of the BeSST is to ensure that services provided are beneficial to recipients and to discover trends and practice information in Tennessee at large.

As a part of the data-informed effort in Tennessee, the development of useful and accurate outcome measures has become a chief priority in the planning and research operations of TDMHSAS. The Department's Three-year Plan, a plan required by state law, includes measurable outcomes for all programs that are described in this grant document. Each program manager develops strategies for ensuring that measures of success are readily available for each program. Those strategies and the applicable outcomes are reported annually to the Commissioner and the Governor. The Three-year Plan is then updated annually to ensure that all priorities, goals and strategies for reaching the goals are applicable to current needs, trends and data. Item 2 in the Planning Steps section provides more information regarding Tennessee's data and information trends.

To confirm that state and federal dollars are spent responsibly and that money is expended to fund programs that are needed and that benefit recipients, each program is monitored by the program manager. In addition, language in the contracts of each provider binds the purchased service to the applicable law and to the best practice or curriculum associated with the program. Each contract includes appropriate language related to state and federal law and each provider is accountable for complying with all state and federal law including, but not limited to, requirements for audited financials, compliance with non-discrimination laws, background checks and credentialing for employees, etc. The current draft of the TDMHSAS Quality Assurance Quality Improvement Plan (QAQIP) is submitted with this grant document in Item R of the Narrative Plan.

Tennessee continues to work to develop Electronic Health Records (EHRs) for use by the Regional Mental Health Institutes (RMHIs). The beginning step of EHR development is the successful standardization of 104 charting forms for use by all four of the RMHIs. To ensure the efficient use of all standardized forms and to begin the ultimate process of EHR development, checklists, chart design and charting order are being standardized as well.

TDMHSAS Office of Planning, Research and Forensics participated in two days of technical assistance arranged through the SAMHSA program office. Guidance was provided regarding data needs and requirements, trends related to future possible needs, and comparison data analysis pertaining to other states and Tennessee's standing on the national stage. Needs for the future may include: continued guidance regarding SAMHSA's data requirements; guidance around new programming related to set-aside dollars from Block Grant funding; and assistance with final implementation of the BeSST data system.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

The Quality Assurance Quality Improvement Plan (QAQIP) for the TDMHSAS is drafted and under review by the Commissioner. Upon approval, the QAQIP will be posted in this item for submission to SAMHSA with the Block Grant application(s).

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

Narrative Answer:

The Tennessee Strategy for Suicide Prevention

Updated February 28, 2013

Originated by the Tennessee Suicide Prevention Network

Adapted and adopted by the Tennessee Department of Mental Health and Substance Abuse Services

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

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

The Tennessee Strategy for Suicide Prevention is the guiding document of the Tennessee Suicide Prevention Network (TSPN) and, in the sense of collaboration and community partnership, has been adopted by the TDMHSAS. This document shapes TSPN and TDMHSAS outreach, education, and awareness efforts throughout the state of Tennessee. The strategy for suicide prevention in Tennessee builds upon the fifteen points raised in “The Surgeon General’s Call to Action to Prevent Suicide” in 1999, the eleven points raised in the “National Strategy for Suicide Prevention: Goals and Objectives for Action”, printed by the U.S. Department of Health and Human Services, United States Public Health Service, Rockville, MD, in 2001, and the thirteen points of the revised edition in 2012. The Tennessee Strategy for Suicide Prevention was adapted from the National Strategy in 2002, with revisions in 2004, 2006, and 2007. Current version was updated in February 2012 and

1. Develop broad-based support for suicide prevention.

- A. Form and sustain public-private partnerships with the widest variety possible of community partners in suicide prevention activities, up to and including state departments and agencies.
- B. Continue to engage state, county, and city government in the annual Suicide Prevention Awareness Month proclamation effort.
- C. Advocate within the General Assembly and state departments for improved access to community-based mental health and substance abuse services.
- D. Educate stakeholders about state budgets and legislation that could negatively affect mental health and substance abuse services and encourage an active role in advocating for suicide prevention services.

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- E. Recruit public figures to promote the cause of suicide prevention and the use of mental health and substance abuse services.
2. Promote awareness that suicide is a public health problem that is preventable.
- A. Promote the National Suicide Prevention Lifeline (1-800-273-TALK or 1-800-273-8255) as the statewide suicide prevention hotline and encourage all local crisis centers in Tennessee to join the network of Lifeline call centers.
 - B. Encourage adequate staffing and funding of local crisis centers and publish their phone numbers on the TSPN website and in regional suicide prevention directories.
 - C. Secure the cooperation of radio and television stations, newspapers, billboard companies, and all other appropriate media in promoting crisis hotlines and suicide prevention services.
 - D. Encourage the cooperation of faith-based alliances to publicize suicide prevention services.
 - E. Maintain updated region-specific resource directories that reference relevant community agencies.
 - F. Update the TSPN website to aid in communication with the people of Tennessee on at least a quarterly basis.
 - G. Promote the use of social media in suicide prevention by training community stakeholders in its use.
 - H. Conduct statewide conferences and symposia to raise public awareness for suicide prevention.
3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.
- A. Produce public service messages for television and radio in order to reduce the stigma associated with mental health and substance use disorders and promote the concept of recovery.
 - B. Arrange for survivors, survivors of attempts, and professionals to offer training and speak to groups and individuals who come into contact with at-risk individuals.
4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.
- A. Monitor references to suicide in locally originating television, radio, news media, and online content, in coordination with the national suicide prevention community, to promote better and more accurate depictions of suicide and mental illness, and to recognize portrayals that observe recommended guidelines in the depiction of suicide and mental illness.
 - B. Promote guidelines for responsible coverage of suicide and mental illness to journalism and mass communication schools and to news agencies.
 - C. Promote guidelines on the safety of online content for new and emerging communication technologies and applications.
5. Develop, implement, and monitor effective programs that promote suicide prevention and general wellness.
- A. Encourage the adoption of a suicide risk screening mechanism by mental health and substance abuse providers, first responders, clergy, educators, and others who may come in contact with high-suicide-risk persons.
 - B. Encourage development of suicide prevention programs in psychiatric hospitals,

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substance abuse treatment programs, schools, correctional institutions, community service programs, peer support centers, and similar facilities that work with high-suicide-risk population groups.

C. Serve as a resource for agencies that work with young people and elderly, providing suicide prevention education and links to other agencies that promote mental wellness.

D. Work with teachers in public and private schools and with others who work with children to implement suicide prevention and mental health screening programs.

E. Encourage the development of suicide prevention curricula in Tennessee colleges and universities, and the inclusion of suicide prevention training in professional licensure requirements.

6. Promote efforts to reduce access to lethal means of suicide and methods of self-harm among individuals with identified suicide risk.

A. Encourage health care providers, especially those involved in inpatient care, home care, and discharge planning, to assess patients' access to lethal means.

B. Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

C. Encourage discussions of lethal means and safe storage practices in well-child care encounters and in educational programs for young people, parents, and gatekeepers.

D. Partner with local drug coalitions, law enforcement agencies and civic organizations, to develop and/or implement existing educational materials to make people aware of safe ways of storing, dispensing, and disposing of medications.

7. Encourage effective clinical and professional practices regarding suicide prevention for community and clinical service providers.

A. Provide training on suicide prevention to community service provider groups that have a role in the prevention of suicide and related behaviors.

B. Promote crisis intervention, suicide prevention training, and collaborative suicide risk management for teachers in the school systems, police officers, first responders, and other community groups that have a role in the prevention of suicide and related behaviors.

C. Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

D. Develop and/or promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professionals, including those in graduate and continuing education and persons seeking credentialing and accreditation.

E. Include focused education in suicide risk management and prevention at regional workshops and conferences.

F. Encourage crisis centers, faith communities, community counseling centers, and community helpers throughout the state to implement effective training programs for family members of those at risk.

G. Encourage mental health assessment centers and emergency departments to refer persons treated for trauma, sexual assault, physical abuse, or domestic violence for mental health services.

8. Promote the assessment and treatment of people at risk for suicide as a core component of health care services.
 - A. Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.
 - B. Adopt, disseminate, and implement guidelines for the assessment of suicide risk and continuity of care for people at suicide risk in all health care and substance abuse treatment settings.
 - C. Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.
 - D. Establish links, collaboration, and coordination of services between providers of mental health and substance abuse services, community-based and/or peer support programs, health care systems, local crisis centers, and the families of patients to create a comprehensive and seamless network of care for people at risk for suicide.
 - E. Develop and/or promote guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.
 - A. Create protocols for postvention response following suicide deaths and disasters with the potential for traumatizing survivors.
 - B. Promote the availability of postvention services by TSPN and others to the general public and institutions that may require such services, up to and including schools, colleges, and businesses.

10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.
 - A. Encourage the development of support groups for survivors of suicide, survivors of suicide attempts, and support group facilitators, and engage the support of these groups by community partners.
 - B. Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context.
 - C. Provide and/or promote appropriate debriefing to health care providers, first responders, and others affected by the suicide death of a patient.

11. Increase the timeliness, viability, and scope of statewide surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.
 - A. Improve the timeliness and usefulness of suicide-related vital records data from state medical examiners, coroners, and hospitals.
 - B. Support the establishment of local task forces that use vital records data to develop targeted prevention efforts.
 - C. Advocate for Tennessee’s inclusion in the National Violent Death Reporting System.

12. Promote and support research on suicide and suicide prevention.
 - A. Encourage Tennessee colleges, universities, hospitals, and clinics to intensify research related to suicide, including cultural-specific risk factors, interventions, and protective

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factors, and to present their results at regional, state, and national conferences, as well as publish such results.

B. Conduct evaluations of suicide prevention programs in Tennessee, both those originating within TSPN and those of other agencies.

13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

A. Disseminate information about effective suicide prevention programs and encourage their implementation across the state.

B. Evaluate the impact and effectiveness of the Tennessee Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Narrative Answer:

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) has, since the submission of the Mental Health Block Grant application in September 2011, developed and begun to implement a plan for the use of technology that accomplishes the following:

1. Succeeds at moving the TDMHSAS along the path towards establishing an Electronic Health Record (EHR) at the Regional Mental Health Institutes (RMHIs);
2. Anticipates present and future information sharing and collaboration with community service providers;
3. Undertakes to decrease the unnecessary transportation of patients/recipients (to an RMHI) who have accessed the crisis services continuum; and
4. Establishes the infrastructure for the collection and warehousing of client-level data with the ultimate goal of providing the public, policymakers, and service-delivery system developers with accurate data for decision support.

The RMHIs have standardized all forms used for charting patient treatment and are implementing the transition to the new forms at all four hospitals. In anticipation of the development and shared use of an EHR, the RMHIs ensure that the various departments within the hospital have access to the most current information regarding the treatment of each patient through the use of standardized forms. The new forms help to transition standardized information into the new EHR for the purpose of accomplishing the same goal: offering RMHI staff the most current information regarding each patient in an electronic format.

In anticipation of future electronic information sharing and collaboration with community service providers, the EHR development efforts include system compatibility with community structures either in place or in process. Information sharing will be HIPAA compliant and include the

necessary pharmacy history, clinical history, test and lab history and aftercare recommendations and/or history. In an effort to increase the ability of patients to receive adequate care in less-restrictive, community-based settings, the development of an EHR creates a bridge between inpatient care and community providers allowing the patient to receive continuous care in every setting.

Since September 2011, telehealth technology has been implemented in all four RMHIs through the use of stationary video conferencing equipment. Presently, the mobile version of the technology is being tested for use with laptop computers. The mobile version allows community crisis workers to move to the location of the patient and establish the patient's eligibility for admission to an RMHI prior to the transportation of that patient. The mobile version of the telehealth program decreases unnecessary transportation of patients (usually completed by law enforcement personnel) and allows for the accurate assessment of patient need in whatever setting the assessment takes place. Referral can be made to appropriate and available services for every patient.

The Division of Mental Health Services, Office of Crisis Services, has developed the Crisis Tracking System for use by providers who are contracted with the Department for providing crisis services. Providers may enter data on a web-based system or may upload information to the system from a compatible program. The Crisis Tracking System is designed to enhance decision support, allow for specific patient tracking by different providers through the crisis services continuum, and allow for client-level data reporting for cyclical needs assessment activities and outcome measure analysis.

Finally, the Behavioral Statistics System of Tennessee (BeSST) is under development and will allow Tennessee to collect and maintain information necessary to meet reporting requirements for client-level data, and to enhance the ability of Tennessee to make data-driven decisions concerning the behavioral health delivery system.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

601 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

January 2, 2012

Mr. Ted Lutterman
NASMHPD Research Institute, Inc.
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314

Re: Technical Assistance Application for Data Infrastructure Grant Implementation

Dear Mr. Lutterman:

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) Division of Planning Research and Forensics (DPRF) officially requests technical assistance to implement Tennessee's Data Infrastructure Grant (DIG) and collect data to meet Uniform Reporting System (URS) and client-level data (CLD) requirements. Responses to this letter of application may be addressed to Karen Edwards, Ph.D., Research Coordinator, 601 Mainstream Drive, Nashville, Tennessee 37243, email karen.edwards@tn.gov, phone number 615-532-6418, and fax number 615-253-1846.

TDMHSAS staff identified three issues requiring technical assistance of the type offered by NRI for implementation of Tennessee's Data Infrastructure Grant. The need associated with these components became clear during the process of developing URS tables, CLD, and SAMHSA Block Grant Implementation Reports submitted on December 1, 2012. The component needs are as follows:

1. What is the best method to collect evidence-based practice (EBP) information for URS Tables 16 and 17?
For the 2012 URS tables, a survey was designed to collect evidence-based practice data with client demographics. Although client demographic information was collected and reported in 2012, the survey needs to be refined to make it easier for providers to complete and use in completing these URS tables. Additionally, providers suggested that the survey be amended to capture information about other SAMHSA evidence-based practices not included for URS reporting requirements. We request:
 - a. Examples and recommendations for collecting this information either as (1) a data extract for a data warehouse or administrative data system; or (2) responses to a provider survey.
 - b. Examples and recommendations for measuring EBP fidelity including who measures fidelity, when measurement occurs, what measures are used, what states require of providers.
2. What is the best way to resolve differences in the time frame requirements of CLD and URS table requirements to collect information about school attendance and criminal/juvenile justice involvement?
Tennessee was unable to collect the information needed to complete URS Tables 19A and 19B because the time frames used by Tennessee Outcome Measurement System (TOMS) to collect this information met CLD requirements but not the timeframes for the URS tables. The TOMS surveys can be found online at: [https://outcomes.telesage.com/Outcomes/\(X\(1\)S\(yxzeexkjcqyiukw2ive4qz0k\)\)/projects/tennessee/home.aspx?AspxAutoDetectCookieSupport=1](https://outcomes.telesage.com/Outcomes/(X(1)S(yxzeexkjcqyiukw2ive4qz0k))/projects/tennessee/home.aspx?AspxAutoDetectCookieSupport=1)

- a. Examples and recommendations for collecting school attendance information that will meet both CLD and URS requirements. Currently, the TOMS states, *In the past 30 days: On how many days were you absent from school due to suspension or expulsion?* This 30-day time frame is inconsistent with the time frame required for *URS Table 19B: Profile of Change in School Attendance* which requires the number of persons suspended/expelled in the last 12 months and an assessment of the impact of services on school attendance.
 - b. Examples and recommendations for collecting criminal/juvenile justice involvement that will meet both CLD and URS requirements. Currently, the TOMS collects arrest data for the past 30 days in compliance with client-level reporting requirements; however, the TOMS survey does not collect arrest data for the prior 12 months which is needed to complete the *URS Table 19A: Profile of Criminal Justice or Juvenile Justice Involvement*.
3. What is the best way to collect CLD and URS information?
- a. Which states have administrative data systems for collecting CLD and URS information?
 - b. Which states have integrated behavioral health (mental health and substance abuse) data systems for collecting CLD and URS information?
 - c. Which states require data entry of CLD and URS into an administrative data system vs. CLD and URS data extracts from existing data systems?
 - d. What are the minimum CLD and URS data elements required by SAMHSA that should be incorporated into a data collection system?

Our Research and Planning Teams are working together to ensure that a behavioral health data infrastructure system is created in such a way that all data is gathered properly for both Tennessee's needs and the needs of our funding sources (including SAMHSA). We welcome your assistance and an in-depth discussion of the ramifications of our system components.

Sincerely,



E. Douglas Varney
Commissioner

cc: Karen Edwards, Ph.D., Research Coordinator
Suzanne Weed, Director, Planning

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Narrative Answer:

TDMHSAS requested technical assistance (TA) as per a letter dated January 2, 2013 included in the attachments associated with this item. The letter requests assistance with the following activities/requirements:

1. Collection of evidence-based practice information from contracted providers;
2. Discrepancies pertaining to collection of school attendance and criminal/juvenile justice information between the Uniform Reporting System (URS) tables and the Tennessee Outcome Measurement System (TOMS) surveys, and;
3. Best practice in collection of Client-level data and URS information via an exploration of other states' success at achieving the collection of this data and completion of the URS tables.

On March 12, 2013, TDMHSAS Division of Planning, Research and Forensics participated in a conference call with National Research Institute (NRI) staff regarding the aforementioned letter requesting TA. It was determined during the conference call that, before summer's end 2013, face-to-face TA will take place in Tennessee to address item 3 (above list). On June 11 and 12, 2013, TDMHSAS Division of Planning, Research and Forensics received a visit from an NRI staffer who provided two partial days of technical assistance related to the above-referenced questions. The visit was most helpful.

At the time of this application, TDMHSAS is considering what types of TA might be needed to implement new or altered programming associated with the Block Grant set-asides and with the state's implementation of the Affordable Care Act. There is a considerable network of professionals and providers in the state of Tennessee who regularly meet, collaborate and assist each other to ensure that the needs of citizens are met and that the practices used to meet those needs are cutting edge best practices. Also, Office of Planning and Office of Research staff maintains collegial

relationships with program staff at SAMHSA and pose questions as needed to obtain information and assistance with concerns that might arise.

TDMHSAS suggests that SAMHSA collaborate with other federal agencies and internally with other Divisions of SAMHSA from which funds are received for behavioral health services. With the purpose of establishing common areas for data collections culminating in consolidated outcome measures, SAMHSA would manage a consistent collection of information for all programs and do so in an online format that allows for every program to be able to accomplish registering outcomes for each program. For example, the Together Including Every Student (TIES) and Building Strong Families (BSF) programs do not collect National Outcome Measures (NOMS) data for the recipients of those services. Creating a common thread of data collection and data dissemination would be most helpful.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

The TDMHSAS maintains collaborative and partnering relationships with other state agencies and membership and provider organizations statewide whose missions are consistent with the Department's mission. State agencies such as Department of Corrections, Department of Education, Department of Health and the Medicaid agency TennCare are important and strategic partners for TDMHSAS to ensure that the needs of the citizenry are recognized and met. Organizations such as the Tennessee Association of Mental Health Organizations, the Tennessee Association of Alcohol, Drug and other Addiction Services, the Tennessee Council on Children and Youth offer opportunities for partnership that span the reach of providers and consumers alike. Most of those organizations associated with the aforementioned groups have served, or presently serve, as members and leadership of the Planning and Policy Councils maintained by TDMHSAS. The relationships formed, the issues addressed, and the problems solved by the ongoing collegial atmosphere of the Councils and the partnerships between TDMHSAS and the aforementioned organizations and agencies ensure that no needs go unmet and that ideas are shared openly regarding mental health and substance abuse services in Tennessee.

BILL HASLAM
GOVERNOR



DERRICK D. SCHOFIELD
COMMISSIONER

STATE OF TENNESSEE
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February 12, 2013

The Honorable E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville, TN 37243

Dear Commissioner Varney:

The Department of Correction wishes to offer our continued support to, and ongoing collaboration with, the Department of Mental Health and Substance Abuse Services. Our missions are interrelated as well as the people we serve and programs we offer. We will continue to build on the initiatives we have started.

The Department of Correction will continue to work with the state and local judicial systems to develop policies and programs that address the needs of individuals living with mental illness and substance use disorders who come in contact with the criminal justice systems. We will 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 diversion.

On behalf of the Department of Correction, I commit to our departments ongoing practice of a collaborative and supportive relationship.

Sincerely yours,

A handwritten signature in blue ink, appearing to read "Derrick D. Schofield".

Derrick D. Schofield

DDS:PC



STATE OF TENNESSEE
DEPARTMENT OF EDUCATION
SIXTH FLOOR, ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243-0375

BILL HASLAM
GOVERNOR

KEVIN HUFFMAN
COMMISSIONER

February 12, 2013

The Honorable E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville, TN 37243

Dear Commissioner Varney:

The Department of Education wishes to offer our continued support to, and ongoing collaboration with, the Department of Mental Health and Substance Abuse Services. Our missions are interrelated as well as the people we serve and programs we offer. We will continue to build on the initiatives we have started.

The Tennessee Department of Education continues to examine regulations, policies, programs, and key data-points in state school districts to ensure that children are safe and supported in their social/emotional development. Children will be exposed to initiatives that target risk and protective factors for mental and substance use disorders. TDOE will ensure that children have the services and supports needed to succeed in school to improve graduation rates and reduce out-of-district placements.

On behalf of the Department of Education, I commit to our departments' ongoing practice of a collaborative and supportive relationship.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kevin Huffman".

Kevin Huffman
Commissioner



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
310 GREAT CIRCLE ROAD
NASHVILLE, TENNESSEE 37243

February 13, 2013

The Honorable E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville, TN 37243

Dear Commissioner Varney:

The Bureau of TennCare wishes to offer our continued support to, and ongoing collaboration with, the Department of Mental Health and Substance Abuse Services. Our missions are interrelated, as well as, the people we serve and programs we offer. We will continue to build on the initiatives we have started.

The Bureau of TennCare will continue to consult with the Department of Mental Health and Substance Abuse Services in the development of services for individuals with chronic health conditions. Our agencies will continue to collaborate regarding the benefits available to the Medicaid-eligible population.

On behalf of the Bureau of TennCare, I commit to our departments ongoing practice of a collaborative and supportive relationship.

Sincerely,

Darin J. Gordon
Deputy Commissioner



March 8, 2013

The Honorable E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville, TN 37243

Dear Commissioner Varney:

On behalf of the Tennessee Association of Alcohol, Drug & other Addiction Services (TAADAS) and our respective member agencies, I am pleased to write this letter of support to, and ongoing collaboration with, the Department of Mental Health and Substance Abuse Services (TDMHSAS). Our missions, being similar in terms of the citizenry served and services offered, allow us to collaborate seamlessly.

The Tennessee Association of Alcohol, Drug & other Addiction Services, on behalf of its membership, is committed to collaboration with organizations that support an effective and robust substance abuse and addiction service delivery system in Tennessee. The Tennessee Department of Mental Health and Substance Abuse Services consistently acts in partnership with TAADAS to work toward that mission.

TAADAS is a statewide association of alcohol and drug abuse service professionals and providers. We represent over 41 treatment services providers statewide and over 15 individual member professionals. In addition to our membership, we have worked closely with the faith community in our Clergy/Faith Community Training program as well as recovery support providers, community prevention partners and Coalitions. Our association has created the opportunity for numerous service providers to work together collaboratively from the local to the state level to address the growing issues related to substance abuse. The Department of Mental Health and Substance Abuse Services actively advocates this kind of collaboration with and collaboration between providers and provider associations such as TAADAS. Their relationships with agencies across the state are true partnerships because they support and foster open dialogue and participation in service planning and development.

I am pleased to confirm that our organizations practice a collaborative and supportive relationship and I appreciate the opportunity to affirm our partnership.

Sincerely yours,

A handwritten signature in black ink that reads "Mary Linden Salter".

Mary Linden Salter, LCSW
Executive Director

1321 Murfreesboro Road, Suite 155 Nashville, Tennessee 37217
615-780-5901 Fax 615-780-5905 Bookstore 877-863-6914 REDLINE 800-889-9789
www.taadas.org taadas@taadas.org



STATE OF TENNESSEE
TENNESSEE COMMISSION ON CHILDREN AND YOUTH

601 Mainstream Drive
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

March 11, 2013

The Honorable E. Douglas Varney, Commissioner
Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville, TN 37243

Dear Commissioner Varney:

This letter exhibits the strong commitment of the Tennessee Commission on Children and Youth (TCCY) to support and engage in ongoing collaboration with the Department of Mental Health and Substance Abuse Services. Our missions, being similar in terms of the citizenry served and services offered, allow us to collaborate seamlessly in efforts to provide and improve mental health and substance abuse services in Tennessee..

The Tennessee Commission on Children and Youth is committed to collaboration with organizations that support an effective and robust mental health and substance abuse service delivery system for at-risk children in Tennessee. The Tennessee Department of Mental Health and Substance Abuse Services consistently acts in partnership with TCCY to work toward that mission. We have had a very strong collaboration in the Council on Children's Mental Health that works toward a system of care in children's mental health that is child focused, family driven, culturally competent and provides services in the least restrictive environment.

On behalf of the TCCY, I confirm that our organizations practice a collaborative and supportive relationship. We look forward to working with you in partnership for a stronger mental health system for Tennessee children. If there are questions or we can provide additional information, please contact me.

Sincerely,

A handwritten signature in blue ink that reads "Linda O'Neal".

Linda O'Neal
Executive Director



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

February 19, 2013

E. Douglas Varney
Commissioner
Tennessee Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville, TN 37243

Dear Commissioner Varney:

I am writing this letter to support the Mental Health and Substance Abuse Block Grant application from the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) to the federal Substance Abuse and Mental Health Services Administration. The Tennessee Department of Health (TDH) is now and will remain firmly aligned with your Department's priorities in addressing multiple serious mental health conditions and situations facing our state.

Throughout the course of Governor Haslam's administration, he has purposefully brought departments together to consider, plan and address Tennessee's difficult issues. This approach has borne important benefits. TDMHSAS and TDH have worked together with other cabinet-level leaders in the areas of public safety, prescription medication safety and abuse, neonatal abstinence syndrome, improving children's readiness for school, and screening families for mental health and substance abuse issues. TDMHSAS has played a leadership role in initiating and supporting creative approaches to use shared data for planning and led shared planning for action. TDMHSAS has collaborated with TDH and other departments in public and professional education in issues of methamphetamine production and abuse, N.A.S., and the controlled substances monitoring database. Indeed, it is important for us all that our departments are seen as collaborative and like-minded in blending our expertise and efforts.

The State of Tennessee has made a firm commitment to assure that an effective safety net is in place through which our residents can gain access to care. State funds are allocated to your Department and have been efficiently administered to assure access on a statewide basis. Your cooperation with the state's Medicaid program (TennCare) has been linked with the Safety Net services to guarantee an important level of mental health

3rd Floor, Cordell Hull Building
425 5th Avenue North * Nashville, TN 37243
(615) 741-3111 * www.tn.gov/health

E. Douglas Varney
February 19, 2013
Page Two

services in all of Tennessee' ninety-five counties. TDMHSAS has continued to promote the demonstration and adoption of other critical services such as SBIRT, prevention activities around wellness, and smoking cessation at the community level.

TDH has supported and participated in your Department's strategic actions including SAMHSA's 2012 State Policy Academy on Preventing Mental and Substance Use Disorders in Children and Youth. The Academy and subsequent team actions have brought together both public and private interests in effective screening for children. Your approach is a model for tapping external resources to organize and promote change within the state.

We at TDH will continue to support the planning and programs made available because of your successful administration of the Mental Health and Substance Abuse Block Grant. State-level collaborations are important for effective use of federal resources. We are proud in Tennessee to be able to assure SAMHSA of that commitment.

Sincerely,



John J. Dreyzehner, MD, MPH, FACOEM
Commissoner

JJD/BB/tls



March 11, 2013

The Honorable E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services
601 Mainstream Drive
Nashville, TN 37243

Dear Commissioner Varney:

The Tennessee Association of Mental Health Organizations (TAMHO) is a trade association representing the community mental health and substance abuse providers in Tennessee. Our members have been the cornerstone of the public behavioral health system in Tennessee for many years. We have a long history of working closely with the Department of Mental Health and Substance Abuse Services in providing treatment to the very population that public resources are designed to assist in their recovery.

We are pleased to offer our support to the Department of Mental Health and Substance Abuse Services and commit to continuing the close collaboration in which we work. We are excited about the Department's continued efforts to enhance the effectiveness of the mental health delivery system in Tennessee and we are happy to work in partnership with you to achieve a mission that we share.

On behalf of the TAMHO membership, please let this correspondence serve as confirmation of our collaborative and supportive relationship. Please do not hesitate to contact me if additional information is needed.

Sincerely yours,

Ellyn Wilbur
Executive Director

42 Rutledge Street
Nashville, TN 37210-2043

www.tamho.org

(615) 244-2220
(800) 568-2642 toll free in TN
Fax: (615) 254-8331

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that 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 (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

Item W: State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and using the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation.

In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.) Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council. There are strict state Council membership guidelines. States must demonstrate (1) that 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 (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

1. What planning mechanism does the state use to plan and implement substance abuse services?
2. How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
3. Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
4. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
5. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Narrative Answer:

TDMHSAS operates a structured planning process with multiple layers of Planning and Policy Council involvement in order to ensure citizen participation in policy and delivery-system planning. The Department oversees seven regional Planning and Policy Councils (Councils) from which local and regional mental health needs and information are funneled to the State Planning and Policy Council (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: representatives of individuals and their families; advocates for children; adults and elderly; service providers; stakeholder agencies and organizations. The majority of each Council's membership is current or former service recipients and members of service recipient families with living with SMI and SUDs. With this membership mix, TDMHSAS ensures that planning for the service-delivery system meets the needs of the citizenry of the state at large.

Within the past two years, TDMHSAS has added representation from the existing Substance Abuse Treatment Advisory Council, the Anti-drug Coalitions and the Prevention Council to each regional Council to assist with planning for substance abuse treatment and prevention services. Advocates, providers, individuals, and family members of individuals with substance abuse disorders were also added to the statewide and seven regional Councils. All eight Councils are fully integrated, the percentage of representation from mental health and substance abuse services communities being monitored and maintained by the Office of Planning.

TDMHSAS continues to actively recruit minorities, residents from rural areas, youth, and caregivers of children with serious emotional disturbance (SED) for membership. Recruitment takes place through a complex networking arrangements accomplished by means of collaboration with present members of the Councils, providers, stakeholders, consumers and caregivers, and strategic partners in the community. The Governor appoints the chairperson of the statewide Council while the Commissioner appoints members of the statewide Council recommended through the recruitment process.

Council Responsibilities:

- Assist the TDMHSAS in planning a comprehensive array of high quality prevention, early intervention, treatment, and habilitation services and supports;
- Advise the TDMHSAS on policy, budget requests, and developing and evaluating services and supports;
- Advise the TDMHSAS on the Three-year Plan including the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families;
- Such other matters as the Commissioner may request;
- Advise the Commissioner as to plans and policies to be followed in the service system and the operation of the TDMHSAS's programs and facilities;
- Recommend to the General Assembly legislation and appropriations for such programs and facilities;
- Advocate for and publicize the recommendations;
- Publicize generally the situation and needs of persons with mental illness, serious emotional disturbance and their families;
- Identify needs of service recipients who are children or elderly and of service recipients with combinations of mental illness, serious emotional disturbance, or substance abuse or dependence;
- Evaluate needs assessment, service and budget proposals;

- Reconcile policy issues among the service areas; and
- Annual review of the adequacy of Title 33 to support the service systems.

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 and substance abuse and mental health disorders within the state. The Council reviews and makes recommendations on the bi-annual Block Grant applications and the annual Implementation Report. TDMHSAS Office of Research provides regional Councils with data, easily accessible through the Department's website, to help members identify prioritized needs. Prioritized needs are shared with staff to develop strategies for the Three-year Plan and report progress bi-annually. The needs assessment process creates an evidence-based method for regional Councils to influence the design of the mental health and substance use delivery system by identifying each region's needs and target limited state and federal financial resources to more effectively and efficiently meet identified needs. This information is used to communicate and integrate results into a strategic planning and action process to ensure assessment information is used in meaningful ways to improve the mental health and substance use system.

One of TDMHSAS's major responsibilities is service system planning. Title 33, Chapter 1, Part 4 of the Tennessee Code Annotated, the mental health law, requires the TDMHSAS to develop a Three-year Plan based on input from the State TDMHSAS Planning and Policy Council's recommendations. The plan must be updated at least annually based on an assessment of the public need for mental health and substance use disorders services. Needs assessments are conducted annually by the TDMHSAS regional Councils to assist Department staff in planning and resource allocation.

The Council, in conjunction with the Department, produces a "Joint Annual Report" outlining the service system, departmental programs, services and facilities, along with accomplishments, challenges and gaps. The Joint Annual Report is submitted to the Commissioner of TDMHSAS and then to the Governor and the State Legislature.

Regional Councils are kept informed about the Department activities through the monthly Executive Staff Report, in-person reporting provided by the Office of Planning at the quarterly regional Council meetings, and ongoing interaction via email and telephone.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Candace Allen	Providers	Helen Ross McNabb	310 Wooded Lane Knoxville, TN 37922	Candace.allen@mnabb.org
Richard Barber	Providers	Aspell Recovery Center	331 N. Highland Avenue Jackson, TN 38301, TN 38301 PH: 731-694-0252	rbarber@aspellrecovery.com
Robert Benning	Providers	Ridgeview Psychiatric Hospital and Center	240 W. Tyrone Road Oak Ridge , TN 37830 PH: 865-481-6170	benningrj@ridgevw.com
Laura Berlind	Providers	Renewal House	P.O. Box 280356 Nashville , TN 37228 PH: 615-255-5222	lberlind@renewalhouse.org
David Bowers	Family Members of Individuals in Recovery (to include family members of adults with SMI)	TN Community Support Services	266 North St. Bristol, TN 37620 PH: 423-989-4558	dbowers@frontierhealth.org
Danae Briggs	Parents of children with SED		P.O. Box 642 Lavergne, TN 37086 PH: 615-625-3209	Charmed-p3@clearwire.net
Charlotte Bryson	Others (Not State employees or providers)	TN Voices for Children	701 Bradford Avenue Nashville, TN 37204 PH: 615-269-8914	Cbryson@tnvoices.org
Brian Buuck	Providers	Ridgeview Psychiatric Hospital and Center	240 West Tyrone Road Oak Ridge , TN 37830 PH: 865-481-6170	Buuckbd@ridgevw.com
Jennifer Dedrick	Providers	Lakeside Behavioral Health Systems	2911 Brunswick Road Memphis, TN 38133 PH: 901-377-4795	Jennifer.wood@uhsinc.com
Carmencita Espada	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2820 Blackwood Drive Nashville, TN 37214 PH: 615-741-9443	Carmencita.Espada@tn.gov
Brennan Francois	Providers	Parkridge Valley Hospital	2200 Morris Hill Road Chattanooga, TN 37421 PH: 423-499-2320	Brennan.Francois@HCAHealthcare.com
Paul Fuchcar	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		207 Spears Avenue Chattanooga, TN 37405 PH: 423-667-3311	paul.fuchcar@cadass.org
Connie Levenhagen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Tennessee Mental Health Association of Middle TN	3931 Gallatin Road Nashville, TN PH: 615-250-1176	jjones@tmhca-tn.org
Ben Harrington	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 32731 Knoxville, TN PH: 865-584-9125	ben@mhaet.com
Luisa Hough	Others (Not State employees or providers)	Mental Health Association of Middle Tennessee	295 Plus Park Blvd Nashville, TN 37217 PH: 615-269-5355	lhough@mhamt.org

Linda Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		207 Forrest, P.O. Box 474 McKenzie, TN 38201 PH: 731-415-3634	llewis38201@yahoo.com
Emma Long	Providers	Pathways	32 Conrad Drive Jackson, TN 38304 PH: 731-343-0615	Emma.long@wth.org
Becky Morris	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		94 Crest View Drive Winchester, TN 37398 PH: 931-962-2993	Becky.morris@fcstn.net
Ginger Naseri	Providers	Nolachuckey Holston Area Mental Health Center	401 Holston Drive Greeneville, TN 37743 PH: 423-639-1104	vnaseri@frontierhealth.org
Martha Padget	Parents of children with SED		1370 Collins Raod Vanleer, TN 37181 PH: 615-763-0489	michellebryant1@aol.com
Ed Rothstein	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		120 South Hancock Street Murfreesboro, TN 37130 PH: 615-867-3538	erothstein@vbhcs.org
Jack Stewart	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1101 Kermit Drive, Suite 605 Nashville, TN 37217 PH: 423-329-4355	advocacy@namitn.org
Wendy Sullivan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1302 Oak Grove Road Dickson, TN 37055 PH: 615-975-7021	wsullivan@invoices.org
Suzette Webster	Parents of children with SED		1508 Fall Drive Nashville, TN PH: 615-876-9892	SzWbs@aol.com
Debbie Hillin	Providers	Buffalo Valley, Inc	5465 Village Way Nashville, TN PH: 615-975-0196	debbiehillin@buffalovalley.org
Mamie McKenzie	Others (Not State employees or providers)	Tennessee Voices for Children	701 Bradford Avenue Nashville, TN PH: 615-269-7751	MMcKenzie@TNVoices.org
Mary Moran	Providers	Centerstone Mental Health Center	Centerstone Mental Health Center, 1101 6th Avenue North Nashville, TN 37208-2650 PH: 615-460-4455	Mary.Moran@centerstone.org
Senator Doug Overby	Others (Not State employees or providers)		4 Legislative Plaza Nashville, TN 37243 PH: 615-741-0981	Sen.doug.overbey@capitol.tn.gov
Joe Page	Providers	Frontier Health	26 Midway Street Bristol, TN 37620 PH: 423-989-4691	jpage@frontierhealth.org
Kim Parker	Providers	Pathways	238 Summar Drive Jackson, TN 38301 PH: 731-541-8988	Kim.Parker@wth.org
Albert Richardson	Providers	C.A.A.P.	4023 Knight Arnold Road Memphis, TN 38118 PH: 901-360-0442	ARichardson@caapincorporated.com
Tim Tatum	Providers	Pine Ridge Treatment Center	2800 Westside Drive Cleveland, TN PH: 423-339-4341	Tim_Tatum@chs.net
Jennifer Jones	Others (Not State employees or providers)	Tennessee Mental Health Association of Middle TN	3931 Gallatin Road Nashville, TN 37216 PH: 615-250-1176	jjones@tmhca-tn.org

Walter Williams	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 241078 Memphis, TN 38124-1078 PH: 901-355-2727	Ww52@aol.com
Evelyn Yeargin	Providers		275 Cumberland Bend Nashville, TN 37212 PH: 615-726-3340	eyeargin@mhc-tn.org
John York	Providers	Samaritan Recovery Community	319 S. 4th Street Nashville, TN 37206	jjork@xmi-se.com
Dianne Young	Providers	Emotional Fitness Center	3885 Tchulahoma Road Memphis, TN PH: 901-370-4673	YHealer@aol.com

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	37	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	19	51.35%
State Employees	0	
Providers	18	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	18	48.65%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

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

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

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

Item X: Improving Enrollment and Business Practices

Narrative Question:

Improving Enrollment and Business Practices, Including Billing – This change inserts the following new language: "Improving enrollment processes and provider business practices Each state is asked to set-aside three percent each of its SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards."

Narrative Answer:

At the time of this application, contracting for the state's fiscal year is concluded.

TDMHSAS will begin planning for this set-aside for the following state fiscal year. See Section II (Planning Steps), Steps 3 and 4, Priority 5, Indicator 3 for the planning indicator, this item. Also, clarification regarding this item from SAMHSA indicated that this item is, at least for the present, requested and not required.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

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

Footnotes:

Item Y: Public Comment

The following responses were received from the public following the opening of the final draft of the Tennessee Mental Health Block Grant application to the public for comment. Noted below in italics are the resulting revisions made after the comment was received.

Received via email:

Suzanne,

As you know, I come from the A&D system of care, so these documents have enlightened me on a several things I didn't know about the MH system. I appreciate the opportunity to be involved in the review. From my perspective, they are all well-written and the responses to the questions seem thorough.

A couple of comments...

This is just an observation – I don't know if it is intentional, or even if it matters at all: The five priority areas listed in Section II, Step 1, page 6 are subsequently discussed in that section, as well as in Section II, Step 3 & 4 in the priority order that they are listed in the Step 1, page 6 list. However, in the Section II, Step 2 document, the priority area "Children & Youth Services", which was Priority 2 in the original list, has been changed to Priority 4, and Prevention and Recovery Services have moved up to become Priorities 2 & 3, respectively. Again, I don't know if this makes any difference but I thought I would mention it.

Also, I'm sure you know that some of the responses about the MH system, particularly in regard to the services that the block grant funds, would be incorrect for the SABG application. For example, in Section IV: Narrative Plan, page 7, third paragraph, it states that "*The programs that utilize dollars that serve MHBG recipients are not direct service programs (psychiatric care, therapy, medication management, etc.).*" For the A&D system, this would be incorrect - there are many programs funded by the block grant that provide these direct services.

Hope this helpful. Let me know if you have questions. jy

John York
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Revisions: No revisions as the result of this comment since the priorities were not arranged in order of importance.

Received via email:

From Ginger Nasiri
Frontier Health
Johnson City, TN

Section II, Step 1

Page 2 under second bold section TDMHSAS serves as the State's mental health, substance use disorders and opioid authority.

Why are we specifying the opioid authority...does this go beyond the substance use disorder???
Sorry, maybe I will catch that in the future steps but it did not seem quite right?

Page 3 first paragraph...do we need to add growing partnership with vocational rehab?

Page 13. Disaster mental health response.. Should we refer this as the Tennessee Recovery Project (this holds a special place in my heart. Anita and Melvin did a great job in helping us recover after our tornadoes!)

And that s all I saw and what I saw may not have been anything.
On to the next step.

Please let me know you got this. Thanks. Ginger

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Revisions: No revisions this response.

Received via phone call:

Phone call August 23, 2013 from Paul Fuschar, EdD, Chair of the Statewide Planning and Policy Council. Paul asked about one spacing typo in Section II, Step 1 that was corrected. He also inquired about the Substance Abuse Block Grant and the differences between services funded between the two Block Grants. His questions were answered as to how funding is allocated and the difference between the two grants.

Revisions: There were no further revisions made as the result of the phone call.

Response via email:

From: Ellyn Wilbur [mailto:ewilbur@tamho.org]
Sent: Tuesday, August 27, 2013 1:51 PM
To: Suzanne Weed
Cc: 'staff@tamho.org'
Subject: RE: Mental Health Block Grant Public Comment

Hi Suzanne,

The document is well written and well organized. The priorities were well stated and the indicators were clearly associated with the priorities. We had very few comments / observations to share:

Page numbers were missing in Table 1. This might be by design since it is still in draft.

Priority #2 – Indicator 7 – we noted that the outcomes for this indicator were less specific than the other indicators – we wonder if there are expected outcomes that should be referenced in this section.

Priority 3 –Indicator 1 – we suggest adding a statement about what happens after an individual is screened.

Indicator 3 – you might want to consider using a disaster response readiness assessment to help ensure that organizations are ready to respond in a disaster situation

p. 40 #6 – typo – should be Center of Excellence

Thank you for giving us the opportunity to review this document. You did a great job with it!

*Revisions: Priority 3 –Indicator 1 – added “to ensure that individuals in need are appropriately referred for services.”
Item O: Children and Youth Services corrected typo to “Center of Excellence.”*

Received via email:

From: Joe Page [mailto:jpage@frontierhealth.org]
Sent: Monday, August 26, 2013 3:06 PM
To: Suzanne Weed
Subject: RE: Mental Health Block Grant Public Comment

Suzanne, I have reviewed and looks very good. I have one comment on Section II, page 4. Only 6.4% had a co-occurring Dx. Is that right? In Frontier we have over 75% with a co-occurring dx. The national average I believe is around 50%. Thanks

Joe Page, M.A., LMFT
Sr. V.P. Tn. Adult Services
Frontier Health
jpage@frontierhealth.org
423-878-1628

Revisions: Director of Office of Research reviewed the statistic. She will follow up with the source of the stat and correct it after submission if there is a change. Otherwise, no revisions for this response.