Tennessee

UNIFORM APPLICATION

FY 2024/2025 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 09/05/2023 12.02.03 PM)

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

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID KNUHYRCNLJC5

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

Agency Name Tennessee Department of Mental Health and Substance Abuse Services

Organizational Unit Division of Planning, Policy and Legislation

Mailing Address 5th Floor Andrew Jackson Building 500 Deaderick Avenue

City Nashville

Zip Code 37243

II. Contact Person for the Grantee of the Block Grant

First Name Marie

Last Name Williams

Agency Name Tennessee Department of Mental Health and Substance Abuse Services

Mailing Address 6th Floor Andrew Jackson Building 500 Deaderick Street

City Nashville

Zip Code 37243

Telephone 615-253-3049

Fax

Email Address Marie.Williams@tn.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date	8/31/2023 3:48:01 PM
Revision Date	8/31/2023 3:49:40 PM

VI. Contact Person Responsible for Application Submission

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
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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**

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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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 Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: ______________________

Title: TDMHSAS Commissioner

Date Signed: ______________________

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

BILL LEE
GOVERNOR
STATE OF TENNESSEE

August 21, 2019

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

Dear Ms. Crocker:

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

Contact information for Commissioner Williams is as follows:

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

Thank you for your assistance.

Sincerely,

Bill Lee

State Information

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

Fiscal Year 2024

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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.
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

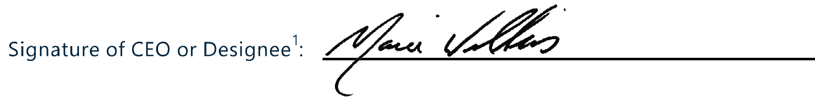
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or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

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

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

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

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

Signature of CEO or Designee[1]: 

Title: TDMHSAS Commissioner

Date Signed: 08/14/2023

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Bipartisan Safer Communities Act (BSCA) Funding Plan 2024 – Tennessee

FY 2024-2025 Mental Health Block Grant Application

BSCA Area of focus	Year 1 Budget *10/17/2022-10/16/2024*	Year 2 Budget *09/30/2023-09/29/2025*	Year 3 Estimated Budget 09/30/2024-09/29/2026	Year 4 Estimated Budget 09/30/2025-09/29/2027
	SFY24	**SFY25**	**SFY26**	**SFY27**
Services - Expand BASIC	$442,462	$579,574	$579,574	$579,574
Services - Ped offices therapists	$450,000	$500,000	$500,000	$500,000
FEPI – Set-Aside (10%)	$104,702	$126,651	$126,651	$126,651
Admin estimated	$49,858	$60,285	$60,285	$60,285
TOTAL	**$1,047,022**	**$1,266,510**	**$1,266,510**	**$1,266,510**

Expand the Better Attitudes and Skills In Children (BASIC) Program

BSCA supplemental funds were used to expand the BASIC Program to six additional rural Tennessee counties that did not previously have the program. The expansion included one additional T /A position to support the expansion. The BASIC program has historically been funded by the MHBG and was expanded by the state supported Tennessee Resiliency Project (TRP) grant in FY22. The program was in 53 of the 95 Tennessee counties and increased to 59 of 95 counties as a result of BSCA funding.

Using BSCA funds support school services to rural counties including individual or group support with social emotional skill development from Child Development Specialists for grades K – 3. The expanded rural counties were selected based on two data elements: 1) counties will be selected based on a designation of “at-risk” or “rural distressed” as delineated by Governor Lee’s Executive Order 1 and 2) “Children in poverty” levels as indicated by the Annie E. Casey Foundation; KIDS COUNT data for 2020.

TDMHSAS has executed grant contracts with three community mental health providers to expand services to Sullivan, Campbell, Morgan, Scott, Cocke, and Hardin Counties. Grant contracts go through 6/30/2027.

Increase the number of therapists imbedded in pediatric offices across Tennessee

BSCA supplemental funds will increase the number of therapists imbedded in pediatric offices across Tennessee. Therapists working for community mental health centers will be imbedded in pediatric offices to help educate medical staff and be available to provide immediate therapeutic services to children. Having mental health services on-site at primary care physician offices will reduce barriers for families to receiving behavioral health treatment. This proposed project would support early intervention efforts to divert from crisis services by providing immediate access to mental health treatment. This model is currently being implemented by community mental health providers in

planning regions 1 and 6 by the state supported TRP grant. BSCA funds will allow for the program to be piloted across all of the state planning and policy council regions.

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

First Episode Psychosis Initiative (FEPI) set-aside

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

State Information

Disclosure of Lobbying Activities

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

Name

Marie Williams, LCSW

Title

TDMHSAS Commissioner

Organization

Tennessee Department of Mental Health and Substance Services

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

This form is not applicable.

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) functions as Tennessee's mental health, substance use disorder, and opioid treatment authority. It is the mission of TDMHSAS to create collaborative pathways to resiliency, recovery, and independence for Tennesseans living with mental illness and SUD, and the Department's vision to be a state of resiliency, recovery, and independence in which Tennesseans living with mental illness and SUD thrive. TDMHSAS administers seven (7) Regional Planning and Policy Councils from which regional mental health and substance abuse needs and information are channeled to the Statewide Planning and Policy Council and to the Department. TDMHSAS collaborates with an array of community mental health providers, community-based organizations, and local governments to support this work. There are nearly 50 providers that support mental health programming with grant contracts statewide. TDMHSAS provides services to individuals and families in Tennessee struggling with mental health and substance abuse issues, providers, legislators, other state agencies, and consumer/advocacy groups.

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

The Division of Mental Health Services (DMHS) is organized into six (6) offices including: Behavioral Health Safety Net and Older Adults, Housing and Homeless Services, Crisis and Suicide Prevention, Children, Young Adults, and Families, Consumer Affairs and Peer Recovery Services, and Wellness and Employment. The DMHS Offices administer and support a diverse array of services and supports for individuals of all ages living with mental illness, co-occurring disorders, and/or serious emotional disturbance. Programs supported by TDMHSAS focus on services for individuals who may not qualify for TennCare, Tennessee's Medicaid program, and/or target those individuals at risk for MI, SED, and COD. The services are provided via over 300 grant contracts annually to community mental health centers and local mental health providers across the state. DMHS creates, expands, and oversees community-based programs and community support services including affordable housing programs; homelessness prevention services; a full continuum of 24-hour crisis services; wellness and recovery services; peer recovery services; supported employment services; suicide prevention services; older adult care management services/Preadmission Screening and Resident Review; disaster MH services; and a comprehensive System of Care-based child, youth, and family supports services. Oversight of provider agencies is done by both programmatic and compliance monitoring of grant contracts by TDMHSAS DMHS, Office of Subrecipient Monitoring, and annual inspections and follow-ups of licensed facilities and services by the TDMHSAS Office of Licensure.

TDMHSAS and its Division of Mental Health Services (DMHS) continue to provide a comprehensive community-based mental health system. DMHS is responsible for planning and promoting a comprehensive array of services and supports for individuals of all ages, living with mental illness, co-occurring disorders, and/or serious emotional disturbances. This is accomplished through the creation, expansion, and oversight of community-based programs and community support services. Initiatives

include affordable housing programs; homelessness prevention services; 24-hour crisis services; wellness and recovery services; peer recovery services; suicide prevention services; geriatric services; disaster emergency services; and comprehensive System of Care-based child, youth, and family support services.

The Intensive Long-term Support (ILS) program serves individuals who have been discharged from the state's Regional Mental Health Institutes (RMHIs) after an extensive length of stay, and who would otherwise not be able to successfully live in the community due to the lack of available housing with the capacity to meet their specific needs.

The ILS program provides enhanced-level support services on-site and utilizes quality residential homes that are licensed by the State of Tennessee as Mental Health Adult Supportive Residential Facilities. Effective coordination between the RMHI and the ILS provider staff to facilitate an effective and efficient flow of referrals includes collaborative meetings and calls, strategically scheduled visits, and the sharing of pertinent information; these measures promote a smooth transition from long-term hospital stays to sustained community living. TDMHSAS recently embarked upon ILS expansion activities to increase the program's number of locations and corresponding bed capacity; this is marked by two releases of funding announcements to solicit competitive grant proposals toward the establishment of residential infrastructure and subsequent provision of ongoing wrap-around support services, one during the state fiscal year 2021 and another during the state fiscal year 2022. The purpose and goal of the SFY 2021 Announcement of Funding (AOF) was to establish and operate an ILS residential facility to serve individuals discharging from Western Mental Health Institute (WMHI), which is located in Bolivar, TN. A quality proposal in response to this AOF was selected to create a 20-bed residential facility in nearby Jackson, TN, which is slated to begin residential occupancy and service delivery during the state fiscal year 2024. The purpose and goal of the SFY 2022 AOF was to establish and operate an ILS facility to serve individuals discharging from Moccasin Bend Mental Health Institute (MBMHI), which is located in Chattanooga, TN. A quality proposal in response to this AOF was selected to create a 21-bed residential facility in Chattanooga, which is also slated to begin residential occupancy and service delivery during the state fiscal year 2024. For the new Chattanooga ILS facility, ongoing operational services funding is being supported with Federal Community Mental Health Service Block Grant funding as part of the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260] and the American Rescue Plan Act (ARPA), 2021 [P.L. 117-2].

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

deposits, rent payments, utilities, vision care, dental care, as well as fees for obtaining documents such as birth certificates, state-issued ID cards, etc.) to support service recipients' ability to sustain community living, and avert homelessness or reduce the risk of homelessness.

Individual Placement and Support (IPS) is the supported employment model promoted by the department. It is a model of supported employment for people living with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar, depression). IPS-supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. There are currently 16 behavioral health agencies that use this model across the state.

Peer Wellness Coaching (PWC) is offered in the eastern part of the state. Adults living with serious mental illness die on average 25 years earlier than other Americans largely due to treatable medical conditions. The My Health, My Choice, My Life (MHMCML) Initiative, led by PWCs, includes evidence-based, self-management workshops along with one-on-one wellness coaching. Peer Wellness Coaches promote healthier behaviors for Tennesseans with mental health and/or substance use disorder conditions. They do this by facilitating holistic, evidence-based curriculums such as Chronic Disease, Diabetes, and Chronic Pain Self-Management Workshops, Matter of Balance Workshops, Whole Health Action Management (WHAM), Nutrition Education Wellness and Recovery (NEW-R), Dimensions: Tobacco Free Workshops, Enhancing Immune Health Workshops, First Aid Arts, and one-on-one Peer Wellness Coaching to help participants achieve their wellness goals, all of which are based around the Eight Dimensions of Wellness. In 2023 Tennessee added two additional Peer Wellness Coaches to increase capacity and increase access to services. MHMCML trains agency staff in health and wellness curriculum and provides technical assistance and support in promoting health and wellness within mental health and substance use services. MHMCML staff also train Peer Support Center Staff in health and wellness curriculum allowing for access to these evidence-based programs statewide.

The First Episode Psychosis Initiative (FEPI) and Clinical High Risk for Psychosis (CHRP) programs provide a continuum of care for youth and young adults who are experiencing or at risk of experiencing early onset psychosis in eighteen (18) counties, expanding from fourteen (14) since FFY2021. These programs utilize a "Coordinated Specialty Care" (CSC) which is a comprehensive intervention model for people who have experienced a first episode of psychosis. Treatment is provided by a team who focus on helping people work toward personal goals and to get their life back on track. The CSC model helps these individuals navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, at a job, and in the social world. The CSC program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, psychopharmacology, peer support, and care coordination and management. The individual and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin.

The System of Care Across Tennessee Network provides intensive care coordination services that bring together a continuum of services and supports that allow for children, youth, and young adults to function in their homes and communities outside of inpatient and residential facilities. Stepdown services are provided to children, youth, and young adults who are being discharged from inpatient, residential, and detention facilities. The System of Care Across Tennessee has an average success rate of 93% in keeping children at home with their biological families. The Tennessee Resiliency Project (TRP)

includes three coordinated care within the crisis system programs that are addressing keeping children and youth out of inpatient and residential services. East Tennessee is served through three specialty crisis teams serving the detention facilities, schools, and those children and youth being seen in the Crisis Stabilization Unit or Walk-In Center. In middle Tennessee, there are two providers focused on crisis, one with five crisis specialists focused on hard-to-place children and the other focused on working with school social workers and school resource officers to identify children and youth in need of diversion from the youth justice system.

The Tennessee Move Initiative teams work to successfully transition identified individuals from long-term units to community-based housing by providing ongoing, intensive, and individualized support to individuals, families, and community providers. Three community mental health agencies provide recovery-focused, intensive, and customized care coordination services through four teams to identify individuals in long-term units within the TDMHSAS Mental Health Institutes.

The purpose of the initiative is to transition the individuals to the least restrictive and most integrated setting appropriate based on their individual needs.

The TN Behavioral Health Safety Net provides essential outpatient mental health services to uninsured adults and children who are uninsured or underinsured.

Services provided through the BHSN promote recovery, treatment, and resiliency and include assessment and evaluation, therapy, case management, peer support, medication management, psychosocial rehabilitation, transportation, and assistance with pharmacy coordination.

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

Tennessee Crisis Services incorporates a continuum of high-quality crisis services, including Crisis Telephonic Triage and Intervention, Mobile Crisis (all ages), Crisis Stabilization Units (CSUs), Crisis Respite, and Walk-In Center (WIC) services. Crisis WIC services may include mental health assessment, referral to services, and follow-up services. Funding for these services is shared between TDMHSAS and the Medicaid authority, TennCare. The approach is based on determining the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual. Certified Peer Recovery Specialists (CPRSs) provide the CSU PeerLink program designed to reduce repeat use of crisis services, increase continuity of care, and help individuals move forward in their recovery. Over the past three years, TDMHSAS has also been awarded funding to formally support Tennessee's 988 Infrastructure. As of July 2022, when an individual calls/chats/texts 988, the contact is routed to a Tennessee-based provider. This vital diversionary

resource provides access to a trained counselor in the provision of risk screening, triage, consultation, and referrals to ensure appropriate and efficient access to resources. Since FY23, Tennessee's 988 providers have handled 35,038 crisis calls. With the implementation and education across the state around this resource, there has been a noted decrease in Emergency Department presentations and Law Enforcement utilization. This includes the average monthly decrease in Emergency Department presentations by 37 individuals, along with an average monthly decrease of 104 individuals requiring law enforcement involvement.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

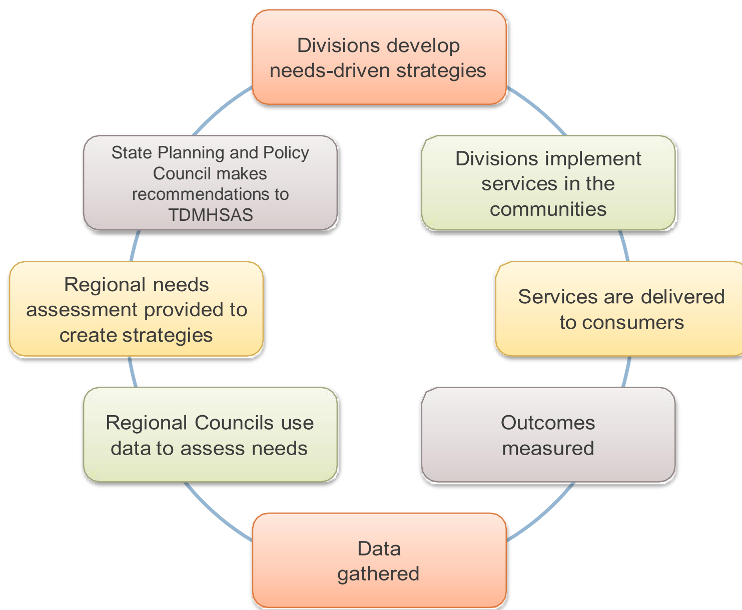
During each fiscal year, TDMHSAS conducts a Needs Assessment that focuses on the population of Tennessee to ascertain unmet service needs and delivery system gaps. In the subsequent year, TDMHSAS develops budget and funding targets that seek to meet the service needs identified by the assessment. TDMHSAS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

Needs Assessment Process

The TDMHSAS needs assessment process involves state level collaboration involving the TDMHSAS Research Team, the TDMHSAS Statewide Planning and Policy Council, and other TDMHSAS staff. The Councils advise the TDMHSAS Statewide Planning and Policy Council on the development of the state Three-Year Plan and provide guidance to the Department on policy, budgeting, and evaluation from the regional perspective. This engagement process embodies TDMHSAS' mission and commitment to establishing a quality, comprehensive prevention, early intervention, treatment, and rehabilitation system based on the needs and preferences of individual consumers and their families. The goals of the needs assessment model are to identify unmet needs and critical gaps, and to allocate limited resources more efficiently. The model is also designed to help Regional Councils prioritize local needs, direct state level planning and resource allocation efforts, and assure compliance with federal block grant funding requirements. The needs assessment model outlines eight steps as part of a cyclical process that begins with implementing needs-driven services in communities, proceeds to collecting and analyzing indicators of prevalence, service use, quality, and outcomes, and results in formulating recommendations for service strategies that reflect emergent regional needs and preferences. These recommendations are further shaped by outside considerations, such as federal and state policy initiatives and priorities, legal requirements, and funding constraints. The TDMHSAS needs assessment model is described in detail in Exhibit 1.2

Exhibit 1.2

TDMHSAS Needs Assessment Model



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

Data Sources

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

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

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

In addition to the data products which are provided to the Statewide and Regional Councils, the Office of Research provides needs assessment resources to provide specific data to councils about needs identified in the statewide needs assessment.

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

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

The 2023 Need Assessment Summary includes needs and critical gaps identified by the Regional Councils, Statewide Children and Adult Committee, and the Consumer Advisory Board (CAB). The Summary is posted on the on the department's website at FINAL 2023 NA Summary.pdf (tn.gov)

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Maintain and improve services

Priority Type: MHS

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

Goal of the priority area:

Maintain and improve effectiveness of community mental health services.

Strategies to attain the goal:

Program strategies supporting objective include 988 Call Centers; Crisis Services Continuum; Behavioral Health Safety Net; Older Adults Program; First Episode Psychosis Initiative; Targeted Transitional Support Services; Housing programs supporting long-term supportive housing; certification for Peer Recovery Specialists; Individual Placement and Support (IPS) services; treatment and recovery support services from MHBG COVID related supplemental funds.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: In state FY2023, there were 35,038 individuals screened by 988 Call Centers (only calls included).

First-year target/outcome measurement: Increase the total number of individuals screened by 988 Call Centers from the prior year.

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Indicator #: 2

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

Baseline Measurement: In state FY2023, there were 73,052 individuals who received a face-to-face crisis assessment.

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

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

Data Source:

The state Crisis Management System will track and report data related to the total number of face-to face assessments conducted by

mental health crisis responders as a result of a mobile crisis call or visit to a TDMHSAS supported crisis walk-in center.

Description of Data:

Aggregate data for this indicator will be compiled from the Crisis Management System from providers statewide to include the following services: mobile crisis face-to-face assessments (adults and youth) and walk- in center crisis face-to-face assessments.

Data issues/caveats that affect outcome measures:

Other outcomes reviewed will include the percentage of individuals receiving a crisis assessment who were diverted to less restrictive community care; the percentage of individuals seen by mobile crisis within two hours of the request for assessment; and percentage of assessments that were completed using telehealth. This indicator includes Mental Health Block Grant Supplemental Funding related to COVID-19 to support supplemental funds for mobile crisis providers for face-to-face assessments.

Indicator #: 3

Indicator: Number of admissions to Crisis Stabilization Units (adults) providing intensive, short-term stabilization and behavioral health treatment for those persons whose behavioral health condition does not meet the crisis for involuntarily commitment to a psychiatric hospital or other treatment resource and who cannot be appropriately and/or safely managed in a less restrictive environment.

Baseline Measurement: In state FY2023, there were 6,602 individuals admitted to a state supported Crisis Stabilization Unit (CSU) for treatment services.

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

Second-year target/outcome measurement: Maintain or increase the total number of individuals receiving treatment services at a CSU from the prior year.

Data Source:

The state Crisis Management System will track and report data related to the total number of CSU admissions. CSUs are licensed by the State to offer twenty-four hours per day, seven days per week, three hundred sixty-five days per year (24/7/365).

Description of Data:

Data collected in the Crisis Management System includes: total CSU Admits by month; total admits by referral source; total admits by payor source; total uninsured served; average daily bed utilization; average length of stay by payor source; and discharge dispositions.

Data issues/caveats that affect outcome measures:

During FY23, there were eight (8) Crisis Stabilization Units in operation across the state for a total of 119 beds. Four new CSU/WIC awards have been granted to support the addition of Walk-In Centers and Crisis Stabilization Units in Henry, Dyer, Montgomery, and Rutherford Counties. Projects are at various stages in terms of infrastructure development but will be completed over the course of state FY24 and FY25.

Indicator #: 4

Indicator: Number of uninsured/indigent adult Tennesseans having a serious mental illness (SMI) and number of uninsured/underinsured Tennessee children having a serious emotional disturbance (SED).

Baseline Measurement: In state FY2023, there were 33,707 total served by the Behavioral Health Safety Net.

First-year target/outcome measurement: Serve as many individuals as are eligible and apply to the Behavioral Health Safety Net with a goal of maintaining or increasing the total number of individuals served from the prior year.

Second-year target/outcome measurement: Serve as many individuals as are eligible and apply to the Behavioral Health Safety Net with a goal of maintaining or increasing the total number of individuals served from the prior year.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

Additional data tracked and reviewed for this program includes units of services and services delivered via telehealth. The top utilized services for this program are consistently psychiatric medication management, case management, and individual therapy. Workforce challenges continue to impact service delivery, specifically with staff credentialed to provide therapy services.

Indicator #: 5

Indicator: Number of older adults served with care management services such as outreach, screening, assessment, linkage, in home therapy and other supportive services to improve their quality of life and to develop skills that will help them to live in the community as independently as possible.

Baseline Measurement: In state FY2023, there were 609 served by the older adult program.

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

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 6

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

Baseline Measurement: In state FY2023, 232 youth and young adults experiencing First Episode Psychosis (FEP) received evidence-based treatment and recovery support services.

First-year target/outcome measurement: Maintain or increase the total number of youth and young adults experiencing FEP to receive treatment and recovery support services from the prior year

Second-year target/outcome measurement: Maintain or increase the total number of youth and young adults experiencing FEP to receive treatment and recovery support services from the prior year.

Data Source:

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

Description of Data:

The First Episode Psychosis Initiative is designed to provide early intervention services for youth and young adults fifteen through thirty

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

Data issues/caveats that affect outcome measures:

The program recently expanded using Mental Health Block Grant Supplemental Funding related to COVID-19 and the Bipartisan Safer Communities Act (BSCA). There have recently been four new sites to expand the OnTrack model for youth and young adults ages 15 to 30 years old who experience a first episode of psychosis, residing in Anderson, Montgomery, Hamilton, or Rutherford County, Tennessee.

Indicator #: 7

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

Baseline Measurement: In state FY2023, 5,852 individuals experiencing mental illness or co-occurring disorders received short- term -financial support for services aimed at living independently and maintaining stable housing.

First-year target/outcome measurement: Maintain or increase the total number of individuals able to live independently and/or maintain stable housing with short-term financial support from the prior year.

Second-year target/outcome measurement: Maintain or increase the total number of individuals able to live independently and/or maintain stable housing with short-term financial support from the prior year.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 8

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

Baseline Measurement: In state FY2023, there were 2,172 individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and support to maintain long-term supportive housing.

First-year target/outcome measurement: Maintain or increase the total number of individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and support to maintain long-term supportive housing from the prior year.

Second-year target/outcome measurement: Maintain or increase the total number of individuals residing in community-based TDMHSAS provider housing facilities and/or receiving services and support to maintain long-term supportive housing from the prior year.

Data Source:

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

Description of Data:

Community Supportive Housing provides flexible funding to agencies to provide supported housing for adults diagnosed with mental illness and co-occurring disorders. Staff is hired by contract agencies to provide on-site supervision for residents and as-needed supervision to non-supervised group homes and apartments; coordinate outside activities for the residents; and work one-on-one to develop a housing plan that identifies the consumer's ideal housing goal and more independent living. The Emerging Adults program in Nashville, TN provides a comprehensive array of supportive housing and habilitation services for youth ages 18 to 25 living with serious emotional disturbances (SED). The Intensive Long-Term Support (ILS) facilities provide intensive long-term, wrap-around support services to allow people to be discharged from RMHIs into supportive living facilities in the community. Funding for Supportive Living facilities is described in the TN Code Annotated 12-4-330 directs TDMHSAS to reimburse certain supportive living facilities in 11 TN counties. Supportive Recovery Housing provides quality, safe, and affordable permanent housing with access to an array of recovery services to support the substance use recovery of adults. Supportive Reentry Housing program provides quality, safe, and affordable permanent housing with access to an array of supportive services that promote sustained community living for adults in Tennessee who re-enter the community from prisons and jails or have been previously incarcerated.

Data issues/caveats that affect outcome measures:

During the grant period (FY24/FY25) there is a new program that will align with this outcome measure. The Residential Re-Entry Housing Program (RRHP) is in development to create six residential facilities to serve individuals with severe and persistent mental health challenges reentering the community from incarceration. These facilities will provide quality, safe, and affordable long-term supportive housing for individuals re-entering the community from incarceration who would otherwise not be able to successfully live in the community due to the lack of available housing with the capacity to meet their specific needs. There are also two additional ILS facilities that are expected to begin placing residents in FY24. This indicator includes Mental Health Block Grant Supplemental Funding related to COVID to support one ILS site.

Indicator #: 9

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

Baseline Measurement: In state FY23, 446 peer specialists were certified.

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

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 10

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

Baseline Measurement: In state FY2023, 1,298 individuals were served through the evidence-based IPS initiative and 50% were employed in competitive and integrated work for at least one day.

First-year target/outcome measurement: Maintain or increase the percentage of the individuals served through IPS who will be

employed in competitive and integrated work for at least one day from the prior year.

Second-year target/outcome measurement: Maintain or increase the percentage of the individuals served through IPS will be employed in competitive and integrated work for at least one day from the prior year.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

In FY23, Supported Employment Expansion (SEE) significantly increased statewide IPS Supported Employment capacity.

Indicator #: 11

Indicator: Number of individuals to receive direct treatment and/or prevention/education targeting SMI/SED populations from Mental Health Block Grant Supplemental Funding related to COVID.

Baseline Measurement: In state FY2023, 69,265 individuals received mental health services and supports from COVID-19 Relief & COVID ARPA related grant projects.

First-year target/outcome measurement: Maintain or increase the total number of individuals who received mental health services and support from COVID- ARPA related grant projects from the prior year.

Second-year target/outcome measurement: Maintain or increase the total number of individuals received mental health services and support from COVID- ARPA related grant projects from the prior year.

Data Source:

Providers submit quarterly progress updates that include data related to grant funded positions, direct treatment and recovery services, and indirect prevention/education services targeting SMI/SED populations, and trainings.

Description of Data:

Data is provided based on services delivered using the supplemental funding provided through the MHBG program to assist in response to the COVID-19 pandemic through the COVID Relief and/or COVID ARPA grants. Grant contracted providers assessed the needs within their community and each community has a unique COVID Relief/ARPA project. Examples of the types of projects supported with these funds include added support to the crisis services continuum, emergency department supports, children and school-based services, training for community professionals, workforce retention, jail therapy, housing services, and peer recovery services. The data reported includes both direct and indirect services provided to SMI/SED populations.

Data issues/caveats that affect outcome measures:

Data in this section does not include the MHBG COVID Relief and/or COVID ARPA grant set-asides related to crisis services specific to mobile crisis assessments or FEPI expansion site. Those data are included in other indicators.

Priority #: 2

Priority Area: Promote early intervention

Priority Type: MHS

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

Goal of the priority area:

Provide effective early intervention, education and prevention services.

Strategies to attain the goal:

Program strategies supporting objective include Suicide prevention programs; School Based Behavioral Health Liaisons; and the Regional Intervention

Program.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: In state FY2023, 124,424 individuals received mental health awareness in Tennessee, through the provision of mental health and suicide prevention training, and/or public awareness activities.

First-year target/outcome measurement: Maintain or increase the total number of individuals receiving suicide prevention training, and/or public awareness activities from the prior year.

Second-year target/outcome measurement: Maintain or increase the total number of individuals receiving suicide prevention training, and/or public awareness activities from the prior year.

Data Source:

Number of individuals will receive suicide prevention and post-vention training as reported by Tennessee Suicide Prevention Network (TSPN) state monthly reports; number of teachers will receive suicide prevention training as reported by Jason Foundation state monthly reports; number of middle and high school students will receive mental health/suicide prevention training as reported by Mental Health Association of East TN state monthly reports to the Office of Crisis Services and Suicide Prevention. Number of individuals receiving suicide prevention training, suicide risk screening, or resource/referral training as reported by Centerstone (Youth and Young Adult Suicide Prevention and Mental Health Awareness Program Provider) state monthly reports to the Office of Crisis Services and Suicide Prevention.

Description of Data:

Tennessee Suicide Prevention Network (TSPN) is a statewide coalition of agencies, advocates, and consumers that oversee the continuing implementation of suicide prevention strategies in Tennessee to eliminate/reduce the incidence of suicide across the life span, to reduce the stigma of seeking help associated with suicide, and to educate communities throughout Tennessee about suicide prevention and intervention strategies. Project Tennessee provides a 2-hour educational curriculum for teachers, students, and parents about the signs of suicide. The program provides tools and resources needed to identify at-risk youth. The Youth and Young Adult Suicide Prevention and Mental Health Awareness Program provides mental health awareness, and suicide prevention training to Institutions of Higher Education in Middle and West TN and Middle TN Pediatric Offices in establishing processes for providing suicide risk screening and referrals.

Data issues/caveats that affect outcome measures:

None noted.

Indicator #: 2

Indicator: Number of students served by the school based behavioral health liaisons using the Multi-Tiered System of Support interventions from Tier II and Tier III services. Examples Public of Tier II and Tier III services include Psycho-Educational Groups, Individual Student Consultations, Behavioral Health Screenings, Individual, Group, Family Therapy.

Baseline Measurement: In state FY2023, 23,490 students received mental health screening, services, or supports in schools from school based behavioral health liaisons.

First-year target/outcome measurement: Increase the total number of students served by school based behavioral health liaisons from the prior year.

Second-year target/outcome measurement: Increase the total number of students served by school based behavioral health liaisons from the prior year.

Data Source:

Data is submitted into REDCap by the school based behavioral health liaisons and evaluated by TDMHSAS Office of Research. The provider submits monthly data on the number of students impacted by Psycho-Educational Groups, Individual Student Consultations, Behavioral Health Screenings, Individual, Group, Family Therapy.

Description of Data:

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

Data issues/caveats that affect outcome measures:

The State has significantly increased investment for school based behavioral health liaisons and is expanding this program in FY24 to add over 100 additional positions.

Indicator #:	3
Indicator:	Number of children under the age of 6 and their families will receive prevention and early intervention services and supports through Regional Intervention Program (RIP) to ensure that young children and their families experiencing challenging behaviors receive services and support.
Baseline Measurement:	In FY2023, 369 children under the age of 6 and their families receive prevention and early intervention services and supports through Regional Intervention Program (RIP) to ensure that young children and their families experiencing challenging behaviors receive services and support.
First-year target/outcome measurement:	Increase the number of children under the age of 6 and their families receiving prevention and early intervention services and support from the prior year.
Second-year target/outcome measurement:	Increase the number of children under the age of 6 and their families receiving prevention and early intervention services and support from the prior year.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

There were two RIP sites that were closed in FY23.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$4,068,802.00			$418,000.00			$293,368.00		$2,728,044.00	$209,404.00
4. Other Psychiatric Inpatient Care			$202,434,320.00		$16,583,200.00						
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$23,590,000.00	$5,681,400.00	$301,020,000.00	$3,838,000.00	$3,515,400.00				
8. Other 24-Hour Care		$11,753,027.00		$0.00	$45,202,648.00			$0.00			
9. Ambulatory/Community Non-24 Hour Care		$20,910,650.00	$702,979,562.00	$22,575,881.00	$211,261,974.00			$0.00		$19,698,977.00	$1,789,672.00
10. Crisis Services (5 percent set-aside)[f]		$2,034,402.00		$33,290,770.00	$57,406,632.00			$0.00		$1,217,568.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$1,921,143.00	$650,800.00	$2,444,200.00	$30,055,460.00	$862,000.00		$14,668.00		$1,299,000.00	$94,968.00
12. Total	**$0.00**	**$40,688,024.00**	**$929,654,682.00**	**$63,992,251.00**	**$661,947,914.00**	**$4,700,000.00**	**$3,515,400.00**	**$308,036.00**	**$0.00**	**$24,943,589.00**	**$2,094,044.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: ____ MHBG Planning Period End Date: ____

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total	$	$	**$**	**$**

[1] The 24-month expenditure period for the COVID-19 Rel 21 - **March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

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

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

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

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

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

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

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

f) Persons with substance use disorders in the justice system

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

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

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

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

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

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

TDMHSAS launched the Project Rural Recovery program in December 2020. Funded through a five-year SAMHSA grant, Project Rural Recovery brings integrated behavioral and physical health mobile care services to ten (10) rural counties in two recreational vehicles (RVs). The RVs park at various sites in the communities, including grocery stores, shopping centers, libraries, health departments, and parks. The multidisciplinary mobile health team, comprised of a program director, nurse practitioners, behavioral health clinicians, integrated care community specialists/certified peer recovery specialists, and mobile office managers provides an array of services, including individual/group counseling, suicide risk screening, psychotropic medication dispensing, tobacco/nicotine cessation, primary health screenings, and access to nutrition and housing services, all at no cost to the patient. The mobile health team refers patients to community providers for specialty services that cannot be provided on the mobile bus. This program has recently been expanded through American Rescue Plan funding in 2022 to support ten (10 additional counties).

The Office of Crisis Services and Suicide Prevention within TDMHSAS has contracts with Mobile Crisis Providers across the state, to ensure access to emergency mental health evaluations are available for all in need. Mobile Crisis Providers establish relationships with providers of all types, including Primary Care Providers, in their regions. These connections serve as a point of entry for consumers in the Crisis Continuum, and Mobile Crisis Staff often respond to requests for evaluations at a Primary Care office. Mobile Crisis staff often consult with Primary Care Providers when gathering information for the crisis assessment. Additionally, Mobile Crisis staff include Primary Care Provider information in the crisis assessment. When a consumer is referred to a higher level of care, such as 23 Hour Observation, Respite, CSU, Detox Facility, or Inpatient Hospitalization, these providers have access to the Primary Care Provider via the information in the crisis assessment. This information is useful for communication during the discharge process. Over the past three years, TDMHSAS has been awarded funding to formally support Tennessee's 988 Infrastructure. As of July 2022, when an individual calls/chats/texts 988, the contact is routed to a Tennessee-based provider. This vital diversionary resource provides access to a trained counselor in the provision of risk screening, triage, consultation, and referrals to ensure appropriate and efficient access to resources. Since FY23, Tennessee's 988 providers have handled 35,038 crisis calls. With the implementation and education across the state around this resource, there has been a noted decrease in Emergency Department presentations and Law Enforcement utilization. This includes the average monthly decrease in Emergency Department presentations by 37 individuals monthly, along with an average monthly decrease by 104 individuals requiring law enforcement involvement. A very small percentage of total calls have resulted in a higher level of intervention via mobile crisis at 4%. In assisting communities post-disaster, TDMHSAS has pursued three (3) Crisis Counseling Programs. These programs provide crisis counseling, outreach, referral linkage and education to communities of impact. Through American Rescue Plan funding, TDMHSAS will be adding an additional three (3) Crisis Stabilization Units for adults and more recently, through state appropriations, will be creating infrastructure for two (2) new Crisis Stabilization Units for children and youth.

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

The Office of Behavioral Health Safety Net and Older Adults oversees the Behavioral Health Safety Net (BHSN) and the Older Adults Program (OAP). The BHSN program provides essential outpatient mental health services to uninsured Tennesseans ages 18 and older and uninsured/underinsured Tennessee children ages 3 to 17 who meet program eligibility criteria through a network of participating Community Mental Health Providers (CMHPs). Essential services offered through the BHSN include assessment and evaluation, therapeutic interventions, case management, psychiatric medication management, laboratory tests related to medication management, pharmacy assistance and coordination, and transportation to BHSN services. The Behavioral Health Safety Net is eligible to individuals with Medicare but without TennCare to receive Case Management services. BHSN Case Management provides assessment and linkage to other community resources and on-going monitoring of care plans and service arrangements. At the onset of the COVID-19 pandemic, telehealth services became a significant venue for delivering services through the BHSN. The embrace of telehealth has allowed mental health services to be offered safely, to eliminate any potential

disruption in mental health treatment and recovery and expand access to rural and vulnerable populations. Throughout FY23, 61% of BHSN enrollees received at least one service via telehealth and 15% of all BHSN services delivered were via telehealth. For individuals 50 years and older, who may have Medicare but are not enrolled in TennCare and who do not qualify for the Behavioral Health Safety Net, the Older Adults Program provides a care coordination component that can include community outreach, education on healthy aging, mental health screening, assessment, in-home therapy, and other supportive services, as needed. Care coordination may include referral and collaboration with other supports and service providers, including primary care services. In response to COVID-19 and for those older adults with limited mobility and access to transportation, telehealth is being widely leveraged to provide direct access to care coordination services.

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

The Office of Housing and Homeless Services leads the Creating Homes Initiative 2.0 program, which seeks to assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable, and permanent housing options for Tennesseans in recovery from substance use disorder, including opioid use disorder. Program grant funds are dedicated to infrastructural costs and support services costs to create new quality supportive housing in this capacity. Quality, safe and affordable permanent housing options and services under this program supports the substance use, in particular opioid use, recovery of prospective residents following four dimensions as identified by the SAMHSA, which include: Health; overcoming or managing one’s disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being; Home; a stable and safe place to live; Purpose; conducting meaningful daily activities and having the independence, income and resources to participate in society; and Community; having relationships and social networks that provide support, friendship, love and hope. The Children and Youth Homeless Outreach Project provides outreach and case management for homeless families to identify children and youth with SED or at risk of SED and assists parents in securing mental health services for children and linkage to services to help keep families intact. Once identified, efforts are made to engage the service recipient and the members of their household to make referrals for behavioral health services and support efforts to obtain housing and/or housing-related resources. As a regionally based program, a total of five provider agencies conducts these efforts by way of hands-on outreach workers.

The Office of Children, Young Adults, and Families (OCYAF) works diligently with community providers to ensure that as many services and supports as possible can be delivered within the community where children, youth, young adults, and their families live, attend school, and work. OCYAF serves ages zero to thirty throughout the State of Tennessee with twenty-two programs ranging from prevention to early intervention to treatment. Programming not only supports those receiving the services and supports but also communities including school faculty and staff, child welfare workers, court employees, health care partners, stakeholders, and those interested in supporting mental health within communities. In recent years a concerted effort has been made to utilize community feedback and needs assessments to ensure best fit of services.

More information about Tennessee’s efforts to improve access to care for substance use disorders for: Pregnant women with substance use disorders, Women with substance use disorders who have dependent children, Persons who inject drugs, Persons with substance use disorders who have, or are at risk for, HIV or TB, and Persons with substance use disorders in the justice system may be reviewed in the TDMHSAS Substance Abuse Prevention and Treatment Block Grant Application.

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

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

In 2021, the Tennessee General Assembly passed, and Governor Bill Lee signed into law SB151/HB360/Public Chapter 244 re: behavioral health parity. Under the aforementioned legislation, by January 31, 2022, and each year thereafter, the Tennessee Department of Commerce and Insurance (TDCI) must issue a report to the Tennessee General Assembly and provide an educational presentation to that body. The bill requires the TDCI to request from the United States Department of Labor and the United States Department of Health and Human Services certain analyses submitted to those entities the previous year in compliance with the federal Consolidated Appropriations Act of 2021 and incorporate these analyses into the report. This bill requires that TDCI's report and presentation:

(1) List health plans sold in this state and over which of these plans TDCI has jurisdiction; (2) Discuss the methodology TDCI is using to check for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and Tennessee Code Annotated (TCA) sections 56-7-2601, 56-7-2602, 56-7-2360; (3) Identify market conduct examinations and full scope examinations conducted or completed during the preceding 12-month period and summarize the results of the examinations;

(4) Detail educational or corrective actions TDCI has taken to ensure health benefit plan compliance with the MHPAEA and TCA sections 56-7-2601, 56-7-2602, 56-7-2360; 5) Detail TDCI’s educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law; and (7) Describe how TDCI examines any provider or consumer complaints related to denials or restrictions for possible violations of the MHPAEA and TCA sections 56-7-

2601, 56-7-2602, 56-7-2360, including complaints regarding, but not limited to: (A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary; (B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested (C) Denials of requests, authorizations, pre-authorizations, prior authorizations, concurrent reviews, or claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication; (D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary; (E) Step therapy requirements imposed before buprenorphine or naltrexone are approved; (F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine; and (G) Denial of in-network authorization or denials of out-of-network services or claims where there is not an in-network provider within 75 miles of the insured patient's home.

Tennessee's state Medicaid authority, TennCare, currently contracts with three (3) managed care organizations (MCOs) to provide inpatient, outpatient, and emergency services to individuals enrolled in the TennCare CHOICES program. The State's Preadmission Screening and Resident Review (PASRR) program can track and monitor mental health parity for any Tennessee resident seeking placement in a Medicaid-certified nursing facility for rehabilitative care or long-term services and supports, as well as prescribing a plan of care for physical and behavioral health specialized services. This plan of care is provided through Tennessee's CHOICES program to include nursing facility services and home and community-based services (HCBS) for adults 21 years of age and older with a physical disability and seniors (age 65 and older). A PASRR screening is federally required as part of this process of eligibility determination for everyone applying to or residing in Medicaid-certi?ed nursing facilities, even individuals not receiving Medicaid bene?ts. The screening ensures prior authorization for timely and appropriate access to medically necessary covered services, and that care is delivered in accordance with generally accepted standards of medical practice, in the most appropriate setting, and to prevent inappropriate service utilization.

Whenever there is a denial for nursing facility placement in a finalized PASRR determination, an individual has a means to appeal the decision directly with the state or by requesting a revision through TennCare's PASRR assessment contractor. CHOICES offers person-centered HCBS services to mitigate institutionalization and so individuals may live more independently in their own homes. HCBS are provided to TennCare enrollees on the job, or in the community to enable self-determination, assist with daily living activities and to allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if this is needed. The PASRR screening process is coordinated through the Division of TennCare in contract partnership with the Department of Intellectual and Developmental Disability (DIDDs), and The Tennessee Department of Mental Health (TDMH) and adheres to all federal Centers for Medicare and Medicaid Services (CMS) and state parity laws in determining appropriate placement and a plan of care based on each individual's level of physical and mental health care needs.

Beginning in 2018, as a recipient of Zero To Three (ZTT) Technical Assistance Funding, TDMHSAS has worked in collaboration with other infant/early childhood mental health (IECMH) sector partners to address Infant and Early Childhood Mental Health Financing Policy, beginning with membership on the State Team. The Infant and Early Childhood Mental Health Financing Policy Team (IECMHFPT) is led by the Association of Infant Mental Health in TN, TennCare (TN State Medicaid Agency), and the State Centers of Excellence. TDMHSAS maintains representation on Action Teams within the broader Financing Policy Team. Current goals for this the IECMHFPT include; "(1) Identify and utilize current mechanisms in place (Medicaid and alternatives) to finance IECMH services, (2) Identify core IECMH services which are not currently reimbursable in Tennessee and explore options to finance those services, (3) Expand workforce and develop messaging of IECMH to families & stakeholders, (4) Identify opportunities to impact systemic change through advocacy & collaboration, (5) Develop strategies to synergize cross sector efforts for IECMH workforce recruitment and retention efforts, (6) Ensure all TN IECMH Financing and Policy Team State Plan goals and action steps are centered on accessibility and culturally and linguistically responsiveness and offer a place for all Tennesseans." TDMHSAS representation leads Action Team 1 (Identify and utilize current mechanisms in place (Medicaid and alternatives) to finance IECMH services.

The School Based Behavioral Health Liaison (SBBHL) program has steadily increased its funding over the last several years, both through the mental health block grant as well as through state appropriations. Following the release of the Surgeon General's Advisory on Children's Mental Health in 2021, the Governor and the state legislature placed an increased attention on meeting children and youth where they are and providing on-site easily accessible mental health care within schools.

TDMHSAS has a long history of contracting NAMI Tennessee, which has a parity project to educate Tennesseans about parity.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

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

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

c) Efforts to integrate primary care into behavioral health settings

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

support. The TNCODC provides training and technical assistance to improve co-occurring capability of M/SUD providers across the state.

A program example of supporting integrated systems of care is through the Statewide Peer Wellness Coach and Trainer program. This program provides and coordinates health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and support assists providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities. In the My Health, My Choice, My Life program Peer Wellness Coaches act as liaisons between case managers, clients, and primary care practitioners. The Peer Wellness Coaches help individuals develop and maintain relationships with primary care practitioners and continue to provide support as needed.

In FY23, TDMHSAS launch a pilot project in partnership with the TN Department of Health to co-locate mental health services, provided through a Community Mental Health Agency (CMHA), at a health department in a rural county. The county health department refers patients to the CMHA, regardless of payor source. The CMHA will coordinate and/or deliver both in-person and telehealth mental health services for individuals referred. Additionally, the CMHA has one staff onsite at the county health department.

The TDMHSAS' Older Adults Program (OAP) provides essential mental health care management services to people ages 50 and older who do not financially qualify for Medicaid (TennCare) or the Behavioral Health Safety Net. Care coordination can include community outreach, education on healthy aging, mental health screening, assessment, in-home therapy, and other supportive services, as needed. The six OAP community mental health provider agencies across the state are contracted to provide coordinated care in direct collaboration with a client's primary care physician and nurses.

The Office of Children, Young Adults, and Families is committed to community-based care whenever possible. In FY21, TDMHSAS received state funding for the Tennessee Resiliency Project (TRP). TRP encouraged proposers to consider the needs of their communities and select one or more of the following goals to address: 1) Promote early childhood mental health; 2) Increase access to school-based mental health services, specifically School-Based Behavioral Health Liaisons (SBBHL) or Project BASIC (Better Attitudes and Skills in Children); and/or 3) Ensure enhanced coordination of crisis care. As a result of the success of Project BASIC and enhanced care coordination between primary care and mental health, funding from the Bipartisan Safer Communities Act (BSCA) was allocated to the expansion of each. Additionally, to address emergency department boarding at children's hospitals, funding was awarded through the Transformation Transfer Initiative (TTI) by the National Association of State Mental Health Program Directors (NASMHPD) and SAMHSA, allowing for enhanced care coordination and ultimately leading to reduced wait times. Due to its success, the project at Monroe Carrell Jr. Children's Hospital at Vanderbilt was extended using MHBG American Rescue Plan Act (ARPA) funding.

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

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

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

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

The Older Adults Program is not insurance or part of TennCare (Medicaid). It is supplemental to Medicare or private pay and funds mental health care management services via six (6) grant contracts annually with regional mental health providers serving 52 counties in Tennessee. Care management services include community outreach, collaboration with other health care providers, healthy aging education, depression screening assessments, in-home therapy via telehealth or face-to-face visits for older adults with limited mobility, person-centered advocacy, and referral/linkage to community resources like respite care and other supportive health services for older adults, their families, and caregivers.

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

mental health services. The teams develop and implement recovery-oriented programming which ensures individual, family, and housing provider support while connecting and coordinating with natural and formal supports within the individual's community.

The Office of Housing and Homeless Services leads a number of programs that include practices in the permanent supportive housing model; each of these programs utilize state and/or federal funding through grant contracts to provide support services. The Community Supportive Housing, Intensive Long-term Support, Supportive Recovery Housing, and Supportive Reentry Housing programs each incorporates access to support services such as peer recovery support, supported employment, SSI/SSDI, Access, Outreach, and Recovery (SOAR), community engagement, skill building for daily living and social engagement, and individualized goal planning. Program service providers often coordinate with various reputable community partners to increase access of support services to program service recipients.

The Office of Children, Young Adults, and Families (OCYAF) oversees the School Based Behavioral Health Liaisons that use the Multi-Tiered Systems of Supports framework to provide face-to-face consultation with classroom teachers to enhance trauma-informed learning environments for children and youth who have or are at-risk for SED, behavior problems, or substance use disorders. Liaisons provide training and education for the classroom teachers regarding mental health and substance abuse topics, as well as behavioral interventions. Liaisons provide a connection between the child's family and school to ensure collaboration and proper communication; assists with transitions between alternative school/classroom placements; supports school staff/families in navigating mental health transitions between alternative school/classroom placements; supports school staff/families in navigating mental health and other needed services; and provides mental health screenings and brief therapy for the child or youth as needed. OCYAF has several programs that use a care coordination approach services. The System of Care Across Tennessee provides Intensive Care Coordination using a wraparound approach with children, youth, young adults, and their families who are at-risk of out-of-home placement. Healthy Transitions and the First Episode Psychosis. FEP programming utilize a Coordinated Specialty Care model that ensures coordination between providers. In FY22, the FEP program was expanded with the use of ARPA funding bringing the total number of FEP sites to 9 in the state. An additional program that was expanded with the MHBG ARPA dollars was the care coordination model being utilized in the Emergency Department at Monroe Carrell Jr. Children's Hospital in Nashville, Tennessee.

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

TDMHSAS continues to provide leadership for advancing integrated systems of care for individuals with co-occurring disorders. Encouraging co-occurring competent and co-occurring friendly programs is key value present in all grant contracts administered by the Division of Mental Health Services. This is evident through the department's support of the Tennessee Co-Occurring Disorders Collaborative (TNCODC). This multi-agency effort aims to create a common understanding of the impact and treatment of co-occurring disorders in Tennessee communities. The primary goals of TNCODC include (1) to share knowledge about the conditions and available resources, (2) reduce stigma, and (3) accurately direct people to timely and effective prevention, treatment, and support. In addition, TDMHSAS supports its Certified Peer Recovery Specialist program, which currently has 1,264 CPRS trained in co-occurring peer support. CPRS have lived experience of mental illness or substance use disorder.

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

The Department of Mental Health partners with the Division of TennCare Long-term Services & Supports and the Department of Intellectual and Developmental Disabilities (DIDDs) through an interagency contract to ensure individuals 18+ seeking nursing facility placement for rehabilitative care or enrollment in TennCare CHOICES HCBSs receive a pre-admission screening and resident review, commonly called a PASRR. This screening is a comprehensive mental health assessment and physical history evaluation that ensures people diagnosed with serious mental illness, intellectual, and/or developmental disabilities, or related conditions such as substance use disorders, are able to live in the most independent settings while receiving the recommended care and interventions to improve their quality of life and address their co-occurring disorders and related conditions. Finding appropriate placement is essential to preventing unnecessary hospitalization and mitigating the development of acute patient destabilization.

The Office of Children, Young Adults, and Families, in addition to having the School Based Behavioral Health Liaisons (SBBHL) program, partners with the Department of Education to provide a program manager for Project AWARE. SBBHL and Project AWARE have provided rapid response to co-occurring incidents with youth within communities as well as have partnered with the Regional Overdose Prevention Specialists (ROPS) to provide training and technical assistance related to co-occurring issues. The Tennessee Resiliency Project also has two agencies providing specialized crisis response to East and Middle TN which includes co-occurring interventions.

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

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

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

Please respond to the following items:

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

a) Race ◉ Yes ○ No

b) Ethnicity ◉ Yes ○ No

c) Gender ◉ Yes ○ No

d) Sexual orientation ○ Yes ◉ No

e) Gender identity ○ Yes ◉ No

f) Age ◉ Yes ○ No

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

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

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

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

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

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

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

The Community Supportive Housing, and Intensive Long-term Support are permanent supportive housing programs that assists with maintaining access to supportive services (mental health, co-occurring, case management, etc.) for service recipients in over 100 quality affordable housing sites across the state. In SFY 2022, the Office of Housing and Homeless Services began its Supportive Recovery Housing program, which provides access to supportive recovery-based services at quality affordable permanent housing sites for individuals in recovery from substance use disorders; as of SFY 2023, a total of 10 sites are in operation, and the program is expected to increase in capacity in the near future after new residential projects are completed. Additionally, in SFY 2023, the Office of Housing and Homeless Services launched its Supportive Reentry Housing program, which provides access to supportive reentry-based services at quality affordable permanent housing sies for individuals with mental illness and/or substance use disorder who are reentering the community from prisons and jails or have a history of incarceration. The Community Targeted Transitional Support (CTTS) program provides temporary financial assistance to support service recipients' ability to sustain community living and avert homelessness or reduce the risk of homelessness. The Inpatient Targeted Transitional Support (ITTS) program assists service recipients exiting the Regional Mental Health Institutes, Crisis Stabilization Units, and State-Contracted Psychiatric Hospitals in their successful transition to community living by providing temporary financial assistance to obtain and maintain residence and related supports in the community until their financial resources can be established, to avert homelessness or reduce the risk of homelessness. Both the CTTS and ITTS programs provide limited, temporary financial assistance for expenses such as rent deposits, rent payments, utilities, vision care, dental care, as well as fees for obtaining documents such as birth certificates, state-issued ID cards, etc. Providing a means for such costs are vital for those who lack these resources to successfully obtain housing at such a critical time of need.

The Office of Children, Young Adults, & Families oversees multiple SAMHSA-funded federal discretionary grants that provide services to all ages including transition-age youth and young adults, including System of Care Across Tennessee (SOCAT), Healthy Transitions, Clinical High Risk for Psychosis (CHR-P), and First Episode Psychosis Initiative/Early Serious Mental Illness. Each initiative includes the development and implementation of a Disparity Impact Statement. These statements address the following: Proposed number of individuals to be served by subpopulations in the grant service area; A quality improvement plan using our data; and Adherence to the CLAS standards. The Regional Intervention Program has a policy for Limited English Proficiency (LEP) that meets Title VI requirements and addresses language services for clients. The LEP policy also includes a 4 Factor Analysis that is completed annually and addresses: Number or proportion of LEP persons eligible to be served or likely to be encountered by the program; Frequency with which LEP individuals come in contact with the program; Nature and importance of the program, activity,

or service provided by the program to people's lives; and Resources available to the LEP grantee/recipient and the cost.

The Office of Crisis Services and Suicide Prevention oversees grant contracts with providers that offer crisis services to every county in the state. These services are available, at no cost, to all in need. These services include access to a statewide crisis phone line 24/7/365. These hotline services are staffed to assist consumers in need with crisis management, offer resources and connection with a wide range of community providers, as well as connection with other services within the crisis continuum. Mobile Crisis Services are also available to anyone experiencing a mental health emergency, at no cost, 24/7/365. These services are available to assess the individual and assist with facilitating connection with services that meet the current need of the client. These crisis providers ensure that the full continuum of crisis services is available across the state. The State currently contracts with eight (8) Walk-In Center and Crisis Stabilization Unit (CSU) providers across the state. These Walk-In Centers are available to provide crisis assessment, and, if needed, referral to a community stabilization services via 23 Hour Observation, Respite and Crisis Stabilization Units. These CSU facilities are utilized as an alternative to hospitalization, where the consumer can receive therapeutic treatment, including medication management, without being admitted to an inpatient psychiatric facility. These CSU facilities take referrals from crisis providers across the state, which allows consumers state-wide to have access to the appropriate level of care. The use of telehealth services for crisis assessments has provided even more efficient connection with a provider, thereby more quickly addressing the needs of the consumer. Telehealth services in an expanded capacity during the pandemic, ensuring that services were continuing to be provided, when a face-to-face assessment was not available. Mobile crisis providers have established relationships with other agencies in their regions, including law enforcement, as well as other transportation services. These relationships ensure a collaborative approach when determining the best treatment outcomes, as well as the most appropriate mode of transportation, for the consumer. The centralized database, Crisis Management System, has been updated to allow for all crisis services efforts to be captured in a standardized manner. All crisis calls, mobile crisis, walk-in center and crisis stabilization unit services data are all captured to, not only include by provider service volume data, but also outcomes data to inform service quality. Additionally, reporting capabilities were enhanced so that both TDMHSAS and provider leadership complete internal quality assurance on data integrity, but also outcomes measures for operational and process improvement.

The TDMHSAS Training and Technical Assistance Center (TTAC) includes a trainer in Cultural Competency in Health and Human Services by the Cross-Cultural Health Care Program. The trainings provided are focused on CLAS standards and cultural and linguistic responsiveness. Trainings are provided to contracted providers and by request from community partners.
The Director for the Office of Wellness and Employment serves as the chair for the Employment First Task Force – Behavioral Health Workgroup. The goals of the workgroup are to increase access to supported employment programs for individuals living with a behavioral health condition, determine methods to reach clients who are dually diagnosed with a mental illness and substance use disorder, and create methods to support clients who wish to work in competitive jobs, but do not have access to IPS. The Office of Wellness and Employed created the Statewide Individual Placement and Support (IPS) Steering Committee. The goals of this committee are to decrease gaps in IPS services and improve service penetration rate by finding and applying for additional funding opportunities, identify and address issues faced by IPS services providers (i.e. lack of access to personalized benefits counseling, difficulty filling vacant IPS positions), expand IPS services to all 95 Tennessee counties ensuring access to all those who want to find employment, and monitoring enrollment and service data to ensure all populations have equal access to IPS services. The Statewide IPS Steering Committee is comprised of TDMHSAS staff, NAMI Tennessee, contracted IPS providers, individuals with lived experience, and other community partners. Individual Placement and Support (IPS) Supported Employment Trainers offer training, support, and guidance to supported employment providers across the state. The training is provided to behavioral health direct support staff, agency leadership, mental health providers, and Vocational Rehabilitation staff who support clients in the search for competitive integrated jobs.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

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

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

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

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

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

In partnership with Governor Lee's office and Tennessee's executive agencies, the Office of Evidence and Impact (OEI) was established in 2019 to support agencies in using data to invest in programs to produce positive outcomes for Tennesseans. TDMHSAS has worked on many projects with OEI to create a program inventory of currently funded programming and develop internal evaluation plans focused on outcomes for current and expanded programs. TDMHSAS promotes the use of evidence-based practices and services in funding announcements. Tennessee is placing a greater focus on ensuring it invests in what works to best serve citizens across the state. As part of the Tennessee's annual budgeting process, state Departments requesting new dollars submit request forms that align with the Tennessee Evidence Framework. Influenced by the Results First Initiative, the framework allows agencies to share data and evidence that support proposed and existing programs during the budgeting process.

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care (CSC)	9

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
2034401	2034401

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

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

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Coordinated Specialty Care/OnTrack teams also utilize the Individual Placement and Support (IPS) model for supported employment and education as well as peer support through Certified Peer Recovery Specialists/Certified Young Adult Peer Support Specialists. TDMHSAS has expanded its grant contracts from four providers to six providers in total. Each program site implements the OnTrackNY coordinated specialty care (CSC) evidenced-based model for structuring the program for youth and young adults experiencing their first episode of psychosis. In addition to the coordinated specialty care (CSC) evidenced-based practice, each program site utilizes the Individual Placement and Support (IPS) model for supported employment and education services. Each program site also offers peer support services through the Certified Peer Recovery Specialists and Certified Young Adult Peer Support Specialists Programs. TDMHSAS has implemented programs across various regions of the state. Alliance Healthcare Services provides FEPI programming in Shelby County, Carey Counseling Center, Inc. offers FEPI programming in rural northwest Tennessee across seven counties, providing coverage in Lake, Obion, Weakley, Henry, Benton, Carroll, and Gibson counties. Mental Health Cooperative provides services in Davidson and Montgomery counties, and Helen Ross McNabb Center provides FEPI programming in Knox, Blount, Loudon, Monroe, and Hamilton counties. Volunteer Behavioral Health provides FEPI services in Rutherford County, while Ridgeview Psychiatric Hospital and Center, Inc. offers FEPI Programming in Anderson County. Each OnTrackTN program team are provided opportunities for further training on youth and young adult engagement (e.g., Transition to Independence Process model (TIP) through the TDMHSAS Training & Technical Assistance Center (TTAC).

The TN Healthy Transition Program, located in Davidson County and rural Greene County, also provides adapted FEPI services to Youth and Young Adults (Y/YA) who may be at clinical high risk for experiencing psychosis. Teams provide services when no FEPI teams are located in the area to support youth and young adults. The Healthy Transitions Team utilizes the Transition to Independence Process (TIP) Model as a framework to provide wrap-around service delivery. Each HT program consists of the following, dependent upon the Y/YA and family needs and desires: Project Coordinator, Supported Employment and Education Specialist (SEES), Certified Young Adult Support Specialist (CYAPSS), Care Coordinator, and Outreach Specialist. However, in Davidson County, there is a Young Adult Peer Stabilizer who is a Young Adult Peer Support embedded within the mobile crisis system with Mental Health Cooperative, working alongside the child and adult crisis teams to provide community-based peer stabilization services to Y/YA between the ages of 16-25 who receive crisis services in Davidson County.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

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

TDMHSAS contracts with Park Center to employ two statewide trainers that provides training, technical assistance, and fidelity monitoring to CSC/OnTrackTN teams across the state. To ensure the promotion of evidence-based best practices with individuals with ESMI, the statewide trainers collaborate with OnTrackUSA for ongoing training and consultation.

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

Since the program's inception, OntrackTN has provided FEPI services to 232 Youth and Young Adults with psychosis-related concerns across 18 counties. In FY2023, FEPI clients enrolled in the program reported an 82% increase in improved psychosis related symptoms and

a 76% decrease in hospitalization days.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

In 2024, the FEPI program has expanded its fidelity monitoring capacity by contracting with Park Center, an expert community IPS consulting agency. The agency will employ two statewide trainers to continue service delivery to the OntrackTN program sites. During 2024-2045 period, MHBG COVID relief funds and MHBG ARPA supplemental funding helped to expand FEPI into Blount, Loudon, Monroe counties. TDMHSAS selected each county based on data from the statewide crisis reports that indicated a significant uptick in Youth and Youth and Young Adult psychosis-related emergencies in those areas. During this same period, the department also expanded support for Youth and Young Adult Initiatives by utilizing the Bipartisan Safer Communities Act (BSCA) funds. The BSCA funds support two Youth & Young Adult Best Practices Trainers/Consultants that provide training, coaching, technical assistance, consultation, and fidelity monitoring on best practices (e.g., OnTrack) to current and new youth and young adult programs across Tennessee.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

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

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

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

Estimated incidence is 2,115 for Tennessee using 2022 Census population totals using the estimate of .0003 rate of incidence.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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

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

N/A

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

Tennessee has 45 peer-run Peer Support Centers throughout the state where Certified Peer Recovery Specialists work with consumers on self-management of their health, including making health care decisions and communicating with their providers. Certified Peer Recovery Specialists provide self-management classes in the Chronic Disease Self-Management Program, Diabetes Self-Management Program, NEW-R, Dimensions: Tobacco Free, Matter of Balance, and the Wellness Recovery Action Plan (WRAP). In addition, the statewide consumer organization, Tennessee Mental Health Consumers' Association, provides peer support throughout the state that engages consumers in managing their health. If a person has developed a Wellness Recovery Action Plan (WRAP), cross system crisis plan or crisis management plan prior to the current crisis situation and/or has a Declaration for Mental Health, the crisis service provider will attempt to locate and follow the plan to the extent possible, including bringing in the people identified to assist with the plan.

The State has a Certified Family Support Specialist certification program in which parents and caregivers use their lived experience to provide peer-to-peer support services to parents and/or caregivers navigating the child serving systems on behalf of a child with a Social Emotional Disturbance (SED) or co-occurring disorder. Following training and experiential hours individuals can apply for certification. The State also has a Certified Peer Recovery Specialist program and a Certified Young Adult Peer Support Specialist program (CYAPSS) for young adults ages 18-30. Within the Office of Children, Young Adults, and Families, the System of Care Across Tennessee provider sites employ Family Support Specialists, and the Clinical Risk for Psychosis (CHR-P), On Track TN (FEPI) and Healthy Transitions lab sites employ Certified Young Adult Peer Support Specialists and Certified Peer Recovery Specialists who collaborate with the consumer's Care Coordinator and Therapist to ensure person-centered planning.

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

The Older Adults Program works through six (6) contracted community mental health providers across the state to offer person-centered mental health care coordination and education on a case-by-case basis, customizing care plans to meet each client's, and their caregivers'/family's specific needs.

The Community Supportive Housing, Supportive Recovery Housing, and Supportive Reentry Housing programs each incorporate the use of individualized housing plans, which are centered around the respective service recipient's goals toward greater independence, recovery, and resiliency. Each service recipient engages with the program service provider staff to collectively formulate their person-centered plan, which promotes client choice in care and wellness decision making. Access to supportive services paired with the permanent housing setting provides service recipients with tools and resources to help establish

achievable steps toward achievement of each identified goal.

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

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

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

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

Another example is through the Community Supportive Housing, Supportive Recovery Housing, and Supportive Reentry Housing programs each of which require provider agencies to enact a person-centered approach to the housing process, including the requirement to have a housing and services plan that is client-driven and person-centered. The Emerging Adult Services program requires the provider agency to conduct an assessment to detail the service recipient's individual strengths and needs, and subsequently develop a transitional plan to guide services and transition to adulthood.

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

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

Certified Peer Recovery Specialists in Tennessee's 45 Peer Support Centers are contractually required to provide training and education to service recipients on Tennessee's version of a Psychiatric Advanced Directive, called the Declaration for Mental Health Treatment. In addition, the Peer Support Center staff make sure the Declaration for Mental Health Treatment brochure is available on site for participants to take home and fill out.

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ◉ Yes ○ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ◉ Yes ○ No

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

All grant contracts are subject to fiscal and programmatic monitoring as part of TN State Policy (2013-007) Grant Management and Subrecipient Monitoring Policy and Procedures.

The Office of Contracts, within the TDMHSAS Division of General Counsel, includes prohibitions within sub-recipient grant contracts. The State Procurement Commission has incorporated the sections into the pro forma statewide grant contract template as an optional language. Sub-recipient contracts that are supported with the Mental Health Block Grant funds include the following language within Section E. Special Terms and Conditions.

E.#) Prohibitions on Use of Federal Mental Health Block Grant (MHBG) Funds. Under federal laws and regulations, the Grantee shall not use any federal Community Mental Health Services Block Grant (now MHBG, formerly CMHS BG) funds made available under this Grant Contract for any of the following purposes: a. to provide inpatient services; b. to make cash payments to intended recipients of health services; c. to purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or to purchase major medical equipment; d. to satisfy any requirement for the expenditure of non-federal funds for the receipt of federal funds; e. to provide financial assistance to any entity other than a public or non-profit private entity. And E.#) Prohibition on Supplantation of Federal Mental Health Block Grant (MHBG) Funds.

Under federal laws and regulations, the Grantee shall not use any funds paid or services rendered under the federal Community Mental Health Services Block Grant (now MHBG, formerly CMHS BG) to supplant any other funds available for the services provided under this Grant Contract. The TDMHSAS Grantee Manual is located on the Grants Management section and includes resources about the grant contracting process, highlights key contract provisions, reviews the programmatic and fiscal requirements for grant contracts, outlines the monitoring process, and provides resources related to grant management. Additionally, the for Providers, the Grants Management section of the TDMHSAS website includes extensive information and guidance for sub-recipients around the use of federal funds including Uniform Guidance, Allowable Vs. Non-Allowable Costs, FFATA, and more.

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

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

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

   N/A

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

   N/A

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

   N/A

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

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

The intensive Long-term Support (ILS) program serves individuals who have been discharged from the state's Regional Mental Health Institutes (RMHIs) after an extensive length of stay, and who would otherwise not be able to successfully live in the community due to the lack of available housing with the capacity to meet their specific needs. The ILS program provides enhanced -level of support services on-site and utilizes quality residential homes that are licensed by the State of Tennessee as Mental Health Adult Supportive Residential Facilities. Effective coordination between the RMHI and the ILS provider staff to facilitate an effective and efficient flow of referrals includes collaborative meetings and calls, strategically scheduled visits, and the sharing of pertinent information; these measures promote a smooth transition from long-term hospital stays to sustained community living. TDMHSAS recently embarked upon ILS expansion activities to increase the program's number of locations and corresponding bed capacity; this is marked by two releases of funding announcements to solicit competitive grant proposals toward the establishment of residential infrastructure and subsequent provision of ongoing wrap-around support services, one during the state fiscal year 2021 and another during the state fiscal year 2022. The purpose and goal of the SFY 2021 Announcement of Funding (AOF) was to establish and operate an ILS residential facility to serve individuals discharging from Western Mental Health Institute (WMHI), which is located in Bolivar, TN. A quality proposal in response to this AOF was selected to create a 20-bed residential facility in nearby Jackson, TN, which is slated to begin residential occupancy and service delivery during the state fiscal year 2024. The purpose and goal of the SFY 2022 AOF was to establish and operate an ILS facility to serve individuals discharging from Moccasin Bend Mental Health Institute (MBMHI), which is located in Chattanooga, TN. A quality proposal in response to this AOF was selected to create a 21-bed residential facility in Chattanooga, which is also slated to begin residential occupancy and service delivery during the state fiscal year 2024. For the new Chattanooga ILS facility, ongoing operational services funding is being supported with Federal Community Mental Health Service Block Grant funding as part of the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260] and the American Rescue Plan Act (ARPA), 2021 [P.L. 117-2].

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

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

currently 16 behavioral health agencies that use this model across the state.

Peer Wellness Coaching (PWC) is offered in the eastern part of the state. Adults living with serious mental illness die on average 25 years earlier than other Americans largely due to treatable medical conditions. The My Health, My Choice, My Life (MHMCML) Initiative, led by PWCs, includes evidence-based, self-management workshops along with one-on-one wellness coaching. Peer Wellness Coaches promote healthier behaviors for Tennesseans with mental health and/or substance use disorder conditions. They do this by facilitating holistic, evidence-based curriculums such as Chronic Disease, Diabetes, and Chronic Pain Self-Management Workshops, Matter of Balance Workshops, Whole Health Action Management (WHAM), Nutrition Education Wellness and Recovery (NEW-R), Dimensions: Tobacco Free Workshops, Enhancing Immune Health Workshops, First Aid Arts, and one-on-one Peer Wellness Coaching to help participants achieve their wellness goals, all of which are based around the Eight Dimensions of Wellness. In 2023 Tennessee added two additional Peer Wellness Coaches to increase capacity and increase access to services. MHMCML trains agency staff in health and wellness curriculum and provides technical assistance and support in promoting health and wellness within mental health and substance use services. MHMCML staff also train Peer Support Center Staff in health and wellness curriculum allowing for access to these evidence-based programs statewide.

The First Episode Psychosis Initiative (FEPI) and Clinical High Risk for Psychosis (CHRP) programs provide a continuum of care for youth and young adults who are experiencing or at risk of experiencing early onset psychosis in eighteen (18) counties, expanding from fourteen (14) since FFY2021. These programs utilize a "Coordinated Specialty Care" (CSC) which is a comprehensive intervention model for people who have experienced a first episode of psychosis. Treatment is provided by a team who focus on helping people work toward personal goals and to get their life back on track. The CSC model helps these individuals navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, at a job, and in the social world. The CSC program includes the following components: individual and group psychotherapy, supported employment and education, family education and support, psychopharmacology, peer support, and care coordination and management. The individual and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin.

The System of Care Across Tennessee Network provides intensive care coordination services that bring together a continuum of services and supports that allow for children, youth, and young adults to function in their homes and communities outside of inpatient and residential facilities. Stepdown services are provided to children, youth, and young adults who are being discharged from inpatient, residential, and detention facilities. The System of Care Across Tennessee has an average success rate of 93% in keeping children at home with their biological families. The Tennessee Resiliency Project (TRP) includes three coordinated care within the crisis system programs that are addressing keeping children and youth out of inpatient and residential services. East Tennessee is served through three specialty crisis teams serving the detention facilities, schools, and those children and youth being seen in the Crisis Stabilization Unit or Walk-In Center. In middle Tennessee, there are two providers focused on crisis, one with five crisis specialists focused on hard-to-place children and the other focused on working with school social workers and school resource officers to identify children and youth in need of diversion from the youth justice system.

The Tennessee Move Initiative teams work to successfully transition identified individuals from long-term units to community-based housing by providing ongoing, intensive, and individualized support to individuals, families, and community providers. Three community mental health agencies provide recovery-focused, intensive, and customized care coordination services through four teams to identify individuals in long-term units within the TDMHSAS Mental Health Institutes. The purpose of the initiative is to transition the individuals to the least restrictive and most integrated setting appropriate based on their individual needs.

The TN Behavioral Health Safety Net provides essential outpatient mental health services to uninsured adults and children who are uninsured or underinsured. Services provided through the BHSN promote recovery, treatment, and resiliency and include assessment and evaluation, therapy, case management, peer support, medication management, psychosocial rehabilitation, transportation, and assistance with pharmacy coordination.

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

Tennessee Crisis Services incorporates a continuum of high-quality crisis services, including Crisis Telephonic Triage and Intervention, Mobile Crisis (all ages), Crisis Stabilization Units (CSUs), Crisis Respite, and Walk-In Center (WIC) services. Crisis WIC services may include mental health assessment, referral to services, and follow-up services. Funding for these services is shared between TDMHSAS and the Medicaid authority, TennCare. The approach is based on determining the most appropriate intervention needed to successfully alleviate the crisis in the least restrictive environment available to meet the needs of the individual. Certified Peer Recovery Specialists (CPRSs) provide the CSU PeerLink program designed to reduce repeat use of crisis services, increase continuity of care, and help individuals move forward in their recovery. Over the past three years, TDMHSAS has also been awarded funding to formally support Tennessee's 988 Infrastructure. As of July 2022, when an individual calls/chats/texts 988, the contact is routed to a Tennessee-based provider. This vital diversionary resource provides access to a trained counselor in the provision of risk screening, triage, consultation, and referrals to ensure appropriate and efficient access

to resources. Since FY23, Tennessee's 988 providers have handled 35,038 crisis calls. With the implementation and education across the state around this resource, there has been a noted decrease in Emergency Department presentations and Law Enforcement utilization. This includes the average monthly decrease in Emergency Department presentations by 37 individuals, along with an average monthly decrease of 104 individuals requiring law enforcement involvement.

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

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

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

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

The Behavioral Health Safety Net, which consists of co-occurring competent providers, delivers core, essential, outpatient, behavioral health services to an estimated 34,000 uninsured and underinsured Tennesseans annually who meet program eligibility criteria through a network of community mental health centers. This includes assessment and evaluation, individual and group therapeutic intervention, case management, transportation, peer support services, psychosocial rehabilitation services, psychiatric medication management, laboratory tests related to medication management, and pharmacy assistance and coordination. Many of the services offered within the Behavioral Health Safety Net are evidence-based practices.

Tennessee's Regional Intervention Program (RIP) Fidelity Model & founding staff were central to the initial development of The Pyramid Model for Promoting Social-Emotional Competence in Infants and Young Children (Pyramid Model). The Pyramid Model is a framework of evidence-based practices for promoting young children's healthy social and emotional development. The Pyramid Model informs implementation for TDMHSAS programming including Child Care Consultation, RIP, and Project BASIC. Additionally, Child Care Consultation & RIP Training & Technical Assistance Staff are trained to deliver Building Strong Brains (Adverse Childhood Experiences) training. Building Strong Brains (BSB), a state-wide approach to promote culture change in early childhood based on a philosophy that preventing and mitigating adverse childhood experiences, and their impact, is the most promising approach to helping Tennessee children lead productive, healthy lives and ensuring the future prosperity of the state. The Tennessee state initiative is born from research gathered in the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study. (https://www.tn.gov/dcs/program-areas/child-health/aces.html). TDMHSAS RIP staff are also trained to deliver the Child Adult Relationship Enhancement (CARE) Model. "The CARE Model is an evidence-based universal approach to help any adult interacting with children or teens. It uses skills designed to enhance child-adult relationships and to reduce mild to moderate behavior problems. CARE is a trauma-informed training model for caregivers and professionals, paraprofessionals, and lay public who interact and work with children." (https://www.icarecollaborative.org/) School-Based Behavioral Health Liaisons use the Multi-Tiered Systems of Support (MTSS) framework to provide face-to-face consultation with classroom teachers to enhance trauma-informed learning environments for children and youth who have or are at-risk for SED, behavior problems, or substance use disorders. The Multi-Tiered System of Support is a service delivery framework focused on prevention and problem-solving for all students. An integrated MTSS connects all of the academic and non-academic interventions, supports, and services available in schools and communities to support instruction and eliminate barriers to learning and teaching. Within an MTSS framework, multiple levels of instruction, assessment, and intervention are designed to meet the academic and non-academic needs of all students.

Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make

adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed. The Transition to Independence Process (TIP) Model was developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties to a) engage them in their future planning process; b) provide them with developmentally appropriate, non-stigmatizing, culturally competent, trauma-informed, and appealing services and supports; and c) involve the young people, their families (of origin or foster), and other informal key players, as relevant, in a process that prepares and facilitates their movement toward greater self-sufficiency and successful achievement of their goals. Youth and young adults are guided in setting and achieving their own short-term and long-term goals across relevant Transition Domains, such as employment/career, educational opportunities, living situation, personal effectiveness/well-being, and community-life functioning. The TIP Model is operationalized through seven Guidelines and their associated Core Practices that drive the work with young people to improve their outcomes and provide a transition system that is responsive to them and also to their families. Coordinated specialty care is a recovery-oriented, team approach to treating early psychosis that promotes easy access to care and shared decision-making among specialists, the person experiencing psychosis, and family members. Specifically, coordinated specialty care involves multiple components: Individual or group psychotherapy, Family support, and education programs, Medication management, Supported employment and education services, and Case management.

3. Describe your state's case management services

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

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

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

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

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

The Inpatient Targeted Transitional Support program provides the opportunity for individuals discharged from the Regional Mental Health Institutes, Crisis Stabilization Units, and State-Contracted Facilities to secure safe, affordable, permanent supportive housing with access to temporary financial assistance to obtain and maintain residence and related support as they transition to community living. The Community Supportive Housing program provides flexible funding to provider agencies to offer supported housing for adults with mental illness or co-occurring disorders, while the new Supportive Recovery Housing provides similar services in supportive housing for individuals in recovery from substance use disorder. These programs incorporate access to community-based services such as peer recovery support, supported employment, and SOAR (SSI/SSDI Outreach, Access, and Recovery), each of which is intended to increase or sustain recovery and independence while living in the community. Individual housing plans are developed for each service recipient to guide the continued transition to independent community living. The Intensive Long-term Support program provides supportive housing for individuals discharged from the Regional Mental Health Institutes (RMHI), who need enhanced supportive services while living in the community. These enhanced services include on-site access to mental health care personnel, and access to opportunities in skill-building, educational, and life skills training and activities, to increase the functionality of each service recipient outside of the institutional setting. The Tennessee Move Initiative also supports the RMHIs by providing community-based teams to provide recovery-focused, intensive, and customized care coordination services to identified patients in long-term units of RMHIs to transition to the least restrictive and most integrated community setting appropriate to individual needs. The teams develop and implement recovery-oriented programming which ensures individual, family, and housing provider support while connecting and coordinating with natural and formal supports within the individual's community.

Crisis Services are available to all consumers experiencing a mental health crisis, at no cost, 24/7/365. These services are designed to connect the consumer with services that meet their clinical needs, in the least restrictive setting possible. The State-wide crisis hotline can assist consumers in connecting with resources in their communities if there is not an identified need for a mobile crisis assessment. TDMHSAS has also contracted with Mobile Crisis provider agencies to ensure these services are available state-wide. Mobile Crisis staff can assess the current needs of the consumer and refer to the least restrictive settings that are clinically appropriate. These referrals include Crisis Stabilization Units (CSU), which are facilities that can treat a consumer, voluntarily, and address needs such as medication management. Respite Services are also available across the state, and these services can assist the consumer, offering voluntary admission, while also connecting them with community resources that can address clinical needs. TDMHSAS also has contracted with providers to establish walk-in centers (WIC) for consumers to access crisis services.

These WIC facilities offer crisis assessment services and can facilitate admission for levels of care such as 23-hour Observation, Crisis Stabilization Unit, or Medically Monitored Crisis Detox Services. All of these services are available at no cost to the consumer and offer treatment outside of the inpatient setting. TDMHSAS supports the Tennessee Mental Health Consumers' Association (TMHCA) in the Peer Intensive Care program, which places Certified Peer Recovery Specialists (CPRS) at the state's four Regional Mental Health Institutes and eight Crisis Stabilization Units (CSUs) to provide peer support services that include aftercare services in the community to prevent recurring use of inpatient psychiatric services. TDMHSAS works to reduce suicide attempts/deaths among individuals ages 10-24 through the Tennessee Lives Count-Connect 2. The Tennessee Lives Count-Connect 2 provides enhanced follow-up services and gatekeeper suicide prevention training.

The Behavioral Health Safety Net of TN is a state-funded program that provides vital mental health services to uninsured adult Tennesseans and uninsured/underinsured Tennessee children who are eligible. The services provided through the BHSN of TN are intended to reduce hospitalizations and the recidivism rate. The services consist of assessment and evaluation, therapy, case management, peer support services, psychosocial rehabilitation services, psychiatric medication management, labs related to medication management, and pharmacy assistance and coordination. Individuals actively enrolled in BHSN are less likely to require inpatient psychiatric care. In FY23, approximately 2.3% of individuals enrolled in BHSN were admitted to a Regional Mental Health Institute (RMHI) within 90 days of a BHSN service.

Through the First Episode Psychosis Initiative, four OnTrackTN teams provide individualized services to youth and young adults experiencing a first episode of psychosis. Youth and young adults involved in these programs experience a large reduction in the number and length of hospital stays. System of Care Across Tennessee provides intensive care coordination services, using High Fidelity Wraparound to families of children with an SED/SMI with the intent of reducing out-of-home placements, including hospitalizations. The Healthy Transitions grant program utilizes a young adult peer stabilizer that will be partnering with the child and adult mobile crisis teams at a local lab site, to reduce hospitalizations and increase engagement in community-based services. The Clinical High Risk for Psychosis (CHR-P) program seeks to prevent or delay the onset of psychosis for youth and young adults who are at clinical risk for developing psychosis through a continuum stepped care approach. The System of Care Across Tennessee Network provides intensive care coordination services that bring together a continuum of services and supports that allow for children, youth, and young adults to function in their homes and communities outside of inpatient and residential facilities. Stepdown services are provided to children, youth, and young adults who are being discharged from inpatient, residential, and detention facilities. The System of Care Across Tennessee has an average success rate of 93% in keeping children at home with their biological families. The Tennessee Resiliency Project (TRP) includes three coordinated care within the crisis system programs that are addressing keeping children and youth out of inpatient and residential services. East Tennessee is served through three specialty crisis teams serving the detention facilities, schools, and those children and youth being seen in the Crisis Stabilization Unit or Walk-In Center. In middle Tennessee there are two providers focused on crisis, one with five crisis specialists focused on hard-to-place children and the other focused on working with school social workers and school resource officers to identify children and youth in need of diversion from the youth justice system.

The Division of Mental Health Services also supports several recovery services that are intending to increase the recovery capital of people with mental health and co-occurring disorders. Individual Placement and Support (IPS) Supported Employment services are recovery services to help people reintegrate into their communities through competitive, integrated employment. IPS is offered statewide in 49 of the state's 95 counties. The Peer Wellness Initiative prioritizes physical health as a tool to improve mental health recovery. Through this initiative, evidence-based, self-management workshops along with one-on-one wellness coaching are offered to clients. Staff members are also CPRS and as such, they use peer support principles to teach and model the value of every individual's recovery experience, inspire hope, provide support and guidance to accomplish goals and encourage effective coping techniques. Over the last five years, an average of 85% of Individuals who attend the state's 45 Peer Support Centers reported that because of their participation at the Peer Support Center, they are less likely to require psychiatric hospital services. TDMHSAS's Creating Homes Initiative, which is mentioned in previous sections of this application, also works to reduce hospitalizations and hospital stays for the individuals TDMHSAS serves.

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

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	386,310	213,937
2.Children with SED	95,870	102,417

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

(A) The Target population is adults with Severe Mental Illness (SMI) and children with Severe Emotional Disturbance (SED).

(B) Tennessee uses the upper limit of 2021 Hendall statewide prevalence estimates of adults with SMI. Tennessee also uses the upper limit of 2021 Hendall statewide prevalence estimates for the Level of Functioning score <=60 for ages 9-17 as an estimate of children with SED. Both prevalence estimates are rounded to the nearest 10.

(C) Tennessee uses the URS tables to estimate the incidence of SMI and SED, because the URS tables contain data provided by the State Medicaid Authority, in addition to individuals served by the Department of Mental Health and Substance Abuse Services.

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

N/A

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

Criterion 3

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

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

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

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

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

The Community Supportive Housing program and the Supportive Recovery Housing program provide opportunities for permanent housing in residential settings that are supplemented with access to support services, such as peer recovery, supported employment, and support staffing. Several of these residences are located in rural counties. The new Supportive Reentry Housing program provides permanent supportive housing opportunities to serve individuals experiencing mental illness and/or substance use disorder with a history of incarceration. New infrastructural projects funded by the Creating Homes Initiative 3.0 (CHI 3.0) grant will be underway for development during SFY 2024; among them, several residential facilities will be established in rural counties, and upon completion will provide Supportive Recovery Housing program services. The Targeted Transitional Support programs are designed to provide temporary financial assistance to individuals to obtain housing or related supports; this helps to avert homelessness during a time in which an individual is in the process of acquiring permanent financial means to sustain housing. Targeted Transitional Support services are delivered by a total of 16 community-based mental health services providers across the state to ensure accessibility to each county in the state. The Creating Homes Initiative seeks to assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable, and permanent housing options for people with mental illness, substance use disorders, and co-occurring disorders. For this initiative, Regional Housing Facilitators and Regional Substance Use Housing Facilitators work in collaboration with the state's Continua of Care and many community stakeholders to create and develop quality, safe, affordable, and permanent housing opportunities. The Regional Housing Facilitators are geographically stationed in each of the Department's 7 Planning and Policy Council regions, and each is made accessible to all stakeholders and community members in each region, including all rural communities and counties across Tennessee to pursue and achieve the creation of new affordable housing opportunities. The Projects for Assistance in Transition from Homelessness (PATH) program is a federal grant program to assist individuals experiencing homelessness who have a mental illness or co-occurring disorders; the program funds community-based outreach services to connect individuals to mental health, substance abuse, case management, and other support services as well as limited housing services. The PATH program is in 36 counties across the state. Some of the counties are in rural areas of the state, where PATH is the only homeless outreach program available to the community. The Children and Youth Homeless Outreach Project provide outreach and case management for homeless families or those at risk of homelessness to identify children and youth with Severe Emotional Disturbances (SED) or at risk of SED. The program then assists parents to secure needed mental health services for children and other family members in need. Assistance to find or restore secure housing is also provided including temporary financial assistance with rent, utilities, and other needs that will assist the child with SED and help keep the family intact. The CYHOP program is in 24 counties, with some of the counties being rural.

Individual Placement and Support (IPS) Supported Employment is a model of supported employment with research indicating that it is a successful model for rural communities. Currently, IPS is offered in 49 counties, 36 of which are IPS Providers in rural communities. IPS is delivered through 35 programs across the state. In 2023 the IPS program significantly increased statewide through a partnership with the Tennessee Department of Human Services, Division of Vocational Rehabilitation. Through this expansion, 55 additional IPS direct support positions were created, nearly doubling the number of IPS staff members in Tennessee. Further, three IPS Peer Support Positions were created, which is a new position to Tennessee allowing for people with lived experience of mental illness and or substance use conditions to support their peers who are looking to find and sustain work. This expansion also allowed for two additional IPS Trainer positions to be created to provide much-needed training and technical assistance to providers who are expanding their IPS reach. This expansion provided an opportunity to hire three Benefits Counselor positions who will offer personalized benefits counseling for Middle and West Tennessee, both of which had limited access to this service, to help individuals understand how employment impacts things such as housing subsidies, Medicaid, and Social Security Disability Insurance/Supplemental Security Income.

The Behavioral Health Safety Net of TN is available to eligible uninsured adult Tennesseans and uninsured/underinsured Tennessee children who live in rural areas of the state. Comprehensively, there are 140 physical sites across the state in 79 counties, with 54 of those counties considered rural. In FY20, transportation became a permanent reimbursable BHSN service to help with transportation needs, especially in rural communities, to behavioral health services for individuals enrolled in BHSN. All BHSN services remain available via telehealth, which greatly improves optional access to care, as well. In FY23, TDMHSAS launched a pilot project in partnership with the TN Department of Health to co-locate mental health services, provided through a Community Mental Health Agency (CMHA), at a health department in a rural county. The county health department refers patients to the CMHA, regardless of payor source. The CMHA will coordinate and/or deliver both in-person and telehealth mental health services for individuals referred. Additionally, the CMHA has one staff onsite at the county health department.

The Older Adult Program provides mental health care management services to people ages 50 and older who do not ?nancially qualify for Medicaid (TennCare) or the Behavioral Health Safety Net. Services can include mental health assessment, community outreach, referral to care supports and services, in-home therapy, and other supportive resources. In addition, community mental health education is provided to promote awareness regarding older adults and healthy aging issues. These services are provided to improve quality of life and to develop skills to enable living as independently as possible in the community or to successfully "age in place". Telehealth is being widely leveraged to provide care

coordination services in the Older Adult program, which greatly improves access for rural communities and individuals with limited mobility.

The crisis continuum provides community-based assessments statewide in both rural and urban areas to Tennesseans. Several of Tennessee's crisis providers serve rural communities within their designated catchment areas and collaborate amongst community stakeholders to meet the needs of rural consumers. Crisis services are available to all age groups and to individuals including those that present in rural county emergency departments, county, jails, consumer's residences, and/or are homeless. Crisis providers often partner with local law enforcement and emergency department personnel to troubleshoot technology-assisted assessments to reduce response times ensure timely response to community locations, reduce the average length of stay in emergency rooms, and improve the overall efficiency of limited crisis resources. Over the past three years, TDMHSAS has been awarded funding to formally support Tennessee's 988 Infrastructure. As of July 2022, when an individual calls/chats/texts 988, the contact is routed to a Tennessee-based provider. This vital diversionary resource provides access to a trained counselor in the provision of risk screening, triage, consultation, and referrals to ensure appropriate and efficient access to resources. Since FY23, Tennessee's 988 providers have handled over 35,000 crisis calls. With the implementation and education across the state around this resource, there has been a noted decrease in Emergency Department presentations and Law Enforcement utilization. This includes the average monthly decrease in Emergency Department presentations by 37 individuals, along with an average monthly decrease of 104 individuals requiring law enforcement involvement. A very small percentage of total calls have resulted in a higher level of intervention via mobile crisis at 4%. In assisting communities post-disaster, TDMHSAS has pursued three (3) Crisis Counseling Programs. These programs provide crisis counseling, outreach, referral linkage, and education to communities of impact. In addressing the need for increased community stabilization resources in rural counties, TDMHSAS utilized funding to add two (2) additional Walk-In Centers and Crisis Stabilization Units. One site will be in Dyersburg (Dyer County) and one in Paris (Henry County).

The Office of Children, Young Adults, and Families (OCYAF) uses a system of care approach to ensure services and supports are tailored to the unique needs of children, young adults, and families in communities all across Tennessee. Our behavioral health providers establish Memorandums of Understanding with local community services, supports, and schools, creating a continuum of care that is accessible to families regardless of where they live. Team-based, wraparound services and supports are provided in the home and community to engage families in more rural areas of the state. Tennessee's First Episode Psychosis Initiative (FEPI) in rural west Tennessee has been recognized as one of the first FEPI programs in the nation to target rural communities. In FY2023, the department expanded FEPI programming utilizing ARPA funds to provide services in three (3) new rural Blount, Loudon, and Monroe Counties. For children, young adults, and families who might not have access to a nearby community mental health center, Telehealth is used to complete mental health assessments and engage them in care. Because 60-80% of children who receive mental health services do so in schools (Burns et al., 1995; Green et al., 2013), the OCYAF continues to expand promotion, prevention, and early intervention services and supports in schools to reduce barriers and increase access to care. In addition to using various social media platforms for statewide outreach and education, the Training & Technical Assistance Center offers behavior health-related training in multiple counties across the state, increasing access to reputable resources and information for families and professionals. The Juvenile Justice Reform Diversion Grant Programs (JJR) provide community-based services and training to increase treatment options for juvenile courts to utilize across the state, specifically services and training that are evidence-based and outcomes-oriented. JJR services have been implemented in 91 of Tennessee's 95 counties, reaching every rural area in the state.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

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

Additionally, limited, one-time financial support is available for immediate needs that can avert homelessness or imminent risk of homelessness, e.g., rent deposit, emergency food or essential items. SSI/SSDI Outreach, Access, and Recovery (SOAR) is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults and children who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder. Tennessee remains one of the top 10 states in the nation, based on the number of applications submitted and overall approval rating when using the SOAR model.

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

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

The Older Adults Program provides mental health care management services to people ages 50 and older who do not ?nancially qualify for Medicaid (TennCare) or the Behavioral Health Safety Net. Services can include mental health assessment, community outreach, referral to care supports and services, in-home therapy, as well as coordination with primary care providers. In addition, community mental health education is

provided to promote awareness regarding older adults and healthy aging issues. These services are provided to improve quality of life and to develop skills to enable living independently in the community or to "age in place". Telehealth is being widely leveraged to provide care coordination services in the Older Adult program, which greatly improves access for rural communities and individuals with limited mobility. The Behavioral Health Safety Net (BHSN) of TN is available to older adults in Tennessee. The BHSN will cover behavioral health services not covered by Medicare Part B, including Case Management, Medication Training and Support, Peer Support, Psychosocial Rehabilitation Services, and Transportation.

TDMHSAS is also responsible for fulfilling the federal mandate for reviewing and approving all Level II Preadmission Screening and Resident Reviews (PASRR) for nursing home admissions for residents/applicants of Medicaid Certified Nursing Facilities. TDMHSAS partners with the Division of TennCare Longterm Services & Supports and the Department of Intellectual and Developmental Disabilities (DIDDs) through an interagency contract to ensure individuals 18+ seeking nursing facility placement for rehabilitative care or enrollment in TennCare CHOICES HCBSs receive a pre-admission screening and resident review, commonly called a PASRR. This screening is a comprehensive mental health assessment and physical history evaluation that ensures people diagnosed with serious mental illness, intellectual, and/or developmental disabilities, or related conditions such as substance use disorders, can live in the most independent settings while receiving the recommended care and interventions to improve their quality of life and address their co-occurring disorders and related conditions. Finding appropriate placement is essential to preventing unnecessary hospitalization and mitigating the development of acute patient destabilization.

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

Criterion 5: Management Systems

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

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

Criterion 5

a. Describe your state's management systems.

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

The annual Wellness Through Employment Statewide Conference was held on May 11 and 12, 2023. The 400-plus attendees participated either in-person or virtually, receiving valuable insights about Individual Placement and Support (IPS) and My Health, My Choice, My Life (MHMCML). Participants reconnected and created connections with leaders in the field and peers from across the state. Highlighted presentations included the keynote presented by the originators of the IPS model, Bob Drake and Debbie Becker, as well as a presentation from Peggy Swarbrick who designed the peer wellness services currently offered in Tennessee. Presentation topics included applying IPS to people living with and recovering from substance use disorder, the Eight Dimensions of Wellness, and the Peer Wellness Coaches participated in a panel discussion entitled “What Does Wellness Have to Do with Employment?” A special highlight was a panel discussion on the second day of the conference looking back at ten years of IPS in Tennessee with the men and women who brought the model to the Volunteer State.

The annual Older Adult conference in 2023, entitled “Aging In Hope Through Recovery & Resiliency” offered six Continuing Education Units (CEUs), providing education, skills, and tools for professionals working with older adults in Tennessee on the following topics: Older Adult Grief and Loss, Elder Law, Substance Use Disorder in Older Adults, Older Adult Nutrition, Suicide Prevention, and TennCare Long-term Services & Supports CHOICES program.

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

The annual Statewide Crisis Services Conference titled “Celebrating Resiliency was held in person on June 21, 2022. That was provided as a virtual option as well. Celebrating Resiliency featured sessions ranging from community partnerships, providing crisis response to consumers with dual diagnoses, staying connected, and self-care for responders from TDMHSAS leadership, community providers/partners, and various dynamic practitioners/presenters. There were a total of 220 attendees, both in-person and virtual.

Approximately 400 eligible individuals become certified as a peer workforce annually from TDMHSAS-certified programs including Certified Peer Recovery Specialists (CPRS), Certified Family Support Specialists (CFSS), and Certified Young Adult Peer Support Specialists (CYAPSS). Certified Family Support Specialists are allowed to attend a spring, summer, and fall Peer Leadership Academy

focused on ensuring the skills needed to provide quality peer services. In FY2022, the department successfully launched the Certified Young Adult Peer Support Specialist Program, certifying 21 Young Adults to date.

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

In 2021 and 2022, TDMHSAS launched a media campaign to promote the Behavioral Health Safety Net for Children. The statewide media campaign targeted parents and other people with roles in the lives of Tennessee children (teachers, coaches, pastors, etc.) as well as raising general awareness of support for children and families. A statewide buy was placed on social media and spots on broadcast television were bought in Nashville, Memphis, Knoxville, Chattanooga, and northeast Tennessee media markets. The success of the campaign was measured by several different criteria, including television impressions, social impressions, BHSN for Children enrollment, and tn.gov website traffic statistics. In all, the campaign generated nearly 28 million impressions.

Tennessee's 988 System handled over 35,000 in FY23 as this service went live in July 2022. Statewide Crisis Phone Line receives more than 128,000 calls annually from Tennessee adults and youth. To increase awareness of this service and increase call volume, we developed the 988Media Campaign. In the calendar year 2022, TDMHSAS leveraged two sources of funding to continue its Emmy-Award Nominated crisis services media campaign. Funding from a grant directed to first responders paid for ads in May and June, and System of Care Across Tennessee carryover paid for ads in August and September. The existing commercial was modified to increase awareness of Tennessee's Statewide Crisis Line as a more appropriate alternative to calling 911 in an emergency and to increase awareness of 988 as a resource for parents and families. Video ads were served to Tennesseans through broadcast television, video streaming services (OTT), Facebook, Instagram, and YouTube. The May/June buy earned 5.4 million impressions, and the August/September buy earned 2.9 million impressions. Crisis responders are required to complete a self-study, web-based crisis training, and complete booster training every three years. Additionally, a six-hour specialized training is provided to qualified mental health professionals that in part, qualifies them as Mandatory Pre-screening Agents (MPA), certified to write the first "Certificate of Need" after conducting the first assessment for involuntary psychiatric hospitalization.

Lastly, as part of a recent partnership with the Tennessee Department of Health, TDMHSAS created a training video around collaboration between crisis providers and law enforcement in the provision of crisis assessment, client and staff safety, along processes and documentation in the emergency involuntary placement. This video included TDMHSAS staff, crisis providers, and representation from the Tennessee Sheriff's Association. The dissemination plan includes inclusion into both law enforcement and crisis provider new hire training.

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

Telehealth services have revolutionized the way behavioral health services can be accessed across the State. In the wake of the pandemic, the use of telehealth surged. This section includes examples to highlight its use to reach and treat individuals with SMI/SED.

At the onset of the COVID-19 pandemic, telehealth services became a significant venue for delivering services through the Behavioral Health Safety Net. The embrace of telehealth has allowed mental health services to be offered safely, eliminate any potential disruption in mental health treatment and recovery, and expand access to rural and vulnerable populations. Throughout FY23, 61% of BHSN enrollees received at least one service via telehealth and 15% of all BHSN services delivered were via telehealth. All BHSN providers use telehealth services and all BHSN services are allowable for telehealth service delivery. BHSN contracts and service rate sheets were updated with language that BHSN Providers follow federal and state guidelines and clinical standards when offering services via telehealth. Telehealth is also being widely leveraged to provide care coordination services in the Older Adult Program, which greatly improves access for rural communities and older individuals with limited mobility. In FY23, TDMHSAS launched a pilot project in partnership with the TN Department of Health to co-locate mental health services, provided through a Community Mental Health Agency (CMHA), at a health department in a rural county. The county health department refers patients to the CMHA, regardless of payor source. The CMHA will coordinate and/or deliver both in-person and telehealth mental health services for individuals referred. Additionally, the CMHA has one staff onsite at the county health department.

The Office of Crisis Services and Suicide Prevention ensures that all crisis providers across the state can provide crisis assessments via in-person or telehealth. At the beginning of the COVID-19 pandemic, crisis providers ensured that all jails and emergency rooms, especially in rural areas, had the equipment they needed to utilize telehealth services for those experiencing a mental health crisis.
Providing telehealth equipment to jails and emergency rooms ensures that crisis providers continue to provide all individuals experiencing a mental health emergency the care and services they need in an efficient and timely manner. In addition to this, crisis providers across the state continue to have the capability to provide crisis assessments via telehealth based on the preference of the individual or referral source requesting a crisis assessment to be completed. The Mandatory Prescreening Agents (MPA) are trained and certified by TDMHSAS to write the first "Certificate of Need" after conducting the first assessment for involuntary psychiatric hospitalization. The MPA training has transitioned to be in a virtual setting. Before the pandemic, MPA

trainings were in-person. Trainees had to travel from all around the state, incurring provider expenses (travel, hotels, meals, etc.) while also taking the professionals away from clinical work to accommodate travel time. When the pandemic hit, the training was moved to virtual training via the ZOOM platform and then later to the Microsoft Teams platform. Due to a tremendously positive response, TDMHSAS has chosen to keep the training virtual. Not only does it cut down on time and expenses for the providers, but it also allows TDMHSAS to conduct any last-minute needs for additional training when necessary.

The Individual Placement and Support (IPS) Trainer Program has created virtual monthly training for both IPS direct service staff and supervisors as well as Tennessee Department of Human Services, Division of Vocational Rehabilitation (VR) staff to increase the accessibility of training. Providing virtual training has allowed the IPS trainers to be able to increase the frequency of training, allowing for new staff to get trained quicker. These virtual trainings have also increased access to technical assistance and training for current staff needing additional assistance. The IPS Benefits Counselors also provide virtual benefits counseling in Middle and West Tennessee to increase access to this resource and increase capacity. The Benefits Counselors can meet clients where they are and can provide individual virtual sessions as well as virtual or in-person group presentations.

At the onset of the COVID-19 pandemic, the Office of Children, Young Adults, and Families (OCYAF) saw a swift response to the need for telehealth options and programs including the Regional Intervention Program, Child Care Consultation, Project BASIC, School Based Behavioral Health Liaisons (SBBHL), System of Care Across Tennessee, First Episode Psychosis (FEP), Clinical High Risk for Psychosis, and Healthy Transitions placed focused on providing direct care services to students in the home and through telehealth. SBBHL provided teacher training, student psycho-educational groups to students, screenings/assessments, and clinical therapy through various telehealth platforms. In FY23 while all liaisons returned to operating in person, some services were still provided via telehealth to ensure continued access to services with 7% of SBBHL services being delivered via telehealth. Like SBBHL most programs have returned to in-person programming, but all have the technology needed to provide telehealth services as an option when in-person is not feasible. At the onset of the COVID-19 Pandemic, each FEP site adjusted services from an in-person format to offering telehealth services only. Currently, all program sites work predominately in person. However, telehealth services are still available for clients in need of accommodations.

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

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? (●) Yes ( ) No

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re -traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

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

[2] *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? (●) Yes ( ) No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No
3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? (●) Yes ( ) No
4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No
5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No
6. Does the state use an evidence-based intervention to treat trauma? (●) Yes ( ) No
7. Does the state have any activities related to this section that you would like to highlight.

   TDMHSAS has more than 1,264 Certified Peer Recovery Specialists (CPRS) throughout the state providing trauma-informed peer support services. Trauma-informed care is a key part of the required training to become a CPRS and ongoing continuing education in trauma-informed care is encouraged. TDMHSAS also partners with the Tennessee Department of Correction to train eligible individuals within their facilities to become CPRS and provide trauma-informed peer support services to their fellow inmates, a population proven to have significant histories of trauma. Through the Peer Intensive Care program, a CPRS is hired

through a community provider and placed at the state's four Regional Mental Health Institutes and Crisis Stabilization Units to provide peer support services that include aftercare services in the community to prevent recurring use of inpatient psychiatric services.

Office of Children, Young Adults, and Families (OCYAF) provides trauma-informed training to staff working in all children, youth, and young adult programming. OCYAF has several trauma-informed trainers and clinicians offering consultation to individuals or groups throughout the state. TDMHSAS partners with the Department of Education to house a full-time mental health clinician for training and consultation as a part of Project AWARE. This full-time trainer and consultant provides resources and support to all programming in OCYAF. The School-Based Behavioral Health Liaisons program expanded to all 95 counties. The grant contract language highlights using a trauma-informed approach to services in schools and aligns with the Tennessee Department of Education's Multi-Tiered Systems of Supports school-based mental health model.

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

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ◉ Yes ○ No

The TDMHSAS Office of Wellness and Employment and Office of Housing and Homeless Services joined the Re-Entry Roundtable in 2023. The Re-Entry Round Table was created and is managed by the Tennessee Department of Labor and Workforce Development, Office of Re-Entry. The focus of this group is to ensure all individuals coming out of incarceration or having criminal justice involvement have access to the necessary resources and to reduce disparities in service receipt across the state. TDMHSAS has been an active partner in this group since its inception and advocate for justice-involved individuals living with mental illness and/or substance use disorder.

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

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

To divert youth and families from further juvenile court and DCS involvement, TDMHSAS, in collaboration with the Department of Children's Services, Administrative Office of the Courts, Tennessee Commissioner on Children & Youth, juvenile courts, and grantee service providers, has implemented the Juvenile Justice Reform Local Diversion Grant (JJR Grant) program. The primary purpose of this program is to expand community-based services and training to provide treatment options for juvenile courts to utilize across the state, specifically services and training that are evidence-based and outcomes-oriented. In addition, the JJR Grant

aims to support Building Strong Brains (Tennessee's ACEs Initiative) by supporting youth served by the JJR Grant in building resiliency and educating professionals on responding in a trauma-informed manner.

In 2021, in collaboration with TDMHSAS's Office of Criminal Justice Services, the Behavioral Health Safety Net adjusted eligibility criteria so specific BHSN services could be provided while an individual was incarcerated. This change allows for intake and assessment services to be provided within 90 days of release to develop and implement concrete processes for the continuity and continuum of mental health services from incarceration into the community setting.

In FY22, TDMHSAS expanded the Creating Homes Initiative to add a focus on the creation of affordable permanent supportive housing options for individuals with mental illness or substance use disorder who are reentering the community from prisons and jails or have a history of incarceration. To launch this expansion, the Office of Housing and Homeless Services partnered with the Tennessee Department of Correction as well as the Office of Criminal Justice Programs to increase awareness of re-entry efforts and provide information and education on reentry to the statewide community and interested stakeholders. Known as Creating Homes Initiative 3.0 (CHI 3.0), this program utilizes state funding appropriations to support infrastructural projects to create new quality residential facilities; CHI 3.0 recurring funds can also be utilized to support ongoing support services and operations through the Supportive Reentry Housing Program. Wrap-around support services are intended to support residents along their path to recovery, resiliency, and greater independence to increase sustained community living and wellness; and reduce the risk of recidivism and relapse. Support services include access to peer recovery support; supported employment; SSI/SSDI, Outreach, Access, and Recovery (SOAR); recidivism prevention; relapse prevention; community engagement; daily living skills training; and social skills training. Program grantees coordinate with community partners to enhance access to resources to support reentry efforts for residents.

Upcoming in 2024, TDMHSAS will launch the Residential Re-entry Housing Program (RRHP), a program intended to meet the unique needs of individuals with severe and persistent mental health challenges re-entering the community from incarceration to reduce recidivism and promote successful community living. RRHP will utilize non-recurring state funds for infrastructure build-out for residential facilities and recurring state funds for ongoing operations and enhanced support services for each facility to provide qualifying individuals with safe, quality, affordable supportive housing. TDMHSAS anticipates releasing an Announcement of Funding during SFY 2024 to solicit quality proposals to establish these residential facilities and provide supportive services.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

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

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

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

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

   TDMHSAS contracts with twelve community behavioral health providers who provide mobile crisis and crisis hotline services. Tennessee has a vast statewide crisis system, with 24-hour crisis line and services, reaching over 126,600 individuals in state fiscal year 2022. Approximately 10,420 of the calls were received by the statewide hotline.

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

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

   *a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
   *b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
   *c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.
d) ***Full Implementation*** *stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
e) ***Program Sustainability*** *stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)
- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

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

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

b. Briefly explain your stages of implementation selections here.

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) directly funds, supports, and oversees the Tennessee Statewide Crisis Services System. This continuum includes the statewide toll-free crisis line, adult mobile crisis response, children and youth mobile crisis response, walk-in centers, crisis stabilization units, crisis respite, and follow-up services. Tennessee’s existing Crisis Services Continuum is an array of services available to eligible individuals who need crisis services to meet their needs in the least restrictive and most appropriate setting to alleviate or stabilize their symptoms as well as strengthen or develop their support system and coping skills to allow each individual to remain in his or her community during and after a behavioral health crisis period.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

TDMHSAS began the buildout of Tennessee’s crisis system in 1991, with the addition of crisis call/mobile crisis services, spanning all 95 counties for children, youth, and adults. Walk-in Center, Crisis Stabilization Unit, and Respite services were added in 2008.

Most recently, in FY22, TDMHSAS began formally supporting the 988 Crisis system with both Mental Health Block Grant recurring funding and, as of June 1, 2022, SAMHSA funding.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The crisis set aside is used to enhance Tennessee’s 988 Network. Funds from the MHBG 5% crisis set aside support for the TN 988 Network in efforts to improve and increase infrastructure while allowing for ongoing data capture to identify service gaps and continued needs. We are actively engaging the six Tennessee National Suicide Prevention Lifeline Center Network providers. Funding is anticipated to primarily support staffing needs at these agencies. Each call center has identified counties of service where they are designated as the “primary” call center. If the primary call center does not answer the call within a certain amount of time, then it shifts to a “backup” NSPL call center in Tennessee. There has been an emphasis in the planning and implementation grants on maintaining a

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

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OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

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

Please respond to the following:

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

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

   b) Required peer accreditation or certification? ◉ Yes ○ No

   c) Use Block grant funding of recovery support services? ◉ Yes ○ No

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

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

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

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

   Recovery and recovery support services for children with SED in TN are being implemented through the Statewide and regional Young Adult Leadership Councils which are comprised of youth and young adults with lived experience, as well as the Family Support Specialist Advisory Council, comprised of parents of a child with an SED and child-serving agency stakeholders. Council members provide meaningful input and feedback on services and support that impact themselves and their peers. Tennessee has recently launched a Transition-Age Designation of the Certified Peer Recovery Specialist, the Certified Young Adult Peer Support Specialist program (CYAPSS) for individuals ages 18-30 with lived experience of mental illness or substance use disorder. In addition, several programs within the Office of Children & Youth employ peers to provide recovery-focused services, including Clinical High Risk for Psychosis (CHR-P), On Track TN (FEPI), and Healthy Transitions, which utilize Peer Recovery/Support Specialists, and System of Care Across Tennessee which utilizes Family Support Specialists. The Healthy Transitions Program has a Young Adult Peer Stabilizer who is a Young Adult Peer Support embedded within the mobile crisis system with Mental Health Cooperative, working alongside the child and adult crisis teams to provide community-based peer stabilization services to Y/YA between the ages of 16-25 who receive crisis services in Davidson County.

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

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

   The Creating Homes Initiative 2.0 (CHI 2.0) grant is to develop and expand the number of safe, affordable, and quality permanent supportive housing options for Tennesseans living with substance use disorder, in particular opioid use disorder. CHI 2.0 employs strategic collaboration and assertive partnering to leverage and secure funds and resources to create these housing options for the stated focus population. CHI 2.0 incorporates regionally based professionals, known as CHI 2.0 Regional Substance Use Housing Facilitators, to serve as "hands-on" collaborators with community partners and stakeholders to stimulate the preservation, development, and enhancement of housing options. Their knowledge, skill, and expertise in housing development, financing strategies, funding sources, and grant writing are vital to the success of CHI 2.0. CHI 2.0 one-time grant funds support the development, construction, acquisition, rehabilitation, and/or conversion of infrastructure to create new housing options for Tennesseans living with substance use disorder; recurring CHI 2.0 grant funds are dedicated to the Supportive Recovery Housing program to support operational costs for recovery support services for the residents of these facilities. CHI 2.0 and the Supportive Recovery Housing program promote the recovery of the targeted population following four dimensions as identified by SAMHSA: 1) Health; 2) Home; 3) Purpose; and 4) Community.

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

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

   Fully co-occurring since 2013, Tennessee's Certified Peer Recovery Specialist trains and certifies individuals with lived experience of mental illness and/or substance use disorder. Currently, 1,264 CPRS serve as a role model for recovery and hope every day in Tennessee.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

1. Does the state's Olmstead plan include:

Housing services provided	◉ Yes ○ No
Home and community-based services	◉ Yes ○ No
Peer support services	◉ Yes ○ No
Employment services.	◉ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ◉ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

TDMHSAS administers programs that address community integration areas such as supports for transitioning from inpatient care to community treatment, housing, peer involvement, and supported employment. These activities are discussed and referenced within this block grant application.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

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

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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

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

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

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

According to data from the 2017 Report to Congress[6] on systems of care, services:

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

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

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);

- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

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

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

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

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

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

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

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

Please respond to the following items:

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

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

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

a) Child welfare?	(●) Yes ( ) No
b) Health care?	(●) Yes ( ) No
c) Juvenile justice?	(●) Yes ( ) No
d) Education?	(●) Yes ( ) No

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

a) Service utilization?	(●) Yes ( ) No
b) Costs?	(●) Yes ( ) No
c) Outcomes for children and youth services?	(●) Yes ( ) No

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

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

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

a) to the adult M/SUD system?	(●) Yes ( ) No
b) for youth in foster care?	(●) Yes ( ) No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	(●) Yes ( ) No
d) Does the state have an established FEP program?	(●) Yes ( ) No
Does the state have an established CHRP program?	(●) Yes ( ) No
e) Is the state providing trauma informed care?	(●) Yes ( ) No

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

The State of Tennessee provides integrated services through partnerships that have been developed throughout the state since the adoption of a system of care in 1999. The system of care in Tennessee is governed by the legislatively mandated Council on Children's Mental Health (CCMH), which brings together individuals from across the state to discuss systems, projects, and

programs that touch the lives of children and youth with mental health concerns. CCMH provides a venue, five times annually, for child-serving agencies to discuss current trends within the state as well as potential barriers to service. In addition to CCMH, there are numerous advisory boards, councils, and committees that system of care represented to work toward improving the lives of young children, children, youth, young adults, and families across the state including the Youth Transition Advisory Council, Healthy Transitions State Transition Team, Young Child Wellness Council, Association for Infant Mental Health in Tennessee, Infant and Early Childhood Mental Health Financing Policy Team, TN Start Advisory Council, and the Tennessee Council on Autism Spectrum Disorder. System of care in Tennessee provides training on the use of high-fidelity wraparound which will further integrate services by providing wraparound services to children and families by bringing together systems to work toward a single treatment plan among child-serving agencies. Several of the department's children and youth programs offer integrated services at the local level by working with schools, faith-based organizations, law enforcement, the juvenile justice system, and child welfare services. Through the work of System of Care Across Tennessee TDMHSAS was able to secure $21 million in funding to expand the System of Care until 2024, $12 million in federal SAMHSA funding, and $9 million in interagency funding with the Department of Human Services TANF program.

TDMHSAS partners with the Tennessee Department of Education on a SAMHSA Project AWARE-SEA (Advancing Wellness and Resiliency in Education-State Education Agency) grant, which expanded school-based mental health services to students in high-need school districts in Tennessee. Project AWARE added grant in FY22 expanding to an additional three counties. Project AWARE staff are also partnering with Shelby County AWARE which was awarded a county-level grant. Project AWARE partners with the School-Based Behavioral Health Liaison (SBBHL) program which has grown exponentially in the last three years. The collaboration with the Department of Education allows for additional partners and community engagement which translates into sustainability for grant-funded projects.

In the fall of 2020, TDMHSAS implemented the Behavioral Health Safety Net (BHSN) for Children. Similar to the existing BHSN for Adults, the BHSN for Children program provides essential outpatient mental health services to uninsured and underinsured Tennessee children, with an emphasis on connecting children to more robust mental health payors like TennCare or CoverKids. The BHSN for Children providers also allocated funds to employ Outreach Coordinators to promote awareness and access to BHSN for Children in their communities. During the first year of implementation, the BHSN for Children program was tweaked based on BHSN Provider and community feedback, including allowing children of any income level to enroll, and providing a limited-service array to children with private/commercial behavioral health benefits or enrolled in CoverKids. In FY23, over 1,300 children were served through BHSN for Children, with 17% of those served being connected to TennCare or CoverKids.

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

The Office of Crisis Services and Suicide Prevention prevent suicide and promote better mental health among Tennesseans up to 25 years of age through the Youth and Young Adult Suicide Prevention and Mental Health Awareness Program. The program expands outcomes-based suicide prevention activities, including conducting outreach, providing mental health awareness, and suicide prevention training to Institutions of Higher Education; and assisting Middle Tennessee Pediatric Offices in establishing processes for providing suicide risk screening and referrals, as indicated to treatment and services. In addition, the School and Communities Youth Screen Program works to identify at-risk youth by utilizing a scientifically based screening tool. TeenScreen is a national mental health and suicide risk screening program for youth. The School and Communities Youth Screen Program also provides effective interventions to assist with their treatment.

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

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

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

The Children and Youth Homeless Outreach Project aims to identify and provide outreach services to link children with Serious Emotional Disturbance (SED) children at risk of SED who are experiencing homelessness or risk of homelessness, and their caregivers to mental health and housing services. The program provides services that help to prevent homelessness or positively

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

The Emerging Adult Services program is a strengths-based program to support young adults, ages 18-25, who have mental illness, serious emotional disturbance, or a co-occurring disorder, as they transition to adulthood. The program is comprised of a housing component and a life skills component. The housing component provides quality, affordable, and safe supportive housing with individualized support services for young adults who have been either in foster care or in treatment for mental illness or a co-occurring substance use disorder and have very low income. As young adults demonstrate their ability to live more independently, the program assists in their transition to more independent community living. The life skills component educates and supports young adults in mental health, substance use disorders, supported employment, community engagement skills, and daily living skills. Group topics include coping skills, medication education, financial management, nutrition, personal grooming and hygiene, relationship building, and more. Young adults actively work toward employment and education goals. The program also incorporates community outings such as visiting museums, parks, and community centers, and involves activities like playing sports and performing music.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

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

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

The Tennessee Suicide Prevention Network is a public-private network to address suicide in the state. The TN State Suicide Prevention Plan developed by the Tennessee Suicide Prevention Network with oversight by TDMHSAS is a comprehensive plan with a focus on Universal, Selective, and indicated interventions. TSPN is overseen by a governor-appointed Advisory Council. Tennessee Suicide Prevention Network provides/ coordinates with the state to provide gatekeeper training and postvention activities. The state also increased efforts to focus on interventions at the community level using evidence-based practices such as supporting screening with the Mental Health America online screening tools for both MHA Tennessee affiliates and Youth/Teen Screen with TN Voices. In addition to this, the state works to expand outcomes-based suicide prevention activities, including conducting outreach, providing mental health awareness, and suicide prevention training to Institutions of Higher Education in Middle and West TN and by helping Middle TN Pediatric Offices in establishing processes for providing suicide risk screening and referrals through their Youth and Young Adult Suicide Prevention and Mental Health Program. Lastly, the state works with the Jason Foundation to provide a series of 2-hour educational curricula for teachers, students, coaches, community members, and parents about the signs of suicide in youth and provides tools and resources needed to identify at-risk youth.

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

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

If yes, please describe how barriers are eliminated.

Through SAMHSA discretionary grant funding, the Tennessee Lives Count-Connect 2 program, has allowed Tennessee to expand partnerships that increase availability of/access to enhanced follow-up (EFU) services for individuals ages 10-24, with rapid crisis assessment and placement into care initiated via telehealth prior to/within 24 hours of discharge. Utilizing evidence-based practices and follow-up services for 30 days, linkages and assistance with benefits enrollment ensures service accesss.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

TDMHSAS continues to develop and promote an initiative to reduce suicide in working age adults called the Be The One Campaign: Suicide Prevention in the Workforce. The Be The One campaign is a component of Tennessee's Zero Suicide Initiative and specifically designed for public and private sectors. The campaign is based on the premise that staff, collectively, can build a supportive workforce which values and affirms life. Be The One includes suicide prevention training, suicide awareness, social marketing strategies, and postvention guidance. As statewide engagement had increased new gatekeeper scenarios have been added including veteran and work from home specific scenarios to better reach those working aged adults at-risk for suicide. Lastly, the state provides mental health training with a focus on youth suicide prevention and resources to middle and senior high school students statewide through their work with the Mental Health 101 program.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

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

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ◉ Yes ○ No

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

If yes, with whom?

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

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

TDMHSAS' Office of Housing and Homeless Services (OHHS) participates in monthly Tennessee Homeless Services calls, led by the Tennessee Department of Health and includes the Tennessee Housing Development Agency (THDA), the Tennessee Department of Human Services, the Tennessee Emergency Management Agency (TEMA), and the Tennessee HUD Continuums of Care, to provide agency and area updates, share information and resources, and discuss issues impacting efforts to serve individuals experiencing homelessness or are at risk of homelessness. In addition, the Office actively participates in the recurring Recovery Housing Roundtable meetings, held regionally across the state, and hosted by the Tennessee Association of Alcohol, Drug, and Other Addiction Services (TAADAS); these meetings convene regional community stakeholders and recovery housing providers along with other entities such as the Tennessee Alliance for Recovery Residences (TN-ARR) to discuss topics, issues, and barriers impacting recovery housing. The Office of Housing and Homeless Services also participates in the Re-entry Roundtable monthly meetings, hosted by the Tennessee Department of Labor and Workforce Development. The purpose of the Re-entry Roundtable is to convene a variety of stakeholders at the local and state levels to identify existing resources, share information and knowledge, and explore collaborative opportunities to positively impact relevant needs for successful reentry and sustained community engagement for the justice-involved population.

The OHHS also partnered with the THDA for the expansion of the Tennessee Creating Homes Initiative (CHI) to increase focus on the creation of new, quality, affordable, and permanent housing opportunities for individuals in recovery from substance use disorders; this is known as Creating Homes Initiative 2.0 (CHI 2.0). This partnership was highlighted by THDA's commitment to a one-time $3 million match for the release of a grant funding opportunity to create new affordable housing for this population; the match dollars resulted in new grant contracts with housing providers to create 74 new permanent housing opportunities in Tennessee. The OHHS continues its solid partnership with THDA, highlighted by the increased engagement of the CHI Regional Housing Facilitators, who serve as "hands-on" collaborators with community partners and stakeholders to stimulate the preservation, development, and enhancement of housing options. Their knowledge, skill, and expertise in housing development, financing strategies, funding sources, and grant writing have proven to be an asset to THDA in its efforts to solicit more quality housing grant applications. CHI recently expanded again to include a specific focus on the creation of new housing for Tennesseans experiencing mental illness and/or substance use disorder who re-enter the community from prisons and jails or have been previously incarcerated, known as "CHI 3.0.". The OHHS established a partnership with the Tennessee Department of Correction to fortify this expansion with collaboration on strategic planning, insight, technical support and guidance, and resource alignment.

TDMHSAS is in the process of another expansion for housing with the Residential Re-entry Housing Program (RRHP), a program intended to meet the unique needs of individuals with severe and persistent mental health challenges re-entering the community from incarceration to reduce recidivism and promote successful community living. TDMHSAS intends to build on its existing partnership with the Tennessee Department of Correction, as well as establish new partnerships with the Tennessee Board of Parole, the Tennessee Corrections Institute, and the Tennessee Rehabilitative Initiative in Correction (TRICOR) for strategic planning and sharing of institutional knowledge to support program structure development of RRHP program.

The Office of Wellness and Employment (OWE)and OHHS joined the Re-Entry Roundtable in SFY 2023. The Re-Entry Round Table was created and is managed by the Tennessee Department of Labor and Workforce Development, Office of Reentry. The focus of this group is to ensure individuals coming out of incarceration or having criminal justice involvement have access to the necessary resources and to reduce disparities in service receipt across the state. TDMHSAS has been an active partner in this group since its inception and advocates for justice-involved individuals living with mental illness and/or substance use disorder.

Recently in 2023, the OWE expanded on the established partnership with the Tennessee Department of Human Services, Division of Vocational Rehabilitation to increase the capacity of the Individual Placement and Support Supported Employment Program (IPS). Through this partnership, IPS expanded by 55 positions direct support service positions, as well added three (3) Peer Support Specialists, three (3) Benefits Counselors, and two (2) additional IPS Trainer positions. The Benefits Counselor positions provide individualized benefits counseling to individuals living in Middle and West Tennessee who receive Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) and are seeking employment. Before this expansion Middle and West Tennessee had limited access to benefits counseling positions.

TDMHSAS recently launched a pilot project in partnership with the TN Department of Health to co-locate mental health services, provided through a Community Mental Health Agency (CMHA), at a health department in a rural county. The county health department refers patients to the CMHA, regardless of payor source.
The CMHA will coordinate and/or deliver both in-person and telehealth mental health services for individuals referred. Additionally, the CMHA has one staff onsite at the county health department.
School-Based programming has seen an increase in the need to expand partnerships related to a rise in school safety concerns. The TN Department of Homeland Security is in ongoing collaboration with TDMHSAS to ensure that SBBHL and Project BASIC staff are in regular communication with local Homeland Security agents to address safety concerns as they arise. TDMHSAS leadership has provided education to leadership regarding children's mental health and the scope of programming. School-Based programming is also in collaboration with the Department of Education and the University of Tennessee – Knoxville for the development and application of a needs assessment for TN. The goal of the study is to ensure that programming is not a duplication of efforts and that good stewardship is maintained about the expansion of programs and the addition of new programs.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality

and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The TDMHSAS, in partnership with the Tennessee Department of Human Services, and Division of Vocational Rehabilitation (TDHS) supports 16 agencies statewide that use IPS, in forty-nine of the state's ninety-five counties. IPS is offered in all Vocational Rehabilitation (VR) and TDMHSAS regions. The division and VR have an interagency agreement that helps to streamline services for persons participating in the Individual Placement and Support (IPS) program. This helps to outline the responsibilities between the two agencies. The division remains actively involved in the Governor's Employment First Task Force, a result of Executive Order 28 to expand community employment opportunities for Tennesseans with disabilities. Division representatives serve on the Task Force, the Employment Roundtable made up of key state agency partners, and chairs the Behavioral Health Work Group. The Employment First Task Force - Behavioral Health Workgroup was created to address the small penetration rate of evidence-based employment services for people with mental health and/or substance use conditions. The workgroup seeks to increase opportunities for individuals with behavioral health diagnoses to access IPS and other supported employment resources where IPS does not exist in the state. health

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

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

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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

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

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

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

The Department oversees seven regional Planning and Policy Councils from which local and regional mental health needs and information are funneled to the State Planning and Policy Council and ultimately to the Department. Needs assessment priorities and recommendations from the Council, combined with requirements associated with federal Mental Health and Substance Abuse Block Grant funding, inform the development of the Department’s Three-Year Plan for the service-delivery system. The Three-Year Plan is then updated annually by TDMHSAS with input from all eight Councils.

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

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

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

TDMHSAS operates a structured planning process with multiple layers of Planning and Policy statewide and regional Council involvement to ensure citizen participation in policy development and delivery-system planning.

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

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

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

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

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

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

RIKKI HARRIS
CHAIR

PAUL FUCHCAR
VICE-CHAIR

August 2, 2023

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

RE: FY 2024 Mental Health Block Grant Application

Dear Commissioner Williams:

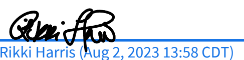
The Tennessee Department of Mental Health and Substance Abuse Planning and Policy Council (TDMHSAS P&PC) is proud to support the Department in its work to serve people of all ages who have mental illness, serious emotional disturbance, and substance abuse disorders through an application for the FY 2024 Mental Health Block Grant.

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

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

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

Best regards,



Rikki Harris (Aug 2, 2023 13:58 CDT)

Rikki Harris
TDMHSAS Planning and Policy Council Chair

Environmental Factors and Plan

Advisory Council Members

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

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

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Sarah Adams	State Employees	State Medicaid Agency	310 Great Circle Road Nashville TN, 37243 PH: 615-925-2192	Sarah.e.adams@tn.gov
Shara Biggs	Providers	Mental Health Cooperative	275 Cumberland Bend Drive Nashville TN, 37228 PH: 615-743-1695	sbiggs@mhc-tn.org
Melissa Birdwell	Providers	Frontier Health	2001 Stonebrook Place Kingsport TN, 37660 PH: 423-224-1000	Mbirdwel@frontierhealth.org
Renee Bouchillon	State Employees	State Social Services Agency	DHS District Office, Suite B Columbia TN, 38401 PH: 931-380-4636	renee.bouchillon@tn.gov
Jim Casey	State Employees	State Criminal Justice Agency	320 6th Ave- North Nashville TN, 37243 PH: 615-253-8163	jim.casey@tn.gov
Courtney Collier	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		648 Bowman Rd Medon TN, 38356 PH: 731-426-5688	firstclass1906@outlook.com
Ben Dickey	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2390 W. Monica Drive Bartlett TN, 38134 PH: 901-517-0681	Bendickey7@gmail.com
Jessyca Foster	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		6830 Conner Lane Chattanooga TN, 37421 PH: 423-508-7057	Jessycafoster1110@gmail.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@cadas.org
Megan Gaylord	Providers	Youth Villages	8047 Hillcrest Drive Milan TN, 38358	Megan.gaylord@youthvillages.org

			PH: 901-233-7712	
Amber Hampton	Others (Advocates who are not State employees or providers)		446 Metroplex Drive, Suite A-224 Nashville TN, 37211 PH: 615-312-3113	ahampton@mhamt.org
Rikki Harris	Others (Advocates who are not State employees or providers)		500 Professional Park Drive Goodlettsville TN, 37072 PH: 615-269-7751	rharris@tnvoices.org
Clarkton Harrison	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1310 24th Avenue South Nashville TN, 37212 PH: 615-427-5207	clarkton.harrison@va.gov
Debbie Hillin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		5465 Village Way Nashville TN, 37211 PH: 615-975-0196	debbiehillin@buffalovalley.org
Amy Irvin	Providers	Omni Community Health	1401 Williams Street, Suite 210 Chattanooga TN, 37408 PH: 423-544-4815	amyirvin@omnicommunityhealth.com
Kayla Jackson	Parents of children with SED		418 N. Willow Avenue Cookeville TN, 38501 PH: 931-319-7876	kjackson@mhc-tn.org
Jennifer Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1321 Murfeesboro Pike Nashville TN, 37217 PH: 615-780-5901	jennifer@taadas.org
Melinda Jones	Parents of children with SED		3235 Royal Knight Dr., Apt. 8 Memphis TN, 38118 PH: 901-428-6494	mlindaj73@yahoo.com
Elizabeth Jones	State Employees	State Health Agency	Andrew Johnson Tower, 5th Floor 710 James Robertson Pkwy. Nashville TN, 37243 PH: 615-253-8483	elizabeth.jones@tn.gov
Lynn Julian	Family Members of Individuals in Recovery (to include family members of adults with SMI)		110 Bon Air Circle Jackson TN, 38305 PH: 731-695-2276	Vlandrum082@gmail.com
Wayne King	Family Members of Individuals in Recovery (to include family members of adults with SMI)		18730 Alberta Street Oneida TN, 37841 PH: 423-215-2607	trulight@live.com
Eric Landry	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1620 Hwy. 73 Newport TN, 37821 PH: 843-509-0764	elandry@gmail.com
Susan Langenus Seabourn	Providers	Centerstone	2400 White Avenue Nashville TN, 37204 PH: 615-460-4451	susan.seabourn@centerstone.org
Danielle LeSure	State Employees	State Education Agency	710 James Robertson Parkway Nashville TN, 37243	Danielle.lesure@tn.gov

			PH: 615-532-4879	
Rebekah Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2716 Brenda Street Thompson Station TN, 37179 PH: 615-330-7312	Rebekah.l.lewis@vanderbilt.edu
Gayle Lodato	Providers	Helen Ross McNabb	9862 Baker Boy Drive Ootlewah TN, 37363 PH: 423-664-2849	gayle.lodato@mcnabb.org
Representative Brock Martin	State Employees	Tennessee House of Representatives	425 Rep. John Lewis Way N, Suite 652 Nashville TN, 37243 PH: 615-741-7478	Rep.brock.martin@capitol.tn.gov
Dawn Mitchell	Parents of children with SED		1010 Drummond Drive Nashville TN, 37211 PH: 615-293-0676	dawnmmitchell@yahoo.com
Morenike Murphy	Family Members of Individuals in Recovery (to include family members of adults with SMI)		909 Meadows Lark Lane Goodlettsville TN, 37072 PH: 615-756-4898	mmurphy@centerofhopebh.org
Mary Neal	Providers	Connections Counseling	297 Mary Ann Drive Memphis TN, 38711 PH: 901-674-1728	maryneal.lpc@gmail.com
Robin Nobling	Family Members of Individuals in Recovery (to include family members of adults with SMI)		329 Harding Place, Suite 203 Nashville TN, 37211 PH: 615-891-4724	rnobling@namidavidson.org
Kim Parker	Providers	Pathways Behavioral Health Services	238 Summar Drive Jackson TN, 38301 PH: 731-541-8988	kim.parker@wth.org
Lauren Pearcy	State Employees	Tennessee Council on Developmental Disabilities	Davy Crockett Tower, 1st Floor Nashville TN, 37243 PH: 615-739-0649	lauren.j.pearcy@tn.gov
Jennifer Phillips	Providers	Helen Ross McNabb	3130 Oakwood Hills Lane Knoxville TN, 37931 PH: 865-414-6559	JenniferV.Phillips@mcnabb.org
Erin Read	Family Members of Individuals in Recovery (to include family members of adults with SMI)		140 Dameron Avenue Knoxville TN, 37917 PH: 615-585-4066	erinreading@gmail.com
Albert Richardson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4041 Knight Arnold Road, Suite 300 Memphis TN, 38118 PH: 901-360-0442	arichardson@caapincorporated.com
Pamela Sessions	Providers	Renewal House	3600 Clarksville Pike Nashville TN, 37218 PH: 615-255-5222	psessions@renewalhouse.org
Dianne Sherrod	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		168 Quail Ridge Jackson TN, 38305 PH: 731-694-3161	dianne@jmprevent.org
			26 Midway Street	

Samantha Slagle	Providers	Frontier Health	Bristol TN, 37620 PH: 423-989-4515	sslagle@frontierhealth.org
Patrick Starnes	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		607 Neill Avenue Nashville TN, 37206 PH: 615-330-1832	trucare10@yahoo.com
Emily Waitt	Others (Advocates who are not State employees or providers)	Tennessee Primary Care Association	710 Spence Lane Nashville TN, 37217 PH: 317-605-5259	ewaitt519@gmail.com
Senator Page Walley	State Employees	Tennessee State Senate	425 Rep. John Lewis Way N, Suite 750 Nashville TN, 37243 PH: 615-741-2368	Sen.page.walley@capitol.tn.gov
Todd Walts	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1102 Kermit Drive, Suite 605 Nashville TN, 37217 PH: 615-361-6608	twalts@namitn.org
Don Watt	State Employees	State Housing Agency	502 Deaderick Street, 3rd Floor Nashville TN, 37243 PH: 615-815-2032	DWatt@thda.org
Eula Whittaker	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3323 Foxwood Drive Memphis TN, 38115 PH: 901-949-0661	e.l.whittaker@att.net
Marie Williams	State Employees	Tennessee Department of Mental Health and Substance Abuse Services	500 Deaderick Street 6th Floor Nashville TN, 37243 PH: 615-532-6500	marie.williams@tn.gov
Kevin R. Wright	State Employees	State Vocational Rehabilitation Agency	James K. Polk Bldg., 15th Floor Nashville TN, 37243 PH: 615-741-3599	Kevin.R.Wright@tn.gov
Evelyn Yeargin	Family Members of Individuals in Recovery (to include family members of adults with SMI)		275 Cumberland Bend Nashville TN, 37228 PH: 615-743-1467	eryeargin@mhc-tn.org

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	12	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	8	
Parents of children with SED	3	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	3	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**26**	**54.17%**
State Employees	11	
Providers	11	
Vacancies	0	
Total State Employees & Providers	**22**	**45.83%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**48**	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

- **a)** Public meetings or hearings? ◉ Yes ○ No
- **b)** Posting of the plan on the web for public comment? ◉ Yes ○ No

  If yes, provide URL:

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

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

  The final version was posted for the previous year at this link: https://www.tn.gov/behavioral-health/planning1/mental-health-block-grant.html
- **c)** Other (e.g. public service announcements, print media) ○ Yes ◉ No

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes: