FFY 2024-2025

BEHAVIORAL HEALTH ASSESSMENT AND PLAN PREPARATION DRAFT

Substance Use Prevention,
Treatment, and Recovery
Services Block Grant
(SUBG or SUPTRS BG)

9/25/2023

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID 000878890425

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 Substance Abuse Services

Mailing Address 6th 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 615-532-6500

Fax 615-532-6514

Email Address marie.williams@tn.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Bev

Last Name Fulkerson

Telephone 615-922-8169

Fax 615-532-2419

Email Address bev.fulkerson@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
Substance Abuse Prevention and Treatment 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 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

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Footnotes:

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."

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Footnotes:

Strengths and Organizational Capacity of the Service System

Provide an overview of the state's mental and substance use disorder (M/SUD) prevention, early identification, treatment, and recovery support systems. Describe how the public M/SUD system is currently organized at the state and local levels. This description should include a discussion of the roles of the Single State Authority (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 behavioral health services or contribute resources that assist in providing the services. In general, the overview should reflect the 11 SUBG or 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 diverse racial and ethnic minorities (i.e., people of color and indigenous and Native American persons, Asian Americans, and Pacific Islanders), members of religious minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

This narrative must include a discussion of the current service system's attention to the SUBG or SUPTRS BG priority populations: Pregnant Women, Persons Who Inject Drugs, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Use Prevention, and, for FY 2024 HIV-designated states or a state designated in any of the prior three FFY and opted to use SUBG or SUPTRS BG funds for early intervention services for HIV (EIS/HIV), Persons at Risk for HIV.

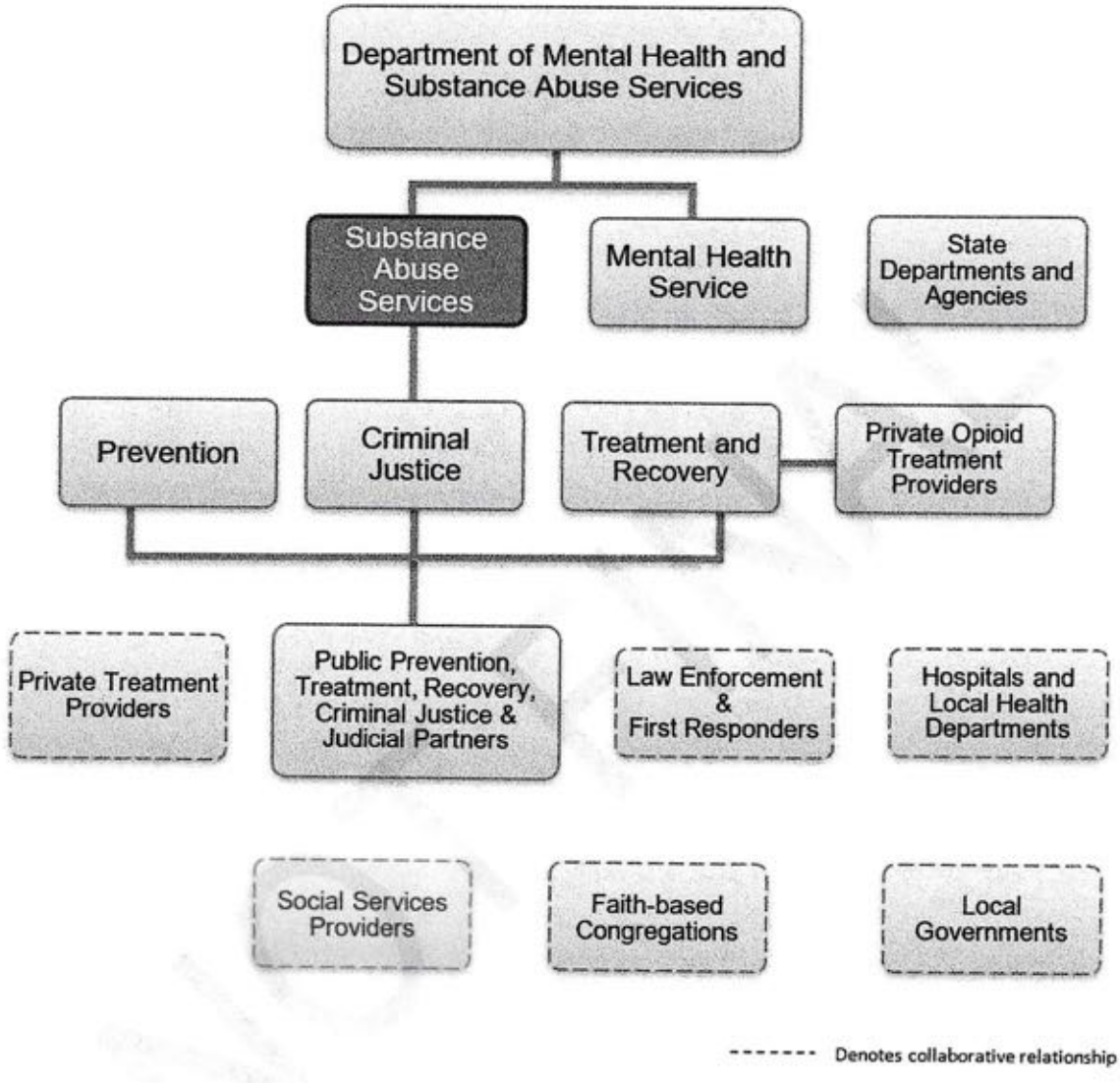
The Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as Tennessee's substance use disorders, mental health and opioid authority. The Department is responsible for system planning; setting policy and quality standards; licensing personal support services agencies, substance abuse and mental health services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who have a substance use, mental or co-occurring disorder, including serious emotional disturbance. TDMHSAS also provides inpatient psychiatric services for adults, including acute, subacute, and secure forensic beds, through its operation of four fully accredited Regional Mental Health Institutes (RMHIs). Listed below and hereafter is Tennessee's substance abuse system.

Tennessee's Substance Use System

Substance use is a pervasive public health issue. It has roots in individual, family, peer, and community conditions that shape risk for experiencing substance abuse and its consequences. It negatively impacts families and children; increases crime and threatens public safety; and

imposes tremendous social and economic cost to society. Not surprisingly, these pervasive social manifestations prompt responses across our public and private institutional systems. While it is difficult to paint a precise picture of the entire system for serving individuals experiencing substance abuse and its consequences, the information below helps to establish the parameters of the role currently played by TDMHSAS, Division of Substance Abuse Services (DSAS) within the entire state system. Understanding the context of this information is important for making realistic strategic decisions about how DSAS' role may be defined more effectively in the future, and how that role may be coordinated with other components of the full system of service for substance use and related problems.

Tennessee Substance Use System



The *Division of Substance Abuse Services* receives and administers federal block and discretionary grants and state funding for substance use services. Our mission is to create collaborative pathways to resiliency, recovery, and independence for Tennesseans living with mental illness and substance use disorders. One of *DSAS' strengths* is its' integrated substance abuse system. This system consists of providers, state departments, state agencies, local governments, social services providers, law enforcement & first responders, hospitals and local health departments, and faith-based organizations that are collaborating to provide an effective and efficient delivery of mental health and substance abuse services to Tennesseans.

According to the National Substance Use and Mental Health Services Survey (N-SUMHSS), in 2021, the overall Tennessee treatment system included 293 facilities. 66.2% were private non-profit facilities and 32.1% were private for-profit agencies. *DSAS purchases services directly from non-profit and for-profit providers; and has established a partnership that is transparent and respectful.*

Profile of Tennessee Treatment Facilities

Type of Facility	Number of Facilities	Total Number of Clients
Private non-Profit	**194**	**20,533**
	66.2%	**45%**
Private for-Profit	**94**	**12,275**
	32.1%	**26.9%**
Public	**5**	**12,808**
	1.7%	**28.1%**
Total	**293**	**45,616**
	100%	**100%**

DSAS works closely with its' Sister Division, *Mental Health Services,* to provide community-based programs and services. The Division of Mental Health Services is responsible for planning and promoting a comprehensive array of services and supports for individuals of all ages, living with mental illness and/or serious emotional disturbances. The Divisions collaborate on activities to train and educate the community on suicide prevention and the linkage to substance use and mental health disorder services; provide support for the certified peer recovery specialists program and work to employ individuals with lived experiences; and criminal justice diversion strategies to help prevent individuals from re-entry into and/or out of jail or prison.

The Opioid Crisis has afforded DSAS the opportunity to partner with ***private substance use treatment providers*** and ***Opioid Treatment Programs*** (OTPs). DSAS utilizes the Hub and Spoke model to deliver a full spectrum of treatment and recovery support services for individuals with OUD by leveraging both private and public providers. Services offered, but not limited to: clinical treatment, MAT, recovery support services. Referrals for resources including health care, mental health, childcare, education, legal assistance, etc. In Tennessee, Opioid Treatment Programs (OTPs) are for-profit agencies. TDMHSAS licensed ***Opioid Treatment Programs*** and the State Opioid Treatment Authority (SOTA) provides administrative, medical, and

pharmaceutical oversight to certified opioid treatment programs. Through the federal opioid funding and state appropriations, DSAS has expanded its medication assisted treatment network to include OTPs.

DSAS has forged vital relationships with other ***state departments and agencies*** to improve coordination of care for individuals with substance use disorders. Formal partnerships have been established with the Departments of Agriculture, Correction, Safety, Health, and Tennessee Bureau of Investigation. These partnerships allow for data sharing, prevention education and treatment services. TDMHSAS' working relationship has grown with TennCare, Tennessee's Medicaid program which has resulted in additional coordination of services, especially with the SOTA. Also, DSAS serves as the behavioral health subject matter experts for the Department of Children's (DCS) Services ***Zero to Three Safe Baby Court Initiative*** to improve outcomes for infants, toddlers and families involved in the child welfare system. DSAS coordinated with DCS for Regional Overdose Prevention Specialists to provide training on opioid use disorder, harm reduction, stigma, and when/how to administer naloxone to all DCS case workers and employees. The community coalitions partner with the Tennessee Department of Environment and Conservation to place permanent drug collection boxes in law enforcement agencies.

Social Services organizations provide a wide range of services to individuals, families, and communities in need. They can be state and local government agencies, nonprofit organizations, or private businesses. Social service organizations play an essential role in helping people overcome challenges and improve their lives. They provide essential services to people who may not be able to afford them on their own, or who may not know where else to turn for help.

Local Governments/county entities serve as fiscal agents for our state-funded community coalitions and recovery courts. They are donating space and other resources to ensure that these programs are effective and sustained into the future. By housing these programs with these entities, the local governments are able to ensure services are administered to benefit their constituents while at the same time meeting the goals of the funding.

First responders and law enforcement are the first people to arrive at the scene of an emergency, such as a fire, accident, or overdose. They work closely together to protect the public and respond to emergencies, often putting their own lives on the line to help others. DSAS partners with them through providing training, education, and naloxone. In addition to training, Law Enforcement provides support to coalitions and community providers through involvement in planning and program implementation as appropriate.

Hospitals and health departments play a vital role in supporting substance use service delivery by screening and assessing patients for substance use disorders, referring them to treatment programs and coordinating their care, providing treatment and support services, and educating the public about substance use disorders and prevention strategies.

Establishing a relationship with the ***Judicial System*** has been essential to developing a structure for coordinating a system of care for justice involved individuals incarcerated or at risk of incarceration due substance use and misuse. There are thirty-two Judicial Districts in Tennessee. DSAS has joined forces with the General Sessions, Circuit, Criminal, , Drug, Mental Health, Veteran, and Family Courts to coordinate behavioral health care for adults.

DSAS has built a cohesive prevention, treatment, and recovery network with ***Faith-Based Congregations/Organizations*** to support a common goal of strengthening individuals and families dealing with substance use disorders; and ultimately, restoring our communities.

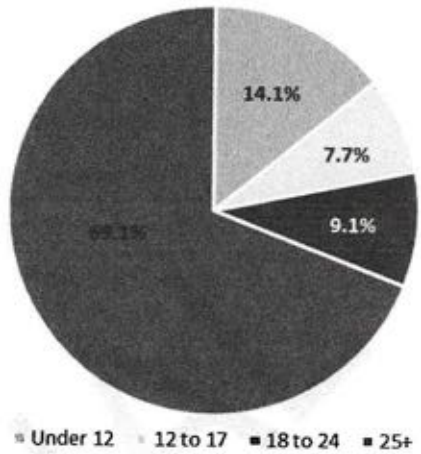
The goals of the Faith-Based Initiative are to:

- Connect individuals struggling with behavioral health challenges to treatment
- Facilitate understanding of treatment and recovery
- Increase knowledge of mental health challenges and substance misuse
- Help others understand the continuum of care and collaborate with it
- Spread awareness of the Faith-Based Initiative certification and its requirements
- Help groups understand and implement the best practice model

Promote and improve the effectiveness of the faith-based initiative in bridging the gap between the faith community and recovery and support services

To understand how substance abuse services are delivered in Tennessee, it is important to understand the nature of the substance abuse problem and characteristics of the state's residents—including where populations are concentrated and how many people are approximately at risk. Tennessee is located in the South Eastern portion of the U.S. and is the 16th most populous state in the nation, with an estimated 6,859,497 residents (Census 2021 five-year estimate). The population is predominantly White (72.2 percent) or African American (15.8 percent) with persons of other races comprising approximately two percent of the total resident population. Nearly one-quarter (22.4 percent) of the overall population are under the age of 18. This presents the possibility of substantial cohort effects if substance abuse intervention and treatment among youth can be implemented effectively. Cohorts whose rates of use are lowered tend to keep those lower rates throughout the aggregated lifetimes of their members. That is, a group of 18-year olds who have their use rates lowered should keep comparatively lower rates compared to other cohorts even when they are in middle age or become elderly. However, both the 12–17 and 18–25 age cohorts represent the smallest population size.[1]

Exhibit 1.1
2022 Tennessee Population by Age Category
U.S. Centers for Disease Control (CDC)



Populations in Tennessee by Age Range		
Age	Population	Percent
Under Age 12	995,486	14.1%
Age 12–17	542,651	7.7%
Age 18–24	738,883	9.1%
Age 25 or Older	4,693,962	69.1%
All Ages	7,051,339*	

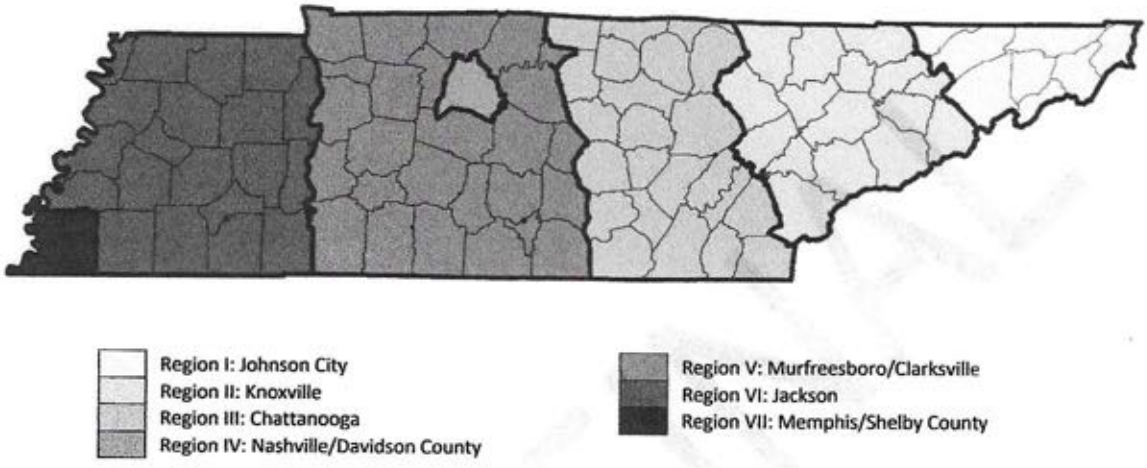
*Because this table's counts come from CDC projections for 2022 based on Census data, total population vary from one source to the other.

There are also seven geographic regions across Tennessee that have been established as state behavioral health planning or sub-State Planning areas. These regional designations allow for

[1] Statewide Assessment of Substance Use Disorders Prevention & Treatment Needs, *A Profile of Priority Needs for Prevention and Treatment, Current System Capacity and Services, and Implications for Service Priorities and Development*, State of Tennessee, 2013.

geographic analysis of survey data on prevalence rates and needs for treatment, as well as service utilization information provided by the State of Tennessee, Division of Substance Abuse Services. The seven Mental Health Planning Regions in Tennessee are displayed below.

Tennessee Mental Health Planning Regions



State funding resources have remained stable for many years. Therefore, DSAS worked to develop and implement "low cost, high impact" programs to expand, enhance and strengthen DSAS' substance use services and state and community partnerships. Examples of "low cost, high impact" programs are:

- Community Coalitions
- DUI Schools
- Oxford Houses
- Faith-Based Recovery Network
- Lifeline Peer Program
- Alcohol and Drug Addiction Treatment Program
- Supervised Probation Offender Treatment Program
- Community Treatment Collaborative
- Recovery Courts
- Criminal Justice Liaison Program
- TN Recovery Oriented Compliance Strategy
- Regional Overdose Prevention Specialists

In 2020-2021, it was estimated that 948,000 Tennesseans ages 18 years and older have a substance use disorder. Of that group, 95,748 (10.1%) are estimated not to have health

insurance (NDSUH 2020-21, Census 2021). Recognizing the increasing need for substance use prevention, treatment, and recovery services, DSAS proactively sought out federal discretionary grant funds to leverage the SABG Block Grant and state appropriations with the goal of helping to close the gap of the number of Tennesseans needing substance abuse services. Since 2018, DSAS has received twenty-two (22) state and federal grants, including STR and SOR.

Prevention Services

DSAS' Prevention structure has three service components to address the prevention needs of individuals, communities, regions, and the State. This structure provides the essential framework and resources necessary to reach Tennessee's high need communities to increase protective factors while decreasing risk factors. Prevention service components included: provider agencies, prevention coalitions, and regional workgroups. Within this system, high need communities and populations are identified by TDMHSAS assessment. ***Provider agencies*** deliver culturally appropriately selected and indicated programs per an assessment through the Tennessee Prevention Network program. A network of county-level ***coalitions*** whose work is governed by the Strategic Prevention Framework (SPF) is the cornerstone of the prevention structure. They work to reduce underage alcohol use, underage tobacco use, marijuana, stimulants, and prescription drug/illicit opioid use across the lifespan by working within their home communities to implement data-based plans that endeavor to solve the problems in their community through environmental and community-based strategies. Additionally, the Coalition for Healthy and Safe Campus Communities serves the Higher Education Institutions in Tennessee, a population known to be at great risk of alcohol and drug misuse. There are currently 48 anti-drug coalitions that are serving 75% of Tennesseans. Regional Overdose Prevention Specialists (ROPS) have been embedded in county coalitions to provide a regional hub to plan and coordinate evidenced-based and emerging practices to maximize community involvement. ROPS work collaboratively with coalitions and communities to ensure that key stakeholders across the state receive training on opioid overdose, opioid use disorder, harm reduction, stigma, and naloxone use. In addition to providing training, ROPS distribute naloxone to individuals at high risk of overdose and other key stakeholders in the community. ***Regional Workgroups*** deliver universal indirect interventions, which leverage the efforts of individual coalitions and program providers by implementing environmental strategies in all areas of the state, including those areas without direct funding or a stand-alone program or coalition.

The purpose of implementing the SPF process is to ensure that the strategies and practices implemented as part of the SAPT Block Grant are effective, culturally appropriate, and sustainable. The SPF is a 5-step planning process that includes a comprehensive community assessment that guides the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The assessment helps communities discern what their community looks like in terms of who makes up their community as well as the community consumption patterns or the way people drink, smoke and use illicit drugs. This information ensures that the strategies that are implemented are designed specifically to

prevent others from using substances in a similar manner. The ultimate goal of SPF implementation is outcomes-based prevention that focuses on population level change, emphasizing data-driven decision making. Cultural competence is a key portion of the SPF. It is part of each step of the process and is always a key consideration.

The Strategic Prevention Framework (SFP) planning process allows different programs to meet the needs of the predominant high-risk populations within their community. One unique program is the Deaf and Hard of Hearing program which serves the selective population of deaf and hard of hearing youth ages 6-20 and their families. Other prevention services programs include Comprehensive Alcohol, Tobacco and other Drug Program, Synar, and Partnerships for Success. All programs work to understand the unique diversity of the participants they are serving and have cultural humility in their relationships. Cultural humility incorporates a consistent commitment to learning and reflection, but also an understanding of power dynamics and one's own role in society. It is based on the idea of mutually beneficial relationships rather than one person educating or aiding another in attempt to minimize the power imbalances in client-professional relationships.

DSAS also supports prevention programs that address the needs of diverse racial, ethnic, sexual, gender, minorities, and military personnel. One example is Just Us, a program that focuses on LGBT youth in the Middle Tennessee area. This program provides a safe place for LGBT youth to come and be validated for their authentic selves; to learn how to use their voices to create change; and to be empowered with the tools to safely navigate the world that is uniquely theirs. Other populations identified as at-risk included, youth with low school performance, delinquency, and/or high school dropouts, rural populations, and college students. The planning process allows different programs to meet the needs of the predominant high-risk populations within their community.

The State coordinates prevention activities through the Tennessee Prevention Advisory Council (TN-PAC). TN-PAC expands and strengthens prevention resources, reduces barriers, and increases communication throughout the prevention system. TN-PAC's members are comprised of state agencies; statewide organizations; regional prevention providers (including coalitions); and the Director of Prevention Services. Its structure and membership intentionally reflect the diverse racial, ethnic, faith, socioeconomic and professional sectors of the State. The Evidence-Based Practices Workgroup has operationalized the definition of Evidence Based Practice (EBP) in Tennessee and serves as the expert panel to determine the viability of proposed interventions through a rigorous review and approval process. DSAS profiles and prioritizes population needs, resources, service gaps and readiness capacity. It provides guidance to the comprehensive strategic planning process at state and community levels, and makes data-informed recommendations to the TN-PAC.

The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a

collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State.

The Office of Prevention Services coordinates with several state agencies to best deliver prevention services. The Department of Health is very interested in many of the substance use and misuse issues because they impact the physical health of many Tennesseans. The Office of Prevention collaborates with TDH on a project that combines law enforcement data to the CSMD and overdose data. This project allows state departments and community partners to better identify and react to emerging and existing hotspots, as well as changes in the opioid crisis. Additionally, they have partnered with coalitions to delivery key prevention messages at physician training events across the state regarding how to safely prescribe opioids.

DSAS, in collaboration with the Department of Agriculture, addresses the issue of underage tobacco access through Synar. The Tennessee Department of Agriculture is responsible for coordinating and implementing the Synar survey. Tobacco compliance checks are completed statewide in establishments that sell tobacco products and are accessible to minors. Synar targets all youth under the age of 21.

DSAS continues its partnership with the National Guard, Counter Drug Task Force; Civil Operations Unit to provide well-trained and adaptable forces capable of developing anti-drug coalitions while implementing effective prevention practices.

Through adherence to Culturally and Linguistically Appropriate Services (CLAS) Standards, TDMHSAS funded prevention programs are well-equipped to serve diverse communities:

a. Diverse cultural health beliefs and practices- As described above, the SPF process begins with assessment. This assessment will uncover the unique health beliefs and practices of the communities that receive TDMHSAS funding. The funded agencies then implement plans that are based on their knowledge of cultural health beliefs and practices for their respective communities.
b. Preferred languages- Again, as described above the SPF process allows for agencies to assess their communities and have a grasp on the specific languages that are unique to their area. TDMHSAS-funded providers understand that if they are truly going to make community-level change, it will be essential to reach people of all languages. Providers are encouraged to translate key informational materials or provide evidence-based programming into languages that are reflective of their community.

Inherent in the work of all TDMHSAS-funded providers is the importance of strategic partnership and collaborations with diverse groups that truly represent the population and needs in their respective communities. TDMHSAS continues to collaborate with community partners who understand that making change involves support and buy-in from all members of a community and work to make decisions that are built on collaboration and a spirit of win-win on a daily basis.

Early Identification

DUI Schools in Tennessee provide educational intervention services based on ASAM Level 0.5, Early Intervention, to individuals that are mandated by the court to receive this service or want to reinstate their driver's license privileges. Offenders receive an assessment, education and, if indicated, appropriate treatment referral. DUI Schools use the *Prime for Life* curriculum as the statewide standardized curriculum. *Prime for Life* curriculum is recognized by the SAMHSA's Evidence-Based Programs and Practices as a Promising Practice. The core focus is on improving attitudes of the student and creating a positive outlook to decrease dependency by using the latest research on brain chemistry and addiction.

Through the Tennessee ***Suicide Prevention Network***, substance abuse professionals are trained on evidence-based suicide prevention strategies to eliminate and reduce the incidence of suicide across the life span, reduce the stigma of seeking help associated with suicide, and educate communities throughout Tennessee about suicide prevention and intervention. SUPTR treatment counselors are required to participate in trainings on conducting Suicide Prevention Screenings using either the Columbia Suicide Severity Rating Scale (C-SSRS), C-SSRS Lifetime/Recent Version, or other instrument approved by the State. The goals of the training are:

a. To reduce the incidence of suicide and suicide attempts.
b. To educate the general public about suicide prevention and intervention.
c. To reduce the stigma associated with mental illness and suicide.
d. To be a resource for information about suicide.
e. To educate mental health and substance abuse counselors and program administrators about the high incidence of mental health and substance abuse disorders and suicide attempts and suicide deaths.
f. To promote the use of evidence-based practices and guidelines for suicide prevention education and training.

DSAS received the Tennessee Opioid ***SBIRT*** (TOS) grant to provide opioid and other drug screening, brief intervention and referral to treatment services for individuals residing in East, Middle and West Tennessee. The overarching mission of this project is to reduce OUD and SUD across the state leading to reductions in alcohol and other drug misuse and associated consequences including overdose, health problems, and social and economic problems for persons suffering from these disorders.

Treatment Services

DSAS' Treatment structure has four service components to address the needs of individuals, communities, and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for the treatment of

persons whose use of alcohol and/or other drugs has resulted in patterns of abuse or dependence. Treatment Services' components included: provider network, recovery courts, emergency departments, coalitions, and the TN REDLINE ***provider network*** is the backbone of DSAS' treatment structure. They offer a full continuum of care based on the American Severity Index (ASI) screening tool and the American Society of Addiction Medicine (ASAM) Criteria to assess adults, pregnant women, and women with dependent children; and the T-ASI and ASAM for adolescents. 98% of all treatment providers have been certified to provide Co-Occurring Disorder services. Utilizing state-funds, ***Recovery Courts*** provide treatment services on-site or refer individuals to DSAS-funded treatment agencies. Tennessee Recovery Navigators are people in long-term recovery who meet patients who have recently overdosed in the ***Emergency Department*** and connect them with treatment and recovery services. ***Coalitions*** work to provide marketing and community linkages to promote resources. The ***TN REDLINE***operates a twenty-four hours per day/seven days per week (24/7) toll-free telephone line (TN-Redline) to answer questions and give referrals to individuals seeking information relative to substance use prevention, treatment, and recovery as well as co-occurring disorders and problem gambling. Callers who would like to communicate directly with a treatment provider can receive a warm handoff or if they prefer to receive the information via text message, the REDLINE has that capability. Other treatment services include: Medical Detoxification (state-funded); Medically Monitored Withdrawal Management; Tele-Treatment Program; HIV Community Outreach Engagement Prevention Program; Problem Gambling Outreach, Education, Referral and Treatment Program; Opioid Treatment Programs; and Medication Assisted Treatment.

DSAS' ***Pregnant Women and Women with Dependent Children (PWWDC)*** programs are rooted in the Recovery-Oriented System of Care model. PWWDC targets women and pregnant women with a substance use disorder or a co-occurring substance use and psychiatric disorder. Providers are required to publicize the availability of services. If a provider does not have capacity, they notify the State and the State assists with locating a treatment facility and/or ensure that interim services are provided until a facility is located. Services offered included but are not limited to: preference in admission to treatment; referral for primary medical care; childcare and prenatal care, including immunization; gender specific treatment and other therapeutic interventions for women; referral for therapeutic interventions for children in custody of women in treatment; case management; and transportation.

Due to the opioid epidemic, Tennessee has seen an increase in heroin treatment rates in the past five years. ***Injecting drug users (IVDUs)*** are a priority population for substance use treatment services and all block grant treatment providers are contractually required to give preference in admission. Other contractually required provisions of services for IVDUs included but are not limited to: notify the State upon reaching 90% capacity; admit an individual who request treatment no later than 14 days after request or within 120 days if treatment facility does not have capacity; notify the State to assist with placement if there isn't capacity; and provide interim services within 48 hours and continue to encourage injecting drug users to seek treatment.

Policies and procedures were developed in conjunction with the Tennessee Department of Health, Tuberculosis Elimination Program, to identify and prevent active ***Tuberculosis*** (TB) disease and TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug (A&D) treatment programs and prevention programs that offer direct services. All treatment providers are contractually required to meet the requirements of the ***Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs.*** DSAS has an agreement with all public health departments to provide TB testing for DSAS funded treatment agencies that do not have the capacity to perform the test. In addition, DSAS offers an on-line training course on the risk factors and symptoms of TB.

Identifying and enhancing services to populations who are vulnerable to disparities; and understanding differences in culture and the need to recognize and focus on those differences are an important part of the work for DSAS' leadership and staff. Through the Tennessee Web-based Information Technology System (TN WITS), DSAS has the capability of tracking enrollment in services, type of services received, and outcomes based on demographics. Individuals can be identified by race, gender, ethnicity, and preferred language; therefore, giving us an overall picture as to who is seeking treatment and recovery support services in our substance use system. Individuals who have experienced violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences are assessed utilizing a trauma screener and a treatment plan is developed that includes trauma specific services and referral for other community support services.

DSAS expects its partners to be or become proficient in the cultural needs of shared constituents through recruitment and retention of diverse staff, and through ongoing participation in focus groups, training, and planning activities. The provisions of services are clear and concise to ensure that clients receive services that are effective and efficient. Treatment agencies are required to provide services that are gender and culturally responsive. Recovery services are supported by a network of faith-based congregations and organizations that provide services and work as advocates to decrease stigma and support a common goal of strengthening individuals and families.

Recovery Services

Recovery Services promotes client engagement in the recovery process and provides services needed for support of continued recovery. Its structure has three service components to address the needs of individuals, communities and the State – provider network, faith-based congregations/organizations and lifeline peer coordinators. Approximately one hundred-three (103) faith-based and non-faith-based agencies provide recovery services through the ***provider network*** to keep individuals engaged in treatment or to provide continued recovery support. Services include transportation, transitional housing, health and wellness, employment skills and recovery activities. DSAS actively engage ***faith-based congregations/organizations*** as a means of increasing outreach, educational activities, access, and visibility to people seeking

substance use services. ***Lifeline Peer Coordinators*** work to reduce stigma related to the disease of addiction, increase the number of recovery groups and meetings, and assist individuals in accessing treatment and/or recovery options in their community. Other recovery support programs are: Recovery Housing, Addiction Disorders Peer Recovery Support Centers, and Peer Recovery Specialist Certification.

DSAS offers an application platform, ***TN Recover,*** for providers to share updates, clients to ask questions, support others, and stay connected throughout recovery through invite only. The app allows for peers and coaches to be able to share updates, ask questions, and offer support. It also allows individuals who have completed treatment or are in the process of completing treatment to receive inspirational messages, updates for onsite events, and prompts to join a dialog around certain topics. There is also a recovery tracker where individuals can share their recovery date as well as a gratitude journal that they can keep private or share with others. The TN Recover app also includes ***primary prevention*** information for alcohol, tobacco, and prescription drugs/opioids; information on opioid overdose prevention, including information about available trainings on opioids and naloxone usage; and contact information for community substance use prevention coalitions and ROPS. It serves as a resource that individuals in the community, first responders, and community agencies access to connect with prevention information from across the state.

The Tennessee Creating Homes Initiative 2.0 (CHI 2.0) 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. The purpose of this CHI 2.0 is to develop and expand the number of quality, safe, affordable permanent housing options for Tennesseans living with substance use disorder, in particular opioid use disorder.

Criminal Justice

Criminal Justice is an integral part of our substance use disorder system. Its' structure has two service components to address the needs of individuals, communities, regions, and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for persons incarcerated or at-risk of incarceration due to the use of alcohol and/or other drugs. The criminal justice components are diversion programs and recovery courts. DSAS has worked persistently to increase the ***diversion programs*** offered to justice-involved individuals with substance use and mental health disorders. The Criminal Justice Behavioral Health Liaison Program collaborates closely with the local jails and court system to facilitate access to service recipients with substance use disorders (SUD), co-occurring disorders (COD), serious mental illness (SMI), and mental illness (MI), who come in contact with the criminal justice system due to incarceration or being at risk of incarceration. Their goal is to determine what services are needed and what referrals are necessary to divert the service recipient from jail and the court system. Other diversion programs are: Alcohol and Drug Addiction Treatment (ADAT) for DUI offenders, Supervised

Probation Offender Treatment program, TN Recovery Oriented Compliance Strategy, and Community Treatment Collaborative for at-risk probation and parole technical violators.

Recovery Courts are specialized courts or court calendars that incorporate intensive judicial supervision; treatment services; sanctions; and incentives to address the needs of non-violent justice-involved individuals with substance use and/or co-occurring mental health disorders. A recovery court team, composed of the judge; prosecutor; defense attorney; recovery court coordinator; probation officer; treatment providers; and other program staff, works in concert to ensure that defendants have the support of the justice system and treatment services to address their substance use and mental health needs. Drug Courts, Mental Health Courts, Veterans Treatment Courts, Family Treatment Courts, Juvenile Recovery Courts, and DUI courts are all part of the recovery court umbrella.

The Recovery Court Advisory Committee works with TDMHSAS in reviewing program criteria, certification process and application, and makes recommendations concerning implementation of programs. By law, the Recovery Court Advisory Committee is made up of the following representatives: two (2) judges who are currently presiding or have presided over a recovery court program for at least 2 years; two (2) recovery court coordinators who have functioned as a drug court coordinator for at least 2 years; and at least two (2) additional members representing recovery court stakeholders (treatment/recovery support providers, court administrator, etc.). Staggered terms with initial appointments are established by the Commissioner. A member serves a four-year term, and a member may be appointed to serve one additional consecutive term. Each member appointed represents a different region in the state (East, Middle and West).

The Criminal Justice System serves a very diverse population. Effectively communicating with justice-involved individuals is essential to providing successful behavioral health care coordination. Recovery courts in the State of Tennessee are required to have policies and procedures addressing their processes for engaging diverse populations. Programs are tasked with ensuring that they are appropriately addressing the needs of minority groups, including racial, ethnic, and sexual gender minorities. Assessment tools are provided for recovery courts to utilize to gauge their effectiveness in this area, and DSAS provides technical assistance for the process.

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.

This step should identify the unmet services 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 populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these 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.

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The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) *Statewide Needs Assessment of Substance Abuse Services* (May 2021) provides an in-depth review of the prevention, treatment, recovery, and criminal justice portions of the system. The needs assessment specifically sought to understand the system in three key areas: access, quality, and workforce.

- **Access** was defined as the ability of persons to receive prevention, treatment, and recovery services.
- **Quality** was defined as having the necessary mechanisms in place to provide effective services.
- **Workforce** was defined as the persons who are employed by contracted agencies to provide publicly funded substance abuse services.

The mixed-method data collection approach was used for the needs assessment with a variety of quantitative and qualitative data sources considered for inclusion. Quantitative Data Sources included the Tennessee Web-based Information Technology System, National Survey on Drug Use and Health and American Community Survey. Qualitative Data was collected using a combination of in person and virtual site visits to address current existing data gaps and collect qualitative data from multiple perspectives on access, quality assurance, and workforce from the different points on the continuum. Five Regional Focus Groups were conducted in each of the seven planning regions of the state.

According to the NSDUH, during 2019, approximately 356,000 Tennesseans 12 and older needed but did not receive treatment for an SUD.[1] Access to effective treatments for SUDs is a critical public health issue. Difficulties in access to care may account for the large proportion of individuals with alcohol and/or substance use disorders who do not receive any care for their disorder and the low proportion who engage in or acheive sustained involvement with treatment.[2]

In an effort to explore these issues, quantitative and qualitative data were obtained from the prevention, treatment, recovery, and criminal justice programs through service data, a survey, and focus groups.

Through participation in working groups coordinated by agencies/ departments that previously participated in the State Epidemiological and Outcomes Workgroup (SEOW), DSAS has been able to enrich relationships, coordinate data collection and program activities, and better understand partner data and outcomes while still meeting the goals of a consolidated centralized SEOW group. This distributed approach to the SEOW includes participation in workgroups lead by the States content experts. A few of the Workgroups that DSAS participates in are described below:

The Dangerous Drugs Task Force (TDDTF) Workgroup is a statewide law enforcement initiative led by the Tennessee Bureau of Investigation (TBI). The TDDTF's mission is to reduce the availability and illegal use of harmful scheduled drugs, including methamphetamine, marijuana, prescription drug diversion, heroin, cocaine, fentanyl, and others. Goals of this group include: conducting and coordinating drug investigations; providing training and equipment to local law enforcement agencies; educating the public about the dangers of drug use; and working with regulatory agencies, healthcare providers, and treatment providers to address substance use issues in the State of Tennessee.

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[1] SAMHSA, Center for Behavioral Health and Quality, National Survey on Drug Use and Health, 2018 and 2019.
[2] Fortney, J., & Booth, B.M. (2002). Access to Substance Abuse Services in Rural Areas. In: *Alcoholism. Recent Developments in Alcoholism (Services Research in the Era of Managed Care)*, vol 15. Springer. https://doi.org/10.1007/978-0-306-47193-3_10

The Tennessee Department of Health (TDH) was awarded the Harold "Hal" Rogers Prescription Drug Monitoring Program: Data-Driven Responses to Prescription Drug Abuse Grant. This grant provides funding support for the TDH Hal Rogers Data workgroup whose primary purpose is to enhance the capacity of regulatory, law enforcement agencies, and public health officials to work together to collect and analyze controlled substance prescription data and other scheduled chemical products through a centralized database administered by an authorized state agency. The TDH is enhancing the existing collaboration between the TDH, law enforcement (Tennessee Bureau of Investigation [TBI]) and substance abuse services (TDMHSAS) to better understand the progression of substance use in the State of Tennessee.

Participating in workgroups lead by the Tennessee Bureau of Investigation, the Tennessee Department of Health, the Tennessee Department of Safety and Homeland Security, the Tennessee Department of Correction, the Tennessee Department of Military, the Tennessee Division of Health Care Finance and Administration, the Tennessee Department of Children's Services, and Tennessee Department of Education allows TDMHSAS to identify data that can be used to establish and target population need, resources, service gaps and readiness capacity. These agencies are able to provide direct and indirect guidance and feedback to the comprehensive strategic planning process at the state and community levels; to allow TDMHSAS leadership to make data-informed observations.

Substance use disorder services are important because those disorders produce serious consequences for individuals, families and society. Need is not determined simply by substance use or abuse, but by those behavior patterns (i.e., disorders) that are highly associated with negative consequences, and by those populations that are most likely to exhibit these patterns of behavior and remain underserved or unserved. Data concerning the incidence and prevalence of use in a population becomes much more useful if there is a focus on those indicators that are most highly associated with the negative consequences that are the cause for concern. Data on problems is also more useful if it provides guidance on who is most likely to experience these problem behaviors, and how they can be identified for outreach and improved service access.

SABG Priority Populations

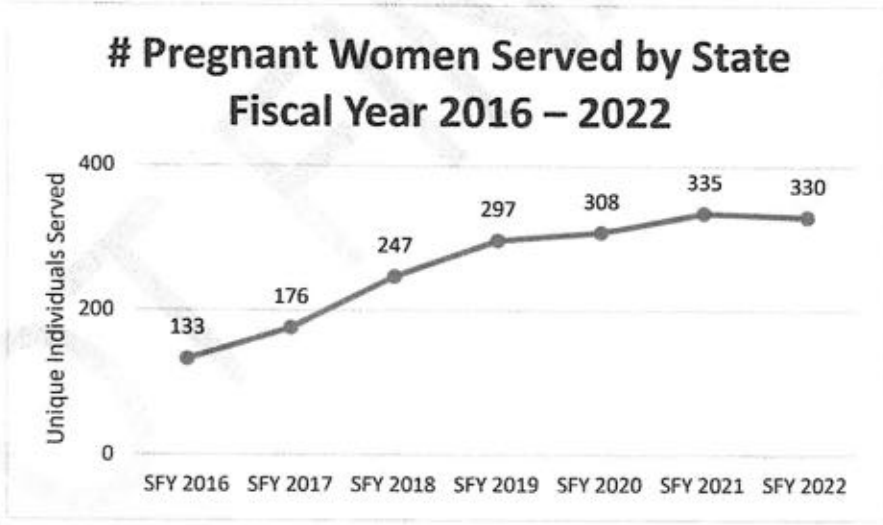
Female Substance Abuse – Pregnant Women and Women with Dependent Children (PWWDC)
Through an agreement with eighteen (18) non-profit providers, Tennessee ensures that PWWDC who seek or is referred for treatment receive the following services:

- Preference in admission to treatment
- Referral for primary medical care
- Childcare and prenatal care; including immunization

- Gender specific treatment and other therapeutic interventions for women
- Referral for therapeutic interventions for children in custody of women in treatment
- Case management
- Transportation

Providers are required to publicize the availability of services for PWWDC. If the provider does not have capacity, they notify the State and the State assist with locating a treatment facility and/or ensure that interim services are provided until a facility is located.

Although comprehensive services are offered for PWWDC and enrollment numbers have more than doubled since SFY16, the percentage of discharges due to success (e.g., no further care needed, treatment completed) or neutral reasons (e.g., participant moved) have decreased in the past few years. In SFY 2022, 41% of PWWDC discharges had successful or neutral dispositions, down from 44% in SFY 2020. The percentage of unsuccessful discharges (e.g., treatment not completed) increased during this time period, from 56% in SFY 2020 to 60% in SFY 2022. The most common reason for unsuccessful discharge in this population consistently has been by far that the treatment provider lost contact with the patient and/or the patient left against medical advice. Though TDMHSAS has had great success in increasing enrollment numbers, serving 330 pregnant women in SFY 2022 compared to 133 in SFY 2016, retaining this population in treatment has been a challenge. Additionally, In January 2023, TennCare (Medicaid) extended the length of time that a post-partum woman could continue to receive substance use treatment services from three (3) months to twelve (12) months. This could continue to impact the number of pregnant women receiving services through the block grant funding.



2021 was a pivotal year for Tennessee as it relates to overdose deaths and other causal factors related to the Covid-19 pandemic with a record 3,814 overdose deaths, a 26% increase from the 2020 total of 3,032. Fentanyl and stimulants continue to be major contributors to this increase. There were 3,043 overdose deaths associated with all opioids in 2021. The growth of the opioid crisis further complicates DSAS treatment efforts for this population because it has

led to more intense treatment needs. In SFY22, DSAS served 179 pregnant women who reported opioids among their substances of use, representing 54% of all pregnant women treated. Eight pregnant women, or 4.5% of those receiving DSAS OUD treatment services, accessed Medication Assisted Treatment. An analysis of DSAS services for pregnant women in SFY22 revealed that individuals who had received recovery services such as childcare and recovery housing were more likely to have a successful discharge than those who did not. In SFY24 and SFY25 TDMHSAS will continue to offer Medication Assisted Treatment to pregnant women and women with dependent children. TDMHSAS will work closely with the providers to ensure that all pregnant women and women with dependent children are offered recovery support services, including recovery housing. TDMHSAS staff will communicate with these providers on a quarterly basis to discuss these efforts.

Individuals with a Diagnosis of Opioid or Heroin Use Disorders – Injecting Drug Users

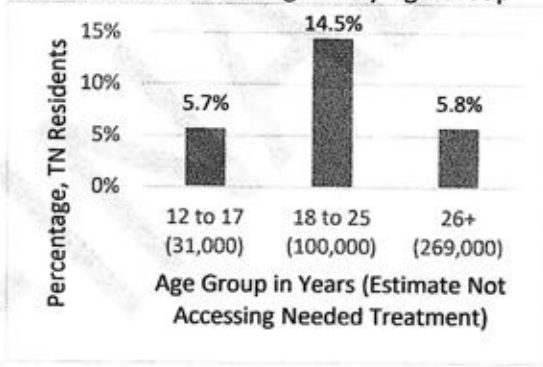
The opioid use disorder (OUD) epidemic is a national problem that requires partnerships among federal, state, and local organizations to address prevention, treatment, and recovery services. According to the Centers for Disease Control (CDC), drug overdose deaths in the United States rose 50%, from 2018 (74,147) to 2022 (111,219). More than 75% of drug overdose deaths in 2021 involved at least one opioid. While the percentage has increased nationally the percentage of drug overdose deaths involving opioids has risen in Tennessee along with the overall drug overdose death rate. In 2018, 71.8% of the 1,818 drug overdose deaths involved opioids; in 2021, 80% of overdose deaths involved opioids.[3] Of the 20,530 unduplicated individuals DSAS served in SFY 22, 49.1% (10,080) had an opioid as a substance of use.

Deaths involving any stimulants have consistently increased over the past four years: a 200% increase from 2018 to 2022. Deaths involving stimulants other than cocaine, a category that includes primarily deaths involving methamphetamine, have increased substantially over this period. Deaths involving both opioids and stimulants have also increased over the past five years, and in 2022, 77% of stimulant-involved deaths also involved an opioid.

[3] Tennessee Department of Health (2022). Tennessee Drug Overdose Data Dashboard.

TN data from the National Survey on Drug Use and Health (NSDUH 2020-2021)[3] reveals that in the past year 4.25% of 18- to 25-year-olds (est. 28,000) and 4.22% 26+ year-olds (est. 197,000) used pain relievers for non-medical purposes. The Tennessee rate of past-year opioid use disorder is 20% higher than that of the U.S. overall (2.4% in TN vs. 2% in U.S.), and Tennessee residents are 42% more likely to have used opioids in the previous year (4.7% in TN vs. 3.3% in U.S.). Of all individuals treated for SUD in the U.S. in 2021, 42% received medication-assisted treatment; in Tennessee, this percentage was 23% (N-SUMHSS 2021). These use rates and the consequences associated with them are devastating to individuals, families, communities, regions and to the State of Tennessee.

Chart 1.
Tennesseans Needing but Not Receiving Treatment for Illicit Drug Use by Age Group



The 2021 National Substance Use and Mental Health Services Survey (N-SUMHSS) report indicates that Tennesseans are more likely to be in treatment compared to other states. Tennessee's rate of 739 individuals in treatment per 100,000 population 18 and older compares to the U.S. rate of 540, meaning Tennessee residents are 37% more likely to seek treatment. Chart 1 compares the percentages of Tennesseans who needed treatment for illicit drug use but did not receive it across age categories, based on 2020–21 annual averages. Tennessee performs on average in providing treatment services for illicit drug use when compared to other states, and the state rate of individuals who need but don't receive treatment for illicit drug use is similar to that of the nation overall (6.8% for both TN and the U.S.). However, the rate of 12- to 17-year olds who needed but did not receive treatment in the previous year (5.7%) is similar to the same rate among Tennesseans ages 26 and older (5.8%), indicating that more outreach to adolescents is crucial to preventing the long-term effects of illicit drug use in the future.

The OUD issue in Tennessee is statewide but depending upon the type of opioid the use pattern can differ greatly. Data for heroin related indicators shows greater rates in the urban areas and moving to suburban areas, while prescription opioid related indicators show greater rates in rural areas of the state.

All block grant treatment providers are required to treat individuals who inject drugs. They are contractually required to do the following:

- Notify the State upon reaching 90% capacity to admit individuals in its programs

- Admit an individual who request treatment no later than 14 days after request or within 120 days after request has been made if the treatment facility does not have capacity
- If there isn't capacity to admit the individual, notify the State to assist with placement
- Provide interim services within 48 hours and continue to encourage injecting drug users to seek treatment

In FY24 and 25 DSAS will continue offering access to long-acting buprenorphine (Sublocade) and naltrexone for individuals with an alcohol use disorder.

Individuals at Risk for Tuberculosis

Through consultation with the Tennessee Department of Health, Tuberculosis Elimination Program, DSAS developed policies and procedures to identify and prevent active tuberculosis (TB) disease and TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug (A&D) treatment programs and prevention programs that offer direct services. All treatment providers are contractually required to meet the requirements of the ***Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs.***

Requirements for TB screening and testing include:

- Testing and medical evaluation to determine the presence or absence of active TB disease or TBI in employees and volunteers of alcohol and drug treatment programs and recipients of alcohol and drug treatment services must conform to current guidelines of the Tuberculosis Elimination Program of the Tennessee Department of Health.
- A&D treatment facilities must provide baseline screening of all new employees and new volunteers for symptoms of active TB disease and appropriate testing for TBI prior to employment or provision of volunteer services.
- A&D treatment facilities must ensure that all employees and volunteers who provide direct care services are screened annually for symptoms of active TB disease and appropriately tested for TBI.
- A&D treatment facilities must counsel all employees and volunteers annually regarding the symptoms and signs of active TB disease.
- Any A&D treatment program employee or volunteer with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to return to work in the facility or provision of direct care services.
- Any A&D treatment program employee or volunteer reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from the facility and from provision of direct care services until the employee or volunteer is determined to be non-infectious by the local health department.

- All A&D treatment facilities must screen all prospective service recipients for symptoms suggestive of active TB disease prior to each admission for A&D treatment services.
- Prospective service recipients presenting with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to admission for A&D treatment services.
- Any service recipient reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from services until the service recipient is determined to be non-infectious by the local health department.
- Prospective recipients of all A&D treatment services who present without symptoms of active TB, and have no documentation of a previous positive TB test and have no documentation of testing for TBI within the past six (6) months must be appropriately tested for TBI within five (5) business days of initiation of A&D treatment services. The exceptions for testing are Outpatient ASAM Levels 1, 2.1 and 2.5; however, all service recipients must be screened for symptoms of active TB disease.
- A&D treatment facilities must counsel all service recipients about the symptoms and signs of active TB disease during each admission for A&D treatment services.
- All A&D treatment facilities must provide case management activities to ensure that employees, volunteers, and service recipients diagnosed with TBI receive appropriate medical evaluation, counseling about the risk of TBI progressing to active TB disease, and TBI treatment if such treatment is recommended to and accepted by the employee, volunteer, or service recipient.
- Testing for TBI may be conducted by qualified medical personnel at an A&D treatment facility or by referral to a licensed medical provider.
- All TB screening and testing records of employees, volunteers, and service recipients are considered personal medical information protected by HIPAA and must be archived accordingly.

DSAS has an agreement with all public health departments to provide testing for DSAS funded treatment agencies that do not have the capacity to perform the TB test. Individuals present DSAS' screening tool to the health department and gives consent to communicate the test results to the treatment agency.

To increase provider's knowledge about the risk factors and symptoms of TB, DSAS provides an on-line training course and examination. When the individual passes the exam, a certificate is provided acknowledging their success. In SFY 2024 and 2025, DSAS intends to continue offering the on-line training course and training at substance abuse treatment facilities.

Individuals in Need of Primary Substance Abuse Prevention

The Office of Prevention continues utilize the TN Together Student survey; participation in workgroups lead by state departments; and DSAS analysis of external, program, process, and outcome data to identify gaps in services, unmet needs, and potential new target populations.

The 2020-2021 Tennessee Together Student Survey captured data on substance use attitudes and behaviors among Tennessee public eighth-, 10th-, and 12th-grade students. The final survey sample included more than 19,000 respondents from five Behavioral Health Planning Regions, 33 counties, and more than 145 schools statewide.

The Tennessee Together Student Survey represents the largest survey of youth alcohol and other drug use ever undertaken in the state. Historically, TDMHSAS - DSAS had been reliant on federal estimates for data on a state or regional level, which would create a local level data gap. Data gathered by the TN Together survey used in conjunction with federal data will allow for a more complete picture of needs and substance use trends among youth in 8th - 12th grades. It fills a critical information gap by providing locally representative data that has been previously unavailable for most Tennessee counties or regions. The addition of local data has allowed for more targeted efforts on substance use prevention by prevention providers in the state.

The comprehensive state report represents the culmination of this survey effort. The report presents aggregated weighted data on alcohol, tobacco, and other drug use among 8th-, 10th-, and 12th-grade students. The report includes data comparisons across demographic subgroups and Behavioral Health Planning Regions. The 2020-21 survey was the second administration in a series of biennial administrations that will be used to monitor trends in substance use behaviors and attitudes over time; identify emerging alcohol, tobacco, and drug use patterns; and inform state and local prevention planning and evaluation efforts to reduce substance use and related consequences throughout the state of Tennessee.

The Tennessee Together Student Survey measurement tool comprises 24 core questions and 70 sub-questions, covering each of the following constructs:

- Lifetime and past 30-day alcohol, tobacco (including e-cigarettes), illicit drug, and prescription drug misuse;
- Age of onset of alcohol, tobacco, marijuana, and prescription drug misuse;
- Ease of access to alcohol, tobacco, marijuana, and prescription drugs, and methods of obtaining alcohol or prescription drugs;
- Peer substance use;
- Riding in a car with someone under the influence of alcohol or prescription drugs;
- Personal, peer, and parental approval of alcohol, tobacco, marijuana, and prescription drug misuse;
- Perceived risk of alcohol, tobacco, marijuana, and prescription drug misuse;
- Family communication about tobacco, alcohol, illicit drug, and prescription drug misuse; and

- Exposure to prevention messaging regarding the dangers of prescription drug misuse.

In 2022, Tennessee was ranked 44th of 50 U.S. states and the District of Colombia by the United Health Foundation on measures of overall health[4]. Tennessee ranked poorly on measures of premature death (potentially due to an increase in opioid related overdoses), chronic health concerns, such as heart disease and diabetes, and a high prevalence of smoking. Although Tennessee was ranked 12th lowest in the nation on measures of binge drinking and excessive alcohol use, indicating low overall prevalence of alcohol-related problems, this was in improvement from the second highest ranking on this measure in 2015. Additionally, the state was ranked 45th out of 50 states on measures of drug-related deaths, highlighting the serious health consequences of drug use and misuse.

As mentioned previously, the number of overdoses in Tennessee has steadily been on the rise showing that there is additional work to be done in this area. As reported by Tennessee Department of Health, in 2021, Tennessee recorded 3,814 overdose deaths, a more than 20% increase from 2020. Fentanyl and stimulants continue to be major contributors to this increase. Positive indicators that show the primary prevention work across the state is having an impact include: In 2021, we saw a decrease of about 10% from 739 pain reliever related overdoses in 2016 to 645 in 2021; as recorded by the controlled substance monitoring database, the amount of morphine milligram equivalents (MMEs) dispensed has decreased by 60% (2015-2022); and the number of opioid prescriptions for pain has reduced by 44% (2015-2022). With block and other discretionary (SPF, COVID, SOR, and ARPA) grant funding TDMHSAS prevention providers will utilize the continuum of prevention services address prescription drug, fentanyl and other illicit drug use in their communities through implementation of data-based plans that include environmental, community, and individual based strategies.

The Tennessee population is also diverse, with numerous subgroups defined based on characteristics that place them at elevated risk for experiencing alcohol and drug disorders. These populations of focus include, but are not limited to, youth and young adults, seniors and older adults, active military and military veterans, lesbian, gay, bisexual, or transgender (LBGTQ+) populations, rural and homeless populations, and people who are disabled. For example, young adults 18–25 years of age, who account for about 9 percent of the total state population, often experience substantially higher rates of alcohol and prescription drug misuse than the general population as they transition between youth and adulthood. Rural populations, which account for about 30 percent of the state population, also experience high relative rates of substance use disorders, influenced by factors such as lower educational attainment, unemployment, and poverty. Rural areas also have more limited access to resources addressing alcohol and drug prevention, treatment, and recovery needs. LBGTQ+ populations are also at heightened risk for disparities and have been historically under-represented and underserved in mainstream prevention planning efforts. Research studies

[4] United Health Foundation. 2022 America's Health Rankings Annual Report. Accessed from https://www.americashealthrankings.org/explore/annual/measure/Overall/state/TN

estimate that as many as 20–30 percent of gay and transgender people abuse substances, compared to 9 percent of the general population (Center for American Progress, 2012).

The difficulty of obtaining estimates of alcohol and other drug prevention need within these sub-populations and communities presents an ongoing data challenge is a critical gap within the prevention system. For this reason, an important focus of continuing work will be to enhance data system capacity to determine where subpopulations are concentrated and to better document sub-population needs, to inform state level prevention planning efforts, and ensure that resources are allocated to regions and communities where priority needs are greatest. Other gaps include lack of funding for prevention services and statewide coalition coverage.

Through support from state and discretionary funding there has been an expansion in the number of TDMHSAS-funded coalitions and an increase in their annual budgets. Some of the current strategies coalitions are implementing are: town hall meetings and medical forums within their counties, the distribution of lock boxes, education on proper storage practices, education on proper prescribing practices, education on the proper use of the CSMD, trainings within their community using the SAMHSA overdose prevention toolkit, collaboration with Regional Overdose Prevention Specialists to educate on opioid overdose prevention and Naloxone training, as well as mentoring other communities within their regions to expand prevention capacity. TDMHSAS-funded coalitions have already been very successful in many of these areas within their communities and look to do more in the remaining years of the availability of these funds.

In addition, DSAS is working closely with the Evidence-Based Practice Workgroup (EBPW) operationalized the definition of Evidence Based Practice (EBP) in TN to assist coalitions in determining the viability of proposed interventions through a rigorous review process. The purpose of EBPWs is to (1) understand the State's Partnership for Success/ Block Grant prevention priorities and logic models; (2) identify and select evidence-based interventions; and (3) review and make recommendations on communities' comprehensive plans. Utilizing this resource enhances services of the states limited resources responsibly.

An extensive needs assessment to better understand the current publicly funded Tennessee substance abuse system was done in 2020-2021. The three areas of focus for the Prevention portion were: Access, Quality, and Workforce.

Access:
A total of 40,016 persons were served with individual-based programs and strategies. Half of persons served (50.0%) were male, most were 18 or older (75.6%), and most identified as White (82.9%). Racial and ethnic minority populations (except for American Indian and Alaska Native and Native Hawaiian and Other Pacific Islander) are underrepresented in the population served through individual-based prevention programs.

Stigma associated with substance use disorders was a key barrier to accessing prevention services. Prevention programs and coalitions often lack funding and resources. Services are not

consistently offered throughout the state, as many counties do not have a coalition or offer individual-based programs.

Prevention programs and coalitions are most effective at engaging with the community when they have built solid partnerships and are trusted sources of information. In addition, coalitions have taken an important role in reducing opioid deaths by distributing Narcan (naloxone), and individual-based programs have effectively reached out to high-risk populations. In SFY 2024 and 2025, TDMHSAS plans to continue leveraging state, federal, and discretionary grant dollars to increase the number of coalitions and counites that can access individual-based primary prevention programming. Also, in an effort to reach hard to access counties a virtual mentoring platform/app that provides awareness around alcohol, opioids, stimulants, and other substances has been developed in partnership with a current TDMHSAS primary prevention provider and will be deployed in areas with limited prevention services.

Quality:
Over 89% of agencies surveyed use EBPs to provide prevention services, including 100% of agencies providing Tennessee Prevention Network services, 88% of agencies providing coalition services, and 84% of agencies providing Regional Overdose Prevention Services (ROPS) services. Approximately 39% of all agencies reported using Mental Health First Aid, with over 43% of coalitions and over 52% of agencies that provide ROPS using this strategy. Key barriers to quality EBP implementation included difficulty implementing EBPs with fidelity due to various constraints, including difficulty implementing in school settings with the dosage and duration that are required and difficulty implementing environmental strategies.

Implementing, monitoring, and sustaining EBPs can be difficult as many are copyrighted and expensive to implement, monitor, and evaluate. Agencies and coalitions would like to be able to train their staff on EBPs, but the curriculum, training, and ongoing coaching can be cost prohibitive. Other barriers to training include the lack of local trainings and taking staff away from their normal work to engage in training. Many agencies mentioned that the increase in online and virtual training has helped defray costs and lost staff time.

All surveyed prevention programs agreed that there are mechanisms in place to determine the effectiveness of services being provided. In addition, over 59% of agencies noted their agency uses strategies to support QA and continuous quality improvement (CQI) for delivery of prevention services. One large barrier to measuring the effectiveness of prevention activities is the difficulty of measuring something that does not occur (i.e., something that you prevented). In addition, respondents felt that when change does occur, specifically at the community level, it is hard to attribute that change solely to prevention work. Other barriers that were discussed included the high cost of evaluation activities. Preventionists reported that having timely opioid overdose data available was helpful for responding quickly to emerging problems. In addition, agencies reported the importance of adopting programs with built-in fidelity and evaluation instruments.

To address quality concerns, in SFY 2024 and 2025, TDMHSAS will continue to provide training through the National Coalition Academy to Substance Use Prevention Coalitions. The Academy is a comprehensive training program developed by CADCA's National Coalition Institute that teaches leaders "what they need to know" (the core competencies) and "what their team needs to do" (the essential processes) to establish and/or maintain a highly effective substance use prevention coalition. In an effort to address concerns around accessing and providing EPBs with fidelity to the model, TDMHSAS will provide funding support to allow for additional training and purchase of supported training and materials to TDMHSAS-funded providers.

The three EBPS that are being recommended are:

- The Strengthening Families Program an evidence-based family skills training program for high-risk and general population families that is recognized both nationally and internationally. Parents and youth attend weekly SFP skills classes together, learning parenting skills and youth life and refusal skills.
- Positive Action is based on the intuitive philosophy that we feel good about ourselves when we do positive actions. The Thoughts-Actions-Feelings Circle (TAF) illustrates how this works in life: our thoughts lead to actions and those actions lead to feelings about ourselves which in turn lead to more thoughts.
- LifeSkills Training (LST) is a three-year universal prevention program for middle/junior high school students targeting the use of gateway substances (tobacco, alcohol, and marijuana) and violence. The program provides students with training in personal self-management, social skills, and social resistance skills

By providing access at the state level to these EPBs the goal is to lessen the burden on providers while creating an environment where they can access materials and training from the state on an as needed basis.

Workforce:

The prevention workforce is largely female, White non-Hispanic, and between the 25 and 44. Most have a higher education degree, either bachelor's or master's, and have worked at their agency for 5 years or longer. Over half of the workforce has an annual income of $30,000 to $49,000.

While 21% of agency leaders noted that recruiting staff was difficult or very difficult, 41% said it was easy. Almost 40% of agency leaders were neutral about the difficulty of recruiting prevention staff. Respondents reported that it was difficult to capture the complexities of prevention work in a job description. Agencies reported that networking with other prevention agencies and being able to offer licensure facilitated recruitment.

While 24% of agency leaders noted that retaining qualified staff for their agency was difficult, 42% reported it was easy or very easy, and 33% felt neutral about the difficulty of retaining staff. Despite these obstacles, retention is bolstered by people's commitment to do the work that they see as meaningful.

To meet any of the aforementioned gaps, TDMHSAS will need to equip the Prevention workforce with the tools that they need to be successful to provide services to Tennesseans in need. Through continually assessing the Prevention workforce for training needs and preferred methods of delivery, TDMHSAS will be able to identify trainings that can be delivered which will provide the most value. A survey of prevention providers in FY 2023 identified some of the training gaps/ opportunities to include: methods on conducting proper environmental/ community scans; RBS training; how to conduct a proper Drug Take Back Day; the need for Substance Abuse Prevention Skills Training; and annual Prevention Ethics training.

In recognizing the need for strong leaders in the prevention sector TDMHAS will partner with the Prevention Alliance of Tennessee to offer a Coalition Business Administration training. This multi-day certificate program will be aimed at individuals in a career in prevention with aspirations to move to high leadership level as well as those in leadership without a business degree who are looking to advance their knowledge. Subject matter for the training will cover a wide variety of topics including branding, accounting, management styles, grant writing, and nonprofit development. The training has been designed to provide instruction on many of the main topic areas relevant to aspiring leaders in the prevention field.

The training will cover 42 hours of coursework with product assignments due for graduation and certification. Participants are expected to attend all courses, participate in follow-up webinars, complete assignments, and participate in one-on-one coaching sessions.

Subject matter to be covered:

- Leadership Qualities Essential for Community Organizing
- Coalition Branding for Effective Community Recognition
- Effective Marketing for Community Coalitions
- Accounting Principles for Nonprofit Professionals
- Managing Nonprofit Financial Operations
- Effective Budgeting for Nonprofits
- Budget Forecasting for Sustainability
- Developing Partners for Effective Community Organizing
- Managing Employees in the Nonprofit Sector
- Sustaining Executive Staff and Operations
- Advanced Grant Writing for Nonprofit Professionals
- Nonprofit Development and Maintaining Compliance with Regulatory Agencies
- Effective Administrative Oversight for Nonprofit Professionals

In SFY 2024 and 2025, to close data gaps, DSAS intends to utilize recurring funds as needed to expand the TN Together Survey to expand counties beyond the 33 surveyed in the most recent administration period. Also, DSAS will continue to collaborate with the Tennessee Department of Health and other departments to identify data resources that can be used by community partners.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Decrease non-medical use of pain relievers for young adults, age 12-25

Strategies to attain the goal:

Substance Use Prevention Coalitions will address prescription drug misuse in their communities through implementation of data-based plans that include environmental and community-based strategies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of young adults, ages 18-25, who report using pain relievers for non-medical use in the past year

Baseline Measurement: 4.03%

First-year target/outcome measurement: 4.0%

Second-year target/outcome measurement: 4.0%

Data Source:

National Survey on Drug Use and Health prevalence estimates on Prescription Pain Reliever Misuse in the Past Year for Tennessee

Description of Data:

Conducted by the federal government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Data issues/caveats that affect outcome measures:

No issues are currently foreseen that will affect the outcome measure

Priority #: 2

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type: SUP

Population(s): PWID

Goal of the priority area:

All contracted providers will provide treatment services to individuals who inject drugs

Strategies to attain the goal:

Ensure individuals who inject drugs and have an opioid use disorder (OUD) have access to MAT services
Action Steps:
- Assess for IVDU
- Assess for route of IVDU administration at intake

- Offer preferences for MAT
- For those with an OUD, discuss options for MAT in conjunction with clinical treatment

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of individuals who disclose they inject drugs and receive MAT services

Baseline Measurement: 41%

First-year target/outcome measurement: 41%

Second-year target/outcome measurement: 41%

Data Source:

Tennessee Web-based Information Technology System (TN-WITS)

Description of Data:

Clients who identify their route of administration as "injection" and receive services

Data issues/caveats that affect outcome measures:

Route of administration

Priority #: 3

Priority Area: Pregnant Women and Women with Dependent Children (PWWDC)

Priority Type: SUP

Population(s): PWWDC

Goal of the priority area:

Access to quality Substance Use Disorder (SUD) treatment and recovery services for pregnant women and women with dependent children with an Opioid Use Disorder (OUD)

Strategies to attain the goal:

Provide training and technical assistance to SUD treatment providers on opioid and other substance use during pregnancy, access to gender-related responsive services, and other related information

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase number of PWWDC with OUD accessing SUD treatment and recovery services

Baseline Measurement: 1,927

First-year target/outcome measurement: 2,119

Second-year target/outcome measurement: 2,119

Data Source:

Tennessee Web-based Information Technology System (TN-WITS)

Description of Data:

Individuals who identify opioids as a substance of use at intake and having at least one dependent child

Data issues/caveats that affect outcome measures:

Potential funding reduction; Length of time post-partum women can continue to receive TennCare (Medicaid) was extended in FY23 from three (3) months to twelve (12) months

Priority #: 4

Priority Area: Medication-Assisted Treatment (MAT) Services

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Increase the number of individuals receiving MAT for Opioid Use Disorder (OUD)

Strategies to attain the goal:

Provide MAT services (methadone, naltrexone, and buprenorphine, and sublocade) for individuals with OUD
Action Steps:
- Assess for OUD at intake
- Offer/refer for preferences for MAT services
- For those with an OUD, discuss options for MAT in conjunction with clinical treatment

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals receiving MAT services

Baseline Measurement: 4,508

First-year target/outcome measurement: 4,600

Second-year target/outcome measurement: 4,600

Data Source:

Tennessee Web-based Information Technology System (TN-WITS)

Description of Data:

Individuals with a group enrollment or service of MAT

Data issues/caveats that affect outcome measures:

Increased cost of medication and length of stay for MAT

Priority #: 5

Priority Area: Tuberculosis (TB)

Priority Type: SUT

Population(s): EIS/HIV

Goal of the priority area:

Increase provider's knowledge about the risk factors and symptoms of TB, providing an online training course and examination. When the individual passes the exam, a certificate is provided acknowledging their success. in SFY2024 and 2025, DSAS intends to continue offering the online training course and training at substance abuse treatment facilities.

Strategies to attain the goal:

Make available an online training course that provides education and training on TB risk factors

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained

Baseline Measurement: 990

First-year target/outcome measurement: 1,050

Second-year target/outcome measurement: 1,100

Data Source:

Formstack

Description of Data:

The number of individuals who take the online training course

Data issues/caveats that affect outcome measures:

Workforce

Priority #: 6

Priority Area: Criminal Justice

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Provide justice involved women who need a higher level of support he opportunity to participate in the Women's Residential Recovery Court program

Strategies to attain the goal:

Provide outreach services to Recovery Courts to inform them of programming options for justice involved women
Action Steps:
- Information regarding the program and eligibility criteria will be made available to Recovery Courts

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of outreach activities

Baseline Measurement: Determine the baseline

First-year target/outcome measurement: Baseline

Second-year target/outcome measurement: Baseline

Data Source:

Email, meetings, etc.

Description of Data:

Number of outreach activities

Data issues/caveats that affect outcome measures:

Justice involved women needing a higher level of support

Priority #: 7

Priority Area: Workforce Development

Priority Type: SUP

Population(s): Other

Goal of the priority area:

Increase the knowledge of evidence-based programs and strategies for the prevention, treatment, and recovery support workforce

Strategies to attain the goal:

Provide on-line and regional face-to-face educational and training opportunities for prevention, treatment and recovery support professionals

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of substance abuse professionals receiving training on prevention, treatment, and recovery support services

Baseline Measurement: 4,014

First-year target/outcome measurement: 4,100

Second-year target/outcome measurement: 4,200

Data Source:

Attendance sheets of training classes, on-line training records

Description of Data:

Attendance sheets are maintained during training courses and are used to determine the number of individuals that attended training. Additionally, online training is tracked through a report generated from the on-line systems

Data issues/caveats that affect outcome measures:

Virtual versus in-person training

Priority #: 8

Priority Area: Recovery Support

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Provide recovery services that promote long-term recovery

Strategies to attain the goal:

Provide an array of adult and adolescent recovery services to increase their chances of long-term recovery
Action Steps:
- Contract with statewide training provider
- Assess the prevention, treatment, and recovery workforce for training needs and preferred methods of delivery
- Convene Workforce Development Workgroup to develop and approve a workforce development training schedule
- Reach out to the workforce to ensure knowledge of trainings/dates offered
- Continually assess the effectiveness and satisfaction of training offered

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals enrolled in recovery support services

Baseline Measurement: 15,049

First-year target/outcome measurement: 15,100

Second-year target/outcome measurement: 15,200

Data Source:

Tennessee Web-based Information Technology System (TN-WITS); TN Recover App

Description of Data:

Individuals who receive recovery support services

Data issues/caveats that affect outcome measures:

Workforce

Priority #: 9

Priority Area: Recovery Housing

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Expand self-supporting and drug free homes through Oxford House International for individuals in recovery

Strategies to attain the goal:

Establish new recovery homes statewide

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of new recovery homes

Baseline Measurement: 143

First-year target/outcome measurement: 150

Second-year target/outcome measurement: 155

Data Source:

Monthly reports

Description of Data:

Monthly reports give details on established and newly established homes; i.e., location, number of bedrooms, numbers of individuals residing in home, etc.

Data issues/caveats that affect outcome measures:

Housing market and Outreach workforce

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-certified nursing facilities, even individuals not receiving Medicaid benefits. The screening ensures prior authorization for timely and appropriate access to medically necessary covered services, and that care is delivered in accordance with generally accepted standards of medical practice, in the most appropriate setting, and to prevent inappropriate service utilization.

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?

Please indicate areas of technical assistance needed related to this section

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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.

[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) ☐ Leadership support, including investment of human and financial resources.

   b) ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focused on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

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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?

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

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

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)

a) ☑ Data on consequences of substance-using behaviors

b) ☑ Substance-using behaviors

c) ☑ Intervening variables (including risk and protective factors)

d) ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

a) ☐ Children (under age 12)

b) ☑ Youth (ages 12-17)

c) ☑ Young adults/college age (ages 18-26)

d) ☑ Adults (ages 27-54)

e) ☑ Older adults (age 55 and above)

f) ☑ Cultural/ethnic minorities

g) ☑ Sexual/gender minorities

h) ☑ Rural communities

i) ☑ Others (please list)

Veterans

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☐ State - developed survey instrument

h) ☑ Others (please list)

Alcohol Epidemiological Data Systems (AEDS), TN Department of Safety and Homeland Security (TDSHS), Fatality Analysis Reporting System (FARS), TN bureau of Investigations, TN Crime Online Website (TBI), Tennessee Council of Juvenile and Family Court Judges (TCJFCJ), TN Department of Mental Health and Substance Abuse Services, 2016 Tennessee Behavioral Health County and Region Services Data Book, TN Bureau of Investigations Lab Data, TN Department of Health, Division of Policy, Planning, and Assessment, Hospital Discharge Data System (HDDS), Neonatal Abstinence Syndrome Surveillance Annual Report 2015, TN Department of Health, Division of Family Health and Wellness (FHW), CDC Wonder, TN Department of Health, Controlled Substance Monitoring Database.

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The Evidence-Based Practices Workgroup has operationalized the definition of Evidence Based Practice (EBP) in Tennessee

and serves as the expert panel to determine the viability of proposed interventions through a rigorous review and approval process. DSAS profiles and prioritizes population needs, resources, service gaps and readiness capacity. It provides guidance to the comprehensive strategic planning process at state and community levels, and makes data-informed recommendations to the TN-PAC (Tennessee Prevention Advisory Council).

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step?

a) If yes, please explain in the box below.

To ensure adherence to CLAS standards TDMHSAS-DSAS has integrated it into not only the assessment processes but also into daily operations by:
Making CLAS a priority - CLAS has been integrated into all aspects of TDMHSAS-DSAS operations, from planning and budgeting to service delivery and quality improvement.

Creating a CLAS culture - Though fostering a culture of respect and understanding for all Tennesseans who are in need of and receive TDMHSAS-funded services, regardless of their cultural background or language skills.

Empowering staff – By encouraging staff to work with providers to ensure that cultural and linguistic needs can be met in services delivery, and to culturally appropriate care can be provided.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step?

a) If yes, please explain in the box below.

Yes, all in addition to all TDMHSAS-funded prevention providers being required to adhere to the Strategic Prevention Framework TDMHSAS uses it as well when planning where sustainability is a basis of the framework and involved in each step of the process. First, the SPF emphasizes the importance of using data to inform decision-making and to track progress over time. This data can be used to identify areas where prevention efforts are most needed and to ensure that resources are being allocated effectively.

Second, the SPF encourages communities to develop and implement sustainable prevention plans. These plans are tailored to the specific needs of the community and based on the best available scientific evidence. While also being flexible enough to adapt to changing conditions.

Third, the SPF emphasizes the importance of building partnerships and coalitions. This helps to ensure that prevention efforts are comprehensive and that they address the root causes of substance use.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

   a) If yes, please describe.

   The Tennessee Certification Board is a statewide entity funded to strengthen the prevention workforce. This entity administers the International Certification and Reciprocity Consortium's Prevention Specialist certification program and helps ensure a high level of prevention competency among the prevention workforce. Every agency funded with prevention block grant dollars is contractually required to have at least one person on staff that has obtained the IC&RC Prevention Specialist credential.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?

   a) If yes, please describe mechanism used.

   The Tennessee Association of Alcohol and other Drug Abuse Services (TAADAS) is funded to provide training and resources to the prevention workforce. Training topics are identified through an annual survey. TAADAS uses the regional prevention advisory council meetings as a venue to conduct prevention specific trainings. These training events are conducted either before or after the regional meetings and the content of the training event is determined by the prevention providers in the region and are consistent with their organizational needs. DSAS also provides online prevention training and requires that each agency funded with block grant dollars complete two courses each year. These courses have been designed by prevention experts and address the latest in prevention research and science.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

   a) If yes, please describe mechanism used.

   The Tennessee Association of Alcohol and other Drug Abuse Services (TAADAS) is funded to provide training and resources to the prevention workforce. Training topics are identified through an annual survey. TAADAS uses the regional prevention advisory council meetings as a venue to conduct prevention specific trainings. These training events are conducted either before or after the regional meetings and the content of the training event is determined by the prevention providers in the region and are consistent with their organizational needs. DSAS also provides online prevention training and requires that each agency funded with block grant dollars complete two courses each year. These

courses have been designed by prevention experts and address the latest in prevention research and science.

The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions funded by the State. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State.

DSAS has also worked to ensure that the state prevention office is well grounded in prevention science. All state prevention staff members have participated in the Substance Abuse Prevention Skills Training and staff regularly participates in conferences to best understand the latest in prevention science. Additionally, staff works to ensure that providers have the tools they need to 1. Ensure that the locations of all permanent prescription drop boxes are communicated to coalitions; 2. Work with other State Departments to design a workable plan; and 3. Incinerate substances. The Office of Prevention Services tries to expand the capacity of coalitions and other providers by providing resources that are timely and meet identified needs. We have started offering annual face-to-face provider meetings where contract requirements are reviewed, but there is also a training component. Also, we are working with Strategic Answers and the National Guard to provide technical assistance to coalitions that best meet their needs.

Every 2 – 3 years TDMHSAS offers the CADCA National Coalition Academy (NCA) to TN substance use prevention coalitions. The NCA is a comprehensive training program developed by CADCA's National Coalition Institute and teaches leaders "what they need to know" (the core competencies) and "what their team needs to do" (the essential processes) to establish or maintain a highly effective substance use prevention coalition. The NCA is designed specifically for coalition staff and volunteer leadership. It combines three weeks of classroom training, three reinforcement on-line sessions and access to a web-based workstation. The Academy's training curriculum is organized within SAMHSA's Strategic Prevention Framework. By the end of the year-long training, in order to graduate, coalitions will have developed five essential products (1) a community assessment, (2) a logic model, (3) a strategic & action plan, (4) an evaluation plan and (5) a sustainability plan.

DSAS is also working collaboratively with the National Guard, Counter Drug Task Force; Civil Operations Unity to provide well-trained and adaptable forces capable of developing substance use prevention coalitions while implementing effective prevention practices. Their vision is to be the preferred source for Technical Assistance for coalitions across the state and for all state agencies involved with the development and training of prevention coalitions by being a force multiplier in a coalition's pursuit to drive positive environmental change in their community and continuously seeking new opportunities to develop effective grassroots coalitions in communities without a drug preventative organization.

4. Does your state integrate the National CLAS Standards into the capacity building step?

a) If yes, please explain in the box below.

Involving community members in the planning process: When planning capacity building activities, involve community members from diverse backgrounds. This helps to ensure that the activities are responsive to the needs of the community and that they are culturally appropriate.

Using a variety of training/teaching methods: By using a variety of teaching methods that include lectures, workshops, case studies, and online training.

Ensuring resources are accessible: This could involve providing translated materials, offering transportation to prevention programs, and scheduling programs at times that are convenient for working families.

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Ensuring resources are accessible: This could involve providing translated materials, offering transportation to prevention programs, and scheduling programs at times that are convenient for working families.

5. Does your state integrate sustainability into the capacity building step?

a) If yes, please explain in the box below.

To integrate sustainability into the capacity building step TDMHSAS and contracted providers identify and assess sustainability needs prior to and during program development. This could include assessing the community's access to

resources, the presence of supportive social networks, and diverse funding availability.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years?

   ○ Yes ◉ No

   If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

   ○ Yes ○ No ◉ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

   a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds

   b) ☐ Timelines

   c) ☐ Roles and responsibilities

   d) ☐ Process indicators

   e) ☐ Outcome indicators

   f) ☐ Cultural competence component (i.e., National CLAS Standards)

   g) ☐ Sustainability component

h) ☐ Other (please list):

i) ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The EBPW reviews training materials and work plan worksheets with TDMHSAS.
The State working with its Evidence-Based Practice Workgroup (EBPW) on an ongoing basis:
• Conduct research into health disparities and environmental strategies that are evidence-based for alcohol and establish correlates for impacts on other substances of abuse (e.g. prescription drugs);
• Conduct discussion groups with coalition staff regarding program implementation to ensure that work products align with evidence based practices;
• Develop fidelity models for environmental practices for a variety of substances of abuse;
• Conduct a literature review of evidence-based prevention program
• Conduct presentations for coalitions and other groups to describe research and make relevant at the practice level; and
• Develop a menu of evidence-based practices and cite relevant research.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

To be approved as an evidence-based practice (EBP), each proposed intervention must:

Be part of a comprehensive plan, documented by using the 8 Strategies for Comprehensive Change Framework;

ii. Be supported by an unambiguous theory of change that is documented in a clear logic model that reflects demonstrated community need;

iii. Fit the community's capacity, resources and readiness to act, documented by the Intervention Fit Form; and

iv. Meet at minimum one of the following three criteria. (If the intervention meets criteria 3: Documented effectiveness supported by other sources of information and the consensus judgment of informed experts, a Documented Effectiveness Worksheet must be completed).

Inclusion in Federal registries of evidence-based interventions; or

2. Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or

3. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts, as described in the following set of guidelines, all of which must be met:

Guideline 1: The intervention is demonstrated to be similar in theory of change, general principles of effective prevention, or content and structure to interventions that appear in registries, federal agency publications, and/or the peer-reviewed literature;

Guideline 2: The intervention is supported by documentation that it has been effectively implemented in the past, including at least one replication, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and

Guideline 3: The intervention is reviewed and deemed appropriate by six or more informed prevention experts that

includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and/or key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

8. Does your state integrate the National CLAS Standards into the planning step?


Yes


No

a) If yes, please explain in the box below.

CLAS standards are integrated in the strategic planning and overall ethos of TDMHSAS as spelled out in the mission and vision of the Department. When planning for new and/or already existing programming DSAS considers how they can be culturally and linguistically appropriate for all populations served and what additional training will be necessary to exceed these expectations.

b) If no, please explain in the box below.

n/a

9. Does your state integrate sustainability into the planning step?


Yes


No

a) If yes, please explain in the box below.

The State coordinates with community providers to understand what data is available and the capacity to support prevention efforts. When planning the State takes into consideration: The cost of the program or strategy; The availability of resources to implement and sustain the program or strategy; and the community's capacity to implement and sustain the program or strategy.

b) If no, please explain in the box below.

n/a

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

a) ☑ SSA staff directly implements primary prevention programs and strategies.

b) ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

c) ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

d) ☑ The SSA funds regional entities that provide training and technical assistance.

e) ☑ The SSA funds regional entities to provide prevention services.

f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.

g) ☑ The SSA funds community coalitions to provide prevention services.

h) ☑ The SSA funds individual programs that are not part of a larger community effort.

i) ☐ The SSA directly funds other state agency prevention programs.

j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars

in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

- Tennessee Prevention Network
- Redline and Clearinghouse
- Workforce Training Program
- Community Based Coalitions
- In-Home Visitation Services for At-Risk Mothers
- SUPT Evidence Based Practices Workgroup

b) Education:

- Tennessee Prevention Network
- Workforce Training Program
- Community Based Coalitions
- In-Home Visitation Services for At-Risk Mother

c) Alternatives:

- Tennessee Prevention Network
- Community Based Coalitions
- Higher Education Coalition

d) Problem Identification and Referral:

- Tennessee Prevention Network
- Redline and Clearinghouse
- In-Home Visitation Services for At-Risk Mothers
- SUPT Evidence Based Practices Workgroup

e) Community-Based Processes:

- Tennessee Prevention Network
- Community Based Coalitions
- Higher Education Coalition
- SUPT Evidence Based Practices Workgroup

f) Environmental:

- Community Based Coalitions

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

DSAS ensures that SUPTRS dollars are used to fund primary substance abuse prevention services by including language within prevention contracts that defines "primary prevention" and explicitly stating that prevention funding can only be used for primary prevention. Additionally, training is provided each year to ensure agencies understand the requirement; and agencies are monitored against their contract during regularly scheduled monitoring visits. The Tennessee Department of Mental Health and Substance Abuse Services conduct programmatic and fiscal monitoring visits on all providers at least once over a three-year period. Programmatic monitoring visits assess achievement of contract performance benchmarks through the examination of personnel and service recipient records and data management as well as evaluation of conformity with agency policies and procedures and DSAS requirements. The fiscal monitoring visit is conducted in accordance to the Tennessee Department of General Services Policy 2013-007, Subrecipient Monitoring. The objectives for the fiscal review include a test to determine if costs and services are allowable and eligible; and to verify contractual compliance. In addition, there is a special term and condition in all grant contracts prohibiting supplanting of SUPTRS funds.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

CLAS implementation is in ongoing process and is reevaluated as the needs of the population served shift. The integration has been broken down into the 3 domains of the CLAS standards.

Leadership: Contracted Providers maintain a policy and procedure manual that outlines your organization's commitment to meeting standards.
Access: All providers are required to maintain a plan that outlines how they will provide language assistance services to individuals with limited English proficiency.
Workforce: TDMHSAS provide training to all staff members on cultural competency and how to become linguistically competent.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step?

a) If yes, please describe in the box below.

By integrating sustainability into the SPF planning and implementation steps, DSAS can increase the likelihood prevention efforts will be sustained in the long term. DSAS has developed a statewide prevention system that includes representatives from local communities, nonprofits, and other stakeholders. Providers could work together to coordinate and develop implementation plans statewide. All of these projects adhere to the SPF model and go through an approval process at the state level to ensure all expectations and guidelines are being followed.

b) If no, please explain in the box below

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years?

   ○ Yes ◉ No

   If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

   a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks

   b) ☐ Includes evaluation information from sub-recipients

   c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements

   d) ☐ Establishes a process for providing timely evaluation information to stakeholders

   e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making

   f) ☐ Other (please list:)

   g) ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

   a) ☑ Numbers served

b) [x] Implementation fidelity

c) [ ] Participant satisfaction

d) [x] Number of evidence based programs/practices/policies implemented

e) [x] Attendance

f) [x] Demographic information

g) [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) [x] 30-day use of alcohol, tobacco, prescription drugs, etc

b) [x] Heavy use

c) [x] Binge use

d) [x] Perception of harm

e) [ ] Disapproval of use

f) [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) [ ] Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? (●) Yes ( ) No

a) If yes, please explain in the box below.

To integrate CLAS standards into the evaluation step by each domain DSAS:

Leadership and Workforce: DSAS surveys staff members to assess their understanding cultural and linguistic competency through program assessments.

Access: Identify types of language services that are being utilized.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

To integrate sustainability into the evaluation step DSAS collects data on sustainability:
The availability of funding

The capacity of the community to implement and sustain the programs and strategies

The level of community support for the programs and strategies

Leverages findings to inform future planning and decision-making.

b) If no, please explain in the box below.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief Intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Detox (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive Outpatient	◉ Yes	○ No
viii)	Inpatient/Residential	◉ Yes	○ No
ix)	Aftercare; Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	○ Yes	◉ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	○ Yes	◉ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling ( ) Yes (●) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare ( ) Yes (●) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance ( ) Yes (●) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Monitoring program compliance is a contractual requirement for all funded providers.

Monitoring. In accordance with Section D.16., the State shall conduct program monitoring as follows:
(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Narratve Question

Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

   a) 90 percent capacity reporting requirement — (●) Yes ( ) No

   b) 14-120 day performance requirement with provision of interim services — (●) Yes ( ) No

   c) Outreach activities — (●) Yes ( ) No

   d) Syringe services programs, if applicable — ( ) Yes (●) No

   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

   a) Electronic system with alert when 90 percent capacity is reached — ( ) Yes (●) No

   b) Automatic reminder system associated with 14-120 day performance requirement — ( ) Yes (●) No

   c) Use of peer recovery supports to maintain contact and support — (●) Yes ( ) No

   d) Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)? — (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Monitoring program compliance is a contractual requirement for all funded providers.

   Monitoring: In accordance with Section D.16., the State shall conduct program monitoring as follows:
   (1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

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Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ◉ Yes ○ No

2. Has your state identified a need for any of the following:

   a) Business agreement/MOU with primary healthcare providers ○ Yes ◉ No

   b) Cooperative agreement/MOU with public health entity for testing and treatment ◉ Yes ○ No

   c) Established co-located SUD professionals within FQHCs ○ Yes ◉ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Monitoring: In accordance with Section D.16., the State shall conduct program monitoring as follows:
(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

   b) Establishment or expansion of tele-health and social media support services ○ Yes ○ No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)?

   (●) Yes ( ) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

   (●) Yes ( ) No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program?

   ( ) Yes (●) No

   If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

   a) Workforce development efforts to expand service access — ( ) Yes (●) No

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No

   c) Establish a peer recovery support network to assist in filling the gaps — ( ) Yes (●) No

   d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ( ) Yes (●) No

   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No

   f) Explore expansion of services for:

      i) MOUD — ( ) Yes (●) No

      ii) Tele-Health — (●) Yes ( ) No

      iii) Social Media Outreach — ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ( ) Yes (●) No

2. Has your state identified a need for any of the following:

   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No

   b) Establish a program to provide trauma-informed care — (●) Yes ( ) No

   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries — Yes / No

b) An organized referral system to identify alternative providers? — Yes / No

c) A system to maintain a list of referrals made by religious organizations? — Yes / No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — Yes / No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments — Yes / No

b) Review of current levels of care to determine changes or additions — Yes / No

c) Identify workforce needs to expand service capabilities — Yes / No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — Yes / No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — Yes / No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — Yes / No

b) Training on responding to requests asking for acknowledgement of the presence of clients — Yes / No

c) Updating written procedures which regulate and control access to records — Yes / No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — Yes / No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — Yes / No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Four (4)

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan

○ Yes ● No

b) Establishment of policies and procedures related to independent peer review

○ Yes ● No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

○ Yes ● No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

○ Yes ● No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ● Yes ○ No

2. Has your state identified a need for any of the following:

   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ● No

   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ● No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

   a) Recent trends in substance use disorders in the state ● Yes ○ No

   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ● Yes ○ No

   c) Performance-based accountability: ○ Yes ● No

   d) Data collection and reporting requirements ● Yes ○ No

2. Has your state identified a need for any of the following:

   a) A comprehensive review of the current training schedule and identification of additional training needs ● Yes ○ No

   b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ● No

   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ● Yes ○ No

   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ● Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

   a) Prevention TTC? ○ Yes ● No

   b) Mental Health TTC? ○ Yes ● No

   c) Addiction TTC? ● Yes ○ No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

   a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

   a) Tuberculosis ( ) Yes (●) No

   b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

   a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

   b) Professional Development ( ) Yes (●) No

   c) Coordination of Various Activities and Services ( ) Yes (●) No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Rules of the Tennessee Department of Mental Health and Substance Abuse Services
https://publications.tnsosfiles.com/rules/0940/0940.htm

Tennessee Code Annotated Title 33, Chapter 10
http://www.lexisnexis.com/hottopics/tncode/

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

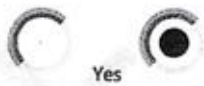
11. Quality Improvement Plan- Requested

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?



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

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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.

All DSAS funded providers are required to provide a screening and assessment for trauma and ensure that treatment meets the needs of those identified as having experienced trauma. The provider can use the AC-OK Adult Screen for trauma or another trauma screen from the SAMHSA's Evidence Based Practices Resource Center on each service recipient upon initial contact. The provider is also required to complete a brief trauma screener in TNWITS (our web-based information system) if trauma is identified during the administration of the ASI.

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

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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
- [ ] 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)
- [ ] 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
- [ ] 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)
- [ ] 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
- [ ] 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

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?

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

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

   a) [ ] Methadone

   b) [x] Buprenophine, Buprenorphine/naloxone

   c) [ ] Disulfiram

   d) [ ] Acamprosate

   e) [ ] Naltrexone (oral, IM)

   f) [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?

(●) Yes ( ) No

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

DSAS has been able to expand medication assisted treatment through state funding as well as federal discretionary grant funding to include all three forms of the FDA- approved medications - naltrexone, buprenorphine, and methadone for the indigent population. There are also plans to provide the injectable form of buprenorphine (Sublocade) through discretionary funding.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers

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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 telephone call coming into the Crisis Hotline is routed to the crisis services provider serving the area from which the telephone call originated. Services provided via statewide Crisis Hotline, as well as

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

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. 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 the TN 988 Network in efforts to improve and increase infrastructure, while allowing for ongoing data to capture and 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 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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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.

   n/a

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

   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. TDMHSAS considers recovery support to be a vital component in the pathway to recovery for individuals with substance use and co-occurring disorders. Recovery Support Services are services provided to promote individual, program, and system-level approaches that foster health and resilience, increase permanent housing, employment and other necessary supports, and reduce barriers to social inclusion. TDMHSAS provides opportunity for recovery support for adults including women and pregnant women as well as adolescents.

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

   TDMHSAS offers Recovery Activities in its array of services. Recovery activities may include cultural activities, community events, and other similar activities. Many of the recovery support providers report that the clients are very engaged in choosing these activities and see this as an effective tool in "teaching" that recovery can be fun.

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

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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);

employment); and

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

[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.

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22. Public Comment on the State Plan - Required

Narrative Question

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:

   https://www.tn.gov/behavioral-health/substance-abuse-services/blockgrant

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

   https://www.tn.gov/behavioral-health/substance-abuse-services/blockgrant

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

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

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