



Department of  
**Mental Health &  
Substance Abuse Services**

**DRAFT**

**FY 2016 - 2017**

**Substance Abuse Prevention  
and Treatment Block Grant**

**Behavioral Health Assessment  
and Plan**

## ***Strength and Needs of the Service System***

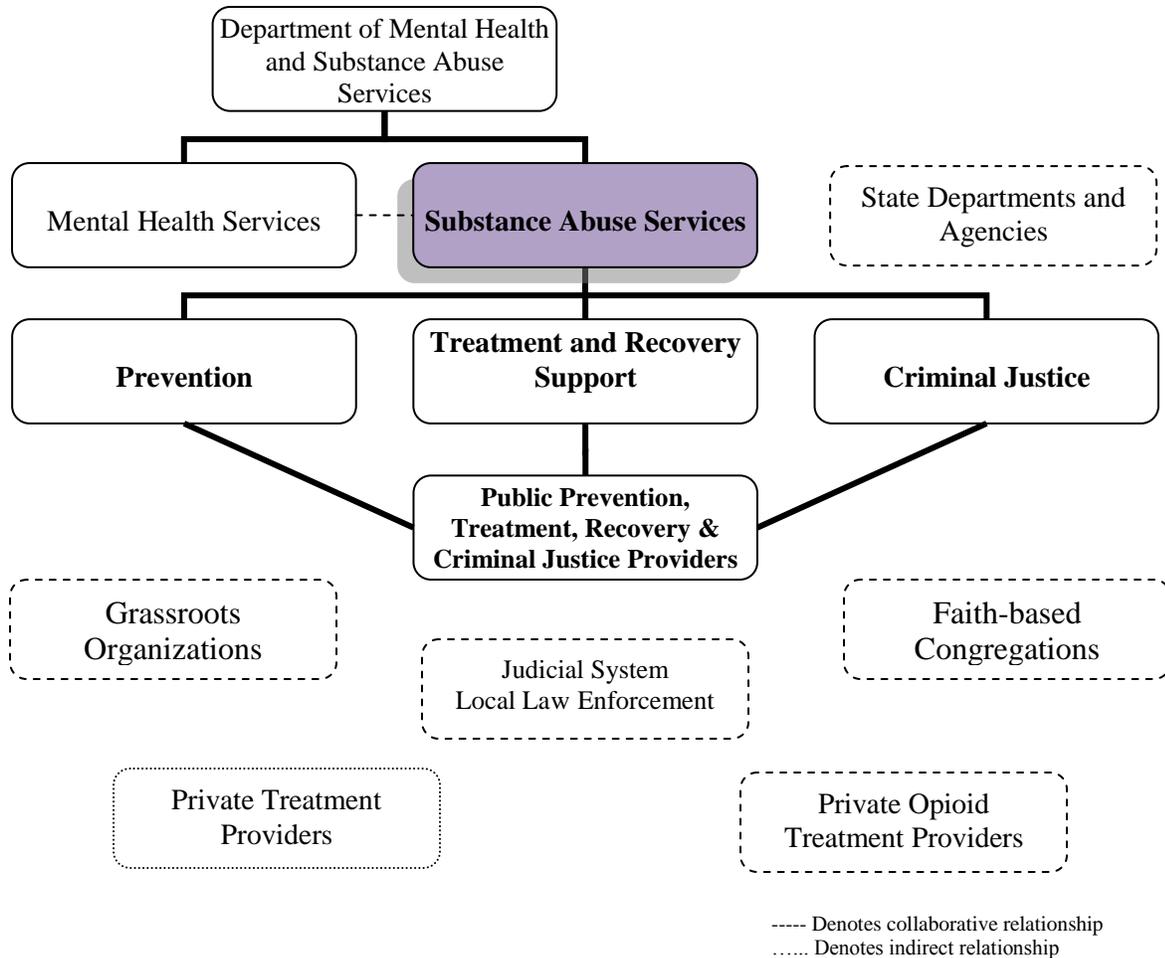
*Assess the strengths and needs of the service system to address the specific populations. Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state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

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 five fully accredited Regional Mental Health Institutes (RMHIs). TDMHSAS submitted an overview of the mental health system in the Community Mental Health Services Plan and Report. Listed below and hereafter is Tennessee's substance abuse system.

### **Tennessee's Behavioral Health Substance Abuse System**

Substance abuse 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 abuse and related problems.

## Tennessee Behavioral Health Substance Abuse System



The ***Division of Substance Abuse Services*** serves as the Single State Authority (SSA) for receiving and administering federal block grant and state funding for substance abuse services. Our mission is to improve the quality of life of Tennessee citizens by providing an integrated network of comprehensive substance use disorders services, fostering self-sufficiency and protecting those who are at risk of substance abuse, dependence and addiction. DSAS' integrated network consist of providers, state departments, state agencies, judicial courts, grassroots organizations and faith-based organizations who are collaborating to provide an effective and efficient delivery of mental health and substance abuse services to Tennesseans.

Through TDMHSAS, Office of Licensure, DSAS assisted with promulgating rules and developing policies for ***private and public substance abuse treatment agencies***. While DSAS does not fund ***Opioid Treatment Providers***, we are responsible for the oversight of Tennessee's opioid treatment programs. The State Opioid Treatment Authority is responsible for providing administrative, medical, and pharmaceutical oversight to certified opioid treatment programs, including, but not limited to planning, developing, educating, and implementing policies and procedures to ensure that opioid addiction treatment is provided at an optimal level.

According to the National Survey of Substance Abuse Treatment Services (N-SSATS), in 2013, the overall Tennessee treatment system included 221 facilities which is an increase from 2011

(208). 76% were private non-profit agencies and 21% were private for-profit agencies. DSAS purchases services directly from non-profit and for-profit providers; and have 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	168	9,070
	76%	64%
Private for-Profit	47	4,630
	21%	33%
Public	6	449
	3%	3%
<b>Total</b>	<b>221</b>	<b>14,149</b>
	100%	100%

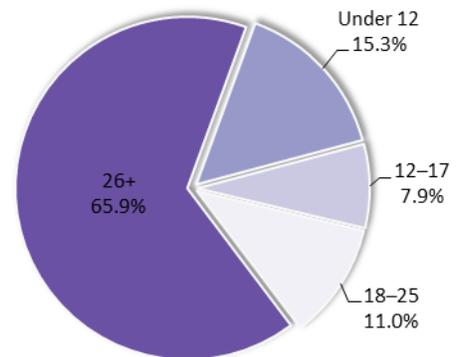
Establishing a relationship with the *Judicial System and local law enforcement agencies* has been essential to developing a structure for coordinating a system of care for non-violent offenders incarcerated or at risk of incarceration due substance use and abuse. There are thirty-one Judicial Districts in Tennessee. DSAS has joined forces with the General Sessions, Circuit, Criminal, Juvenile, Drug, Mental Health, Veteran and Family Courts, to coordinate behavioral health care for adult and juvenile offenders.

*Grassroots organizations* are the foot soldiers of the community. DSAS has brought a formal structure to existing organizations, assisted communities establish community coalitions, and provided technical assistance on how to develop strategies to help prevent substance use and abuse. The Department also works with local/county entities to deliver prevention services. Many of the entities that serve as fiscal agents for our state-funded community coalitions are county entities that are donating space and other resources to ensure that their community coalition is effective and sustained into the future.

DSAS is building 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. To be certified as a Faith-Based Congregation/Organization, there is an application process and training in the following areas: Providing Spiritual/Pastoral Support; Viewing addiction as a treatable disease, not a moral issue; Embracing and support people in recovery and walk with them on their journey; Providing a visible outreach in the community; Sharing recovery information; and Hosting recovery support groups. Individuals can also be certified as *Faith-Based Ambassadors*. They serve as a point of contact with DSAS, referral source for recovery support services, and the conduit for information sharing between the churches and organizations.

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 6,214,888 residents (CDC 2012 estimate). The population is predominantly White (80.2 percent) or African American (17.5 percent) with persons of other races comprising approximately two percent of the total resident population. Nearly one-quarter (23.2 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 its 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.<sup>1</sup>

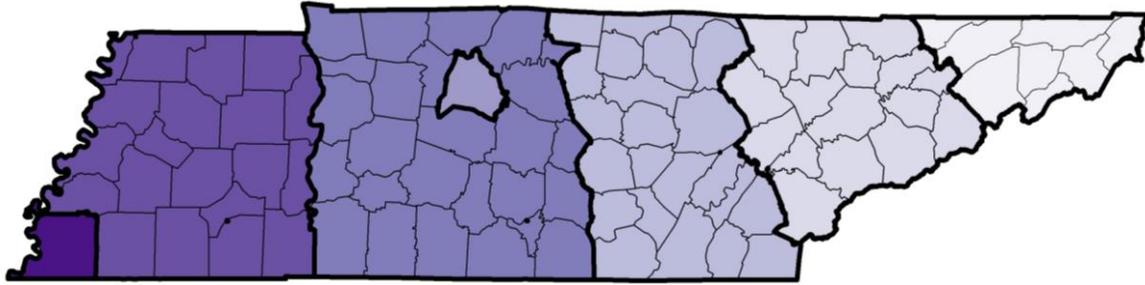
Exhibit 1.1  
2012 Tennessee Population by Age Category  
U.S. Centers for Disease Control (CDC)



Populations in Tennessee by Age Range		
Age	Population	Percent
Under Age 12	986,323	15.3%
Age 12–17	507,693	7.9%
Age 18–25	708,467	11.0%
Age 26 or Older	4,253,760	65.9%
All Ages	6,456,243	

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 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 Regions in Tennessee are displayed below.

<sup>1</sup> 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.



***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. Prevention service components include: provider agencies, prevention coalitions, and regional workgroups. Within this system, high need communities and populations are identified by a State Epidemiological and Outcomes Workgroup (SEOW) assessment. ***Provider agencies*** deliver culturally appropriate selected and indicated programs per the assessment through the Tennessee Prevention Network program. A network of county level ***coalitions*** whose work is governed by the Strategic Prevention Framework (SPF) work to reduce underage alcohol use, underage tobacco use, and prescription drug 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. ***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. All prevention providers are contractually required to take part in their respective Regional Prevention Council. The Regional Prevention Councils are responsible for leveraging and broadening the activities of community coalitions in their area. The Councils meet quarterly to discuss implementation of approved Regional Prevention Plans; and to identify and address specific prevention needs of the region.

DSAS also supports prevention programs for specific high risk populations; such as, 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. *Just Us* is 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 prevention

services programs include: School Based Mental Health and Substance Abuse Liaisons, Comprehensive Alcohol, Tobacco and other Drug Program, Synar and Partnerships for Success.

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 twenty-seven members are comprised of state agencies; statewide organizations; regional prevention providers (including coalitions); and the Director of Prevention Services. Its structure and membership intentionally reflects 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. The SEOW 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 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 that is part of each step of the process and is always a key consideration.

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 misuse and abuse issues because they are impacting the physical health of many Tennesseans. The Department of Health is very interested in the prescription drug problem and has partnered with the TDMHSAS on legislation to increase the utility of the Controlled Substance Monitoring Database. Additionally, they have partnered with coalitions to delivery key prevention messages at physician training events across the state regarding how to safely prescribe opioids. One key area where this is evident is through partnership around underage tobacco use. The Department of Health receives CDC funding for tobacco prevention and closely coordinates with the Office of Prevention Services to impact our shared goals. The Department of Health uses prevention coalitions as a delivery mechanism for tobacco prevention initiatives across the state because they have recognized that coalitions are able to reach their community members. Additionally, the Department of Health is in conversation with the Department of Mental Health about a website that would make data readily available to coalitions and other Tennesseans.

### ***Early Identification***

In FY 2012, DSAS received a Screening, Brief Intervention, and Referral to Treatment (SBIRT) Grant. SBIRT-TN's purpose is to identify individuals using substances at risky levels (individuals at high risk for, or diagnosed with, a Substance Use Disorder (SUD) [mild, moderate or severe]) and implement SBIRT services for these individuals in primary care and community health settings. SBIRT-TN is designed to expand and enhance the continuum of care for substance misuse services and reduce alcohol and drug consumption and its negative impact; increase abstinence and reduce costly health care utilization; promote sustainability and behavioral health information technology. DSAS is working with two medical residency programs and a Federally Qualified Health Center to implement SBIRT in their primary care practices. This approach to SBIRT-TN will ensure that thousands of high risk individuals in urban inner city and rural Appalachian settings will be screened for substance misuse, substance abuse and co-occurring disorders. Services are provided in an opportunistic setting tailored to the individual patient needs. In addition, by collaborating with residency programs, DSAS is ensuring that medical residents are trained in the SBIRT model, increasing the likelihood of integrated SBIRT services into their practice. DSAS is also working with the Tennessee National Guard, a population at especially high risk for alcohol misuse and abuse. Tennessee SBIRT will screen Army National Guard soldiers in a community setting, during their annual Physical Health Assessment and provide onsite needed brief interventions or when clinically appropriate, brief treatment in locations close to their home by using DSAS' established network of substance use and co-occurring treatment agencies.

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 has been recognized by SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). 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.

### ***Treatment Services***

DSAS' Treatment and Recovery structure has three 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 and recovery of persons whose use of alcohol and/or other drugs has resulted in patterns of abuse or dependence. Treatment and Recovery Services' components include: provider agencies, faith and community-based organizations, and coalitions. ***Provider agencies*** offer a full continuum of care based on the American Severity Index (ASI) screening tool and the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised (ASAM PPC-2R) 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 Co-Occurring Disorders Capable or Co-Occurring Enhanced Disorders. ***Faith and community-based organizations*** work to expand recovery support capacity and services through peer support centers, churches and recovery housing. ***Coalitions*** work to provide marketing and community linkages to promote resources. Other treatment services include: Medical Detoxification (state-funded); Medically

Monitored Withdrawal Management; Tele-Treatment Program; HIV/AIDS Early Intervention Program; Problem Gambling Outreach, Education, Referral and Treatment Program; and Opioid Treatment Program.

With the increasing Hispanic in population in Tennessee, DSAS recognizes the need for training on cultural differences in the delivery of treatment and recovery services. DSAS recently partnered with the National Hispanic and Latino Addiction Technology Transfer Center (ATTC) Network to convene a *Substance Use and Hispanic/Latinos, Implications for Work* Stakeholders Round Table discussion to gather information on how the National Hispanic and Latino ATTC can support the work of the stakeholders and strengthen workforce capacity.

### ***Recovery Support Services***

Recovery Support Services promote client engagement in the recovery process and provide services needed for support of continued recovery. DSAS launched a new initiative in 2015 that provides the framework for faith-based congregations/organizations across Tennessee to join in a recovery network. The *Faith-Based Recovery Network* is an opportunity for places of worship and fellowship to support and strengthen families in their communities by offering recovery programs to help individuals beat their addictions. DSAS is actively engaging faith communities and organizations as a means of increasing outreach, educational activities, access, and visibility to people seeking substance abuse services. Through the Faith-Based Recovery Network, a variety of faith-based organizations have been certified to be Recovery Congregations. As a Recovery Congregation, the spiritual leader pledges to integrate recovery in their message and to be a conduit for recovery services.

The *Lifeline Peer Program* work to reduce stigma related to the disease of addiction and increase the number of recovery groups meeting in the State of TN. Lifeline approaches include establishment of evidence-based addiction and recovery programs, including 12-step programs, as well as educational presentations for civic groups, faith based organizations, and community leaders to increase understanding of the disease of addiction and support for recovery strategies. *Recovery Housing* is provided in partnership with Oxford House, International. Oxford Houses are self-run, self-supporting homes for individuals in recovery from drug and alcohol addiction. Other recovery support programs are: The Addiction Recovery Program, Addictions Disorder Peer Recovery Support Centers and Peer Recovery Specialist Certification.

Treatment and recovery services are coordinated through the Tennessee Treatment and Recovery Advisory Council (TNTRAC). TNTRAC meets quarterly to provide guidance to the Division regarding programmatic (including the use of evidence-based practices), funding, and administrative decisions, as well as strategic planning. The Council is comprised of service providers and other stakeholders, as well as key Division staff. As needed, ad hoc committees are formed to address specific areas of concern/need. Each committee is co-chaired by members of TNTRAC with Division staff representation and 4 – 6 additional individuals representing provider agencies, advocates and consumers. There is an HIV, Women’s Treatment and Recovery Committee and Adolescent Committee that meet at least annually or as often as needed. These committees are comprised of representatives from provider organizations as well as the State.

### ***Criminal Justice***

Criminal Justice has become an integral part of our substance abuse 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 offenders with substance use and mental health disorders. Through the Criminal Justice Behavioral Health Liaison Program, DSAS collaborates with jail administrators, public defenders, District Attorney's, judges, and sheriffs to screen and identify an individual's most immediate clinical or recovery support needs to divert him/her from re-entry into or out of jail or prison. Other diversion programs are: Alcohol and Drug Addiction Treatment (ADAT) DUI offenders, individuals on supervised probation, at-risk probation and parole technical violators. ***Recovery courts*** address the needs of addicted non-violent offenders who meet the criteria of the recovery court program and voluntarily want to participate in the program. Other types of recovery courts are veteran courts and mental health courts.

The Criminal Justice System serves a very diverse population. Effectively communicating with offenders is essential to providing successful behavioral health care coordination. DSAS requires all criminal justice providers to develop policies and procedures that address Limited English Proficiency for offenders with language barriers. The Recovery Courts have interpreters available within the court.

The Recovery Court Advisory Committee works with TDMHSAS in reviewing program criteria, certification process and application, makes recommendations concerning implementation of programs and advises the Commissioner on the allocation of funds when funds are available. 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 in actively implemented recovery courts 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).

### ***Service Needs and Gaps within the System***

*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 *Tennessee Substance Use Disorders Prevention and Treatment Needs Assessment* process is used to facilitate and inform decisions about state priorities for policy making and resource allocation to ensure accountability and promote the achievement of intended results with respect to behavioral health problems in Tennessee. The decision process incorporates the use of criteria and data to prioritize issues and appropriate strategies for addressing behavioral health problems. To establish need, the assessment follows a more comprehensive evidence-based process that includes: a) using research-generated knowledge, i.e.; substance use prevalence, consumption patterns, and trends in local or national populations, about the epidemiology and consequences of substance use disorders to target those circumstances and behaviors that are particularly associated with consequences and social cost; b) state and county level data sources are used to document incidence, prevalence and trends in consumption patterns and use consequences in Tennessee. Data is drawn from multiple sources, such as state wide school surveys (e.g., CDC's Youth Risk Behavior Survey), crime and health indicators, and reports; and c) identifying those accessible populations that are at high risk for substance use disorders and/or have constrained access to services. A variety of data sources and existing research was used to identify and rank priority needs for substance use disorders in Tennessee. These data sources consist of the U.S. Census; Healthy People, 2010; National Center on Addiction and Substance Abuse (CASA); National Institute of Drug Abuse (NIDA); Youth Risk Behavior Surveillance System; National Survey on Drug Use and Health; Treatment Episode Data Set (TEDS); etc. Interviews and focus groups were conducted with treatment and recovery support providers and other community stakeholders to determine local gaps and needs; program development issues; and concerns and technical assistance needs. DSAS Leadership utilized the needs assessment, data generated from the Tennessee Web-based Information Technology System (TN WITS), SAMHSA's Strategic Initiatives and reports from TDMHSAS' Division of Research, Planning and Forensics. The state priorities were presented to the Statewide Planning and Policy Council for review and comment.

Development of the needs assessment was closely guided by the State Epidemiological and Outcomes Workgroup (SEOW). Tennessee's SEOW is composed of representatives from the Tennessee Departments of Mental Health and Substance Abuse Services (TDMHSAS), Education, Health, Correction, Children's Services, and Safety and Homeland Security; Governor's Highway Safety Office; TennCare; Tennessee Bureau of Investigation; East Tennessee State University; Oasis Center; Allies for Substance Abuse Prevention of Anderson County, Inc.; and the University of Tennessee School of Social Work. The SEOW profiled and prioritized population need, resources, service gaps and readiness capacity. They provided guidance to the comprehensive strategic planning process at the state and community levels; and made data-informed recommendations. A list of recommended priorities was provided to the Tennessee Prevention Advisory Council for consideration. The priorities are listed below in Exhibit 2.1 in the Column entitled "Prevention Service Needs" by Age Cohort.

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 vulnerable 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. To support a service system that helps apportion services according to need, data and findings are organized according to seven age cohorts (see Exhibit 2.1). Utilizing this approach associates the indicator data with consequences, prevalence in Tennessee and the presence of vulnerable populations at high risk for developing substance use disorders in the cohort.

**Exhibit 2.1.** Lifelong Indicators and Targets of Substance Use Disorder Needs for Tennessee: Behaviors and Vulnerable Populations

Age Cohort	Priority Cohort Problem Indicators	Relevant Target Populations	Prevention Service Needs	Treatment Service Needs
Neo-natal to 5 years		<ul style="list-style-type: none"> <li>Female substance abusers</li> <li>Families experiencing Domestic Violence</li> <li>Families experiencing substance related Health Problems</li> <li>Families in low service rural areas</li> </ul>	<ul style="list-style-type: none"> <li>Family programs,</li> <li>Community awareness and system improvements</li> </ul>	<ul style="list-style-type: none"> <li>Female treatment access and orientation</li> <li>Anger management</li> <li>Domestic violence interventions</li> </ul>
6 to 10 years	<ul style="list-style-type: none"> <li>Early initiation</li> </ul>	<ul style="list-style-type: none"> <li>Female substance abusers</li> <li>Families experiencing Domestic Violence</li> <li>Families experiencing substance related Health Problems</li> <li>Families in low service rural areas,</li> <li>Youth with low school performance/ truancy</li> <li>Homeless families</li> </ul>	<ul style="list-style-type: none"> <li>Family programs</li> <li>Community awareness and system improvements</li> <li>Age appropriate selective prevention (e.g., mentoring)</li> </ul>	<ul style="list-style-type: none"> <li>Female treatment access and orientation</li> <li>Anger management</li> <li>Domestic violence interventions</li> <li>School outreach programs</li> </ul>
11 to 13 years	<ul style="list-style-type: none"> <li>Early initiation</li> <li>Inhalant use</li> <li>Mental health disorders</li> </ul>	<ul style="list-style-type: none"> <li>Youth with low school performance/ truancy</li> <li>Youth in Foster Care System</li> </ul>	<ul style="list-style-type: none"> <li>Community programs for youth development</li> <li>Age appropriate selective and indicated prevention</li> <li>Family programs</li> </ul>	<ul style="list-style-type: none"> <li>Counseling services</li> <li>Mental health counseling</li> <li>Family counseling</li> </ul>
14 to 17	<ul style="list-style-type: none"> <li>Binge drinking</li> <li>Prescription drug use</li> <li>Mental health disorders</li> <li>High risk illicit drug use</li> </ul>	<ul style="list-style-type: none"> <li>Youth in Juvenile Justice System</li> <li>High School Dropouts</li> </ul>	<ul style="list-style-type: none"> <li>Selective and indicated programs</li> <li>Brief interventions</li> <li>Community awareness and systems improvement</li> <li>Age appropriate indicated prevention</li> <li>Age appropriate environmental policies</li> </ul>	<ul style="list-style-type: none"> <li>Adolescent treatment</li> <li>Recovery support services</li> <li>Recovery high schools</li> </ul>
18 to 25 years	<ul style="list-style-type: none"> <li>Binge drinking</li> <li>Methamphetamine use</li> <li>Prescription drug use</li> <li>DUI</li> <li>Substance abuse and dependence</li> </ul>	<ul style="list-style-type: none"> <li>Transition-aged Youth</li> <li>Victims of Trauma</li> <li>Veterans</li> <li>Smokers</li> </ul>	<ul style="list-style-type: none"> <li>Environmental policies</li> <li>College focused programs</li> </ul>	<ul style="list-style-type: none"> <li>Young adult oriented treatment and outreach</li> <li>Comprehensive treatment and recovery support services</li> <li>Collegiate recovery communities</li> </ul>
26 to 55 years	<ul style="list-style-type: none"> <li>Substance Abuse and Dependence</li> </ul>	<ul style="list-style-type: none"> <li>Military families</li> <li>Victims of Trauma</li> </ul>	<ul style="list-style-type: none"> <li>Environmental policies</li> </ul>	<ul style="list-style-type: none"> <li>Culturally responsive treatment, Outreach, Co-occurring disorders</li> </ul>

	<ul style="list-style-type: none"> <li>• DUI</li> <li>• Prescription drug use</li> </ul>	<ul style="list-style-type: none"> <li>• Female substance abusers</li> <li>• Minority populations</li> <li>• Veterans</li> <li>• Smokers</li> <li>• Rural populations</li> <li>• Persons experiencing physical health conditions</li> </ul>		programs
<b>Over 55 years</b>	<ul style="list-style-type: none"> <li>• Substance abuse and dependence</li> <li>• Prescription drug use</li> </ul>	<ul style="list-style-type: none"> <li>• Military families</li> <li>• Victims of Traumas</li> <li>• Female substance abusers</li> <li>• Minority populations</li> <li>• Veterans</li> <li>• Smokers</li> <li>• Persons experiencing physical health conditions</li> </ul>	<ul style="list-style-type: none"> <li>• Environmental policies</li> </ul>	<ul style="list-style-type: none"> <li>• Culturally responsive treatment, Outreach, Co-occurring disorders programs</li> </ul>

Tennessee added vulnerable populations to the needs assessment because the identification of populations with high risk for specific disorders and/or challenges in accessing services provides a practical and credible approach to effectively targeting outreach for treatment and prevention services.

DSAS leadership analyzed data from the needs assessment, TN WITS and the SEOW in conjunction with SAMHSA’s Strategic Initiatives to prioritize which vulnerable populations will be addressed. In SFY 2016 and SFY 2017, the following vulnerable populations were ranked as the top priorities:

- Female Substance Abuse—Neonatal Abstinence Syndrome
- Adult Criminal Justice Offenders
- Individuals with a Diagnosis of Opioid Use Disorder
- Individuals with a Diagnosis of Heroin Use Disorder

***Female Substance Abuse—Neonatal Abstinence Syndrome***

Tennessee has been one of the states hardest hit by the Neonatal Abstinence Syndrome (NAS) epidemic. Between 1999 and 2011, there has been an eleven percent increase in the NAS hospitalization rate.<sup>2</sup> Since 2012, the Neonatal Abstinence Syndrome Subcabinet Working Group which includes the Departments of Mental Health and Substance Abuse Services, Health, Human Services and Children’s Services; and the Division of Health Care Finance and Administration (TennCare); have been meeting to develop meaningful solutions to address this crisis. One of the solutions was to make NAS a reportable condition. As of January 1, 2013, providers who diagnose NAS are required to report to the Department of Health through an online portal within 30 days of diagnosis. Since NAS reporting began, there have been over 2,000 reports of NAS cases made to the surveillance portal.<sup>3</sup> More infants were diagnosed with NAS in 2014 (1,018) than in 2013 (936), but the case rate, relative to the number of births, did not change significantly. As of August 2015, the number of cases reported is in line with this

<sup>2</sup> Neonatal Abstinence Syndrome Subcabinet Work Group , The Tip of the Iceberg: Understanding and Preventing NAS in Tennessee, Tennessee Department of Health, August 2015.

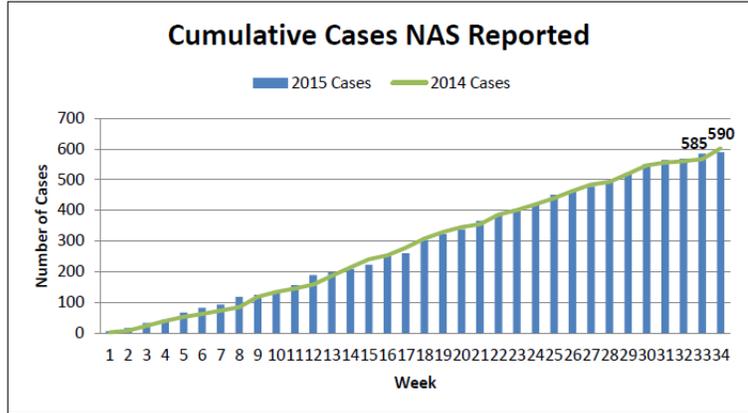
<sup>3</sup> Miller AM and Warren MD (2014). Neonatal Abstinence Syndrome Surveillance Annual Report 2014. Tennessee Department of Health, Nashville, TN.

# Drug Dependent Newborns (Neonatal Abstinence Syndrome) Surveillance Summary For the Week of August 23 – August 29, 2015<sup>1</sup>

## Reporting Summary (Year-to-date)

Cases Reported: 590  
Male: 318  
Female: 272  
Unique Hospitals Reporting: 45

Maternal County of Residence (By Health Department Region)	# Cases	% Cases <sup>2</sup>
Davidson	35	5.9
East	135	22.9
Hamilton	15	2.5
Jackson/Madison	0	0
Knox	73	12.4
Mid-Cumberland	59	10.0
North East	84	14.2
Shelby	20	3.4
South Central	28	4.8
South East	13	2.2
Sullivan	51	8.6
Upper Cumberland	61	10.3
West	16	2.7
<b>Total</b>	<b>590</b>	<b>99.9</b>



Source of Maternal Substance (if known) <sup>2</sup>	# Cases <sup>3</sup>	% Cases
Supervised replacement therapy	359	60.9
Supervised pain therapy	64	10.9
Therapy for psychiatric or neurological condition	45	7.6
Prescription substance obtained WITHOUT a prescription	202	34.2
Non-prescription substance	135	22.9
No known exposure but clinical signs consistent with NAS	4	0.7
No response	11	1.9

1. Summary reports are archived weekly at: <http://tn.gov/health/article/nas-summary-archive>  
 2. Total percentage may not equal 100.0% due to rounding.  
 3. Multiple maternal substances may be reported; therefore the total number of cases in this table may not match the total number of cases reported.

same point in time last year. It is also important to note that Tennessee began tracking NAS cases born in Tennessee to residents of neighboring states. Since July 1, 2014, fifty-seven out-of-state cases of NAS have been reported. Forty percent of these cases were born out of state and transferred to a Tennessee hospital to receive advanced care.<sup>4</sup>

The financial impact of NAS births has been costly for Tennessee. TennCare, Tennessee’s Medicaid agency, determined that the average cost of care for a NAS infant in the first year of life is more than 13 times higher than the average cost of care for normal birth weight infants and approximately 64% higher than the average cost of care for low birth weight infants. NAS babies are also 2.7 times more likely than non-NAS Medicaid babies to be low birth weight, with close to 25% born weighing less than 2,500 grams.<sup>5</sup>

<sup>4</sup> Miller AM and Warren MD (2014). Neonatal Abstinence Syndrome Surveillance Annual Report 2014. Tennessee Department of Health, Nashville, TN.

<sup>5</sup> Division of Health Care Finance and Administration, TennCare, Neonatal Abstinence Syndrome Among TennCare Enrollees Provisional 2012 Data, Last updated 22 October 2013.

### Impact of NAS on Infant Health Care Expenditures, CY 2012\*

Metric	NAS Infants
Number of Births	736
Cost for Infant in First Year of Life	\$45,870,410
Average Cost per Child	\$62,324
Average Length of Stay (days)**	26.2

\* Includes all expenditures paid through 9/1/2013. Totals are subject to change based on updated data.

\*\*Length of stay was based on infants initial hospital visit following birth.

TennCare also determined that 179 of the 736 infants diagnosed with NAS in CY 2012 (24.3%) were placed in Department of Children’s Services custody within one year of their birth, a 9% increase from CY 2011. Among all TennCare infants born in CY 2012, 1.6% was placed in DCS custody within one year of birth. Infants born with NAS are 14.8 times more likely to be in DCS custody during their first year of life as compared with other TennCare infants.

### Percentage of Newborns in Department of Children's Services (DCS) Custody Within One Year of Birth, CY 2012

Metric	All Infants	NAS Infants
Total # of Infants	54,984	736
Total # infants in DCS	906	179
% in DCS	1.60%	24.30%

DSAS’ membership on the NAS Subcabinet Working Group has been instrumental in educating members on best practice guidelines for prevention and treatment and developing strategies to address the NAS problems in Tennessee. The Working Group has recognized that there is a need for increased funding for substance abuse treatment programs. According to the statistics, East Tennessee, particularly Knox County, continues to have the highest number of NAS births. Over the last couple of years, DSAS management has worked with one of its state-funded agency’s in Knox County to start a NAS program at the East Tennessee Children’s Hospital, which is the primary treatment hospital for infants born with NAS in the East Tennessee region. The program, entitled *Silver Linings*, has successfully started. It is an intensive outpatient program (IOP) for women who have infants diagnosed with NAS or pregnant women who are at risk of having infants born with NAS. The *Silver Linings* program addresses mental health challenges and trauma; helps the women maintain sobriety; and enhances parenting skills needed to care for their infants upon release from the NICU. In FY 2016 and 2017, DSAS intends to

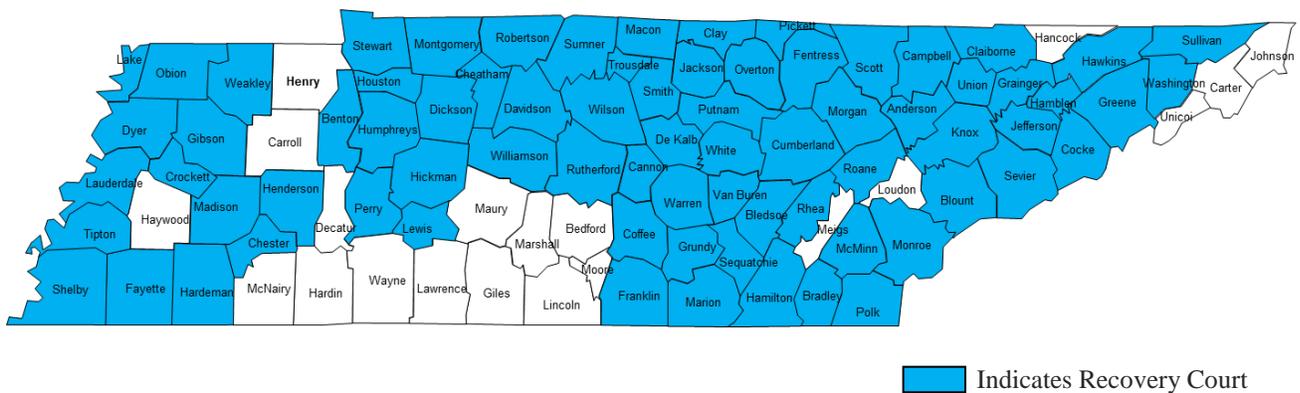
fund the *Silver Linings* program. In addition, DSAS intends to designate Women with Dependent Children and NAS a priority population. Women up to three months post-partum will be given priority admission to state-funded substance abuse treatment agencies. This designation will give the woman an opportunity to be in treatment while the baby is hospitalized; subsequently, the mother and baby will return to a sober environment, thus avoiding the baby entering State custody.

**Adult Criminal Justice Offenders**

Diverting offenders in need of substance abuse treatment from prison has been a core belief of DSAS for over sixteen years. In 2012, transferring the management and oversight of Drug Courts (hereafter referred to as Recovery Courts) to DSAS by the Governor was a natural fit. In three years, the Recovery Courts have grown from thirty-two adult and four juvenile courts to thirty-nine adult, three juvenile, three veterans, one family and two residential recovery courts. Buy-in to the Recovery Court concept was not an easy sale for some individuals. But after numerous testimonials, graduation ceremonies, newspaper articles and TV news stories; Legislators, law enforcement agencies, the general public and most importantly, offenders, now believe that there is hope through Recovery Courts.

Establishing a relationship with the Department of Correction, Judicial System, and local law enforcement agencies have been essential to developing a structure for coordinating a system of care for non-violent offenders incarcerated or at risk of incarceration due to substance use and abuse. Tennessee has thirty-one Judicial Districts. In many of these districts, DSAS partners with the General Sessions, Circuit, Criminal, Juvenile, Mental Health, Veteran and Family Courts, to coordinate behavioral health care for adult and juvenile offenders. Some counties have limited access to treatment and recovery services for individuals incarcerated; and use Recovery Courts as a resource for individuals who would like to receive treatment as opposed to incarceration. One of DSAS’ goals is for every county in Tennessee to have access to a Recovery Court.

**DSAS Funded Recovery Courts**

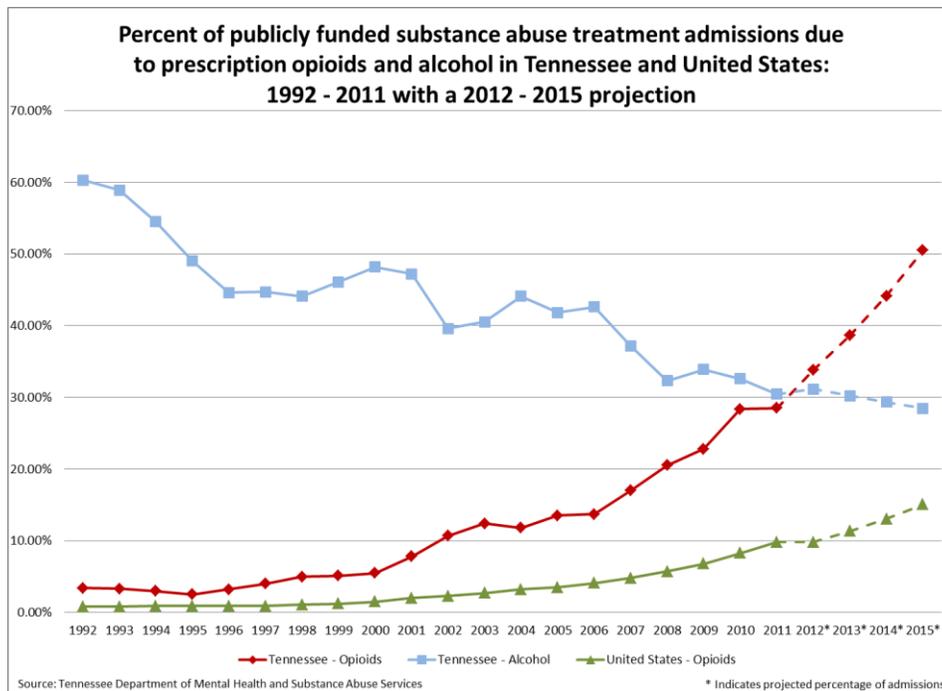


As indicated in the map above, there are twenty out of ninety-five counties in Tennessee that do not have access to a Recovery Court.

In SFY 2014, there were 2,345 Recovery Court admissions and in SFY 2015, there were 3,910 admissions, which is a 67% increase in admissions. For SFY 2016, DSAS intends to develop strategies to open nine new courts (primarily Circuit Courts) and two Veteran Courts. This will give access to a Recovery Court in all ninety-five counties. In SFY 2017, DSAS will implement the plan.

***Individuals with a Diagnosis of Opioid Use Disorder***

The abuse of prescription opioids has been identified as one of the most serious and costly public health issues facing Tennesseans and other Americans today. Of the 4.85 million adults in Tennessee it is estimated that 230,000 or almost 5% have used pain relievers in the past year for non-medical purposes. Of those adults, it is estimated that 75,000 are addicted to prescription opioids and require treatment for prescription opioid abuse. The other 155,000 are abusing prescription opioids using risky behaviors and would benefit from early intervention services.<sup>6</sup> The abuse of prescription drugs, specifically opioids, is resulting in increases in: overdose deaths; emergency department visits; hospital costs; newborns with Neonatal Abstinence Syndrome; children in State custody; and persons incarcerated for drug related crimes.



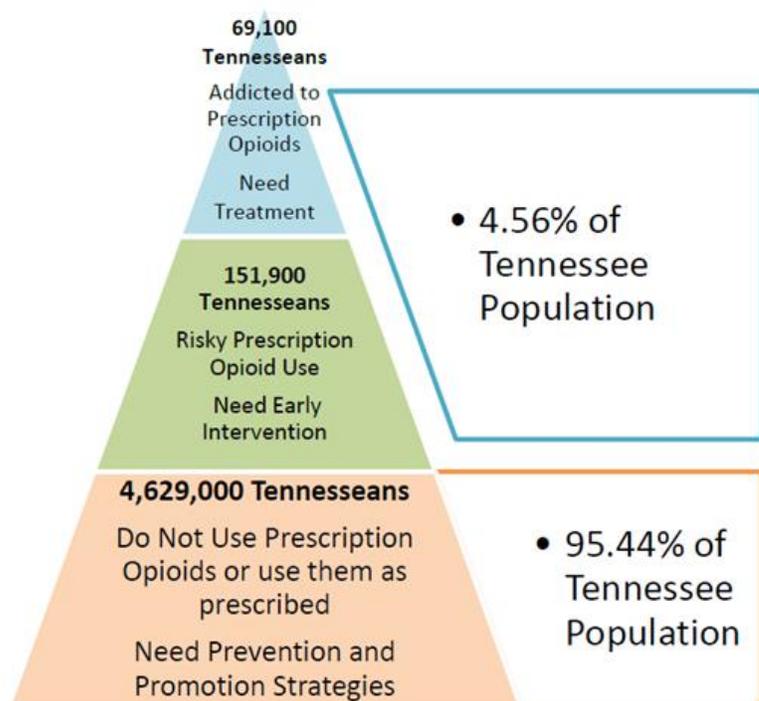
Over the past ten years we have seen a drastic shift in the primary substance of abuse for Tennesseans receiving publicly funded treatment services. For many years, alcohol was the primary substance of abuse and our prevention and treatment efforts focused on that population. However, in 2012, prescription opioids surpassed alcohol as the primary substance of abuse for

<sup>6</sup> SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data – Revised March 2012).

persons whose treatment was funded through the Department of Mental Health and Substance Abuse Services. According to 2010 data that compared persons in state funded treatment programs across the United States, Tennesseans were 3.5 times more likely to identify prescription opioids as their primary substance of abuse than the national average.<sup>7</sup>

In 2014, TDMHSAS published a strategic plan, *“Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee”*, in collaboration with other State agencies impacted by the prescription drug epidemic—Departments of Health, Children’s Services, Safety and Homeland Security, and Correction; Bureau of TennCare; Tennessee Bureau of Investigation; and the Tennessee Branch of the United States Department of Justice, Drug Enforcement Administration.

“Prescription for Success” is comprehensive and multi-year plan with three components: description of the prescription drug problem in Tennessee; information about how the problem is being addressed; and a plan for the future that includes specific, measurable goals that will help us to determine if the lives of individuals and families in Tennessee have been improved as a result of these Prescription for Success efforts. Most of the general public will be best served by prevention strategies that aim to reduce the risk of becoming addicted to prescription drugs. Some people who are at increased risk will benefit from early intervention efforts that include screening and brief interventions.



People who need treatment will benefit from access to effective treatment options and recovery supports after they complete treatment. The goals of *Prescription for Success* are:

- Decrease the number of Tennesseans that abuse controlled substances.
- Decrease the number of Tennesseans who overdose on controlled substances.
- Decrease the amount of controlled substances dispensed in Tennessee.
- Increase access to drug disposal outlets in Tennessee.
- Increase access and quality of early intervention, treatment and recovery services.
- Expand collaborations and coordination among state agencies.
- Expand collaboration and coordination with other states.

<sup>7</sup>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data – Revised March 2012).

DSAS applied for and received its second Partnership for Success Grant in 2014. The grant's primary focus is to reduce the non-medical use of prescription drugs among persons ages 12 to 25 in Tennessee. The grant is working with ten counties in East Tennessee where the prescription drug problem is elevated. The grant's implementation plan states that each county coalition will work toward disseminating information about the prescription drug problem in their local community in order to increase understanding of the problem; and take part in *Count It, Lock It, Drop It*, a public awareness campaign to fight prescription drug abuse among young people. This campaign includes important policy and practice changes. In addition to distributing free lock boxes and disposal guides, doctors and pharmacists now discuss the importance of tracking, locking up, and disposing of medications with their clients. Furthermore, the coalitions are conducting medical education forums to train doctors on safe prescribing habits as well as discussing the need to check the Controlled Substance Monitoring Database before prescribing opioids to their patients.

In FY 2016 and 2017, DSAS intends to continue implementing the initiatives outlined in *Prescription for Success* including increasing the number of persons screened through SBIRT, increasing the number of persons enrolled in Recovery Courts, increasing the capacity of the Oxford Houses, and connecting additional individuals to recovery services through programs; such as, the Addiction Recovery Program, Lifeline and Faith-based Recovery Network.

#### ***Individuals with a Diagnosis of Heroin Use Disorder***

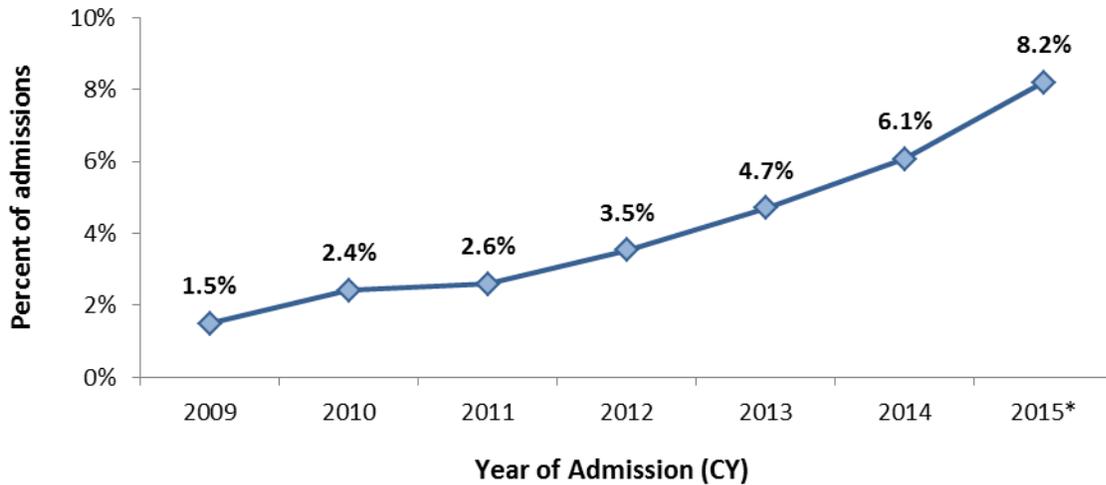
According to the National Survey on Drug Use and Health (NSDUH), in 2012 about 669,000 Americans reported using heroin in the past year,<sup>8</sup> a number that has been on the rise since 2007. This trend appears to be driven largely by young adults aged 18–25 among whom there have been the greatest increases. The number of people using heroin for the first time is unacceptably high, with 156,000 people starting heroin use in 2012, nearly double the number of people in 2006 (90,000).<sup>9</sup> Tennessee is seeing a similar increase in the number of individuals reporting heroin use as a substance of abuse in state-funded treatment agencies.

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<sup>8</sup> Substance Abuse and Mental Health Services Administration. *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

<sup>9</sup> National Institute on Drug Abuse, Research Report: Heroin, Revised November 2014, <http://www.drugabuse.gov/publications/research-reports/heroin/letter-director>.

**Figure 1. Percent of total admissions to TDMHSAS substance abuse treatment when heroin is named as a substance of abuse: Tennessee CY 2009-2015**



Note: 2015 data based on admissions between January and June.  
 Data sources: TEDS-A, SAMHSA (2009-2011); TN-WITS, TDMHSAS (2012-2015)

The number of admissions has increased from 152 (1.5%) in 2009 to a projected 1,094 (8.2%) in 2015; representing a 620% increase in the number of admissions over a six year period. There has been an assumption that the increase in heroin use is a direct result of Tennessee’s work to decrease prescription drug abuse. Effective January 1, 2013, Tennessee passed a law that required “Any pharmacy, or licensed healthcare practitioner, who has a DEA number and dispenses controlled substances in (or into) Tennessee must report to the Controlled Substance Monitoring Database every seven (7) days for each controlled substance they have dispensed over the last seven (7) days.”<sup>10</sup> Beginning on January 1, 2016, dispensers must report daily. As a result of enhancing the reporting requirements, Tennessee is beginning to see progress toward reducing the amount of Morphine Milligram Equivalents (MMEs) prescribed. Comparing the number of MMEs prescribed in 2013 versus 2014, there has been a four percent decrease in the number of MMEs prescribed.<sup>11</sup> While Tennessee is very pleased with the drop in MME’s, there is concern that heroin use is on the rise.

The Commissioner of TDMHSAS has commissioned a Heroin Stakeholder Workgroup consisting of the Governor’s Office, Cabinet members from the Departments of Health and Safety and Homeland Security; Director of the Tennessee Bureau of Investigations; United States Department of Justice, Drug Enforcement Administration; trade associations and treatment and recovery support providers. The purpose of the workgroup is to address the increasing use of heroin in Tennessee. It is understood that an indepartmental, community and Governor’s Office is needed to effectively address this pending epidemic. This was confirmed

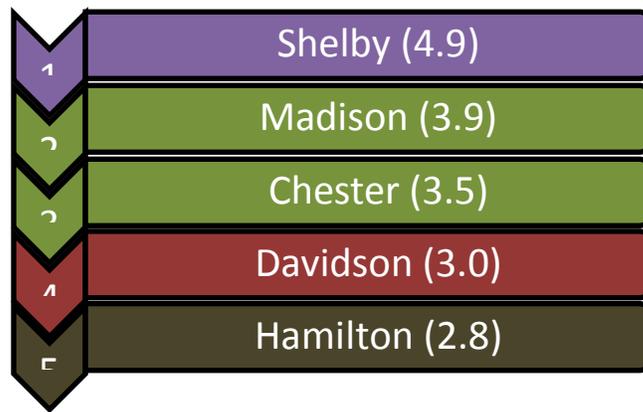
<sup>10</sup> Tennessee Prescription Safety Act of 2012, Tennessee Public Acts, Chapter 880, Tennessee General Assembly, May 2013.

<sup>11</sup> Control Substance Monitoring Database, Tennessee Department of Health, 2015.

by a recent visit by Director Michael Botticelli, ONDCP, who stated that there are “three components of addressing the heroin problem: Leadership, Coordination and Collaboration.”

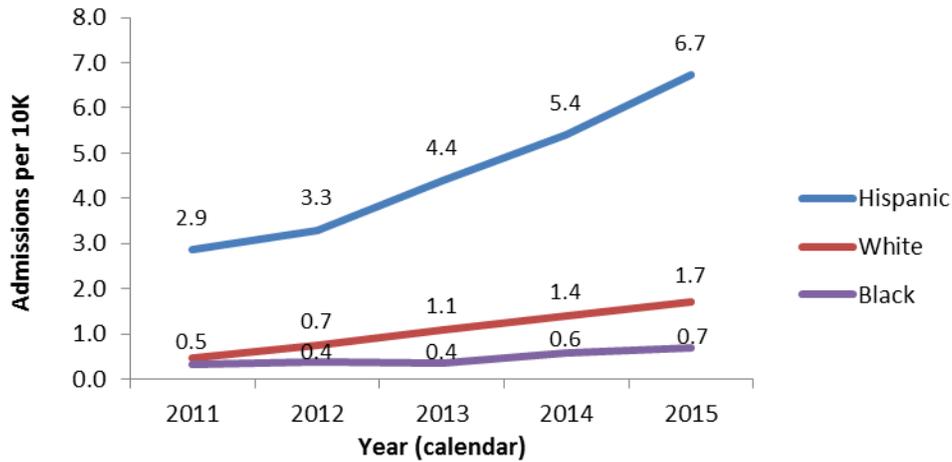
One of the first goals of the group is to best understand the heroin problem by taking a comprehensive look at the data. The Commissioner has asked the SEOW to serve as the data committee. Preliminary reports of TN WITS data indicates that the highest heroin admission rates per capita are likely to be in and around metropolitan areas. Shelby County (Memphis) has the highest rate. Also, Shelby County (Memphis) per capita rates of admissions for Hispanics are higher than for both whites and blacks combined.

**Top 6 rates per county: Heroin TDMHSAS admissions per 10K: TN 2014/2015\***



Notes: \*2015 rates estimated of Jan-Jun, 2015; rates computed per 10K of the population of those 12 years and older.  
Source: TN-WITS 2011-2015

**Heroin TDMHSAS treatment admission rates (per 10K)  
by race/ethnicity: TN 2011-2015\***



Notes: \*2015 rates estimated of Jan-Jun, 2015; rates computed per 10K of the population of those 12 years and older.  
Source: TN-WITS 2011-2015

The SEOW will complete a multi-agency assessment of the heroin problem which will be evaluated by the Heroin Stakeholder Workgroup. This data assessment will inform the workgroup in developing strategies to address this increasing problem. In FY 2016 and 2017, TDMHSAS intends to implement the strategies developed by the Heroin Stakeholder Workgroup.

As a result of the preliminary data, DSAS joined the The Gulf Coast High Intensity Drug Trafficking Area (GC HIDTA), which is an organization that identify, quantify, and prioritize the nature, extent, and scope of the threat of illegal drugs and its impact on the GC HIDTA region. The region encompasses a four-state area which include the states of Alabama, Arkansas, Louisiana and Mississippi as well as Shelby County, Tennessee. Annually, a Drug Threat Assessment is conducted and includes the drug situation in each state’s designated HIDTA counties/parishes. The 2016 GC HIDTA Drug Threat Assessment focuses on six major drug categories: cocaine, methamphetamine, diverted pharmaceuticals, heroin, other dangerous drugs, and marijuana.

***Prioritize State Planning Activities***

*States should identify specific priorities that will be included in the MHBG and SABG. The priorities must include the core federal goals and aims of the MH/SA Block Grant programs: target populations (those that are required in legislation and regulation for each block grant) and other priority populations described in this document. States should list the priorities for the*

*plan in Plan Table 1 and indicate the priority type (i.e., substance abuse prevention (SAP), substance abuse treatment (SAT), or mental health services (MHS)).*

### ***Develop Goals, Objectives, Performance Indicators and Strategies***

*For each of the priorities identified, states should identify the relevant goals, measureable objectives, at least one-performance indicator for each objective, for the next two years. For each objective, the state should describe the specific strategy that will be used to achieve the objective. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, improving emotional health and prevention of mental illness, and system improvements that will address the objective.*

**Priority 1: Prevent substance use and abuse specifically underage drinking, the sale of tobacco products to minors and prescription drug misuse and abuse using culturally responsive strategies**

**Priority**

**Type:** Substance Abuse Prevention (SAP)

**Population:** PP (Primary Substance Abuse Prevention)

**Goal 1.1: Decrease young adult nonmedical use of pain relievers (age 18-25).**

**Strategy:** Community anti-drug coalitions will address underage drinking, the illegal sale of tobacco products to minors and prescription drug abuse in their community and develop comprehensive community plans to address these issues. The community plans will have the following SPF components: 1. Assessment of Need; 2. Capacity Assessment; 3. Planning Process; 4. Implementation Plan and 5. Evaluation Plan.

**Indicator:** Reduction in the percentage of young adults, ages 18-25, who report using pain relievers for a nonmedical use in the past year.

**Baseline**

**Measurement:** 9.5% (2011-2012 rate in TN)

**1<sup>st</sup> yr target/**

**Outcome:** 9%

**2<sup>nd</sup> yr target/**

**Outcome:** 8.5%

**Data Source:** National Survey on Drug Use and Health

**Description**

**of Data:** The National Survey on Drug Use and Health measures the prevalence of drug and alcohol use among household members ages 12 and older, and is administered annually by the Substance Abuse and Mental Health Services Administration (SAMHSA).

**Data issues/  
caveats that**

**affect outcome:** Although the survey is conducted annually, there is a delay in publishing the data.

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**Priority 2: Ensure intravenous drug users and pregnant women are receiving treatment services**

**Priority**

**Type:** Substance Abuse Treatment (SAT)

**Population:** IVDUs

**Goal 2.1:** All contracted providers will provide treatment services to intravenous drug users.

**Strategy:** Contracted agencies will provide treatment services to intravenous drug users and will be monitored for compliance through DSAS' contract monitoring process.

**Indicator:** Percentage of individuals who disclosed that they were an intravenous drug user.

**Baseline**

**Measurement:** 30% (FY 15)

**1<sup>st</sup> yr target/**

**Outcome:** 32%

**2<sup>nd</sup> yr target/**

**Outcome:** 34%

**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description**

**Of Data:** Clients who, during the intake process, responded "yes" to Injection Drug User.

**Data issues/  
caveats that**

**affect outcome:** Potential budget reductions and route of administration

---

**Priority**

**Type:** SAT

**Population:** Pregnant Women with Dependent Children (PWWDC)

**Goal 2.2:** **Require admission preference to women up to three months post-partum who has delivered a baby that is drug dependent or diagnosed with FASD.**

**Strategy:** **Disseminate information to all treatment providers who serve women.**

**Indicator:** Number of messages delivered and organizations contacted

**Baseline**

**Measurement:** Establish baseline in 2016

**1<sup>st</sup> yr target/**

**Outcome:** Notify all state funded treatment providers, state departments, public health departments, FQHCs, MCOs

**2<sup>nd</sup> yr target/**

**Outcome:** Add priority admission requirement to all state funded treatment providers contract

**Data Source:** Written communication and contractual agreements

**Description**

**of Data:** Electronic mail, letters, memorandums, grant contract and delegated authority

**Data issues/**

**caveats that**

**affect outcome:** There are not any issues that will affect outcome measures.

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**Priority 3: Providing comprehensive gender responsive treatment and recovery services for pregnant women and women with dependent children**

**Priority**

**Type:** SAT

**Population:** PWWDC

**Goal 3.1:** **Increase the retention rate for pregnant women and women with dependent children in treatment and recovery support services**

**Strategy:** Request technical assistance from SAMHSA utilizing the on-line tracker.

**Indicator:** None

**Baseline**

**Measurement:** None

**1<sup>st</sup> yr target/**

**Outcome:** Receive technical assistance

**2<sup>nd</sup> yr target/**

**Outcome:** Implement strategies received from technical assistance, as appropriate.

**Data Source:** SAMHSA Block Grant Technical Assistance

**Description**

**Of Data:** SAMHSA provides technical assistance, as requested, to support States with block grant activities and goals.

**Data issues/  
caveats that**

**affect outcome:** Technical assistance can't be provided and/or barriers to implementation

---

**Priority 4: Address needs of individuals with or at risk of contracting HIV or Tuberculosis (TB)**

**Priority**

**Type:** SAT

**Population:** Intravenous Drug Users (IVDUs)

**Goal 4.1: Evaluate the DSAS funded HIV/EIS services in Tennessee to determine the effectiveness of the program**

**Strategy:** Use a standardized pre- and post- test to determine if HIV/EIS services are effective.

**Indicator:** Number of consumers who are enrolled in treatment and completed the pre- and post-test.

**Baseline**

**Measurement:** 84%

**1<sup>st</sup> yr target/**

**Outcome:** 86%

**2<sup>nd</sup> yr target/  
Outcome:** 88%

**Data Source:** Pre- and Post HIV/EIS/TB/HCV test

**Description**

**Of Data:** The Pre- and Post-HIV/EIS/TB/HCV test is a client’s personal risk assessment administered before and after HIV testing. It is used as a teaching tool, correct misinformation and identifies personal risks and coping strategies.

**Data issues/  
caveats that**

**Affect outcome:** There are not any issues that will affect outcome measures

---

**Priority**

**Type:** SAT

**Population:** TB

**Goal 4.2:** Increase block grant treatment provider’s knowledge about the risk factors, symptoms and testing methods for Tuberculosis (TB).

**Strategy:** Use a standardized pre- and post- test to determine if TB training is effective.

**Indicator:** Number of consumers who are enrolled in treatment and completed the pre- and post-test.

**Baseline**

**Measurement:** 67%

**1<sup>st</sup> yr target/  
Outcome:** 69%

**Outcome:** 69%

**2<sup>nd</sup> yr target/  
Outcome:** 71%

**Outcome:** 71%

**Data Source:** Pre- and Post TB test

**Description**

**Of Data:** The Pre- and Post-HIV/EIS/TB/HCV test is a client’s personal risk assessment administered before and after HIV testing. It is used as a teaching tool, correct misinformation and identifies personal risks and coping strategies.

**Data issues/  
caveats that**

**affect outcome:** There are not any issues that will affect outcome measures

---

**Priority 5: Provide substance abuse and co-occurring treatment services that are culturally responsive to individuals involved in or at risk of involvement in the criminal justice system**

**Priority**

**Type:** SAT

**Population:** Other – Criminal Justice

**Goal 5.1: Provide diversion opportunities for individuals in the criminal justice system with a substance use or co-occurring disorder.**

**Strategy:** Make available programs that serve individuals who have been convicted of a non-violent crime and have a substance use or co-occurring disorder.

**Indicator:** Number of individuals receiving diversion services

**Baseline**

**Measurement:** 8,713 offenders

**1<sup>st</sup> yr target/**

**Outcome:** 8,800 offenders

**2<sup>nd</sup> yr target/**

**Outcome:** 8,887 offenders

**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description**

**Of Data:** Offenders who have a group enrollment in the Alcohol and Drug Addiction Treatment Program, Supervised Probation Offender Treatment Program, Community Treatment Collaborative, Recovery Courts, and Criminal Justice Liaison Program

**Data issues/  
caveats that**

**Affect outcome:** Potential budget reductions

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**Priority**

**Type:** SAT

**Population:** Other – Criminal Justice

**Goal 5.2** Ensure quality services are delivered through the recovery court system.

**Strategy:** Certify new and recertify existing recovery courts utilizing the National Drug Court Ten Key Components

**Indicator:** Number of drug courts certified and recertified

**Baseline**

**Measurement:** 10 certifications

**1<sup>st</sup> yr target/**

**Outcome:** 12 certifications

**2<sup>nd</sup> yr target/**

**Outcome:** 15 certifications

**Data Source:** Certification documents and site visit

**Description**

**Of Data:** A team of peers review the application, policies and procedures and participant handbook. Staff observes team staffing of court session.

**Data issues/**

**caveats that**

**affect outcome:** Funding request may impact new certifications

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**Priority 6: Enhance professional growth of the substance abuse prevention, treatment and recovery support workforce.**

**Priority**

**Type:** SAP

**Population:** Other – Prevention, Treatment and Recovery Support Workforce

**Goal 6.1:** Increase the knowledge of evidence-based programs and strategies for the prevention, treatment, and recovery support workforce.

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

**Indicator:** Increase the number of persons receiving training.

**Baseline**

**Measurement:** 1,400 persons

**1<sup>st</sup> yr target/**

**Outcome:** 1,500 persons

**2<sup>nd</sup> yr target/**

**Outcome:** 1,600 persons

**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:** Potential budget reductions

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## **Priority 7: Provide culturally responsive opportunities for individuals to access recovery support services**

**Priority**

**Type:** SAT

**Population:** Other – Persons in need of recovery support services

### **Goal 7.1: Supplement treatment service with recovery support services**

**Strategy:** Provide an array of recovery support services for adult and adolescent consumers to supplement their treatment and to increase their chances of long term sobriety. These services may include case management, transportation, transitional housing, recovery support groups, spiritual/pastoral support, relapse prevention, etc.

**Indicator:** Number of consumers currently enrolled in both treatment and recovery services.

### **Baseline**

**Measurement:** 2,683 consumers

**1<sup>st</sup> yr target/**

**Outcome:** Increase baseline by 2% for a total of 2,736 consumers

**2<sup>nd</sup> yr target/**

**Outcome:** Increase baseline by 5% for a total of 2,763 consumers

**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description**

**Of Data:** Consumers who have a group enrollment in the Addictions Recovery Program, Adolescent Services, Women Services, and Criminal Justice Liaison Program

**Data issues/  
caveats that**

**Affect outcome:** Potential budget reductions.

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**Goal 7.2: Expand access to recovery support services through the faith community**

**Priority**

**Type:** SAT

**Population:** Other – persons in need of recovery support services

**Strategy:** Certify recovery congregation/community organizations on the Tennessee Faith-based Community Initiatives

**Indicator:** Number of faith-based congregations/organizations certified

**Baseline:** 21 congregations/organizations

**1<sup>st</sup> yr target/**

**Outcome:** Increase by 49 for a total of 70 congregations/organizations

**2<sup>nd</sup> yr target/**

**Outcome:** Increase by 30 for a total of 100 congregations/organizations

**Data Source:** Faith-based Network Certification documents

**Description**

**Of Data:** Best Practices for faith-based recovery support

**Data issues/  
caveats that**

**Affect outcome:** There are not any issues that will affect outcome measures

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**Priority 8: Address the needs of individuals who have experienced trauma**

**Priority**

**Type:** SAT

**Population:** Other: Individuals who have experienced trauma

**Goal 8.1:** Treatment agencies will provide assurance that individuals who have experienced trauma are receiving trauma informed care services

**Strategy:** Individuals who have disclosed experience with trauma

**Indicator:** Number of individuals who have been screened for trauma.

**Baseline**

**Measurement:** 4,000

**1<sup>st</sup> yr target/**

**Outcome:** Increase baseline by 3% for a total of 4,120

**2<sup>nd</sup> yr target/**

**Outcome:** Increase baseline by 5% for a total of 4,200

**Data Source:** Tennessee Web-based Information Technology System (TN-WITS)

**Description**

**Of Data:** Individuals who, during the intake process, responded “yes” to Violence or Trauma

**Data issues/  
caveats that**

**Affect outcome:** Potential budget reductions.

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**Priority 9: Provide recovery housing for individuals in recovery from drug and alcohol addiction**

**Priority**

**Type:** SAT

**Population:** Other: Individuals in recovery who need housing

**Goal 9.1:** Expand self-supporting and drug free homes through Oxford House International for individuals in recovery

**Strategy:** Establish new recovery houses statewide.

**Indicator:** Number of new recovery houses

**Baseline**

**Measurement:** 27 houses

**1<sup>st</sup> yr target/**

**Outcome:** Increase by 9 for a total of 36 new recovery houses

**2<sup>nd</sup> yr target/**

**Outcome:** Increase by 9 for a total of 45 new recovery houses

**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:** Potential budget reductions.

***Quality and Data Collection Readiness***

*SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.*

The Tennessee Web-based Information Technology System (TN-WITS) utilizes the Web-based Information Technology System (WITS) application platform which is a multi-tier architecture that optimizes performance and flexibility by separating data, business logic, and user interfaces. The platform is customized for use in Tennessee to support different functionalities, screens, business logic, and business process flows as needed in support of the Tennessee’s substance abuse prevention, treatment, recovery support and criminal justice programs. The WITS application platform contains modules to address:

- Prevention Services
- Prevention Coalition Services
- Treatment and Recovery Services
- Statewide Client Waitlist
- HIV Early Intervention Services Data Collection and Reporting
- Criminal Justice Behavioral Health Liaisons
- Consent and Referral
- Problem Solving Court
- Client Management

- Provider Management Functions (Electronic Health Record)
- Provider Billing
- Contract Management
- Grants Management (GPRA)

When a client is enrolled into TN WITS, a unique client identifier is created consisting of first initials of the first, middle and last names, date of birth and the social security number. Depending on the module, client data can consist of demographics, drug and alcohol use, crime and criminal justice status, HIV status, prevention curriculums – evidence based practice, goals and objectives, wait list, Addiction Severity Index Assessment (ASI), American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) scores, service episode details, level of care at admission, level of care at discharge and service encounters. Tennessee is currently reporting client level outcome data via TN WITS to SAMHSA. Other levels of data collected and **can be reported** are:

- Provider data— includes profiles of the provider, facility and staff. Also, through contract management, DSAS has the flexibility and control in regards to treatment services offered by providers, funding amounts, claims adjudication and burn rate management.
- Program data— included, but not limited to, number of clients served, length of stay, average cost per client, prevention curriculum, group sessions, transitional housing, recovery skills, etc.
- Insurance data—capture on all treatment, recovery support and criminal justice clients
- Encounter data— released for payment by providers.

### ***The Health Care System and Integration***

*SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. 37 Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.*

Over the last four years, the Screening, Brief Intervention and Referral to Treatment (SBIRT) grant have allowed the Division of Substance Abuse Services (DSAS) to coordinate care in Tennessee’s substance abuse system. At-risk individuals are those who consume alcohol or other substances in ways that could lead to dependency and interfere with healthy lifestyles. Often, patients are not conscious of substance use behaviors leading to disruptive and unhealthy

conditions such as addictions, physiological and mental disorders, and negatively impacted family and communal relationships. Through SBIRT-TN, individuals using substances at risky levels are identified and SBIRT services are implemented for these individuals in primary care and community health settings. DSAS is working with two medical residency programs and a Federally Qualified Health Center to implement SBIRT in their primary care practices. This approach to SBIRT-TN will ensure that thousands of high risk individuals in urban inner city and rural Appalachian settings will be screened for substance misuse, substance abuse and co-occurring disorders. Services will be provided in an opportunistic setting tailored to the individual patient needs. In addition, by collaborating with residency programs, DSAS is ensuring that medical residents are trained in the SBIRT model, increasing the likelihood of integrated SBIRT services into their practice. DSAS is also working with the Tennessee National Guard, a population at especially high risk for alcohol misuse and abuse. Army National Guard soldiers are screened in a community setting, during their annual Physical Health Assessment and provided onsite brief interventions or when clinically appropriate, brief treatment in locations close to their home by using DSAS' established network of substance use and co-occurring treatment agencies.

In 2014, DSAS implemented the SBIRT Champion's Program. The "Champions Program" is designed to engage doctor's to act as SBIRT ambassadors and advocates within their professional sphere of influence. The Champions screen for substance misuse in their practices using the SBIRT model; and educate medical students, residents, and doctors about early intervention related to substance over-use. As experienced physicians who are respected by their peers, they share information about SBIRT best practices with colleagues across the state. The goal of the Champions program is to increase the number of Tennessee physicians, practices and clinics that offer Screening, Brief Intervention and Referral to Treatment to patients. In 2016, TDMHSAS will hire a board certified addictionologist to fulfill this role.

SBIRT-TN has also given DSAS an opportunity to enhance other State Departments knowledge about substance abuse disorders and the importance of early intervention. The Department of Children's Services Juvenile Justice, Foster Care and Child Protective Services Assessment employees have been trained on the SBIRT model. Also SBIRT Train the Trainer was provided for Case Workers and Supervisors. This coordination of care will potentially impact hundreds or thousands of individuals. To learn more about SBIRT-TN, visit [www.sbirttn.org](http://www.sbirttn.org).

DSAS screens all clients for tobacco use through either the Tennessee Web-based Information Technology System or prevention assessment tool. At a recent Treatment and Recovery Advisory Council Meeting, providers were asked about their smoking policy. A vast majority indicated that they allow smoking only in designated areas. They expressed that they would like to have a No Smoking Policy, but know from "past experience" that clients will leave treatment if enacted. Some providers indicated that they do address nicotine dependence with the client. If the client requests assistance, it becomes part of their treatment plan and the agency makes the appropriate referral. Some of the referral sources are: tobacco cessation classes, peer centers, primary care physicians and Quit Helplines.

## ***Health Disparities***

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

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern.<sup>12</sup> DSAS continues to work on identifying and enhancing services to populations who are vulnerable to disparities. 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, preferred language and sexual orientation; therefore, giving us an overall picture as to who is participating in prevention programs; and seeking treatment and recovery support services in our substance abuse system. Also, through the Trauma Screener, individuals who have experienced violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences will be assessed and receive a treatment plan that includes trauma specific services and referral for other community support services.

DSAS' needs assessment identifies its vulnerable populations and management utilizes it to guide the decision making process for the delivery of services. For many years, through block grant funding, DSAS has offered a prevention program for deaf and hard of hearing youth. The Deaf and Hard of Hearing Prevention Services Program serve the selective population of deaf and hard of hearing youth ages 6-20 and their families. This program focuses on: In-school alcohol tobacco and other drug information via the evidence based program *All Stars* and *PATHS*, in-home American Sign Language classes, after-school programs, summer camps, and exposure to post-secondary education and career options. The program is offered year-round and is available to all deaf and hard of hearing students in Metro Davidson County schools. It serves an average of 47 deaf and hard of hearing youth and 30 family members annually, and offers services five days a week with direct contact ranging from an average of 24 hours per week during the school year and to 35 hours a week during the two month summer camp.

Individuals engaged with the criminal justice system are at risk for poor health outcomes. Research shows that a vast number of individuals who enter the criminal justice system have mental health and substance abuse issues. Through its diversion programs, DSAS is addressing the behavior health needs of offenders in Tennessee's criminal justice system. The *Alcohol and*

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<sup>12</sup> U.S. Department of Health and Human Services Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

*Drug Addiction Treatment* program and the *Supervised Probation Offender Treatment Program* provides alcohol and drug treatment services statewide to indigent DUI offenders and other non-violent offenders who are committing crimes because of their substance abuse addiction. The *Criminal Justice Behavioral Health Liaisons* project examines issues (e.g. referral to behavioral health treatment and recovery support services, stabilized housing, medication assistance, etc.) affecting adults with serious mental illness and/or substance abuse issues who are involved in the criminal justice system and assists in helping the offender move from incarceration to the community and assists in helping the offender move from incarceration to the community. *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. The *Community Treatment Collaborative* program diverts at risk probation and parole technical violators with substance abuse and co-occurring disorders from returning to state prison. This program requires a collaborative treatment approach which engages service recipient, provider, Tennessee Department of Correction staff and other supports. *Recovery Courts* will not only serve individuals with substance abuse needs, but will combine the drug courts with Mental Health and Veteran's Courts. Services offered include but are not limited to: detoxification, screening, assessment, education, counseling, social reintegration, employment, housing, and other aftercare and recovery activities. There is also a residential statewide drug court and family court.

Through the SAPT Block, DSAS is supporting a program that focuses on LGBT youth in the Middle Tennessee area. *Just Us* is program that is open to all young people who identify as LGBT; and is committed to provide 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 for themselves; and to empower them with the tools to safely navigate the world that is uniquely theirs. *Just Us* offers cultural competency training classes for school based professionals, social workers, counselors, mental health professionals, and community based professionals who work with young people. Projects that *Just Us* has actively worked on are:

- A directory of open and affirming faith communities made available to LGBT youth who need someone to talk with about reconciling their spirituality with their sexuality. They are very active in the community.
- Providing a linkage between the faith community with Department of Children's Services (DCS) to provide more open and affirming resource families into the foster care system so that LGBT youth can be placed in supportive and non-judgmental homes.
- Community initiatives which support prevention efforts to end the spread of HIV.
- Improve the quality of healthcare provided to LGBT youth.

### ***Use of Evidence in Purchasing Decisions***

*SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In*

*addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.*

The Division of Substance Services (DSAS) has integrated into its' programs clinical expertise, scientific evidence and individual values to provide high quality services for individuals with substance use disorders. Evidence-based interventions are contractually required for all DSAS agencies, regardless of funding source. Vendors must prove through documentation that they are meeting the following evidence based requirements:

- Inclusion in Federal registries of evidence-based interventions;
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
- 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:
- The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
- The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
- The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.

Annually, agencies must submit a program plan that describes the evidence based program/ intervention that they will be implementing as well as information about how they will assure fidelity to the evidence based model. Technical Assistance and training are offered when required by an agency.

DSAS programmatic staff is responsible for assisting providers with evidence-based programming. Also, through the Independent Peer Review process, reviewers look at the fidelity of the prevention or treatment programs to determine if the evidence-based intervention is working. Peer Reviewers examine the effectiveness of the intervention and provide technical assistance if needed.

While DSAS does not have funding available to assist agencies in assessing emerging or promising practices, we have been fortunate to have agencies receive the CAPT Service to Science awards to assist them in evaluating their practices to determine if they are emerging or promising.

### ***Program Integrity***

*States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately*

*directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.*

Program integrity is an integral part of DSAS' operations. Program Specialists dedicate up to 40% of their work time providing technical assistance and ensuring that providers comply with program guidelines and scope of services outlined in their contract or vendor agreement. Through contractual agreement, all federal and state requirements, deliverables, terms and conditions are communicated to the providers. All providers are required to display the Fraud, Waste & Abuse Hotline phone number and Title VI posters in an area that is visible to the public.

DSAS' efforts to ensure all funds are expended efficiently and effectively are conducted through extensive program and fiscal compliance reviews. 98% of all prevention, treatment, recovery and criminal justice programs are required to enter their client data in the Tennessee Web-based Information Technology System (TN WITS). Staff has the capability of retrieving a treatment, recovery, or criminal justice client encounter or reviewing a prevention programmatic service. 93% of the programs are Fee for Service and adjudicate payment through TN WITS. The system will only allow for payment of approved services. For agencies that receive payment through Cost Reimbursement invoice, a line item budget is required and expenditures are reviewed and approved. During the fiscal compliance review, accountants examine the general ledger, time sheets, receipts, etc. to ensure funds are expended accurately. DSAS management review expenditure reports monthly to determine under/over utilization of services and spending patterns. For those agencies who have received \$750,000 or more in state/federal funds, Tennessee requires a 3<sup>rd</sup> party audit within 9 months after the end of the contract period. These audits are compared against department records for accuracy and to determine if the agency is facing fiscal problems which can often indicate a program problem.

An essential component of the program compliance review is the Corrective Action Plan. Providers are offered training and technical assistance to help with program requirements. If a Corrective Action Plan is needed and after it has been approved, staff conducts a follow-up visit to offer additional technical assistance and training and to make certain that the provider is still in compliance with program requirements. TDMHSAS Office of Licensure conduct visits on life safety standards for all licensed providers. DSAS' Program Development Director is notified when treatment agencies have any deficiencies and receives the corrective action plan. For the non-licensed programs, program specialists check life safety standards during the program compliance review.

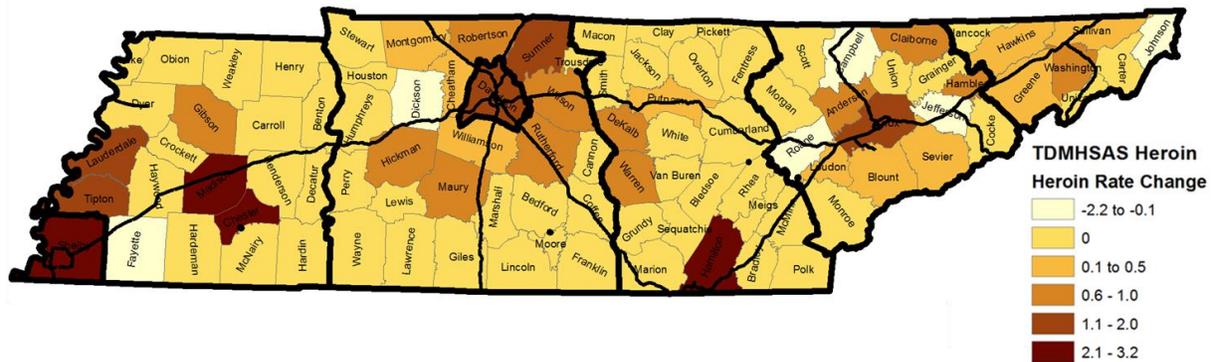
DSAS uses two payment methodologies to reimburse providers for the delivery of services. The State of Tennessee's Cost Reimbursement Grant and Delegated Authority. The Cost Reimbursement Grant is limited to reimbursement for actual, reasonable, and necessary costs as determined by the State and in accordance with an approved grant budget. The Delegated Authority gives DSAS approval to purchase services for an individual program, within specified limits, guidelines and reimbursement schedule. A written authorization to vendor is used to make purchases with a Delegated Authority. Providers who receive block grant and state funds for block grant designated programs are contractually required to use those funds as a “payment of last resort”. Providers are required to enter into TN WITS the payor source for each client.

### ***Primary Prevention for Substance Abuse***

*Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG 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 abuse.*

Through the Tennessee Web-based Information Technology System (TN WITS), DSAS has collected a vast amount of data on individuals receiving state-funded substance abuse prevention, treatment, recovery support and criminal justice services. This data, along with other state and national resources, has been utilized by Tennessee’s State Epidemiological and Outcomes Workgroup (SEOW) to inform the Governor, Cabinet members, Legislators, and general public about Tennessee’s substance use and abuse disorders. Tennessee’s SEOW resides in TDMHSAS’ Office of Research and Evaluation, which enables the work of the SEOW to be incorporated into the larger work of the Department. The SEOW uses a variety of different types of data to get the most complete picture of the substance abuse patterns in Tennessee. Consequence data is used including substance abuse treatment data, information from the Tennessee Bureau of Investigation about drug seizures, information from the Tennessee Redline, a free information and referral line that are available 24 hours a day to assist Tennesseans who need substance abuse treatment services. The treatment data comes from TN WITS as well as TEDS and informs us about the primary substances of abuse as well as demographic characteristics of individuals that are using certain substances. For instance, we can use the treatment data to determine characteristics about the age, race, ethnicity, and place of residence (i.e. urban or rural) of individuals in the publicly funded treatment system. This data is very useful and has informed us about the nature of both the prescription drug problem; i.e., largely a problem in the Eastern part of Tennessee and now the heroin problem, which seems to be concentrated in Metropolitan areas and rapidly moving out from those areas.

## Change in Heroin TDMHSAS Admissions by County: from 2011/12 to 2014/15



Notes: Rates and change in rates are only shown for counties where the number of admissions of one or both of the time periods (2011/2012, 2014/2015) are greater than 5.  
 \*2015 rates estimated of Jan-Jun, 2015; rates computed per 10K of the population of those 12 years and older.  
 Source: TN-WITS 2011-2015

The demographic data also illustrates what specific factors seem to protect against using specific substances; i.e., African Americans in urban areas are less likely to use prescription drugs. Additionally, we are using risk factor data including information from Tennessee’s Controlled Substance Monitoring Database (CSMD), as well as Medicare prescribing information to better understand the prescription drug problem in our state. The CSMD and the Medicare prescribing information have been keyed to better understanding how prescription opioids are accessed in our State. Again, this data can be mapped and shows where problematic prescribing patterns are evident and where prevention efforts should be targeted. The SEOW also uses incidence information including the NSDUH and the YRBS to best understand the nature of the substance abuse problem in Tennessee. Both of these sources of information are helpful because they track trends over time and help us better understand both where the problems are located as well as if our prevention efforts are successful.

Data on consumption patterns, consequences of use, and risk and protective factors are reviewed to formulate a prevention strategic plan that clearly articulates which substances should be targeted and incorporates this information into contracts with coalitions and other grantees. In addition, the State requires each funded agency and coalition to review the data available at the local level and conduct the Strategic Prevention Framework (SPF). The five step SPF process guides the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The effectiveness of the SPF begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process. Each step contains key milestones and products that are essential to the validity of the process. The SPF focuses on systems development, and a public health or community-based approach to delivering effective prevention. The assessment portion of the SPF reveals the levels of substance abuse and related problems, the available resources to support prevention efforts, and the community’s readiness to address identified prevention problems or needs. During an assessment coalitions collect consequence and consumption data to understand the nature, extent, and impact of identified problems at the local level to uncover the factors that drive them and to identify appropriate solutions. During this stage, coalitions identify the “intervening variables” or the specific community problems strongly related to mitigating or supporting substance use behaviors and substance related consequences as well as

the “local contributing factors” or the local causes of the identified problems. The coalition’s set priorities based on an assessment of the data and several key factors including magnitude (the number of people impacted by the problem), changeability (how easily a problem can be changed), impact (depth of the problem across a variety of dimensions such as health economic or criminal), and concentration (how concentrated the population is in a specific population). Once communities have selected their prevention priorities, they also need to assess the factors driving the priority problems through an assessment of risk and protective factors. During the capacity building phase, coalitions work to improve awareness of substance abuse problems and readiness of stakeholders to address these problems while strengthening the existing partnerships and/or identifying new opportunities for collaboration and improving organizational resources. Next, during the planning phase risk and protective factors are prioritized, a community level logic model is created, and a comprehensive, logical, and a data driven plan for addressing identified resource and readiness gaps is developed. After a considerable amount of planning work, coalitions begin to implement. Special attention is paid to fidelity in this stage. During implementation there is constant evaluation of current work and always an eye toward sustainability.

In FY 2016 and 2017, DSAS intends to collect prevention outcome data through two methods—program providers (i.e. TPN) and coalitions. Each program is contractually required to have a goal that they reduce (or maintain abstinence of/from) substance use among program participants. This goal is based upon the substance abuse problem that was identified during their needs assessment and each goal is specific to the contracted agency. Agencies report on their progress toward meeting the goals quarterly and annually. In addition, DSAS collects data on the Tennessee Prevention Network funded programs using a pre- and post- test methodology. The following areas are measured as part of the evaluation: Substance Use including prevalence and attitudes, peer use, norms of approval, and perceptions of risk; Family Connectedness; School Connectedness; Self-Reflection; Self-Efficacy; Alcohol Refusal Skills; Drug Refusal Skills; Decision Making; Self Esteem; Self- Control; and Communication. Agencies will receive regular reports of the evaluation data and technical assistance will be given to agencies that are not making progress in each area. Additionally, aggregate information from all agencies will inform the State about whether prevention programs are effective in increasing protective factors and decreasing risk factors. DSAS will use the information to make future funding decisions.

Coalition outcomes are measured by their long term (3 to 5 year) impact on past 30-day substance use and/or consequences rates as set forth in their approved comprehensive strategic plan. Short term outcome measures (1 to 3 years) impact intervening variable measures as set forth in the coalition’s strategic plan. Coalitions and programs are asked to use each of the five steps of the SPF in order to ensure that the programs/strategies they are using are responsive to the needs in their community. Community coalitions use the SPF as the model for writing their comprehensive strategic plans, which include an Assessment of Need; a Capacity Assessment; a Planning Process; an Implementation Plan; and an Evaluation Plan. Additionally, programs use the SPF to guide their program planning and implementation process.

Process and outcome measure information is used to guide training and technical assistance for agencies and coalitions as well as make future funding decisions. DSAS intends to collect the following types of process data for prevention programs: number served, demographic

information about those served (i.e. age, race, ethnicity, gender, county of residence), reason for referral (i.e. which of the identified selective or indicated populations do they belong), number of sessions offered, number of sessions attended, length of session and content of sessions. In addition, the following process information will be collected for coalitions: demographic information (i.e. age, race, ethnicity, gender, county of residence), targeted substance, type of intervention (i.e. media, enforcement, etc), and number of times interventions are conducted.

### ***Needs Assessment***

Tennessee's process for identifying primary prevention service needs is based on two intertwined and mutually supportive approaches. The first of these is a *Statewide Assessment of Substance Use Disorders Prevention and Treatment Needs* to identify and prioritize those populations most at risk. The second is a statewide strategic planning process that uses the Strategic Prevention Framework as its model. This process includes a comprehensive assessment of state data to define and illuminate substance use issues and the state's capacity to deliver the primary prevention services most effective for eliminating or delaying their impact. Fundamental to this process is identification of available resources as well as places where resources are lacking. This assessment process provides opportunities for changes in policies and practices and is the basis for the creation of a logic model. The logic model demonstrates the relationship among the consequences of substance use and the related risk and protective factors. The logic model then guides the development of strategies that include: programs, policies, procedures and a mechanism for evaluating the effectiveness of the chosen strategies. The State has found this approach to be extremely valuable for focusing available resource on delivery of the most appropriate prevention program/strategy to the most vulnerable populations.

Tennessee was awarded the Strategic Prevention Enhancement Grant and through that grant was able to complete a multi-agency strategic prevention plan. The plan was developed collaboratively among the following state departments: Tennessee Departments of Education, Children's Services, Health, and Mental Health and Substance Abuse Services Divisions of Substance Abuse Services and Mental Health Services; Governor's Highway Safety Office, Alcoholic Beverage Commission, and the Tennessee Primary Care Association. The assessment phase of the grant included extensive research and understanding about the specific prevention strategies being funded through each department. Efforts were made to collaborate on projects when there were shared goals and not duplicate efforts. Discussions continue among different departments to best understand how we can provide maximum impact for the State. For instance, we are currently in conversations with the Department of Health about how to help coalition's access data more readily through an online resource that the Department of Health is developing.

### ***Workforce Development***

In FY 2016 and 2017, Tennessee intends to establish and fund three statewide entities whose purpose is to strengthen the capacity of the prevention system and the workforce. First, 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. Another statewide entity funded to strengthen the prevention workforce is the Tennessee Certification Board. This entity administers the International Certification and Reciprocity Consortium’s Prevention Specialist certification program in Tennessee 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. The Tennessee Association of Alcohol and other Drug Abuse Services (TAADAS) is also funded to provide training and resources to the prevention workforce. Training topics are identified through an annual survey. TAADAS has begun using 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.

Tennessee has also worked to ensure that the state prevention office is well grounded in prevention science. All 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 be successful from ensuring that the locations of all permanent prescription drop boxes are communicated to coalitions to working with other State Departments to design a workable plan to 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 to provide technical assistance to coalitions that best meet their needs.

### ***Prevention Funding***

In previous years, a definition of Evidence Based Practice was developed using the guidance document for the Strategic Prevention Framework State Incentive Grant, *Identifying and Selecting Evidence-based Interventions*. All funded programs must meet the definition of Evidence Based Practice ensuring that 100% of the prevention set-aside is used for evidence based interventions. The EBPW also developed guidelines for environmental strategies. These guidelines state that environmental strategies must be implemented as part of a comprehensive plan. The comprehensive plan must include each of the following strategies for community change: Providing Information, Enhancing Skills, Providing Support, Enhancing Access/ Reducing Barriers, Changing Consequences, Physical Design, Modifying/ Changing Policies. Taken as a whole, the approved implementation plan is considered to be evidenced-based. The following table depicts strategies employed by coalitions.

### **Coalition Strategies**

Community Assessment  
Education  
Policy, Practice, and Procedure Enhancement  
Skill Development

Media Campaign  
Strategic Planning  
Leveraging Resources  
Information Dissemination  
Awareness Campaigns  
Responsible Beverage Server Training  
Capacity Building  
Coordinate Community Prevention Activities  
Evaluation  
Engaging Sectors

The State is in the process of revitalizing its evidence-based practice workgroup and hopes to accomplish the following under the new structure:

- Conduct research into 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 presentations for coalitions and other groups to describe research and make relevant at the practice level
- Develop a menu of evidence based practices and cite relevant research

For FY 2016 and 2017, Tennessee intends to use its prevention funding to deliver services according to the Institute of Medicine’s “Mental Health Intervention Spectrum.” Universal activities, those targeted to the general public or a whole population not identified on the basis of individual risk, are conducted using three methods. First, community coalitions use the Strategic Prevention Framework model to develop comprehensive strategic plans that address the substance abuse problems in their community. Second, communities use the Strategic Prevention Framework to guide their efforts by completing an Assessment of Need, Capacity Assessment, Planning Process, Implementation Plan and Evaluation Plan. And third, these essential plans are then used to implement environmental and community based change processes in the community. Plans must include each of the following strategies for community change: Providing Information, Enhancing Skills, Providing Support, Enhancing Access/ Reducing Barriers, Changing Consequences, Physical Design and Modifying/ Changing Policies. **Community coalitions** use block grant dollars to develop and implement proven strategies that address state substance use priorities. Current priority areas include: underage alcohol use, underage tobacco use, and prescription drug misuse across the lifespan. In addition, the **Higher Education Initiative** delivers environmental strategies focused on decreasing access to substances and how students perceive (approve or disapprove) their use. The Coalition for

Healthy and Safe Campus Communities (CHASCo) works with a consortium of 30 public and private educational institutions to fulfill the goals of the Higher Education Initiative. An additional universal strategy is the ***Substance Abuse Clearinghouse***. The Clearinghouse provides information, assistance, and referral services for the prevention, treatment, and recovery of/from Alcohol, Tobacco and Other Drug (ATOD) use and abuse and problem gambling. The Clearinghouse serves as the Tennessee statewide repository and distribution center. The information is available to prevention and treatment providers, other professionals, consumers and the general public. Also available at the Clearinghouse is the Tennessee Redline (TN-Redline), a toll-free telephone line that operates 24/day, 365 days a year, where persons who call can get assistance, referrals, and resources on ATOD use and abuse and problem gambling by talking to an individual.

The ***Tennessee Prevention Network*** provides selective and indicated evidence-based primary prevention services to groups and/or individuals determined by assessment to be at increased risk of abusing alcohol and drugs. Primary Prevention Programs are “those directed at individuals who have not been determined to require treatment for substance abuse.” The goals of the Tennessee Prevention Network Program are: to delay the onset of substance use, abuse, and dependence; to reduce illegal use of substances; and to reduce the prevalence of negative consequences associated with substances. Additionally, Tennessee Prevention Network programs focus on specific selective and indicated populations shown to be at higher risk for developing substance abuse problems. The following populations are targeted: Selective: High school dropouts; Foster care children; Juvenile offenders; Children of substance abusing parents; Lesbian Gay Bisexual Transgender Questioning (LGBTQ) individuals; Children of incarcerated parents; Military families; Youth with Low School Performance/ Truancy; Youth with Mental Health Problems. Indicated: Early initiation (age thirteen (13) years and under) of alcohol and drug use and associated problems; Adolescent binge drinking and excessive alcohol use (ages thirteen to eighteen (13-18) years) and associated problems; Young adult binge drinking (ages eighteen to twenty-four (18-24) years) and associated problems; Adolescent high rate/ excessive use of alcohol and/or drugs (ages thirteen to eighteen (13-18) years); Inhalant use (ages ten to sixteen (10-16) years) and associated problems; and adolescent prescription drug use (ages thirteen to eighteen (13-18) years) and associated problems. Services provided through Tennessee Prevention Network Programs include education activities, mentoring, referral activities, tutoring, service learning, student assistance programs, and alternative activities.

The ***In-Home Visitation Services for At-Risk Mothers*** provides in-home visitation services to improve pregnancy outcomes and ensure the health, growth and development of infants most at-risk. The program’s goal is to improve the health status of women and children by reducing the use and misuse of tobacco, alcohol, and other substances and to increase the early identification and management of maternal depression. These services will be provided from pregnancy until the infant’s second birthday.

The ***School Based Mental Health Liaison*** service provides primary prevention services to youth and their parents or guardians. Liaisons are hired to assist school staff in enhancing the classroom learning environment and provide training around a variety of mental health and substance abuse topics. The Liaison services utilize the CSAP strategies of information

dissemination, prevention education, and problem identification and referral. Services are provided in each of the three grand divisions of the State.

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 18.

Tennessee ensures that SABG 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 Finance and Administration’s *Policy 22, Subrecipient Monitoring*, and the *Tennessee Subrecipient Monitoring Manual*. 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 SABG funds.

### ***Quality Improvement Plan***

*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.*

The Tennessee Department of Mental Health and Substance Abuse Services have developed a Quality Assurance and Quality Improvement Plan (QAQIP) to assist the department in “designing, implementing, and enforcing a systemic process to detect and prevent criminal, civil and administrative violations of the Patient Protection and Affordable Care Act (PPACA)”. The Corporate Compliance Committee meets quarterly to provide updates on action items and to discuss any pertinent issues or concerns.

## Trauma

*To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.*

Research shows that the experience of traumatic events and the possible sequelae of posttraumatic stress disorder (PTSD) often co-occur with a substance abuse disorder<sup>13</sup> and are present among many substance abuse treatment clients.<sup>14</sup> Because of the relationship between substance use and trauma-related mental health problems, it is recommended that substance abuse treatment facilities offer mental health screenings and assessments to determine whether or not a client is suffering from a trauma-related illness<sup>15</sup> and/or has been involved in domestic violence.<sup>16</sup> The 2012 National Survey of Substance Abuse Treatment Services provides information on the frequency of use of trauma-related counseling. 78.7% of Tennessee’s substance abuse treatment facilities reported that they use trauma-related counseling “always, often or sometimes”<sup>17</sup> which is an increase from 2011 (73.6%).

DSAS is committed to developing a Trauma Informed System of Care; thereby integrating the knowledge of violence and abuse into its service delivery practices. Simply put, we will be able to understand people’s problems looking through the eyes of trauma. To integrate DSAS’ substance abuse system, management chose a trauma informed model. After researching several interventions, *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* was chosen. This model can be used as a group or individual format; for male and female clients; and in a variety of settings; i.e., outpatient, inpatient and residential. All block grant treatment providers have been trained in the *Seeking Safety* model.

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<sup>13</sup> Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52, 1048-1060.

<sup>14</sup> Nanjavits, L. M. (2002). Clinicians’ views on treating posttraumatic stress disorder and substance use disorder. *Journal of Substance Abuse Treatment*, 22, 79-85.

<sup>15</sup> Center for Substance Abuse Treatment. (1995). Anxiety disorders. In Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse (Treatment Improvement Protocol [TIP] Series 9, DHHS Publication No. SMA 95-3061). Rockville, MD: Substance Abuse and Mental Health Services. (Original work published 1994) Retrieved from <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A30236>

<sup>16</sup> Fazzone, P. A., Holton, J. K., & Reed, B. G. (Consensus Panel Co-Chairs); Center for Substance Abuse Treatment. (1997). *Substance abuse treatment and domestic violence* (Treatment Improvement Protocol [TIP] Series 25, DHHS Publication No. SMA 97-3163). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A46712>

<sup>17</sup> Substance Abuse and Mental Health Services Administration. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2012. Data on Substance Abuse Treatment Facilities*, BHSIS Series: S-64, HHS Publication No. (SMA) 12-4730, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Proper screening is an important tool to addressing trauma. DSAS has implemented a simple trauma screening module in the Tennessee Web-based Information Technology System that assists providers with identifying substance abuse clients who have experienced trauma. The screening tool is modeled after the Trauma Screening Questionnaire, (C. R. Brewin, et al, 2002). In addition, DSAS contractually requires that each agency conduct a separate specific trauma screening on each service recipient upon initial contact; i.e., AC-OK COD Screen, or a CAGE-AID and Modified Mini Screen (MMS), or Mental Health Screening Form III (MHSF-III or others that are referred to in the DDCAT toolkit.

If the screening indicates trauma, the provider is required to create a treatment plan that includes trauma specific services and refer the individual for other community support services, if needed.

DSAS is also committed to provide training to contract providers on the role of trauma in people's lives. Technical assistance and training strategies will continue to be developed for providers so that they will have the capacity to prevent, identify, intervene and effectively treat people in a trauma-informed approach. On-line training and regional workshops are currently provided to treatment, recovery support and criminal justice providers.

## ***Criminal and Juvenile Justice***

*More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>18</sup>*

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

The Division of Substance Abuse Services (DSAS) continues to work diligently with Tennessee's criminal justice system to expand its diversion programs for offenders with substance use and mental health disorders. Through the Alcohol and Drug Addiction Treatment program (ADAT) and the Supervised Probation Offender Treatment Program (SPOT), DSAS has been providing alcohol and drug treatment services statewide to indigent DUI offenders and other non-violent offenders who are committing crimes because of their substance abuse addiction and/or co-occurring disorders. ADAT and SPOT are statutorily initiated, state funded programs. Offenders must be deemed indigent by the court, have a conviction, and be mandated to treatment by the court system. If the offender completes the court order treatment program, the judge may reduce their sentence by the time served in treatment. DUI Schools in Tennessee

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<sup>18</sup> <http://csgjusticecenter.org/mental-health/>

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. Tennessee uses The *Prime for Life* Curriculum is the statewide standardized curriculum in the DUI schools. This is an N-REPP recognized program and provides the participants guidance around making the low risk choices when it comes to the use of alcohol and drugs.

The Criminal Justice Behavioral Health Liaisons (CJBHL) is a community project that examines the issues affecting adults with serious mental illness and/or substance abuse issues who are involved in the criminal justice system. The purpose of the project is to facilitate communication/coordination between the community, the criminal justice, substance abuse and mental health systems to achieve common goals; to support the establishment of services that would promote diversion activities; and provide liaison activities for adults with serious mental illness and/or substance abuse issues who are incarcerated or at risk of incarceration. CJBHLs work collaboratively with jail administrators, public defenders, District Attorney's, judges and sheriffs to screen and identify an individual's most immediate clinical or recovery support needs, pre- and post-adjudication, to divert him/her from re-entry into or out of jail or prison. The services included but are not limited to: early identification, linkage and referral to behavioral health treatment and recovery support services; stabilized housing and medication assistance; and other community supports. CJBHLs also advocate on behalf of individuals with SMI, MI, COD or substance abuse disorders who are incarcerated or at risk of incarceration; coordinate release plans that include linkage and referral to behavioral health and recovery support services and other community supports; and conduct follow-up activities when they are released from jail into community programs to facilitate successful integration from incarceration into the community. In addition, the CJBHLs provide training on crisis intervention to local jails and law enforcement agencies; medication management of the jail population as well as ways to deal with the co-occurring offenders in overcrowded detention facilities.

The Community Treatment Collaborative (CTC) is funded through an interagency agreement between the Tennessee Department of Correction (TDOC) and the Tennessee Department of Mental Health and Substance Abuse Services. The CTC program is a collaborative effort to divert at risk probation and parole technical violators with substance abuse and co-occurring disorders from returning to state prison. This program requires a collaborative treatment approach which engages the service recipient, provider, TDOC staff and other supports. The CTC program provides a full continuum of care including Detoxification, Residential Rehabilitation, Halfway House and Outpatient services.

On July 1, 2012, the management and oversight of Tennessee's drug court programs were transferred by Executive Order of the Governor to the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). TDMHSAS is one of two Substance Abuse and Mental Health Single State Authorities nationally to have oversight of drug courts. The decision to transfer the drug court programs was to "lessen duplication of effort and align with the department's role as the substance abuse authority in the state". DSAS manages forty-four adult drug courts, three juvenile drug courts, three veterans treatment courts, one mental health court, and one family court. These court programs are specialized courts or court calendars that have completed an extensive certification process based on the *National Drug Court Ten Key*

*Components.* They incorporate intensive judicial supervision; treatment services; sanctions; and incentives to address the needs of addicted non-violent offenders who meet the criteria of the drug court program and voluntarily want to participate in the program. Each court has a team that is composed of a judge, prosecutor, defense attorney, drug court coordinator, probation officer, SUD mental health and treatment providers, and other program staff who all work in concert to ensure that defendants have the support of the criminal justice system and access to treatment and recovery services that will address their substance abuse problems and recovery needs. The services offered include but are not limited to: detoxification, screening, assessment, education, counseling, social reintegration, employment, housing, and other aftercare and recovery activities. There are two Misdemeanor Drug Courts that will allow a non-violent offender to volunteer to go through drug treatment pre-adjudication. When the offender completes the program, the charges are dropped. The goals of the drug court program are: to reduce the use of jail and prison beds and other correctional services by non-violent, chemically dependent offenders by diverting them to rehabilitative programs; to reduce incidences of drug use and the drug addiction among offenders; to reduce crimes committed as a result of drug use and addiction; to promote public safety; to increase the personal, familial, and societal accountability of offenders; and to promote effective interaction and the use of resources among local criminal justice and community agencies. On July 1, 2013, the Drug Courts expanded and are now known as Recovery Courts. The Recovery Courts serve individuals with substance abuse, mental health and co-occurring disorders. Many of the recovery courts in rural areas of the state have created different tracks in their courts to serve individuals with mental health issues and our veteran population that has become involved in the criminal justice system. Recovery courts focus on the positive impact for individuals to move towards recovery no matter what type of specialty court program they participate in. Drug Courts, Mental Health and Veteran's Courts, Family courts, Juvenile courts, and DUI courts are all part of the recovery court umbrella. This move to recovery courts focuses on the positive aspect of recovery and allows for better coordination of care, as many individuals with a substance use disorders also have co-occurring mental health needs and are veterans. DSAS will assist existing drug courts to move to a Recovery Court model.

DSAS is collaborating with the Tennessee Department of Correction to operate the first statewide residential recovery (drug) court in the nation. In SFY 2014, DSAS opened the Morgan County Residential Drug Court in rural East Tennessee. Non-violent, male felony offenders who have been referred by other recovery (drug) courts across the state who have been assessed as needing a high level of co-occurring treatment will be eligible for the program. These individuals participate in residential co-occurring treatment services for approximately six to nine months and then transfer back to the recovery (drug) court that made the initial referral to finish out their program. DSAS continues to establish additional recovery courts and increase capacity. Additionally, DSAS provides funding to Knox County for a Family Court to address the needs of Women with Dependent Children and Pregnant Women who may be at risk of delivering babies with Neonatal Abstinence Syndrome. This family court gives the women an opportunity to receive treatment services for their addiction while being under judicial supervision and work to keep custody rights.

### ***State Parity Efforts***

*Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.*

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) is meeting with representatives of TennCare (Medicaid) to ensure that TDMHSAS continues to be in full compliance with all current requirements of MHPAEA.

### ***Medication Assisted Treatment***

*SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.*

In the 2015 – 2016 General Appropriations Act, the Tennessee General Assembly gave a non-recurring state appropriation to TDMHSAS to commence a pilot project for Opioid Addiction Treatment. The propose of the pilot project is to provide opioid addiction treatment, including non-narcotic medication-assisted treatment, to individuals in the custody of the Department of Correction who have a significant history of opioid use disorder and are scheduled for release from the correctional system through parole or flattening of their sentence.

The Department of Correction and DSAS staff met and decided that the goals of the project are to assist offenders with opioid use disorders to live a life of recovery; and to decrease the odds of overdose upon release from the correctional system. It was also determined that VIVITROL injections would be used as the medication assisted treatment protocol.

The Department of Correction has been tasked with compiling a list of offenders in custody who:

1. Meet the criteria for opioid use disorder;
2. Have an upcoming release date; and
3. Participated in a substance abuse program within the correctional system.

Once these individuals are identified, they will be educated on the benefits of using VIVITROL and then given the option to volunteer for the project. If the individual agrees to volunteer for the project, they will be screened by the medical professionals at the correctional facility to determine if they medically meet the guidelines for this project. Once they have been cleared by the medical professionals, and a release date verified, then the individual will then be given an injection of VIVITROL approximately five weeks prior to the release date and a second injection one week prior to release. The correctional staff will refer individual to a DSAS funded Criminal Justice Forensic Social Worker in the community where they will be released. The Forensic Social Worker will refer the individual to a DSAS funded local substance abuse treatment agency. The treatment agency will provide outpatient treatment as well as the individual's monthly VIVITROL injection for up to six months post release from prison.

Extensive training of the correctional treatment and medical staffs and substance abuse treatment provider and medical staffs is required not only to educate them on the benefits of VIVITROL but also to address the proper administration of the injection as well as possible side effects. The project is scheduled to begin September 2015.

## **Recovery**

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

Recovery is a unique journey for each individual, and each person in recovery must choose the range of services and supports ranging from clinical treatment to peer services.<sup>19</sup> TDMHSAS DSAS has fully embraced recovery and has integrated it into all of its treatment programs. DSAS' definition of recovery is:

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

Research indicates that having a stable job helps individuals in recovery to integrate back in society and their communities. TDMHSAS has a history of hiring individuals in recovery. Currently, the Director of Peer Support Services and the Co-Occurring Disorders Coordinator are in recovery. These individuals were hired not only for their expertise in their respective areas but because they are people who have experienced mental health, substance use or co-occurring disorders.

DSAS has adopted the Recovery Oriented Systems of Care (ROSC) model for treatment services offered to women and pregnant women with a primary or secondary alcohol or other drug abuse or dependency diagnosis or co-occurring substance use and psychiatric diagnosis. Services include case management, nursing assessment, prenatal nursing assessment, medication

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<sup>19</sup> Substance Abuse and Mental Health Services Administration, Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014. HHS Publication No. (SMA) 11-4629. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

management, medication training and support, trauma counseling, family/relationship support, parenting support, recovery activities, recovery skills and recovery checkups. DSAS also provides recovery support services based on consumer choice through the Addiction Recovery Program. Services include case management, transportation, transitional housing, recovery skills, spiritual/pastoral support and relapse prevention. In addition, recovery support services are offered in the adolescent programs. Services include case management, family intervention support, recovery activities and recovery skills.

DSAS will continue to offer an array of recovery support services for those individuals in need including veterans and military families, people with a history of trauma, racial/ethnic groups, LGBT populations and families/significant others. These services include:

- *Addictions Disorder Peer Recovery Support Centers* will provide peer support services to assist individuals in recovering from a substance use disorder or co-occurring disorder. Services include but are not limited to mentoring, education, and addictions disorder peer recovery support services including, but not limited to, peer counseling, 12-step meetings, transportation, and employment skills. Peer support services often begins while an individual is on the wait list in order to keep the person engaged.
- *Women's ROSC* program includes services for pregnant women and women with dependent children. Services include outreach, advocacy, case management, transportation, and aftercare services.
- The *Addiction Recovery Program*, which is available to consumers in treatment as well as keeping those who have completed treatment; and recovery support services for adolescents.
- *Lifeline Peer Program* is designed to reduce stigma related to the disease of addiction and increase community support for policies that provide for treatment and recovery services. Lifeline approaches will include the establishment of evidence-based addiction and recovery programs including 12-step programs, as well as educational presentations for civic groups, faith based organizations, and community leaders to increase understanding of the disease of addiction and support for recovery strategies.
- *Peer Addiction Recovery Services* for those in recovery. These services may include mentoring, education and addictions peer disorder recovery support services including, but not limited to, peer counseling, transportation, and employment skills. DSAS will also offer training for trauma-informed services.
- Through the *Faith-Based Recovery Network*, DSAS is actively engaging faith communities and organizations as a means of increasing outreach, educational activities, access, and visibility to people seeking substance abuse services. Congregations of faith have committed to be Recovery Congregations. As a Recovery Congregation, the spiritual leader pledges to integrate recovery in their message and to be a conduit for recovery services.

Workforce development is essential to providing quality care to individuals in need of substance abuse prevention, treatment and recovery support services. DSAS provides continuing education for the employees of contracted agencies that provide prevention activities and treatment and recovery services. Training is provided through two mechanisms: online learning and regional training workshops. Second, DSAS also has a contract to provide regional trainings on a variety of relevant subjects which include recovery-oriented approaches as well as trauma-focused care. DSAS has also provided *Seeking Safety* trauma training to all of our treatment providers.

Tennessee has established a process for Peer Recovery Specialist certification for substance use for people who have lived experience with addiction or co-occurring disorder recovery. These persons would have successfully navigated the service system to access treatment and resources necessary to build personal recovery and success with their life goals and have completed the recognized training established by the Department of Mental Health and Substance Abuse Services (TDMHSAS) on how to assist other persons with substance abuse disorders in fostering their own wellness, based on the principles of self-directed recovery. They must meet the following qualifications: be a current or past recipient of substance use disorder services, and/or co-occurring disorders services and self-identify, be sober at least two years, hold a minimum of a high school diploma or GED, have 3 letters of professional reference, have a minimum of 75 hours of peer to peer contact (does not have to have been paid), complete a 40 hour peer recovery specialist training and pass the peer recovery specialist competency test.

DSAS has worked diligently with Tennessee's criminal justice system to offer alternative treatment resources for offenders with substance use and mental health disorders. DSAS has further expanded these resources to include recovery support services. Indigent DUI offenders and individuals who are on supervised probation can now receive recovery skills, relapse prevention and care coordination through the Alcohol and Drug Addiction Treatment and Supervised Probation Treatment Programs.

### ***Involvement of Individuals and Families***

TDMHSAS offers consumers, family members, and other stakeholders a variety of forums to voice their preferences and needs related to the Department's service system. One way that consumers and family members provide input into the development and implementation of services is through the Department's seven regional councils and a statewide policy and planning council (TDMHSAS PPC). The Councils are designed to encourage citizen-based participation into the planning of a comprehensive array of high quality prevention, early intervention, and treatment services and supports and to advise the Department on policy, budget requests, and developing and evaluating services and supports for persons with mental illness, serious emotional disturbance (SED), and substance use disorders (SUD). The Councils also advise the Department on the Three Year Plan, Mental Health Block Grant and Substance Abuse Prevention and Treatment Block Grant applications, Joint Annual Report to the Governor, conduct annual needs assessments, and develop legislative proposals. Each of these advisory planning and policy councils must maintain a majority membership of current or former consumers and members of consumer families, including parents or caregivers of children with SED. TDMHSAS promotes efforts to include youth and families in service development, implementation; and evaluation of services, policy-making and advisory capacities. The

Department strives to ensure that services for children, youth, and their families are family driven, youth-guided, culturally and linguistically competent, and community-based.

TDMHSAS also coordinates involvement of individuals and families through the Consumer Advisory Board (CAB). The CAB serves as the voice of consumers, regardless of age, ethnicity, sexual orientation, gender identity, or social or educational opportunity, on issues related to recovery and resiliency, policy and planning, system evaluation, and the rights of service recipients. The Chair of the CAB serves as a member of TDMHSAS PPC and its Executive Committee to ensure that CAB members' issues and recommendations are incorporated into the Council process. Members include individuals with lived experience in mental health and substance abuse.

One of the goals of Title II of the Americans with Disabilities Act is the inclusion of consumers and their families in all activities of state government. Their participation at all levels of government enriches the government process and serves to affirm the efficacy of consumer empowerment. Consumer advocates in the Department give voice to the consumer perspective and serve many roles:

- Represent the interests and issues of consumers within the department.
- Participate in the development and implementation of departmental planning, policies, and programs.
- Work closely with advocacy organizations such as Tennessee Association of Alcohol and other Drug Abuse Services Organization, Tennessee Association of Drug Court Professionals, Prevention Alliance of Tennessee, Tennessee Association of Mental Health Organization, CAB, Tennessee Voices for Children (TVC), NAMI-Tennessee, and the Tennessee Mental Health Consumers' Association (TCMHA), to track stakeholder issues.
- Influence public policy and practice.
- Coordinate the Department's response to consumer and family questions and concerns.
- Represent and articulate departmental policies and programs to the consumer community.
- Review and make recommendations on critical legislation and regulations.
- Equip consumers and their families with tools to advocate for themselves.
- Provide education through presentations and printed material that promotes self-determination in treatment decisions and improves recovery outcomes, such as the Declaration for Mental Health Treatment.

The Department maintains a library of brochures that outline the signs, symptoms, and possible treatments and supports for individuals with mental health disorders, substance use disorders, and co-occurring disorders. This information is designed to assist individuals and family members in the identification of programs and services that will best serve them and promote

recovery, resiliency, and community integration. The Department also disseminates informational materials on the importance of promoting mental health in children and identifying and treating mental health problems very early in life, and participates in the National Depression Screening Day each October during Mental Illness Awareness Week by offering free, confidential screenings to the public either by appointment or on a walk-in basis.

Other DSAS programs that support, strengthens, and expands recovery support are:

- **Problem Gambling Services**

The Problem Gambling Treatment Services Program (PGTSP) is a multi-purpose program designed to increase knowledge about problem gambling and gambling addiction to those persons at risk, their families and the general community; to identify those with problem gambling and pathological gambling; to provide assessment and outpatient treatment services to those in need; and to continually assess regional needs and coordinate outreach activities for potential service recipients

- ***School Based Liaison for At-Risk Youth*** (SBL-ARY) program provides face- to-face consultation with classroom teachers to assist them in structuring the classroom to enhance the learning environment for children whose risk of developing an emotional or behavioral problem or a substance use or abuse problem is significantly higher than average or children who have minimal but detectable signs or symptoms foreshadowing a disorder but not yet meeting diagnostic levels. Training and education regarding childhood mental health and substance abuse will be provided to classroom teachers, school staff, and students to promote a healthy teaching environment. The SBL-ARY program will provide liaison support between the family and the school and will assist parents and youth with the Individualized Education Plan (IEP) process.

- **Criminal Justice Behavioral Health Liaison**

The Criminal Justice Behavioral Health Liaison Project (CJBHL) is a community project to facilitate communication and coordination among the community, and criminal justice systems to achieve common goals of decriminalizing mental illnesses, co-occurring disorders (COD) and substance abuse disorders. Providers develop and maintain working relationships with local criminal justice authorities; community mental health and substance abuse service providers; and consumer, family and advocacy groups in an effort to identify resources that will enhance and sustain the work of the CJBHL.

- **Adolescent Substance Use Disorders Service Program**

The Adolescent Substance Use Disorders Service Program (ASUDSP) provides for the treatment of adolescents, thirteen (13) through eighteen (18) years old, with a primary or secondary alcohol or other drug abuse or dependency diagnosis or co-occurring substance use and psychiatric diagnosis. Treatment services offered include an assessment, individual therapy, group therapy, family therapy, or any combination of such counseling services. One

of the goals of the program is for service recipients to show an improvement in the life domain areas of substance abuse/dependence, mental health, physical health, housing, employment, family/social relations and legal involvement.

- **Women’s Recovery-Oriented System of Care**

The Women’s Recovery Oriented System of Care (WROSC) provides for the treatment of women and pregnant women with a primary or secondary alcohol or other drug abuse or dependency diagnosis or co-occurring substance use and psychiatric diagnosis. Recovery Support Services may include, but are not limited to: primary pediatric care and immunizations for children; recovery skills building; child care, child maintenance, and family relationship support.

- **Addictions Disorder Peer Recovery Support Centers**

The Addictions Disorder Peer Recovery Support Centers services give service providers an opportunity to engage consumers in the addictions disorder peer recovery process that are on the waiting list for admission to treatment. The modalities, interventions, and services that are used include those for addressing COD, family involvement, and the spiritual dynamics of addiction and recovery.

- **Addiction Recovery Program**

The Addictions Recovery Program (ARP) promotes consumer choice for the purchase of addiction recovery support services. The goals of the program are to expand recovery support capacity, support consumer choice, and increase the array of faith-based and community-based providers.

These programs require community outreach; i.e., engagement with individuals to develop release a plan, dissemination of information, educational activities, community informational meetings and public service announcements. Through TN WITS, DSAS has the capability of capturing agency events, release plans, and contacts to ensure that the individuals are receiving the recovery support services needed; and to ensure agencies are meeting contractual obligations.

### ***Wellness***

DSAS screens all clients for tobacco use through either the Tennessee Web-based Information Technology System or prevention assessment tool. Analysis of TN WITS treatment and recovery admissions for SFY 2015 indicates that eighty-nine percentage of the clients used tobacco. At a recent Treatment and Recovery Advisory Council Meeting, providers were asked about their smoking policy. A vast majority indicated that they allow smoking only in designated areas. They expressed that they would like to have a No Smoking Policy, but know from “past experience” that clients will leave treatment if enacted. Some providers indicated that they do address nicotine dependence with the client. If the client request assistance, it becomes part of their treatment plan and the agency makes the appropriate referral. Some of the referral sources are: tobacco cessation classes, peer centers, primary care physicians and quit helplines.

## ***Housing***

DSAS uses the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised (ASAM PPC-2R) criteria to determine recommended level of care. The recovery environment domain addresses the person's living situation. All providers are contractually required to use the ASAM for placement, continued stay and discharge for the most appropriate placement.

As part of the continuum of care, DSAS provides residential services (111.3, 111.5 and 111.7) for those assessed as needing intensive treatment along with a more restrictive living environment and the halfway house level of care (111.1) for those with less intensive treatment needs but still require a structured living environment. The Addiction Recovery Program offers transitional housing to support consumers in need of a stable, recovery environment. DSAS recognized that there was a need to provide a safe, substance-free, supportive living environment for individuals in recovery. Therefore, in SFY 2014, DSAS began contracting with Oxford House International to open recovery houses for men and women in recovery. Prior to our partnership with Oxford House, Tennessee had ten houses in operation with the majority being in Middle Tennessee (Nashville). Eight new houses were opened in SFY14, and in SFY15 nine houses were opened for a total of twenty-seven. Houses are located in Memphis, Johnson City, Chattanooga, Knoxville and Nashville. It is expected that a minimum of eighteen additional houses will be opened in SFY 2016 and 2017.

## ***Children and Adolescents Behavioral Health Services***

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

Tennessee's System of Care is managed by TDMHSAS Division of Mental Health Services. There are currently three federally funded system of care grants located in East, Middle and West Tennessee. TDMHSAS partners with the departments of Children's Services, Education, Health and Human Services; Tennessee Commission on Children and Youth (TCCY); service providers; youth; families and other stakeholders in developing a comprehensive and coordinated System of Care to support and sustain effective and appropriate services for children and youth with intensive mental health needs. The 2008 General Assembly established a Council on Children's Mental Health (CCMH) to design a plan for a statewide system of mental health care for children. It requires the CCMH to develop a plan for a statewide system of care where children's mental health services are child-centered, family-driven, and culturally and linguistically

competent; and provide a coordinated system of care for children's mental health needs in the state. The Council is co-chaired by the Commissioner of the Department of Mental Health and Substance Abuse Services and the Executive Director of TCCY.

The Youth Transitions Advisory Council (YTAC) was established by the Legislature to assist the Department of Children's Services (DCS) with developing extension of foster care services for youth in state custody who age out of the child welfare and juvenile justice systems. Extension of foster care services assists young people who age out of state custody in completing their high school diploma, GED or High School Equivalency Test, and post-secondary education. These young people are no longer in state custody, but voluntarily agree to remain under juvenile court supervision continuing to receive needed services from DCS, while completing their education. The Executive Director of the Tennessee Commission on Children and Youth is the Chair of the Youth Transitions Advisory Council. All state departments providing services to youth and young adults participate on this council.

Although the System of Care structure resides in our "sister" Division, DSAS has served as the subject matter expert on prevention, treatment and recovery support services. DSAS management has been working with the Division of Mental Health Services to integrate substance use disorders into its plan. It is important to note that DSAS has funded adolescent residential, outpatient and intensive outpatient services for over 20 years. We know from our needs assessment that Tennessee's youngest citizens are its most vulnerable. Research has established the critical importance of pre-natal health of the mother; family engagement and support; and access to supportive resources for the mental and social-emotional development of the child. Parental substance use disorders contribute to inadequate parenting and to an impoverished environment for positive development. Because the substance use-related needs of these young citizens reside in their environments, DSAS is committed to assisting with the development of a sound structure that supports the recovery and resilience of children and youth with mental and substance use disorders.

DSAS funded prevention, treatment and recovery programs for children/adolescents are evidenced-based; and listed in the KidCentral tn state services directory. KidCentral tn is an on-line list of state-operated and state-funded programs available to Tennessee families, children and parents—many available at no cost to low-income families and individuals. These services are provided to adolescent's age thirteen (13) to eighteen (18) years of age. In addition, professional development is offered to contract providers to educate them on and assist them with the delivery of evidenced-base programs and practices. All DSAS funded providers receive a programmatic monitoring and independent peer review site visit at least once every three years to ensure compliance with the contract and fidelity of the program. DSAS staff actively participates on many committees to improve care coordination and outcomes for youth. Some of the committees are: Resource Mapping of Funding Resources for Children; Neonatal Abstinence Syndrome (NAS) Subcabinet Working Group; NAS Subcabinet Working Group, Prevention Work Group; Children's Council on Mental Health; and Youth Transitions Advisory Council.

Currently, DSAS is collaborating with the Department of Education to fund a School-based Mental Health and Substance Abuse Liaison project in the Division of Mental Health Services.

This project consist of two programs—School-based Mental Health Liaison and School-based Liaison for At-Risk Youth.

The ***School Based Mental Health Liaison*** (SBMHL) program provides face-to-face consultation with teachers to assist them in structuring the classroom to enhance the learning environment for children at risk of developing an emotional or behavioral problem or with serious emotional disturbance. Training and education regarding childhood mental health and classroom behavior management techniques assist the teachers in promoting a healthy teaching environment. Each SBMHL shall provide psycho-educational groups to youth identified by teachers and/or other school officials. The SBMHL program will provide liaison support between the family and the school and when invited, assist parents and youth with the Individualized Education Plan (IEP) process.

The ***School Based Liaison for At-Risk Youth*** (SBL-ARY) program provides face- to-face consultation with classroom teachers to assist them in structuring the classroom to enhance the learning environment for children whose risk of developing an emotional or behavioral problem or a substance use or abuse problem is significantly higher than average or children who have minimal but detectable signs or symptoms foreshadowing a disorder but not yet meeting diagnostic levels. Training and education regarding childhood mental health and substance abuse will be provided to classroom teachers, school staff, and students to promote a healthy teaching environment. The SBL-ARY program will provide liaison support between the family and the school and will assist parents and youth with the Individualized Education Plan (IEP) process.

DSAS received a four year State Youth Treatment SAMSHA grant in 2013 to provide substance abuse treatment and recovery services to adolescents and transitional aged youth. ***Treatment and Recovery for Youth (TRY)***, provides treatment and recovery services for the adolescents and transitional aged youth through two community-based providers who deliver services in their entire region. They use the evidenced- based treatment model Adolescent Community Reinforcement Approach (A-CRA), which is an intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with pro-social activities and behaviors that support recovery. DSAS partners with the Departments of Children’s Services, Education, Health, and Human Services to enhance statewide efforts to increase access and improve treatment quality for adolescents and youth with substance use disorders.

All agencies are required to collect and enter data into the Tennessee Web-based Information Technology System on a weekly basis.

### ***Pregnant Women and Women with Dependent Children***

*Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a*

*“set-aside” was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations.*

The effects of substance abuse have been well documented for pregnant women and their babies; i.e., Fetal Alcohol Syndrome, Neonatal Abstinence Syndrome, children entering state custody. These risk factors have been brought to the forefront of our State and each branch of government is working to improve the outcomes for this vulnerable population.

Through the Substance Abuse Block Grant, DSAS provides a treatment and recovery service continuum of care for pregnant and women with dependent children who abuse substances. Providers are required to publicize the availability of services to pregnant women and the fact that pregnant women receive preference for admission.<sup>20</sup> Providers use strategies such as monitoring the gender of intake calls. Some providers are working to leverage their community relationships (OBGYN, Health Department, Recovery Court) by providing tools for referral. In addition, providers are utilizing speaking engagements, newspaper, radio, websites, brochures and other local and federal grants to establish priority admission.

If a provider determines that there is insufficient capacity to admit a pregnant woman, then the provider must try to place the pregnant woman at a facility with capacity. If the provider is not able to locate a facility, then the provider must notify the Director of Treatment and Recovery Services and the State will attempt to place the pregnant woman at a facility with capacity. If the State is unsuccessful in placing the pregnant woman at another treatment facility, the provider must place the pregnant woman on the Statewide Client Wait List, with the highest admission priority, and the provider must provide interim services within forty-eight (48) hours.<sup>21</sup> During the forty-eight hour timeframe, providers will do an initial screening or nursing assessment. Interim services offered include peer recovery support; referral for other community services such as housing, transportation, medical and psychiatric; in-home case management, contact woman to see if other services are needed; etc.

Program Specialists dedicate up to 40% of their work time providing technical assistance and ensuring that providers comply with program guidelines and scope of services outlined in their contract or vendor agreement. All federal and state requirements, deliverables, terms and conditions are communicated to the providers through the contractual agreement. Providers are required to enter their client data in the Tennessee Web-based Information Technology System (TN WITS). Staff has the capability of retrieving a pregnant and parenting female’s treatment and/or recovery client data. An essential component of the program compliance review is the

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<sup>20</sup> Women’s Recovery Oriented System of Care (WROSC) [Women’s Services/Pregnant Women’s Services] Grant Contract, Scope of Services, July 1, 2015 – June 30, 2016.

<sup>21</sup> Women’s Recovery Oriented System of Care (WROSC) [Women’s Services/Pregnant Women’s Services] Grant Contract, Scope of Services, July 1, 2015 – June 30, 2016.

Corrective Action Plan. Providers are offered training and technical assistance to help with program requirements. If a Corrective Action Plan is needed and after it has been approved, staff conducts a follow-up visit to offer additional technical assistance and training and to make certain that the provider is still in compliance.

Tennessee funds seven agencies that offer services to pregnant women and their infants. Of these agencies, one offer medication assisted treatment and others are exploring the possibility.

Services	Number of Programs
Outpatient	0
Intensive Outpatient	5
Residential III.3	0
Residential III.5	2
Residential III.7	0
Case Management	7
Transportation	7
Housing	4
Wrap Around i.e. childcare	7

Tennessee funds twelve agencies that offer services to parenting women. Of these agencies, six offer medication assisted treatment.

Services	Number of Programs
Outpatient	0
Intensive Outpatient	11
Residential III.3	1
Residential III.5	1
Residential III.7	0
Case Management	12
Transportation	12
Housing	5
Wrap Around i.e. childcare	12

Over the last several years, DSAS has seen a decline in the number of pregnant women seeking treatment from FY 2011 (219) to FY 2015 (155). The Director of Treatment and Recovery Services convened a meeting of all women providers to discuss about the strategies to keep women more engaged. The group was also asked to provide their feedback on the decline in women seeking treatment. They expressed the following barriers:

- Need more residential beds
- Home environment
- Limited childcare and transportation in rural areas
- Need more housing for women and children

- Need more supportive services and relationships with referral sources; i.e., Legal Aid, Department of Children’s Services
- Engaging clients who are exhibiting negative symptoms of their addiction
- Coordination of care

The decline in pregnant women seeking treatment, the increase in NAS babies and the barriers that exist are very disturbing to the DSAS management team. Therefore, Tennessee will officially request technical assistance on how to improve our strategies to increase the census of and retention rate for women.

### ***Suicide Prevention***

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) partners with the Tennessee Suicide Prevention Network (TSPN) to develop annual strategies pertaining to suicide prevention in Tennessee. TSPN is comprised of representatives from many providers, representatives from the TDMHSAS Planning and Policy Councils, and individuals who have great personal interest in preventing suicide and educating others about the warning signs of possible or impending suicide. Additionally, DSAS contracts with TSPN to provide mental health and substance abuse providers and program administrators suicide prevention training and related activities. The Tennessee Suicide Prevention Plan can be viewed at <http://tspn.org/tennessee-strategy-for-suicide-prevention-2>.

### ***Support of State Partners***

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

DSAS has a multitude of partners along the continuum of care to assist with developing system capacity and services. DSAS continues to engage in community outreach, constantly looking for new ways to partner and create a more integrated system of providing for the health and wellness of all Tennesseans. State-level partners include: Tennessee National Guard, Drug Demand Reduction (DDR); Tennessee Association of Alcohol, Drug and Other Addiction Services (TAADAS); Coalition for Healthy and Safe Campus Communities (CHASCo); Tennessee Commission on Children and Youth (TCCY); Prevention Alliance of Tennessee; Tennessee Certification Board; Tennessee Department of Education’s Office of School Safety, Office of Coordinated School Health; Tennessee Association of Mental Health Organizations; Bureau of TennCare; and Departments of Health, Safety and Homeland Security, Children’s Services, Correction, Education, Agriculture and Veterans Services; Tennessee Bureau of Investigation; Tennessee Association of Drug Court Professionals; Administrative Office of the Courts (AOC); Tennessee District Attorneys; and Tennessee Public Defenders.

## ***State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application***

*Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.*

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

TDMHSAS administers seven Regional Planning and Policy Councils (Council[s]) from which regional mental health and substance abuse needs and information are funneled to the Statewide Council and to TDMHSAS. Needs assessment priorities and recommendations from the Statewide Planning and Policy Council, combined with requirements associated with federal Mental Health and Substance Abuse Block Grant funding, inform the development of the Department's Three-Year Plan. Title 33, Chapter 2, Part 2 of the Tennessee Code Annotated requires the TDMHSAS to develop a Three-Year Plan (Plan) based on input from the TDMHSAS Planning and Policy Council. The plan must be revised at least annually based on an assessment of the public need for mental health and substance use disorders services.

A needs assessment is conducted annually by the TDMHSAS Regional Councils to assist TDMHSAS with planning for resource allocation. Data is provided to the Regional Councils to assist members with identifying and prioritizing needs. Prioritized needs are shared with TDMHSAS staff to inform the development of strategies for the Three-Year Plan and report progress annually. The needs assessment process creates a data-informed method for Regional Councils to influence the design of the mental health and substance use service delivery system by identifying each region's needs and targeting limited state resources to more effectively and efficiently meet identified needs. This information is used to communicate and integrate results into a strategic planning and action process that ensures assessment information is used in meaningful ways.

In addition to the needs assessment, the Councils also review and provide input on the Block Grant plans and funding, the annual budget for TDMHSAS, legislative proposals for review of the Commissioner and possible consideration by the Governor, and other departmental reports and initiatives.

The Council system is large, active, fully-integrated SA-MH with a consistently successful method of integration in Tennessee. It acts as an independent body and great care is taken by the Planning Program Manager (administrator for the Council system) to avoid influencing the deliberations of, and recommendations made by, the Councils. The Regional Council system serves a secondary purpose that, although not part of the legal requirement, is beneficial to the service delivery system in Tennessee: the Councils allow all participants to become acquainted with each other and with services, events, and other aspects of the service delivery system.

Public comment for the SABG is solicited through both public availability and direct distribution of the draft plan to members of the Tennessee Department of Mental Health Planning and Policy Council, substance abuse prevention and treatment contract providers, TDMHSAS executive staff, any other individuals or organizations requesting access and the general public.

Copies of the FY 2016-2017 Block Grant draft application was e-mailed to members of the groups mention above and a link was posted on the Tennessee Web-based Information Technology System and Department's website homepage for general public access, review and comment during the development of the plan and submission to HHS. Comments were directed to the Block Grant Coordinator; although comments could also be directed to either the Council Chair or Department Commissioner.