



# Mental Health Issue

# The Advocate

Vol. 9 No. 4

A newsletter on children's issues

December 1999

## State, U.S. Focus on Mental Health

Attention is beginning to be paid to suicide and other mental health problems.

On the national level, personal revelations by Tipper Gore and Rep. Harry Reid have focused attention and efforts on depression and suicide, respectively.

Surgeon General, and former Tennessean, Dr. David Satcher is leading federal efforts to prevent suicide and focus attention on mental health needs.

A state expert task force is working to implement Tennessee's version of the national suicide prevention initiative. Policy initiatives within the Tennessee



Department of Mental Health and Mental Retardation (DMHMR) are overhauling the way state and local government officials address these problems.

Two statewide groups are looking at the way Tennessee treats those with mental problems. The Title 33 Revision Commission has been working all year on a major revision of all state laws relating to mental health and mental retardation.

The Criminal Justice Task Force is looking at law enforcement's response to the mentally ill. Changes in health care funding and the current crackdown on crime have contributed to an increase in the number of mentally ill being housed in correctional facilities.

In recent years mental health and mental retardation advocates have been successful in achieving their legislative goals. In 2000 legislation mandating that limits on payments for mental health coverage be on par with limits imposed on medical and surgical benefits goes into effect. Earlier mental health activists fought to retain a department dedicated to serving those with mental illness and developmental delays.

Much work is needed to eliminate the stigma that prevents victims from seeking appropriate help for their problems and to increase the willingness of insurers and the public to pay for those services as they do physical problems.

### Statistics about Suicide

(1997 Data)

<u>Race/Sex</u>	<u>Age</u>	<u>Number</u>	<u>Rate</u>
<b>United States</b>			
All	All	30,536	11.4
<b>Tennessee</b>			
All	All ages	729	13.6
"	5-14	8	1.9
"	15-19	43	11.3
Males	15-19	37	18.8
Females	15-19	6	3.2

Suicide was the second leading cause of death for U.S. white females ages 15 to 24 in 1997.

An average of one young person killed him or herself every 1 hour and 57 minutes in 1998.

More teens and young adults die from suicide than from the following diseases combined: cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease..

In Nashville, the Crisis Intervention Center received 5,961 calls concerning suicide in 1998.

# Suicide

More people die from suicide than from homicide in the United States. In both the United States and Tennessee, suicide is the eighth leading cause of death and the third leading cause of death of the young. In addition, youth suicides and suicides by African-American males have risen sharply in the past 30 years.

In 1997, Tennessee ranked 16<sup>th</sup> in the rate of suicide, at a rate of 13.6 per 100,000, compared to 11.4 nationally. The South as a region had the second highest rate of suicide, following the West, during 1990-94, and firearm suicides were highest in the South (130 percent higher than the Northeast, which had the lowest suicide rate).

**Youth and African-American Suicide.** Suicide rates have increased in the 10-19 age group and among young African-American males since the 1940s, according to the Centers for Disease Control. Since 1980 the rate of suicide for African-Americans ages 15-19 more than doubled, going from 3.6 per 100,000 to 8.1 per 100,000. While suicide rates for all youths 10 to 19 years old in the United States increased from 1980 to 1995, the rates increased more for African-American youths than for white youths. In 1980, the rate for whites ages 10-19 was 157 percent greater than that for African-Americans; by 1995, the difference was only 42 percent. The rate for African-Americans ages 10-19 increased 114 percent during those 15 years, with the rate increasing the most (233 percent) for youths ages 10-14 years. The rate for those 15-19 increased the most in the South (223 percent). In ages 15-19 years, the increase for African-Americans was 126 percent; for whites, 19 percent.

**Causes.** It has been suggested that, as the African-American middle class grows, more African-Americans experience middle-class stresses and adopt middle-class responses. At least one researcher suggests that the differences between the

racess may be attributed to a failure to accurately report the cause on death certificates. Suicide rates are higher in communities with low levels of social integration and unstable social environments, according to the CDC.



## Risk Factors

Risk factors include:

- ◆ Previous suicide attempt;
- ◆ Mental disorders – particularly mood disorders such as depression and bipolar disorder;
- ◆ Substance abuse;
- ◆ Family history of suicide;
- ◆ Hopelessness;
- ◆ Impulsive and/or aggressive tendencies;
- ◆ Barriers to accessing mental health treatment;
- ◆ Relational, social, work, or financial loss;
- ◆ Physical illness;
- ◆ Easy access to lethal methods, especially guns;
- ◆ Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts;
- ◆ Influence of significant people – family members, celebrities, peers who have died by suicide – both through direct personal contact or inappropriate media representations;
- ◆ Cultural and religious beliefs – for instance, the belief that suicide is a noble resolution of a personal dilemma;
- ◆ Local epidemics of suicide that have a contagious influence;
- ◆ Isolation, a feeling of being cut off from other people.

Source: Surgeon General's Call to Action to Prevent Suicide 1999

Firearm-related deaths accounted for 96 percent of the increase in the suicide rate for African-American youths ages 10 to 19 years, according to the CDC. Firearms are the most common methods of suicide by all youths – male or female; younger or older; African-American, white or other. Firearm suicides occur most frequently in the home and are successful 78 percent to 90 percent of the time. The Jason Foundation, based in Hendersonville, says that a home with a handgun is almost 10 times more likely to have a teen suicide than a home without handguns. In addition to educating families about this problem, the foundation gives out free trigger locks, as funding allows.

**Attempts.** While a previous suicide attempt is considered a major risk factor for suicide, no national

**Continued on page 3.**

# Suicide

Continued from Page 2.

data are compiled. Tennessee plans to start an anonymous reporting system. However, an estimated 5 million Americans have unsuccessfully attempted to kill themselves, and there are an estimated 765,000 attempts annually. Women are three times as likely to attempt suicide as men. Estimates about the number of people committing suicide who have made at least one previous attempt vary from one in 20 to four out of five. There are approximately 8-25 attempts to every completed suicide, according to the National Institute of Mental Health.

**Survivors.** The American Association of Suicidology estimates that each suicide leaves six survivors. It suggests that up to 3.68 million survivors are living today and that 180,000 more are added as a result of the 30,000 people who commit suicide each year. The stigma of suicide complicates an already complex grieving process.

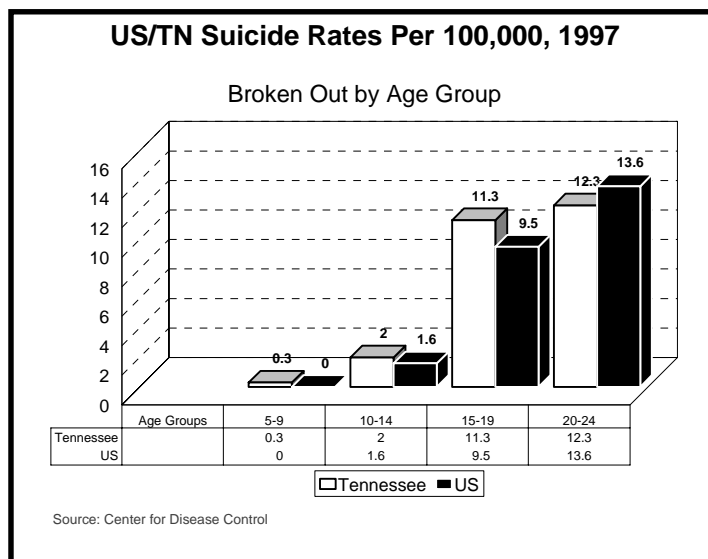
**Responses.** In 1998, a collaboration of national public and private groups held a conference to analyze the problem. The results of this conference have been compiled in "The Surgeon General's Call to Action." The National Strategy for Suicide Prevention is organized around AIM:

- ◆ Awareness: Appropriately broaden the public's awareness of suicide and its risk factors;
- ◆ Intervention: Enhance services and programs, both population-based and clinical care; and

## Protective Factors

- ◆ Effective and appropriate clinical care for mental, physical, and substance abuse disorders;
- ◆ Easy access to a variety of clinical interventions and support for help seeking;
- ◆ Restricted access to highly lethal methods of suicide;
- ◆ Family and community support;
- ◆ Support from ongoing medical and mental health care relationships;
- ◆ Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes;
- ◆ Cultural and religious beliefs that discourage suicide and support self-preservation instincts.

Source: Surgeon General's Call to Action to Prevent Suicide 1999



- ◆ Methodology: Advance the science of suicide prevention.

The strategy contains 15 recommendations for implementing these strategies. Specific recommendations for preventing youth suicide include working with the media to de-sensationalize coverage of suicide, preventing substance abuse, and encouraging young people to seek help for both substance abuse and depression.

**Proposed Tennessee plans** to fight suicide include creating a statewide toll-free suicide hotline; improving media cooperation; supporting local Survivors of Suicide and Suicide Anonymous meetings; education efforts; increased collaboration with clergy, teachers, health care professionals, including primary care physicians, and others who regularly encounter hurting people; and encouraging workers to earn certification from the American Association of Suicidology.

The Middle Tennessee Coalition, of which the Mid-Cumberland Council on Children and Youth is a member, pools counselors from more than 10 agencies and helps educate schools and helps them deal with losses. A Survivors of Suicide support group has met at the Nashville Crisis Intervention Center since 1984, and other chapters meet around the state.

The Jason Foundation sponsors parent seminars and distributes free educational kits to parents, etc.

# Title 33 Revision Commission Nears End of Task

The Title 33 Revision Commission, which was formed by the governor in late 1998, has begun to review draft legislative changes.

The Commission was formed to comprehensively review Title 33 of the Tennessee Code Annotated, the law that governs provision of services to Tennesseans with mental illnesses and mental retardation and recommend changes.

The Commission was made up of mental health and disability consumers, family members and advocates (including East Tennessee Council on Children and Youth member Ann Ince); providers, state legislators, and representatives of state government. Committees considered mental health services, mental retardation services, transportation, children's issues, powers and duties, privileges and responsibilities, interstate relationships, and definitions and technical issues.

Consumers commented to the Commission at public hearings held across the state. State agencies reported on how the system is currently working, and legal scholars addressed legislation in other states.

## Community Services System

Proposed statement of the Title 33 Revision Committee

The Tennessee Department of Mental Health and Mental Retardation will plan, coordinate, administer, monitor, and evaluate state and federally funded services and supports for people with mental illness, serious emotional disturbance, mental retardation, developmental disabilities, and alcohol and substance abuse issues and their families.

All functions will be carried out in consultation and collaboration with consumers, their families, guardians or conservators, and other stakeholders. Within the limits of available resources, the State will develop and maintain a system of care providing:

- ◆ A comprehensive array of quality prevention;
- ◆ Early identification;
- ◆ Treatment; and
- ◆ Habilitation or rehabilitation services and supports which are geographically available, equitably and efficiently allocated statewide, allowing people to be in their own communities in settings based on the needs and choices of the individuals and families served.

Core values of the system envisioned are:

- ◆ Person-centered and family-focused care;
- ◆ Individualized services and supports based on a comprehensive, personalized services plan;
- ◆ Least restrictive, most appropriate setting for community-based care;
- ◆ Services responsive to the cultural, racial, and ethnic difference of the people served;
- ◆ Attention to safety and health, while respecting the choices and protecting the rights of clients.

## Draft Recommendations Related to Children.

The Commission has added the more inclusive developmental disability designation to include conditions such as autism. When referring to children, the term mentally ill individual was replaced with individual with a "serious emotional disturbance."

Issues relating only to children will be placed in a separate children's chapter in the code. The group also set the age of consent for admission to and release from treatment, release of information, and medication decision-making at age 16. People ages 16-18 years old would have the same rights as adults regarding mental health treatment, medication decisions, confidential information, and participation in conflict resolution procedures. Confidential information may be disclosed by an identified client who is 16 years of age or older or the parent, legal guardian, or legal custodian of an identified child client.

The Department of Mental Health and Mental Retardation's responsibilities for children would include:

- ◆ Case findings after the department has adopted rules regarding children with SED;
- ◆ Determining eligibility;
- ◆ Providing standards for evaluation;
- ◆ Outlining and facilitating the planning process;
- ◆ Entering them into the system of services;
- ◆ Defining and listing an array of services;
- ◆ Assisting youth who have been in the public system of care with transition to adult services.

Specific regulations would limit the use of convulsive therapy to children to emergency situations.

# Criminal Justice Task Force Formed

The commissioner of the Tennessee Department of Mental Health and Mental Retardation has appointed a task force to consider the problems of mental illness and the criminal justice system. The task force is expected to contribute to a more comprehensive mental health and criminal justice policy and better use of scarce resources, according to Commissioner Elisabeth Rukeyser. The group may also recommend changes in state law.

The 25-member Criminal Justice Task Force, made up of representatives of the mental health and law enforcement communities, will work on the following areas:

- ◆ TennCare eligibility for people who are incarcerated;
- ◆ Gaps in services, including a lack of access to mental health services for at-risk people prior to incarceration;
- ◆ Inadequate information and education resources within the criminal justice system.

If the state figures mirror national figures, more than 2,500 of the 16,639 inmates in Tennessee's prisons and nearly 5,000 of the nearly 31,000 Tennesseans on probation suffer from mental problems.

More than 800,000 mentally ill people were either in the nation's prisons or jails or on probation in 1998, according to estimates issued this summer by the federal Bureau of Justice Statistics.

The report estimates that seven percent of inmates in federal prisons and 16 percent of inmates in state prisons and local jails and of those on probation have a mental illness.

The study reported that rates of mental illness in the inmate population are believed to be twice that of the general population.

Dual diagnosis was also a problem in this population. One-third of prisoners in state and local custody and one-fourth of those in federal prison had symptoms of alcohol dependency.

Mentally ill prisoners were more likely to have committed violent acts. Nearly one in five of the

violent offenders in the population studied were mentally ill. While incarcerated, the mentally ill were more likely than others to be involved in fights or to violate prison rules and procedures.

Mentally ill prisoners were more likely to have repeated sentences. More than three-fourths had had one prior sentence; half had had three or more prior sentences. Prisoners with mental illnesses were also more likely to have been unemployed or homeless.

According to the study, since admission, 61 percent of the mentally ill state and federal prison inmates and 41 percent of the local jail inmates said they had received treatment for a mental condition in the form of counseling, medication, or other mental health services. Fifty-six percent of mentally ill on probation had received treatment since beginning their sentences.

Changes in health care financing have been blamed for the changes in the prison population by those who say that people who might have been served by the health care system now are in the correctional system.

The task force is a cooperative effort of the state department, the Tennessee Mental Health Planning Council, and the Davidson County Sheriff's Office.

## Mental Health Statistics

Depression is the leading cause of disability worldwide among people ages 5 and older.

### United States:

The cost of mental illness from direct and indirect costs is estimated at \$148 billion.

### Adult Incidence

19 million adult Americans suffer from a depressive illness.

2 million adult Americans (1%) - schizophrenia.

16 million - anxiety disorders.

2.4 million - panic disorder.

3.3 million - Obsessive-Compulsive Disorder.

5.2 million - Post-Traumatic Stress Disorder.

5.3 million (4%) - Social phobia.

### Children

ADHD affects 3-5% of school-age children.

# Mental Illness Affects Many in Tennessee and the U.S.

One in five people with major depression and half of those with manic depression will attempt suicide, according to estimates. Therefore, appropriate treatment for depression and other mood disorders and substance abuse is important.

The World Health Organization says mental illness accounts for 15 percent of the burden of disease in established market economies like the United States and that five of the top 10 causes of disability worldwide are mental health problems.

Some estimates are that one in every three Americans will experience a mental illness during their lifetimes. The National Institute of Mental Health (NIMH) reports vary from an estimate that 12 percent of children have mental and emotional disturbances to one that 20 percent of children have a diagnosable mental disorder. The Tennessee DMHMR estimates that 6.3 percent of the population (230,617 people) has a severe mental illness, and 2.6 percent (95,175 people) has a severe and persistent mental illness. The department also estimates that 20 percent of the state's population under 18 (243,321 people) need mental health services and 9 percent (109,494 people) are severely emotionally disturbed. The TennCare Partners mental health program had 94,941 adults and 31,936 children enrolled in July 1999.

Treatments can be effective. Anti-depressant medicines help reverse the symptoms of depression in 80 to 90 percent of those who are prescribed them. Eighty percent of those who receive medication for schizophrenia will remain free of the disease for at least two years after being discharged from a psychiatric hospital.

Unfortunately, the Surgeon General estimates that nearly two-thirds of people with diagnosable mental illness do not seek treatment. The NIMH said that one in five children receives treatment. According to the National Alliance for the Mentally Ill, 40 percent of those with brain disorders - schizophrenia, panic disorder, obsessive-compulsive disorder (OCD), bipolar disorder (manic-depressive illness), and major depression - do not seek treatment.



## Surgeon General Releases Report on Mental Health

The Surgeon General released the first report on mental health in America in response, it reports, to the rising awareness of the burden of mental health problems. While the report emphasizes the need for more research, it says that a variety of treatments have been found effective in treating mental illnesses. The report says:

Research highlighted in the report demonstrates that mental health is a facet of health that evolves throughout the lifetime. Just as each person can do much to promote and maintain overall health regardless of age, each also can do much to promote and strengthen mental health at every stage of life.

## Resources

The Jason Foundation, Inc., 116 Maple Row Blvd., Suite C, Hendersonville, TN 37075, (615) 264-2323 ([www.jasonfoundation.com](http://www.jasonfoundation.com)).

American Association of Suicidology, 4201 Connecticut Ave., NW, Suite 408, Washington, DC 20008 (202) 237-2280, FAX: (202) 237-2282 ([www.suicidology.org](http://www.suicidology.org)).

American Foundation for Suicide Prevention, 120 Wall Street, 22nd Floor, New York, New York 10005, FAX: (212) 363-6237, (888) 333-AFSP, phone: 212-363-3500. ([www.afsp.org](http://www.afsp.org)).

### Crisis Hotlines in Tennessee

Athens Area – (423) 337-3800, (423) 745-9111

Chattanooga Area – (423) 870-2651

Clarksville Area (913) 552-4636 (infoline), (931) 648-1000, (800) 639-5370

Johnson City Area – (423) 926-0144

Kingsport Area (423) 246-2273

Knoxville Area – (423) 523-9124

Memphis Area – (901) 274-7477

Nashville Area – (615) 244-7444

Oak Ridge Area – (423) 481-3333, (423) 482-4949

Tulahoma Area – Teen-2-Teen (800) 454-8336

For more information, contact [www.suicidology.org/crisis\\_centers\\_in\\_your\\_area.htm](http://www.suicidology.org/crisis_centers_in_your_area.htm).

# IMPACT Study Looks at TennCare Mental Health Services

The IMPACT Study, conducted by Vanderbilt University's Center for Mental Health Policy, is producing important information about the performance of TennCare and TennCare Partners programs for children and adolescents with mental health problems. Funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the IMPACT Study is part of a national multi-site collaborative study assessing the effects of managed care on use, costs, clinical outcomes, and consumer for traditional Medicaid populations. In particular, the national study assesses performance for adults and children with serious mental health problems and adults and adolescents with alcohol or other drug problems.

The IMPACT study has followed a three-pronged approach to assess these elements for TennCare children and adolescents. It has:

1. Collected standardized interview data from a sample of 750 TennCare children and adolescents;
2. Conducted in-depth "case reviews," modeled after TCCY's C-PORT program, for a subset of children with serious emotional disorders and adolescents with substance abuse problems; and
3. Obtained TennCare enrollment and encounter data for a representative sample of children, including the sample of interviewed children.

The Impact Study has been a collaborative effort among academic, government, provider, and consumer and advocacy groups in Tennessee and Mississippi. In Tennessee, the following agencies have been particularly involved with Vanderbilt's Center for Mental Health Policy:

- ◆ **State agencies:** the Tennessee Department of Mental Health and Mental Retardation, the Department of Children's Services, the TennCare Bureau, and the Department of Health's Bureau of Alcohol and Drug Services; and
- ◆ **Advocacy agencies:** Tennessee Commission on Children and Youth and Tennessee Voices for Children, which also collected interview data using the standardized interview protocol.

This article is extracted from the first in a series of reports and includes information from a standardized baseline parent interview on the mental health status and the health status of children enrolled in the TennCare program and their use of mental health and other services. This article is focused on children with serious emotional disorders, but information on a representative sample of TennCare children is included in the full report.

The impact study interviewed the parents or guardians of 483 TennCare recipients between the ages of 4 and 17. Using TennCare eligibility and encounter data, Vanderbilt created a stratified sample of children based on their use of mental health services in the year prior to TennCare Partners' implementation, July 1995 to June 1996. This ensured that the study would recruit an adequate sample of children who had used "high end" services (e.g., inpatient hospitalization, day treatment). Sample weighting was used to make statistically valid inferences about the population of children who, in the absence of the TennCare program, would be "categorically eligible" for Medicaid.

"Categorical eligibility" in this report includes all groups who are potentially eligible for Medicaid coverage, regardless of whether coverage is federally mandated. However, children in state custody were excluded because they were eligible for a different benefits package to be managed outside of the TennCare Partners Program Behavioral Health Organization (BHO) network by the Department of Children's Services. This parallels the decision of the other study sites in the national study.

## What is the Mental Health Status of TennCare Children?

Federal criteria for a serious emotional disorder (SED) were applied in order to examine the mental health status of TennCare children. Federal block grant funding required that the assessment of functional impairments, or the ability of children to meet their everyday requirements in the home or community, be a component of applications for federal assistance, and the definition of SED requires both a mental health

**Continued on page 8.**

## Impact

Continued from Page 7.

diagnosis and an impairment in psychosocial functioning. The diagnosis provides a direction or category of emotional/behavioral problems, and the level of functioning provides the depth or degree of problems in home, school, and community.

Federal SED status for this project was determined from baseline interview data from the parent or caregiver interviews using scores on two standardized surveys: the Columbia Impairment Scale (CIS), where the cutoff for significant psychosocial impairment was used, and the Child Behavior Checklist (CBCL), where a score in the clinical range was used to identify a significant behavioral or emotional problem equivalent to a mental health diagnosis.

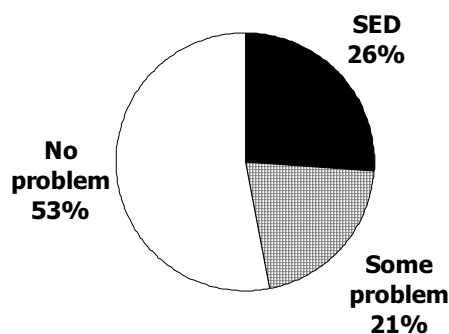
- ◆ Over one quarter (26 percent) of the representative sample of all categorically eligible TennCare children and adolescents met federal criteria for SED.

An additional 21% of TennCare children were reported as having severe problems with behavior or psychosocial functioning, but not to an extent to be classified as SED.

Community research samples have estimated an average SED prevalence rate of 16 percent. TCCY's C-PORT study of children in state custody found somewhat higher rates of SED (31 percent) using methods very similar to those employed in the IMPACT Study. The higher rates observed in the IMPACT Study may be due in part to the composition of the population being examined. Most TennCare children (80 percent) meet Medicaid eligibility based primarily on income level, and poverty has been shown to be an important predictor of health and behavioral health problems. The differences may also be a result of the methodology for identifying SED in children. Compared to community studies using structured diagnostic interviews, the CBCL has been found to slightly over-identify children with disorders.

As might be expected, the group of children with a history of high use of mental health services during the pre-TennCare Partners year showed a much higher rate of SED. More than two-thirds (71 percent) of these children and adolescents met the criteria for SED during interviews approximately two years later. This indicates a

### TennCare Children with Mental Health Problems



group of children and adolescents with chronic and severe mental health needs.

#### What Types of Behavioral Health Problems were Experienced by Children with SED?

Symptoms, or types of behavioral health problems, were described using the general scales on the CBCL.

- ◆ Three quarters (74 percent) of the children and adolescents with SED showed severe problems with anxiety and depression, while 84 percent had serious problems with attention and behavioral difficulties.

The CBCL subscales show the specific types of problems. The two areas showing greatest difficulty of children with SED were attention problems (82 percent) and aggression (77 percent).

**Mental health diagnoses** were also reported:

- ◆ Three-quarters (76 percent) of the parents of children with SED reported their child had received a formal mental health diagnosis, indicating some past contact with a health or mental health provider about their children's emotional and behavioral problems.

Many parents reported that their children had more than one formal mental health diagnosis. Of these diagnoses, by far the most prevalent was some form of Attention Deficit Disorder, which was named for 80 percent of the youth whose parents knew of any diagnoses. The next most frequently named diagnoses by parents were depression and bi-polar disorder. TennCare claims data confirmed that Attention Deficit Disorder was the most

**Continued on page 9.**



## Impact

Continued from Page 8.

commonly used diagnosis for this group of children with SED.

### What Other Types of Health-Related Needs Were Reported for Children with SED?

Two other types of health-related needs were striking among this group of TennCare children and adolescents. One was the use of alcohol and other drugs by adolescents with SED, and the second was the high rate of health problems in this population.

**Substance Use:** In the broadest sense, almost one-fourth (24 percent) of the adolescents with SED could be said to have a co-occurring substance abuse disorder based on use within the past 6 months: 17 percent had used alcohol; 8 percent, marijuana; 3 percent, hallucinogens; and 2 percent, cocaine. Use of “uppers” and “downers” was reported by 2 percent of the adolescents with SED. Tobacco is an illegal substance for children and youth under age 18 and a health risk, so its use was included in the interview, with 14 percent reporting current use. Overall, these rates of substance use for adolescents with SED are somewhat lower than those reported for Tennessee youth in the High School Survey conducted by the University of Tennessee.

**Health Problems.** Parents or caregivers provided information about the child’s physical health status. The survey asked about limitations in daily activities due to health problems, the presence of any chronic illnesses, and a standardized rating of the child’s “overall” current health status. These findings show consistently poorer health status for this group of children than other samples of American children:

- ◆ 47 percent of children with SED were rated as being in excellent or good health, in contrast to a national sample of similar socioeconomic status with 65 percent. Children with SED were rated with significantly poorer health status than the general Tennessee TennCare population.
- ◆ Children with SED were significantly more likely to be reported as having limitations in activities due to health problems than other TennCare children. Half (50 percent) were rated as having some type of limitation.
- ◆ Half (50 percent) of the children with SED were

reported to also have chronic health illnesses. Children with SED were significantly more likely to have a chronic illness reported than children without SED.

The most frequent types of chronic illnesses reported were asthma and severe allergies and speech and language and vision problems.

**Summary and Implications.** This statewide sample of TennCare children and youth showed a high rate of serious emotional and behavioral problems, with a smaller group of them exhibiting severe and chronic long-term mental health needs. In addition, almost one-quarter of the adolescents with serious emotional disorders (SED) had problems with alcohol or drug use. Half of the children and adolescents with SED were reported to have chronic physical health problems. This indicates a group of children with not only high needs for behavioral health care but also needs for access to comprehensive assessment, diagnostic, and treatment services that coordinate care for mental health, substance abuse, and physical health problems.

### Next Steps

The IMPACT Study is continuing its work, including:

- ◆ A focus on adolescents with substance abuse problems, particularly those with both substance abuse and mental health disorders;
- ◆ Case review results for approximately one-third (n=250) of the sample based on the C-PORT format, with particular focus on quality of care issues;
- ◆ Clinical outcomes after 12 months for children with serious emotional disorders and adolescents with substance abuse problems;
- ◆ Trends in TennCare use for mental health and substance use problems over time (1993-2000); and,
- ◆ National study information on changes in Medicaid programs from multiple states.

**Supplied by Craig Anne Heflinger, Ph.D.,**  
**Vanderbilt Center for Mental Health Policy,** 1207 18<sup>th</sup>  
Ave., S, Nashville, TN 37212, (615) 322-8275 (phone),  
(615) 322-7049 (fax), [c.heflinger@vanderbilt.edu](mailto:c.heflinger@vanderbilt.edu).

# Governor's Prevention Initiative Update

The Governor's Prevention Initiative (GPI) is a primary prevention program that seeks to achieve the long-term goals of reducing teen substance use and abuse, teen pregnancy, teen violence, and school dropout rates.

Thirty-five programs funded by the GPI have been able to achieve one or more of the goals or objectives that were identified in their program proposal. Program providers were able to document the following outcomes: increased attendance in school, improved grades, changes in knowledge about drugs and alcohol, improvement in self-esteem, reduction in truancy, reduction in disciplinary problems, improved family relationships, family management skills, and problem solving.

Individual communities were involved in the planning process for these programs, using the local health council infrastructure. This allowed programs to be tailored to meet the needs of the children in each area. These GPI programs were successful in many instances because the community as a whole was involved and resources were made available to the provider.

A model program is **Northwest Elementary School** in Cocke County. A social worker or counselor is on site at the school to provide prevention and intervention activities to at-risk students in grades kindergarten through six. Peer helpers and student volunteers add to the success of the program. Goals and objectives were met by an increase in attendance in school, decrease in disciplinary actions, and an increase in favorable attitudes toward school.

The **Bledsoe County Board of Education** provides case management services to families with children younger than age 13. The program was tailored to improve family management, school readiness, and reduce truancy and juvenile delinquency. The Family Environment Scale Survey analyzed by the University of Memphis was used to evaluate the program. The survey reflected a statistically significant improvement in cohesion, expressiveness, conflict, independence, achievement orientation, active recreational orientation, organization, and control.

**History of the GPI.** This major prevention initiative was announced in January 1996. In July 1998 an additional \$1 million was added to the GPI funding pool from the Governor's Office. The Department of Health presently funds 71 prevention projects in 45 rural counties and in specific target areas in Memphis, Chattanooga, Nashville, and Knoxville.



**Goals.** The Governor's Community Prevention for Children was designed to:

- ◆ Give communities input in assessing needs of the target population and available resources and in proposing solutions to the identified needs;
- ◆ Assure that community intervention facilitates the development of protective factors for at-risk youth before high risk behaviors develop by targeting children before they reach age 13;
- ◆ Maximize the coordination of state and federal funding that is allocated to address any of these issues affecting youth;
- ◆ Provide for comprehensive and coordinated services within the community.

**Research Basis.** Research consistently indicates that:

- ◆ The risk factors are essentially the same for each of the four problem behaviors addressed by the GPI;
- ◆ Some children who have been exposed to these risks do not exhibit these problem behaviors due to protective factors;
- ◆ Communities can provide programs that

**Continued on page 11.**

*The Advocate* is published by the Tennessee Commission on Children and Youth as an information forum on children's issues. The Tennessee Commission on Children and Youth, an independent state agency, serves as an advocacy agency and information resource for planning and coordination of policies, programs, and services on behalf of the state's children and youth. The 21-member Commission, appointed by the governor, works with other agencies and with regional councils on children and youth in each development district to collect information and solve problems in children's services. To receive *The Advocate*, contact Fay L. Delk, Publications Editor, Tennessee Commission on Children and Youth, 710 James Robertson Parkway, 9th Floor, Nashville, TN 37243-0800. Phone: (615) 741-2633. Fax No.: (615) 741-5956.

The state of Tennessee is an equal opportunity, equal access, affirmative action employer.

No person shall on the grounds of race, color, national origin, sex, age, disability, or ability to pay, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity operated, funded, or overseen by the Tennessee Commission on Children and Youth (TCCY). It is the intent of TCCY to bind all agencies, organizations, or governmental units operating under its jurisdiction and control to fully comply with and abide by the spirit and intent of the Civil Rights Act of 1964.

## Governor's Prevention Initiative

Continued from Page 10.

facilitate the development of protective factors for at-risk youth, and;

- ◆ The age of 12 is the last best chance to intervene with prevention strategies.

### Risk Factors

#### ◆ Community Risk Factors

Availability of drugs and firearms;  
Community laws and norms favorable toward drug use and crime;  
Transitions and mobility within the community;  
Low neighborhood attachment and community disorganization;  
Economic and social deprivation.

#### ◆ Family Risk Factors

Family history of high risk behavior;  
Family management problems;  
Family conflict.

#### ◆ School Risk Factors

Early and persistent antisocial behavior;  
Academic failure in elementary school;  
Lack of commitment to school;

#### ◆ Individual and Peer Risk Factors

Alienation or rebelliousness;  
Friends who engage in the problem behavior;  
Favorable attitudes toward the problem behavior;  
Early initiation of the problem behavior.

### Protective Factors

#### ◆ Protective Factors within the Family

Caring and support;

High expectations;

Encouragement of children's participation.

#### ◆ Protective Factors Within the School

Caring and support;

High expectations;

Youth participation and involvement.

#### ◆ Protective Factors Within the Community

Caring and support;

High expectations;

Opportunities for participation.

**Funding.** Three sources of funding are included in the Governor's Prevention Initiative:

- ◆ Title V funds of the Juvenile Justice and Delinquency Prevention Act through TCCY;
- ◆ Safe and Drug-Free School and Community funding through the Department of Education;
- ◆ Pooled funding through the Department of Health and the Department of Children's Services.

The process supported by the GPI proceeds in steps:

Step One: Focus on reducing known risk factors;

Step Two: Focus on increasing protective factors;

Step Three: Address risk factors at appropriate developmental stages;

Step Four: Intervene early before the behavior stabilizes;

Step Five: Include those at high risk;

Step Six: Address multiple risks with multiple strategies.

**Supplied by the GPI staff.**

## Tennessee Commission on Children and Youth Regional Coordinators

### Northeast Tennessee Council

Diane Wise  
1233 Southwest Ave., Extension  
Johnson City, TN 37604  
(423) 979-6600

### Upper Cumberland Council

Kathy Daniels  
435 Gould Drive  
Cookeville, TN 38506-4194  
(931) 432-4494

### Northwest Tennessee Council

Frances Lewis  
Post Office Box 505  
Dresden, TN 38225  
(901) 364-5000

### East Tennessee Council

Robert Smith  
531 Henley St., 7th Floor  
Knoxville, TN 37902  
(423) 594-6658

### Mid-Cumberland Council

Scott Ridgway  
710 James Robertson Parkway, 9th Floor  
Nashville, TN 37243-0800  
(615) 532-1579

### Southwest Tennessee Council

Rodger Jowers  
225 Dr. Martin Luther King Drive  
Jackson, TN 38301  
(901) 423-6545

### Southeast Tennessee Council

Marilyn Davis  
540 McCallie Ave., Suite 643  
Chattanooga, TN 37402  
(423) 634-6210

### South Central Tennessee Council

Elaine Williams  
Post Office Box 397  
Columbia, TN 38402-0397  
(931) 388-1053

### Memphis/Shelby County Council

Gwendolyn Glenn  
170 N. Main St., 9th Floor  
Memphis, TN 38103  
(901) 543-7657

# Meetings and Events

## Council Activities

### Northwest

Feb. 4, Quarterly Meeting, Adoption, tba.

### East Tennessee

Feb. 2, Meeting, Church St. Methodist

March 1, Meeting, CAD Planning.

### Southeast

Jan. 13-14, Children's Rights Conference, Chattanooga.

### Northwest

March, Juvenile Justice Conference, tba.

### Southwest

Jan. 14, CAD Training, tba.

Feb. 24, Prevention Committee Workshop, tba.

March 23, Juvenile Justice Spring Conference, tba.

### Memphis Shelby County

Feb. 23, Quarterly Meeting, Shelby County Schools Auditorium, 8:30 a.m., Child Abuse.

Feb. 24, Day Care Program Management, Shelby County Extension Service, Memphis.

March 23, Council's 9th Annual Spring Training Conference, Fogelman Center.

### Commission on Children and Youth

March 21, Children's Rights Conference, War Memorial, Nashville, 8 a.m.-4:30 p.m.

March 22, Children's Advocacy Day (CAD), War Memorial, 8 a.m.-4:30 p.m.

### Commission Meetings

Feb. 8-9, Nashville, tba.

May 9-10, Nashville, tba.

### C-PORT Review Schedule

Feb. 14-18, Hamilton County. Exit Conference TBA.

March 13-17, Southeast Region. Exit Conference TBA.

April 3-7, Southwest Region, Exit Conference TBA

Call TCCY at (615) 741-2633 for more information.

### Special Events

Feb 6-9, Tennessee Council of Juvenile

and Family Court Judges Mid-Winter Conference. Crowne Plaza Hotel, Nashville. Contact (615) 741-3980.

Feb. 21-22, Training for Adults Reaching Children, Cool Springs Marriott Conference Center, Brentwood. Contact University of Tennessee Institute for Public Service, (615) 320-4967.

March 1-3, CWLA National Conference-Children 2000: Faces of the Future, Washington, D.C. Contact (202) 638-2952.

March 19-22, 27th National Conference on Juvenile Justice. Tampa Marriott Waterside, Tampa, FL. Contact (775) 784-6012.

March 27-29, Tennessee Conference on Social Welfare Spring Conference. Loew's Vanderbilt Plaza, Nashville. Contact TCSW (615) 353-8000.

Mar. 28-Apr. 1, Coalition for Juvenile Justice Spring Conference, Bethesda, MD. Contact (202) 467-0864.



**The Tennessee Commission  
on Children and Youth**  
Betty Cannon, Chair  
Nashville

Angi Agle  
Oak Ridge

Alisa Malone  
Franklin

Beth Alexander  
Nashville

Jerry Maness  
Memphis

Betty Anderson  
Covington

Sharon T. Massey  
Clarksville

Kimalishea Anderson  
Knoxville

Linda Miller  
Memphis

Shirlene Booker  
Gray

Semeka Randall  
Knoxville

P. Larry Boyd  
Rogersville

Mary Kate Ridgeway  
Paris

Wendy Ford  
Memphis

M. Kate Rose  
Covington

Connie Givens  
Rogersville

Susie Stanley  
Johnson City

Johnny Horne  
Chattanooga

James Stewart  
Jackson

Drew Johnson  
Johnson City

Brenda Vickers  
Cookeville

Jim Kidd  
Fayetteville

Jim Ward  
Alamo

Mary Lee  
Dickson

Paige Wilson Williams  
Knoxville

Christy Little  
Jackson

Linda O'Neal,  
Executive Director

**Commission on Children & Youth**  
**Andrew Johnson Tower, Ninth Floor**  
**710 James Robertson Pkwy.**  
**Nashville, TN 37243-0800**  
**(615) 741-2633**

*Address Correction Requested*



**BULK RATE**  
**U.S. POSTAGE**  
**PAID**  
**NASHVILLE, TN**  
**PERMIT NO. 1446**



TCCY Authorization No. 316005. May 1998. 5,000 copies per issue. This public document was promulgated at a cost of 23 cents each.

