



STATE OF TENNESSEE
COUNCIL ON CHILDREN'S MENTAL HEALTH

Andrew Johnson Tower, Ninth Floor
710 James Robertson Parkway
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

Oasis Center Conference Room
Youth Opportunity Center
1704 Charlotte Avenue, Suite 200
March 13, 2009
10:00 a.m.

MEETING SUMMARY

Participant List:

Susan Adams	Caroline Hannah	Sue Pilson
Sumita Banerjee	Vickie Harden	Dawn Puster
Heather Baroni	Raquel Hatter	Kathy Rogers
Kathy Benedetto	Craig Anne Heflinger	Mary Rolando
Ginna Betts	Robbie Hutchens	Mary-Linden Salter
Shawn Brooks	Jeanne James	Traci Sampson
Pam Brown	Angie McKinney Jones	Stephanie Shapiro
Charlotte Bryson	Shay Jones	Teresa Shelton
Leon Caldwell	Dustin Keller	Sara Smith
Angelia Cannon	Randal Lea	Elliot Sparks
Kristin Conley	Ray Lyons	Debrah Stafford
Katrina Donaldson	Kim Crane Mallory	Millie Sweeney
Bob Duncan	Jules Marquart	Linda Tift
Emel Eff	Michael Myszta	Pat Wade
Jeff Feix	Jena Napier	Kristie Wilder
Kathy Gracey	Linda O'Neal	Andrea Willis
Christi Granstaff	Freida Outlaw	Doug Wright
Veronica Gunn	Cindy Perry	
David Haines	Steve Petty	

I. Welcome and Introductions – Commissioner Virginia Trotter Betts and Linda O'Neal

Commissioner Betts:

- She expressed her gratitude for being able to participate in Children’s Advocacy Days and TCCY board meeting in February.
- Tennessee is facing a \$1.1 billion dollar deficit, and regardless of this, must balance the budget by end of year. The Governor is expected to propose his budget sometime between March 23rd and 30th to the Legislature including what Tennessee will be receiving from the Federal Stimulus: \$3.8 - \$4.2 billion dollars with most directed toward Transportation and Education (including higher education and K-12).
- While the Legislature discusses this budget for the next few months, it gives citizens the opportunity to claim their stake in all this and tell the Legislators what they want, and what they want Tennessee to look like at the end of the day.
- Sara Smith and Angie Cannon from Department of Education (DOE) added DOE is receiving Title 1 funding for services for low income students and funding for special education from the Stimulus. Most of that money will go directly to Title 1 schools and into the school systems. People will be able to go online (on the DOE website) to view what their county is receiving.
- Linda O’Neal added advocacy at the local level could be beneficial in improving services for children with Severe Emotional Disturbances.
- Commissioner Betts encouraged members to meet with Freida Outlaw (TDMHDD) and her staff if they had any ideas that could be presented to schools using stimulus funding. For example, suicide prevention and training as a part of teacher training, teaching teachers/coaches to notice issues and then linking children to services. We need to use our influence to make that happen.
- Sara Smith from DOE added all school systems are developing mental health and juvenile justice teams looking at how to integrate within the school system as well as with providers.
- Commissioner Betts added SCHIP (State Children’s Health Insurance Program) has parity for Mental Health/Substance Abuse (MH/SA) services and as people are losing jobs and health insurance, if there isn’t an increase in funding and availability in AccessTN, there will be an opportunity for youth to access CoverKids which will now include mental health access.
- This year’s legislative session will include bills about inclusion benefits for services to address autism in insurance plans, changes in screening for mental illnesses in schools, and changes surrounding people who can be foster parents or adoptive parents.
- Commissioner Betts added no matter our job title, we are all Tennesseans and we need to take a stake in the services and programs in the proposed budget.

Linda O’Neal:

- Welcomed everyone to the meeting and expressed gratitude to Oasis Center for making this facility available at no cost. She expressed appreciation to Commissioner Betts for her participation in Children’s Advocacy Days by providing an overview of the work of the Council. The level of enthusiasm and commitment of CCMH members is wonderful and we appreciate all of you so much.
- We also appreciate all of the supporters, speakers and sponsors of children’s advocacy days including some who are here.

- Thank you to all who worked to complete the preliminary report before deadline especially Mary Rolando, Kim Crane Mallory, GOCCC and TDMHDD staff who compiled and drafted the report.
- The next report is due in July 2010.

All attendees introduced themselves.

II. Acceptance of Meeting Summary for January 22, 2009 CCMH Meeting

MOTION (ROLANDO) AND SECOND (OUTLAW) TO ACCEPT MEETING NOTES FROM JANUARY MEETING.

UNANIMOUSLY APPROVED.

III. Presentation about CoverKids and Children's Mental Health

Andrea Willis, M.D. presenting on/announcing Mental Health care coming to CoverKids
Handout was provided which included web link to enrollment criteria and eligibility.

- CoverKids is TN's SCHIP for mental health care for children and youth.
- SCHIP was reauthorized on February 4, 2009 with a 4 ½ year extension and provisions in authorization include mental health parity.
- Implementation is set to begin on April 1, 2009 with Blue Cross/Blue Shield (BC/BS) partnering to complete implementation. BC/BS will send information to members.
- Reauthorization regulations will come from the Center for Medicaid and Medicare Services. The pending confirmation of a Health and Human Services Secretary could delay implementation.
- This will be positive for children's mental health coverage.

Questions were solicited from the audience:

- Q: Is anything offered for children whose families have lost their jobs?
- A: CoverTN's category "Tennesseans Between Jobs" provides an option. Children are evaluated on an as needed basis to bring them into the program for 12 months.
- Q: Please explain program.
- A: CoverTennessee is an umbrella that Governor Bredesen introduced after the reorganization of TennCare. It includes CoverTN for employees in small businesses, Tennesseans Between Jobs, a new category for people who have recently lost employment or had a drastic reduction in hours, AccessTN for the uninsurable/high risk population, CoverRx (pharmacy program), and CoverKids, SCHIP program for Tennessee covering uninsured children. For CoverKids, the federal government provides a three to one federal to state ratio of funding for coverage, including vision, dental and wellness visits with no co-pay. Eligibility criteria include children 18 and under who are Tennessee residents and have no comprehensive insurance for at least three months, with an exception for a sudden loss of parent's job. The premise of SCHIP is to cover children with families above Medicaid income eligibility who are unable to afford private insurance.
- Q: What is the common framework for parity? What does parity mean?

- A: CoverKids is based on the benchmark of the state employee health insurance program. It has expanded flexibility in working with partners and doesn't limit physical health or mental health benefits. Parity means there is no difference in the type of benefits (copays/limits) on mental health services and physical health services.
- Q: Does CoverKids provide residential treatment for children, and will this change with April 1 implementation? Will families see any information on expansion of resources? How will people be notified?
- A: The first wave of communication comes from providers. BlueCross/Blue Shield's Network "S" is utilized and meets the requirements for GEOAccess per SCHIP regulations. If you want to know who is in that network or more about coverage options, please visit the Blue Cross website.
- Q: Will CoverKids be increasing enrollment?
- A: We are already ahead of enrollment expectations with 34,000 children enrolled to date. We are trying to realize cost savings so we can cover the most children possible. We have to be very cognizant of state budget. Currently, we are still enrolling children.
- Q: Is there an enrollment cap?
- A: Not right now, but there may be a cap in future.
- Q: Are there hospitalization benefits for kids?
- A: Yes. There are always hospital benefits and now parity will apply to that benefit.
- Q: What is the basis for the 34,000 children projected for the program?
- A: The numbers were based on the state census. There are 125,000 uninsured children in Tennessee and about half of those children are eligible for Medicaid. We felt there were approximately 45,000 children eligible for SCHIP.
- Q: What are the prior authorization requirements for mental health/substance abuse?
- A: They will be the same as before but without limits on benefits.
- Q: Is there any consideration for streamlining the application process for SCHIP and TennCare?
- A: There has been talk and legal teams will need to be involved but there is not a final answer on that piece.

Linda O'Neal thanked Dr. Willis and noted she would be available later for additional questions participants may have.

IV. Managed Care Organizations and Children's Mental Health

Dr. Jeanne James, Medical Director at TennCare presented on TennCare. She provided a handout, power point slides, and link to online reports.

- The Medicaid program in Tennessee is TennCare and is the largest insurance provider in Tennessee, covering half of baby births and 1.2 million enrollees, 700,000 of them children. However, half of TennCare funds are not spent on children.
- TennCare operates under a waiver program from the Federal Government to contract with Managed Care Organizations (MCO). It assigns all enrollees to an MCO with the exception of long-term care in nursing homes. All MCOs are at full financial risk, paid a per member per month payment plus incentives. We have a Contract Risk Agreement stating all the requirements for MCOs, and most are from federal requirements.
- State requirements include: National Committee on Quality Assurance (NCQA) accredited; requirements related to prevention and well child visits; Early and Periodic

Screening, Diagnosis and Treatment (EPSDT) rules; disease management for education of members with certain illnesses so they can keep up with screenings and tests needed for illnesses, for example, pregnancy and prenatal care; asthma; mental health diagnoses; diabetes.

- Case management requirements include: identifying the most complex patients to coordinate complicated care and help the patients navigate the system.
- All members must be assigned to a Primary Care Physician (PCP) for a medical home.
- Effective January 1, 2009, Current MCOs in East Tennessee are AmeriChoice and Volunteer State Health Plan, Inc. (VHSP); Middle Tennessee, AmeriChoice and AmeriGroup; and West Tennessee, AmeriChoice and VHSP.
- TennCare Select manages children with special needs: children in DCS custody and children with Supplemental Security Income (SSI).
- Primary functions of MCOs:
 1. Assure access to care by maintaining provider networks, recruit and credential doctors, and claims processing.
 2. Deliver high quality care including ongoing quality improvement activities and targeted interventions for issues/concerns.
- At the state level, TennCare's role is to monitor MCOs; interface with the federal government; report expenditures; select MCOs; maintain eligibility and assignments of enrollees to MCOs (so they cannot recruit their own members); develop, manage, and assure compliance; monitor claims payment, some benefits (long-term/nursing home), dental, pharmacy; and to monitor the collection and analysis of encounter data; enrollee and provider fraud; quality of care monitoring through network adequacy standards for each area and report standardized performance measures.
- The first full year of data will be available in June for 2008. Children's mental health follow-up information after hospital discharge will be included, but we won't be able to separate mental health conditions from other conditions.
- Surveys for members' satisfaction of care will include a category on children with chronic conditions including several chronic mental health conditions. Feedback will be available in the fall.
- The process and monitoring of appeals is to be reviewed by experts at state level.
- Site visits for mental health integration have been completed with exciting results and the opportunity to think about how to treat the whole child and the whole family. This will improve the way the provider community will work and communicate, leading to exciting changes in delivery systems.
- Appeal process timeline will be individually addressed. Greer dictates the rules for appeals/notifications. Emergencies have faster timelines.

Heather Baroni, AmeriGroup presented on AmeriGroup children's initiatives.

- Works with TennCare, providers, and community leaders.
- AmeriGroup is one of the two MCOs in middle Tennessee.
- Provides community focused managed care, coordinating mental health and substance abuse needs.
- Standards for contracting with providers are based on specialties, locations of members, and availability of adequate services.
- Tennessee is very progressive with a full continuum of services for adults and children with mental health issues.

- Network providers range from acute psychiatric, detoxification to out-patient services, and peer support specialists. There is a large array of services in Tennessee.
- AmeriGroup is fully contracted with all available mental health/substance abuse providers for children in Middle Tennessee although some rural areas don't have services.
- Transportation is included so members do have access even if it isn't geographically convenient.
- AmeriGroup believes a medical home is the key to keeping children and adolescents healthy.
- The PCP is the point of contact for medical home. AmeriGroup looks to them to coordinate with other providers and be the point of contact for the child's healthcare.
- Severely Emotionally Disturbed children are worked with closely to coordinate care between specialists.
- There is a specialty network with behavioral health specialists for children. AmeriGroup looks to bordering states for providers for children with specific needs that can't be provided locally. In that case there are single case agreements with them.
- Strong belief that family preservation and involvement are the keys to the health and welfare of child and his/her ability for recovery and development of resiliency. AmeriGroup believes in the least restrictive, most appropriate level of care, including in home services like Youth Villages to work with families to address mental health and substance abuse issues with children.
- Providers have stepped up to the plate to deal with over and under utilization of services.
- AmeriGroup promotes and aspires to adhere to system of care core values, child and family-centered, culturally competent requirements for providers, including fully contracted network with a full array of services, and very individualized attention.
- TennCare, TDMHDD, advocacy groups and community based services all work together to take care of our children.
- Q: What are the requirements for cultural competence?
- A: Federal law compliance, sponsor education, awareness, movement of needs. We do not have a report but site visits include it. Cultural competence is consumer driven and we rely on advisors to improve our services within those realms.
- Q: What is the mechanism to pay for meetings among different providers?
- A: None are contracted. Meetings take place between peer groups and providers. It is not a traditional setting.
- Disease Management and Case Management are one single point of contact for members regardless of physical or mental health issues. One individual is appointed for the member to discuss healthcare needs and this has had very positive results. Other methods of communication include face-to-face, telephonic and written communication.

Mary Linden Salter, Director of Network Services, AmeriChoice and Elliot Sparks, Field Care Management for TN, AmeriChoice presenting on AmeriChoice programs and developments for Tennessee. A handout and power point slides were provided.

- Request for Information (RFI) was sent to providers in West Tennessee on 12/22/2008. AmeriChoice received responses interested in addressing all identified issues. Mental Health/Substance Abuse (MH/SA) service needs for children were addressed. All applications for services will be reviewed.

- RFI for East Tennessee went out March 12, 2009 for children's innovative programs to meet access and availability standards, and promote integrated care concepts. Programs that submit integration are going to get extra points in process and creativity is encouraged.
- Asked East Tennessee providers to join the Intensive Out-Patient (IOP) Program.
- Carey Counseling Center will try to put an IOP in Northwest part of the state. Lake County area is having a hard time addressing some children's issues. The highest rates of inpatient care are in that area and they are relatively underserved with no local providers.
- Ideas to remedy this include: integrated contract to open clinic in a school in Lake county; identify a Primary Care Physician (PCP) office to co-locate a behavioral health provider with one day a week services; informally brainstorm to link providers; develop evidence-based practices around the state for children; expand Continuous Child and Family Team and Continuous Treatment Teams; asking providers to share other programs and criteria for evidence-based practices (SAMHSA requirements); Level of Care revisions; maximize tele-health capabilities and provide management contracts through tele-health; promote linkage closer to home and have family understand what discharge plan is when child comes home.
- Increased fees to child and adolescent psychiatrists.

Elliot Sparks:

- Field Care Program, as it relates to children, delegates one person to child in residential treatment center. Every child is known about and their case is followed by that person. Primary responsibilities are: coordinate care; partner with providers in a positive way; participate in treatment team meetings for both in-patient and out-patient levels of care; have a 'do whatever it takes' mentality and be willing to talk with any agency/provider to help child get care they need; assist providers when there is a need to facilitate appropriate discharge services and help to coordinate discharge and find services making sure they are provided correctly, right time/amount/place; attend Individual Education Plan (IEP) meetings (which is a unique activity that other MCOs don't do) helping facilitate those meetings and advocate for the children involved.
- Integration and Wrap-around services are most important.
- **Residential Treatment Care (RTC) diversion program** is in the early stages and hopefully will eventually be statewide. Initially will be implemented in Middle Tennessee using face-to-face assessments for appropriate level of care. The idea is to utilize and explore least restrictive level of care, with community based care preferred; expand respite services to help those that need to have time apart from family; more emergency referrals to Comprehensive Child and Family Treatment (CCFT); cost-effective alternatives to Residential Treatment Center (RTC); and therapeutic foster care and group homes for children who have finished a treatment program but aren't ready to go home, especially for those that have been in RTC for a long period of time. This works as a positive transition to the child eventually going home.

Ron Wigley, Manger of Behavioral Health Programs, VSHP presenting on Integration at VSHP.

- VSHP has a strong investment in co-location integrating behavioral and medical.
- What VSHP is doing to integrate (internally)?

- Care managers, disease managers and utilization management are currently trying to integrate internally by combining medical and behavioral staff physically within the office giving better opportunity to access help and coordination of care.
- Case rounds including medical professionals and psychiatric professionals, mental health clinicians and nursing care are having a profound impact on the degree of services and decision making.
- VSHP has highly experienced/seasoned staff including nurse care managers and behavioral health clinicians, many with a background in working with children in mental health care environments.
- VSHP is integrating behavioral health into a broader arena.
 - Memphis City Schools are currently placing health clinics in four schools and are going to include behavioral health screenings and initiatives.
 - East Tennessee support for behavioral health and medical providers is being provided with telemedicine in 17 schools in Sevier County (through Cherokee Health Systems). Federally Qualified Health Centers (FQHC) has a behaviorist located in each of their clinics and a good deal of consultation takes place between doctors and psychiatrists. Cherokee is helping to spread this model across the state.
 - Memphis is working with their four largest pediatric groups to establish a referral line, making it easier to call VSHP for an assessment with care management and to help with appointments, transportation, and follow-up.
 - Community Mental Health Centers in Memphis will provide mobile behavioral health clinicians for home/practice visits.
 - Trying to make sure early screenings always include a behavioral health assessment to identify children with mental health needs as early as possible.
 - Partnering Columbia University with Teen Screen to integrate mental health checkups into routine health care visits (early detection of mental illness and suicide prevention), originally developed for school settings works just as well in PCP visits/offices.
 - Making a psychiatric consult line available to PCPs as an easy way to talk to a psychiatrist for questions/referral/treatment/medications.
 - Presently surveying provider network to determine scope of PCP needs from psychiatric consults to see if there is a need for further development of consult line (psychiatric residents in university settings).

Jeanne James added this is an opportunity for MCOs to work with delivery systems and centralize services to be more child/family friendly, and more easily navigable. She also added cultural competency makes services better and more child-focused.

Commissioner Betts commented the policy decision to move from carve out to carve in is reflected in what we have heard today and this is the beginning of our vision for opportunity to have a carve in contract. The promise of integration might include us getting there even if there are still concerns we need to overcome. Presentations are very encouraging because we are seeing some real movement on services that are helpful to the individual. Follow up will be in three and six month intervals. Presentations are appreciated and work is being done to move in that direction.

Linda O'Neal added she would like everyone to share their notes so information can be distributed to CCMH members.

V. Policy Academy Report – Dr. Freida Outlaw, TDMHDD and other attendees

- Gave an overview of accomplishments, preplanning and the work to follow.
- Introduced delegation: Millie Sweeney (Tennessee Voices for Children), Jeanne James (TennCare), Katrina Donaldson (Parent Representative), Bob Duncan (Governor's Office of Child Care Coordination), Randal Lea (Department of Children's Services).
- Academy was a competitive process from the application to the acceptance.
- Six states accepted out of 22 applications submitted.
- This was the first time that an academy had been sponsored by National Federation of Families for Children's Mental Health and co-sponsored by SAMHSA.
- Academy focused on family-driven care.

Millie Sweeney presented on the preparation: Technical assistance was provided when we were accepted into program and conference calls/surveys were conducted. The survey was a way to get an idea of what people across the state thought about family-driven care. We received 101 responses from providers, statewide organizations, education, advocates, parents, state government agencies, juvenile court and legislators. All agreed family-driven means the family has a primary decision making role. Barriers include lack of insurance coverage, funding, stigma that families are not able to be decision makers and perceptions limiting roles family members can play in the process.

Jeanne James presented on what happened at the Academy (see handout): Lesson learned came from other states' presentations and our interactions with other states. We worked well together with experts on guidance regarding funding and working with programs giving us a chance to be in the room together and talk about how organizations interact with each other, how we can coordinate our work and reach our every day goals.

Katrina Donaldson presented on the motto and vision: Motto: "Tennessee: One state, one family." Vision: "We believe that families must be included at all levels of intervention for their child/children including service development, service planning, evaluation, training, decision-making and communication between systems."

Randal Lea presented on Tennessee's future objectives and evidence of success: We came to the conclusion that "non-compliant" is a bad word. Family members, consumers, children are labeled non-compliant. We would like to wipe this phrase out of the state. Instead, we ask ourselves: "What about our approach, our style, our engagement is failing to meet children's needs" instead of using the term "non-compliant" to "blame" client. Tennessee wants to get to a point where there is a work force that will not tolerate the exclusion of families in policy planning. We really want family driven services to be the hallmark of system. One objective focused on family being effective policy makers along with us, understanding the language and participating at every level of the process. Another objective is to prepare the systems to have a professional behavior that deliberately includes families and brings them to the table to move forward with care, not tolerating family exclusion. There needs to be a marriage

between evidence-based services and family-driven services to allow families to help find evidence of successes.

Bob Duncan presented on the “Ah Ha moments.” Tennessee was one of six states participating. While other states said they were having disagreements within, Tennessee was working together. How fortunate we are to have the group we have, and how far Tennessee has come with interagency collaboration. We are making great strides and lot of great work is happening in Tennessee. Tennessee will probably hit the mark before the other states.

Freida Outlaw added they will be talking more to CCMH regarding integration of family-driven initiatives into work that already exists and will come back with a plan. It was not hard to be a leader of a group that was so great. Thank you.

Linda O’Neal added her thanks to the Policy Academy noting their hard work.

VI. Juvenile Justice and Mental Health Collaboration Program Grant Proposal

Dr. Jeff Feix, Department of Mental Health and Developmental Disabilities gave update on JCCO Workgroup and presented on Specialized Crisis Services Teams (see handout)

- JCCO meeting held February 12, 2009 was well attended with 13 in the room and five participating via conference call.
- Explained Juvenile Court Commitment Order (JCCO), mental health evaluation ordered by a juvenile court judge, can have in-patient or outpatient evaluations conducted and the state supports both types of evaluations.
- This summer, Tennessee Court of Appeals ruled counties must pay for in-patient evaluations. Commissioner of Mental Health can establish contracts with Community Mental Health Agencies for outpatient evaluations.
- Mental health evaluations are very involved and it is a very comprehensive process to decide whether a child is committable or not, competent to stand trial or not.
- Mission is to determine services available to children, if children are being evaluated, and are there other ways to do this evaluation?
- Specialized Crisis Services (SCS) could be utilized in assisting courts in the assessment of children’s mental health needs/services.

Dawn Puster from Youth Villages presented on the Do’s and Don’ts offered by Youth Villages Specialized Crisis Services: (see handout listing the do’s and don’ts).

- Different definitions are to cover a variety of behaviors.
- Contractual agreements for response time are one hour for emergent, four hours for non-emergent. Youth Villages tries to get to each call as soon as possible, emergent or not.
- Assessment process includes an individual assessment for the child that day including information from family members and other providers involved in behavioral history of child. Recommendations are made for the next level of care for child. Assessment time takes approximately two and one-half hours, longer if there is hospitalization. Placement in a private hospital is attempted before placement in a public hospital, even if child is uninsured.
- Safety Plan is provided for each child, regardless of where they go (home, hospital, group home) and is individualized to the setting where the child will go.

- Recommendation options, inpatient, which is most restrictive, formal respite, and residential treatment, are not taken lightly.
- Cannot force a hospital to take a child, even if hospitalization is recommended; cannot make direct referrals to treatment, can only make recommendations; typically don't provide transportation unless going to Youth Villages' formal respite; cannot determine legal issues.
- Q: Will funding for this program remain after the state budget cuts?
- A: Hopefully.
- Q: Why can't you do the forensic evaluation?
- A: Our staff doesn't have that specific training. Our assessment process is to determine what is happening with child and what they need immediately versus a look back at what their thinking was at the time of the incident. It takes different qualifications to do forensics (training, professional qualifications and it takes third party collections to put together the forensic puzzles). This program is clinical only, short-term and immediate.
- Commissioner Betts: We can sit down and see if forensics can be eventually provided or paid for by this program. A child that is to be admitted will need to meet standards for that level of care.
- Q: Does Youth Villages go anywhere the child is, including schools?
- A: Yes.
- Q: Are some judges using service to make decisions about secure detentions?
- A: Typically not. Generally they (the judges) accept the recommendation. There is a two step procedure: 1) Crisis services are called and 2) child is placed. Crisis services do a different type of assessment than forensics. A counselor has been placed at the crisis services once or twice a week in order to check in with the kids. Crisis Services are not going to replace JCCOs.
- Q: What is happening with the children now?
- Before court ruling, there were 60 children a month going through the system. After court ruling, there have been six children total.

Shay Jones Crisis Management Team Coordinator with Department of Children's Services (DCS), addressed the question of "where are the kids now?" Her position was created to work with children in danger of coming into state custody. DCS will know about at risk children across the state coming into custody. Residential treatment calls are the largest number of calls received. When the ruling came out, court liaisons were educated on the changes to connect everyone with the changes and what they could now do. Crisis Management Teams saw a decreased number of calls and continued to educate DCS staff across state to help them work through MCOs and outpatient mental health providers in the community. We know it is working because people are being proactive about getting in touch with providers in the community and starting to refer to residential treatment. A lot of children are being served by existing means that haven't been fully utilized before. DCS staff is being creative in accessing respite and respite stays and detention until we are able to meet with the children. There are a lot of families reaching out to providers to have on site assessments done with providers. There are now a lot of mobile assessors across the state that will go on site to detention facilities or to the court to do an assessment on the child.

- Q: Is there a quantifiable tracking system about what happens to these children? Is there a disconnect with the children between detention and receiving services?
- A: The only way to capture that would be to know what the judge was thinking about that moment. We are heading in that direction.
- Q: Does the child have to have a payer source?
- A: Not to our knowledge.
- **KidLink** is a networking service run by United Health Services that owns residential programs across the state. It is a referral system to triage the case and then evaluate if the child is appropriate for any of its facilities, which are all TennCare contracted. They are able to be accessed very quickly. But the first preference is to get in contact with provider.

David Haines, J.D., Administrative Office of the Court (AOC):

- We are asking judges across the state to engage in a tremendous shift of how they deal with children who commit felony-level crimes. We are going from a system where the child is transported for an inpatient evaluation and brought back to court on a certain date to a system with an array of contacts to find a place for these children and a place to assess them.
- We need to find a better way to utilize all of the existing resources. It's going to be hard to get judges to switch to this method, but that doesn't mean we shouldn't try.
- Initial approach to have Youth Villages as primary contact did not get warm perception.
- Judges need to be engaged in the process of figuring out if Youth Villages is the way to go. The task is getting the judges to call them.
- Four bills are pending in the General Assembly, three of them reversing the ruling made last June. They carry \$7.5 million fiscal notes and will most likely not pass. A different approach is going to have to be put together. Educate judges and staff on how to do this. Asked for two pieces of info from judges: 1) be specific about numbers/circumstances of children coming into state custody and 2) tell me about your experience with Youth Villages, specific experiences.
- AOC wants to sit down with a group of judges to figure out how to make this work. Amazed by amount of resources. If we could just map them together and figure out how to deliver them.
- If there is a place for a child to be held, outpatient services can come to that child, but if that place is a judge's office, it adds difficulty to trying to get an assessment.
- Smaller counties with no detention facilities are most frequently saying Youth Villages is not fast enough. Outlying areas being hit the hardest with no money to pay for evaluations and no place for kids to go.

Linda O'Neal added incredible work has been done on this issue expressing appreciation and thanks. On the surface, it sounds like we are getting mixed messages. Judges are putting kids in custody faster than usual, but the kids would have gone into custody eventually. It's a timing issue more than anything.

Haines added a survey for judges and staff is being developed to help pinpoint what is being done and what can be done. The keys are building bridges between services and judges and developing other ways to screen non-emergency kids.

Mary Rolando, Governor's Office of Children's Care Coordination presented on Grant Application to solve some of the JCCO issues. (See handout)

- Contributors: Jeff Feix, David Haines, Elvie Newcomb, Linda O'Neal, Bob Duncan, Randal Lea, Mike Cull and Richard Epstein.
- Proposal: Tennessee Integrated Court Referral and Screening Project submitted to U.S. Department of Justice.
- Purpose: to increase public safety.
- Focuses on non-violent offenders.
- Collaborators: MHDD, AOC, DCS, Vanderbilt COE, TCCY and GOCCC.
- Program will serve 6,000 children and youth with non-violent charges, screening for mental health and substance abuse services needs.
- Two goals when applying for level two grant:
 1. Complete strategic planning process for implementation (October 1, 2009 - December 31, 2009).
 2. Divert children with mental health and substance abuse needs from entering state custody and provide less restrictive care.
- Able to cite a number of things relevant to JCCO and this project. Close to seeing what this plan will really look like.
- Project Implementation: Ten courts initially with particular locations surrounding MuleTown.
- Chaired by Bob Duncan with membership of Marthagem Whitlock (TDMHDD) David Haines, Linda O'Neal, Mike Cull, and family members from partnering agencies.
- Grant Panel will be led by Jeff Feix (TDMHDD), Elvie Newcomb (data management adequate), Shay Jones, Dora Stafford (to assure linkage of quality and monitoring) and Richard Epstein (data analysis with CANS).
- This project demonstrates real collaboration. TCCY supplied courts with computers and grant supplies web connection.
- Want to hire project coordinator as soon as possible so they can be part of planning process.
- We think this is doable and easily replicated because so many of the parts are already in place. It will provide screening, not an assessment.
- Feix and S. Jones generated some basic issues to pose to youth service officers and we will get them surveyed in order to learn where people are being referred.

David Haines added what we found and what we know is children are in custody and 75% have identified mental health disorders diagnosed, but nothing is done to screen for mental health issues when they show up in court. Upfront screening is the number one thing that can be done to improve mental health issues with children. We need to do this with every child in every county.

Linda O'Neal added this is a really exciting opportunity reflecting the level of collaboration evidenced by everyone here today.

- Q: Purpose of juvenile justice mental health collaboration program has substance abuse as a specific focus of the application. Is that a tension between how the grant was written and are you addressing that in the grant?

- A: We hope that it is NOT a tension. The Department was very clear that it would be mental health and substance abuse. The actual application denotes prevalence of both.

Linda O'Neal gave thanks to Jeff, David and Mary. David thanked GOCCC for doing all the work.

VII. Evidence-Based Services Workgroup Update and Discussion

Mike Cull and Vickie Hardin, Co-Chairs

- Mike Cull was unable to attend the meeting today.
- Members were asked to go back to the report between today (March 13, 2009) and next meeting and be prepared to discuss pages 47 and 48. The group wants to try to come to a level of agreement/consensus. People actively involved in this will prepare a presentation.

Service Array Workgroup: Dustin Keller asked members to look at and give input on pages 42-43 of report. An email will be sent to group asking for opinions to help add to report.

Linda O'Neal added a survey is being developed to get a snapshot of evidence-based practices across the state.

VIII. Discussion of Plans for Next Steps for the Council on Children's Mental Health – Linda O'Neal facilitating:

- Meeting schedule through the end of June 2010 was discussed. A vote was taken on the October meeting date to decide whether or not to hold a meeting during the week of the Tennessee Voices for Children conference (week of October 22, 2009). Members decided to hold the meeting for CCMH on October 8, 2009.
- The April meeting is two days, Thursday, April 23, 2009 and Friday, April 24, 2009 to accommodate guest speaker Sheila Pires, who will be providing technical assistance around funding children's mental health systems of care. This is a very important topic. The second day will be a half day.
- We are not going to have time to have discussion about definitions of evidence-based practices or agenda items in April.
- Q: Will she include substance abuse funding?
- A: Yes
- Members were asked to carve out time for Legislation and Budget during April meeting as well.
- Meetings before next report is due in 2010 include April 23-24, June 25, August 20, October 8 and December 10, 2009 and February 11, April 22, and June 24, 2010.
- Discussion to bring in John Lyons to provide more in depth explanation of CANS use and benefits. Most likely this will be in June and it will take a substantial amount of the meeting time.
- There is minimal time for other issues at both the April and June meetings, but the workgroups can remain active to address a range of issues and there will be opportunity to distribute written info about what is going on.
- In August, there will be a lot to deal with in terms of activities and decision making in planning process.

- Linda O'Neal is re-sending all the dates for the upcoming meetings and will distribute handouts electronically.
- Q: Is it a capacity issue to be able to bring other folks to attend the meeting with Sheila?
- A: Freida Outlaw responded Day two can be about specialty issues and we could work out people coming on the second day. Linda O'Neal responded, yes, other people can attend. Send any special issues to Freida Outlaw with a specific request. Anyone who would like to come and work with us is welcome.
- Discussion on determination of future meeting locations. Going to look at other venues with better acoustics.
- Any time there are issues that need to be on the list for future agendas, you can send email to Linda O'Neal and Freida Outlaw. Please keep a list and send it regarding what we need to work on at subsequent meetings.
- Hope workgroups meet regularly and we will have really good reports in August.

IX. Other Business

- Recognized Sue Pilson and her work. She is retiring so this is her last meeting. She is also a member of the Commission on Children and Youth.
- Q: Cindy Perry: Town hall meetings were discussed as a strategy to share information across the state about work of council. Any thoughts/comments at this point? Is the timing any better?
- A: Millie Sweeney: Timing is better since we have completed a report to the legislature. Families love to share information and it is a great way to keep them engaged.
- A: Linda Tift suggested inviting Community Advisory Boards to town hall meetings. It is good training for them and a lot aren't running as efficiently as they could be.
- A: Angelia Cannon, Department of Education, asked members to share any postings with their Department so they can post on their website and share with their councils in order to keep collaborating with other agencies. Just having them be aware of it keeps them involved and asking questions.
- A: Linda O'Neal added town halls need to be revisited. We didn't move forward when they were discussed previously because it wasn't the right time, but now we have a preliminary report submitted to the Legislature. The momentum has been fabulous and now provides concrete information to provide across the state.
- Tracey Sampson suggested if we could piggyback on some issues/events, there are other channels like Parent Teacher Associations (PTAs). We need to think about what these would be and how to utilize them. If we get out there, we have to get out there pretty soon.
- Cindy Perry commented at the time of the Town Hall proposal, it was agreed the Council was too new, but now it sounds like a message has been formed. She suggested we ask Community Services Agencies (CSAs) to look at proposal and get it back to us in a timely manner.
- Comment: Tracy is right. Take the concept and come back with a plan on how we could take the information and standardize it across the state. Maybe we need to figure out what the message is, how it is synthesized and make sure it is standardized and then how it will be delivered.

- Linda O'Neal commented it is something we will continue to look at in order to move forward and try to figure out a better distribution of the wonderful work everyone is doing.
- Comment "canned" presentation can be put together and people can be trained to distribute that message. Small town "guest speakers" at the chamber of commerce, Lions Club, and local, small town clubs can be better utilized.
- Q: Sara Smith: What is the purpose of the town hall meeting?
- A: Millie Sweeney: Each meeting had someone from each region speak and even though it was the same message it was individualized for every area. It was effective.
- Linda O'Neal stated town hall meetings came from the SJR 799 process. There is a dual purpose: 1) to share information about what is happening and 2) to solicit input from people who are there.
- Q: Sara Smith: Any ideas about what we would want participants to do at that time to further our goals?
- A: Millie Sweeney suggested "kick off" meetings at the State of the Child Conference and having the first town hall meeting there.
- Tracy added Commissioner Betts is always happy to talk to local clubs. She has been a very good resource and would be willing to be a speaker.
- Q: Dustin Keller added town hall meetings take a lot of resources and a lot of time. Is there is a better way to get a better bang for our buck and get people to attend that aren't already involved? Can we reach out to all the different councils to have a three minute media presentation? Is there a better way to spend that time and those resources?
- A: Linda O'Neal added a lack of support comes from people feeling overloaded already. There is a lot of benefit from town hall meetings and most of them have had good attendance. They need to be an effort where all of us are encouraging our counterparts and people in those areas to attend.
- Tracy Sampson added Millie made a good point about keeping the community engaged while gaining feedback on what we need to do and results we have from our work so far.
- Comment: If we have town hall meetings, maybe they can be later in the year and be tied to existing events so we don't have to start from scratch.
- Millie Sweeney: All the previous town hall meetings are on video if people want to view them.
- Randal Lea encouraged everyone to remember this is about change.
- Linda O'Neal stated there is a lot of potential and interest in these and now we have to figure out how to make something happen.

Call for other comments, discussions, or issues.

- Pending Legislation
 - Linda O'Neal: There are four bills on JCCOs, as was mentioned earlier, three of which take the system back to the way it was with courts ordering inpatient evaluations. The fourth bill is an administration bill and it places the current situation in statute. A more appropriate system is going to have some kind of cost to it and will therefore have trouble going through the Legislature this year.
 - Two other bills of interest: One will prohibit universal screening for mental health problems in schools. This was proposed in previous sessions, but is more likely to pass this year since there is organized support for passing and lack of organized

opposition to it. The second is about the Mental Health Safety Net and is focused on adults.

- Millie brought up youth on the Sex Offender Registry. Linda O'Neal added there are three bills that could do this and there is Federal legislation to require this as well. There is interest around country to repeal the children's part of this. Commission on Children and Youth and the Council of Juvenile and Family Court Judges oppose these bills. This is a great concern.
- Mary Rolando: abbreviated litany of important legislation was included in Children's Advocacy Days handout and suggested distributing a copy of this document.
- Linda O'Neal stated Monday we will expect the first send. CAD briefing sheets. 468 people at this event and a number of speakers. Distributed briefing sheets on Commissioners' positions on legislation which included:
 - Yes: Acceptance of Stimulus dollars;
 - No: Adoption restrictions;
 - No: Joint custody when parents don't agree;
 - Yes: Child support with equal custody;
 - No: Juvenile sex offender registration.

TCCY works very hard and puts a lot of emphasis on keeping bad legislation off the books. We need to be looking at good public policy for children in Tennessee

There being no further business, meeting adjourned.