PUBLIC CHAPTER 1062

COUNCIL ON CHILDREN'S MENTAL HEALTH

FEBRUARY 2009 REPORT TO THE LEGISLATURE

STATE OF TENNESSEE
COUNCIL ON CHILDREN'S MENTAL HEALTH
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MEMORANDUM

To: The Honorable Phil Bredesen, Governor
The Honorable Ron Ramsey, Lieutenant Governor
The Honorable Kent Williams, Speaker of the House
Honorable Members of the Tennessee Senate and House
Members of the Governor's Children's Cabinet

From: Virginia Trotter Betts, Commissioner, Department of Mental Health and Developmental Disabilities, Co-Chair, Council on Children's Mental Health
Linda O'Neal, Executive Director, Tennessee Commission on Children and Youth, Co-Chair, Council on Children's Mental Health

Date: January 30, 2009

RE: Council on Children's Mental Health Preliminary Report

This memorandum transmits the Preliminary Report of the Council on Children's Mental Health as required by Public Chapter 1062 enacted in 2008. As directed by P.C. 1062, we have co-chaired a Council on Children's Mental Health composed of stakeholders from all across Tennessee who have met and exceeded the statutory requirements for membership and have come together without compensation and largely without reimbursement for travel.

Council members have worked diligently together to develop this Preliminary Report and we are well on our way in the planning process for implementation of a System of Care to better meet the mental health needs of children in Tennessee. The level of commitment and excitement has been extraordinary. Over 100 Tennessee citizens have volunteered to be involved in this process and meetings have averaged attendance of 50.

As you review this report, we think you will see the great potential for improving outcomes for Tennessee children's lives. If you are interested in receiving a briefing on this report individually or before committees, please contact Commissioner Betts at 532-6500 or Linda O'Neal at 741-2633. We look forward to collaborating with the General Assembly in improving mental health services for Tennessee children.

cc: Council on Children's Mental Health Members

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EXECUTIVE SUMMARY

Public Chapter 1062 established the Council on Children's Mental Health (CCMH) to design a plan for a statewide system of mental health care for children. The law recognizes that attaining children's mental health goes beyond administrative and service boundaries of any one department or agency. It articulates the fundamental structures to assure interdepartmental, grassroots, constituency-based planning to achieve a system of care responsive to the needs of children and their families.

The February 2009 Report to the Legislature addresses the requirements of P.C. 1062.

Status of the Plan

The Council on Children's Mental Health (CCMH) was initiated in June 2008, meeting and exceeding the requirements for participation. The CCMH has met five times, co-chaired by the Commissioner of the Department of Mental Health and Developmental Disabilities and the Executive Director of the Tennessee Commission on Children and Youth. Workgroups established during SJR 799 were sustained and revised. One new group was added. Over 100 people—state agency leadership, representatives of the Governor's Office, Legislature, Comptroller's Office, Community Service Agencies, providers, advocates, judges and parents of children who have received services—are participating regularly.

The Council focused on organizational matters, then quickly turned to substantive concerns about children's mental health beginning with the first meeting. In that and subsequent meetings, the CCMH has explored a wide range of issues and activities relevant to P.C. 1062, among them:

- SJR 799 inclusive of its history, town hall meetings, workgroup processes and products, recommendations and legislative outcome;
- Programs and priorities of the major child-serving state departments;
- Numerous activities occurring statewide and nationally that can inform and influence the CCMH;
- The state's experience with systems of care to date;
- Issues which rose to a level of visibility because of emergent conditions that warranted the Council's attention;
- The state's budget.

Workgroups have met regularly to help the CCMH move forward efficiently, focused on:

- Accountability and Management Information Systems;
- Funding;
- Interagency Collaboration;
- Comprehensive Service Array;
- Cultural and Linguistic Competency;
- Evidence-based Services;
- Media Relations.

Timeline for Plan Development

P.C. 1062 requires a plan for a statewide system of care. Implementation of the plan is staggered. The CCMH will develop a plan for:

- Three demonstration sites by July 2010 for inclusion in 2011 budget;
- 10 sites by July 2012 if the initial plan is funded;
- A statewide system by 2013 if prior plans are funded.

The CCMH will meet during March and April 2009 and every two months thereafter through June 2010 or more often as needed to complete a plan by July 2010. Workgroups will meet as necessary to support the Council's agendas and development of the plan.

Barriers to Implementation

Potential barriers to implementation of systems of care in Tennessee were identified in SJR 799 Town Hall meetings, DMHDD's Title 33 Planning and Policy Council rankings, and captured in CCMH discussions. In January, Council members were surveyed about perceived barriers to implementation of systems of care in four areas:

- Administrative;
- Service;
- Policy;
- Implementation of System of Care principles.

One barrier has been youth participation in the Council resulting from scheduling conflicts. Youth were surveyed about their experiences with mental health and support services. Input came from:

- Youth councils affiliated with Tennessee Voices for Children.
- Tennessee Alliance for Children and Families.
- Residential Treatment Center Boards, youth board members.
- Youth in DCS custody.

Youths' comments were very informative, especially when asked what they wanted most from providers, which was primarily for someone to hear and honor what was disclosed.

List of All Programs

The CCMH is respectfully requesting deferral of this requirement, pending the results of the FY 2010 Budget. The Report does include the array of services identified as part of SJR 799.

Status of Interagency Collaboration

P.C. 1062 calls for a report of the status of interagency cooperation. The Council and Workgroups were surveyed about perceived status. The results were very favorable about interagency cooperation currently, but the challenges going forward are substantial.

Financial Resource Map

The CCMH is working in concert with the Resource Mapping Advisory Group of P.C. 1197, also passed in 2008, which requires mapping of all federal and state funds supporting youth. The resource mapping process is moving forward with timelines for implementation, indicating a report will be available Spring 2010, which will also provide a financial map for the July 2010 report for P.C. 1062.

Recommendations for Improving Efficiency in Use of Funds

The CCMH will be able to make definitive recommendations for improving efficiency in the future, but not at this time. However, there are contributions to achieve efficiency noted in the Report.

Related Considerations

The CCMH explored statutorily-related matters and other administrative and organizational initiatives relevant to P.C. 1062 and planning for systems of care. The Council intends to stay abreast of all related functions, on-going and as new issues emerge.

The Council on Children's Mental Health is fully engaged in an exciting process to fulfill the requirements of P.C. 1062 to plan for a system of care. It is a complex but achievable task. The CCMH appreciates the commitment of all involved, the support of the Legislature in this endeavor and the opportunity to work with the Legislature, the Administration and others to accomplish the goal.

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Public Chapter 1062 established the Council on Children's Mental Health (CCMH) to design a plan for a statewide system of mental health care for children. The principles for systems of care were promulgated in Title 33, the Mental Health and Developmental Disabilities law, in 2000. However, children's mental health issues span across departmental lines at the state and local levels. The significance of P.C. 1062 is its recognition that attaining children's mental health goes beyond administrative and service boundaries of any one department or agency.

While "system of care" is conceptual in nature, identifiable relationships among all the parties make systems of care tangible. Relationships among administrative agencies, funders, providers, community supports, educators, advocates, children and their families are seminal. P.C. 1062 articulates the responsibility for the CCMH to design a system that is qualitative, quantitative and functional. This Report responds to the requirement for a report on the status of development of the plan to the Legislature by February 1 of this year.

The organization of this Report is derived from the requirements of P.C. 1062 to address:

I. Status of the Plan;
II. Timeline for Plan development;
III. Barriers to implementation;
IV. List of all programs;
V. Status of interagency cooperation;
VI. Financial resource mapping;
VII. Recommendations for improving efficiency in use of funds;
VIII. Related considerations.

Restatement of System of Care Values and Principles

The goal of the State's system is for children with multi-system needs to be served in their homes and communities. Briefly, values in such a system are demonstrated in services and supports that are

- Child-centered;
- Family-driven;
- Community-based;
- Culturally and linguistically competent.

The values are evidenced in implementation of System of Care Principles. The System has:

- A comprehensive array of services;
- Individualized services based on children's and families' strengths and needs;
- Services and supports occurring in least restrictive environments;
- Families as full partners in planning, implementing and evaluating their experiences;
- Services that are integrated and coordinated;
- Early identification, prevention and intervention services;
- Smooth transition to adult services;

- Advocacy;
- Culturally competent services;
- Accountability for system performance and family outcomes.

When the components are in place with fidelity, one can expect these system outcomes:

- Reduced school suspensions, expulsions, and dropout rates;
- Reduced utilization of inpatient mental health services and residential placements;
- Reduced juvenile court involvement and adjudications;
- Reduced commitments to state custody.

I. STATUS OF THE PLAN
The Council on Children's Mental Health

The Council: Membership of the CCMH meets and exceeds the participation articulated in P.C. 1062. The Co-chairs of the Council—the Commissioner of the Department of Mental Health and Developmental Disabilities (DMHDD) and the Executive Director of the Tennessee Commission on Children and Youth (TCCY)—in conjunction with the Executive Director of the Select Committee on Children and Youth and many others, very quickly identified, invited and assembled state agency leadership, representatives of the Governor's Office, Legislature, Comptroller's Office, Community Service Agencies, providers, advocates, judges and parents of children who had received services to be members of the Council. Youth representatives have been identified but their participation has been limited because of scheduling conflicts.

The CCMH has met five times between July 2008 and January 2009, typically from 10:00 a.m. through 3:00 p.m. in Nashville. A decision was made early in the process that all participants in Council meetings would be considered members in order to be inclusive of all who have an interest. Level of participation has been remarkably high, given the constraints of travel restrictions and significant demands on every person's time. CCMH members and their affiliations are appended at p. 62. Attendance averaged 50 persons for the five Council meetings.

The Council focused on organizational matters; familiarized itself with the history of SJR 799, the programs and priorities of the child-serving departments, and with ongoing activities related to the work of the CCMH like the Early Childhood Comprehensive System grant in Department of Health (DOH), Coordinated School Health in Department of Education (DOE) and a Collaborative on Adolescent Substance Abuse Services in the Governor's Office of Children's Care Coordination (GOCCC). The Council agenda became very expansive due to willingness of members to identify and recommend activities, processes and research that could contribute to and inform system design going forward. It was on this basis that the Council was provided, among other things, overviews of the federally funded System of Care grant programs through DMHDD, depicted in February Report Table 3, p. 15; assessment instruments being used in the State including the Child and Adolescent Needs and Strengths (CANS) utilized by DCS, Tennessee Outcome Measurement System (TOMS) utilized by DMHDD, and the System of Care National Evaluations required of the federally funded grant projects.

A full representation of agendas and outcomes is depicted in February Report Table 1 Summary of Agenda, Purposes and Outcomes, p. 3.

Council Workgroups: Six Workgroups formed during the period of SJR 799 were revised for continuation under P.C. 1062, combining two groups and adding a new one. The Workgroups have met independently of each other as frequently as needed to achieve their objectives and reported their activities and next steps at CCMH meetings. The Workgroups and their foci are reflected in the following February Report Table 2, p. 11.

FEBRUARY REPORT TABLE 1
SUMMARY OF AGENDAS, PURPOSES AND OUTCOMES

January 2009

DATE	AGENDA ITEM	PURPOSE	RESULTS/CONSIDERATIONS
MEETING 1 7/22/08 10:00 A.M.- 3:00 P.M.	Welcome/Introductions	Familiarize Council w/ participants, affiliations, and interests. --Virginia Trotter Betts --Linda O'Neal --Rep. Sherry Jones	❍ Identified additional people to invite to participate. Clarified responsibilities of participants. ❍ Reviewed national Report on Children's MH definition of mental health: successful performance of a variety of functions and the ability to adapt to change and to successfully cope with adversity.
	Overview of P.C. 1062	Familiarize Council w/ requirements of the law. --Linda O'Neal	❍ Identified elements for improving children's mental health in TN from the law. ❍ Discussed why families, the mental health system, and education each need a system of care.
	Overview of SJR 799 ❍ Select Committee Child/Youth ❍ SJR 799 Survey ❍ Service Array Workgroup ❍ Interagency Collaboration WG ❍ Management Information WG ❍ Funding Workgroup ❍ Accountability Workgroup	Describe historical perspective on SOC activities to date. --Cindy Perry --Workgroup Chairs	❍ Discussed results of survey of perceived needs and issues; reviewed products of SJR 799 Workgroups to list all desired services and supports in SOC, Interagency Collaboration vision for a SOC, existing and potential management information systems, funding streams for the service array, focus and locus of accountability measures which assure quality services.
	Clips from SJR 799 Town Hall Meetings	Provide highlights of 14 Town Hall meetings	❍ Demonstrated recurring themes of need for better outcomes and to hear from constituents statewide and need for community leadership in SOC.

	Updates on Activities Related to P.C. 1062 Requirements ❍ Center on Social Emotional Foundations for Early Learning (CSEFEL) ❍ Early Childhood Comprehensive System (ECCS) ❍ Schools & MH Integration Grant ❍ Financial Mapping/T-ACT	Familiarize Council w/ other activities that could inform or influence implementation of P.C. 1062 --Matt Timm --Rosie Wooten --Sara Smith --Mary Rolando	❍ Learned the plan for Team Tennessee's training and technical assistance for child care workers through a pyramid model developed by CSEFEL. ❍ Related umbrella planning structure of ECCS to the CCMH. ❍ Discussed implications of Coordinated School Health inclusive of mental health and of the TN Schools and MH Systems Integration Grant funded by IDEA Safe and Drug Free Schools resources. ❍ Conveyed information about financial mapping from a collaboration of departments and other agencies with an interest in children/youth substance abuse issues.
	Strategies for Accomplishing Requirements of the Law	Open discussion about next steps	❍ Council suggestions included reviewing TN experiences w/ SOC, local marketing/public awareness about P.C 1062 implementation, various presentations, identifying barriers and conflicts at local levels, laws and experiences of other states, identifying quick wins/barriers that can be addressed easily and soon.
	Committee Structure and Assignments	Assess status of SJR 799 workgroup structure and utility going forward.	❍ Workgroups—retain workgroups; have representatives of each state department in each group; add cultural/linguistic competency and EBPs workgroups. ❍ Council—model collaboration required by SOC; identify smaller executive steering committee to develop structure for strategic plan. ❍ Report—establish timeline, identify needed information, gain information on perceived barriers.
DATE/TIME	AGENDA ITEM	PURPOSE	RESULTS/CONSIDERATIONS
MEETING 2 8/28/08 10:00 A.M.-3:00 P.M.	Requirements of P.C. 1062	Overview for first-time Council participants; review for others.	❍ Focused on deliverables: o February 1 2009 Report to Legislature o July 1 2010 Plan for three demonstration sites for inclusion in 2011 budget o Plan for 10 sites by July 1 2012 if prior plan is funded o Plan for system statewide by 2013 if prior plan is funded.

	Overview of Child-serving Departments ❍ DCS ❍ DOE ❍ DOH ❍ DMHDD ❍ TennCare ❍ TCCY	Familiarize or update Council on agency priorities, services and other characteristics. --Viola Miller --Mike Herrmann --Veronica Gunn, MD --Virginia Trotter Betts --Jeanne James, MD --Linda O'Neal	❍ DCS—As the state's public child welfare agency (foster care, juvenile justice, child protective services, in-home services) serving children w/ complex issues, the need is for multi-system approach to treatment and early identification. Improvements are being made by use of CANS assessments and multi-agency focus on MH issues of children in custody. ❍ DOE—Acknowledging the effect of mental health issues on ability to learn and variability in school districts, relevant programs include Coordinated School Health (Meeting 1), Special Education and school safety and support. ❍ DOH—DOH's mission is to protect, promote and improve well being of all Tennesseans, including emotional well being. Have experienced rise in WIC referrals and families with more mental and behavioral health needs. ECCS, home visitation programs, child immunization, Fetal/Infant Mortality Review (FIMR) and suicide prevention programs are relevant to P.C. 1062. ❍ DMHDD—As the state's public mental health and A&D authority, the department plans for and promotes the development of a comprehensive array of quality prevention, early intervention, treatment habilitation and rehabilitation services for individuals and families. The department also runs the Regional Mental Health Institutes (RMHIs) and provides policy oversight of TennCare funded services. The department has federally funded SOC grants that include sustainability plans, as do other DMHDD state and federal block grant programs. An important message is that mental health and substance related care are fundamental and integral to health and economic prosperity. ❍ TennCare—Of 1.2M enrollees, 700K are children served in integrated models of physical and behavioral health. Relevant programs are TENNderCare and EPSDT. Foci include EBP, screening, identification, referral and treatment inclusive of mental health, behavioral and school functioning. ❍ TCCY—With a primary mission of advocacy to improve quality of life for children and families, has statutory responsibilities to report impact of impending legislation and make budgetary recommendations. TCCY administers Juvenile Justice grants/contracts in all Tennessee counties, reviews DCS cases through CPORT, produces the state's KIDS COUNT and manages the Ombudsman Program for children involved with child welfare programs and Juvenile Justice.

	Developing Common Language	Familiarize Council with definitions of comprehensive array of services developed during Collaborative on Adolescent Substance Abuse project. --Stephanie Shapiro	❍ Definitions, which focus on substance-related and co-occurring disorders, can serve as root for comprehensive mental health definitions and terms used in a variety of child-serving setting. ❍ Council recommended expansion to include community supports and other non-clinical services.
	Barriers/Challenges in Children's Mental Health	Recognize issues Council will need to address going forward	❍ Council will submit additional perceived barriers to those identified by individual Council members and DMHDD Planning & Policy Council Children's Committee.
	Regional Stakeholder Focus Group Proposal	Explore proposal to get community level information and promote Council activities thru 20-25 focus groups organized by CSAs statewide. --Sue Pilson	❍ Council decided to consider the proposal when there is a better sense of what the Council and workgroups need to learn from community stakeholders.
	Description/Charge to Workgroups	Assure workgroup participation has multi-agency representation.	❍ Accountability Workgroup and Management Information Systems Workgroup were combined. ❍ Cultural and Linguistic Competency Workgroup and EBP Workgroup were added. ❍ Retained Funding, Interagency Collaboration, Service Array Workgroups.
	Workgroup Reports	Work in content areas to hone focus on charges.	❍ Workgroups reported anticipated needs, strategies, deliverables, and next steps appropriate to the individual content areas. ❍ Workgroups were charged to meet, conduct and review work and communicate outcomes to Council Co-Chairs for inclusion in subsequent agendas. ❍ Recommended agenda for next meeting.

DATE/TIME	AGENDA ITEM	PURPOSE	RESULTS/CONSIDERATIONS
MEETING 3 10/21/08 10:00 A.M.- 3:00 P.M	TN Systems of Care Presentation	Familiarize Council w/ TN's System of Care experiences resulting from three federally funded grants.	❍ Reference February Report Table 3. ❍ Presenters at Council Meeting --Freida Outlaw --Alisia Martin --Jeune Wood --Jules Marquart --Cindy Potts --Traci Sampson --Millie Sweeney --Sheila Taylor --Susan Steckel --Lygia Williams --Sonya Beasley --Charlotte Bryson --EAnn Ingram --James Schut
	Workgroup Updates ❍ Accountability and Management Information Systems ❍ Cultural and Linguistic Competency ❍ Evidence-based Practice ❍ Funding ❍ Interagency Collaboration ❍ Service Array	Updates/status reports by Workgroups to full Council.	❍ Reference February Report Table 2. ❍ Workgroup Co-Chairs --Traci Sampson and Pam Brown --Deborah Stafford --Michael Cull and Vicki Harden --Mary Linden-Salter and Nneka Gordon --Dustin Keller and Freida Outlaw --John Page and Pat Wade
	Report of Grand Rounds: Child and Adolescent Needs and Strengths (CANS)	Introduce Council to strengths-based assessment tool being used by DCS & in several other states. Explore expanded application potential in SOC.	❍ Council determined it needed more information in order to answer some questions which included, among many others, ❍ Whether one assessment tool can meet needs of unique children and all child-serving disciplines ❍ Relationship to Tennessee Outcome Measurement System (TOMS) which meets national mandates for data ❍ How this could be implemented system-wide, statewide
DATE/TIME	AGENDA ITEM	PURPOSE	RESULTS/CONSIDERATIONS
MEETING 4 12/5/08 10:00 A.M.- 2:00 P.M	DMHDD Budget Hearing Update	Provide Council with status report about requirements of all departments, DMHDD specifically, to reduce budgets. --Virginia Trotter Betts	❍ Commissioner Betts discussed the budget hearing and recent departmental activities, informing the Council of the 3 ways to reduce the budget (central office staff/expenses; RMHI capacity; community contracts) to reach 15% reduction. Tennessee is one of 41 states experiencing serious reductions in mental health. ❍ Linda O'Neal recommended that in this period of such significant budget restrictions and short-falls, it is crucial to maximize resources, improve coordination and continue to strive for quality services.

	TCCY/MHDD/GOCCC Collaboration	Announce agreement to develop February Report for P.C. 1062. --Linda O'Neal	❍ GOCCC will organize, develop and compile information required by P.C. 1062 for the Report; provide a draft Executive Summary, Report and related documents for review, comment and revision to the co-chairs of the Council and others as appropriate; finalize the Report for timely delivery to the General Assembly.
	Media Relations Workgroup	Establish new Workgroup --Linda O'Neal	❍ The new workgroup will initially focus on publicizing the work of the CCMH and opportunities for involvement.
	Policy Academy Application: Family Driven Care	Inform Council about grant application to Federation of Families --Freida Outlaw --Millie Sweeney	❍ Grant (which was funded) will support 7-9 participants with technical assistance in developing family-driven SOC through resource mapping, Medicaid and other finance mechanisms, workforce development and engaging young people in work.
	Assessment Instrument Reports ❍ Child and Adolescent Needs and Strengths (CANS) ❍ Tennessee Outcome Measurement System (TOMS) ❍ SOC National Evaluations	Expose Council to current types of assessments being done that relate to SOC processes. --Michael Cull --Richard Epstein --Paula DeWitt --Freida Outlaw	❍ Council considered the distinctions and compatible processes of ❍ CANS—a tool administered by trained raters to identify child/family strengths and needs at intake and periodically thereafter that can be used across domains and which can lead to systems change by utilizing aggregate data. ❍ TOMS—a self-report instrument administered at 20 CMHCs, analyzed by a third party and distributed to the department, CMHCs and one MCO. ❍ SOC National Evaluations—a set of 17 descriptive, outcome and service experience measures collected primarily from caregivers as their children enter SOC services and some data such as diagnostic assessments drawn from intake records, all of which contribute to one of 4 studies: Cross-sectional Descriptive; Longitudinal Child and Family Outcome; Service Experience; or Services and Costs studies.
	Workgroup Reports ❍ Accountability/Management Information Systems ❍ Cultural and Linguistic Competency ❍ Evidence-based Practice ❍ Funding ❍ Service Array ❍ Service Integration	Provide updates on activities, assure communication among workgroups, identify information needed by groups, identify next steps and responsible parties.	❍ Reference February Report Table 2. ❍ Workgroup Co-Chairs --Traci Sampson and Pam Brown --Deborah Stafford --Michael Cull and Vicki Harden --Mary Linden-Salter and Nneka Gordon --Dustin Keller and Freida Outlaw --John Page and Pat Wade

	February Report to General Assembly	Solicit input from Council about content to be included in Report.	❍ Report is to include status of Plan, timeline for plan development, barriers to implementation, current programs, status of interagency cooperation, financial resource map, recommendations for improving efficiency in use of funds and other considerations. ❍ Council recommended inclusion of statement about impact of economic downturn on programs and services to children.
DATE/TIME	AGENDA ITEM	PURPOSE	RESULTS/CONSIDERATIONS
MEETING 5 12/5/08 10:00 A.M.- 3:00 P.M	Juvenile Court Commitment Orders (JCCOs)	Learn the issues and perspectives about JCCOs that were discussed during Mtg. 4 more definitively --Jeff Feix, DMHDD --David Haines, Admin Office of the Courts	❍ Council expressed serious concern about the status of youth, reflected in the reduction of inpatient evaluations, having gone from 60+ in the month preceding the court order to only one after implementation of the ruling about State/County responsibilities for costs for evaluations. ❍ Council formed a workgroup focused on resolving complex issues associated with accessing timely forensic evaluations for the courts to rely on when a juvenile has charges against them that would be a felony were they an adult. One criterion is to avoid unnecessary costs but meet the need for timely evaluation, safety and placement of the youth.
	Impact of Economic/Funding Situation on CMHCs	Update on the experiences of CMHC providers since conversion to integrated health and mental health MCOs. --Kathy Benedetto --Vickie Harden --John Page --Kathy Gracey	❍ Implementation of integrated MCO contracts varies but the current status is better than had been forecasted during Meeting 4 when provider contracts were not signed and there were numerous unanswered transition questions. ❍ Providers are sustaining services at an operational level of reimbursement, are attempting to blend funding to sustain responsive, innovative services, focusing on implementation of EBP with an expectation that appropriate funding will follow. ❍ MCO representatives expressed willingness to explore incentives for early intervention services vs. more intrusive, costly residential treatment.

	Impact of Economic/Funding Situation on Other Private Not for Profit Agencies	Bring perspectives of private not for profit providers other than CMHCs to the attention of the Council. --Raquel Hatter --Bonnie Benecke --Millie Sweeney	o Number of responses to brief survey was limited but informative about collaboration, impact of compassion fatigue on front line staff and tangible needs of organizations. o Agencies are dealing with numerous unknowns and are reluctant to add staff. o Are following guidance from Center for Non-profit Management re: cutting administrative costs, renegotiating (rental agreements) and restructuring capital and development campaigns.
	Policy Academy Plans	Update on 2009 Policy Academy: Transforming Children's Mental Health through Family-Driven Strategies. --Freida Outlaw	❍ State is one of six selected by National Federation of Families for Children's Mental Health 2009 Policy Academy in February. ❍ Purpose is to get technical assistance to enhance implementation of P.C. 1062 in asset mapping, theories of change, approaches to get buy-in from decision makers, Medicaid and other finance mechanisms, workforce development and overcoming disparities. ❍ Participants include representatives of DMHDD, GOCCC, Select Committee on Children and Youth, TennCare, DCS, TVC, Muletown SOC, AOC, parents and Legislature.
	K-Town System of Care Application	Update on SOC application. --Freida Outlaw	❍ Application was submitted timely. ❍ Refer to February Report Table 3 for description of the project.
	Draft Preliminary Report Discussion	Overview of draft February 2009 Report to the Legislature --Mary Rolando	❍ Council considered and discussed elements of draft report organized to correspond to requirements of P.C. 1062 (listed on p.1 of this Report) ❍ Agreed to provide comments and additional information to complete the Report timely.
	Next Steps for CCMH	Schedule of next meetings. --Linda O'Neal	o The Council will meet next in March and April and every two months thereafter through June 2010 in order to deliver a Plan to the Legislature by July 2010.
	Acceptance of Meeting Summaries for Meetings 1-4	Formal vote on Meeting Summaries provided by DMHDD on behalf of the Council. --Linda O'Neal	o Council voted unanimously to accept meeting summaries provided by DMHDD staff.

February Report Table 2

CCMH WORKGROUPS
OVERVIEW OF PURPOSES, ORGANIZATION AND PRODUCTS

ACCOUNTABILITY/MANAGEMENT INFORMATION SYSTEMS WORKGROUP

CHARGE: Determine outcomes, performance measures, and evaluation processes needed for a System of Care.

GOAL: Define proposed key indicators; define business rules to deliver key indicators; define options and implications for implementation relative to information system needed, policies and workforce development.

ACTIVITIES: Distributed and reviewed a variety of SOC outcome measurement systems and indicators used within Tennessee and other states; developed "Guiding Principles" for design of statewide indicators; reviewed various sources and developed initial draft of possible outcome indicators based on adjustments to Muletown outcome indicators among numerous other actions to build a foundation for accountability measures.

PRODUCTS: Draft Target Outcome Indicators.

NEXT STEPS: Focus on business rules to deliver key outcome indicators; define options and implications for implementation.

FUNDING WORKGROUP

CHARGE: Determine current funding streams and expenditures to inform resource mapping requirement and identify potential additional funding sources.

GOAL: Assist the CCMH in developing financial resource map and cost analysis of all federal and state funded programs for children's mental health SOC.

ACTIVITIES: Matched list of comprehensive services with federal, state, local funding streams during SJR 799; in process of researching SOC funding in other states.

PRODUCTS: Preliminary mapping of services and funding sources.

NEXT STEPS: Coordinate Workgroup activities with those of P.C. 1197, Resource Mapping for all children's state services and programs; assess benefits of blending, braiding and pooling resources; procure technical services to develop a funding resource map to inform planning processes.

INTERAGENCY COLLABORATION WORKGROUP

CHARGE: Determine how to establish mechanisms to ensure interagency communication and cooperative work toward more seamless systems for children and families.

GOAL: Identify and explore more comprehensive, coordinated system to address individualized mental health needs of children/youth and their families.

ACTIVITIES: Integrated Interagency Collaboration work from SJR 799 into P.C. 1062 processes; identified critical barriers to implementation of SOC in Tennessee; reviewed existing statewide infrastructures and interagency agreements; consulted with leadership of successful Tennessee SOC projects and New Jersey statewide SOC; extended criteria beyond quality interagency collaboration to service integration constructs.

PRODUCTS: Articulation of barriers and a set of recommendations for consideration by the CCMH; framework for movement from Collaboration to Services Integration, inclusive of definition of terms, levels at which integration needs to occur, and criteria for achieving integration; a set of recommendations to establish state level authority to direct development and maintain a statewide SOC and for structures for regional and community level entities.

NEXT STEPS: Bring recommendations before the CCMH.

SERVICE ARRAY WORKGROUP

CHARGE: Determine the services and supports currently available and those needed to implement systems of care statewide.

GOAL: Identify a comprehensive array of services that address physical, emotional, social, and educational needs of children.

ACTIVITIES: Identified potential barriers to achieving the goal and charge; reviewed possible current sources of information about services and supports available statewide; redefined a more viable task for the completion of the work; and continued to refine the comprehensive array of services list developed under SJR 799.

PRODUCTS: An updated comprehensive array of services list that will continue to be refined throughout the P.C. 1062 process

NEXT STEPS: Working with several existing documents or groups [i.e., national taxonomy of service definitions for 2-1-1; comprehensive service array definitions; P.C. 1197 resource mapping], develop consensus definitions for each of the array of services; then prioritize services in each area as core services and specialty services.

CULTURAL AND LINGUISTIC COMPETENCY WORKGROUP

CHARGE: Determine how to ensure services and supports are reflective of the cultural, community characteristics and languages of children and families served.

GOAL: Assist the CCMH in designing policies and procedures that assure cultural and linguistic competence in all facets of SOC.

ACTIVITIES: Researched resource tools from other SOCs and the National Center for Cultural Competence; consulted with parents.

PRODUCTS: Extensive set of recommendations have been formed for CCMH adoption.

NEXT STEPS: Prioritize recommendations and develop appropriate methods to get needed information; disseminate results; evaluate and monitor quality of applications and interventions.

EVIDENCE-BASED SERVICES WORKGROUP	
CHARGE:	Determine the status of current service provision relative to evidence-based practice (EBP) and how to move forward with implementation of more such practices.
GOAL:	To formulate a consensus definition of evidence-based practice, consolidate information about current EBP initiatives and ensure an approach that maintains integrity of SOC principles.
ACTIVITIES:	Workgroup meets via teleconference twice monthly, has developed elements from which to develop final products and done extensive research to guide EBP definitions and criteria for the State.
PRODUCTS:	A consensus definition for EBP has been drafted and a survey of providers about experience with and need for assistance with EBP are in final stages of development.
NEXT STEPS:	Finalize definition of EBP for adoption in March 2009; survey providers and analyze results; form recommendations including developing methodology for consistent monitoring among agencies and organizations.

MEDIA RELATIONS WORKGROUP	
CHARGE:	Develop strategies for disseminating information about System of Care and work of CCMH.
GOAL:	To assure communities are knowledgeable about, supportive of and contributors to systems of children's mental health care.
ACTIVITIES:	A Workgroup has been formed.
PRODUCTS:	Column: Special to *The Commercial Appeal*, November 2008.: When we help children, everyone wins: A "system of care" approach provides a comprehensive foundation of assistance for youngsters with mental health issues. Column: Commentary in The Tennessean, January 2009: Science shows transfers are not the answer. Newsletter: TCCY *The Advocate*, December 2008: Tennessee Moves to Improve Children's Mental Health Care; Creates Council on Children's Mental Health.
NEXT STEPS:	Press Release planned for February 2009 with submission of Preliminary Report to the Legislature.

Complete reports of the Workgroups and Workgroup participants are in February Report Document Group 1, pages 26 through 52.

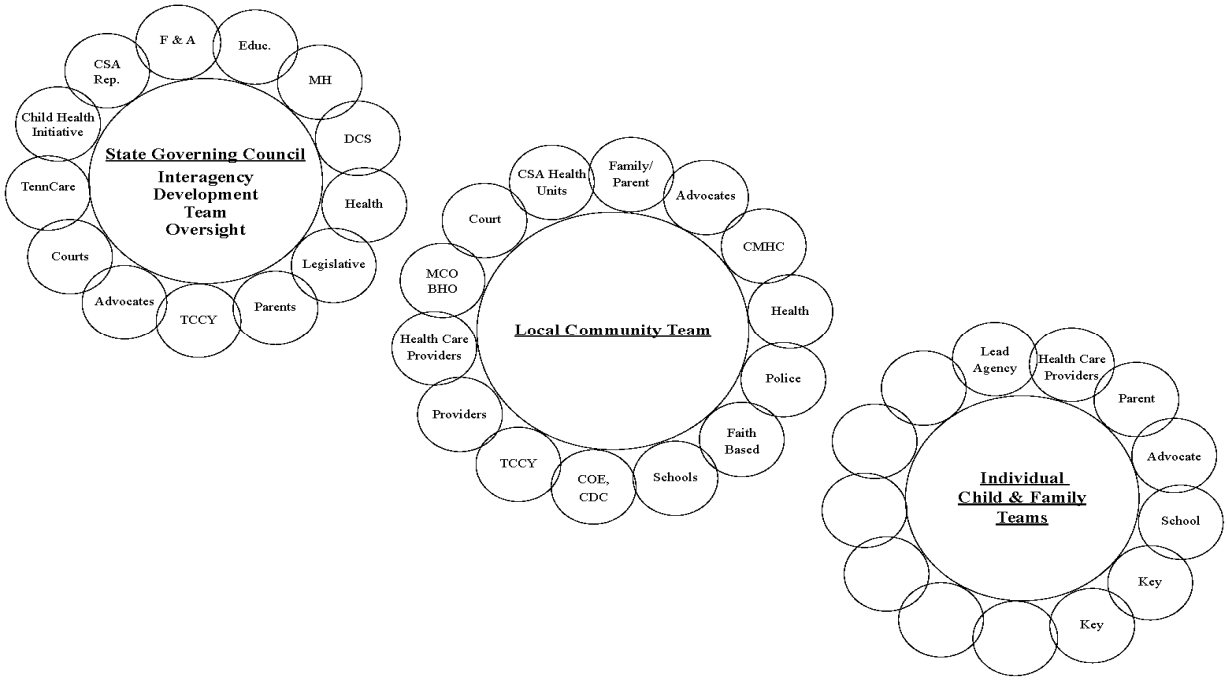
Tennessee System of Care Experience: Senate Joint Resolution 799 Final Report to the Tennessee General Assembly, April 1 2008, identified four cornerstones of a system of mental health care for children:

1. Vision and principles-based mental health care;
2. Interagency coordination and collaboration in delivering and accessing mental health care;
3. Delivery of high quality, effective care;
4. Development of infrastructure that includes mental health system personnel carrying out efficient delivery of services and supports.

The legislation that resulted from the SJR 799 process, P.C. 1062, was constructed to assure the cornerstones are developed to implement and sustain systems of care statewide.

Graphic representations of systems of care depict the infrastructure to include these elements:

- At the state level, i.e., the CCMH, an interagency, multidisciplinary group inclusive of families and youth authorized to develop and maintain accountability for and oversight of systems of care;
- At the community level, an identifiable leadership team which implements a system of care based on SOC values and principles, tailored to unique community features and which has the authority to commit resources to the system;
- For individual child and families, teams chosen by families who support them in developing and implementing plans, document and communicate successes, barriers and challenges, and sustain families in services as objectives are met.



The State has had substantial experience with development and implementation of federally funded systems, matched with cash and in-kind resources, with the criteria and concepts above to guide SOC projects. Tennessee's experiences are summarized in the February Report Table 3: the Status of the projects, Characteristics of Families Served and Selected Outcomes.

February Report Table 3
TENNESSEE SYSTEM OF CARE EXPERIENCE

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
NASHVILLE CONNECTION Funding over 6 Years: $6.3M Federal $4.2 Match Provided**	Initiated: 1999 Ended: 2006	323	❍ Davidson County residents; ❍ Children with SED age 5-18; ❍ Global Assessment Function (GAF) of ≤ 50; ❍ Multi-agency involvement; ❍ Imminent risk of state custody or psychiatric hospitalization; ❍ Most (69%) at or near poverty level; ❍ One third w/ 4 or more family risk factors; ❍ 40% of children w/ 2 diagnoses and 15% w/ 3 or more diagnoses; ❍ 30% had previous psychiatric hospitalizations; ❍ 50% of caregivers had mental illness or dual diagnosis.	❍ 97% of children remained in the community; ❍ All demonstrated clinical improvement over time; ❍ Decreased school absenteeism; ❍ Decreased residential care and hospitalization; ❍ Increased service coordination; ❍ Improved grades; ❍ Decreased suspensions; ❍ Estimated annual cost savings: $2.6M (based on 120 children); ❍ When grant ended: (1) sustained and expanded MH-School Liaisons to rural East, Middle and West Tennessee through DMHDD/DOE collaboration; (2) used carry-over for Leadership Training statewide; (3) w/ DCS developed SOC-based program, “Family Connection”.
MULETOWN FAMILY NETWORK Funding Over 6 Years: $6.7M Federal $6.7M Match Required**	Initiated: 2005 Anticipated End Date: 2011	Target: 440 Current: 173	❍ Maury County residents; ❍ Birth-21 years of age; ❍ SED diagnosis (include but not limited to ADHD, bipolar disorder, depression, OCD); ❍ Multi-agency involvement; ❍ 74% below poverty and 12% at or near poverty level; ❍ 48% have IEP.	❍ Improved internalizing and externalizing clinical outcomes at 12 mos.; ❍ Reduced impairment in overall functioning; ❍ Reduced bullying and fighting; ❍ Somewhat reduced caregiver strain; ❍ Some improvement in grades; ❍ Stability of living arrangements improved ❍ Caregivers give high ratings of fidelity to wraparound, especially during initial; engagement and implementation phases. ❍ Caregivers rate staff cultural competency highest among 10 wraparound principles.

				Note: The results above are very early. All are after 6 months unless otherwise noted.
JUST CARE FAMILY NETWORK Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 10/2008 Anticipated End Date: 2014	Target: 450	❍ Shelby County residents; ❍ 5-19 years old at time of enrollment; ❍ Emotional, behavioral or mental health disorder present; ❍ Multi-agency involvement; ❍ At risk of placement outside home; ❍ Caregiver/parent willing to maintain child in home, school and community.	PROJECTED Outcomes in addition to improved Clinical Outcomes: ❍ Family Support Providers integral to SOC success; ❍ Youth In Action Council established as community leaders & peer advocates; ❍ Mental health support to child/family in school settings; ❍ Formal relationship w/ JUSTCARE 180, a youth, family and neighborhood development approach to reducing youth delinquency and promoting youth success. Funded by the Memphis City Council, this is a dedicated commitment by the community to building community.
K-TOWN YOUTH EMPOWERMENT NETWORK Funding Request Over 6 Years: $9M Federal $8.5M Match Required**	Grant Application Submitted: 1/14/09 Anticipated Award Date: 9/30/09 Anticipated End Date: 2015	Target: 400	❍ Knox County residents; ❍ Youth age 14-21 in transition to adulthood; ❍ Emotional, behavioral or mental health disorder present; ❍ Impaired functioning at home, school and community so that involvement with multiple service agencies is required; ❍ At risk of placement to a higher level of care (inpatient hospitalization, residential treatment, or state's custody for treatment); ❍ A parent or caregiver willing to participate in the wraparound process to maintain the child at home, at school, and in the community OR youth willing to participate in WRAP services to remain independently in the community.	PROJECTED Outcomes in addition to improved Clinical Outcomes: ❍ Family and Transition Support Providers integral to SOC success; ❍ Youth In Action Council established as community leaders and peer advocates; ❍ Mental health support to youth in transition to adulthood in high school, vocational, and higher education settings; ❍ Improved functioning in the home, school, and community; ❍ Successful youth transition into adulthood.

* For purposes of this Table, the term "Families" is inclusive of caregivers with whom children/youth reside in a family setting.
** Match can be in the form of cash or in-kind contributions. Most match has been in-kind and much of it from the community.

Common themes among the projects include a focus on at risk children, children with complex mental health and other needs, or children who have contact with multiple agencies, and who have families willing to partner in processes to improve their lives together; there are recognizable geographic boundaries and clearly defined criteria for eligibility, even though the criteria differ from project to project; families are at or near poverty. A significant theme is that the projects are structured to be replicated and sustainable, with outcomes measured by the SOC National Evaluations.

These projects provide a superior foundation for designing and planning for systems of care statewide, as required by P.C. 1062.

II. TIMELINE FOR PLAN DEVELOPMENT

The CCMH plans to meet during March, April, June, August, October, December in 2009 and February, April and June in 2010 or more often as needed to complete a plan by July 2010 for statewide implementation of systems of care. Workgroups will meet as often as necessary to support the agendas of the Council and development of the plan.

III. BARRIERS TO IMPLEMENTATION

Potential barriers to implementation of systems of care in Tennessee were identified in SJR 799 Town Hall meetings, through DMHDD's Title 33 Planning and Policy Council rankings, and captured in discussion in CCMH meetings. During early January, Council members were surveyed individually and anonymously about perceived barriers to successful implementation of systems of care and the structures that might overcome the barriers.

Members were surveyed about barriers in four areas:

- Administrative;
- Service;
- Policy;
- Implementation of SOC principles.

Key Findings of the CCMH Survey: Of Council respondents, almost half (47.4%) identified overcoming administrative and provider territoriality as the greatest barrier and almost 40% (38.9%) listed lack of integrated information systems as second in rank relative to Administrative barriers. For Services, the results about barriers to implementation were clear. Over half (54.5%) perceived the limited number and array of services to be the greatest impediment to implementation, followed by difficultly in implementing Evidence-based Practices, an increasingly mandated requirement of state agencies for publicly funded services. The Policy barriers were equally clear. Half the respondents perceived inadequate cross-agency coordination about children's mental health to be the greatest barrier. Conflicting state agency rules and requirements was a distant second-ranked Policy barrier at 24%.

The results were consistent across the four areas. The top Administrative barrier—overcoming administrative and provider territoriality—and the top Policy barrier—inadequate cross-agency coordination—are fundamentally linked, obvious and, therefore, a target for problem solving. One approach to the resolution of disparate perspectives is to ask: Who is the system for? In a System of Care the only response is it is for the children and families, not providers, organizations and agencies. Again relative to consistency of the Council responses, while the greatest challenge to implementation of the Principles was achieving commitment/buy-in by state agencies, local communities and providers, when asked the most important factors to overcome the barriers, respondents rated joint planning among all child-serving agencies and statewide culture change to a shared vision about responsive systems for children and families.

The survey about Barriers also indicated the preponderance of the respondents (68%) had been involved in children's mental health systems of care and half had been in leadership roles, again suggesting that knowledge about barriers was based on experiences. The entire results of the survey of the CCMH about Barriers are appended as Figure 1 in February Report Document Group 2, Survey Results, pages 53 through 59.

Key Findings from the Youth Survey: One barrier for the Council has been that of getting input from youth. As noted in the earlier description of the CCMH, youth have been identified to participate in the Council but participation has been limited as a result of scheduling conflicts. Most Council members are able to meet during normal business hours, which coincide with school hours, making it difficult for youth to attend CCMH meetings. The Council is seeking alternative venues for including youth. Options include holding focus groups in the future, associating with the chapters of the national mental health youth movement, Youth In Action, and periodically repeating the survey process used for this Report.

Input from youth for this Report came from these sources:

- Youth Councils affiliated with Tennessee Voices for Children.
- Tennessee Alliance for Children and Families.
- Residential Treatment Center Boards, youth board members.
- Youth in DCS Custody.

The following figures describe from whom youth had received services, who had been most helpful to them and where, outside their homes, they had resided for mental health services.

Figure 2: Percentage of Youth Respondents Served by Various Agencies & Individuals Youth Survey Results

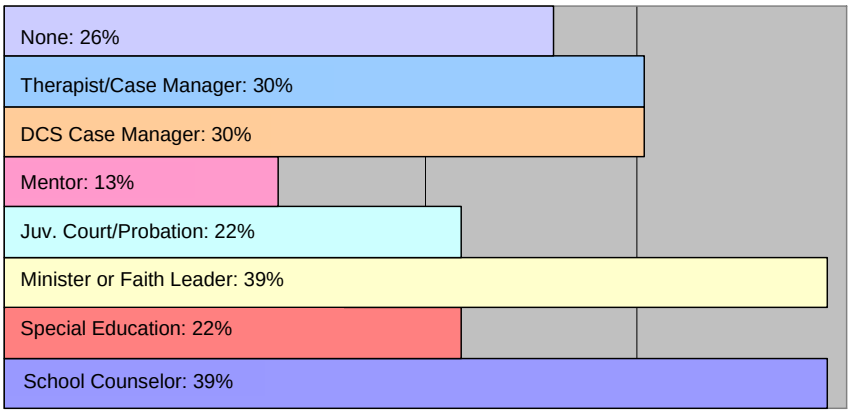


Figure 3: Most Helpful Services Youth Survey Results

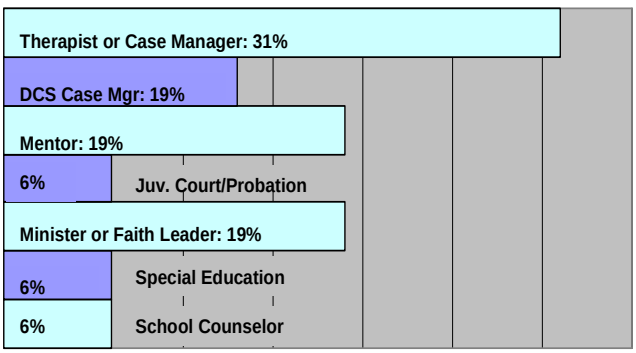
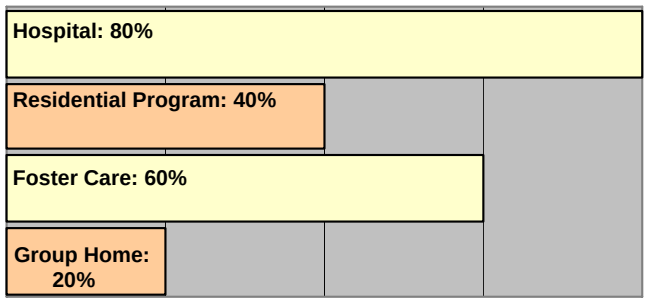


Figure 4: Places Stayed to Receive Mental Health Services



The most striking findings were factual: Services provided by school counselors was matched by contacts with youth ministers or faith leaders. Of the 26 youth respondents, 80% had been hospitalized for mental health services. The preponderance (73%) live with birth parents, certainly encouraging given the DCS priority for family unification. The median age of respondents was 15; the median age at which youth entered services was 12.

Youth's comments were very informative, especially when asked what they wanted most from service providers, which was primarily for someone to hear and honor what was disclosed. They said:

- Listen to us about what we think will help.
- We need to know you really care about us.
- Need more services in my community, close to my home.
- Involve youth in positive activities.
- Peer-to-peer support would help me.
- Involve my family.
- Confidentiality is important to us.
- I need to know that you believe in me.

IV. LIST OF ALL PROGRAMS

The CCMH respectfully requests deferral of this requirement, pending the results of the FY 2010 Budget. It is a difficult time for all state agencies, which are being asked to make severe reductions in programs and services. Child-serving agencies are not exempt. It would be misleading to inventory programs on this date when those services may not be available in the near future because of reduced financial support or changes in TennCare. However, the array of services identified as part of SJR 799 is included on p. 42 of this Report.

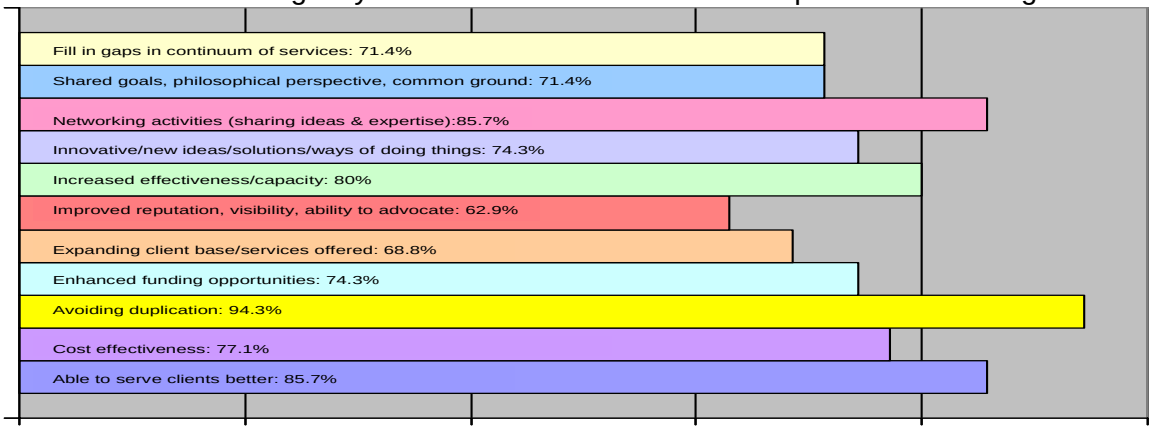
V. STATUS OF INTERAGENCY COOPERATION

P.C. 1062 asks for a report of the status of interagency cooperation. This somewhat nebulous construct was made tangible by researching criteria for assessment of perceived status and applying it to experiences of Tennessee's CCMH and Workgroups. The results indicated very favorable perceptions of interagency cooperation currently, but the challenges going forward are substantial.

Key Findings from the Survey of the CCMH and Workgroups: Communication about the CCMH is good.

- 94% of respondents are actively participating in at least one Council Workgroup;
- 91% of agencies indicated commitment to development of systems of care;
- 82% of agencies have consistent, high-level participation in the CCMH;
- 77% of agencies understand goals of the CCMH and regularly get information about the progress of the Council.

The CCMH and Workgroups also see challenges ahead: only 41% perceived the Council to have a plan for provision of culturally, linguistically competent services. The Council was asked to rate the perceived benefits of Interagency Collaboration with the results depicted below in Figure 6.



Additional results of the Status of Interagency Cooperation survey are in Figure 6, February Report Document Group 2, Survey Results, p. 58.

IV. FINANCIAL RESOURCE MAP

P.C.1062 calls for financial resource mapping for SOC planning. Financial resource mapping of services is a work in progress. During SJR 799, the Funding Workgroup identified fund sources for each individual service and support in the comprehensive service array. P.C. 1197, also passed in 2008, requires TCCY to design and oversee resource mapping of all federal and state funding support for health, safety, permanence, growth, development and education of children from birth through age of majority or through the period of one's state custody. The CCMH is working in concert with the Resource Mapping Advisory Group to identify, quantify, and geographically locate federal and state funds supporting children's/families' mental health and substance use related supports and services. The resource mapping process is moving forward with current timelines for implementation, indicating a report will be available Spring 2010, which will also provide a financial map for the July 2010 report required by P.C. 1062.

V. RECOMMENDATIONS FOR IMPROVING EFFICIENCY IN USE OF FUNDS

The CCMH will be able to make definitive recommendations for improving efficiency in the future, but not at this time. However, there are notable contributions to demonstrate and achieve efficiency in structuring SOCs: (1) An agreement has been reached among TCCY, DMHDD and the GOCCC to meet the requirement of P.C. 1062 to develop a Council on Children's Mental Health and report the status of its work to the Legislature by February 2009. A Memorandum of Understanding about the respective agency commitments for this purpose is appended on p. 60. (2) The CCMH is working closely with the leadership group identified in P.C. 1197, a law that requires mapping of all federal and state resources for children—conception through age of majority or until youth in custody are no longer eligible for services from DCS. There is more about the relationship of P.C 1062 and P.C. 1197 below and in VI above; (3) The Report on the Collaborative on the Funding and Administration of Substance Abuse Services for Children/Youth and Their Families, a product supporting the T-ACT Grant noted below, contains recommendations for prevention, early intervention and alternatives to hospitalization and residential treatment. That Report is expected to inform the work of the CCMH and P.C. 1197.

VI. RELATED CONSIDERATIONS

In addition to the specific activities and work products of P.C. 1062, there are a number of statutory requirements and initiatives by the administration and other organizations that are building blocks for achieving and sustaining fidelity to SOC principles, many of which have been explored by the CCMH. In brief, some of the related considerations are noted here.

Statutorily-related Considerations

P.C.1197—Resource Mapping of Funding Sources: This law gives TCCY the responsibility to oversee "resource mapping" of all federal and state funding of comprehensive services for children, birth through transition to adulthood. The term "resource mapping" refers to creating an inventory of state and federal funds, their uses, target populations, geographical distribution and agency auspices. The law requires a preliminary report in February 2009 and annual reports to the Legislature thereafter. Resource mapping is a daunting task. It requires creation of mechanisms to reconcile service definitions, age ranges, integration of differing management and financial reporting systems among state agencies, and staff capacity to do the work. TCCY leadership undertook this set of challenges by enlisting the ranking financial officers and program staff of the child-serving departments, the TennCare Bureau, representatives of the Comptroller, Legislative Budget Office, Administrative Office of the

Courts, GOCCC, TAMHO and others. The TCCY Executive Director has lead the agenda and TCCY staff have supported Resource Mapping meetings and activities, in addition to a multitude of other duties.

Relevance to P.C. 1062: One requirement of the P.C. 1062 is to create a "financial map" for services and supports in systems of care. Representatives from the CCMH are working in sync with the Resource Mapping Advisory Group, as noted in the CCMH Funding Workgroup summary and report, in order to avoid duplication, assure consistency in results, and achieve economy of effort.

T.C.A. 37-5-607—Multi-level Response System (MRS) Advisory Boards: This section of T.C.A. 37-5-601, which establishes provisions for a multi-level response system to safeguard families, prevent harm to children and strengthen families, defines the composition and functions of independent local advisory boards, referred to as Community Advisory Boards (CABs). Under the law, when possible harm to children is reported, there are four levels of intervention in the MRS: (1) Investigation of the circumstances; (2) Assessment of the child and family's need for services; (3) Referral to services immediately without assessment or investigation; (4) Initial assessment with a determination that no further action is required. Responses are based on risk to the child and, at the same time, on the assumption that most children are better off in their own homes than not. Guided by a state level advisory committee of leadership from state departments, TCCY, and other public and private agencies selected by the Commissioner of DCS, Community Advisory Boards have been implemented in most regions across the state and will be implemented in all by the end of 2009.

Relevance to P.C. 1062: CABs were defined with SOC principles in mind. They are composed of community representatives of schools, health departments and other health care and mental health providers, juvenile courts and law enforcement, families and others. They are to recommend strategies for coordination and development of community-based resources that may be needed by families. CABs have the authority to review individual cases so long as confidentiality is protected. It is incumbent upon the CCMH to stay abreast of the successes and challenges to the effective functioning of the CABs as they can inform and influence the development of initial and subsequent cites for P.C. 1062 SOC locations. Notably, the CAB in Maury County also serves as the Muletown Family Network System of Care grant local coordinating group.

T.C.A. 37-5-121—Juvenile Justice EBP: This law provides definitions for Evidence-based, Research-based and Theory-based practices and requires implementation of sound practices in all juvenile justice prevention, treatment and support programs, with the goal of identifying and expanding the number and type of EBPs in the Juvenile Justice service delivery system. Implementation is staggered: 25% of JJ funds are to support EBP programs by FY 2010; 50% by FY 2011; 75% by FY 2012; and 100% by FY2013. The law permits pilot programs which are eligible for funding to determine if evidence supports continued funding. DCS has made tremendous strides in meeting requirements of the law.

Relevance to P.C. 1062: No matter how strong the infrastructure of a SOC to improve access to and coordination of services, that alone is not sufficient to achieve desired clinical outcomes. EBPs are essential for improved outcomes for children. Implementation and expansion of use of EBPs are fundamental to the design of statewide system of care. The work on Juvenile Justice EBPs has provided a foundation and guidance for the work of the CCMH Evidence-Based Services Workgroup.

T.C.A 37-1-128—Juvenile Court Commitment Orders (JCCO) Attorney General's Opinion: An issue about JCCO evaluations was brought before the Council. Under previously issued Attorney General opinions, DMHDD paid for outpatient and inpatient evaluations for youth with charges that would be a felony if the youth were an adult. If charged with a misdemeanor, payment for evaluations would be from the county. In 2001, Knox County and other counties ordered inpatient forensic evaluations of a number of youth charged with misdemeanors. When billed, some counties paid; Knox County refused to pay. Suit was filed by the Attorney General for payment. At trial, the court confirmed the responsibility of the county to pay for misdemeanor evaluations. Knox County appealed the decision.

The Court of Appeals issued a ruling in June 2008 that payment for all evaluations is the responsibility of the county or parent regardless of severity of the crime. Relying on other statutory provisions, the Attorney General determined DMHDD has authority to pay for outpatient evaluations. DMHDD sent letters to all juvenile courts when the ruling became final, 60 days after publication, and DMHDD ceased paying for new inpatient evaluations. The ruling did not alter the ability of the Juvenile Court to order evaluations, only the responsibility for payment. This is a complicated situation because it mixes need for mental health evaluation with need for safety and placement with payment issues.

Relevance to P.C. 1062: SOC principles promote early intervention, community-based supports and reduced reliance on inpatient services. For some time DMHDD has advocated use of outpatient evaluations as the first resort, unless there is clear and compelling clinical indication of need for inpatient evaluation. The immediate concern, however, is that the staggering reduction in inpatient forensic evaluations since the finding, with no concomitant increase in outpatient evaluations, suggests some youth are not getting the services they need. This was one factor that led to formation of a CCMH Workgroup focused on JCCO issues and opportunities to improve the system.

Administrative and Organizational Initiatives

Youth Councils: There are numerous youth councils and advisory groups across the state:

- Tennessee Voices for Children (TVC) currently sponsors three Youth in Action (YIA) Councils and will develop a fourth in Memphis within the next year. Two YIA Councils are connected with SAMHSA System of Care sites in Tennessee. YIA Councils are comprised of youth with mental health diagnoses or youth with diagnosed siblings. Their goal is to erase the stigma about mental illness through educational outreach to peers and professionals, active participation in community events, and effective leadership on advisory groups and councils.
- DCS has regional Youth 4 Youth groups comprised of youth who are or have been in foster care. These youth lend their voice and experience to DCS to ensure the system is aware of the needs and concerns of youth in custody. Many residential facilities also have youth representation on their boards to provide youth voice in decisions regarding the facility program and resident concerns.
- The Tennessee Alliance for Children and Families (TACF) is spearheading a statewide initiative to bring youth from the various councils across the state to form a state level council to provide youth voice and choice to legislators and state departments on the issues that concern them most. The Statewide Youth Council will be comprised of representatives from thirteen regions who will meet quarterly to address the needs of youth and communicate youth issues to policymakers.

Relevance to P.C. 1062: Youth are to be represented on the CCMH. It is anticipated that at least two of the youth representatives on the statewide council described above will participate in the CCMH, which will clearly bolster the work of the Council. Schedules have been barriers to youth participation in Council meetings to date, so alternatives to achieve youth input have been surveys of the sort used to inform this Report.

The Statewide Family Support Network (SFSN): Operated by TVC with both state (TDMHDD) and federal (small CMHS grant) funds, the SFSN provides a unique and critical service to families of children and youth with emotional and behavioral disorders. Parent professionals provide support, advocacy, training and information to parents, advocates, and professionals in all 95 counties. At least one Parent Advocate or Outreach Specialist is located in each grand region of the state. Hired for their experience with the system for their own children and trained to assist other parents in similar situations, SFSN staff offer individual consultation and support, assistance in system navigation to identify and obtain services, training on a variety of mental health topics, and facilitation of effective relationships between parents and providers. Staff participate in over 148 councils, advisory groups, and policymaking committees each year, ensuring that there is parent/family voice involved in decisions about services for children. They offer training for other parents to help them understand how the system works and how to be involved at all levels. SFSN staff have been integrally involved in each of

the SOC sites funded in Tennessee as family representatives and trainers. The SFSN served approximately 80,000 parents and professionals in FY 08.

Relevance to P.C. 1062: Parent voice is critical in transforming the system, and parent representation is required on the CCMH. The SFSN provides parents with information and skills necessary to be effective on the CCMH and other local, state, and national policymaking groups.

Tennessee Adolescent Coordination of Treatment (T-ACT): This grant, administered in the GOCCC and funded by SAMHSA Center for Substance Abuse Treatment, has met and exceeded its purpose to develop an infrastructure to promote services that are accessible, high quality and effective for adolescents with substance abuse problems and their families. It has had a high level of involvement and support from its Project Advisory Board. Recent products of the grant include definition of a comprehensive array of services, achieved through consensus among state agencies, COEs, other providers and other key informants; a matrix of EBP screening and assessment tools; an inventory and schematic of numerous planning and advisory functions focused on children/youth with substance abuse issues; and creation of a substance abuse learning module for TVC's Parent Advocacy Training Program.

Relevance to P.C. 1062: Some of the products and processes, particularly the comprehensive array of services and the matrix of EPB screening and assessment tools, are springboards for CCMH Workgroup consideration. In addition, the Collaborative on Funding and Administration of Substance Abuse Services for Children/Youth and Their Families, completed in November 2008 in support of T-ACT objectives, paved new paths for collaboration and defined mechanisms to achieve financial mapping for substance abuse services, a sub-set of financial mapping requirements of P.C. 1062 and P.C. 1197.

Centers of Excellence for Children in State Custody (COEs) Learning Collaborative: The Tennessee Child Maltreatment Best Practices Project was designed to advance the implementation of Best Practices in treatment of child maltreatment and attachment problems by mental health treatment providers across the state. The focus of the current COE Learning Collaborative is Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Leadership for the project is a collaborative effort of the statewide network of COEs and other members of the Planning Committee of the Child Maltreatment Best Practices Task Force, specifically the Executive Director of the Tennessee Chapter of Children's Advocacy Centers and the Director of Public Policy for Tennessee Association of Mental Health Agencies (TAMHO). The full task force is comprised of providers and advocates with expertise in and/or commitment to evidence-informed treatment in child abuse and neglect, including Children's Advocacy Centers, TAMHO, Family and Children's Services, DCS, TVC, TCCY, Division of Juvenile Justice, DMHDD, and Tennessee Center on Child Welfare. The Planning Committee includes representatives from the COEs, Children's Advocacy Centers, and TAMHO. The Collaborative has successfully spread across the state and is actively working in West, Middle and East Tennessee, with one hundred and sixty-two mental health practitioners/supervisors and thirty-two agencies participating. Five hundred and ninety-two cases are currently using TF-CBT.

Relevance to P.C. 1062: The COEs provide unique, essential services for the State, primarily that of laying the ground work of translating science into services, which the CCMH must consider as it moves forward. In taking on consultative roles for the most difficult cases and direct provision of some services, the COEs' decision to master and implement an EBP among similar provider types for one of the most frequently occurring conditions in children in custody—trauma—has created a Tennessee model for community-based, parent-involved services with fidelity to the model. This sets a standard for successful replication, which the CCMH expects not only in the service domain but in other aspects of SOC design and implementation.

Centers of Excellence for Children in State Custody (COE) Child and Adolescent Needs and Strengths (CANS) The COEs worked with DCS to support state-wide implementation of a standardized assessment and service planning process using the CANS. The CANS was chosen by DCS as the assessment tool that best exemplifies strength-based, culturally responsive and family focused casework. The CANS was originally developed as a tool for mental health services and was subsequently adapted for child welfare, juvenile justice, mental retardation services and a variety of other social service settings. The CANS provides a communication basis for understanding permanency and treatment needs of youth and their families, allowing for informed decisions about care and services. The CANS consists of about 65 items used to evaluate how DCS and its partners should act in the best interests of children and families. Each item is discrete and relates directly to the child and/ or families' needs and strengths.

The COEs have consultants assigned to DCS regional offices to provide training, consultation and third-party review of CANS assessments. Ninety-five percent of all children entering custody now receive a CANS and the COEs have trained over 4,000 child welfare workers to reliably administer the instrument.

Relevance to P.C. 1062: The CANS project represents successful statewide implementation of a strengths-based service planning tool consistent with the goals of a system of care. The CANS helps to create a common language to communicate a child's needs and strengths across systems. Additionally, the CANS provides data necessary for individualized, child-centered treatment plans, which can be translated in the aggregate to evaluate system performance and child and family outcomes.

School-Based Mental Health Services: Providing mental health services in school settings has been shown to be effective in addressing children's/youths' needs and enhancing continuity of services. Education, the one constant in every child's life, offers an opportune setting for case management, group and individual therapy, and behavioral support for child, parent, and teacher. The State has three good examples of school-based mental health services: (1) Centerstone Mental Health Center received national recognition for its School-Based Therapist program which operates throughout Middle Tennessee, offering both case management and therapy to students in middle and high schools onsite and behavioral supports for teachers in the classroom. (2) Through federal Safe Schools Healthy Students grants, select school systems in each of the three grand regions have shown that providing mental health support and services at school have positive impacts on academic achievement, behavior in and out of school, and clinical functioning. Project Class in the Shelby County School system has utilized Mental Health Consultants in this capacity for several years, and has successfully engaged school staff and parents in multiple evidence-based proven effective resources and programs for helping children with social, emotional and behavioral health needs. Nearly half the students served have been TennCare eligible. (3) A third school-based program found to be effective in the first federal SOC site is being piloted on a limited basis by TDMHDD across the state. In the pilots, Mental Health Liaisons hired by community mental health centers serve at risk children/youth in middle school and act as links between school and home to improve behaviors, academic performance and overall functioning.

Relevance to P.C. 1062: As education is the one system involving all children and youth, school-based mental health services are a vital part of a coordinated SOC for prevention, early identification, intervention and transition services.

Coordinated School Health (CSH): Tennessee school children and staff benefitted significantly from the expansion of CSH statewide in FY 08. Because the CSH approach emphasizes serving the needs of the "whole" child, school staff are now coordinating efforts to address physical and also social, emotional and behavioral health needs of all students. As a result of CSH school health screenings, 104,532 students who may not have otherwise been referred to care were referred to a doctor, predominantly for Body Mass Index (BMI), vision and dental care during the 2007-2008 school year.

Another trend occurring in schools as a result of having CSH Coordinators is growth in the number of school-based clinics providing both physical as well as mental health services for students and staff.

Relevance to P.C. 1062: The CSH approach strongly encourages building community partnerships to more effectively meet the health needs of students. The process of building partnerships is creating a more positive climate for system of care to be adopted once the CCMH develops implementation guidelines.

Schools and Mental Health Systems Integration Grant: The DOE Office of Coordinated School Health received an 18 month grant from the U.S. Office of Education to develop school policy, protocols, training and linkages with community mental health providers regarding prevention, identification, referral and follow-up of students needing mental health services. Teams from each LEA will receive training and technical assistance to create a more seamless system of care among schools, mental health providers and juvenile justice staff.

Relevance to P.C. 1062: Coordination and collaboration among different child-serving systems developed through the Schools and MH Systems Integration Grant is a building block in the foundation of the more expansive expectation for systems of care called for in P.C. 1062. It is yet another springboard for effective, efficient communication and utilization of resources.

There may be other notable activities occurring in the State that are relevant to P.C. 1062 which have not been included in this Report. The CCMH welcomes notice of other functions and activities for inclusion in future CCMH deliberations.

SUMMARY

The Council on Children's Mental Health is pleased to report the accomplishments that are noted throughout this February 2009 Report to the Legislature. The CCMH is prepared to move ahead in design of systems of care statewide that are qualitative, quantitative and functional. It is also prepared to move forward to overcome challenges. It must be stated that the serious fiscal constraints of the nation and State create significant barriers to improved mental health systems for children. Transforming systems does not always require additional resources, but resources to bridge system reform do help. At the same time, the CCMH acknowledges fiscal constraints prompt more efficient use of existing resources and more collaborative communication and service provision to assure the focal point of the system is visible and clear: children and their families.

February Report Document Group 1

WORKGROUP REPORTS

COUNCIL ON CHILDREN'S MENTAL HEALTH

ACCOUNTABILITY/MANAGEMENT INFORMATION SYSTEMS WORKGROUP
COUNCIL ON CHILDREN'S MENTAL HEALTH
February 2009 Report

Purpose and Objectives

In this first phase of work, the key objectives were defined in August, 2008 as:

1. Define proposed key indicators – engage full Council to develop in October meeting
2. Define business rules to deliver key indicators
3. Define options and implications for implementation
   a. Information system needed
   b. Policies
   c. Workforce development

Workgroup Process:

The Workgroup conducted three full group conference calls and numerous individual discussions with targeted experts from August – December, 2008. The sequence of the calls and process was as follows:

August, 2008 Conference Call:

- Reviewed work from the Accountability workgroup as part of the SJR 799 process to ensure continuity on work previously completed.
- Agreed to look at a variety of outcome measurement systems to distill the target outcome measurements as the workgroup output.
- Identified a variety of possible sources to review.

Prep work for September Conference Call:

- Distributed and reviewed a variety of SOC outcome measurement systems and indicators used within Tennessee and other states
  - *National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program*
  - *Wraparound Fidelity Assessment System (1) Wraparound Fidelity Index and (2) Team Observation Measures developed at the University of Washington.*
  - *Muletown Family Network proposed outcome indicators*
  - *Nashville Connections outcome indicators*
  - *JustCare Family Network proposed outcome indicators*
  - *Available data from Juvenile Courts around Tennessee (supplied by TCCY)*
  - *National Information/presentation from the The Fifth National Wraparound Initiative Advisors Meeting*
  - *Promising Practices in Behavioral Health Quality Improvement: Summary of Key Findings and Lessons Learned, Center for Health Policy and Research, UMass Medical School, 2007*
  - *The MHSIP Quality Report: The Next Generation of Mental Health Center for Mental Health Services, Mental Health Statistics Improvement Program, May 2005.*

September, 2008 Conference Call:

- Developed "Guiding Principles" for design of statewide indicators
- Reviewed various sources and developed initial draft of possible outcome indicators based on adjustments to Muletown outcome indicators
- Discussed feasibility of outcome indicator measurement systems and their impact on proposed outcome indicators
- Identified need for entire Council to review potential measurement systems to assess feasibility of potential outcome indicators as measurement system

Preparation work for October Conference Call:

- Attendance of overview of CANS assessment system to inform feasibility of outcome indicator design

October Conference Call:

- Reviewed information about CANS assessment system to inform feasibility of outcome indicators
- Develop First Draft of Outcome Indicators

Presented workgroup report to full Council and secured guidance in October, 2008

- Received direction to ensure that outcome indicators are aligned with national CMHC evaluation
- Catalyzed group decision to have full Council review primary candidates for statewide assessment systems – CANS and TOMS – at December council meeting

November, 2008 – Preparation for December conference call:

- Committee members met with other team members in their department and gathered additional input and suggestions on Outcome Indicator draft. *Contributors* at this phase included:
  - *DCS*
  - *DOE*
  - *Vanderbilt University*
  - *TAMHO*
- Muletown evaluation team reviewed Outcome Indicator draft to calibrate indicators with national CMHC evaluation

December Conference Call:

- Committee members incorporated all input into Final Draft of Outcome Indicators for presentation to full Council members

December Full Council Meeting:

- Presented Final Draft of Outcome Indicators to full Council members and secured department liaisons and agreement to distribute to other departments for final input

December, 2008:

- Distributed Final Draft of Outcome Indicators to department liaison
- Received final input from departments, including possible data sources for future consideration

January, 2009:

- Finalized Draft of Target Outcome Indicators

Next Steps:

Although the workgroup fully delivered on its first proposed objective–to develop a draft of outcome indicators with a broad base of input and buy-in–it was not able to deliver on its other proposed objectives during this timeframe.

It is recommended that further work in this area focuses on completion of the original workgroup objectives, as follows:

1. Define business rules to deliver key outcome indicators
2. Define options and implication for implementation
   d. Information system needed
   e. Policies
   f. Workforce development

In addition, the group identified the future need for a set of system-level accountability indicators. These must correspond to the eventual policies and procedures agreed upon to govern the overall provider, funding and delivery systems. It is assumed these will be developed based on the assessment of barriers being conducted in January, 2009 among system stakeholders.

Attachment 1. Final Draft—Outcome Indicators
Attachment 2. System Accountability Structure (developed during SJR 799 and carried forward as recommendation for P.C. 1062 utilization)

Participants:
Traci Sampson, Consilience Group, LLC, Co-chair
Pam Brown, TCCY, Co-chair
Emel Eff, TCCY
Mary Beth Franklyn, DCS
Nneka Gordon, Comptroller of the Treasury
Petrina Jones-Jesz, DCS
Craig Ann Heflinger, Peabody College, Vanderbilt University
Sheila Keith, Blue Cross Blue Shield Tennessee
Marlin Medlin, Quinco Mental Health Center
Cindy Perry, Select Committee on Children and Youth
Mary Rolando, GOCCC
James Schut, Centerstone Research Institute
Stephen Sparks, DOE

Accountability Attachment 1

Accountability/Management Information Systems Workgroup
Proposed Outcome Indicators

Guiding Principles

- Indicators will be based in reality and easy to convey to others.
- Indicators must be feasible to measure.
- There must be several levels of accountability local, state, and possibly regional or county level.
- Family perspective is an imperative.

For Children, Youth, and Young Adults		
Outcomes	**Indicators**	**Measurement Tools**
1. Increased functioning in the community	1. Increased participation in social activities 2. Improved peer relationships 3. Improved quality of life 4. Increased resiliency, assets	CBCL CANS Other normed instruments?
2. Increased functioning in schools	1. Increased school attendance 2. Improved school performance (e.g., improved test scores and grade point average) 3. Decreased truancy, unruly, and parental relinquishment petitions from the school system 4. Reduced suspensions and expulsions. 5. Reduced dropout and improved promotion rates 6. Meeting NCLB benchmarks, making necessary adequate yearly progress.	Grades, disciplinary reports, test scores
3. Improved behavior	1. Reduced conduct problems (e.g., bullying)	Disciplinary reports from school
4. Reduced substance use/abuse	1. Decreased use or cessation of tobacco, alcohol, marijuana, other illegal drug use, or prescription drug abuse.	Education questionnaire
5. Reduced law enforcement and juvenile justice involvement	1. Decreased contact with law enforcement (e.g., arrests) 2. Decreased court appearances, convictions, and probation 3. Reduced delinquent behavior (e.g., violent crimes, property crimes, and other behaviors)	Probation officer report, parent report

6. Increased stability of living situations	1. Increased percentage of children living at home 2. Decreased number of moves between households 3. Reduced out-of-home placements 4. Successful increase in reunifications	DCS Tracking System
7. Appropriate and least restrictive services and placements	1. Increased number of youth placed in appropriate levels of care 2. Reduced number of trips to the emergency room	CANS Other normed instruments?

For Families		
Outcomes	Indicators	Measurement Tools
1. Increased family functioning	1. Improved family communication 2. Improved family management	Pre and post intervention questionnaire, Caregiver Strain Questionnaire
2. Decreased caregiver strain	1. Reduced objective strain (e.g., impact on time, finances) 2. Reduced subjective strain (e.g., worry, internal stress)	Caregiver Strain Questionnaire; Parent Stress Index
3. Family satisfaction	1. Caregivers and youth satisfied with overall quality of services 2. Caregivers and youth satisfied with aspects of service delivery (individualization, input on decision-making, cultural competency, etc.) 3. Caregivers and youth engaged in educational planning and decision making.	Targeted questionnaire TOMS
4. Increased empowerment	1. Improved self-efficacy 2. Increased reliance on natural supports 3. Increased hopefulness	Pre and post intervention questionnaire
5. Experienced high quality wraparound (process)	1. Selected self-report indicators (e.g., family selection of team members, other National Wraparound Initiative indicators) 2. Program record indicators	Wraparound Initiative Fidelity Index (WIFI) – only if using High Fidelity Wraparound as the service model

For Service System		
Outcomes	Indicators	Measurement Tools
1. Achieve and sustain fidelity to the Wraparound Model.	1. Selected indicators from National Wraparound Initiative	Wraparound Initiative Fidelity Index (WIFI) – only if using High Fidelity Wraparound as the service model
2. Increased collaboration and service integration.	1. Identifiable resources contributed by state and local agencies 2. Assessment of progressions from networking and cooperation to collaboration and services integration	Participant list from Child and Family Team meetings
3. System will provide a full array of formal services with timely access that incorporates natural supports	1. Network adequacy standards are met. 2. Utilization of Family Support Specialists	
4. All services are provided within the structure of being culturally and linguistically appropriate and competent	1. Caregivers and youth satisfied with cultural competency of services	
2. Each community maintains a self sustaining governance structure, assuring commitment and adherence to the principles of coordination of systems of care	1. Agreed upon Governance structure reflective of interagency participation and responsibilities	

Accountability Workgroup Attachment 2

Accountability Structure

State Level Entity:
Comprised of all child and family-serving agencies (policy leaders)

<u>Accountability</u>:
- Ensure high quality services
  - Respond to needs and recommendations for state reform:
    - Funding availability
    - Reimbursement/Admin policy
  - Monitor and hold funded providers accountable to individual agency measures and shared measures
- Maximize revenues

Region, County, or Municipal Level Entity:
Comprised of all child and family-serving public agencies and private stakeholders (TBD)

<u>Accountability</u>:
- Identify resource needs of larger area (roll-up of community-level plans)
- Monitor fulfillment of service plans
- Identify barriers to service
- Develop needs assessment and recommendations for local and state resources

Localized Community-Level Entity (possibly municipal area, neighborhood, zip code, etc):
Comprised of local community stakeholders

<u>Accountability</u>:
- Identify resource needs of local area
- Monitor fulfillment of service plans
- Identify barriers to service
- Develop needs assessment and recommendations for local and state

Direct Service Providers (<u>full</u> services array)

Youth and Family Assessors/ Facilitators/ Referrers

Youth and Families

<u>Shared Accountability</u> (with specific standards for each role):
- Fulfillment of service plan

<u>Accountability for Quality of Individual Service delivered:</u>
- Accessibility
- Outcomes (including client feedback)

FUNDING WORKGROUP
COUNCIL ON CHILDREN'S MENTAL HEALTH
February 2009 Report

Purpose: To assist the Council on Children's Mental Health (CCMH) in developing a financial resource map and cost analysis of all federal and state funded programs for children's mental health system of care.

Objectives:
- Updated financial resource map and cost analysis of all federal and state funded programs for children's mental health annually
- Set out requirements for the financial resource map and cost analysis
- Encourage matching federal funds.
- Stimulate more effective use of resources
- Identify amount spent on mental health services

Funding Workgroup process:
Public Chapter 1197 (2008) also requires the development of a Tennessee children's resource map of services and programs across state agencies and systems, including their funding source, target population, performance measures, and intended outcomes. Additionally, this resource map is required to include all federal and state funding streams that support the health, safety, permanence, growth, development and education of Tennessee's children from conception to the age of majority.

In order to reduce duplication of efforts, the Funding Workgroup Co-chairs participated in the Resource Mapping Advisory Group because analysis of the two public chapters showed apparent overlap between the purposes of these two entities. The mapping activities for Public Chapter 1197 will be extremely useful to the Council and will provide a mechanism for the ongoing compilation of budget information from all the child serving state agencies.

To date, the Service List Workgroup of the Resource Mapping Advisory Group has identified a common, broad list of services provided by the child serving agencies. This list was reviewed earlier by the funding workgroup for SJR 799 to assess completeness and to preliminarily identify funding streams for various levels of care. This preliminary mapping enabled the workgroup to discern the extent to which more formal information was needed and to preliminarily identify the kind of template they wanted to create to publish and distribute the information. This template for mapping the information has been shared with the Council on Children's Mental Health Chairs and Resource Mapping Advisory Group for Public Chapter 1197. This preliminary list of services will further ease compilation of the amount of funds (actual and estimated) Tennessee allocates for mental health services.

Additionally, the workgroup has begun collecting information on systems of care funding for other states. The Public Chapter 1197 Resource Mapping Advisory Group has reviewed reports from New Mexico that present their funding for services for children. This information should assist the Funding Workgroup in identifying ways to use the data and to affect the system as well.

Results/recommendations of the Workgroup:
The workgroup intends to make formal recommendations for the funding of a system of care that will include consideration of blended, braided or pooled funding. The workgroup will assess any benefits that could come from such changes to the funding streams that would promote and maximize available resources and plan resource allocation in the most effective manner. Additionally, the workgroup will promote the development of a funding or resource map that will inform the service planning processes within the state.

Next steps:

The Funding Workgroup will continue to monitor and participate in the Public Chapter 1197 Resource Mapping Advisory Group and related activities that promote the objectives of the Council as well. The focus of this group's next steps will be to identify strategies for mapping the state's resources in a way that will enable the Workgroup to meet its purpose and objectives as well as the mandates of the Council.

In further support of the purpose of the Funding Workgroup, TDMHDD will host a two day training for the Council by a national expert in strategic financing for systems of care to be held April 23-24, 2009. This national expert works closely with states in designing financing strategies to support more integrated service delivery for children with serious emotional disorders and their families and the Council will benefit greatly from this training.

Participants:

Mary Linden-Salter, AmeriChoice, Co-chair
Nneka Gordon, Comptroller of the Treasury, Co-chair
Sumita Banerjee, TCCY
Louise Barnes, DMHDD
Vickie Harden, Volunteer Behavioral Health Care System
Dustin Keller, Tennessee Lives Count
Susan Steckel, DMHDD

INTERAGENCY COLLABORATION WORKGROUP
COUNCIL ON CHILDREN'S MENTAL HEALTH
February 2009 Report

Purpose/Objectives

The Interagency Collaboration Workgroup (ICW) was created for the purpose of identifying and exploring a more comprehensive and coordinated system to address the individualized mental health needs of children and their families.

Workgroup Process/Activities

Initial study tasks included convening participants from a broad range of state and county and from public and private agencies, service providers, child advocates, and family members to develop a list of critical areas of need to develop a comprehensive and strategic plan for a coordinated system of care. Once established, the workgroup agreed the concept and philosophy of a "system of care" provided a guide and framework for system reform in children's mental health. Questions addressed included:

- What kind of system reform is needed for children's mental health care in Tennessee?
- How do we achieve system reform in children's mental health?
- What kind of structure is needed to support a statewide system of care approach?
- How do we motivate partnership and interagency collaboration?

The workgroup reviewed the core values of the system of care philosophy, which specify services be community based, child-centered, family-focused and culturally competent. The members also reviewed the current TCA Title 33 provisions that include system of care guiding principles of what services should be. The ICW holds to these same principles and incorporated them into its development of a coordinated system of mental health care for children ages birth to 24 and their families. Reference Interagency Collaboration Workgroup Attachment 1, Vision Statement, which articulates the integration of overarching criteria for systems of care in Tennessee.

The Interagency Collaboration Workgroup reviewed other state examples of reform and policy legislation and heard other presentations regarding current interagency agreements in Tennessee.

In November of 2007, a summit meeting was held to re-engage all interested parties already involved or wished to be involved in the SJR 799 study. The summit provided an opportunity to further review and refine the existing work product of the ICW. Following the summit meeting, the ICW reconvened to discuss the summit results and incorporated the suggestions into the final work product.

In 2008, legislation established the Council on Children's Mental Health for continuing the development of a system of children's mental health care. The ICW continues its work to address interagency coordination and collaboration in delivering and accessing mental health care.

Through much study, the ICW has included a review of the current barriers toward a comprehensive, coordinated and collaborative system of mental health care for children.

Review of Current Barriers

In the current services environment, there is no single entity with legitimate or mandated authority to ensure or enforce a comprehensive, collaborative and coordinated system of service delivery to meet the needs of children with mental health/behavioral health needs of children, adolescents and young adults. In addition, there is no single entity to hold key stakeholders or providers of services accountable for interagency or interdepartmental

cooperation to develop a viable system of care in each county, or among a group of contiguous counties.

Access to quality mental health services were consistently raised across the state, but more specifically a larger problem in rural areas attributing to an unequal distribution of resources.

There appear to be language barriers and cultural mandates of agencies or department that interfere with better cooperation and coordination of services. These issues affect roles and responsibilities and prohibit the development of a system of care culture.

A multitude of funding challenges exist that point to the need to identify funding streams, sources of funds, services that are funded and how those same dollars could be better spent by blending or braiding funding. There is the need for dedicated and consistent funding for maintaining coordination and consistency in service delivery.

There appears to be a need for an integrated data management system structured to inform case-specific management processes, identify resource allocations, and enhance information sharing to establish formal linkages for providing services and improving outcomes for children with mental health needs.

Ensure the work of the Council on Children's Mental Health and the Council workgroups is widely disseminated to expand awareness of the challenges in children's mental health.

Next Steps

Recommendations for Action:

1. There is a critical need for a state infrastructure for oversight and accountability of a comprehensive, coordinated system of care to address the mental and behavioral health services to meet the needs of children ages 0-24. This entity would hold the responsibility to develop and maintain a system of care that provides a comprehensive array of services and supports, and holds state departments, state agencies and other public and private service providers accountable in the collaboration and coordination of services and supports needed to exact the goals and purposes of a mental health system of care.

2. The same need is critical for a structure at the regional level to integrate service providers. Such existing entities need to be identified and explored to provide coordination among agencies and assist in pulling services together, identifying gaps in services, coordinating services, and to build on the existing regional resource linkages to ensure all partners coordinate services.

3. The same need is critical for replication at the community level creating a structure or entity representing the child and family interest.

4. There is a critical need to provide incentives to attract quality service providers to the rural areas. A model program like the University Consortium for Masters Certification may improve this particular gap in services and provide incentives to increase the work force in those areas.

5. There is a critical need to reference System of Care practices and principles in statutes for each state department as currently exists in TCA Title 33, Chapter 2, Department of Mental Health and Developmental Disabilities. This common language serves as a uniform guide for understanding and implementing best practice principles for a coordinated system of care.

6. There is a critical need to track the funding sources and improve service delivery by blending or braiding funding or creating local and regional collaboratives, thus sharing in providing existing service and recognizing gaps where monies are better spent. Explore other funding strategies such

as 1915-C alternative funds for children at risk of residential care, thus reducing expenditures for residential treatment and using the monies for alternative evidence-based interventions.

7. Create an integrated data system for interface between departments or entities for coordinated case management, resource allocation and outcome evaluation.

8. There is a critical need to continue the work of the Council on Children's Mental Health and to move forward in planning for developing a comprehensive system for children's mental health care.

9. There is a critical need to develop information sharing and training strategies to further the education of legislators, key stakeholders, providers, etc. regarding the need to improve the state's system for children's mental health care; utilize a variety of venues for presenting the current barriers and strategies for reform; continue town hall meetings for follow-up and up-date of the current work of the Council on Children's Mental Health; and include presentations on currently funded Systems of Care operating in Tennessee.

Participants:

Pat Wade, TCCY, Co-Chair
John Page, Centerstone
Jo Bruce, Family Resource Center
Charlotte Bryson, TVC
Tiffany Cheuvront, Tennessee Alliance for Children and Families
Linda Copas, DOE
Michelle Covington, Centerstone
Rhonda Ewing, TVC
Deborah Gatlin, MD, DCS
Nneka Gordon, Comptroller of the Treasury
Kathy Gracey, VU CMHC
Veronica Gunn, M.D., DOE
Jeanne James, M.D., TennCare
Michael Myszka, TennCare
Michael Lefkowitz, DHS
Cindy Perry, Select Committee on Children and Youth
Sue Pilson, Tennessee CSA
Mary Rolando, GOCCC
Servella Terry, Community Partnerships & Support Services
Linda Tift, Parent and Grandparent
Kristie Wilder, Intern, Comptroller
Lygia Williams, DMHDD
Christina Kloker Young, Creative Planning Systems

Interagency Collaboration Attachment 1

SJR 799 VISION STATEMENT

The following Vision Statement was a product of SJR 799 and it subsequently carried over as a foundation for the CCMH:

Tennessee will deliver a comprehensive, coordinated system of mental and behavior health services to meet the needs of children ages 0-21. Children and families will be viewed as customers and experience community-based services that are tailored to meet their unique needs, are family centered and family driven. These services will be data-informed, based on promising and proven practices. This system will leverage the resources of all public, private and nonprofit mental and behavior healthcare providers, supported across systems through finances, data and mutual accountability. In order to accomplish this vision, there will be one single entity with the infrastructure in place to support coordination, early identification, evidence-based practice and enforce accountability among all partners in the system.

Principles of service:

1. Children with emotional and behavioral health disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.

5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.

6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of children with emotional disturbances should be protected and effective advocacy efforts for children and youth with emotional disturbances should be promoted.

10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics; and services should be sensitive and responsive to cultural differences and special needs.

Interagency Collaboration Attachment 2

Framework: Moving from Collaboration to Services Integration

What is Collaboration?
- Definition: To work together, especially in a joint effort;
- Related terms: communicating, networking, coordinating, cooperating;
- Will have some duplication and inefficiencies in services;
- Collaboration is only as good as the working relationships between the agencies;
- Low toleration for conflict.

What is Services Integration?
- Definition: Process by which two or more entities establish more formal linkages for purpose of providing services and improving outcomes for a target population with related needs;
- Builds on strengths of each organization to avoid fragmentation, inefficiency, gaps in services, as well as duplication;
- More formal linkages increase commitment to work together and increases tolerance of conflict.

Benefits of Services Integration;
- Ability to address needs of clients with multiple problems in comprehensive manner;
- Greater service accessibility and continuity;
- Early identification, intervention and prevention;
- Reduced duplication;
- Reduced waste and inefficiency.

Levels on Which Collaboration/ Services Integration Occur—Example: The System of Care for Maury County
- State level: TDMHDD, DCS, DOE, DOH;
- County level: Community Advisory Board (CAB), Steering Committee, South Central DCS, Maury County Juvenile Court, Maury County Schools, Maury County Health Department, mental health providers, substance abuse providers, other service providers;
- Agency/staff level: MTFN Project Director, Supervisors, Family Support Providers, Community Liaisons, other MTFN staff.

Moving from Collaboration to Services Integration:
- Identify partners;
- Set goals;
- Plan governance and authority;
- Define service model and way partners interact;
- Plan financing/budgeting;
- Consider licensing and contracting issues;
- Define outcomes and accountability;
- Plan information systems and data management.

SERVICE ARRAY WORKGROUP
COUNCIL ON CHILDREN'S MENTAL HEALTH
February 2009 Report

Purpose/Objectives:
The purpose of the Service Array Workgroup is to identify a comprehensive array of services that address physical, emotional, social, and educational needs of children and determine the services and supports currently available and those needed to implement systems of care statewide.

Workgroup Process/Activities:
As a part of SJR 799, the Service Array Workgroup developed a litany of clinical mental health and other services and supports that are important to address needs of children/youth and their families in SOCs. A fundamental criterion emerged as a guiding principle: Children need a comprehensive array of services that address physical, emotional, social, and educational needs. All services will reflect the core values of the System of Care: child/youth centered, family driven, community based, culturally and linguistically competent.

Next Steps:
The Workgroup recommends as the work of the Council goes forward, the comprehensive service array can be further developed to include consensus descriptions of the services in the listing on the following pages, as well as delineating core and specialty services.

Participants:
Dustin Keller, Tennessee Lives Count, Co-Chair
Freida Hopkins Outlaw, DMHDD, Co-Chair
Susan Adams, Tennessee Community Service Agency
Mark Baldwin, Youth Town
Sumita Banerjee, TCCY
Richard Barbee, Private Practitioner
Kathy Benedetto, Frontier Health
Bonnie Beneke, TennesseeChild Advocacy Centers
Colleen Bohrer, Parent
Charlotte Bryson, TVC
Richard Edgar, DMHDD
Richard Gillespie, Taft Youth Development Center
Nneka Gordon, Comptroller of the Treasury
Carla Babb, Youth Villages
Raquel Hatter, Family and Children's Services
Richard Kennedy, TCCY
Nancy Reed, GOCCC
Mary Rolando, GOCCC
Theresa Shelton, Magellan Health Services
Millie Sweeney, TVC
Jude White, Renewal House
Ronald Wigley, Volunteer State Health Plan
Ellyn Wilbur, United Ways of Tennessee

Service Array Workgroup Attachment 1

COMPREHENSIVE ARRAY OF SERVICES

The comprehensive array of services identified during SJR 799 includes the following:

Mental Health Services
- Prevention
- Outpatient evaluation
- Psychological evaluation
- Psychiatric evaluation
- Outpatient individual, group and family therapy
- Specialized outpatient services for specific populations (i.e. dually diagnosed - MH/DD, MH/SA, traumatized youth, attachment issues, sexually abusive youth)
- Intensive Outpatient Programs
- School-based programs
- Early Intervention
- Case Management
- Transportation
- Partial Hospitalization
- Medical Drug Screen
- Home-Based Services
- Day Treatment
- Emergency Services
- Respite Care
- Therapeutic Foster Care
- Therapeutic Group Care
- Therapeutic Camp Services
- Independent Living Services
- Crisis Residential Services
- Inpatient Hospitalization
- Residential Treatment Services (short term)
- Aftercare

Substance Abuse Services
- Prevention Services (Universal, Selective, Indicated)
- Early Intervention
- Screening and Assessment
- Outpatient Services
- Day Treatment
- Detoxification
- Relapse Prevention
- Residential Treatment
- Intensive Outpatient
- Case Management
- Community Residential Treatment and Recovery Services
- Inpatient Hospitalization and Freestanding Inpatient

Educational Services
- Assessment and Planning
- Resource Rooms
- Self-Contained Special Education
- Specialized Schools
- Homebound Instruction
- Residential Schools
- Alternative Programs

Health Services
- Health Education and Prevention
- Screening and Assessment
- Primary Care
- Acute Care
- Long-term Care

Social Services
- Protective Services
- Financial Assistance
- Home Aid Services
- Respite Care
- Shelter Services
- Foster Care
- Long-term Care
- Adoption
- Aftercare

Recreational Services
- Relationships with Significant Others
- After School Programs
- Summer Camps
- Special Recreational Projects

Vocational Services
- Career Education
- Vocational Assessment
- Job Survival Skills Training
- Vocational Skills Training
- Work Experience
- Job Finding, Placement, and Retention Services
- Supported Employment

Operational Services
- Case Management and Case Coordination
- Juvenile Justice Services
- Family Support and Self-Help Groups
- Advocacy
- Transportation
- Legal Services
- Volunteer Programs
- Probation/Parole

Non-traditional Services
- Mentoring services
- Peer-to-Peer mentoring/learning
- Caregiver Skills training and education
- Faith-based Services
- Availability of Flexible Funds
- Family Resource Centers
- Team memberships (sports, YMCA, etc.)
- Provider/Parent engagement training
- System of Care training

CULTURAL AND LINGUISTIC COMPETENCY WORKGROUP
COUNCIL ON CHILDREN'S MENTAL HEALTH
February 2009 Report

Purpose: To assist the Council on Children's Mental Health (CCMH) in designing policies and procedures that are culturally and linguistically competent for a mental health system of care to serve children and families in Tennessee.

Objectives:

- Have services available for all who need them.
- Have provider services tailored to meet the needs of each family.
- Decrease stigma attached to mental health services.
- Enhance cultural/linguistic competence of service providers.
- Ensure cultural competency training is available for all service providers.
- Ensure adequate transportation is available for families to obtain needed services.
- Devise flexible appointment schedules, meeting places and accommodations for families.
- Establish culturally responsive ways to connect with families of color.
- Involve faith-based organizations in promoting cultural awareness emphasis on mental health.

Process:

The Cultural and Linguistic Competency Workgroup (CLCW) used several avenues to obtain information for CCMH:

- Held conference calls with workgroup members.
- Reviewed resource tools from other system of care programs and the National Center for Cultural Competence, Georgetown University Center for Child and Human Development. Materials included:
  - "Planning for Cultural and Linguistic Competency in a System of Care"
  - "Conceptual Frameworks/Models, Guiding Values and Principles"
- Had discussions with parents.

Results/Recommendations

- Need to emphasize awareness of cultural issues underlying mental health concerns of parents, caretakers, school representatives and service providers.
- Have Family Support Providers assist parents in advocating for their child(ren) in schools to make sure mental health services are available and appropriate.
- Determine a simplified process for identifying families of color in need of mental health services and establish an appropriate mental health referral process for services and resources without the family going to several agencies.
- Explore cultural competency training curriculum conducted for providers to ensure all necessary skill development aspects are included. Include cultural/linguistic competency training for all providers who have not had training. Conduct an assessment of providers regarding their needs to be more effective in delivering culturally/linguistically competent services and include the ways to address those needs in the curricula.
- Perform needs assessments with culturally and linguistically diverse groups in service areas, specifically rural/urban distinctions.
- Develop and administer policies in partnership with families, youth and primary consumers.
- Address barriers to delivery of interventions such as staff attitudes, service hours, service locations, languages, insurance, lack of knowledge about diverse cultural groups, and fear/distrust of the service system.
- Collect and analyze data according to different cultural groups (i.e. age, race, ethnicity, language, sexual orientation, geographic location, religion, immigration/refugee status, socioeconomic status, and literacy levels). Include other factors impacting mental health such as violence and trauma.

- ❍ Evaluate and monitor quality of interventions, services and supports through family and youth satisfaction surveys, focus groups, comparative analyses and other mechanisms.
- ❍ Use evidence-based practices in design and delivery of services and supports for culturally and linguistically diverse groups.

Some of the concepts above were obtained from Checklist for Systems of Care Communities, National Center for Cultural Competence—Georgetown University Center for Child and Human Development, April 2004.

Participants:
Debrah Stafford, TCCY, Co-Chair
Anne Pouliot, Parent, Co-Chair
Tonja Sesley Baymon, Memphis Urban League
Kristi Faulkner, DCS
Nneka Gordon, Comptroller of the Treasury
Tomeka. R. Hart, Memphis Urban League
Ray Lyons, Northeast CSA
Freida Outlaw, DMHDD
Mary Rolando, GOCCC

EVIDENCE-BASED SERVICES WORKGROUP
CHILDREN'S COUNCIL ON MENTAL HEALTH
February 2009 Report

Purpose/Objectives of the Workgroup:

The Evidence-based Practice Workgroup was established to assist the Council in formulating a consensus definition of evidence-based practice (EBP), consolidating information about current EBP initiatives across Tennessee and ensuring an approach to EBP that maintains the integrity of a "no wrong door" System of Care (SOC). The workgroup developed the following as guiding points:

- How should EBPs be addressed/considered in future legislation?
- How will EBPs be disseminated in a SOC?
- The Workgroup will consider a bi-directional approach to 1) identifying existing EBPs and 2) establishing evidence for services identified as essential parts of the services array.
- The Workgroup will consider both 1) training existing providers and 2) pre-service strategies (i.e. partnering with our graduate schools).
- What is currently available across the state?

In addition, three basic decision-making tenets were incorporated into workgroup process:

- The framework must support a "no wrong door" approach within a system of care.
- Recommendations should include acquiring practices that are able to be implemented with current resources or with ability to gain needed resources.
- Include prevention, early intervention and treatment as part of the recommendations and workgroup product.

Goals established to guide outcome of workgroup activities include the following:

- Establish a roadmap for disseminating and supporting (i.e. fidelity measurement) EBP across the state.
- Provide an assessment of the "state of EBP" in Tennessee.
- Provide a framework for supporting pre-service strategies with graduate schools to prepare professionals as they come into the field.
- Focus recommendations on collaborations with system of care sites in adoption of EBP.

Workgroup Process

The workgroup met via teleconference on the second and fourth Friday of each month. A number of stakeholders from various backgrounds participated in the meetings, ensuring input is obtained from a diverse group. An outline was developed to help guide the process and give the workgroup a common set of elements from which to develop the final product. The workgroup maintains a task list with identified action items, responsible parties and timeframes for completion.

Current activities include research of definitions of evidence-based practice and the development of a draft consensus definition, review of EBP across Tennessee, and assimilation of information about activities conducted by Department of Children's Services (DCS) and other agencies to identify EBP. The draft definition will be presented to the Council at the March meeting.

In addition, as DCS completes the Juvenile Justice EBP project, this information will be incorporated into the overall review of the Tennessee systems. Other resources utilized by the workgroup include the Department of Mental Health and Developmental Disabilities' Best Practice Guidelines for Children and Adolescents currently in place and research produced by the Governor's Office of Children's Care Coordination, Tennessee Adolescent Coordination of Treatment project.

The EBP Workgroup is in the development phase of a survey to providers. This survey will assist the workgroup synthesizing data regarding current EBP strategies being used across Tennessee. The survey results will be used to assist the workgroup in noting gaps in the service system regarding EBP

and in making recommendations for EBP adoptions and implementation. Survey dissemination is planned for the first week of February, 2009. A preliminary dissemination strategy has been developed and will be further refined at the next workgroup meeting.

Results / Recommendations

The workgroup has developed a draft definition of evidence-based practice which will be provided to the Council for review and adoption at the March meeting. The definition is as follows:

Establishing a consensus definition of EBP

There is considerable agreement in the scientific literature that often the day-to-day practice of mental health providers does not reflect the latest findings of clinical research (e.g. Drake, R. E., et. al., 2001, p. 180; Institute of Medicine, 2001; U.S. Department of Health and Human Services, 1999). The last 10 years have seen a call for increased use of Evidence Based Practices by mental health clinicians (Kazdin, 2008; Whalley & Davis, 2007; Weisz, et. al., 2006; Drake, et. al., 2001; Institute of Medicine, 2001; U. S. Department of Health and Human Services, 1999). However, this "call to action" has not been without its problems and controversies, not the least of which is the definition of what constitutes Evidence-Based Practices (EBP) (e.g., Hoagwood, et al., 2001; Leff, 2004; Kazdin, 2008). In the fields of medicine, social work, psychology, counseling, juvenile justice, and mental health there are many definitions of EBP with differing emphases. Not withstanding the many controversies in the literature, in the simplest sense EBP are "treatments that work". One of the goals of the CCMH EBP Workgroup is to provide guidance in defining EBP.

A Continuum of Evidence

Evidence that a given practice is a "treatment that works" exists on a continuum from practices supported with the most rigorous high-quality experimental research to practices supported by theoretical constructs that have general support in the professional community.

The highest level of evidence is EMPIRICALLY SUPPORTED PRACTICE. A program, practice, or treatment can be considered to be an Empirically Supported Practice if:

1) high-quality research using two or more between group design experiments show efficacy by having either:
    a) a statistically significant superior effect over placebo or another practice, or
    b) an equivalent effect to an established practice in experiments with adequate sample sizes.

OR

2) A large series of single case study design experiments (at least 9 such studies) demonstrating efficacy which:
    a) used good experimental design, and
    b) compared the practice to another practice (or placebo).

3) Experiments (and the program or practice) were conducted using treatment manuals.

4) Sample characteristics were clearly specified.

5) Effects were demonstrated by two different investigators or investigating teams. (Chambless, et. al., 1998).

The next highest level of evidence is RESEARCH-BASED PRACTICE. Research-Based Practice is a program, practice, or treatment that has some empirical support demonstrating efficacy and effectiveness but does not yet meet the requirements to meet the standard of Empirically Supported Practice. For instance, a Research-Based Practice may not reach the threshold of at least 9 single case study design experiments or may be so new that positive effects have not yet been demonstrated

by two different investigators or teams of investigators. However, it is expected that a Research-Based Practice would be manualized.

The minimal level of evidence which qualifies as Evidence Based Practice is THEORY-BASED PRACTICE. Theory-Based Practice is a program, practice, or treatment that has general support among treatment providers and experts, based on experience and the professional literature. Theory-Based Practice may have anecdotal (i.e., client reports of effectiveness) or case-study support for efficacy and effectiveness and has the potential for becoming either a Research-Based practice or an Empirically Supported Practice.

Evidence Based Practice and Children and Adolescents

Those who seek to develop Evidence Based Practices for use with children and adolescents face an additional challenge. It is evident that children differ from adults, so it logically follows that EBP for children must differ from those for adults. However, it is not enough to merely pay attention to age-related differences between adults and children/adolescents, but attention must also be directed to age differences among children and adolescents; the differences in rate and stage of development; the context in which the intervention will be delivered (e.g., schools); the complex and dynamic interactions among the child, the family, and the environmental context; and the central role the family plays in the life of he child, including the understanding of the diagnosis itself (Hoagwood, et.al., 2001).

Other recommendations are being deferred until the workgroup obtains survey results and has additional data from other initiatives.

Next Steps:

As the workgroup continues to assimilate information, we expect to begin building recommendations around monitoring evidence-based practice implementation within the System of Care. We have discussed key concepts including developing a methodology by which monitoring activities are consistent across all bodies, including state agencies, accrediting organizations, licensure entities, etc.

In addition, especially in the field of mental health, there is growing awareness of the difficulties and costs of implementing EBPs. As an alternative, some advocate "practice-based evidence," which places emphasis on accountability through performance measurement and use of continuous quality improvement strategies with clinicians to monitor and improve practice. We will plan to convene an intensive discussion about practice-based evidence, to determine how this concept can be included into the report.

Participants

Michael Cull, VU CMHC, Co-chair
Vickie Harden, Volunteer Behavioral Health Care System, Co-chair
Sumita Banerjee, TCCY
Bonnie Beneke, Tennessee Child Advocacy Centers
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MEDIA RELATIONS WORKGROUP
COUNCIL ON CHILDREN'S MENTAL HEALTH
February 2009 Report

Purpose/Objectives:
Develop strategies for disseminating information about System of Care and work of the Council in order to assure communities are knowledgeable about, supportive of and contributors to systems of children's mental health care.

Workgroup Process:
The Workgroup was formed in late January and had not officially met as of 1/30/09 but it will convene prior to the meeting of the CCMH scheduled for early March.

Products:
Column: Special to *The Commercial Appeal*, November 2008: When we help children, everyone wins: A "system of care" approach provides a comprehensive foundation of assistance for youngsters with mental health issues.

Column: Commentary in The Tennessean, January 2009: Science shows transfers are not the answer.

Newsletter: TCCY *The Advocate*, December 2008: Tennessee Moves to Improve Children's Mental Health Care; Creates Council on Children's Mental Health.

Next Steps:
Press Release planned for February 2009 with submission of Preliminary Report to the Legislature.

Participants:
Linda O'Neal, TCCY, Chair
Colleen Bohrer, Parent
Fay Delk, TCCY
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When we help children, everyone wins

A "system of care" approach provides a comprehensive foundation of assistance for youngsters with mental health issues.

By Linda O'Neal
Special to The Commercial Appeal
Wednesday, November 19, 2008

Scientists now know that it is the interaction of genes and experience that shapes a child's developing brain.

Even children who have strong, supportive relationships with their parents, family members and others in the community may develop brain-based illnesses that present emotional and behavioral issues. In fact, such problems are among the leading health concerns of U.S. parents: In 2005 and 2006, the parents of one in seven children in this country consulted health care providers or school staff concerning their child's emotional or behavioral difficulties.

Evidence demonstrates that a "system of care" approach to providing the mental health services many children need -- using child-focused, family-driven, culturally competent strategies -- improves prospects for long-term success for the child, family and community. A system of care is a coordinated network that includes a full array of mental health and other services. It meets the diverse needs of children with serious emotional disturbances who require services from multiple systems.

A system of care approach involves collaboration by a variety of entities at the state, local and individual levels. Schools, health and mental health care providers, juvenile courts, law enforcement, the faith community, children's advocates, and the families and children themselves are among those who must work together to produce optimum outcomes.

The positive outcomes from a system of care for children's mental health services include reductions in school suspensions, expulsions and dropout rates, reduced use of hospital or residential placements, fewer commitments to state custody and less juvenile court involvement.

In response to a two-year study by the Select Committee on Children and Youth, the Tennessee General Assembly this year established a Council on Children's Mental Health. The council brings together key stakeholders, including youth and families, to lay the foundation for a high-quality system of care for children who need mental health services.

The council will develop a financial resource map of programs currently funded by the federal and state governments. Its plan will identify a core set of services that appropriately and effectively address the mental health needs of children and families.

The legislature established timelines for the council to recommend system of care pilot sites in each of the state's three grand divisions by 2010. If funded, 10 sites are to be operating by 2012, and the system will be in use statewide by 2015.

In partnership with the nonprofit group Tennessee Voices for Children, Shelby County's Just Care Family Network, Dr. Leon Caldwell of Rhodes College's psychology department and the Comprehensive Counseling Network, the Tennessee Department of Mental Health and Developmental Disabilities recently received federal funding to implement a system of care project in Shelby County that will serve children ages 5 to 19 with serious emotional disturbance.

The approach will involve trained local parents-caregivers as care coordinators with support from mental health consultants and an emphasis on school-based mental health delivery.

The Just Care network is on the path to being designated as one of the Council on Children's Mental Health pilot sites for 2010 and it will be instrumental in developing additional system of care sites across Tennessee.

The council's efforts will build on other successful strategies already in place for improving the mental health outcomes for young children in Tennessee. Existing partnerships involving the state departments of education and health and Vanderbilt University promote the social and emotional development of infants and young children. The state health department is also implementing a comprehensive early care system. For school-age children, Coordinated School Health Programs include an emphasis on health promotion for staff, family/community involvement, health education, physical education, health services, nutrition services, healthy school environment and counseling, psychological and social services.

The work of the Council on Children's Mental Health provides an important opportunity for improving the children's mental health system in Tennessee. When educators, mental health care providers and other service providers partner with families and children to assure needs are met in a comprehensive, coordinated manner, the outcomes are better for everyone.

Providing needed mental health services improves children's opportunities for success, and strengthens families, schools and communities.

Linda O'Neal is executive director of the Tennessee Commission on Children and Youth and co-chair of the Council on Children's Mental Health.

This is one in a series of monthly guest columns designed to focus public attention on issues that affect children. It is part of a Shelby County initiative to remind everyone, in every aspect of daily life, to "Ask First: Is It Good for the Children?" For more information, visit shelbycountychildren.com or call the Shelby County Office of Early Childhood and Youth at (901) 526-1822 ext. 249.

Linda O'Neal Op-Ed: http://www.tennessean.com/apps/pbcs.dll/article?AID=2009901030330

Science shows transfers are not the answer

By Linda O'Neal • January 3, 2009

Community safety and best interests of children align when it comes to transferring children for trial as an adult. The answer is clear: Children should be kept in the juvenile justice system except in extremely rare cases.

Historically one of the greatest strengths of the juvenile justice system in Tennessee was the reluctance of juvenile courts to transfer children for trial as adults except in those rare cases. Judges intuitively knew what science now tells us.

Through brain imaging science, we now know the frontal lobe of the brain, the part controlling rational thought and decision making, does not fully develop until well past 18. Children are often impulsive and act without adequately thinking through consequences. However, with maturation and appropriate intervention, judgment skills develop but are less likely to successfully do so in the adult criminal justice system.

Tennessee managed to avoid the knee-jerk reaction of many states in the 1990s when laws were changed to automatic transfer of children to adult court or transfer solely at the discretion of the prosecutor. Among other criteria, Tennessee law requires a judicial determination of reasonable grounds to believe the child committed the offense and whether the child can be rehabilitated in the juvenile system.

In August 2008, the Office of Juvenile Justice and Delinquency Prevention released "Juvenile Transfer Laws: An Effective Deterrent to Delinquency?" It reports extensive research on this topic. While the report indicates the evaluations of the impact of "deterrence" are varied, the impact on recidivism is clear. Transfer is found to increase recidivism: "The practice of transferring juveniles for trial and sentencing in adult criminal court has, however, produced the unintended effect of increasing recidivism, particularly in violent offenders, and thereby of promoting life-course criminality."

The 2008 Kids Count Data Book introductory essay discusses both the adverse impact of excessive transfer on community safety, and the brain science understanding of important differences in children and adults.

Effective strategies for improving juvenile justice include using evidence-based interventions, more intensive work with families, more effective interventions in schools, and improved early access to mental health and substance abuse services. Incarceration is not an evidence-based intervention.

Tennessee is striving to implement more effective strategies, including using child and family team meetings to engage families and guide service plans for children in custody, and implementing bullying prevention and other school-based programs. Established in 2008, the Council on Children's Mental Health has begun a planning process to improve the children's mental health and substance abuse service systems.

Legislation enacted in 2007 requires use of evidence-based services for juvenile delinquency prevention and intervention. Transfer to adult court is not an evidence-based solution. The Department of Children's Services and community providers should be supported and encouraged in this move to evidence-based services.

Reducing recidivism and avoiding "promoting life-course criminality" are important goals for the justice system. These goals are best achieved by keeping children in juvenile court.

Linda O'Neal is executive director of the Tennessee Commission on Children and Youth.

February Report Document Group 2

SURVEY RESULTS

COUNCIL ON CHILDREN'S MENTAL HEALTH

Council on Children's Mental Health Barriers Survey: Figure 1

Rank the ADMINISTRATIVE barriers/challenges to systems of care in Tennessee.

Answer Options	1: Least Barrier	2	3	4	5: Greatest Barrier	Rating Average
Accountability for performance and for resources	14%	19%	38%	19%	10%	2.90
Lack of integrated information systems	26%	16%	0%	16%	42%	3.32
Overcoming administrative and provider territoriality	0%	5%	15%	35%	45%	4.20
Poor historical relationships among those expected to be partners	27%	23%	23%	18%	9%	2.59
Quantifying the amount of resources & effort related to positive outcomes	19%	38%	24%	14%	5%	2.48

Rank the SERVICES barriers/challenges to systems of care in Tennessee.

Answer Options	1: Least Barrier	2	3	4	5	6: Greatest Barrier	Rating Average
Inadequate culturally competent services	30%	50%	10%	5%	0%	5%	2.10
Lack uniform eligibility criteria to enter SOC	21%	11%	16%	16%	21%	16%	3.53
Inadequate youth/parental engagement	14%	5%	18%	46%	14%	5%	3.55
Inability to track outcomes	18%	14%	23%	18%	14%	14%	3.36
Difficulty implementing Evidence Based Practices	5%	23%	18%	0%	46%	9%	3.86
Limited number and array of services	13%	0%	13%	13%	9%	52%	4.61

Rank the POLICY barriers/challenges to systems of care in Tennessee.

Answer Options	1: Least Barrier	2	3	4	5: Greatest Barrier	Rating Average
Conflicting state agency rules/requirements	14%	19%	10%	33%	24%	3.33
Lack of uniform service eligibility criteria statewide	9%	18%	46%	18%	9%	3.00
Inadequate cross-agency coordination about children's mental health	10%	0%	14%	24%	52%	4.10
Inadequate transition to adult mental health services	29%	33%	10%	14%	14%	2.52
Differing federal & state confidentiality rules among departments/agencies	32%	27%	23%	18%	0%	2.27

Rank the barriers/challenges to systems of care PRINCIPLES in Tennessee.								
Answer Options	1: Least Barrier	2	3	4	5	6	7: Greatest Barrier	Rating Average
Fidelity to SOC wrap-around model	9%	9%	14%	14%	27%	23%	5%	4.27
Achieving commitment/buy-in by state agencies, local communities and providers	14%	0%	10%	10%	10%	14%	43%	5.14
Historical relations among agencies	5%	26%	21%	16%	21%	11%	0%	3.53
Sustainability of SOC	0%	10%	5%	5%	14%	24%	43%	5.67
Transition to strengths-based service planning	27%	14%	23%	23%	9%	5%	0%	2.86
Lack of workforce development/qualified staff	4%	22%	13%	30%	9%	13%	9%	3.91
Educating/engaging community	38%	14%	24%	0%	14%	10%	0%	2.67

What are the most important elements to put in place to overcome the barriers?									
Answer Options	1: Least Important Element	2	3	4	5	6	7	8: Most Important Element	Rating Average
Statewide culture change to shared SOC vision.	15%	0%	15%	5%	0%	10%	20%	35%	5.60
Joint planning among all child-serving agencies	10%	14%	0%	0%	10%	19%	19%	29%	5.62
Clear SOC governance structures	0%	0%	20%	25%	15%	15%	15%	10%	5.10
Memoranda of Understanding among agencies	5%	15%	15%	10%	25%	15%	15%	0%	4.40
Shared information systems among agencies	25%	0%	10%	25%	20%	5%	10%	5%	3.95
Fiscal accountability among agencies	10%	14%	19%	24%	10%	19%	0%	5%	3.90
Collaborative funding	0%	24%	19%	5%	19%	0%	24%	10%	4.62
Economies of scale, i.e., # of enrollees justifies cost of system	27%	27%	5%	9%	9%	14%	0%	9%	3.32

What is your experience with Mental Health Systems of Care?		
Answer Options	Yes	No
Have you participated in a children's mental health system of care?	65%	35%
Were you in a leadership role in the SOC?	50%	50%
Did you experience effective communication w/ other participants?	88%	13%
Did all participants contribute resources (time and expertise) to the SOC amicably?	63%	38%
In your opinion did services to families improve?	81%	19%

Council on Children's Mental Health: Youth Survey

Figure 2: Percentage of Youth Respondents Served by Various Agencies & Individuals
Youth Survey Results

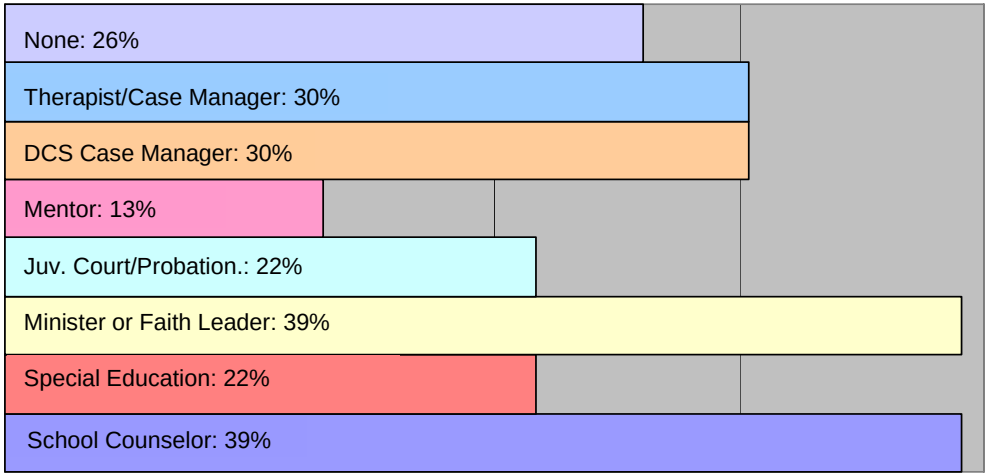


Figure 3: Most Helpful Services
Youth Survey Results

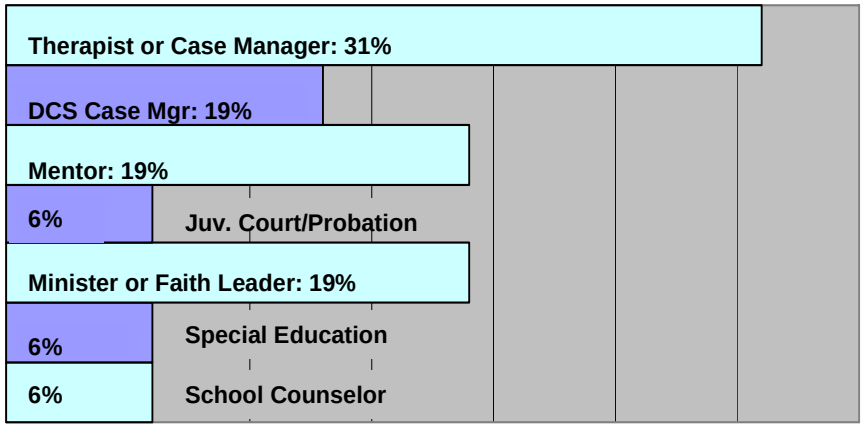


Figure 4: Places Stayed to Receive Mental Health Services
Youth Survey Results

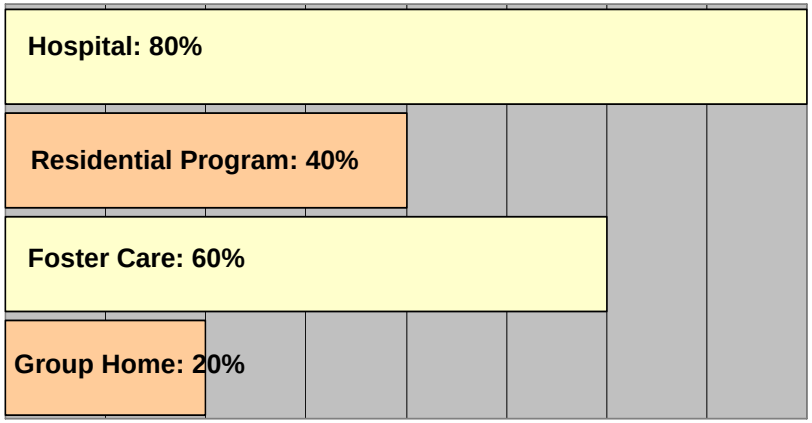
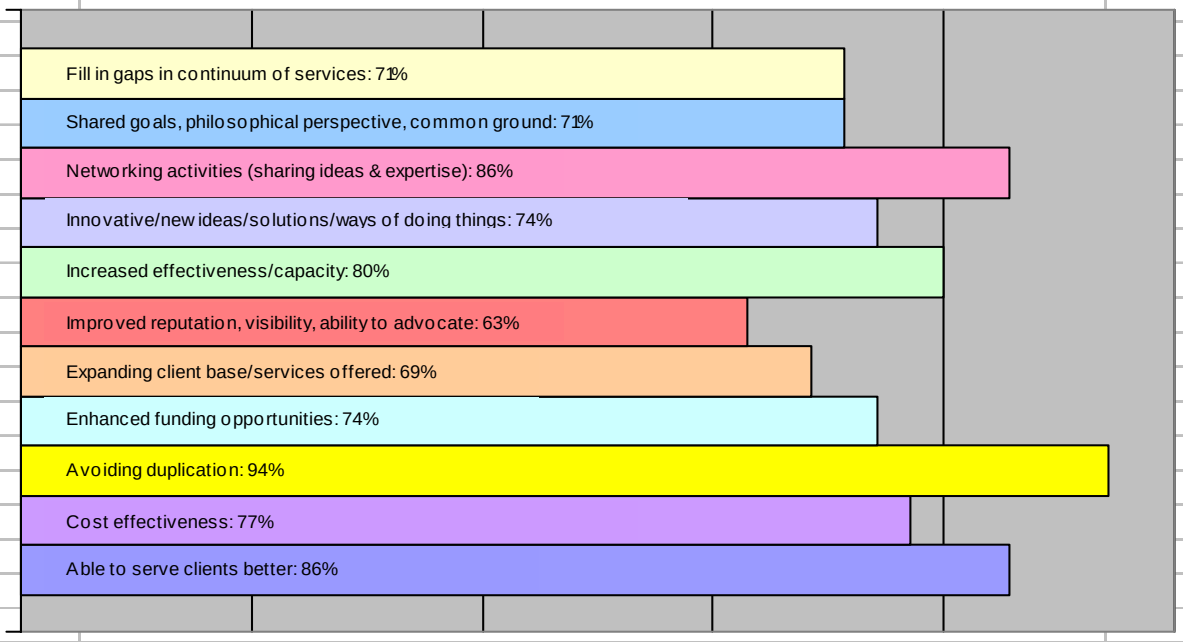


Figure 5: Council on Children's Mental Health: Status of Interagency Collaboration Survey Results	Agree/ Strongly Agree
All appropriate child-serving agencies are represented in the Council on Children's Mental Health.	85%
My agency is committed to the development of a system of care for children in Tennessee.	91%
My agency has consistent, high-level participation in the Council on Children's Mental Health.	82%
I regularly receive information regarding the progress of the Council on Children's Mental Health.	77%
My agency understands its role in the Council on Children's Mental Health.	76%
My agency is actively participating in at least one Council on Children's Mental Health work group.	94%
My agency understands the goals of the Council on Children's Mental Health work groups.	77%
My agency's "voice" is heard as a part of the Council on Children's Mental Health.	82%
The Council on Children's Mental Health has given my agency a better understanding of the goals of other child-serving state and community-based agencies.	68%
The work of the Council on Children's Mental Health has led to opportunities to partner with other child-serving state and community-based agencies.	59%
Family voices are represented in the Council on Children's Mental Health.	68%
All appropriate child-serving agencies are represented in the Council on Children's Mental Health.	77%
The Council on Children's Mental Health has the right membership at the table to meet its goals.	74%
The Council on Children's Mental Health has clear structure and policies in place to organize and guide	62%
Members of the Council on Children's Mental Health have a shared definition of evidence-based	53%
The Council on Children's Mental Health has a plan for the provision of culturally and linguistically competent services to children and their families.	41%
My agency is easily able to share data and information across systems on a routine basis.	52%
My agency regularly partners with other child-serving state and community-based agencies on funding opportunities.	56%
My agency has Agreements/Memoranda of Understanding with other agencies focused on children's mental health.	64%
My agency involves families and youth in the development of policy, practice standards and outreach	57%

Figure 6: Council on Children's Mental Health Perceived Benefits of Collaboration



Council on Children's Mental Health Figures: Status of Interagency Collaboration Survey Results

Figure 7:
Barriers to a System of Care are Identified

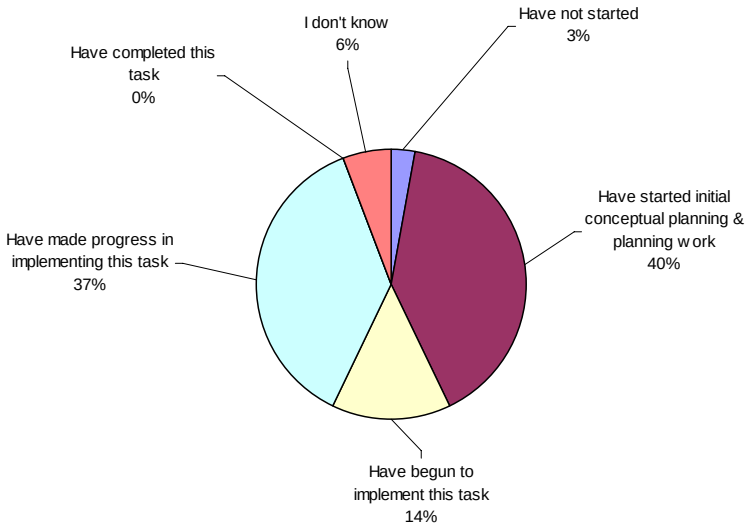


Figure 8:
There is a clear understanding of available evidence-based, theory-based or research-based services to children in Tennessee.

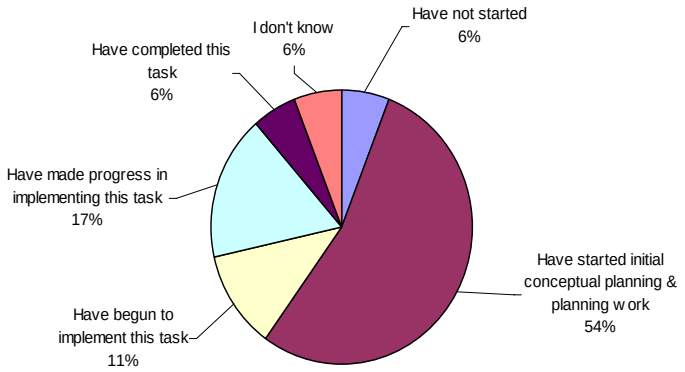


Figure 9:
Interagency agreements are in place to support a system of care in Tennessee.

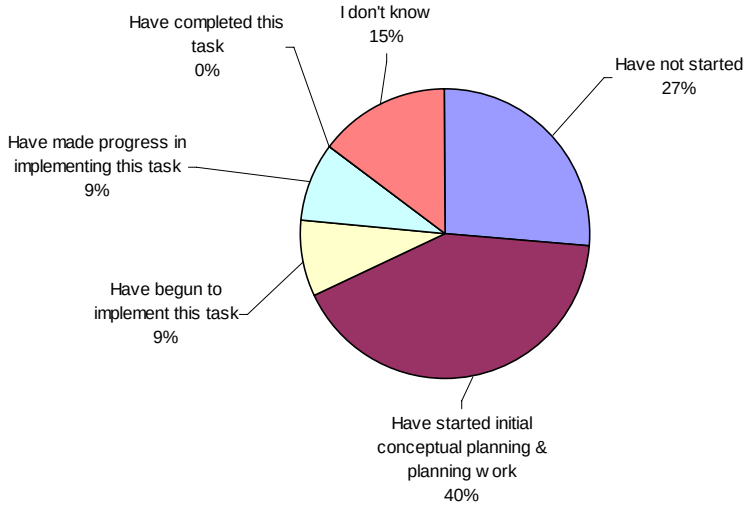
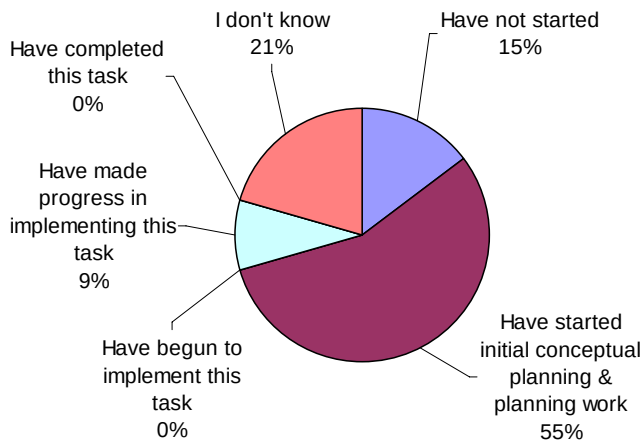


Figure 10:
A financial resource map outlining available state and federal funding for children's mental health is developed.



Council on Children's Mental Health Figures Status of Interagency Collaboration Survey Results

Figure 11:

A cost analysis of federal and state funded programs is completed.

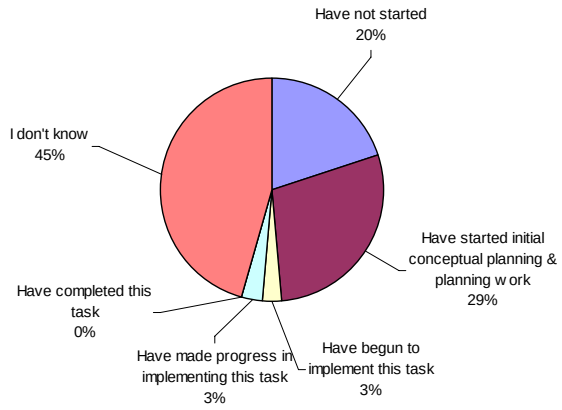


Figure 12:

A plan for a statewide system of care in Tennessee is developed.

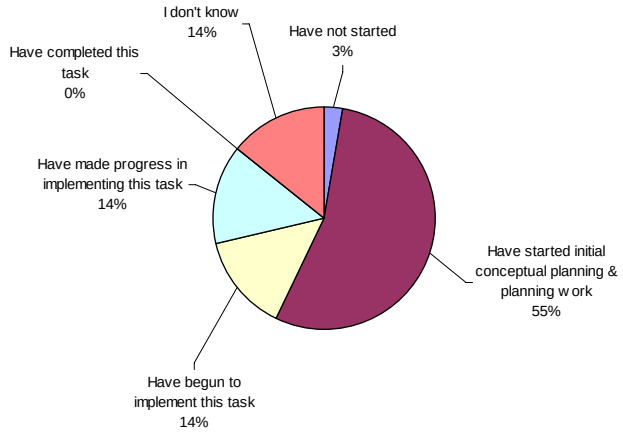


Figure 13:

Formal recommendations are in place to implement a statewide system of care in Tennessee.

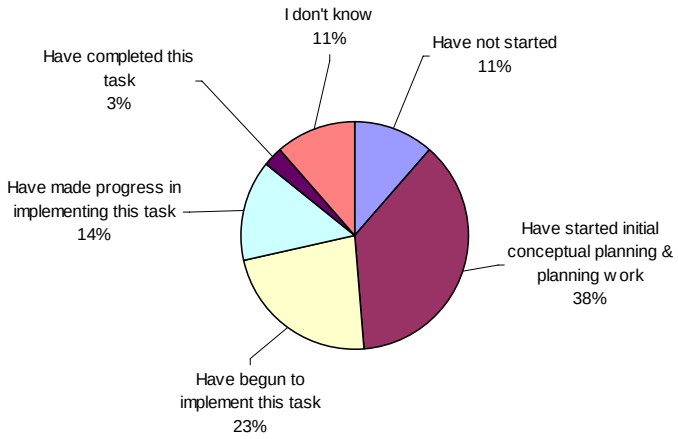
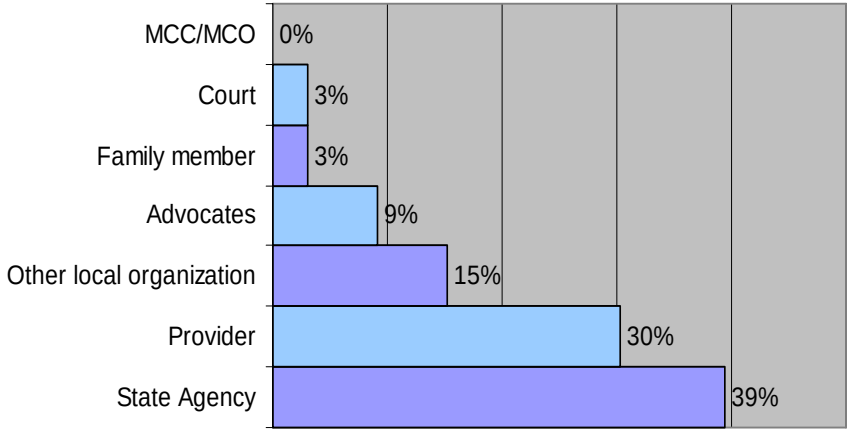


Figure 14:

What group or type of agency do you represent?



MEMORANDUM OF UNDERSTANDING
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES;
TENNESSE COMMISSION ON CHILDREN AND YOUTH;
AND
GOVERNOR'S OFFICE OF CHILDREN'S CARE COORDINATION

This Memorandum of Understanding by and between the parties named above is to provide the framework for the collaboration, development and compilation of the Council on Children's Mental Health (CCMH) February 1, 2009 and July 2010 Report to the Tennessee Legislature.

WHEREAS, the Public Acts, 2008 Chapter No. 1062 (P.C 1062), established a Council on Children's Mental Health (CCMH) to design a plan for a statewide system of care for children. CCMH is comprised of leadership from child-serving state and community-based agencies, the courts, legislators, families and advocates. The CCMH is co-chaired by the Commissioner of the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) and the Executive Director of the Tennessee Commission on Children and Youth (TCCY).

WHEREAS, the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) is designated by both the State and SAMHSA as the single State Authority for mental health and substance abuse services in the State of Tennessee and, as such, is charged with the establishment of the policy for Tennessee's public mental health and substance abuse system based on the application of science, evidence, data and national standards to mental health and substance abuse programs, services and outcomes.

WHEREAS, the Tennessee Commission on Children and Youth (TCCY) is an independent state agency whose primary mission is advocating for the improvement of the quality of life for Tennessee children and families.

WHEREAS, the Governor's Office of Children's Care Coordination (GOCCC) assists in the coordination of children's policy among the child serving departments of the state, in establishing appropriate partnerships among academics, communities, providers, faith-based services, and businesses, and in bridging science and public policy.

WHEREAS, TDMHDD, TCCY and the GOCCC agree to collaborate to develop in Tennessee a coordinated system of care for children's mental health needs that is child-centered, family-driven, and culturally and linguistically competent. THEREFORE, the Parties agree:

General Responsibilities

1. TDMHDD and TCCY shall assist CCMH by providing logistical and administrative support as needed for CCMH meetings and activities.

2. TDMHDD and TCCY shall provide final approval of the work products of CCMH and its committees, assuring that the work product(s) are representative of CCMH's goals and purposes.

3. TDMHDD, TCCY and GOCCC will develop strategies that lead to the July 1, 2010 report to the General Assembly for review and approval by the CCMH.

TDMHDD Responsibilities

1. The Commissioner of TDMHDD or designee shall Co-chair the CCMH with TCCY.

2. The Commissioner of TDMDD shall select two individuals from TDMHDD to serve as members of the CCMH. Of the two individuals selected one shall have experience with or a basis of knowledge about children and youth services and the other shall have experience with or a basis of knowledge about alcohol and drug abuse services.

3. TDMHDD shall identify specific content areas that require the establishment of CCMH workgroups and provide guidance to the workgroups.

4. TDMHDD shall review, comment and provide input on processes and documents developed by the GOCCC for CCMH use.

5. TDMHDD shall work with TCCY and GOCCC, in consultation with CCMH, to determine and establish the commitments of the parties in the development of the July 1, 2010 CCMH report to the General Assembly.

6. TDMHDD shall provide other support to CCMH as determined appropriate and feasible by TDMHDD.

TCCY Responsibilities

1. TCCY Executive Director or designee shall Co-chair the CCMH with TDMHDD.

2. The Chairman of the TCCY or designee shall serve as a member on the CCMH.

3. TCCY shall identify specific content areas that require the establishment of CCMH workgroups and provide guidance to the workgroups.

4. TCCY shall review, comment and provide input on processes and documents developed by the GOCCC for CCMH use.

5. TCCY shall work with TDMHDD and GOCCC, in consultation with CCMH, to determine and establish the commitments of the parties in the development of the July 1, 2010 CMCH report to the General Assembly.

6. TCCY shall provide other support to CCMH as determined appropriate and feasible by TCCY.

GOCCC Responsibilities

1. GOCCC shall participate on a regular basis in CCMH meetings and CCMH workgroup meetings.

2. GOCCC shall organize, develop and/or compile information required by the P.C. 1062 for the February 1, 2009 report to the General Assembly; provide a draft of an Executive Summary, report and related documents for review, comment and revision to the co-chairs of the CCMH and others as appropriate; and finalize the report for timely delivery to the General Assembly.

3. GOCCC shall work with TDMHDD and TCCY in consultation with CCMH to determine and establish the commitments of the parties in the development of the July 1, 2010 CCMH report to the General Assembly.

WHEREBY: This Memorandum of Understanding (MOU) shall not be altered or otherwise amended except pursuant to an instrument in writing signed by each of the parties. This MOU will be reviewed regularly by all parties in *September 2009 and will be renewed or will terminate by January 1, 2010.*

AGREED AND EXECUTED BY:

_____ _____

Virginia Trotter Betts Date

Commissioner, Tennessee Department of Mental Health and Developmental Disabilities

_____ _____

Linda O'Neal Date

Executive Director, Tennessee Commission on Children and Youth

_____ _____

Bob Duncan Date

Director, Governor's Office of Children's Care Coordination

STATE OF TENNESSEE

COUNCIL ON CHILDREN'S MENTAL HEALTH

MEMBERSHIP

January 28, 2009

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Susan Adams, Deputy Director
TN Community Services Agency
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Janie Palazolo, Program Director (Alternate)
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Rachel Anthony, Judge
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Mark Baldwin, Director of Programs
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Heather Baroni, Vice President
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Pam Brown, KIDS COUNT Director, Chair
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Emel Eff, Statistical Research Analyst
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Richard Kennedy, Director of Field Operations
TN Commission on Children and Youth
Nashville

Steve Petty, Legislative Specialist
TN Commission on Children and Youth
Nashville

Debrah Stafford, Juvenile Justice Director
TN Commission on Children and Youth
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Pat Wade, CPORT Director
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