Council on Children's Mental Health

A Report to
the Legislature
July 2010

Council Co-Chairs

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Commissioner
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of Mental Health and
Development Disabilities

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Tennessee Commission on Children and Youth authorization number 316098. July 2010. 111 copies. This public document was promulgated at a cost of $3.12 each.

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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, Tennessee 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: June 29, 2010

RE: Council on Children's Mental Health July 2010 Report

This memorandum transmits the July 2010 Report of the Council on Children's Mental Health as required by T.C.A. 37-3-115. 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 July 2010 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 and families in Tennessee. The level of commitment and excitement has been extraordinary. Over 200 Tennessee citizens have volunteered to be involved in this process and meetings have averaged attendance of 59.

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

COUNCIL ON CHILDREN'S MENTAL HEALTH

JULY 2010 REPORT TO THE LEGISLATURE

EXECUTIVE SUMMARY

T.C.A. 37-3-110-115 directs 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 July 2010 Report to the Legislature addresses the requirements codified at T.C.A. 37-3-115.

Plan Development Overview

CCMH was initiated in June 2008, meeting and exceeding the requirements for participation. The CCMH has met fourteen times, co-chaired by the Commissioner of the Tennessee Department of Mental Health and Developmental Disabilities and the Executive Director of the Tennessee Commission on Children and Youth. A steering committee was established to help organize the work of the Council and has met four times. Workgroups have continued to meet and two new groups were added since the February 2009 Report. Over 200 people have participated—state agency leadership, representatives of the Governor's Office, Legislature, Comptroller's Office, Community Service Agencies, providers, advocates, judges, parents of children who have received services and youth who received services—with an average of 59 persons at each meeting.

Current Plan Recommendations

Report recommendations/suggestions are part of an on-going learning, vetting, and organizing process of the Council and Workgroups. T.C.A. 37-3-112 outlines the required components of the plan recommendations at this stage. Additional reports/plans are due July 2012 and July 2013 requiring 10 demonstration sites and statewide implementation respectively. This report discusses the requirement for three demonstration sites and other plan aspects related to this initial implementation. The plan is organized into two units: services/supports and administrative/financing.

Services and Supports

The three demonstration sites will be the current federal funded System of Care initiatives as follows:

- Mule Town Family Network (MTFN), Columbia/Maury County, Middle Grand Region
- Just Care Family Network (JCFN), Memphis/Shelby County, West Grand Region
- K-Town Youth Empowerment Network, Knoxville/Knox County, East Grand Region

Pending approval of federal funding, a fourth demonstration site may be added:

- Early Connections Network (ECN), Cheatham, Dickson, Montgomery, Robertson, Sumner Counties, Middle Grand Region

Additional sites will be added as possible based on areas building capacity and areas with high need because of poverty, lack of services and supports, and disproportionate contact with juvenile justice or child welfare systems.

The Council has discussed the eligibility and populations to be served relative to current ages served by the various departments and agencies, including TennCare and CoverKids. The Council has also considered a phase-in period for children with different payer sources. Developing a competent workforce is also crucial to System of Care and the Council will rely on the demonstration sites to inform this aspect.

A Core Value of a System of Care is the system must be culturally and linguistically competent. Guidelines have been provided to ensure on-going tasks of the Council and plan implementation meet and exceed these expectations.

Evidence Based Practices (EBP) has been a considerable focus of the Council. The Council has considered varying options to ensure a mutual understanding of various definitions of EBP and allow the system to develop evidence for existing services – commonly known as "practice-based evidence."

Administrative and Financing

One of the most effective ways to demonstrate differences from the current system to statewide implementation of a System of Care is the governance and financing of mental health services for children and families. While the Council is not ready to endorse one particular structure or model, various examples are given to illustrate the benefits of cross-cutting collaboration and system-wide infrastructure, data-sharing, and service planning.

The Council has researched several universal service planning and data collection tools. During this process, the Council began to focus attention on the Child and Adolescent Needs and Strengths (CANS) instrument. CANS is currently being used in Tennessee through the Department of Children's Services as well as other collaborative projects. CANS is a promising tool allowing multiple agencies to understand the needs and strengths of a child and family. The Council supports adoption and use of this instrument by departments and agencies and will monitor its adaptability and usefulness to a statewide System of Care.

Systems of Care have a high level of need for uniform and standard tools, forms, formats, and data collection systems. By having all participating entities using the same instruments, collaboration and service planning is enhanced. When multiple data systems can interface and communicate, greater accountability, better reporting and better outcome measures can be achieved.

Summary of Recommendations

The following is a summary of the current CCMH plan to move forward a statewide System of Care for children and families:

- Study the three existing demonstration sites;
- Examine the resource mapping data;
- Study the MTFN infrastructure and sustainability efforts;
- Continue to develop other sites;
- Continue to leverage federal funding as available; and

- Coordinate discussions with gubernatorial candidates and newly appointed Commissioners of child-serving state departments.

Barriers to Implementation

In June, Council members were surveyed about perceived barriers to implementation of systems of care in four areas: administrative, service, policy, and implementation of System of Care principles. Overcoming administrative and provider territoriality and lack of integrated information systems were listed as barriers yet to overcome.

Youth Council members were surveyed about their experiences with mental health and support services. 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

A listing of all children's mental health services and programs provided by state departments during resource mapping data collection is provided. Additional information about on-line and telephone listings of providers and services available across the state is also included.

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 and challenges ahead are noted.

Financial Resource Map

The CCMH has worked in concert with the Resource Mapping Advisory Group of P.C. 1197, also passed in 2008, requiring mapping of all federal and state funds supporting youth. Information regarding all state and federal funds supporting mental health services to children and families is included. In FY 08, approximately $391,840,851 was spent on children's mental health services, representing only 8.75 percent of all funding spent on children and youth.

Current Economic Climate and Budget Situation

CCMH's greatest concern is that existing essential services and supports are maintained. Loss of services will erode the foundation of public-private partnerships and reduce the opportunity for children and families to receive needed services and supports. Without these resources, more children will fail in school, have mental health and substance abuse problems, and come into the child welfare and juvenile justice state custody systems. Tennessee must ensure these essential services and supports survive to provide and maintain a foundation for a brighter, more prosperous future for the state as the economy recovers.

Related Considerations

The CCMH explored statutorily-related matters and other administrative and organizational initiatives relevant to 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 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 General Assembly in this endeavor, and the opportunity to work with the Legislature, the Administration and others to accomplish the goal of implementing a statewide System of Care.

TABLE OF CONTENTS

COUNCIL ON CHILDREN'S MENTAL HEALTH

JULY 2010 REPORT TO THE LEGISLATURE

In 2008, 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 philosophical 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 critical. P.C. 1062 articulates the responsibility for the CCMH to design a qualitative, quantitative and functional system. This Report responds to the requirement to submit a plan to the Legislature by July 1, 2010 to implement three demonstration sites in keeping with System of Care principles.

The organization of this Report is derived from the requirements of P.C. 1062, codified at 37-3-110-115 to address:

I. Plan development overview;
II. Current plan recommendations;
III. Barriers to implementation;
IV. List of all programs;
V. Status of interagency cooperation;
VI. Financial resource map;
VII. Current economic climate and budget situation;
VIII. Related considerations.

Restatement of System of Care Core Values and Guiding Principles

The goal of the state's system is for children with multi-system needs to be served in their homes and communities. Briefly, core 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 Guiding 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 and linguistically competent services;
- Accountability for system performance and family outcomes.

When the components are in place and when core values and guiding principles adhered to, 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.

In this report, mental health services may be referred to as mental health and substance abuse services or simply mental health services alone. In all instances of this report, mental health services are intended to include substance abuse services as well.

I. THE PLAN DEVELOPMENT OVERVIEW
The Council on Children's Mental Health

The Council: Membership of the Council on Children's Mental Health (CCMH) meets and exceeds the participation articulated in T.C.A. 37-3-111. The Co-chairs of the Council—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)—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 and have been attending when scheduling allows. We are continuing to explore models of family and youth engagement to ensure their participation continues.

The CCMH met fourteen times between July 2008 and July 2010, typically from 10:00 a.m. to 3:00 p.m. in Nashville. Five of these meetings were detailed in the February 2009 report that can be found at http://www.tn.gov/tccy/ccmh-report09.pdf. A decision was made early in the process to allow all participants in Council meetings 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. 74. Attendance averaged 59 persons for the nine Council meetings since February 2009. Membership is relatively stable. Over 50 percent of members in attendance at meetings have attended over three-fourths of the total number of meetings held.

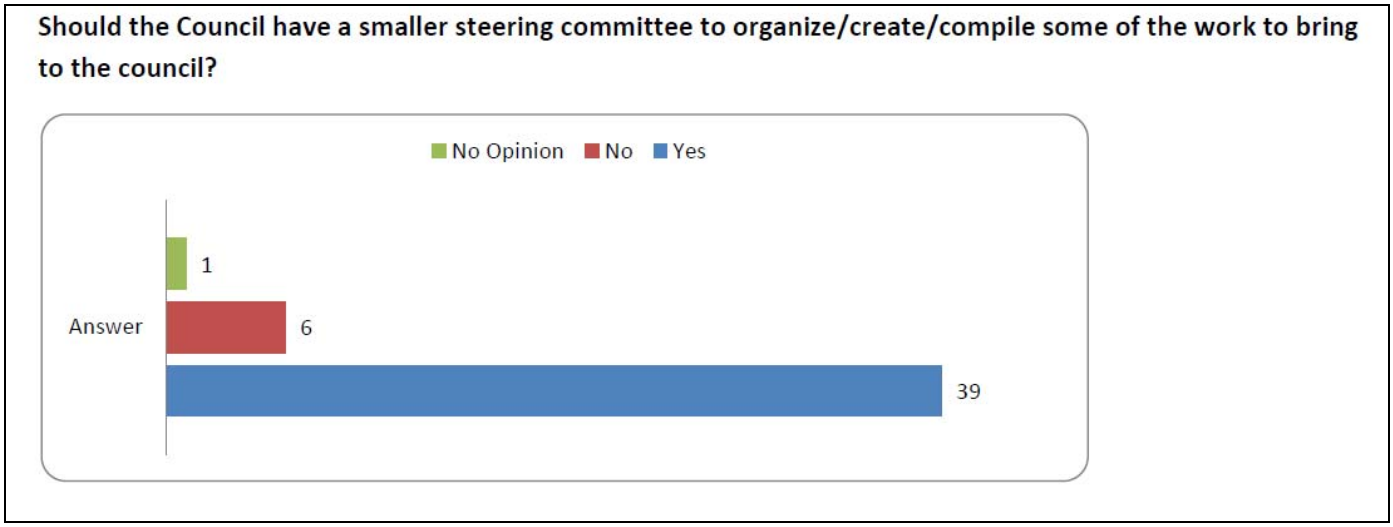
The Council initially focused on organizational matters and familiarized itself with the history of System of Care-related initiatives in the state as described in the February 2009 report. The Council agenda has focused on issues related to comprehensive services for children and youth, such as, the Child and Adolescent Needs and Strengths (CANS) service planning and data collection tool and the integration of school, mental health, and juvenile court services. The Council has most recently focused on providing workgroup meeting and discussion time to allow the members to further improve recommendations about statewide governance system structures, common tools and instruments, and other components of the plan detailed in this report. As one example of this work, an updated review of the state's federally funded System of Care grant programs through TDMHDD, depicted in July 2010 Report Table 1, p. 6; has been included as these sites are identified as our logical first three demonstration sites.

A full representation of CCMH meeting agendas and outcomes since the February 2009 report is depicted in Table 1 of July 2010 Report Document Group 1, Tables, p. 49.

Steering Committee: Following several discussions and workgroup co-chair suggestions, the Council considered its governance structure and the need for a smaller working group to help organize, coordinate, and assemble information before presentation to the full Council. This group would assist in developing the meeting agenda, facilitating accountability of workgroups including the plan timeline,

and assisting the Council Staff and workgroups. An anonymous survey of CCMH membership was conducted via Survey Monkey in late July 2009. The July 2010 Report Figure 1 displays the responses received:

July Report 2010 Figure 1: Steering Committee Survey Results



This information was presented to the full Council at the August 20, 2009 meeting. Members of the Council asked for a proposal from the Council Co-Chairs and Workgroup Co-Chairs. A formal proposal was presented to the Council membership at the October 8, 2009 meeting. This proposal was revised and adopted by the Council. The adopted proposal can found in the appendices at p. 71.

Since its inception in October 2009, the Steering Committee has met four times with an average of 20 members at every meeting. A full representation of agendas and outcomes of the Steering Committee is presented in Table 2 of July 2010 Report Document Group 1, Tables, p. 55.

Council Workgroups: The Council has continued to utilize a workgroup structure to research and discuss various topics related to the statewide plan. Workgroup recommendations have been presented to the Steering Committee and then to the full Council. The Council has adjusted the workgroups since the February 2009 report. There are currently nine workgroups providing recommendations and information about their respective topics. The eight primary workgroups and their foci are reflected in Table 3 of July 2010 Report Document Group 1, Tables, p. 57. This table entitled CCMH Workgroup Structure and Next Steps has served as the roadmap and guide for the Council working toward the completion of the plan.

Based on the current research about the effectiveness of merging a Multiple Response System and System of Care values and principles, the Select Committee on Children and Youth has asked the Council and its members to be involved in their study of the Department of Children's Services Child Protective Services System. The Council readily agreed to assist with this process and made the study's working group a formal workgroup of the Council.

II. CURRENT PLAN RECOMMENDATIONS

The following recommendations/suggestions are part of an ongoing learning, vetting and organizing process of the Council and Workgroups. All workgroups have also had an opportunity to make recommendations as well as comment on other Workgroup products.

Services and Supports Unit

Demonstration Sites: The current economic climate, coupled with the potential opportunity for sustainability, caused the Council to focus on the current federally funded System of Care sites in Tennessee as the three demonstration sites required by statute. Currently, TDMHDD has three System of Care initiatives, one in each grand region of the state, and has recently applied for a fourth regional site in northern Middle Tennessee. In T.C.A. 37-3-110-115, the Council was charged with proposing three demonstration sites for this stage of the plan. These sites meet the statutory requirement, and little or no additional funding is proposed in this plan at the current time. The Council also has the possibility of adding a fourth regional site pending the successful grant award from the Substance Abuse and Mental Health Services Administration (SAMHSA). If funded, this site would be the first multi-county regional System of Care initiative in Tennessee and the first to focus on the early childhood (0-5) age group. The grant application is for a System of Care Initiative in Cheatam, Robertson, Sumner, Montgomery, and Dickson counties

TDMHDD has had substantial experience with development and implementation of federally funded System of Care grants including securing the required federal match of cash and in-kind resources, using the SOC core values and guiding principles to guide the initiative. Tennessee's experiences are summarized below in the July 2010 Report Table 1. Federally funded System of Care grants are typically awarded for a six-year grant cycle with the possibility of a seventh year no-cost extension if funding allows. The first full year of the grant cycle is considered a planning year for the Initiative to organize, hire and train staff, develop the local governance structure, etc. Typically sites do not begin serving children until well into the second year of funding. The federal expectation and understanding of the importance of system and sustainability planning and development for the demonstration sites also has relevance to the CCMH efforts for System of Care across Tennessee.

July 2010 Report Table 1: Tennessee Current and Proposed System of Care Initiatives

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
Mule Town Family Network Funding Over 6 Years: $6.7M Federal $6.7M Match Required**	Initiated: 2005 Anticipated End Date: 2011	Target: 440 Current: 300	• Maury County residents; • Birth-21 years of age; • SED diagnosis (includes but not limited to ADHD, OCD, bipolar, depression); • Multi-agency involvement; • 72% below poverty and 10% at or near poverty; • 44% have IEP; • 49% have witnessed domestic violence; • 66% have lived with someone who was depressed; • 13% have attempted suicide; • 70% of caregivers report a family history of depression; • 62% of caregivers report a family history of substance abuse.	• Increased stability of living arrangements; • Decreased school suspensions; • Decreased delinquent behaviors; • Decreased use of marijuana; • Improvement in measures relating to anxiety, depression, internalized and externalized behavior problems; • Reduced overall caregiver strain; • Increased behavioral and emotional strengths; • Over 95% of families reported positive experience on access to services, participation in treatment, cultural sensitivity, and satisfaction with services at both 6 and 12 month follow up.
Just Care Family Network Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 10/2008 Anticipated End Date: 2014	Target: 450 Current: 15 youth enrolled, 66 total family members served	• 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.	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 with Memphis City Council funded JUSTCARE 180, a youth, family and neighborhood approach to reducing youth delinquency and promoting success.

K-Town Youth Empowerment Network Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 9/2009 Anticipated End Date: 2015	Target: 400 Currently in planning year, scheduled to enroll families 10/1/10	• Knox County residents; • Youth age 14-21; • Emotional, behavioral or mental health disorder present; • Multi-agency involvement; • At risk of placement to a higher level of care (inpatient hospitalization, residential treatment, or state's custody); • Caregiver/parent willing to maintain child in home, school and 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.
Early Connections Network: Fulfilling the Promise Funding Request Over 6 Years: $9M Federal $8.5M Match Required**	Grant Application Submitted: 12/2009 Anticipated Award Date: 9/2010 Anticipated End Date: 2016	Target: 400	• Residents of Cheatham, Dickson, Montgomery, Robertson, and Sumner Counties; • Young children ages 0-5 and their families; • Emotional, behavioral or mental health disorder present; • A parent or caregiver willing to participate in the wraparound process to maintain the child at home, at school or childcare and in the community.	PROJECTED Outcomes in addition to improved Clinical Outcomes^: • Family Support Providers integral to SOC success; • Improved functioning in the home, pre-school, child care and community; • Expanded early childhood training of local community service providers

* 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.

^ Clinical Outcomes vary for each System of Care Initiative. Examples of these types of outcomes include: increased stability of living arrangements; decreased school suspensions, decreased delinquent behaviors; decreased use of marijuana; and improvement in measures relating to anxiety, depression, internalized and externalized behavior problems.

Federally mandated SOC eligibility requirements include a focus on: children at-risk of placement at a higher level of care such as inpatient hospitalization, residential placement, or state custody for the purposes of treatment; children with complex serious emotional disturbance (SED) needs; children who have contact with multiple agencies; and who have families who serve as partners in the initiative. There are recognizable geographic boundaries and clearly defined criteria for eligibility, even though the criteria differ from initiative to initiative. Families are usually at or near the federal poverty level. The initiatives are structured to be replicated and sustainable, with outcomes measured by the SOC national and local evaluations. A common staffing model for Tennessee's System of Care initiatives is also present in each system in which each child and family is served by a community liaison/mental health specialist and a family support provider. The family support provider is a trained and certified parent who has experience working in the system with their child or family member.

These initiatives provide an informative foundation for designing and planning for Systems of Care statewide, as required by T.C.A. 37-3-110-115.

The Council will work to identify additional demonstration locations as needed to allow the Council to be informed about locations other than those funded by a federal System of Care grant. Criteria for these sites could be based on the following:

- Areas building capacity like Northeast Tennessee, which support coordinated care without the requirement of additional funding; and
- High need areas based on poverty, lack of services and supports, disproportionate contact with juvenile justice or child welfare systems.

Eligibility and Populations to be Served: As noted in July 2010 Report Table 1, considering the federal sites as our demonstration sites, the eligibility and population to be served has been determined under the federal funding. However, all of these sites fall within the range currently being discussed by the Council. Current Council recommendations range from birth to 25 years with varying degrees of disability, service involvement or diagnoses (federal requirements are 0-21 years of age). Additionally, the Council has considered a phase-in period for children with different payer sources. For example, the system could feasibly serve children and families currently receiving services from TennCare or CoverKids as well as those served by a child-serving department such as Children's Services or Education. Using the demonstration site criteria as a guide, the Council will continue to study and research all potential options for serving the majority of Tennessee's children who need System of Care mental health services and their families.

Staffing Patterns and Workforce Development: TDMHDD has developed a staffing model unique to Tennessee System of Care initiatives. As previously noted, each child and his/her family is served by a community liaison or community mental health professional and a family support provider (FSP). The family support provider is a trained and certified parent or transitioned youth who has experience working in the system with their child, family member or themselves. A formal certification process for family support providers has been approved by TDMHDD and is currently being implemented. Council members and SOC site staff are working to make the service provided by an FSP reimbursable through

traditional payer sources such as TennCare, Cover Kids, and private insurance. Additionally, in the Mule Town Family Network, the community liaison has been able to seek reimbursement for case management services; however, this does not cover the cost associated with the extensive collateral contact and case coordination occurring without the child or family present. The Council will continue to assist in determining funding sources for these necessary components to a statewide SOC.

Additionally, the Council will rely on the demonstration sites to inform staffing patterns and ratios needed in local System of Care initiatives. Staff ratios are inherent in achieving fidelity to the model currently being used in Tennessee's initiatives. The recommended caseload for a community liaison or family support provider is no more than 10 to 15 families. This ratio varies somewhat because caseloads can be weighted based on high needs of a particular family, such as multiple children with SED and caregiver needs. The recommended number of families is currently 12.

Early training and education for mental health professionals in System of Care core values and guiding principles, as well as other related aspects of the statewide system, are crucial for success. Providing training in college and other vocational settings that involves experiences outside the classroom is recommended. The Council will explore avenues to ensure appropriate compensation for traditional and non-traditional service staff, as both are equally valued in a System of Care.

Cultural and Linguistic Competence Monitoring Plan: As a core value of System of Care, the Council is committed to making certain the plan for a statewide system will be culturally and linguistically competent. The Council has identified the following on-going tasks for the work of the CCMH and to continue through implementation of a System of Care statewide:

- Emphasize awareness of cultural/linguistic issues underlying mental health services for all workgroups of CCMH;
- Determine a common conceptual and operational definition of cultural and linguistic competency for the System of Care;
- 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;
- Use the cultural competency training curriculum developed by Tennessee Mental Health and Social Service Workers for service providers, line staff, management, licensed professionals, facility personnel, security personnel, faith-based representatives. Training curriculum is to ensure all necessary skill provisions are included in their professional development.
- Conduct cultural/linguistic competency training on a periodic basis (i.e. annual face-to-face training, webinar training, workshops at conferences, CDs and on-line training for easy access);
- Have contract agencies that provide mental health services conduct a cultural competency assessment to determine their capacity to sensitively and effectively serve diverse populations (i.e. age, race/ethnicity, disabled, hearing impaired, urban/rural, etc.);
- Develop Regional Cultural/Linguistic Networks as a part of the local/regional structure to keep communities abreast of new and varied changes in cultural issues;

- Conduct a needs assessment of culturally and linguistically diverse groups in regions to determine what their specific needs are. Conduct a similar needs assessment to determine what provider agencies need in order to do an efficient and effective job with diverse populations;
- Conduct peer-to-peer reviews (within and among agencies) to assess cultural/linguistic competency; and
- Implement the use of a cultural/linguistic competent protocol to evaluate the services and supports provided for diverse populations.

Evidence Based Practices: 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. The last 10 years have seen a call for increased use of Evidence Based Practices (EBP) by mental health clinicians as well as funding sources. However, this "call to action" has not been without its problems and controversies, not the least of which is the definition of what constitutes EBP. In the fields of medicine, social work, psychology, counseling, juvenile justice, and mental health there are many definitions of EBP with differing emphases. Notwithstanding controversies in the literature, in the simplest sense EBP are "treatments that work".

In March of 2010, the Council surveyed direct service providers in the state's mental health delivery system to better understand their use and understanding of EBPs. Surveys were disseminated very broadly to access the largest number of clinical providers, and 175 completed surveys were returned. Most of the respondents worked either in rural (50%) or suburban settings (14%) and provided outpatient behavioral health services to a wide variety of diagnoses.

On average, clinicians surveyed did not think EBPs should be required in their practices and did not endorse high levels of confidence in their effectiveness. Similarly, the majority of respondents reported having been trained in an evidence-based practice, although a minority endorsed their use in practice and on average, those who used EBPs reported low levels of fidelity to published standards.

Clinicians in all areas reported providing services for a wide variety of behavioral and emotional needs. On average, clinicians reported low levels of familiarity with the most common available treatment modalities (i.e., Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavior therapy). Depressive disorders, disruptive behavior disorders and Attention Deficit/Hyperactivity Disorder were the most commonly treated conditions. Trauma treatment, treatment of disruptive behavior disorders and treatment of anxiety disorders were respondent's three training priorities.

The results of the work group's survey suggest a gap in the service system's understanding and use of EBPs. To close this gap the system will need to establish an infrastructure to support use of established effective practices and promote their use in the child serving system.

Two active projects serve as excellent examples of how the system can support EBPs and help us understand the state of EBP in Tennessee:

- The Trauma-Focused Cognitive Behavior Therapy (TF-CBT) Learning Collaborative: Multiple indicators speak to the success of the Learning Collaborative. The monthly metrics suggest increasing numbers of children receiving TF-CBT and reductions in post-traumatic stress symptoms. Verbal reports from agencies and clinicians also suggest high levels of success including improved client outcomes and increased clinician confidence in working with this challenging population. Many agencies are now further disseminating TF-CBT by training additional cohorts of clinicians within their agencies. In doing so, they have relied on their own newly developed expertise as well as those of the Tennessee faculty and national TF-CBT trainers. Currently this collaborative is managed by the Centers of Excellence (COEs) funded through the Governor's Office of Children's Care Coordination (GOCCC).
- Department of Children's Services response to T.C.A. 37-5-121 – Juvenile Justice EBP: As full implementation takes root, Tennessee will have a solid base of effective treatments for Juvenile Justice youth. Documentation already gathered by the Department suggests Tennessee is well positioned to be among the nation's leaders in provision of services proven to reduce criminal recidivism. DCS looks forward to continued work on an interdepartmental and interdisciplinary level to ensure the continuance of this work.

CCMH suggests the following regarding evidence-based practices as part of a statewide System of Care:

- Future legislation/policy should be guided by the following:
  - Clarifying Definitions: In order to avoid confusion, it is first necessary to clearly define terms. For the purposes of this discussion, "Evidence Based Practices" (EBP) or "Evidence-Based" will be used as an inclusive term that encompasses programs, practices, and treatments that demonstrate a range of evidence regarding efficacy and effectiveness. The term "Empirically Supported Treatment" (EST) will be used to identify programs, practices, and treatments that meet the highest level of evidence for Evidence-Based Practices. Various sources use the terms "treatment," "therapy," "psychotherapy" and "counseling" to mean essentially the same thing. The term "treatment" will be used as a generic term that is understood to mean treatment, therapy, psychotherapies, and counseling. Although the term "treatment" is used throughout this document and the literature, it is understood that the scope of Evidence Based Practices is not limited to treatment or therapy but also includes such service practices as referral, assessment, and case management, as well as various levels of prevention (universal, selected, and indicated).
  - A Continuum of Evidence: Evidence that a given practice is a "treatment that works" exists on a continuum from treatments supported with the most rigorous high-quality experimental research to treatments supported by theoretical constructs that have general support in the professional community.
    - The highest level of evidence is <u>EMPIRICALLY SUPPORTED TREATMENT</u>. A program, practice, or treatment can be considered to be an Empirically Supported Treatment 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 treatment, or
b. an equivalent effect to an established treatment in experiments with adequate sample sizes.

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

- The medium level of evidence is RESEARCH-BASED TREATMENT. Research-Based Treatment 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 Treatment. For instance, a Research-Based Treatment may not reach the threshold of at least nine 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 Treatment would be manualized.
- The minimal level of evidence which qualifies as Evidence Based Practice is THEORY-BASED TREATMENT. Theory-Based Treatment is a program, practice, or treatment that has general support among treatment providers and experts, based on experience and the professional literature. Theory-Based Treatment 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 Treatment.

- 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 the child, including understanding of the diagnosis itself.

- The System should take a bi-directional approach to:
  - Identify existing EBPs: A resource for technical assistance around identification of existing and emerging EBPs should be developed. This resource should have had success

working with the state's child-serving agencies in support of efforts to improve access, services and outcomes for families of children with intensive needs. The Centers of Excellence (COEs) are a current entity that could perform this function:

- Promote and provide resources for state mental health providers on effective evidence based practices in children's mental health.
- Work with mental health providers and policy makers on the identification and/or development of tools needed to address the mental health needs of Tennessee's children.

- Establish evidence for services identified as essential parts of the service array: The system should implement a standardized assessment, service planning and outcomes management process. This approach will allow the state to manage service delivery based on the principle that system-level decisions should be informed by knowledge of the child and families' needs and strengths (Lyons 2003). The systematic collection and use of standard and reliable data will allow the system to develop an evidence base for existing services – an approach commonly known as "practice-based evidence."

- A formal process should be established to disseminate and support EBPs that includes:
  - Training existing providers; and
  - Pre-service strategies (i.e. partnering with our graduate schools).

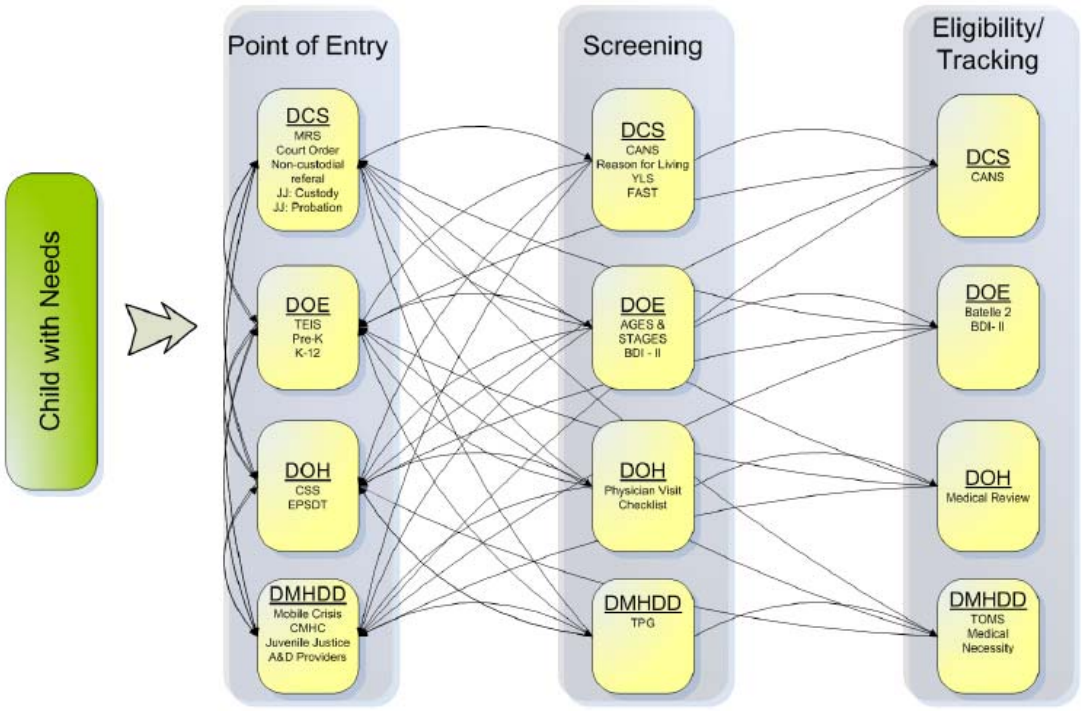
Administrative and Financing Unit

System Governance and Funding (Statewide and Local): CCMH is not currently prepared to endorse one particular model of statewide governance or funding structure as more research and study is needed in this area. The Council will use the three demonstration sites as an opportunity to learn about the necessary components required in state and local governance structures.

After technical assistance training provided by Shelia Pires - Partner, Human Service Collaborative - the Council reviewed structures of other statewide Systems of Care. Two draft prototype models, July 2010 Report Figure 4: Structure Example A and July 2010 Report Figure 5: Structure Example B, were presented to the Council for discussion and feedback. The major differences in these two models are the funding stream and how services are compensated. As the Council begins the process of reviewing statewide structures of a community-based program, other related or similar structures have and will be considered and reviewed, such as July 2010 Report Figure 6 and Figure 7.

CCMH members worked to provide a graphic overview of the current child serving system. July 2010 Report Figure 2: Referral Pathways Between Child Serving Systems depicts how a child might enter into one of many child-serving agencies and receive screening for eligibility, as well as tracking from numerous instruments and tools.

July 2010 Report Figure 2: Referral Pathways Between Child Serving Systems

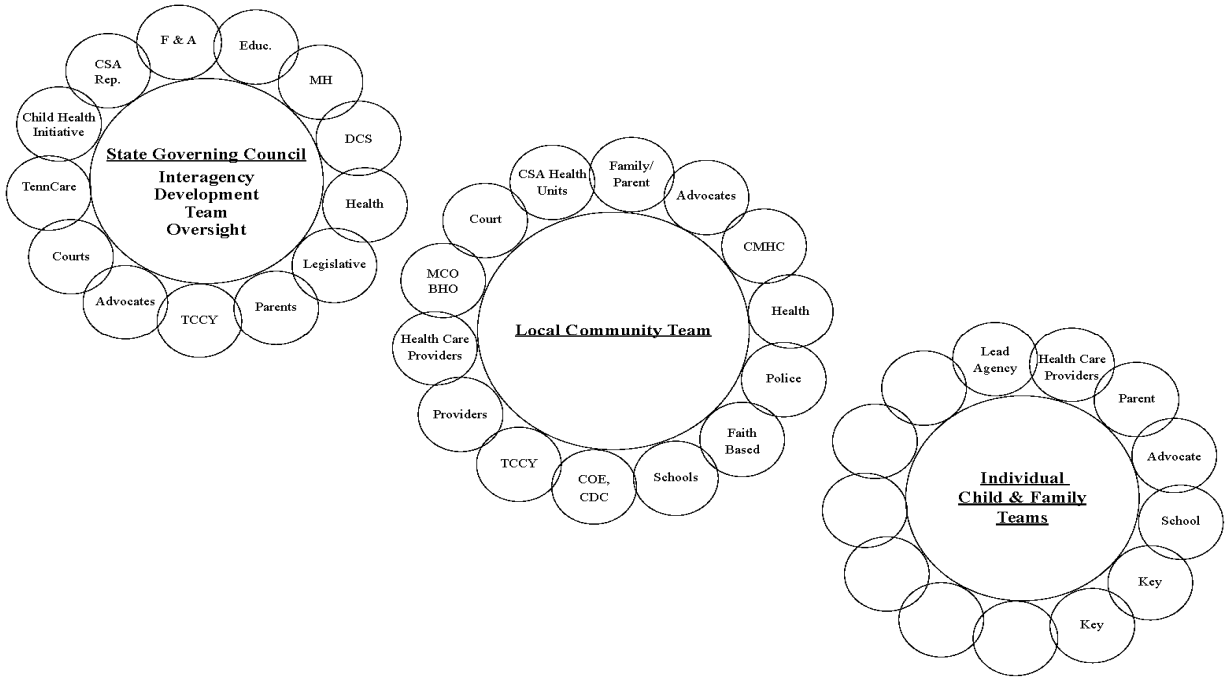


In contrast to July 2010 Report Figure 2, a System of Care would be able to benefit from interagency collaboration and services being wrapped around the child and family. Graphic representations

illustrated in July 2010 Report Figure 3: Levels of System of Care depict the System of Care infrastructure to include these elements:

- At the state level, 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 children 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.

July 2010 Report Figure 3: Levels of System of Care



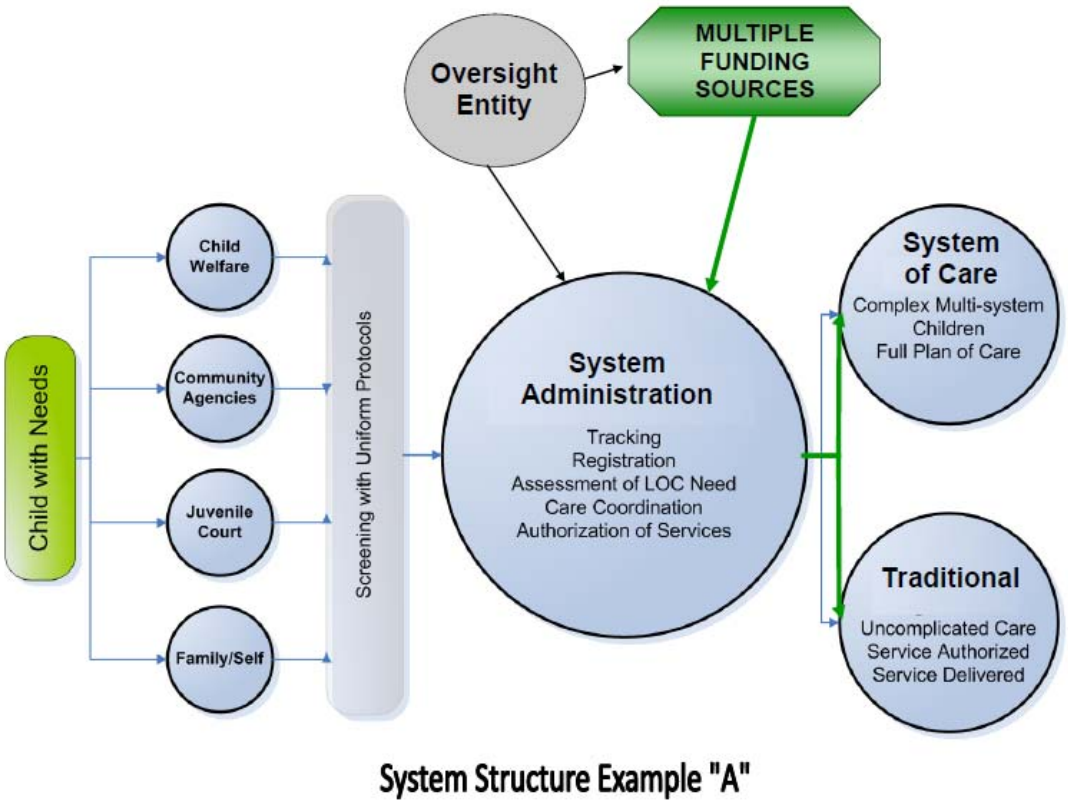
The system structure graphs on the following pages were created after a collaborative effort to review other state structures and follow the provided technical assistance. The samples were intended to provide a general overview to the council of how a statewide System of Care could address some of the issues created by the current system. This basic structure will create "No Wrong Door." Wherever a child may initially or subsequently have contact with the system, he/she will ultimately be connected to a system administration function that coordinates services, tracks level and quality of care, and provides for a service array striving to be culturally and linguistically competent.

How the system is funded has proved to be the most striking difference in System of Care statewide governance models nationwide. As would be expected in any broad-based collaborative effort, the administrative aspects and financing of the new system have precipitated much discussion. CCMH does not anticipate creating an additional layer of bureaucracy to complicate the system and drain limited

financial resources from existing services. System of Care Core Values and Guiding Principles would naturally support funding streams that are "pooled", "braided", "blended" or leveraged to provide a comprehensive service array for children and families. CCMH has begun initial discussions of the restrictions, guidelines, and regulations around current funding streams available in the state to inform our options of achieving adequate payment for services.

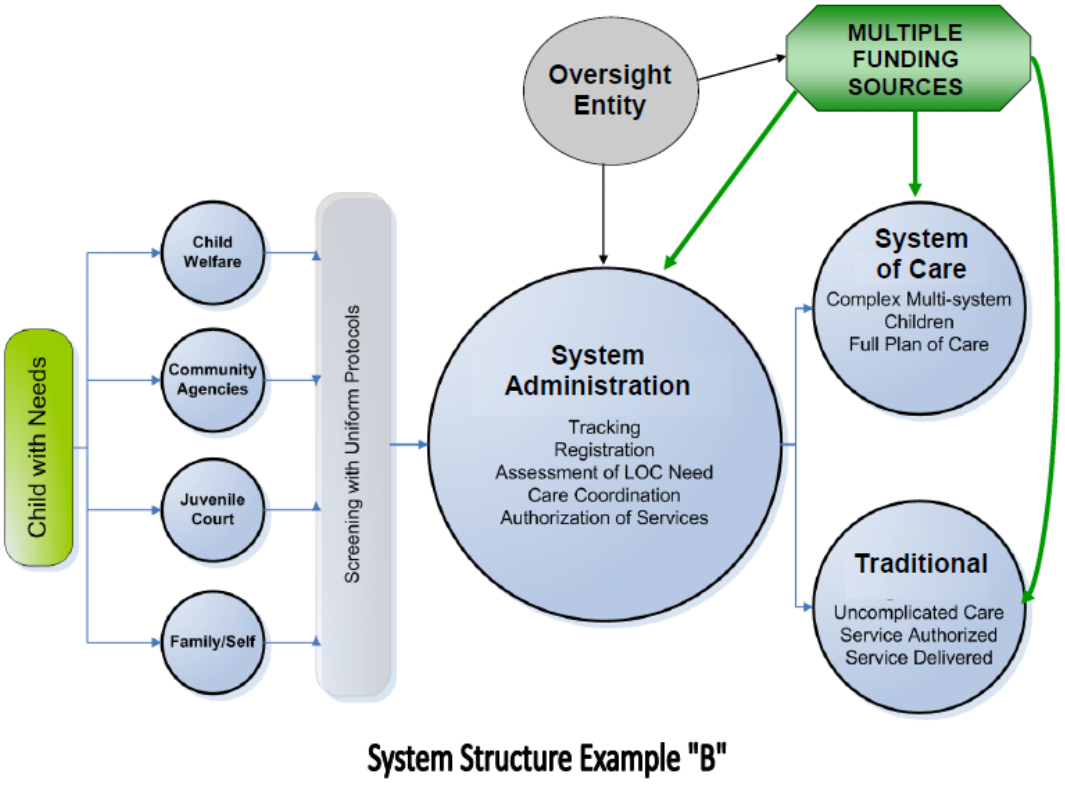
July 2010 Report Figure 3: System Example A illustrates a model where funding for children's mental health services are "pooled, braided or blended" and funneled through the system administration function that then contracts with providers for services.

July 2010 Report Figure 4: Structure Example A



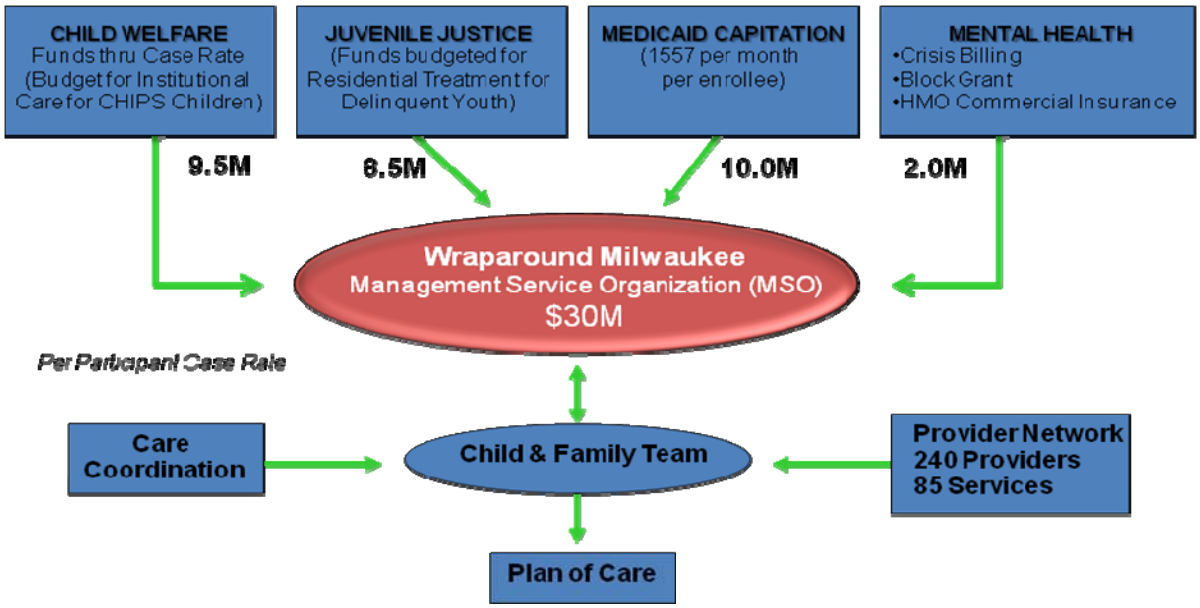
July 2010 Report Figure 4: System Example B somewhat follows current funding mechanisms already in place. The oversight entity would need to "pool, braid or blend" funding to support system administration in care coordination and additional activities not currently provided or funded while traditional funding mechanisms would continue to support services directly.

July 2010 Report Figure 5: Structure Example B



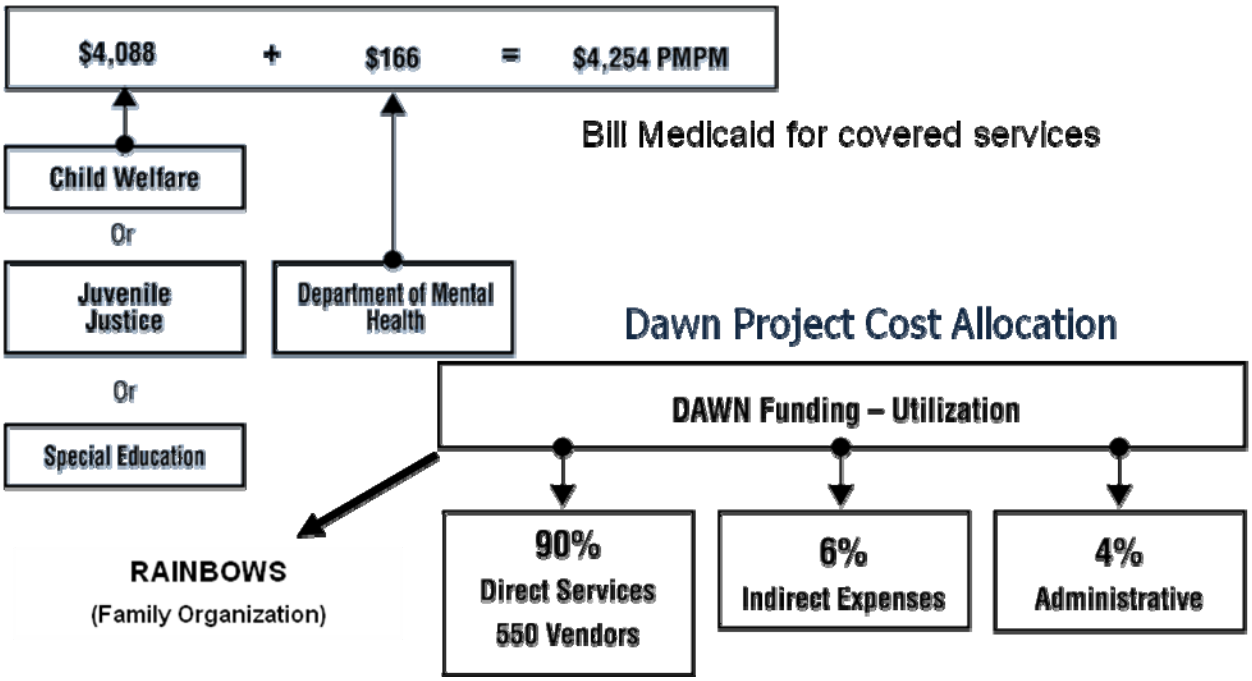
In addition to the structure examples above, the following figures give more detailed examples of two current projects outside Tennessee using blended and braided funding to create Systems of Care. July 2010 Report Figure 6 is of Wraparound Milwaukee. A local county initiative in Milwaukee, Wisconsin.

July 2010 Report Figure 6: Wraparound Milwaukee



July 2010 Report Figure 7 is of the Dawn Project's cost allocation. The Dawn Project is a local initiative in Indianapolis, Indiana.

July 2010 Report Figure 7: Dawn Project Cost Allocation



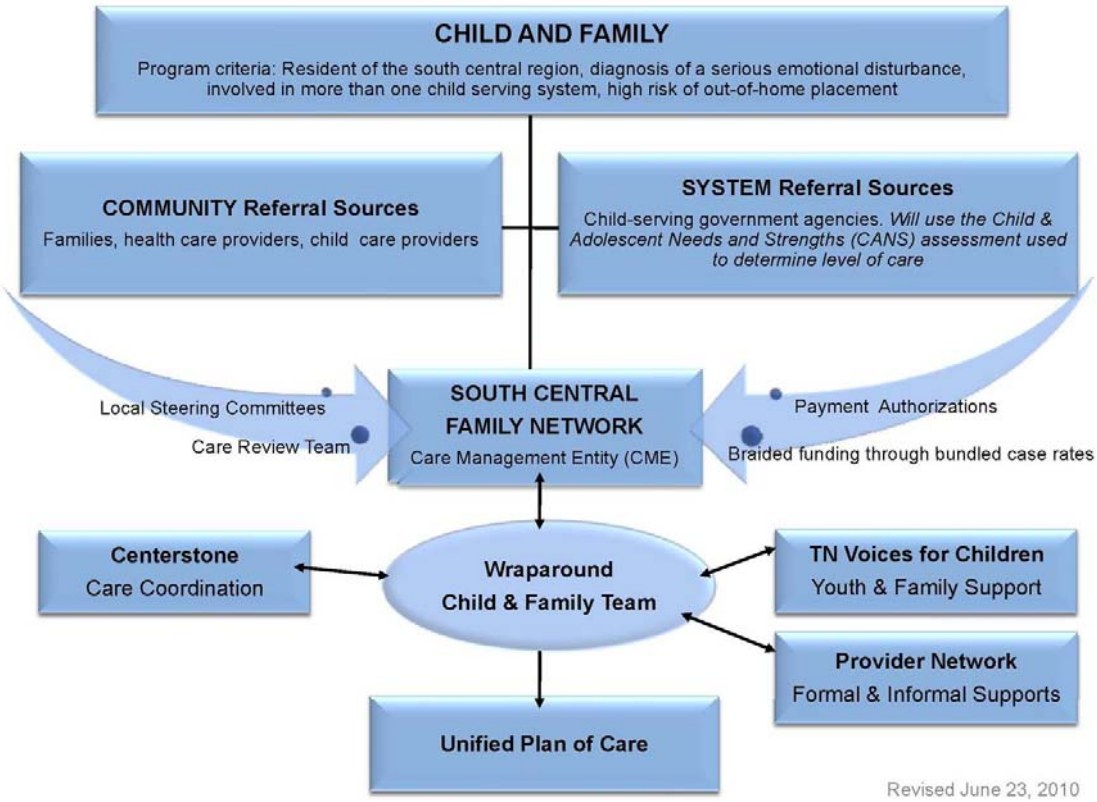
All three federally funded system of care initiatives: the Muletown Family Network in Maury County, the JustCare Family Network in Shelby County, and the K-Town Youth Empowerment Network in Knox County are at different stages of development and implementation, but each is working toward sustaining the work accomplished during the six year grant period. Of the three sites, the Muletown Family Network is closest to the end of their grant and therefore provides a more immediate opportunity to pilot a funding infrastructure. The Mule Town Family Network (MTFN) grant in Maury County is currently planning for sustainability of its infrastructure and services beyond the end of the six year federally funded period ending September 2011. This will provide CCMH with an opportunity to support and have input to local funding structure to assist in sustaining a current federally funded System of Care initiative. MTFN proposes working with the CCMH to secure memorandums of agreement with various child-serving state departments to increase the efficient use of funds. The funds ordinarily spent on the most intensive services for children and their families could be spent on providing the services of MTFN to keep the child in his/her least restrictive environment, thereby reducing costs.

Over the past year, the MTFN Sustainability Workgroup has collaborated with members of the local MTFN Sustainability Committee, the MTFN Grant Management Team and the CCMH Funding Workgroup to develop a model for a financial infrastructure to be implemented in Maury and surrounding counties as part of MTFN's overall plan for sustainability. Members of the MTFN Sustainability Workgroup, which is comprised of representatives from MTFN, TDMHDD, Tennessee Voices for Children (TVC), and managed care organizations, received technical assistance from national experts on financial infrastructure models (including Shelia Pires), researched various models being implemented nationwide and completed a local children's mental health needs assessment. The

workgroup integrated information from these resources with input from the CCMH Funding Workgroup and local community stakeholders.

The coordinated efforts of the MTFN Sustainability Workgroup resulted in the financial infrastructure model presented below:

July 2010 Report Figure 8: MTFN Local Financial Infrastructure.



Standardized Forms/Formats: A standard tenet of System of Care philosophy is the coordination of care among various providers and entities. Traditionally, this effort has been hindered by the multitude of assessments and forms used to discern and plan a child's treatment needs. By utilizing common tools across agencies and departments, service providers will be able to speak a universal language and understand the child's treatment needs, goals, and plan of care based from one set of common forms and instruments. The following are several areas of consideration for commonality in service delivery.

Universal Service Planning and Data Collection Tool: The Council has reviewed assessment and service planning tools currently in use in the state as well as those used in other states. The Council was fortunate in June 2009 to receive technical assistance from John Lyons, who developed the Child and Adolescent Needs and Strengths (CANS) instrument. Department of Children's Services (DCS) currently uses the CANS to determine the service needs of each child within their care. The adaptability and affordability of the CANS instrument has encouraged several other departments as well as grant funded projects to use the CANS as an assessment tool. The State Board of Education recently adopted recommendations urging local school systems to use an adapted version of the CANS. The Tennessee

Integrated Court Screening and Referral Project is implementing a CANS version in 11 juvenile courts across the state with the potential to expand its use to additional courts over the course of the project. Council members are currently in discussions with representatives of the Managed Care Companies (MCCs) on possible implementation of the CANS for certain levels of service. The Council will continue to explore ways to integrate and expand the use of the CANS and monitor its adaptability and usefulness to ensure the instrument will address the outcome indicators set forth by the Accountability and Management Information Systems Workgroup.

Outcome Indicators and Management Information Systems (MIS): CCMH has focused on charting a course for development of an MIS system and related policies to monitor, report and use outcomes for accountability and continuous quality improvement. Council members reviewed and discussed a variety of systems used by different departments and stakeholders for data tracking of children's services. Council work on accountability and MIS moving forward will be guided by these understandings:

- "Handshakes" between systems is critical because large systems are not likely to change their current data structures. A "data repository" may be useful to store information while allowing access by other agencies.
    - Need to focus on business agreements.
    - Multiple layers of access/sharing could be used:
        - State-funded agencies – Departments of Health, Mental Health, Children's Services, Education and Local Education Authorities all have their own systems.
        - Community agencies without state funding are included, such as social service agencies, mentoring and home visiting, among others.
        - Ensure Family preferences for privacy in data sharing.
    - Families must be apart of system design as they may have concerns about data sharing as well as have suggestions for privacy concern solutions.
- System should target the highest priority data for sharing. Data collection and sharing is difficult, so focusing on a small data set will eliminate the collection of unneeded or potentially unusable data.
- Additional data collection should be imbedded within the service delivery system at the service delivery level rather than establishing an outside infrastructure to collect data. System must ensure the availability of resources for data collection at this level to ensure new funding is not necessary.
- In addition to "real time" shared data, access to historical elements of other systems' data can provide important information to be used during the assessment phase (i.e. immunization history, previous involvement with DCS, TennCare claims data, etc.).
- The approach to the design of a shared data system should be accomplished in a cost-neutral fashion by asking the following of all systems measuring outcomes currently:
    - What would it take for these systems to measure the same set of outcome indicators?
    - What would it take to re-align the measurement systems to report shared outcomes?

The Council has also begun to review and research the following state initiatives related to infrastructure and data sharing:

- State child-serving agencies have begun working with the Tennessee Longitudinal Data System (TNLDS), developed by DOE and now accelerated with "Race to the Top" Funds.
    - This system will link into a broader set of indicators while using the DOE system as a foundation.
    - Every child has a unique identifier in TNLDS.
    - Historical data from other systems can be associated with the unique identifier.
- The newly implemented data system used by DCS has the capability to interface with other systems, but requires substantial negotiation between systems.
    - This system can share partial information with external stakeholders.
    - System was constructed to identify contract providers needs and concerns given their individual data systems.
    - Selected external partners have the ability to access various information:
        - Certain reports provided to them;
        - Careful negotiation must occur between multiple agencies.
- Mule Town Family Network has recent experience in using multiple systems to track client data:
    - Qualifacts for System of Care Data Collection;
    - Centerstone Data System for payment and provider record keeping.
- The Tennessee Early Intervention System (TEIS) data system was reviewed by the Council. TEIS is able to combine service provision, activity across clients and a shared payment system on one platform.
- Many states, including TDMHDD's Division of Alcohol and Drug Abuse Services, use the TN-WITS system. TN-WITS collects data on all admission episodes of care and discharging plans of care in the public alcohol and drug substance abuse system; collects services outcome and impact data; and serves as the billing solution for all alcohol and drug abuse services. In the future, this system will be reviewed by the Council.
- Just Care Family Network (JCFN) is currently exploring various data systems. As a proposed demonstration site, JCFN's work in this regard will also inform the Council's work.

The following grid displayed in July 2010 Report Table 2: Criteria Grid for Assessing Potential Shared Data Platforms was developed by the Council as a way to evaluate potential data system platforms.

July 2010 Report Table 2: Criteria Grid for Assessing Potential Shared Data Platforms

Function/Attribute	Issues/Requirements
Maintenance of HIPPA/FERPA confidentiality	• Absolute requirement.
Simplicity of user interface for data collection	• How easy it the system to use? • What user training is required?
Data analysis capability	• What data would be analyzed? For what purposes?
Availability of reporting	• Who would need reports? • What views are needed?
Billing system capacity	• Who would be billed? • Who would do the billing?
Data sharing capabilities	• What data would be shared? • Who would share the data?
System administration	• How is the system administration handled (e.g. adding/subtracting users)?
Costs and affordability	• What are the start-up costs? • What are the maintenance costs? • What is the cost structure (one time vs. on-going user licenses)? • Who pays for what?
"Handshake" capability	• What are the opportunities to "handshake" to data from other systems? • How can we ensure that family wishes and agency confidentiality are respected in terms of limiting data sharing for certain data elements (can't be "all or nothing" sharing)? • What handshakes would have to occur and for what purpose? In other words, what data needs to be accessed and shared?
Client/case management capacity	• What are the options for client management in addition to data sharing across agencies?

Summary of Recommendations: The following is a summary of the current CCMH plan to move forward a statewide System of Care for children and families:

1. Study the three existing demonstration sites in their efforts to develop and sustain Systems of Care in local communities and how these initiatives can inform the development of a statewide System of Care.
2. Examine the resource mapping data in order to identify both gaps and adequacies of current mental health services for children and youth across the state.
3. Study the implementation of the Mule Town Family Network financial infrastructure as a model for sustainability of a System of Care.
4. Continue to develop and pilot opportunities for blended and braided funding across state departments and agencies.
5. Continue to leverage federal dollars available for statewide children's mental health services.
6. Coordinate a discussion with gubernatorial candidates between the primary and general elections about the research, support and need for a statewide System of Care.
7. In winter 2011, discuss with newly appointed Commissioners of child-serving state departments the research, support and need for a statewide System of Care and secure their on-going support for CCMH.

III. BARRIERS TO IMPLEMENTATION

Potential barriers to implementation of Systems of Care in Tennessee were identified in 2007 in SJR 799 Town Hall meetings, through TDMHDD's Title 33 Planning and Policy Council rankings, captured in discussion in CCMH meetings, as well as surveys conducted in early January 2009. During June 2010, Council members were once again surveyed individually and anonymously about perceived barriers to successful implementation of Systems of Care and the structures that might overcome the barriers. The results of the most recent survey were then compared with the earlier results to see what, if any, progress the Council made in addressing identified barriers or reducing the perception of the barrier.

Members were surveyed about barriers in four areas:

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

Key Findings of the June 2010 CCMH Survey: Participation doubled from 20 in January 2009 with 40 participants completing the survey. For the identified administrative barriers/challenges, overcoming administrative and provider territoriality was the greatest perceived barrier with an average rating of 3.58 on a scale of 1-5 with 5 being the greatest. This compares with an average rating of 4.20 on the January 2009 survey when this barrier was also rated the greatest administrative barrier.

Lack of integrated information systems also ranked closely on the current survey with an average rating of 3.56. From a services perspective, a limited number and array of services again was considered the greatest barrier at an average rating of 4.13, slightly less than the January 2009 rating of 4.61. Inability to track outcomes was the second rated services barrier, a requirement of many state and federal funding sources.

Inadequate cross-agency coordination about children's mental health was again rated as the greatest policy barrier in Tennessee with an average rating of 3.79 compared with 4.10 in January 2009. This slight decline could be attributed to the growing number of interagency coordinated projects related to children's mental health, including but not limited to, school based mental health liaisons, the Tennessee Integrated Court Screening and Referral Project, Coordinated School Health and the Schools and Mental Health Systems Integration Grant.

As in January 2009, the current results are relatively consistent across the four areas with slight improvement in some areas. However, as noted on the interagency collaboration survey results, the task of implementing a statewide System of Care is a collaborative process requiring cross-agency consensus and buy-in. Additional education, research, collaborative decision-making are required to move the plan forward.

The entire results of the survey of the CCMH about Barriers are appended in July 2010 Report Document Group 2, Survey Results, page 61.

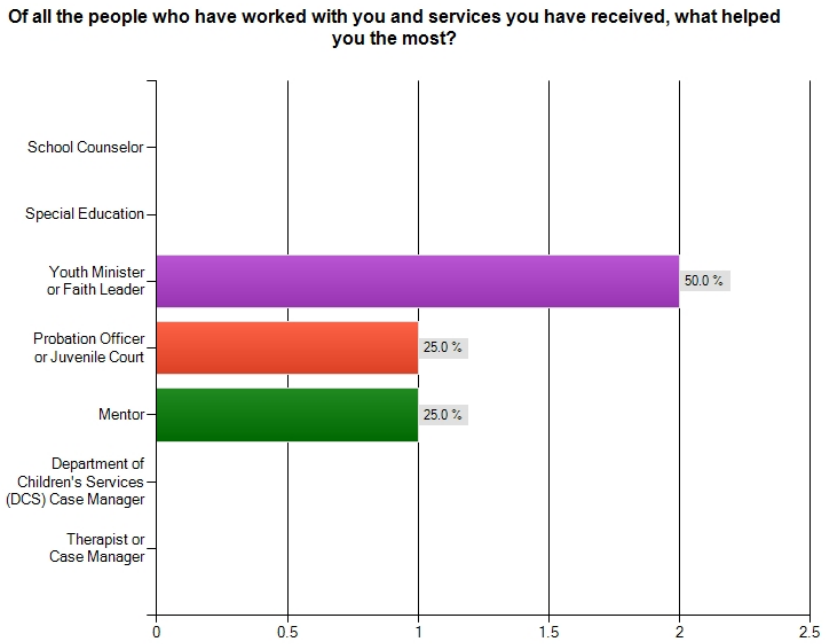
Key Findings from the Youth Survey: Since the preliminary report in February 2009, CCMH has been very successful in having a vocal youth presence at Council meetings as well as sustaining youth membership as required. The Council has relied on the Youth In Action Councils from the System of Care initiatives in the state to provide youth members. Additionally one of the youth members was recently presented Tennessee Commission on Children and Youth's Youth Excellence Award.

In January 2009, youth from various youth groups and venues were surveyed about their involvement and perception of mental health and substance abuse services. The following survey results are from the Council's current youth participants with five youth completing the survey. July 2010 Report Figure 9: Helpful Services and July 2010 Report Figure 10: Service Involvement on the next page describe from whom youth had received services and who had been most helpful to them. The median age of the participants was 18 with the median age of receiving treatment at 11. The findings illustrate the growing need for mental health services to be a culturally competent blend of traditional and non-traditional services because mentors and youth pastors were overwhelmingly most identified as the helpful service providers.

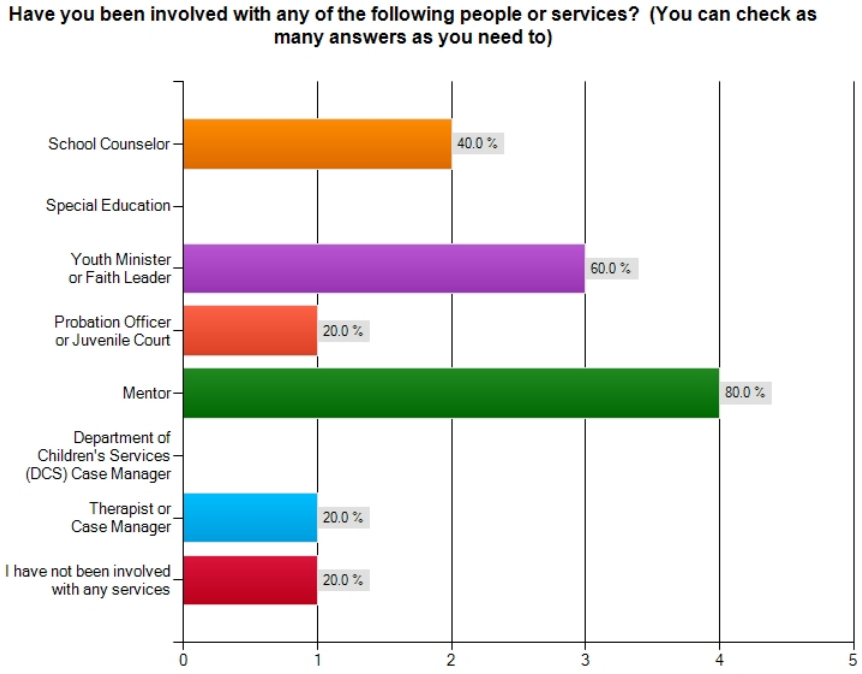
Youth comments were also very informative, especially when asked what they would change or initiate to help other youth in their situation. They said:

- Offer mentors who have been in our situation and have experienced our issues.
- Ask youth about their goals and plans and listen to their answers.
- Let youth have a voice in system change.

July 2010 Report Figure 9: Helpful Services



July 2010 Report Figure 10: Service Involvement



IV. LIST OF ALL PROGRAMS

CCMH has worked in concert with TCCY's Resource Mapping project to provide a "snap-shot in time" of the program and service types funded by various departments and agencies in the state. This service listing was developed using data from the resource mapping process for fiscal years 2006-2007 and 2007-2008. July 2010 Report Table 3: Departmental Service List provides a service listing by department. The CCMH recognizes the value of the Resource Mapping data for fiscal years 2006-2008 but notes its is limited because of recent cuts to children's services for fiscal years 2008-2010, changing the landscape of services and programs available across the state. Information about changes will be provided through subsequent resource mapping data collection.

A complete detailed listing of the current providers and services offered across the state is virtually impossible, as this list is ever evolving and changing. Agencies in the state have dedicated staff continuously updating their resource and service lists. Several listings are available on-line. Tennessee Department of Mental Health and Developmental Disabilities has a service provider listing at http://state.tn.us/mental/MentHealtSerProviders.html. The Tennessee Alliance for Legal Services, National Association of Social Workers – Tennessee and Department of Children's Services have a joint program listing a variety of services and providers at www.tennhelp.com. Additionally, individuals can call 2-1-1 in most parts of the state to receive assistance locating mental health resources. This information is provided through United Way agencies across Tennessee.

July 2010 Report Table 3: Departmental Service List

	Agency	Service As Submitted (For Reference)	Primary Service Descriptor To Use For Reporting
1	Department of Children's Services	Assessment/Evaluation	Assessment/Evaluation
2	Department of Children's Services	Child Advocacy Center	Child Advocacy Center
3	Department of Children's Services	Full Clinical Treatment Options	Full Clinical Treatment
4	Department of Children's Services	Intervention-Abuse/Neglect	Intervention-Abuse/Neglect
5	Department of Children's Services	Behavioral Intervention	Intervention-Behavioral
6	Department of Children's Services	Intervention-Provider Service Continuum Array	Intervention-Provider Service Continuum Array
7	Department of Children's Services	Intervention-Residential Treatment	Intervention-Residential Treatment
8	Department of Children's Services	Intervention-Sexual Abuse	Intervention-Sexual Abuse
9	Department of Children's Services	Parent Support/Education	Support-Family
10	Department of Education		Prevention - Drug and Violence
11	Department of Education		Prevention - Professional Development - Bullying
12	Department of Education		Prevention - Professional Development - Emergency Preparedness
13	Department of Education		Prevention - Professional Development - Social / Emotional
14	Department of Health	ECCS (Early Childhood Comprehensive Systems)	Prevention-Physical Health
15	Department of Health	Suicide Prevention (2007-08)	Prevention-Suicide
16	Dept of Mental Health and Developmental Disabilities	Administrative-Community Mental Health Services	Administration-Community-Mental Health Services
17	Dept of Mental Health and Developmental Disabilities	Administrative-Crisis Services-Adult	Administration-Crisis Services-Adult
18	Dept of Mental Health and Developmental Disabilities	Administrative-Crisis Services-Child	Administration-Crisis Services-Child
19	Dept of Mental Health and Developmental Disabilities	Administrative-Education	Administration-Education
20	Dept of Mental Health and Developmental Disabilities	Administrative-Forensic Services	Administration-Forensic Services
21	Dept of Mental Health and Developmental Disabilities	Administrative-Hospitalization Services	Administration-Hospitalization
22	Dept of Mental Health and Developmental Disabilities	Administrative-Early Childhood Intervention	Administration-Intervention-Early Childhood
23	Dept of Mental Health and Developmental Disabilities	Administrative-Outreach Services	Administration-Outreach
24	Dept of Mental Health and Developmental Disabilities	Administrative-Alcohol and Drug Abuse Prevention Services	Administration-Prevention-Alcohol and Drug Abuse
25	Dept of Mental Health and Developmental Disabilities	Administrative-Suicide Prevention	Administration-Prevention-Suicide
26	Dept of Mental Health and Developmental Disabilities	Administrative-System of Care Project	Administration-Project-System of Care
27	Dept of Mental Health and Developmental Disabilities	Administrative-Psychiatric Rehabilitation Services	Administration-Psychiatric-Rehabilitation
28	Dept of Mental Health and Developmental Disabilities	Administrative-Respite Services	Administration-Respite
29	Dept of Mental Health and Developmental Disabilities	Administrative-School Based Services	Administration-School Based Services
30	Dept of Mental Health and Developmental Disabilities	Administrative-Support Services	Administration-Support
31	Dept of Mental Health and Developmental Disabilities	Administrative-Child and Family Support Services	Administration-Support-Child and Family
32	Dept of Mental Health and Developmental Disabilities	Administrative-Housing Support Services	Administration-Support-Housing
33	Dept of Mental Health and Developmental Disabilities	Administrative-Peer Support	Administration-Support-Peer
34	Dept of Mental Health and Developmental Disabilities	Administrative-Training	Administration-Training
35	Dept of Mental Health and Developmental Disabilities	Administrative-Alcohol and Drug Abuse Treatment Services	Administration-Treatment-Alcohol and Drug Abuse

	Agency	Service As Submitted (For Reference)	Primary Service Descriptor To Use For Reporting
36	Dept of Mental Health and Developmental Disabilities	Community Mental Health Services	Community-Mental Health Services
37	Dept of Mental Health and Developmental Disabilities	Crisis Services-Adult	Crisis Services-Adult
38	Dept of Mental Health and Developmental Disabilities	Crisis Services-Child	Crisis Services-Child
39	Dept of Mental Health and Developmental Disabilities	Education	Education
40	Dept of Mental Health and Developmental Disabilities	Forensic Services	Forensic Services
41	Dept of Mental Health and Developmental Disabilities	Hospitalization Services	Hospitalization
42	Dept of Mental Health and Developmental Disabilities	Early Childhood Intervention	Intervention-Early Childhood
43	Dept of Mental Health and Developmental Disabilities	Outreach Services	Outreach
44	Dept of Mental Health and Developmental Disabilities	Alcohol and Drug Abuse Prevention Services	Prevention-Alcohol and Drug Abuse
45	Dept of Mental Health and Developmental Disabilities	Suicide Prevention	Prevention-Suicide
46	Dept of Mental Health and Developmental Disabilities	System of Care Project	Project-System of Care
47	Dept of Mental Health and Developmental Disabilities	Psychiatric Rehabilitation Services	Psychiatric-Rehabilitation
48	Dept of Mental Health and Developmental Disabilities	Respite Services	Respite
49	Dept of Mental Health and Developmental Disabilities	School Based Services	School Based Services
50	Dept of Mental Health and Developmental Disabilities	Support Services	Support
51	Dept of Mental Health and Developmental Disabilities	Child and Family Support Services	Support-Child and Family
52	Dept of Mental Health and Developmental Disabilities	Housing Support Services	Support-Housing
53	Dept of Mental Health and Developmental Disabilities	Peer Support	Support-Peer
54	Dept of Mental Health and Developmental Disabilities	Training	Training
55	Dept of Mental Health and Developmental Disabilities	Alcohol and Drug Abuse Treatment Services	Treatment-Alcohol and Drug Abuse
56	Governor's Office of Children's Care Coordination	Children's Mental Health	Mental Health
57	TennCare_F&A	Mental and Behavioral Health-Case Rates	Mental and Behavioral Health-Case Rates
58	TennCare_F&A	Mental and Behavioral Health-23 Hour	Mental and Behavioral Health-23 Hour
59	TennCare_F&A	Mental and Behavioral Health-In Home Services	Mental and Behavioral Health-In Home Services
60	TennCare_F&A	Mental and Behavioral Health-Inpatient	Mental and Behavioral Health-Inpatient
61	TennCare_F&A	Mental and Behavioral Health-Intensive Outpatient	Mental and Behavioral Health-Intensive Outpatient
62	TennCare_F&A	Mental and Behavioral Health-Outpatient	Mental and Behavioral Health-Outpatient
63	TennCare_F&A	Mental and Behavioral Health-Partial Hospitalization	Mental and Behavioral Health-Partial Hospitalization
64	TennCare_F&A	Mental and Behavioral Health-Supported Housing	Mental and Behavioral Health-Supported Housing
65	TennCare_F&A	Mental and Behavioral Health-Transportation	Mental and Behavioral Health-Transportation
66	TennCare_F&A	Pharmacy-Mental and Behavioral Health	Pharmacy-Mental and Behavioral Health

V. STATUS OF INTERAGENCY COOPERATION

T.C.A. 37-3-110-115 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 the CCMH and Workgroups. As previously noted, participation in CCMH has far exceed these requirements. CCMH has held fourteen meetings since its inception in 2008. Eleven agencies and departments are listed in the code requiring CCMH participation. CCMH has an average of 88 percent participation from all eleven agencies and departments. Eight of these departments have 100 percent participation. This sustained and frequent attendance demonstrates the commitment and willingness of participants to change the mental health system serving children and families.

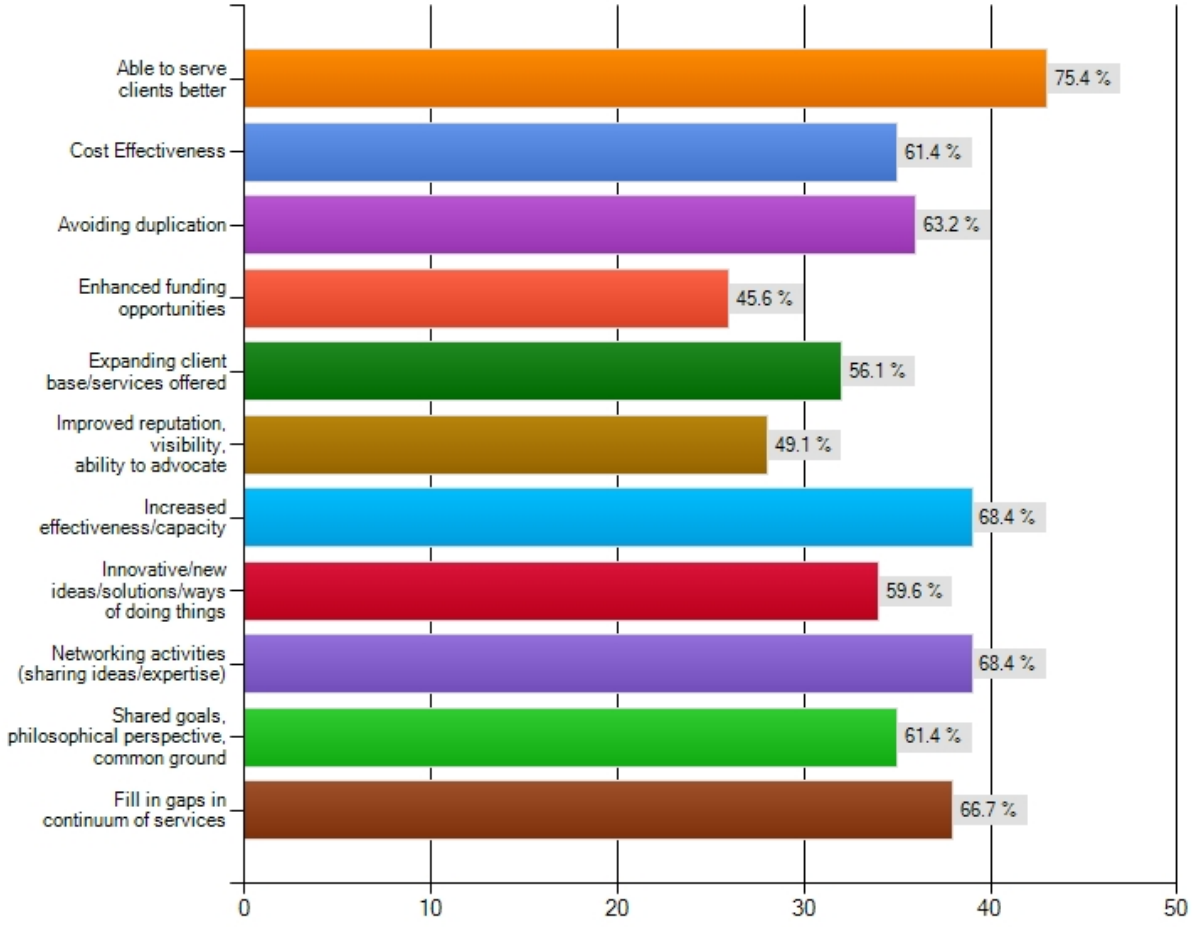
A survey of the CCMH membership was conducted in January 2009 to assess their perceptions of interagency collaboration and the ongoing challenges of collaboration. This survey was repeated in June 2010 to assess the membership's current perceptions and to ascertain if any shift in perception or challenges had occurred. Because of the substantial increase in survey participation and the survey's anonymity, direct comparisons to the 2009 data are not feasible. However, it is worth noting survey participation increased by two-fold. Additionally, survey results illustrate the on-going difficulty in implementing such broad system change. The current survey results revealed favorable perceptions of interagency collaboration currently, and the challenges going forward are not as substantial as were indicated in the prior survey. Responses related to "departments" or "agencies" include not only state departments and agencies; they also include private providers, families and others.

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

- 86 percent of respondents are participating in at least one Council Workgroup and regularly get information about the progress of the council;
- 83 percent of agencies indicated some commitment to the development of Systems of Care; and
- 78 percent of agencies have consistent, high-level of participation in the CCMH and respondents believe their agency's "voice" is heard as a part of the CCMH.

The CCMH and Workgroups also see some challenges ahead: only 42 percent perceived their agency is easily able to share data and information across systems on a routine basis. Respondents were asked to rate the perceived benefits of interagency collaboration with the results depicted below in July 2010 Report Figure 11: Perceived Benefits of Interagency Collaboration. Additional results of the Status of Interagency Collaboration survey are in July 2010 Report Document Group 2, Survey Results, p. 64.

July 2010 Report Figure 11: Perceived Benefits of Interagency Collaboration



VI. FINANCIAL RESOURCE MAP

T.C.A. 37-3-110-115 requires financial resource mapping for SOC planning. P.C. 1197, also passed in 2008 and codified at 37-3-116, 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 eligibility for services for children in state custody. CCMH has worked 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. Below are several tables and graphs detailing funding for mental health and related services in the state.

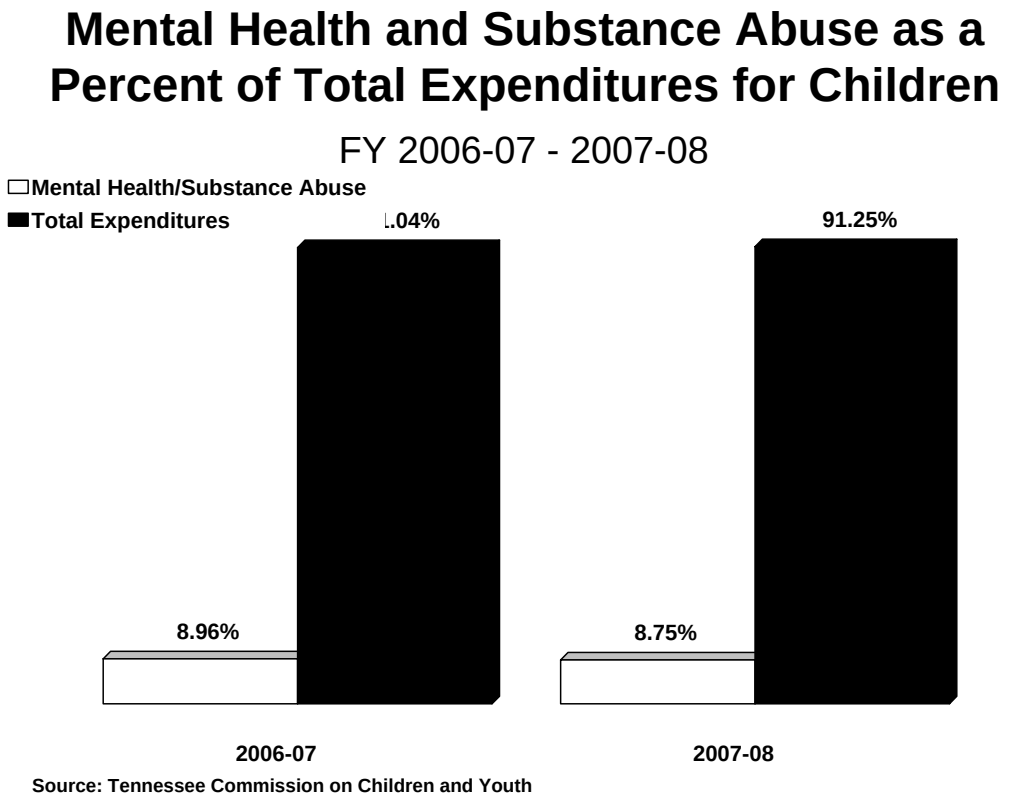
Mental Health and Substance Abuse Resource Mapping Statewide Overview

Number of Agencies	**6**
Number of Data Records	**245**

Total Expenditures

FY 2006-07	**$**	**371,209,378**
FY 2007-08	**$**	**391,840,851**

Total Expenditures and Funding Source: Mental health and substance abuse services account for less than 10 percent of the total funding allocated to children in Tennessee in both fiscal years 2006-2007 and 2007-2008. Additionally TennCare is the largest source of mental health and substance abuse expenditures for children followed closely by the Department of Children's Services. Roughly, 60 percent of all expenditures spent on services for children and their families are federal. State funding accounted for 39 percent of funding.



Mental Health and Substance Abuse Expenditures By State Agency By Funding Source
FY 2006-07

State Agency	Federal Expenditures	State Expenditures	Other Expenditures	Total
Department of Children's Services	$86,763,800	$55,765,600	$79,400	$142,608,800
Department of Education	$5,344,604	$0	$100,000	$5,444,604
Department of Health	$24,096	$2,897	$0	$26,993
Dept. of Mental Health and Developmental Disabilities	$4,112,370	$20,475,707	$4,885,860	$29,473,937
Governor's Office of Children's Care Coordination	$1,484,625	$1,484,625	$0	$2,969,250
TennCare, Finance and Administration	$121,725,080	$68,960,714	$0	$190,685,794
Grand Total	$219,454,575	$146,689,543	$366,144,118	$371,209,378

Source: Tennessee Commission on Children and Youth

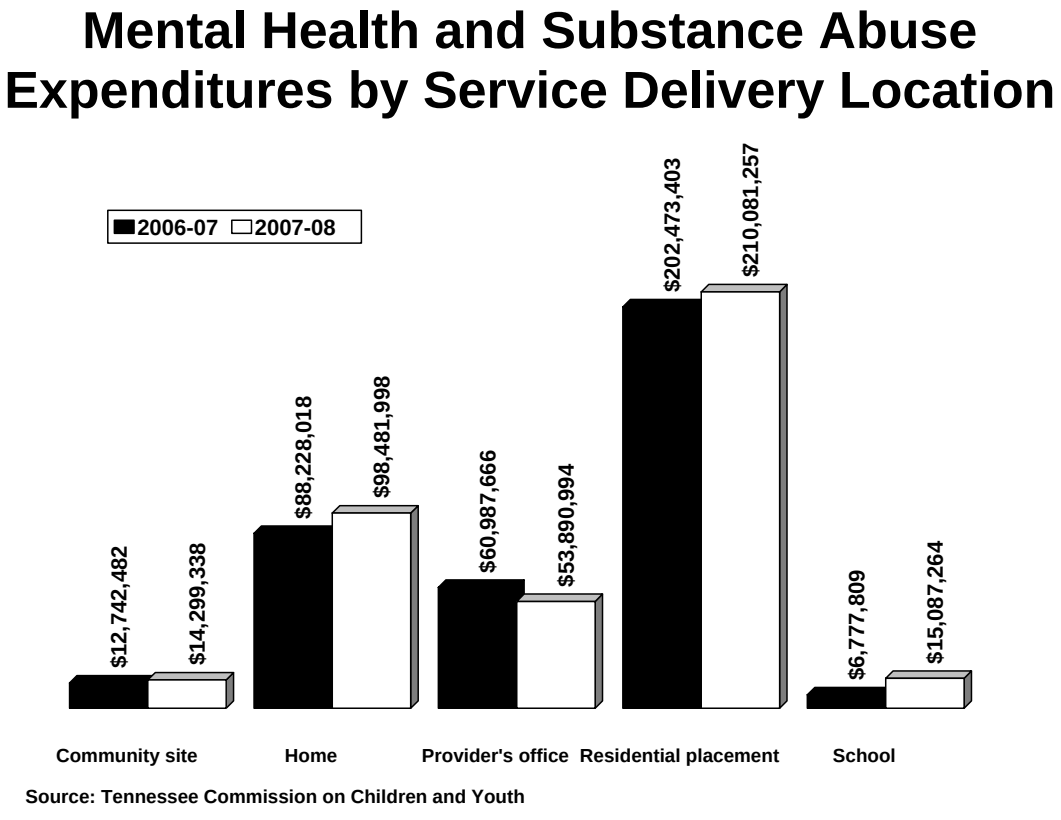
Mental Health and Substance Abuse Expenditures By State Agency By Funding Source
FY 2007-08

State Agency	Federal Expenditures	State Expenditures	Other Expenditures	Total
Department of Children's Services	$92,015,200	$61,412,900	$67,700	$153,495,800
Department of Education	$5,248,917	$0	$100,000	$5,348,917
Department of Health	$127,192	$147,500	$0	$274,692
Dept. of Mental Health and Developmental Disabilities	$14,213,367	$21,130,834	$2,817,879	$38,162,080
Governor's Office of Children's Care Coordination	$1,818,313	$1,818,313	$0	$3,636,626
TennCare, Finance and Administration	$121,848,330	$69,074,406	$0	$190,922,736
Grand Total	$235,271,319	$153,583,953	$2,985,579	$391,840,851

Source: Tennessee Commission on Children and Youth

Service Delivery Location: As expected, residential placement accounts for almost two-thirds of expenditures for mental health and substance abuse services. All locations increased in funding from FY 06-07 to FY 07-08 except provider's office. Location options included:

- Home;
- Community site;
- School;
- Provider's office; and
- Residential Placement

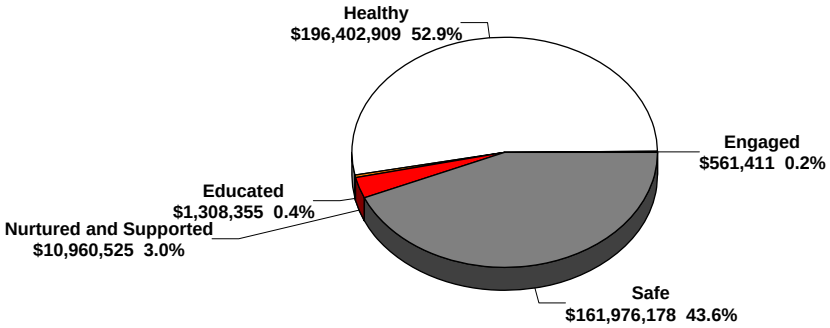


Primary Outcomes: Departments were also asked to select one primary outcome area best capturing the intended outcome of the program. The five outcome area options included:

- Safe (Example: suicide prevention)
- Healthy (Examples: crisis response, mental health case management, substance abuse prevention, substance abuse intervention)
- Educated (Examples: regular education, special education)
- Supported and Nurtured (Examples: foster care, youth development centers)
- Engaged (Examples: mentoring, after-school programs)

Mental Health and Substance Abuse Expenditures by Primary Outcome

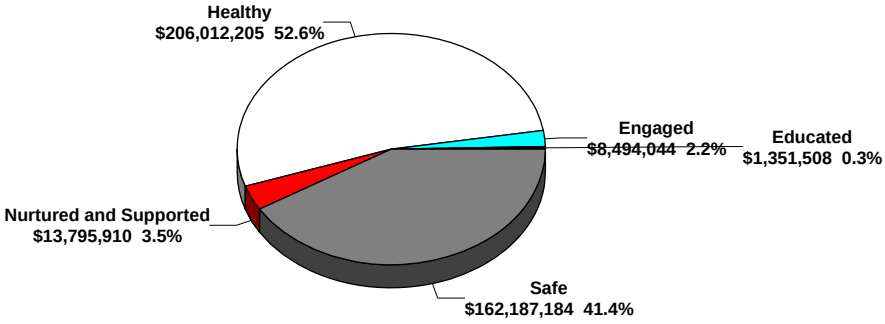
Total Expenditures $371,209,378 FY 2006-07



Source: Tennessee Commission on Children and Youth

Mental Health and Substance Abuse Expenditures by Primary Outcome

Total Expenditures $391,840,851 FY 2007-08



Inventory of Funds: Tennessee relies heavily on federal funding for the provision of essential services and supports for Tennessee children and families. Of the total mental health and substance abuse expenditures for FY 2006-07 and FY 2007-08, 60 percent were federal dollars. Many of the federal funding streams are reliant on matching funds. If substantial reductions are made in state dollars, this will curtail the state's ability to continue to apply and seek certain federal grants including System of Care Grants.

TDMHDD has consistently submitted proposals for multi-year funding to implement System of Care initiatives across the state as well as youth suicide prevention projects. TDMHDD has been extremely successful. As a recent example, TMDH partnering with the Administrative Office of the Courts and the GOCCC received a Tennessee Integrated Court Screening and Mental Health Referral Project grant from the federal Department of Justice.

VII. CURRENT ECONOMIC CLIMATE AND BUDGET SITUATION

CCMH's greatest concern in this regard is ensuring essential services and supports are maintained. Over the past twenty-five years, Tennessee has built a foundation for the very basic infrastructure for mental health services for children and their families. The current funding realities for the state place this foundation in jeopardy. The loss of essential services and supports would erode the foundation of public-private and state-local partnerships and reduce the opportunity for children and families to receive the services and supports necessary for success in school and in life. Services and supports most threatened are prevention and early intervention strategies. Without these resources, more children will fail in school, have mental health and substance abuse problems, and come into the child welfare and juvenile justice state custody systems; fewer children would be prepared to be active citizens and productive adults. The state's legacy cannot be one of dismantling these partnerships. The state must ensure these essential services and supports survive to provide and maintain a foundation for a brighter, more prosperous future for Tennessee as the economy recovers.

VIII. RELATED CONSIDERATIONS

In addition to the specific activities and work products of CCMH, 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. The Council is fortunate to have members and participants currently serving on these related initiatives taking part in the CCMH meetings and workgroups. The Council also has an official presence on several of these projects. Building a statewide System of Care begins with open collaboration cross-cutting departments, agencies, projects and initiatives.

In brief, some of the related considerations are noted here.

Statutorily-related Considerations

P.C. 487 (2009)—Study of Child Protective Services System: This law states the Select Committee on Children and Youth (SCCY) shall study the effectiveness of the child protective services system in Tennessee and develop recommendations for its improvement. SCCY is also authorized to establish a study committee of appropriate persons from whom it may obtain consultation and receive advisement. The state currently uses a multiple response system (MRS) approach to child protective services detailed later in this section. The Executive Director of SCCY has completed research into effective models for the protection of children suggesting the combination of MRS and SOC principles have shown effectiveness. A small working group of CCMH members and staff from the Department of Children's Services was convened to assist in the continued study and to review strategies for the combination of the two mutually beneficial strategies.

Relevance to CCMH: At the February 2010 meeting of the CCMH, the membership approved the creation of the small working group as an official workgroup of CCMH. CCMH continues to support efforts to expand use of the core values and guiding principles of System of Care philosophy. The continued integration of understanding of System of Care will only ensure its success.

T.C.A. 36-3-116—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. Resource mapping 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 financial officers and program staff of the child-serving departments, TennCare Bureau, representatives of the Comptroller, Legislative Budget Office, Administrative Office of the Courts, GOCCC, TAMHO and others. The first full Resource Mapping report was submitted to the General Assembly on April 15, 2010.

Relevance to CCMH: One requirement of CCMH is to create a "financial map" for services and supports in Systems of Care. Representatives from the CCMH have worked 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. Results of this work have been included in the Resource Mapping section of this report

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 statewide.

Relevance to CCMH: 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 of 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 Mule Town 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 to be eligible for funding to determine if evidence supports continued funding. DCS has made tremendous strides in meeting requirements of the law.

Relevance to CCMH: 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, TDMHDD 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 TDMHDD has authority to pay for outpatient evaluations. TDMHDD sent letters to all juvenile courts when the ruling became final, 60 days after publication, and TDMHDD 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. 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. Through this collaborative effort, legislation was passed in 2009 codifying the court's ruling but also providing some limited funding to ensure the counties' ability to provide appropriate placements for juveniles while receiving outpatient evaluations.

Relevance to CCMH: SOC principles promote early intervention, community-based supports and reduced reliance on inpatient services. Several Juvenile Courts across the state began to access and collaborate with local community resources thereby ending their reliance on inpatient evaluations for mental health treatment. The Council continues to monitor this issue to ensure children and their families receive the needed treatment and support.

Selected Administrative and Organizational Initiatives
Relevant to Establishing a Statewide System of Care/Council on Children's Mental Health

Centers of Excellence for Children in State Custody (COE): The COEs funded through the Governor's Office of Children's Care Coordination assist the state in meeting federally required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under 21. The consultation, diagnostic and care plan development services are available to the Department of Children's Services, Department of Health, community providers and Best Practice Network providers involved in the care of children in or at-risk for custody. The Centers of Excellence currently exists at East Tennessee State University (Johnson City), University of Tennessee (Knoxville), University of Tennessee – Health Science Center (Memphis) and Vanderbilt University (Nashville). In addition to the above reference services, COEs have additional contracts or grants as noted below:

- **Child and Adolescent Needs and Strengths (CANS)** COEs worked with DCS to support statewide implementation of a standardized assessment and service planning process using the CANS. CANS was chosen by DCS as the assessment tool best exemplifying 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, supporting informed decisions about care and services. The CANS consists of about 65 items used to guide 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 CANS and the COEs have trained over 4,000 child welfare workers to reliably administer the instrument.

  Relevance to CCMH: 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.

- **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 256 mental health practitioners/supervisors and 34 agencies participating. Over 800 cases are currently using TF-CBT.

Relevance to CCMH: The COEs provide unique, essential services for the state, primarily laying the groundwork 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.

Coordinated School Health (CSH): Tennessee students and school staff continue to benefit significantly from the FY 08 expansion of CSH statewide. Because the CSH approach emphasizes serving the needs of the "whole" child, school staff are now coordinating efforts to address physical as well as social, emotional and behavioral health needs of all students. As a result of strategies implemented through CSH: the Tennessee childhood overweight/obesity rate dropped from 40.9 percent in 2007-2008 to 39.0 percent in 2008-2009; 116,659 students were referred to a health care professional for additional health screenings/services; 28,965 students received EPSDT exams in school-based clinics; and over $12 million dollars in grants and in-kind donations were awarded to Tennessee LEAs to address school health issues during the 2008-2009 school year. Over $1 million in comprehensive health education curriculum has been provided and teachers trained to address and prevent social and emotional behaviors with their students. An average of 21 local private and public partnerships were active in each Tennessee school system. These partnerships expand school health service capacity for schools while at the same time avoid services duplication. CSH Coordinators developed 54 school-based clinics that provide physical and in some cases mental health services for students and staff. The U.S. Department of Education *Tennessee Schools and Mental Health Integration grant* focused on assisting LEAs in building strong relationships with community mental health providers and other child serving agencies, strengthening the infrastructure available to support a system of care and better serve students' mental health needs.

Relevance to CCMH: The CSH approach strongly encourages building community partnerships to more effectively meet the health needs of students, including their mental health needs. The process of

building partnerships is creating a more positive climate for System of Care to be adopted when the CCMH develops implementation guidelines.

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 CCMH: 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.

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 CCMH: The State Board of Education recently recommended mental health guidelines for Local Education Authority to consider adopting. These guidelines were based in SOC core values and guiding principles. These guidelines also used several CCMH proposed initiatives such as a modified version of the CANS and increased collaboration of community based services through local mental health resource teams. CCMH will continue to support the Office of Coordinated School Health efforts to meet the mental health needs of students.

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 participates in over 148 councils, advisory groups, and policymaking committees each year, ensuring 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 75,000 parents and professionals in FY 09.

Relevance to CCMH: 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 Integrated Court Screening and Referral Project: TDMHDD, in partnership with the Administrative Office of the Courts, Centers of Excellence, Department of Children's Services, Tennessee Voices for Children, and Tennessee Commission on Children and Youth, provides juvenile courts with a CANS based instrument to assist the Court in addressing the mental health needs of youth who come in contact with the juvenile justice system. This pilot project will serve 6000 children and youth with non-violent charges who present in 11 juvenile courts across the state, with special emphasis on rural jurisdictions and females. The intervention makes available a truncated version of the CANS instrument for identifying mental health needs prior to the detention hearing required (T.C.A. 37-1-114), provide results of the instrument to the court at the hearing, and facilitate referral of identified children and youth to community-based services if appropriate. Five of the identified counties will also be provided with a Family Support Provider to assist the child and family in navigating the mental health service system.

Relevance to CCMH: This project utilizes the CANS instrument as a universal service planning and data collection tool. System of Care principles encourage the use of a universal tool to aid in the ability to improve collaboration as well as streamline data collection providing standard outcome measures and indicators. CCMH supports any project using the CANS and seeks to encourage its use across departments and agencies.

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 together 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 concerning 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 CCMH: Youth are currently represented on the CCMH from several of these youth groups, clearly bolstering the work of the Council. Youth input in the development of System of Care is required by 37-3-110-115 as well as in the System of Care core values and guiding principles. The Council has also relied on these groups to provide input on the surveys regarding barriers to implementation.

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 our accomplishments as well as our working plan noted throughout this July 2010 Report to the Legislature. Accomplishments of the CCMH include:

1. Sustained a high level of commitment to developing and implementing a statewide System of Care in Tennessee evidenced by nine meetings since the prior report, with an average attendance of 58 persons from all across the state.
2. Moved forward in developing financial structure models to support a statewide System of Care.
3. Identified the CANS as a universal screening tool and, in principle, CCMH members support the use of the CANS across departments and agencies.
4. Developed a Steering Committee to more efficiently provide governance for the CCMH.

The CCMH is prepared to move ahead in design of a statewide System of Care that is based on qualitative and quantitative data and is functional. It is also prepared to move forward to overcome challenges. One of the major challenges of the CCMH is the serious fiscal constraints of the nation and the State which create a significant barrier to system transformation efforts like implementing a

statewide System of Care. However, transforming systems does not always require additional resources. The CCMH recognizes moderate fiscal constraints foster more efficient use of existing resources and more collaborative partnerships help to ensure mental health services provided for children and their families are effective, coordinated, community-based, culturally and linguistically competent, family-driven and youth-guided. Ultimately, the CCMH acknowledges adequate funding streams will be necessary for statewide system transformation.

July 2010 Report Document Group 1: Tables

Table 1: Summary of Council Agendas, Purposes and Outcomes

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 6 3/13/09 10:00 A.M.-3:00 P.M	CoverKids and Children's Mental Health	Learn about the mental health benefit provided by CoverKids. --Andrea Willis
	Managed Care Organizations and Children's Mental Health	Provide the Council with an update and overview of the changes with TennCare providers and their services related to Children's Mental Health. --Jeanne James --Heather Baroni --Ron Wigley --Mary Linden Salter --Elliot Sparks
	Policy Academy Report	Update the Council on the recent policy academy related to System of Care and Children's Mental Health attended by several Council members. --Freida Outlaw --Bob Duncan --Jeanne James --Elvie Newcomb --Millie Sweeney --Randal Lea --Katrina Donaldson
	JCCO Workgroup Report	Inform the Council about the recommendations to judges from the workgroup due to the change in court ordered juvenile evaluations. --Jeff Feix --David Haines
	Justice and Mental Health Collaboration Grant Proposal	Describe a submitted grant application to assist the courts in linking to mental health and substance abuse services. --Jeff Feix --David Haines --Mary Rolando
	Evidence-Based Services Workgroup Update and Discussion	Discuss the workgroup's recent progress in drafting a consensus definition for EBP. --Mike Cull --Vickie Hardin
DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 7 4/23/09 and 4/24/09 10:00 A.M.-4:30 P.M and 8:30 A.M. – Noon	Technical Assistance for System of Care – Children's Mental Health	Provided a two-day discussion of system structure and presentation by a national expert in system of care and building Systems of Care on a statewide level. --Shelia Pires

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 8 6/25/09 10:00 A.M.-3:00 P.M	Child and Adolescent Needs and Strengths (CANS): Overview, Properties, and Principles	Provide the Council with an Overview of a common assessment tool that could be used across systems in a statewide System of Care. --John Lyons --Richard Epstein
	Presentation of DCS' CANS Data	Inform the Council about DCS's current use of the CANS as well as Data. --Michael Cull --Richard Epstein
	Discussion Regarding Common Assessment Tool	Discuss the possibilities for the use of the CANS or similar instrument in Tennessee for a statewide System of Care. --Linda O'Neal facilitating
	JCCO Workgroup Report	Inform the Council about recent legislation relating to court ordered juvenile evaluations. --Jeff Feix --Shay Jones --David Haines --Aaron Campbell
	Legislative/Budget Update	Provide the Council with a recent update on the state's budget and funding restored to mental health programs. --Linda O'Neal --Virginia Trotter Betts
DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 9 8/20/09 10:00 A.M.-3:00 P.M	Review of P.C. 1062 Requirements and Council's Role	Provide Members a review of the legislated mandate --Linda O'Neal
	Overview of Council's Progress	Inform the Council of the work accomplished to date. --Dustin Keller
	Overview of Possible Next Steps	Provide a framework for the work in preparing the plan. --Mary Rolando
	Steering Committee and Survey Results Discussion	Discuss the possibility of forming a steering committee. --Linda O'Neal
	Individual Workgroup Meetings	Allow committees to discuss the provided framework.
	Workgroup Reports and Discussion	Reports from workgroup chairs about their committee's suggestions and feedback to the framework. --Traci Sampson --Richard Kennedy --Michael Cull --Millie Sweeney --Mary Linden Salter
	CCMH Recommendations for Funding Priorities to the TDMHDD Policy and Planning Council.	Discussion of the Council's feedback to TDMHDD about funding priorities in the next fiscal year. --Debbie Shahla --Linda O'Neal --Marie Williams

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 10 10/8/09 10:00 A.M.-3:00 P.M	Overview of Sunset Hearing	Provide Members an overview of the sunset subcommittee hearing related to the CCMH --Linda O'Neal --Freida Outlaw
	Conflict of Interest	Distribute and discuss conflict of interest forms for members --Linda O'Neal
	Title VI Training	Provide an overview and understanding of Title VI as well how to file a complaint. --Debrah Stafford
	Youth Video and Presentation	Inform the Council about the work of the Mule Town Family Network's Youth in Action Council --Kathy Rogers --Maquisha McClain --Geronn Moore --Summer Anderson
	Sample System Structures Discussion	Begin a discussion about statewide system structures for a System of Care --Dustin Keller --Freida Outlaw
	Steering Committee Discussion	Review and act on a proposal for a steering committee for CCMH --Linda O'Neal **ACTION: STEERING COMMITTEE PROPOSAL APPROVED BY THE COUNCIL**
	Integrated Court Screening and Referral Project	Provide the Council with a overview of this grant project --Jeff Feix
	K-TOWN Youth Empowerment Network and Related Grant Opportunities	Inform the Council about TDMHDD's recent grant award for the K-TOWN Youth Empowerment Network (the state's fourth System of Care grant) and discuss two additional funding announcements related to the work of the Council. --Freida Outlaw --Dustin Keller --Millie Sweeney

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 11 12/10/09 10:00 A.M.-3:00 P.M	Tennessee Integration of Schools and Mental Health Systems Grant	Update the Council on the work of this grant as well as provide the mental health guidelines recently adopted by the State Board of Education. --Sara Smith --Nicole Cobb
	Mule Town Outcome Data Presentation	Provide the Council with the initial data analysis from the youth served at Mule Town Family Network --E. Ann Ingram --Kathy Rogers --Cherri Hoffman
	Early Connections Network: Fulfilling the Promise Grant Application	Present information about a recent federal System of Care grant application submitted by the Tennessee Department of Mental Health and Developmental Disabilities --Freida Outlaw
	CoverKids Update Presentation	Report to the Council about recent events with CoverKids including the closure of enrollment --Bob Duncan
	Overview of Steering Committee Meeting	Set the framework of the rest of the meeting by organizing into committees and answering several questions drafted by the Steering Committee --Linda O'Neal
	Workgroup Meetings	Allow workgroups time to meet and respond to questions from the Steering Committee --Workgroup Co-Chairs
	Workgroup Reports and Discussion	Discuss Workgroup responses to the provided questions --Linda O'Neal Facilitating

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 12 2/25/10 10:00 A.M.-3:00 P.M	TennCare HEDIS Data Presentation	Provide the Council with recent Healthcare Effectiveness Data Information System (HEDIS) results since our integration of health and behavioral health services --Jeanne James
	Select Committee on Children and Youth Child Protective Services Study	Inform the Council about the Select Committee's Study and elicit the support of the Council **ACTION: ADDITION OF STUDY GROUP AS WORKGROUP APPROVED BY THE COUNCIL**
	Northeast Collaboration Efforts	Illustrate the current collaborative efforts of Northeast Tennessee mimicking a System of Care model without federal System of Care funding. --Kathy Benedetto --Judge Sharon Green
	Legislative Overview and Update	Report to the Council about related children and youth legislation and provide an update on the Council's sunset process legislation --Steve Petty --Kurt Hippel
	Workgroup Meetings	Allow workgroups time to meet and respond to questions from the Steering Committee --Workgroup Co-Chairs
	Structured Workgroup and Feedback Discussion	Discuss Workgroup responses to the provided questions --Linda O'Neal Facilitating --Dustin Keller Facilitating
DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 13 4/22/10 10:00 A.M.-3:00 P.M	Council Draft Report Discussion	Provide an overview of the draft July 2010 report as well as discuss the information needed during the workgroup meetings --Dustin Keller --Mary Rolando
	Workgroup Meetings for completion of products/ recommendations	Allow workgroups time to meet and complete recommendations for the July 2010 report. --Workgroup Co-Chairs
	Planning Unit Meetings for completion of products/ recommendations	Allow Planning Units time to meet and complete recommendations for the July 2010 report. --Workgroup Co-Chairs
	Structured Feedback Discussion	Discuss planning unit recommendations --Dustin Keller Facilitating

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 14 6/24/10 10:00 A.M.-3:00 P.M	Legislative Update	Report to the Council about related children and youth legislation and provide an update on the Council's sunset process legislation --Linda O'Neal
	Integration of Cost Effective Mental Health Prevention Strategies into a Statewide System of Care Using a Public Health Approach	Provide the Council with a overview of the recent Institute of Medicine's report and strategies for integration prevention strategies into a System of Care. --Denis Embry
	Youth Transition Panel	Present information from youth about their challenges, successes, and suggestions about transitioning from the youth serving system to the adult serving system. --Kathy Rogers and Sita Diehl Facilitating --Emily Williamson --Justin D. --Roger Diehl --Giovonte Baker --Tierra Fremch
	Council Draft Report Discussion	Provide an overview of the draft July 2010 report as well as discuss the information needed during the workgroup meetings --Dustin Keller

Table 2: Summary of Steering Committee Agendas, Purposes and Outcomes

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 1 12/11/09 10:00 A.M.-11:00 A.M	Overview of Steering Committee and Purpose	Discuss the next steps for the steering committee and process for achieving our stated outcomes
	Workgroup Discussions (Items for Steering Committee Consideration)	Allow time for Workgroup Co-Chairs to discuss recommendations, feedback, and comments from each Workgroup
	Review and Discussion of the next CCMH Meeting Agenda	Review the upcoming agenda for the CCMH meeting and propose changes and additions
	Discussion Plans for Future Meetings	Schedule next meeting for the steering committee and provide input on the agenda for that meeting
DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 2 1/21/10 11:00 A.M.-12:00 Noon	Workgroup Discussions (Items for Steering Committee Consideration)	Allow time for Workgroup Co-Chairs to discuss recommendations, feedback, and comments from each Workgroup
	Draft Questions for Workgroup Follow-up before CCMH meeting	Discuss feedback questions workgroups will answer or comment on before the next CCMH meeting
	Review and Discussion of the next CCMH Meeting Agenda	Review the upcoming agenda for the CCMH meeting and propose changes and additions
	Review Proposed Dates for future CCMH Meetings	Provide dates for the remainder of 2010 for full Council meetings
	Discussion Plans for Future Meetings	Schedule next meeting for the steering committee and provide input on the agenda for that meeting

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 3 3/29/10 11:00 A.M.-12:00 Noon	Mule Town Sustainability Proposal	Review a proposal from the Mule Town Family Network sustainability committee
	Madison County Juvenile Mental Health Court Grant Letter of Support	Ascertain approval from the committee to provide a support letter for a county juvenile court grant application for federal funding
	Workgroup Discussions (Items for Steering Committee Consideration)	Allow time for Workgroup Co-Chairs to discuss recommendations, feedback, and comments from each Workgroup
	Discussion of Report Outline	Discuss the provided draft report outline for the July 2010 report
	Review and Discussion of the next CCMH Meeting Agenda	Review the upcoming agenda for the CCMH meeting and propose changes and additions
	Discussion Plans for Future Meetings	Schedule next meeting for the steering committee and provide input on the agenda for that meeting
DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 4 5/24/10 11:00 A.M.-12:00 Noon	Discussion of Report Progress	Discuss the draft July 2010 report and information needed from Workgroups
	Review and Discussion of the next CCMH Meeting Agenda	Review the upcoming agenda for the CCMH meeting and propose changes and additions
	Mule Town Sustainability Proposal	Review a proposal from the Mule Town Family Network sustainability committee
	Discussion Plans for Future Meetings	Schedule next meeting for the steering committee and provide input on the agenda for that meeting

Table 3: CCMH Workgroup Structure and Next Steps

OVERVIEW OF OBJECTIVES, ORGANIZATION AND PRODUCTS

I. SERVICES AND SUPPORTS UNIT				
Work Group	Current Objective	Intermediate Objectives	Work Group Products	PLANNING UNIT PRODUCTS
• Service Array	Develop consensus definitions for each service; prioritize services as Core, Specialty and Ancillary.	In conjunction with Interagency Collaboration Workgroup, inventory locations for consideration as possible pilot sites. Develop indicators of "community readiness" for sites. Recommendations to overcome barriers to service delivery.	Criteria for pilot and subsequent locations. Possible Data sources: DCS custody rate/1000 pop.; school dropout rates; JCCO volume; MRS capacity, community readiness, other.	Recommendations for • Initial and subsequent System of Care (SOC) locations • Populations to be served • Eligibility criteria • Staffing patterns; Family Service Provider (FSP): family ratios • Workforce development ▪ EBP capacity ▪ FSP capacity ▪ Clinical capacity ▪ Human Resource policies re: recruitment, retention, training, and fidelity to SOC principles. ▪ Credentialing for MCC purposes. • Approach to monitor cultural and linguistic competence.
• Evidence-Based Services	Finalize definition of Evidence Based Programs (EBP) and providers' survey; develop protocol for monitoring implementation.	Link to Center of Excellence (COE) capacity-building; develop strategies to extend TennCare reimbursement for EBP using Vanderbilt University Intensive Sex Offender Program as model.	Matrix of EBPs for treatment needs of target populations. Sustainability plans for EBP.	
• Cultural and Linguistic Competency (C/L)	Prioritize recommendations; develop protocols to monitor and evaluate quality of applications.	Work w/ Media Relations to develop statewide and local media campaigns. Partner with Interagency Collaboration WG to assure C/L competence in MOU requirements.	Protocols to monitor and evaluate quality of application of Cultural and Linguistically competent services and materials.	
• (New) Youth and Family Engagement	Work with existing youth councils for input to the CCMH.	Engage youth in CCMH; work w/ C/L Competency WG to get input about services and Media Relations for youth messaging.	Results of surveys, focus groups and presentation materials by youth.	

II. ADMINISTRATION AND FINANCING UNIT				
• Interagency Collaboration	Inventory structural components to support SOC such as MRS, DCS Court Liaisons, school-based MH liaisons, CANS assessments.	With Service Array WG, inventory locations with greatest and least capacity for consideration as possible pilot sites. Develop indicators of "community readiness" for sites. Recommendations for methods to overcome barriers to service delivery. Partner with C/L Competency WG to assure C/L competent services going forward.	Design/depict SOC service model for each of three local sites. Develop model MOUs for state and local levels.	Recommendations for • Criteria for local governance. • Schematic for local SOC organizational relationships • Tennessee SOC "brand" • Standardized forms/formats for ▪ Screening and assessments ▪ Eligibility determination ▪ Intake ▪ Engagement ▪ Individual Support Plans ▪ Case closure ▪ Performance standards ▪ Evaluation
• Accountability/ MIS	Complete business rules for key outcome indicators.	Investigate options for system-wide use of CANS, unified information systems among SOC sites and determine repository for data base. Research tools for assessing indicators of efficient, effective administrative functions and return on investments.	Recommendations for unified information system and accountability measures.	
• Media Relations	Develop overall plan for CCMH and SOC publicity.	Work w/ C/L to develop local media campaigns.	Tennessee SOC "brand," marketing materials reflecting SOC brand statewide.	
• Funding	Work with TennCare and MCOs to promote utilization of early intervention services, EBP and correspondence of ASAM criteria to medical necessity.	Analyze Tennessee fund sources relative to Pires technical assistance guidance. Explore relationship of EPSDT and SOC behavioral services for TennCare eligible children/youth and those who are not.	Resource map of children's mental health related resources as a subset of P.C. 1197 Resource Mapping, 2008.	Plan including fiscal requirements 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

Among first tasks of each Work Group would be to identify data sources and other individuals who could inform their work. The Steering Committee would establish the timeline for development and sequence for deliverables.

July 2010 Report Document Group 2: Survey Results

Rank the ADMINISTRATIVE barriers/challenges to Systems of Care in Tennessee. Use 5 to indicate the greatest barrier and 1 the least barrier. Do not use a number more than once.						
Answer Options	**1: Least Barrier**	**2**	**3**	**4**	**5: Greatest Barrier**	**Rating Average**
Accountability for performance & for resources	13%	26%	16%	21%	24%	3.16
Lack of integrated information systems	5%	18%	18%	33%	26%	3.56
Overcoming administrative & provider territoriality	6%	17%	28%	14%	36%	3.58
Poor historical relationships among those expected to be partners	39%	26%	21%	11%	3%	2.11
Quantifying the amount of resources & effort related to positive outcomes	31%	13%	21%	23%	13%	2.74

Rank the SERVICES barriers/challenges to Systems of Care in Tennessee. Use 6 to indicate the greatest barrier and 1 the least barrier. Do not use a number more than once.							
Answer Options	**1: Least Barrier**	**2**	**3**	**4**	**5**	**6: Greatest Barrier**	**Rating Average**
Inadequate culturally competent services	29%	29%	18%	5%	16%	3%	2.58
Lack uniform eligibility criteria to enter SOC	10%	10%	23%	21%	15%	21%	3.82
Inadequate youth/parental engagement	22%	27%	24%	8%	11%	8%	2.84
Inability to track outcomes	3%	13%	21%	26%	18%	18%	4.00
Difficulty implementing Evidence Based Practices	21%	11%	3%	26%	32%	8%	3.61
Limited number and array of services	15%	10%	10%	15%	8%	41%	4.13

Rank the POLICY barriers/challenges to Systems of Care in Tennessee. Use 5 to indicate the greatest barrier and 1 the least barrier. Do not use a number more than once.						
Answer Options	**1: Least Barrier**	**2**	**3**	**4**	**5: Greatest Barrier**	**Rating Average**
Conflicting state agency rules/requirements	5%	21%	16%	24%	34%	3.61
Lack of uniform service eligibility criteria statewide	10%	23%	36%	31%	0%	2.87
Inadequate cross-agency coordination about children's mental health	10%	10%	15%	18%	46%	3.79
Inadequate transition to adult mental health services	18%	32%	24%	16%	11%	2.68
Differing federal & state confidentiality rules among departments/agencies	54%	15%	10%	13%	8%	2.05

Rank the barriers/challenges to Systems of Care PRINCIPLES in Tennessee. Use 7 to indicate the greatest barrier and 1 the least barrier. Do not use a number more than once.								
Answer Options	**1: Least Barrier**	**2**	**3**	**4**	**5**	**6**	**7: Greatest Barrier**	**Rating Average**
Fidelity to SOC wrap-around model	8%	14%	14%	14%	17%	22%	11%	4.28
Achieving commitment/buy-in by state agencies, local communities and providers	5%	11%	11%	11%	16%	26%	21%	4.84
Historical relations among agencies	16%	16%	8%	22%	14%	22%	3%	3.76
Sustainability of SOC	11%	11%	8%	6%	11%	11%	42%	4.94
Transition to strengths-based service planning	22%	24%	8%	22%	8%	5%	11%	3.30
Lack of workforce development/qualified staff	16%	11%	24%	14%	24%	11%	0%	3.51
Educating/engaging community	21%	16%	29%	8%	11%	3%	13%	3.32

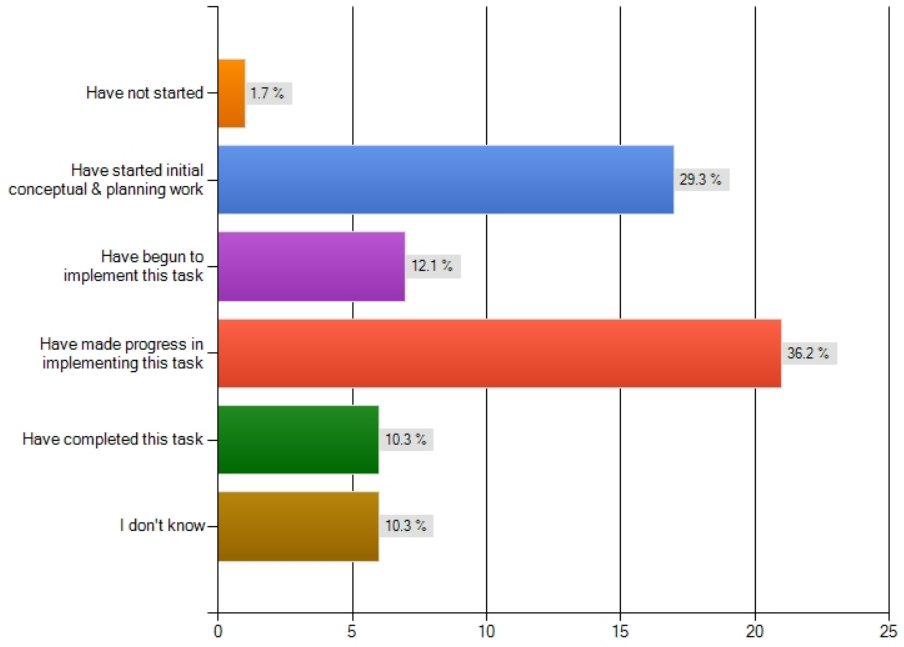
What are the most important elements to put in place to overcome the barriers? Use 8 to indicate the most important element and 1 the least important. Do not use a number more than once.									
Answer Options	**1: Least Important**	**2**	**3**	**4**	**5**	**6**	**7**	**8: Most Important**	**Rating Average**
Statewide culture change to shared SOC vision.	8%	3%	8%	14%	16%	8%	16%	27%	5.51
Joint planning among all child-serving agencies	3%	5%	8%	11%	18%	21%	8%	26%	5.63
Clear SOC governance structures	6%	6%	8%	19%	11%	8%	28%	14%	5.31
Memoranda of Understanding among agencies	11%	21%	11%	16%	21%	8%	11%	3%	3.95
Shared information systems among agencies	3%	13%	8%	8%	16%	24%	16%	13%	5.21
Fiscal accountability among agencies	11%	16%	27%	16%	14%	14%	3%	0%	3.57
Collaborative funding	5%	18%	26%	13%	8%	8%	8%	15%	4.31
Economies of scale, i.e., # of enrollees justifies cost of system	46%	18%	5%	3%	0%	13%	13%	3%	2.95

Please indicate your experience w/ Mental Health Systems of Care.		
Answer Options	**Yes**	**No**
Have you participated in a children's mental health System of Care?	23	16
Were you in a leadership role in the SOC?	17	15
Did you experience effective communication w/ other participants?	21	10
Did all participants contribute resources (time and expertise) to the SOC amicably?	17	14
In your opinion did services to families improve?	22	8

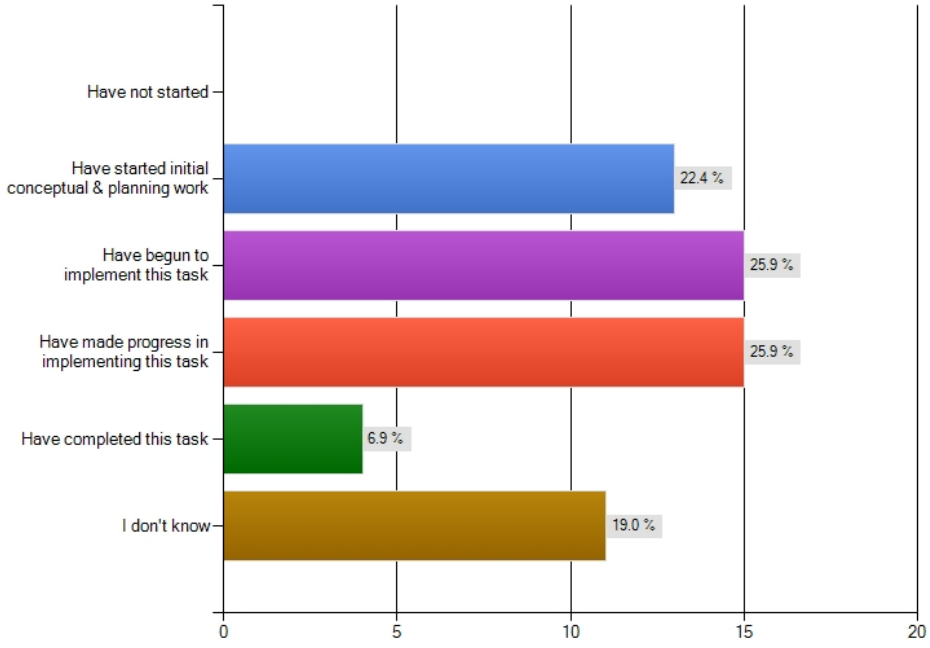
SOC INTERAGENCY COLLABORATION SURVEY 2010

Please indicate your level of agreement with each of the following. You may select the same answer more than once.	
Answer Options	**Agree/ Strongly Agree**
My agency understands the goal of the Council on Children's Mental Health.	76%
My agency is committed to the development of a System of Care for children in Tennessee.	83%
My agency has consistent, high-level participation in the Council on Children's Mental Health.	78%
My agency regularly receives information regarding the progress of the Council on Children's Mental Health.	86%
My agency understands its role in the Council on Children's Mental Health.	72%
My agency is actively participating in at least one Council on Children's Mental Health work group.	84%
My agency understands the goals of the Council on Children's Mental Health work groups.	69%
My agency's "voice" is heard as a part of the Council on Children's Mental Health.	78%
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.	71%
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.	67%
Family voices are represented in the Council on Children's Mental Health.	60%
All appropriate child-serving agencies are represented in the Council on Children's Mental Health.	70%
The Council on Children's Mental Health has the right membership at the table to meet its goals.	66%
The Council on Children's Mental Health has clear structure and policies in place to organize and guide its work.	43%
Members of the Council on Children's Mental Health have a shared definition of evidence-based services.	55%
The Council on Children's Mental Health has a plan for the provision of culturally and linguistically competent services to children and their families.	46%
My agency is easily able to share data and information across systems on a routine basis.	42%
My agency regularly partners with other child-serving state and community-based agencies on funding opportunities.	67%
My agency has Agreements/Memoranda of Understanding with other agencies focused on children's mental health.	70%
My agency involves families and youth in the development of policy, practice standards and outreach efforts.	48%

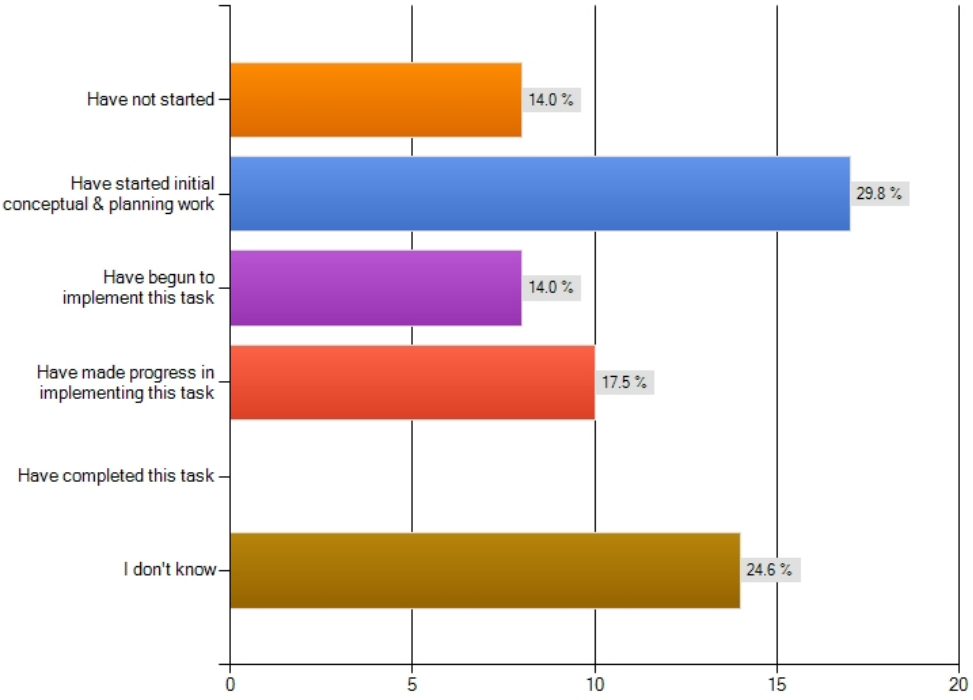
Barriers to a system of care in Tennessee are identified.



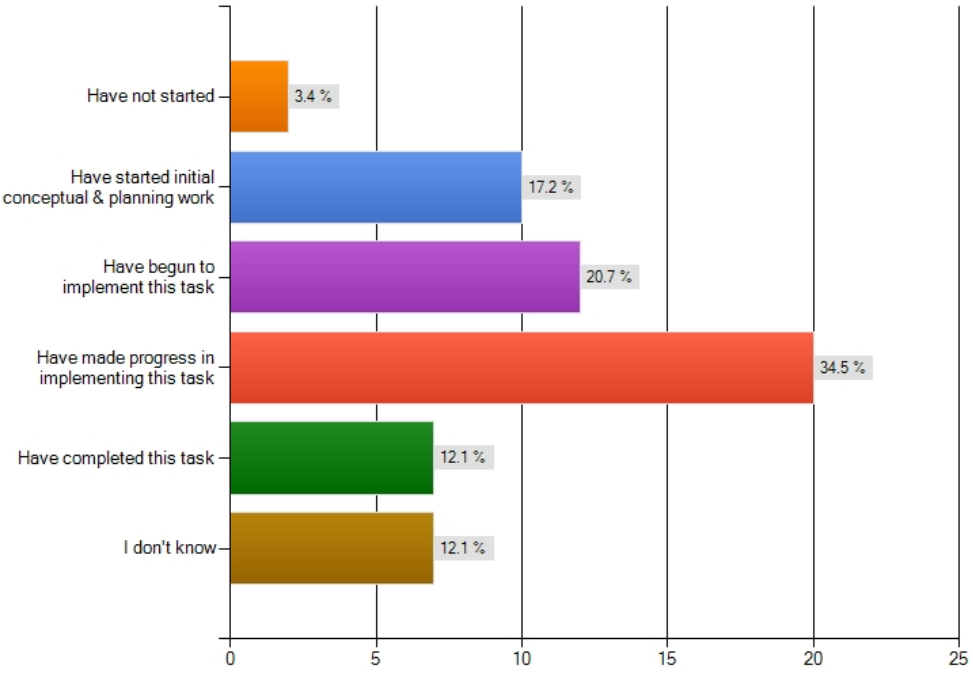
There is a clear understanding of available evidence-based, theory-based or research-based services to children in Tennessee.



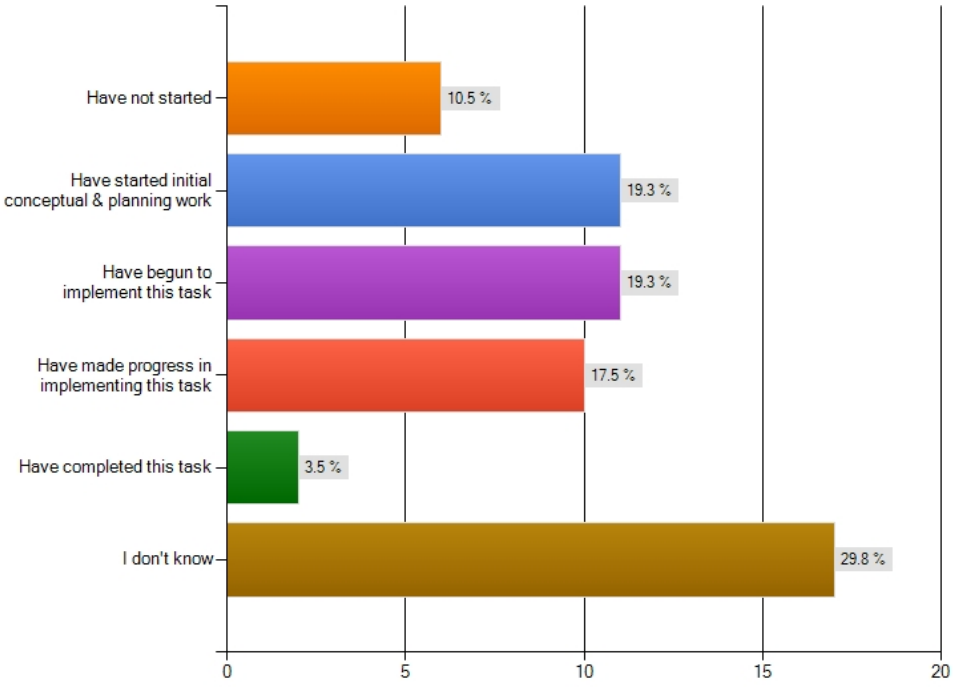
Interagency agreements are in place to support a system of care in Tennessee.



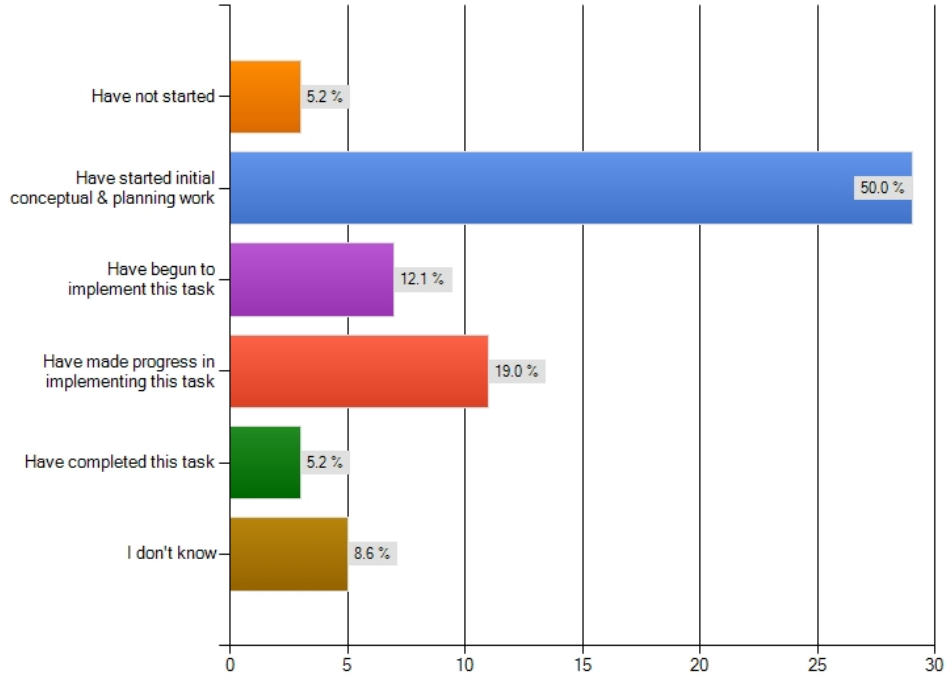
A financial resource map outlining available state and federal funding for children's mental health is developed.



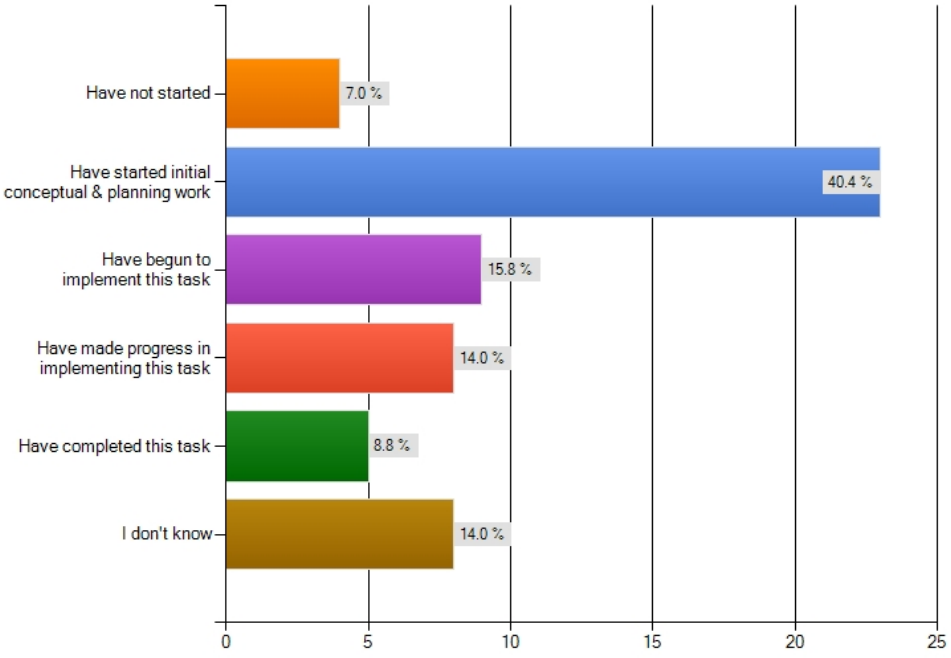
A cost analysis of federal and state funded programs is completed.



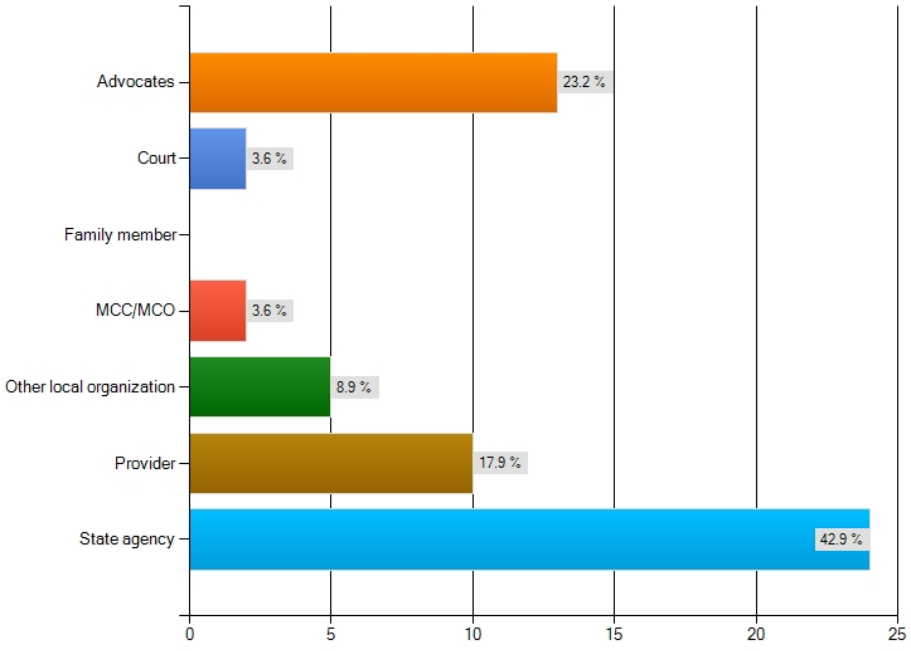
A plan for a statewide system of care in Tennessee is developed.



Formal recommendations are in place to implement a statewide Sytem of Care in Tennessee.



What group or type of agency do you represent? (Select all that apply.)



July 2010 Report Document Group 3: Other Related Documents

Steering Committee Proposal
(Revised and Accepted at 10/08/09 CCMH Meeting)

- The steering committee would meet at least once between Council meetings.
- The steering committee would not have authority to make binding decisions on the Council.
- The steering committee would assist in setting agendas for Council meetings, reviewing work of the workgroups and ensure the workgroups and Council stay on track with the "Next Steps."
- Would contain the following representatives:
    - Council Co-chairs (Virginia Trotter Betts and Linda O'Neal)
    - Workgroup Co-chairs (Listed below or subsequent replacements as neccessary)
        - Traci Sampson (JustCare Network/Consilience Group)
        - Pam Brown (TCCY)
        - Anne Pouliott (NAMI/Parent)
        - Debrah Stafford (TCCY)
        - Michael Cull (COE/Vanderbilt)
        - Vicki Harden (TAMHO Rep. - Provider)
        - Nneka Gordon (Comptroller)
        - Mary Linden Salter (MCO - AmeriChoice)
        - John Page (Centerstone - Provider)
        - Pat Wade (TCCY)
        - Freida Outlaw (TDMHDD)
        - Millie Sweeney (TVC)
        - Kathy Rogers (TVC - Muletown)

    - TDMHDD Division of Alcohol and Drug Abuse Services Representative (Bruce Emery)
    - Governor's Office of Children's Care Coordination (GOCCC) Representative (Mary Rolando)
    - Department of Education Representative (Steve Sparks or Angie Cannon)
    - Department of Health Representative (Veronica Gunn)
    - Department of Children's Services Representative (Randal Lea)
    - Department of Human Services (Paul Lefkowitz)
    - Muletown Project Director (E. Ann Ingram)
    - Project Director/Representatives from JustCare for Kids and K-Town Youth Empowerment (TBD)
    - Additional Parent (Katrina Donaldson)
    - Youth (Geronn Moore)
    - TennCare Representative (Dr. Jeanne James)
- If workgroup co-chairs change, then representatives would be added to ensure all groups currently represented would continue to be adequately represented with an emphasis on parents, providers, departments, agencies, etc.

Mule Town Family Network Sustainability Expansion Overview

For the sustainability expansion of the MTFN System of Care grant it has been proposed that MTFN will serve as the care management entity for the twelve county System of Care demonstration site in Middle Tennessee. As the care management entity, MTFN will coordinate the Care Review Team, maintain system accountability, provide care coordination through the implementation of Wraparound, and ensure reporting to system partners and funding agencies is standardized.

Eligibility Criteria for Entering the MTFN System of Care

The eligibility criteria for children and families entering the MTFN System of Care are as follows:

1) Children and youth from birth to 21 years who live in the 12 counties of the South Central Region as designated by the Department of Children's Services (Bedford, Coffee, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, Wayne);
2) Children and youth with a diagnosis of Serious Emotional Disturbance (SED) or Serious and Persistent Mental Illness (SPMI) (e.g. Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Depression, Obsessive Compulsive Disorder, Anxiety Disorder, etc.), and their families;
3) Children and youth who are involved in more than one system (e.g. education, child welfare, primary health, juvenile justice, mental health, community service agency, etc.); and
4) Children and youth at high-risk of placement outside the home.

Community and System Referrals

Referrals into the MTFN System of Care will come from community agencies, child-serving governmental agencies, or through a self-referral. Community system referrals will include community nonprofits such as the YMCA or Boys and Girls Clubs, local mental health agencies, youth sport leagues, managed care companies, faith-based organizations, etc. Payment plans and authorizations for children and families referred through community agencies or self-referral will be authorized through a Care Review Team (see below).

Referrals from governmental child-serving agencies will include Department of Children's Services, Department of Education, Tennessee Department of Mental Health and Developmental Disabilities, and the Department of Health. The referring agency will be responsible for authorizing payment for MTFN services for the child and family, cooperating with MTFN partners in data sharing, and the administration of the Child, Adolescent Needs and Strengths (CANS) assessment where applicable.

Care Review and Child and Family Teams

The Care Review Team will meet on a regularly scheduled basis to review incoming referrals without payment authorizations and work with governmental and community agencies to establish a funding plan for these referrals. The Care Review Team will be comprised of representatives from various financial decision makers from referring agencies. These would include but are not limited to managed care companies, Department of Education, Department of Children's Services, Tennessee Department of Mental Health and Developmental Disabilities, TennCare, and other community stakeholders such as the Boys and Girls Club, as well as the families and MTFN staff.

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The Care Review Team will also assist the Child and Family Team (CFT) in determining the appropriate level of care for the child or youth. The CFT is made up of the child or youth, family members, mental

health specialist/community liaison, family support provider, and other representatives from traditional and non-traditional supports as needed to create and support the individualized plan of care for the family. The CFT is the central component of the Wraparound process.

Wraparound Implementation

Wraparound is a process within a System of Care that individualizes services for children and youth with complicated multi-dimensional problems, such as youth with emotional/behavioral disturbances with multi-system needs. The term "wraparound" originated from the idea that these youth could best be served in their home, in the mainstream education classroom, and in their communities. Wraparound is a philosophy of care that includes a planning process involving the child and the family that results in a unique set of community services and natural supports individualized for the child and family to achieve a positive set of outcomes. This planning process is done by the Child and Family Team with the ultimate goal for the child to live an independent, fulfilling, and constructive life in the community.

MTFN staff will provide the care coordination to support the Child and Family Team process as the child and family strive to reach their goals. Progress toward the goals is reviewed at regularly held Child and Family Team meetings.

System Accountability and Standardized Reporting

In an effort to streamline reporting requirements across system partners, community stakeholders, funding agencies and families, MTFN will develop standardized reporting tools. Standardized reports on the child and family's progress through the System of Care, including payment authorizations, service costs, assessments, etc. will ensure greater coordination and enhanced accountability measures among System of Care partners.

Accountability for the MTFN sustainability expansion demonstration site will include three components: community assessments, evaluation of the System of Care, and child and youth assessments. Community assessments include local resource mapping, needs surveys, and additional methodology to be determined by system partners on an as needed basis. The System of Care evaluation will include ongoing evaluations of the care coordination process, outcome measures, services and costs studies, and child and family satisfaction surveys. The CANS will be used to monitor the level of care needed for the child as he/she moves through the MTFN System of Care and serve as a standardized tool for assessing the appropriate level of care needed.

Expected Outcomes

The purpose of implementing a financial infrastructure demonstration site is to test the implementation of the MTFN System of Care model in Tennessee without federal grant funding. It is important to note that what is being proposed is not "the" way to fund a System of Care within the State of Tennessee, but is "a" way to fund it. The MTFN financial infrastructure demonstration site will test out a model for supporting the clinical, programmatic and financial components of a System of Care. The outcomes will inform stakeholders statewide about how the local implementation of a System of Care funding model can be duplicated, adapted, or expanded in other local communities and at the regional and state levels.

COUNCIL ON CHILDREN'S MENTAL HEALTH MEMBERSHIP

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TN Commission on Children and Youth
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