Council on Children's Mental Health

A Report to the Legislature

July 2012

Council Co-Chairs

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Commissioner
Department of Mental Health and Substance Abuse Services

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Executive Director
Tennessee Commission on Children and Youth

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MEMORANDUM

To: The Honorable Bill Haslam, Governor
The Honorable Ron Ramsey, Lieutenant Governor
The Honorable Beth Harwell, Speaker of the House
Honorable Members of the Tennessee Senate and House
Members of the Governor's Children's Cabinet

From: E. Douglas Varney, Commissioner, Tennessee Department of Mental Health and Substance Abuse Services, 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, 2012

RE: Council on Children's Mental Health July 2012 Report

This memorandum transmits the July 2012 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 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 to develop this July 2012 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 215 Tennessee citizens have volunteered to be involved in this process and meetings have an average attendance of 52.

As you review this report, we think you will see the great potential for improving outcomes for the children of Tennessee. If you are interested in receiving a briefing on this report individually or before committees, please contact Commissioner Varney at 532-6500 or Linda O'Neal at 532-1600. We look forward to collaborating with the General Assembly in improving mental health services for children in Tennessee.

cc: Council on Children's Mental Health Members

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COUNCIL ON CHILDREN'S MENTAL HEALTH

JULY 2012 REPORT TO THE LEGISLATURE

OVERVIEW

Child well-being is important for community and economic development. Children with strong mental health are prepared to develop important skills and capacities beginning in early childhood. These children are the basis of a prosperous and sustainable society — contributing to things like good school achievement, solid workforce skills, and being strong citizens. When we ensure the healthy development of the next generation, they will pay that back through productivity and responsible citizenship.

Innovative states and communities have been able to design high quality programs for children that solve problems in early childhood showing significant long-term improvements for children. As a state, we need to develop and replicate more effective policies and programs for young children. With one in four children struggling with mental health issues, it is critical they receive services and supports to become productive citizens of Tennessee. The Council on Children's Mental Health (CCMH), codified in T.C.A. 37-3-110 – 37-3-115, works to design a comprehensive plan for a statewide System of Care (SOC) for children and families that is family-driven, youth-guided, community-based, and culturally and linguistically competent. This work cuts across all child-serving agencies in the state and is recognized in the statute.

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. This Report responds to the requirement to submit a plan to the Legislature by July 1, 2012 to implement twelve demonstration sites in keeping with SOC principles.

Restatement of System of Care (SOC) 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

- Family-driven and youth-guided;
- 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.

NOTE: *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.*

RECOMMENDATIONS

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

Recommendation 1: Collaborate with TennCare and Managed Care Organizations (MCO) through the current managed care service delivery system to begin reviewing the possibility of integrating SOC values and principles into the managed care system of Tennessee's three grand divisions. There were 1.46 million children in Tennessee's population in 2009 with 745,991 eligible to receive services through TennCare. Considering over half of children and youth may receive mental health related services through TennCare, the Council recommends exploring the opportunities to integrate SOC concepts into the current MCO system. After researching viable options for demonstration sites and our state's historical trends of sustaining and funding programs, the Council also recommends rather than 10 communities or "sites," the state consider demonstrating SOC sites through an entire grand region. Since our MCO's are set up by grand region, this would allow for additional collaboration.

Recommendation 2: Extend the Council's due date for the plan for statewide expansion to July 1, 2015. Currently T.C.A. 37-3-115(b) requires the Council (pending approval of this plan by the legislature) to submit a plan for statewide expansion of SOC on or before July 1, 2013. Given the legislative process in Tennessee, funding and approval of this plan may not be known until late in the second quarter of 2013. The Council needs time and resources to implement this plan and be able to learn from this process. If the Council submits a new plan in 2013, it will not have had time to begin enacting this plan. Therefore, the Council recommends ample time and resources to be allowed following approval and funding of this plan prior to the requirement of submitting a subsequent one. The time span between the previous report in 2010 and this current report was two years. Therefore, the Council recommends the plan for statewide expansion be due on or before July 1, 2015.

Recommendation 3: Adequate State funding should be provided to continue staffing and supporting the Council on Children's Mental Health. In 2008 when the Council began, the Tennessee Commission on Children and Youth (TCCY) was able to completely staff and support the Council using federal juvenile justice funds. An overwhelming proportion of youth in the juvenile justice system have mental health treatment needs. Since then, federal juvenile justice funds have been dramatically reduced and in order to meet grant and other requirements of the funding, TCCY has been forced to discontinue funding CCMH with federal juvenile justice dollars and is challenged in providing ongoing funding for staff salary and supplies with the current state appropriation. CCMH has received broad-based support and participation from providers, families, youth, child-serving state departments and advocates. As the Council is midway through its work of planning for a statewide SOC, it is imperative this work continue to provide a more coordinated network of services and supports.

Recommendation 4: Funding to sustain and/or create a Technical Assistance/SOC Center of Excellence for System of Care Expansion to serve as a support to communities/groups in developing local/regional SOC initiatives. Currently, the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) is exploring the option of creating a training and technical assistance/SOC Center of Excellence (TA/SOC COE) using federal grant funds from SOC initiatives. This center could provide training on a variety of topics including: family-driven and youth-guided services, wraparound services, family support provider certification, trauma-focused cognitive behavioral therapy, strategies for implementing trauma screening, trauma treatment, and trauma informed approaches to care; Child/Adolescent Needs and Strengths (CANS) service planning tool; accountability and resource management; care coordination; and local governance development. The TA/SOC COE would also develop toolkits for SOC implementation, including readiness assessments, tools for managing conflict, and tips for engaging families and youth. The center is imperative to expanding SOC statewide and ensuring on-going quality of and fidelity to SOC concepts. The Council recommends on-going funding for any center created for this purpose by TDMHSAS and/or initial funding to create a center for this purpose if TDMHSAS does not have available funding.

Recommendation 5: Expand use of the Child/Adolescent Needs and Strengths (CANS) Service Planning Tool to become a universally recognized tool among child-serving agencies, departments, providers, families and youth. As reported in the July 2010 report from CCMH, CANS is currently being used or recommended for use by TDMHSAS, Department of Children's Services and Department of Education. Since the July 2010 report, TennCare and the MCOs are currently in discussions about using CANS for selected children and youth prior to receiving intensive in-home services. CANS is currently used by several states for all children who receive mental health services and as a planning tool and a quality assurance measurement. The Council continues to recommend expansion and use of CANS in Tennessee to eliminate gaps in understanding family and youth needs and strengths across providers, agencies, departments and individuals.

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 Substance Abuse Services (TDMHSAS) and the Executive Director of the Tennessee Commission on Children and Youth (TCCY), have continued to monitor membership of the Council to ensure its compliance with the statute. Youth representatives have been identified and have been attending when scheduling allows. We continue to explore models of family and youth engagement to ensure meaningful participation continues, including identifying an advisory group charged with ensuring family and youth engagement in all Council workgroups.

CCMH met twenty-three times between July 2008 and July 2012, 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. Another nine of these meetings were detailed in the July 2010 report that can be found at http://www.tn.gov/tccy/ccmh-report10.pdf. A decision was made early in the process to allow all participants in Council meetings to 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, no CCMH reimbursement for travel, and significant demands on every person's time. Attendance averaged 52 persons for the nine Council meetings since July 2010. Membership has remained relatively stable except for some state department representatives who changed with the administration change in January 2011. Over 50 percent of members in attendance at meetings have attended over three-fourths of the total number of meetings held.

The Council agenda since July 2010 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 develop recommendations about statewide expansion of SOC, common tools and instruments, and other components of the plan detailed in this report. One example of this work, an updated review of the state's federally funded SOC grant programs through TDMHSAS, is on page 11. It has been included as these sites were identified as our logical first demonstration sites.

A summary of CCMH meeting agendas and outcomes since the July 2010 report is included on page 41.

Steering Committee: Since its inception in October 2009, the Steering Committee has met 11 times with an average of 18 members at every meeting. A summary of agendas and outcomes of the Steering Committee and meetings of the workgroup co-chairs since the July 2010 report is presented in Table 2 on page 47.

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 July 2010 report. There are currently seven workgroups providing recommendations and information about their respective topics. The seven primary workgroups and their individual foci are reflected in Table 3 on page 51. 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.

Demonstration Sites: Current economic conditions coupled with the potential opportunity for sustainability led the Council to focus on the federally funded SOC sites in Tennessee as the three demonstration sites required by statute for the July 2010 Report to the Legislature. Currently, TDMHSAS has four active SOC initiatives, with at least one in each grand region of the state. TDMHSAS has had substantial experience with development and implementation of federally funded SOC grants, including securing the required non-federal match of cash or in-kind resources, and using SOC core values and guiding principles to guide the initiatives. As an on-going update from the prior two Council reports, Tennessee's SOC experiences are summarized below in Table 1. Federally funded SOC grants are now typically awarded for a six-year grant cycle with the possibility of a seventh year no-cost extension if funding allows. (Some prior awards were for five-year cycles.) 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 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 SOC across Tennessee.

July 2012 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 (now known as South Central System of Care (SCSC)) Funding Over 6 Years: $6.7M Federal $6.7M Match Required**	Initiated: 2005 Anticipated End Date: 2012	Target: 440 Served to Date: 414	• Maury County residents (under SCSC is now expanded to 12 counties that make up South Central DCS Region); • 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;	• Increased stability of living arrangements; • Decreased school suspensions; • Decreased delinquent behaviors; • 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,

			• 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.	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 Served to Date: 95 youth , 140 family members	• 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.	• Increased natural supports for enrolled youth and families • Increased creation of and compliance with IEPs/504s • Decreased school suspensions • Decreased delinquent behaviors • Increased compliance with mental health treatment recommendations Projected outcomes in addition to improved Functional and Clinical Outcomes noted above: • Family Support Provider/Mental Health Consultant working as a team integral to SOC success in Shelby County • Youth That Care Youth Council and Parents That Care Support Group now established as vehicles for youth and family members to serve as community leaders & advocates for promoting awareness of and need to destigmatize mental health issues • Formal referral and collaborative care relationship with DCS, Juvenile Court and school system • Creation of county-wide child and family serving system that utilizes the wraparound approach to service delivery

K-Town Youth Empowerment Network Funding Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 9/2009 Anticipated End Date: 2015	Target: 400 Served to Date: 95	• 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^: • Youth In Action Council established as community leaders and peer advocates; • Improved functioning in the home, school, and community; • Successful transition into adulthood, per individual youth's definition.
Early Connections Network: Fulfilling the Promise Funding Request Over 6 Years: $9M Federal $8.5M Match Required**	Awarded: 10/2010 Anticipated End Date: 2016	Target: 400 Enrollment Opens July 2012	• Residents of Cheatham, Dickson, Montgomery, Robertson, and Sumner Counties; • Young children ages 0-5 and their families; • Emotional, behavioral or mental health disorder present or at risk of being developed; • 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^: • Improved functioning in the home, pre-school, child care and community settings; • Expanded early childhood training of local community service providers • Increased number of early childhood specialists

* 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.

SAMHSA-funded SOC grants require children and families served with federal dollars to meet the following eligibility criteria: 1) child/youth at-risk of placement to a higher level of care such as inpatient hospitalization, residential placement, or state custody; 2) child/youth with serious emotional disturbance (SED); 3) child/youth who have multiple system involvement; 4) caregivers willing to participate in child's service delivery team; and 5) child/youth lives within defined geographic areas served by the grant (i.e. specific county). Families are usually at or near the federal poverty level. The initiatives are structured to be replicated and sustainable with outcomes measured by SOC national and local evaluations. A common staffing model for Tennessee's SOC initiatives is also present in each system where a child and family are served by a community liaison/mental health specialist and a family support provider. Typically, the family support provider is a parent or caregiver of a child with a mental health disorder who has successfully navigated multiple child-serving systems (i.e. mental health, child welfare, juvenile justice) and has been trained and/or certified as a Family Support Specialist by TDMHSAS.

The Council also relies on monitoring outcomes pieces of the first graduated SOC initiative in Tennessee to understand possibilities of the current federal initiatives to be sustained. The graduated SOC site information is presented below.

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
NASHVILLE CONNECTION Funding over 7 Years: $6.3M Federal $4.2 Match Provided**	Initiated: 1999 Ended: 2007	323	• Davidson County residents; • Children with SED age 5-18; • Global Assessment Function (GAF) of ≤ 50; • Multi-agency involvement; • Imminent risk of state custody or psychiatric hospitalization; • Most (69%) at or near poverty level; • One third w/ 4 or more family risk factors; • 40% of children w/ 2 diagnoses and 15% w/ 3 or more diagnoses; • 30% had previous psychiatric hospitalizations; • 50% of caregivers had mental illness or dual diagnosis.	• 97% of children remained in the community; • All demonstrated clinical improvement over time; • Decreased school absenteeism; • Decreased residential care and hospitalization; • Increased service coordination; • Improved grades; • Decreased suspensions; • When grant ended: (1) sustained and expanded MH-School Liaisons to rural East, Middle and West Tennessee through DMHSAS partnership with DOE; (2) sustained a piloted family support SOC-based program, "Family Connection" through DCS funding, local and state grants and single case agreements with MCOs.

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

II. BARRIERS TO IMPLEMENTATION

Potential barriers to implementation of Systems of Care in Tennessee were identified in surveys conducted in early January 2009 and again in June 2010. In order to show change over time, Council members were again surveyed in June 2012 about perceived barriers to successful implementation of Systems of Care and structures potentially overcoming 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 2012 CCMH Survey: Council member participation in the survey was consistent, with 37 participants completing the 2012 survey and 40 completing the 2010 survey. For the identified administrative barriers/challenges, lack of integrated information systems was the greatest perceived barrier with an average rating of 3.88 on a scale of 1-5 with 5 being the greatest. Integrated systems previously had an average rating of 3.56 in June 2010. This is a significant change from the prior two surveys where overcoming administrative and provider territoriality had been the greatest perceived barrier. Territoriality rated at an average of 3.47 compared to 3.58 in June 2010 and 4.20 in January 2009. Territoriality has consistently decreased as a perceived barrier, indicating increased interagency collaboration has been achieved over time.

Relative to services, a limited number and array of services again was considered the greatest barrier at an average rating of 4.73, increasing from the June 2010 rating of 4.13 and the January 2009 rating of 4.61. Inability to track outcomes has remained the second services barrier for all three surveys, a requirement of many state and federal funding sources and therefore a consistent challenge across systems.

Inadequate cross-agency coordination about children's mental health was again rated as the greatest policy barrier in Tennessee with an average rating of 3.53 but it continues to decline in comparison with the June 2010 rating of 3.79 and 4.10 in January 2009. This continuing 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. Additionally, the new administration's commitment to TDMHSAS's current goal to increase coordination and collaboration among children and youth's mental health services must also be considered a contributing factor.

Unlike the survey results of January 2009 and June 2010 when the perceived barriers remained consistent, the current results show some barriers have lessened across the four areas with slight improvement in several areas. As noted on the interagency collaboration survey results, the task of implementing a statewide SOC is a collaborative process requiring cross-agency consensus and buy-in with on-going education, research, collaborative decision-making required to continue to move the plan forward.

The entire results of the CCMH survey are appended on page 55.

III. LIST OF ALL PROGRAMS

CCMH has again worked in concert with TCCY's Resource Mapping project to provide a "snap-shot in time" of the programs and service types funded by various departments and agencies in the state. This service listing has been updated from the June 2010 report and was developed using data from the resource mapping process for fiscal year 2010-2011. The following table provides a service listing by department.

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 Substance Abuse Services has a service provider listing at http://state.tn.us/mental/MentHealtSerProviders.html. The Tennessee Alliance for Legal Services, National Association of Social Workers, and 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 2012 Report Table 2: Departmental Service List

	Agency	Primary Program Service
1	Department of Children's Services	Assessment-Child Advocacy Center
2	Department of Children's Services	Assessment-Mental Health
3	Department of Children's Services	Mental Health-Abuse and Neglect Counseling
4	Department of Children's Services	Mental Health-Sexual Abuse Counseling
5	Department of Children's Services	Placement-Continuum of Care
6	Department of Children's Services	Placement-Mental Health-Full Clinical Treatment
7	Department of Children's Services	Placement-Residential
8	Department of Children's Services	Support-Medical and Behavioral Services
9	Department of Children's Services	Support-Parent Education
10	Department of Children's Services	Support-Reunification
11	Department of Education	Admin-Title IV-A, Safe and Drug Free Schools
12	Department of Education	Coordinated School Health
13	Department of Education	Education-Bullying Prevention
14	Department of Education	Education-Drug and Violence Prevention
15	Department of Education	Support-Family Resource Centers
16	Department of Education	Training-Professional Development-Social and Emotional
17	Department of Health	Coordination-Early Childhood
18	Department of Health	Education-Tobacco Prevention
19	Department of Health	Mental Health-Substance Abuse-Tobacco Cessation
20	Department of Health	Outreach-Tobacco Prevention
21	Department of Health	Support-Community Prevention Initiative
22	Department of Mental Health	Administration-Assessment-Mental Health
23	Department of Mental Health	Administration-Education-Mental Health
24	Department of Mental Health	Administration-Education-Mental Health-Early Childhood
25	Department of Mental Health	Administration-Education-Mental Health-Substance Abuse
26	Department of Mental Health	Administration-Education-Mental Health-Suicide Prevention
27	Department of Mental Health	Administration-Emergency-Crisis Services-Child
28	Department of Mental Health	Administration-Mental Health-Early Childhood
29	Department of Mental Health	Administration-Mental Health-Forensic Services
30	Department of Mental Health	Administration-Mental Health-Home Based Services
31	Department of Mental Health	Administration-Mental Health-Inpatient
32	Department of Mental Health	Administration-Mental Health-Outpatient
33	Department of Mental Health	Administration-Mental Health-Safety Net
34	Department of Mental Health	Administration-Mental Health-School Based Services
35	Department of Mental Health	Administration-Mental Health-Substance Abuse
36	Department of Mental Health	Administration-Mental Health-System of Care
37	Department of Mental Health	Administration-Respite-Mental Health
38	Department of Mental Health	Administration-Support-Housing
39	Department of Mental Health	Administration-Support-Housing-Transitional Youth
40	Department of Mental Health	Administration-Support-Mental Health
41	Department of Mental Health	Administration-Support-Mental Health-Housing
42	Department of Mental Health	Administration-Training-Mental Health
43	Department of Mental Health	Administration-Training-Mental Health-Cultural Competency
44	Department of Mental Health	Assessment-Mental Health
45	Department of Mental Health	Administration-Behavioral Health-Safety Net
46	Department of Mental Health	Behavioral Health-Safety Net

Agency	Primary Program Service
47 Department of Mental Health	Education-Mental Health
48 Department of Mental Health	Education-Mental Health-Early Childhood
49 Department of Mental Health	Education-Mental Health-Substance Abuse
50 Department of Mental Health	Education-Mental Health-Suicide Prevention
51 Department of Mental Health	Emergency-Crisis Services-Child
52 Department of Mental Health	Mental Health-Early Childhood
53 Department of Mental Health	Mental Health-Forensic Services
54 Department of Mental Health	Mental Health-Home Based Services
55 Department of Mental Health	Mental Health-Inpatient
56 Department of Mental Health	Mental Health-Outpatient
57 Department of Mental Health	Mental Health-Safety Net
58 Department of Mental Health	Mental Health-School Based Services
59 Department of Mental Health	Mental Health-Substance Abuse
60 Department of Mental Health	Mental Health-System of Care
61 Department of Mental Health	Respite-Mental Health
62 Department of Mental Health	Support-Housing
63 Department of Mental Health	Support-Housing-Transitional Youth
64 Department of Mental Health	Support-Mental Health
65 Department of Mental Health	Support-Mental Health-Housing
66 Department of Mental Health	Training-Mental Health
67 Department of Mental Health	Training-Mental Health-Cultural Competency
68 Department of Safety	Education-Drug Abuse Resistance
69 Department of Transportation	Education-Safety-Alcohol Awareness
70 Governor's Office of Children's Care Coordination	Assessment-Centers of Excellence

IV. STATUS OF INTERAGENCY COOPERATION

T.C.A. 37-3-110 – 37-3-115 asks for a report of the status of interagency cooperation. As previously noted, participation in CCMH has far exceeded the requirements. CCMH has held twenty-three meetings since its inception in 2008. Eleven agencies and departments are listed in the code requiring CCMH participation. CCMH has an average of 92 percent participation from all eleven agencies and departments. Eight of these departments have 100 percent participation even with the administration change. This sustained and frequent attendance demonstrates the commitment and willingness of participants to support transformation of the mental health system serving children and families.

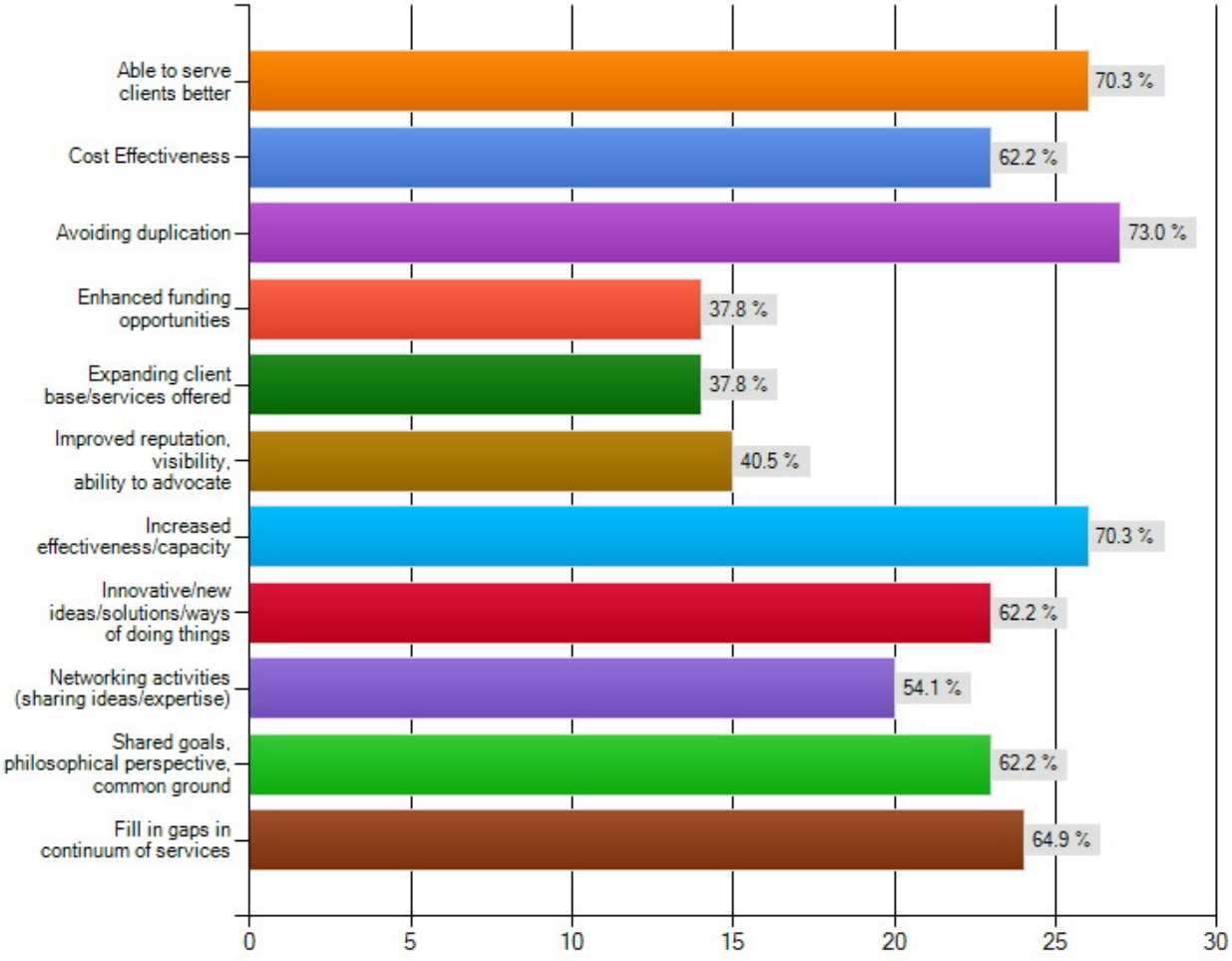
A survey of the CCMH membership was conducted in January 2009 to assess their perceptions of interagency collaboration and the ongoing challenges of collaboration. This survey was repeated in June 2010 and June 2012 to assess members' current perceptions and to ascertain if any shift in perception or challenges has occurred. Because of the substantial increase in survey participation and the survey's anonymity, direct comparisons to the 2009 data are not feasible. However, survey participation increased by two-fold in June 2010 and remained consistent in June 2012, thereby allowing some comparisons in the data. Significant improvement has been made in the self-reported measures about interagency collaboration. The current survey results revealed very positive perceptions of interagency collaboration currently, and the challenges going forward have shown a significant decline since January 2009 and are not as substantial as indicated in the prior surveys. Responses related to "departments" or "agencies" include not only state departments and agencies, but private providers, families and other stakeholders.

Key Findings from the June 2012 Survey of the CCMH and Workgroups: Communication about CCMH is positive.

- 100 percent of respondents state their agency understands the goals of CCMH and is committed to the development of SOC in Tennessee;
- 98 percent of respondents regularly get information about the progress of the council;
- 86 percent of agencies have consistent, high-level of participation in the CCMH;
- 83 percent of respondents state CCMH has given their agency a better understanding of the goals of other child-serving state and community-based agencies; and
- 72 percent of respondents state the work has led to opportunities to partner with other child-serving state and community-based agencies.

The CCMH and Workgroups also see some challenges ahead: only 67 percent perceived their agency is easily able to share data and information across systems on a routine basis. While this indicator has increased from 42 percent in June 2010, information sharing was also listed as one of the greatest perceived barriers of implementing SOC in Tennessee. Respondents were asked to rate the perceived benefits of interagency collaboration with the results in Figure 11. Additional results of the Status of Interagency Collaboration survey are appended on page 58.

July 2012 Report Figure 1: Perceived Benefits of Interagency Collaboration



V. FINANCIAL RESOURCE MAP

T.C.A. 37-3-110 – 37-3-115 requires financial resource mapping for statewide System of Care (SOC) planning. 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. CCMH and Resource Mapping are required to collect this information on an annual basis. Mapping information for fiscal years (FY) 2006-2007 and 2007-2008 was presented in the July 2010 report. This report presents information from fiscal years 2008-2009, 2009-2010, and 2010-2011. Several tables and graphs detail funding for mental health and related services in the state.

Mental Health and Substance Abuse Resource Mapping Statewide Overview

Number of Agencies	10
Number of Data Records:	
FY 2008-2009 & FY 2009-2010	486
FY 2010-2011	347

Total Expenditures

FY 2008-2009	$547,636,900
FY 2009-2010	$537,576,621
FY 2010-2011	$418,450,500

Total Expenditures and Funding Source: Mental health and substance abuse services accounted for less than 7 percent of the total funding allocated to children in Tennessee in all three fiscal years, declining to less than 5 percent in FY 2010-2011. TennCare is the largest source of mental health and substance abuse expenditures for children, followed by the Department of Children's Services.

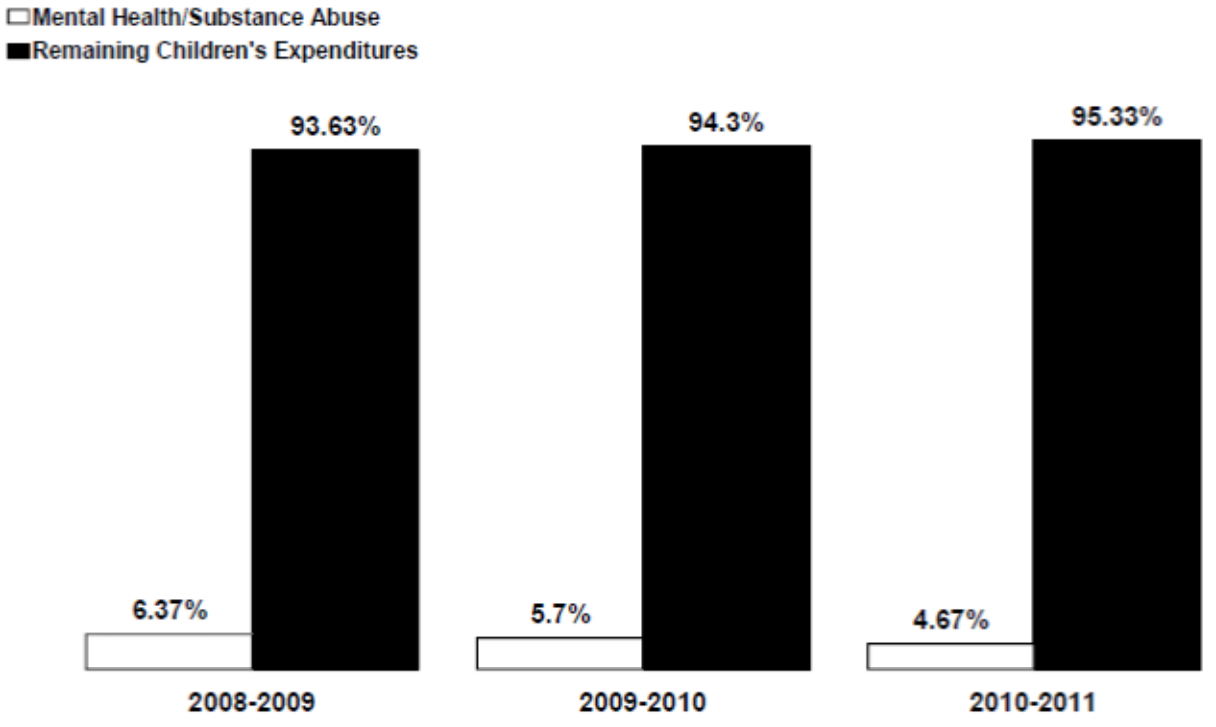
Percent of Mental Health Funding by Source

Fiscal Year	Federal	State
2008-2009	59%	41%
2009-2010	68%	32%
2010-2011	59%	41%

*Other expenditures account for less than 1 percent of the total.

Mental Health and Substance Abuse as a Percent of Total Expenditures for Children

FY 2008-2009, 2009-2010, and 2010-2011



Source: Tennessee Commission on Children and Youth. Remaining children's expenditures are all expeditures except mental health expenditures.

Mental Health and Substance Abuse Expenditures By State Agency By Funding Source
FY 2008-2009

State Agency	Federal Expenditures	State Expenditures	Other Expenditures	Total
Department of Children's Services	$66,155,706	$87,311,700	$702,900	$154,170,306
Department of Education	$5,186,910	$17,530,200	$100,000	$22,817,110
Department of Health	$753,100	$1,492,500	$24,900	$2,270,500
Dept. of Mental Health	$15,161,810	$23,181,761	-	$38,343,571
Department of Safety	-	$861,677	-	$861,677
Department of Transportation	$154,000	-	-	$154,000
Governor's Office of Children's Care Coordination	$797,900	$1,054,800	-	$1,852,700
Office of Criminal Justice Programs	-	$484,575	-	$484,575
TennCare	$232,218,518	$94,343,875	-	$326,562,393
Tennessee Commission on Children and Youth	$111,468	$8,600	-	$120,068
Grand Total	$320,539,411	$226,269,688	$827,800	$547,636,900

Source: Tennessee Commission on Children and Youth

Mental Health and Substance Abuse Expenditures By State Agency By Funding Source
FY 2009-2010

State Agency	Federal Expenditures	State Expenditures	Other Expenditures	Total
Department of Children's Services	$76,419,100	$67,798,600	$36,100	$144,253,800
Department of Education	$18,656,233	$3,513,200	-	$22,169,433
Department of Health	$655,400	$391,700	$9,400	$1,056,500
Dept. of Mental Health	$13,163,895	$12,325,036	-	$25,488,930
Department of Safety	-	$869,948	-	$869,948
Department of Transportation	$154,000	-	$15,000	$169,000
Governor's Office of Children's Care Coordination	$1,361,900	$1,403,084	-	$2,764,984
Office of Criminal Justice Programs	$100,000	$484,575	-	$584,575
TennCare	$255,255,709	$84,690,898	-	$339,946,607
Tennessee Commission on Children and Youth	$265,344	$7,500	-	$272,844
Grand Total	$366,031,581	$171,484,541	$60,500	$537,576,621

Source: Tennessee Commission on Children and Youth

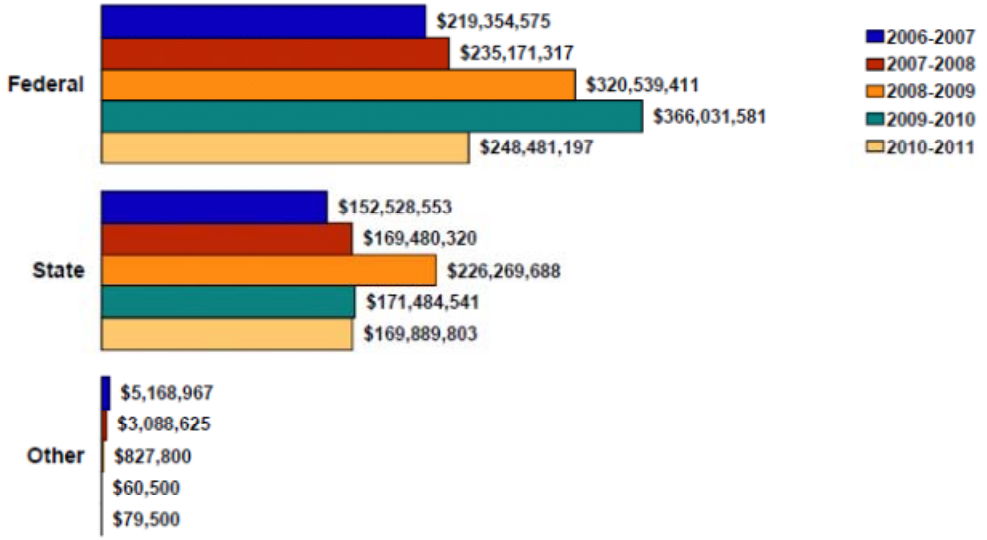
Mental Health and Substance Abuse Expenditures By State Agency By Funding Source
FY 2010-2011

State Agency	Federal Expenditures	State Expenditures	Other Expenditures	Total
Department of Children's Services	$68,164,500	$87,595,800	$78,400	$155,838,700
Department of Education	$13,457,000	$3,396,600	-	$16,853,600
Department of Health	$506,200	$227,500	$1,100	$734,800
Dept. of Mental Health	$11,883,711	$21,461,856	-	$33,345,568
Department of Safety	-	$859,529	-	$859,529
Department of Transportation	$74,000	-	-	$74,000
Governor's Office of Children's Care Coordination	$1,438,340	$1,474,472	-	$2,912,812
Office of Criminal Justice Programs	$81,651	$425,425	-	$507,076
TennCare	$152,321,153	$54,429,062	-	$206,750,215
Tennessee Commission on Children and Youth	$554,642	$19,558	-	$574,200
Grand Total	$248,481,197	$169,889,803	$79,500	$418,450,500

Source: Tennessee Commission on Children and Youth

Total Mental Health and Substance Abuse Expenditures by Source

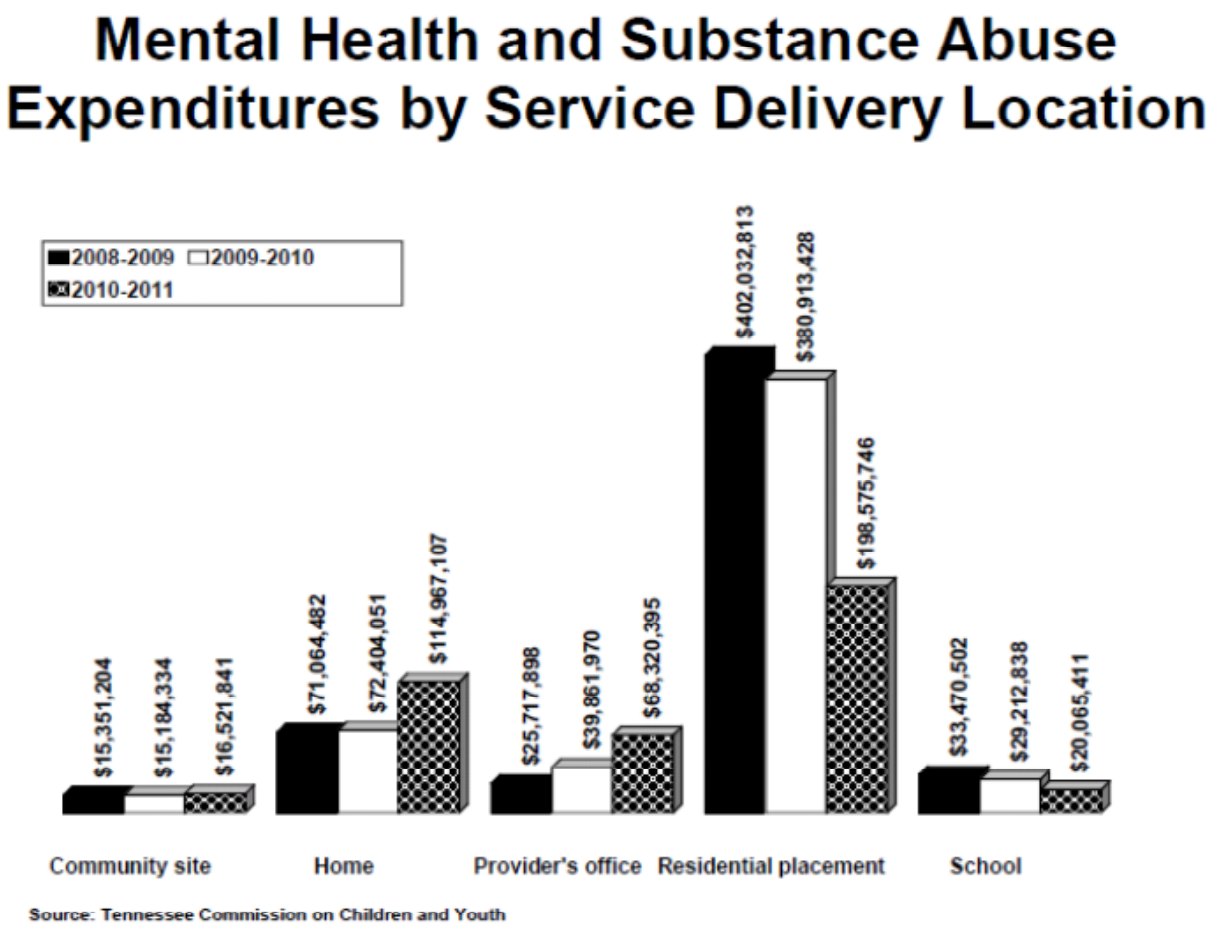
Fiscal Years 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011



Source: Tennessee Commission on Children and Youth Resource Mapping Project

Service Delivery Location: Residential placement accounted for 73 percent of funding in FY 2008-2009, 52 percent in FY 2009-2010 and 47 percent in FY 2010-2011. Funding expended on residential placement has continued to decline while expenditures for provider's office and home only incrementally increased. The majority of the decrease in residential placement funding from FY 2009-2010 to FY 2010-2011 can be attributed to reduced inpatient costs and funding allocation changes from a 23 hour service to a case rate service in TennCare. Twenty-three (23) hour service typically refers to an inpatient stay where any portion of a day is used but does not qualify for a complete day while a case rate service refers to a standard rate encompassing the type of service provided. While CCMH and SOC principles recommend least restrictive and in-home placements as the most effective service delivery location, due diligence should be exercised to ensure children with a clinical need for more restrictive inpatient services have those options available. Location options included:

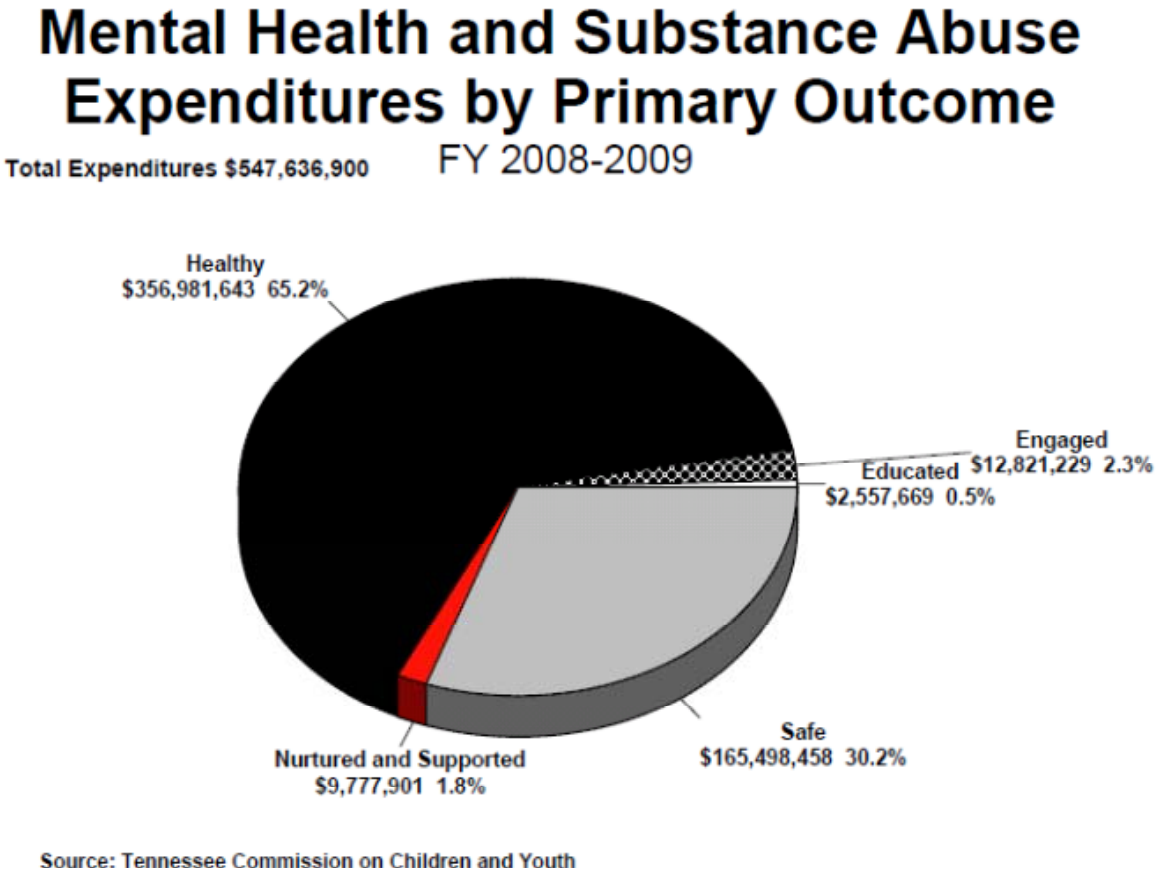
- Home;
- Community site;
- School;
- Provider's office; and
- Residential Placement.



**This data for expenditures by service delivery location is preliminary and still in the process of being reviewed for accuracy.*

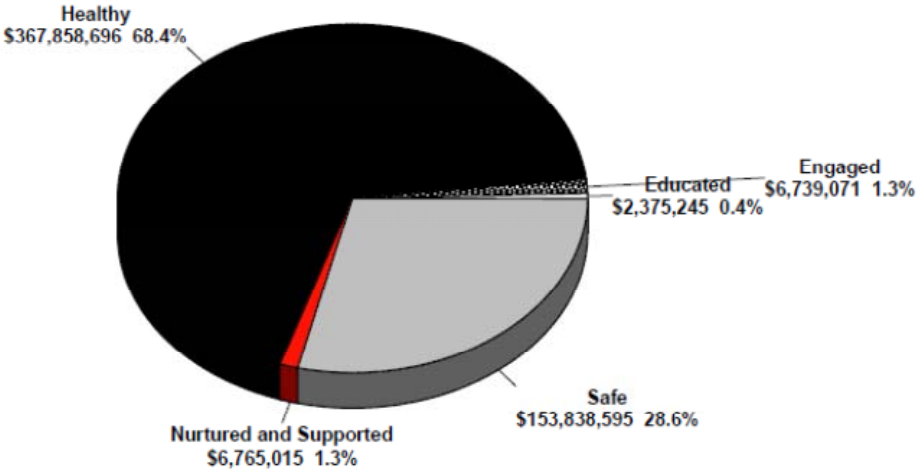
Primary Outcomes: Departments were asked to select one primary outcome area best capturing the intended outcome of the program. The five outcome area options included:

- 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); and
- Engaged (Examples: mentoring, after-school programs).



Mental Health and Substance Abuse Expenditures by Primary Outcome

Total Expenditures $537,576,621 FY 2009-2010

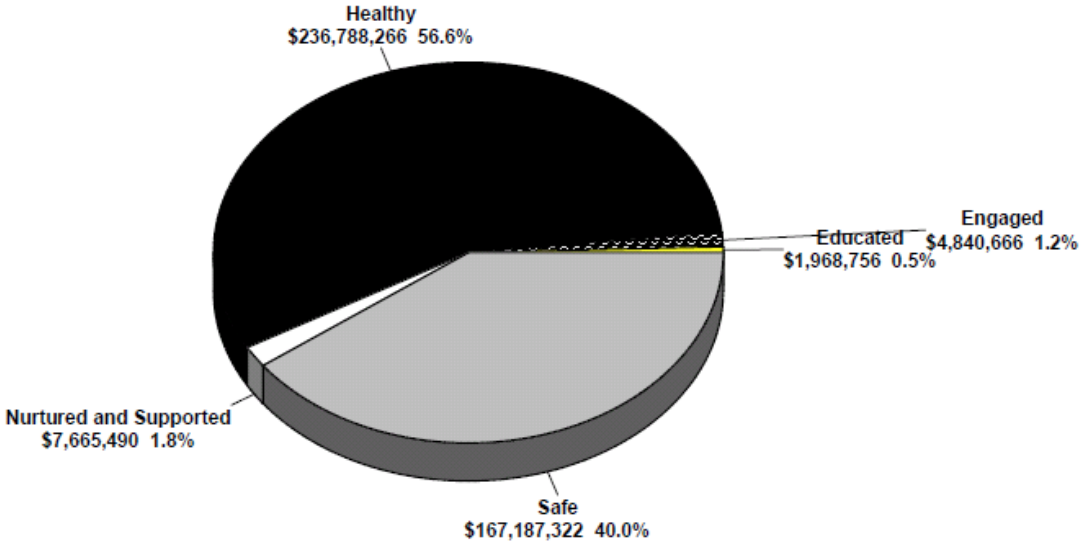


Source: Tennessee Commission on Children and Youth

Mental Health and Substance Abuse Expenditures by Primary Outcome

FY 2010-2011

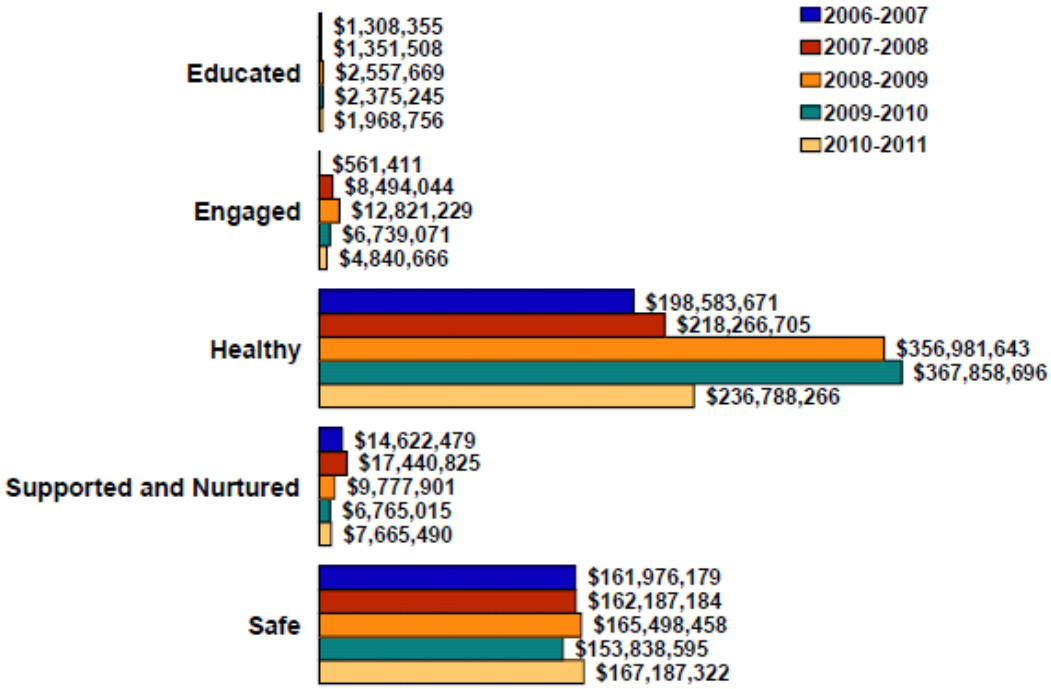
Total Expenditures $418,450,500



Source: Tennessee Commission on Children and Youth

Total Mental Health and Substance Abuse Funding by Outcome Area

Fiscal Years - 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011



Source: Tennessee Commission on Children and Youth Resource Mapping Project

***NOTE**: Several additional mental health related programs have been included in this report that were not included in the prior reporting of Fiscal Years 2006-2007 and 2007-2008. In continuing to analyze the resource mapping information and receiving updated descriptive information in later years of collection, several programs were identified as mental health related and included in this report to be as comprehensive as possible. For comparison purposes, these programs were then included in the FY 2006-2007 and 2007-2008 data and then reconfigured in this report. This explains any difference in the data reported in the July 2010 Report.*

Inventory of Funds: Tennessee has historically relied 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, the majority of funding was 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 receive certain federal grants, including System of Care (SOC) Grants.

TDMHSAS has consistently and successfully submitted proposals for multi-year funding to implement SOC initiatives across the state as well as youth suicide prevention projects. TMDHSAS partnering with the Administrative Office of the Courts also received a Tennessee Integrated Court Screening and Mental Health Referral Project grant from the Federal Department of Justice.

VI. 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 SOC begins with open collaboration crosscutting departments, agencies, projects and initiatives.

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

Statutorily-related Considerations

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 support. 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, TAMHO and others. The first full Resource Mapping report was submitted to the General Assembly on April 15, 2010. Updated reports were submitted by April 15, 2011 and 2012.

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 with the Resource Mapping Advisory Group in order to avoid duplication, ensure 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. 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 sites for SOC locations. For example, the Maury County CAB served as a community wide local governance group for the Mule Town Family Network. Of note is DCS' newly implemented *In Home Tennessee* initiative, which is working to expand the network of consistently available services within the community for children at risk of being placed into state custody.

T.C.A. 37-5-121—Juvenile Justice (JJ) Evidence Based Practice (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 percent of JJ funds are to support EBP programs by FY 2010; 50 percent by FY 2011; 75 percent by FY 2012; and 100 percent 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 SOC to improve access to and coordination of services, the infrastructure 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 SOC.

T.C.A. 68-1-125—Home Visitation EBP: This law requires the Department of Health to ensure a certain percentage of funding for in-home visitation services are used for evidence-based models. In-home visitation refers to a service delivery strategy that is carried out in the homes of families of children from conception to school age providing culturally sensitive face-to-face visits by professional to promote positive parenting practices, enhance the social-emotional and cognitive development of children, improve the health of the family, and empower families to be self-sufficient. Implementation is staggered: 50 percent of in-home visitation funds are to support EBP programs during FY 2013 and 75 percent by FY 2014 and each fiscal year thereafter.

Relevance to CCMH: Implementation and expansion of use of EBPs are fundamental to the design of statewide SOC. These programs serve to reduce child abuse and other toxic stress leading to adverse trauma on an infant or child. CCMH recognizes the need to ensure the early development of the brain architecture is healthy and free from trauma and toxic stress.

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

Best Practice Guidelines: Behavioral Health Services for Children and Adolescents: TDMHSAS is currently in the process of updating and expanding its best practice guidelines for behavioral health services for children and adolescents. The last revision in July 2008 included a section on Interagency Children's SOC. This section includes information on the department's promotion SOC core values and guiding principles. During the current process of revision, the CCMH Director has been asked to participate in the drafting of the best practice guidelines and specifically to update the SOC section in reference to the Council's work. These guidelines intend to:

- Promote high quality care for children and adolescents served by Tennessee's public health system;
- Promote continuity of care through establishment of uniform treatment options and the best use of multidisciplinary treatment resources; and
- Aid in identification, evaluation, and provision of effective treatment for youth with severe mental illness and or severe emotional disorders.

Relevance to CCMH: The overall purpose of the Council on Children's Mental Health is to expand SOC statewide. These guidelines are intended for use by all healthcare practitioners, physical and behavioral, in the state. By including CCMH and SOC in the guidelines, it further serves as an opportunity to encourage and inform practitioners of the benefits and availability of collaboration and coordination as a best practice for serving children and youth with SED and their families.

Centers of Excellence (COE) for Children in State Custody: The COEs funded through the Department of Children's Services 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 of custody. The Centers of Excellence currently exist at East Tennessee State University (Johnson City), University of Tennessee Knoxville Cherokee Health Systems, University of Tennessee – Health Science Center Boiling Center (Memphis), Southeast (Chattanooga) 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, developmental and intellectual disability 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, and 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.

Relevance to CCMH: The CANS project represents successful statewide implementation of a strengths-based service-planning tool consistent with the goals of SOC. 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. Further, MCOs are about to implement CANS to inform Utilization Management authorizations and re-authorizations for intensive home-based behavioral services (Comprehensive Treatment Team (CTT) and Comprehensive Child and Family Treatment (CCFT) services).

- **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, including the Executive Director of the Tennessee Chapter of Children's Advocacy Centers and the Director of Public Policy for Tennessee Association of Mental Health Organizations (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, Tennessee Voices for Children, TCCY and TDMHSAS. The Planning Committee includes representatives from the COEs, Children's Advocacy Centers, and TAMHO. Over 600 practitioners in Tennessee have been trained in TF-CBT through the learning collaborative. To build on this success, the COE Best Practices Collaborative has developed the ARC Learning Collaborative to train community mental health providers in the ARC model (Attachment, Self-Regulation and Competence) to further develop trauma responsive systems for children. ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their caregivers, while recognizing that a one-size-model does not fit all. ARC is designed for youth from early childhood to adolescence and their caregivers or caregiving systems.

Relevance to CCMH: The COEs provide unique, essential services for the state, primarily laying the groundwork of translating science into service, 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 service 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. 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 SOC 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 SOC to be adopted when the CCMH develops implementation guidelines.

Early Childhood Advisory Council (ECAC): An interdepartmental effort of Children's Cabinet and other identified early childhood stakeholders, the ECAC is a federal grant project awarded to the state in 2010. The ECAC seeks to align and enhance existing statewide early childhood system of care and education for children ages birth through five years, which promotes school readiness; through a two-step process, conduct a statewide needs assessment identifying the availability of services and defines indicators of the quality of early childhood education opportunities for children ages birth to five years, and how providers of related state services interact with each other at the local level; enhance collaboration and coordination across state departments specifically in the areas of training for early childhood educators and providers, and parent engagement, training and empowerment; and develop recommendations regarding the sharing of appropriate child data across state departments and regarding establishment of a unified data collection system.

Relevance to CCMH: The ECAC seeks to increase coordination and collaboration among early childhood providers and enhance the existing statewide early childhood system of care and education. The Council is working to coordinate services related to children's mental health including infant and early childhood services.

School-Based Mental Health Services: Providing mental health services in school settings has been shown to be effective in addressing the needs of children and youth and enhancing continuity of services. Education, often the one constant in every child's life, offers an opportune setting for case management, group and individual therapy, and behavioral support for children, parents and teachers. 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 resources and programs for helping children with social, emotional and behavioral health needs. Nearly half the students served have been TennCare eligible. The Northeast region has received four grants over the period of time funding has been available. These grants have resulted in demonstrated outcomes and sustainability of certain projects.
3. A third school-based program found to be effective in the first federal SOC site is being piloted on a limited basis by TDMHSAS across the state. Through a partnership with the Department of Education, School Based Mental Health Liaisons hired by community mental health centers serve at risk children/youth in middle and high schools, work with teachers/principals to improve the classroom/school environment to better address behavioral health need in students, 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 received training and technical assistance to create a seamless System of Care among schools, mental health providers and juvenile justice staff.

Relevance to CCMH: In July 2009, the State Board of Education recommended mental health guidelines for Local Education Authorities (LEAs) 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 Tennessee Voices for Children with both state (TDMHSAS) 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, as well as numerous trained parents who assist with support groups and other family support activities. 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 and system topics, and facilitation of effective relationships between parents and providers. Staff participates in over 150 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. Training is also provided to professionals, community members and agency personnel statewide to encourage family engagement and understanding of parent perspectives. SFSN staff has been integrally involved in each of the SOC sites funded in Tennessee as family representatives and trainers.

Relevance to CCMH: Meaningful engagement of parents and caregivers is critical to transforming the children's mental health 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 Infant and Early Childhood Mental Health Initiative: This initiative is a network of volunteer early childhood professionals, experts, family members, and state agency partners organized and facilitated by the Centers for Excellence (COEs). The task of the initiative is to bring together individuals and agencies interested in infant and early childhood mental health to develop relationships across departments and agencies, identify existing resources and opportunities, and address the mental health needs of infants, young children, and their families.

Relevance to CCMH: Prevention and early intervention are key aspects of SOC work. With early identification of potential social emotional concerns, treatment is less expensive and outcomes are overwhelmingly positive. The Council is currently working with the initiative to ensure the needs of the population are included in a statewide SOC.

Tennessee Integrated Court Screening and Referral Project: TDMHSAS, in partnership with the Administrative Office of the Courts, Vanderbilt University Center 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 serves eight 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 required detention hearing (T.C.A. 37-1-114), provides results of the instrument to the court at the hearing, and facilitates referral of identified children and youth to community-based services if appropriate. Four of the identified counties are also 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. SOC 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 Youth in Action (YIA) Councils across the state, two YIA Councils are currently connected with SAMHSA SOC sites in Tennessee (K-Town and South Central System of Care), and two YIA Councils are supported through the SFSN. 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. TVC is also the site for the statewide Youth M.O.V.E. Chapter.

The Urban Youth Initiative in Memphis provides support for a local youth council and youth activities through the JustCare Family Network and has plans to become a local Youth M.O.V.E. chapter, connecting these local efforts to the national youth movement in Systems of Care.

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.

Relevance to CCMH: Youth are currently represented on the CCMH from several of these youth groups, bolstering the work of the Council. Youth input in the development of SOC is required by T.C.A. 37-3-110 – 37-3-115 as well as in the SOC 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 CCMH, 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 2012 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 through an administration change, as evidenced by nine meetings since the prior report, with an average attendance of 52 persons from all across the state.

2. Identified the CANS as a universal service planning tool and, in principle, CCMH members support the use of the CANS across departments and agencies.
3. Developed a Steering Committee to more efficiently provide governance for the CCMH.

The CCMH is prepared to move ahead in design of a statewide SOC 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 2012 Report Document Group 1: Tables

Table 1: Summary of Council Agendas, Purposes and Outcomes

CCMH Meetings

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 15 10/21/10 10:00 A.M.-3:00 P.M	TCCY Children and Youth Budget Recommendations	Provide the Council with an overview of the budget recommendations made to the Governor by TCCY --Linda O'Neal, TCCY
	Feedback to the July 2010 Report	Update the Council on responses to the Council's report submitted in June 2010 --Freida Outlaw, TDMHSAS --Dustin Keller, TCCY
	Georgetown Training Institutes Update	Update the Council on the recent system of care training institutes attended by several Council members --Attendees
	TAMHO Technical Assistance Meeting from Indiana	Inform the Council about TAMHO's recent meeting with representatives from system of care initiative in Indiana --Michelle Covington, Centerstone
	Mule Town Proposed Financial Infrastructure Model for Sustainability	Describe Mule Town current proposal for sustainability following the end of their federally funded project --E. Ann Ingram, Centerstone --Shawn Brooks, Centerstone --Freida Outlaw, TDMHSAS
	Recent Grant Awards to Tennessee	Provide an overview of several recent grant awards to the state --Freida Outlaw, TDMHSAS --Mary Rolando, GOCCC
	Overview of Research on Home-Based Services (CTT-CCFT)	Inform about GOCCC's work on defining and understanding current home-based services provided in Tennessee --Mary Rolando, GOCCC
	CCMH By-Laws Discussion	Discuss the work of the workgroup drafting By-Laws for CCMH --Dustin Keller, TCCY

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 16 2/17/11 10:00 A.M.-3:00 P.M	Children's Mental Health: Where We Have Been and Where We Are Going	Provide an overview of children's mental health initiatives in the state --Virginia Trotter Betts, TDMHSAS --Doug Varney, TDMHSAS
	Coordinated School Health	Update the Council on Coordinated School Health --Sara Smith, DOE --Tammy Oliver, Lebanon Special Schools
	Overview of Quality Service Review (QSR) Process	Inform about the process evaluating DCS's adherence to the practice wheel --Frank Mix, DCS --Pat Wade, TCCY
	Mule Town Evaluation Project	Describe an evaluation project at Mule Town involving youth in the process --James Martin, TVC --Antonette Hatton --Stephanie House --Hannah Boyd --Deterrius McClain --Hailey Boyd
	Legislative Overview and Update	Report about related children and youth legislation and provide an update on the Council's sunset legislation --Steve Petty, TCCY --Kurt Hippel, TDMHSAS
	Family and Youth Engagement Discussion	Discuss methods of increasing participation of youth and families in CCMH --Kathy Rodgers, TVC
	CCMH By-Laws Update and Workgroups Next Steps Planning	Provide an update on drafting By-Laws for CCMH and next steps for the workgroups --Dustin Keller, TCCY

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 17 4/21/11 10:00 A.M.-3:00 P.M	Legislative Overview and Update	Report about related children and youth legislation and provide an update on the Council's sunset legislation --Linda O'Neal, TCCY
	Overview of Fiscal Year 2012 Budget	Provide a recent update on the state's budget and funding restored to mental health programs --Representatives of Child-Serving Departments
	System of Care Grant Opportunity	Discuss a recent grant announcement from SAMHSA for planning statewide expansion of SOC --Susan Steckel, TDMHSAS --Dustin Keller, TCCY
	Community Mental Health Budget Impact	Provide an overview of the potential impact of the proposed budget on community mental health providers --Vickie Hardin, Volunteer Behavioral Health Care Systems --John Page, Centerstone --Ellyn Wilbur, TAMHO
	Tennessee Lives Count Project	Update on the second statewide youth suicide prevention project focused on juvenile justice --Lygia Williams, TDMHSAS --Jason Padget, MHAMT
	Children's Mental Health Day Overview	Discuss participants' events planned in recognition of Children's Mental Health Day --Sonya Beasley Facilitating, Centerstone
	Lead Family Contact Training	Inform about a recent training the SOC Initiatives attended to better understand the role of the Lead Family Contact --Susan Steckel, TDMHSAS
	CCMH By-Laws Update and Workgroups Next Steps Planning	Provide an update on drafting By-Laws for CCMH and next steps for the workgroups --Dustin Keller, TCCY

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 18 6/16/11 10:00 A.M.-3:00 P.M	Planning Next Steps Process	Provide an overview of the process used by the workgroup co-chairs to draft a next steps document for CCMH --Dustin Keller, TCCY
	Overview of Statewide Expansion Planning Grant Application	Inform about the planning grant application submitted in May 2011 --Susan Steckel, TDMHSAS --Dustin Keller, TCCY
	Moving SOC Forward	Provide a framework for the work in preparing the plan --Mary Rolando, GOCCC
	Workgroup Next Steps Document Overview and Cafe	Allow committees to discuss the provided framework
	Regional Intervention Program	Update about the RIP program funded by TDMH --Alysia Williams, Volunteer Behavioral Health Care Systems --Scott O'Neal, Parent/TDMHSAS
	Family-Driven Care	Provide training around family-driven care --Shani Cutler, TVC
	Legislative Update	Report about related children and youth legislation and provide an update on the Council's sunset legislation --Linda O'Neal, TCCY

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 19 8/25/11 10:00 A.M.-3:00 P.M	Tennessee Teen Institute	Inform Members about activities related to the recent Tennessee Teen Institute --Giovonnt'e Baker, Youth
	Infant and Childhood Mental Health Overview	Provide an overview of infant and childhood mental health and related activities occurring in the state --Mindy Kronenberg, private practice
	Workgroup Meeting Cafe	Allow members to participate in two committee meetings
	System of Care Community Training: Expanding Systems of Care (Chicago)	Inform about a recent training regarding expanding systems of care --Susan Steckel, TDMHSAS
	Budget Recommendations	Provide an overview of the budget recommendations made to the Governor by TCCY --Linda O'Neal, TCCY

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 20 10/19/11 Committee Meetings: 10:00 A.M.-11:30 A.M CCMH: 11:30 A.M.-3:00 P.M.	Workgroup Reports	Allow workgroups to discuss business prior to the start of the general meeting --Workgroup Co-Chairs
	Departmental Updates	Provide a recent update on related departmental programs --Representatives of Child-Serving Departments
	Managed Care Organization (MCO) Updates	Provide a recent update on MCOs' children's mental health programs --Representatives of MCOs

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 21 12/8/11 Committee Meetings: 10:00 A.M.-11:30 A.M CCMH: 11:30 A.M.-3:00 P.M.	Workgroup Reports	Allow workgroups to discuss business prior to the start of the general meeting --Workgroup Co-Chairs
	Statewide Planning Grant for Children and Youth with Autism Overview	Inform about a recent grant award to Tennessee related to a system of care approach to children and youth with autism --Carol Westlake, Tennessee Disability Coalition
	TennCare HEDIS Data Presentation	Provide recent Healthcare Effectiveness Data Information System (HEDIS) results --Jeanne James, TennCare
	Early Connections Network (ECN) Community Connections Overview	Report about a recent community event to begin ECN in Northwest Middle Tennessee --Susan Steckel, TDMHSAS
	ECN Needs and Strengths Assessment Report	Provide an overview of the needs and strengths assessment report created for ECN --Sarah Suiter, Centerstone Research Institute
	Tennessee Lives Count III Overview	Update on the third statewide youth suicide prevention project focused on emergency rooms, colleges, postvention, and specialized follow up --Lygia Williams, TDMHSAS

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 22 2/23/12 Committee Meetings: 10:00 A.M.-11:30 A.M CCMH: 11:30 A.M.-3:00 P.M.	Workgroup Reports	Allow workgroups to discuss business prior to the start of the general meeting --Workgroup Co-Chairs
	Department Budget Update	Provide a recent update on the state's budget and funding of mental health programs --Representatives of Child-Serving Departments
	Tennessee Court Integrated Screening and Referral Project (TCISRP)	Discuss preliminary findings from the TCISRP related to the use of CANS in selected juvenile courts --Jeff Feix, TDMHSAS
	Attachment, Self-Regulation and Competency (ARC)	Update on a new training program being used by the Centers for Excellence --Jon Ebert, Vanderbilt
	Legislative Update	Report about related children and youth legislation --Steve Petty, TCCY

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 23 4/19/12 Committee Meetings: 10:00 A.M.-11:30 A.M CCMH: 11:30 A.M.-3:00 P.M.	Workgroup Reports	Allow workgroups to discuss business prior to the start of the general meeting --Workgroup Co-Chairs
	Draft Report Outline Discussion	Provide an overview of the draft July 2012 report outline and discuss information needed --Dustin Keller, TCCY
	Structured Feedback Discussion of Report Items	Discuss targeted items for the July 2012 report --Dustin Keller, TCCY
	Legislative Update	Report about related children and youth legislation --Steve Petty, TCCY

Table 2: Summary of Steering Committee and Workgroup Co-Chair Agendas, Purposes and Outcomes

Steering Committee and Workgroup Co-Chair Meetings

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 5 7/26/10 11:00 A.M.-12:00 Noon Steering Committee	Discussion of Report Feedback	Review feedback received about CCMH's July 2010 report
	CCMH Structure and Governance Discussion (By-Laws)	Ascertain if by-laws are needed and should be drafted for CCMH
	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 6 11/29/10 2:00 P.M.-3:00 P.M. Steering Committee	Discussion of Draft By-Laws	Discuss a first draft of possible by-laws for CCMH
	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
	Dates for Next CCMH and Steering Committee Meeting	Provide Dates for 2011 CCMH meetings and steering committee meetings

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 7 6/13/11 10:30 A.M.-3:30 P.M. Workgroup Co-Chair Retreat	Here and Now	Review progress of CCMH and previous structure used to reach the July 2010 report
	Overview of Statewide Expansion Planning Grant Application	Inform about the planning grant application submitted in May 2011
	Moving SOC Forward	Provide a framework for the work in preparing the next plan
	Group Brainstorm and Discussion	Discuss the overarching goals and needs of CCMH, System of Care, and moving forward
	Workgroup Cafe	Develop the outcomes and goals of the reconstituted workgroups
	Individual Planning Time	Allow Co-chairs time to discuss and consolidate the work of the cafe as it relates to their workgroup
	Chair Reports	Report of each workgroups final draft goals and outcomes
	Workgroup Next Steps	Create the workgroup next steps document and discuss structure of next CCMH meeting.

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 8 10/4/11 10:00 A.M.-11:30 A.M. Steering Committee	Dates for Next Steering Committee Meeting and December CCMH Meeting	Decide on dates for the next steering committee meeting and if the Council should meet in December
	Review of Steering Committee Purpose and Membership	Provide an overview of why the committee was created and who serves on the committee
	Workgroup Discussions, Progress and Next Steps	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 9 4/13/12 9:00 A.M.-12:00 Noon Workgroup Co-Chairs	Overview of Timeline and Requirements	Review the next steps document and the timeline needed to reach the July 2012 report submission
	Review of July 2010 Report	Provide an overview of the previous report outline and items included
	Discussion of Possible Outline Items for July 2012 Report	Discuss possible items for the July 2012 report and what is needed from each committee
	Group Brainstorm and Discussion of Key Items	Decide on possible major recommendations and plans for July 2012 report
	Chair Reports	Inform others about the work of each individual workgroups and their needs
	Workgroup Next Steps for Report	Review timelines and types of reports and items needed from workgroups

Table 3: CCMH Workgroup Structure and Next Steps

STEERING COMMITTEE			
Objective	**Interfaces with Other Groups**	**Products or Outcomes**	**PLANNING UNIT PRODUCTS**
Guidance and oversight for CCMH; serves as a gateway for ideas from WG to CCMH; coordinates and creates the working agenda; and articulates the group's vision.	All workgroups; Governor's subcabinet groups; TDMH Policy and Planning Councils; TCCY Regional Councils; serves as Ambassadors to other groups	Required reports; statewide plan; agendas; develops and proposes by-laws and CCMH governance structure.	• July 2012 Report to the Legislature

I. ADMINISTRATION AND FINANCING UNIT			
Work Group	**Objective**	**Interfaces with Other Groups/Activities**	**Products or Outcomes**
Collaboration and Adoption	Facilitate statewide adoption of SOC values and principles; Adopt common policies, MOUs, etc. supporting SOC values and principles; assist in the creation of a statewide vision for SOC	All WGs; local and state groups for educational purposes; CABs; SOC Sites; Other states; General Assembly	Adoption of effective SOC strategies and approaches; development of a standard policy and practice language for SOC implementation; disseminate vision of statewide SOC and be involved in education opportunities on SOC; adoption of SOC values/principles in statue and contracts
MIS & Accountability	Determine specific datasets for SOC for overall management and limiting agency costs in revamping existing data system; data sharing agreements among local SOC entities; site comparison to evaluate model effectiveness (include lessons learned, strengths/weaknesses of models, etc.); overall data storing and analysis with interface across systems	All WGs; individuals, Departments and agencies; all groups needing data or needing evaluation tools	Data-sharing agreements; MOUs; mapped outcomes/results; mapped needs; track costs; provides substantial cost reductions by improving system effectiveness
Financing Strategies and Resource Development	Cost benefit analysis of SOC; local resource mapping; redirection of funds based on SOC savings; establish payer of last resort; reinvestment strategies for use at local level; determine resources for non-traditional services	All WGs; meetings to engage funding or resource managers; Children's Resource Mapping; CABs; other states	Financial benefits overview document; Identification of local resources; services are enhanced/ increased as funding is reinvested; creates a seamless delivery system (w/ and w/o insurance); ensures all families have equal access to SOC; bring community funding sources together using the payer of last resort.

II. SERVICES AND SUPPORTS UNIT			
Work Group	**Objective**	**Interfaces with Other Groups/Activities**	**Products or Outcomes**
Service Capacity and Readiness	Ensure all SOC services meet established SOC policies and practices; determine service capacity at local level, including gaps in services; develop plans for service enhancement and expansions; ensure services provided meet the needs of families and respond to cultural aspects of each community; assess readiness of community to develop SOC	Financial strategies and resource development; Community Advisory Boards (CABs)	Localize service array and resource map to determine unmet community needs and services; toolkit to develop structure for local SOC; readiness assessment (local and state levels); community capacity map/directory; adoption of most effective SOC strategies and approaches
Community Outreach and Awareness	Inform community/state about SOC values, principles, efficacy and cost benefits; provide statewide training on local implementation and operationalization of SOC values and principles; local identification of particular goals/objectives and cultural identification; effectively engage communities in SOC	Social media (facebook, twitter, etc.); informal peer support groups; networking opportunities between SOC entities; and financing strategies WG	SOC toolkit for implementation; training/ materials on SOC related topics and approaches; speakers' bureau including families, youth and providers; curriculum for providers, funding/resource mapping; social media groups for people to join; statewide SOC brand; policies developed by agencies for SOC participation; and family examples of SOC success
Cultural Linguistic Competency Advisory Group	Ensure CLC in process; CLC should always be occurring; have input into training and education	All WGs and CLC Coordinators of SOC Initiatives	All work products get reviewed or addressed through CLC; CLC Toolkit
Youth and Family Engagement / Advisory Group	Recruit and engage families and youth in the design, development, and implementation of SOC; educate stakeholders, providers, and communities on family-driven, youth-guided approaches and involvement at all levels; use family members to hold the SOC accountable.	A part of all WGs; involved in all trainings for CCMH	Family/youth engaged in all levels of care and providing feedback on implementation strategies; policy changes or development promoting the use of individualized , strengths-based, family-driven, and youth-guided strategies; all CCMH participants will facilitate family and youth engagement on CCMH; and manual of how to work with SOC

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 2012 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	31%	20.7%	13.8%	31%	3.4%	2.55
Lack of integrated information systems	3.1%	9.4%	28.1%	15.6%	43.8%	3.88
Overcoming administrative & provider territoriality	6.7%	16.7%	26.7%	23.3%	26.7%	3.47
Poor historical relationships among those expected to be partners	32.4%	29.4%	11.8%	14.7%	11.8%	2.44
Quantifying the amount of resources & effort related to positive outcomes	23.5%	20.6%	23.5%	20.6%	11.8%	2.76

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%	38.7%	19.4%	6.5%	0.0%	6.5%	2.29
Lack uniform eligibility criteria to enter SOC	17.6%	17.6%	26.5%	14.7%	11.8%	11.8%	3.21
Inadequate youth/parental engagement	21.9%	15.6%	25%	15.6%	12.5%	9.4%	3.09
Inability to track outcomes	12.1%	0.0%	18.2%	27.3%	27.3%	15.2%	4.03
Difficulty implementing Evidence-Based Practices	11.8%	20.6%	14.7%	29.4%	14.7%	8.8%	3.41
Limited number and array of services	6.1%	9.1%	3.0%	9.1%	33.3%	39.4%	4.73

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	12.9%	19.4%	29%	12.9%	25.8%	3.19
Lack of uniform service eligibility criteria statewide	18.2%	30.3%	18.2%	30.3%	3.0%	2.70
Inadequate cross-agency coordination about children's mental health	12.5%	15.6%	15.6%	18.8%	37.3%	3.53
Inadequate transition to adult mental	14.3%	17.1%	17.1%	22.9%	28.6%	3.53

health services						
Differing federal & state confidentiality rules among departments/agencies	36.4%	18.2%	24.2%	12.1%	9.1%	2.39

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	9.1%	24.2%	3%	21.2%	21.2%	15.2%	6.1%	3.91
Achieving commitment/buy-in by state agencies, local communities and providers	9.1%	3.0%	9.1%	9.1%	12.1%	30.3%	27.3%	5.12
Historical relations among agencies	15.2%	12.1%	24.2%	15.2%	15.2%	9.1%	9.1%	3.67
Sustainability of SOC	2.9%	2.9%	11.8%	14.7%	11.8%	14.7%	41.2%	5.38
Transition to strengths-based service planning	29.4%	11.8%	20.6%	17.6%	11.8%	8.8%	0.0%	2.97
Lack of workforce development/qualified staff	12.1%	21.2%	18.2%	18.2%	18.2%	9.1%	3.0%	3.48
Educating/engaging community	17.6%	23.5%	11.8%	5.9%	11.8%	11.8%	17.6%	3.76

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.	17.6%	14.7%	11.8%	8.8%	8.8%	2.9%	23.5%	11.8%	4.3
Joint planning among all child-serving agencies	3.1%	9.4%	12.5%	6.3%	12.5%	18.8%	21.9%	15.6%	5.3
Clear SOC governance structures	16.1%	16.1%	25.8%	12.9%	3.2%	6.5%	12.9%	6.5%	3.7
Memoranda of Understanding among agencies	15.6%	12.5%	9.4%	18.8%	9.4%	15.6%	12.5%	6.3%	4.2
Shared information systems among agencies	6.1%	9.1%	3.0%	21.2%	21.2%	18.2%	15.2%	6.1%	4.8
Fiscal accountability among agencies	16.7%	13.3%	23.3%	10.0%	13.3%	16.7%	6.7%	0.0%	3.6
Collaborative funding	3.1%	6.3%	9.4%	12.5%	21.9%	12.5%	3.1%	31.3%	5.5
Economies of scale, i.e., # of enrollees justifies cost of system	23.5%	20.6%	2.9%	11.8%	11.8%	11.8%	11.8%	14.7%	3.8

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?	19	16
Were you in a leadership role in the SOC?	16	14
Did you experience effective communication w/ other participants?	20	8
Did all participants contribute resources (time and expertise) to the SOC amicably?	15	13
In your opinion, did services to families improve?	19	9

SOC INTERAGENCY COLLABORATION SURVEY 2012

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 is committed to the development of a System of Care for children in Tennessee.	100%
My agency understands the goal of the Council on Children's Mental Health.	100%
My agency regularly receives information regarding the progress of the Council on Children's Mental Health.	98%
My agency understands the goals of the Council on Children's Mental Health work groups.	95%
My agency is actively participating in at least one Council on Children's Mental Health work group.	89%
My agency has consistent, high-level participation in the Council on Children's Mental Health.	86%
My agency understands its role in the Council on Children's Mental Health.	86%
Members of the Council on Children's Mental Health have a shared definition of evidence-based services.	83%
My agency's "voice" is heard as a part of the Council on Children's Mental Health.	83%
The Council on Children's Mental Health has a plan for the provision of culturally and linguistically competent services to children and their families.	83%
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.	83%
My agency involves families and youth in the development of policy, practice standards and outreach efforts.	81%
The Council on Children's Mental Health has clear structure and policies in place to organize and guide its work.	80%
The Council on Children's Mental Health has the right membership at the table to meet its goals.	78%
Family voices are represented in the Council on Children's Mental Health.	77%
My agency regularly partners with other child-serving state and community-based agencies on funding opportunities.	75%
All appropriate child-serving agencies are represented in the Council on Children's Mental Health.	72%
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.	72%
My agency is easily able to share data and information across systems on a routine basis.	67%