STATE OF TENNESSEE
COUNCIL ON CHILDREN'S MENTAL HEALTH
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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, 2013

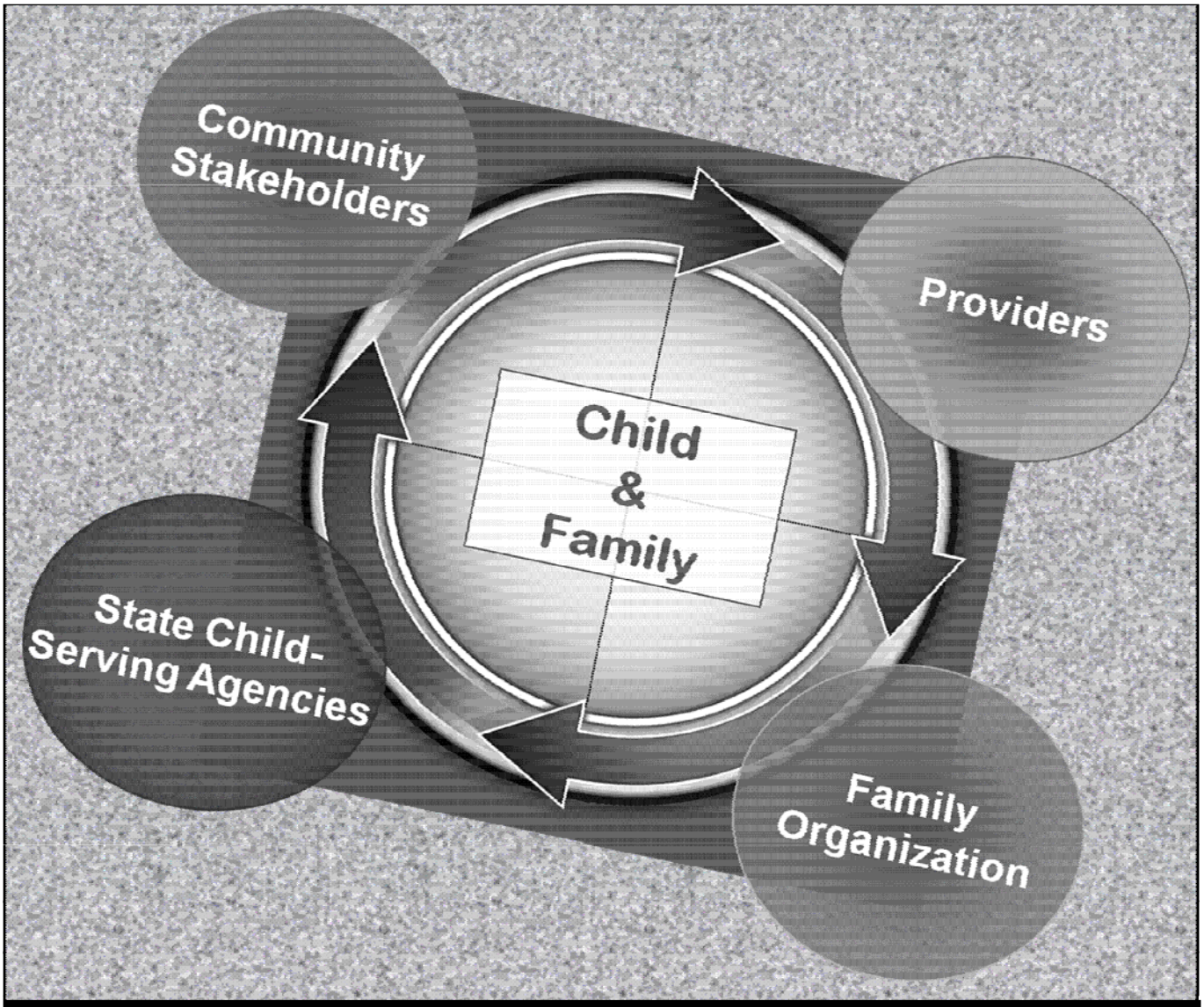
RE: Council on Children's Mental Health July 2013 Report

This memorandum transmits the July 2013 Report of the Council on Children's Mental Health as required by T.C.A. 37-3-115. We have co-chaired a Council on Children's Mental Health composed of stakeholders from all across Tennessee who have met and exceeded the statutory requirements for membership and have come together without compensation and largely without reimbursement for travel.

Council members have worked diligently to develop this July 2013 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. Meetings have an averaged attendance of 50.

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 Administration and the General Assembly in improving mental health services for children in Tennessee.

cc: Council on Children's Mental Health Members



Council on Children's Mental Health

A Report to the Legislature

July 2013

Council Co-Chairs:

E. Douglas Varney
Commissioner
Department of Mental Health and Substance Abuse Services

Linda O'Neal
Executive Director
Tennessee Commission on Children and Youth

Tennessee Commission on Children and Youth authorization number 316098. July 2013. 300 copies. This public document was promulgated at a cost of $2.70 each.

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COUNCIL ON CHILDREN'S MENTAL HEALTH

JULY 2013 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 school achievement, solid workforce skills, and becoming strong citizens. When we ensure the healthy development of the next generation, they will pay that back through productivity and responsible citizenship.

Scientists say children's mental health affects how they socialize, how they learn, and how well they meet their potential. One way to think about child mental health is that it's like the levelness of a piece of furniture, say, a table. The levelness of a table is what makes it usable and able to function, just like the mental health of a child is what enables him or her to function and do many things. Some children's brains develop on floors that are level. This is like saying that the children have healthy supportive relationships, access to things like good nutrition and health care. For other children, their brains develop on more sloped or slanted floors. This means they're exposed to abuse or violence, have unreliable or unsupportive relationships, and don't have access to key programs and resources. Remember that tables can't make themselves level — they need attention from experts who understand levelness and stability and who can work on the table, the floor, or even both. We know that it's important to work on the floors and the tables early, because little wobbles early on tend to become big wobbles later. So, in general, a child's mental health is like the stability and levelness of a table.

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 to the Legislature by July 1, 2013 a plan to implement a statewide system of care for children's mental health in keeping with SOC principles.

Restatement of System of Care (SOC) Core Values and Guiding Principles

The goal 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, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of programs, processes, and relationships at the community level; and,
- Culturally and linguistically competent, with agencies, programs, and services reflecting the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.

The values are evidenced in implementation of System of Care Guiding Principles. The System is designed to:

- Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports;
- Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family;
- Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate;
- Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their communities, states, territories, tribes, and Nation;
- Ensure cross-system collaboration, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management;
- Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs;
- Provide developmentally appropriate mental health services and supports that promote optimal social and emotional outcomes for young children and their families in their homes and community settings;
- Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult-service system as needed;

- Incorporate or link with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents;
- Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level;
- Protect the rights of children, youth, and families and promote effective advocacy efforts; and,
- Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; services should be sensitive and responsive to these differences.

NOTE: *In all instances of this report, mental health services are intended to include substance abuse services whether explicit or not.*

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: Provide opportunities for children and their families to receive the supportive services they need to develop good mental health. If our society is to prosper in the future, all children must have the opportunity to develop intellectually, socially and emotionally. When communities make family mental health services available so early interventions can take place, they put in place a preventable system catching children before they fall. Repeated studies have established that young people who participate in quality youth programs are more likely to be active voting citizens, settled in stable personal relationships, employed and economically self-sufficient, and happy with their lives as adults. These are important measurable benefits to the community. Investment in youth and their families is investment in healthy communities. The Council supports a prevention and early intervention framework for children and families to reduce toxic stress and ensure stable and productive futures for children and their families.

Recommendation 2: Support advances in infant and early childhood mental health. Extensive research highlights how early experiences and relationships form the basis for future development and learning as well as impact lifelong health. The earlier a child is able to receive appropriate healthy nurturing and supports to ensure a more level and stable foundation, the more benefit that can be gained and the more cost effective the services and supports. Recent science demonstrates that many children's futures are undermined when stress damages the early architecture of the brain. This stress may come from family tensions over a lost job or death in the family or even changes in caregivers. The damage done by these critical experiences affects whether the foundation on which future growth must depend is

either a strong or weak structure. Serious and prolonged stress – toxic stress – makes babies' brains release a chemical that stunts cell growth. Children must develop fundamental skills for success in life to include recognizing and managing their emotions, developing caring and concern for others, establishing positive relationships, making responsible decisions, and handling challenging situations. For the public-private infrastructure to take effective action, all stakeholders must acquire this knowledge and understand how to apply these findings within their own systems. When communities invest in a stable workforce of trained early childhood service providers, they also help to ensure that a child's basic foundation will be durable. These early investments reap dividends as child development translates into economic development later. A child with a solid foundation becomes part of a solid community and contributes to our society. Promoting children's social and emotional skills is critical to improving their success in school and in life. The Council recommends CCMH, the Tennessee Infant and Early Childhood Mental Health Initiative, the Early Childhood Advisory Council, Young Child Wellness Council, and other groups focused on early childhood work together to ensure collaborative, coordinated care for infants and young children.

Recommendation 3: Continue to collaborate with TennCare, Managed Care Organizations (MCOs), mental health providers and other partners to infuse System of Care values and principles into the service delivery system for Tennessee children with mental health treatment needs.

There were 1.49 million children in Tennessee in 2010 with 740,633 eligible to receive services through TennCare. Considering over half the children and youth may receive mental health related services through TennCare, the Council recommends exploring the opportunities to integrate SOC values and principles into the current system of services provided by TennCare. Working with the Council, TennCare and MCOs are better equipped to ensure quality, evidence-informed and culturally and linguistically competent services. In order to ensure continuity and consistency of services for children across the state, the Council recommends implementing the SOC philosophy statewide under TennCare's centralized funding structure rather than creating funding mechanisms only available within individual counties or regions. As TennCare only services roughly half of the children in Tennessee, the Council also recommends working with providers, agencies, payer sources and other partners to ensure the philosophy of a System of Care is infused at all levels of the system for maximum reach and impact.

Recommendation 4: Educate and train the children's health and community services workforce in System of Care philosophy. The Council recognizes the importance of workforce development in Tennessee as we seek to expand services and supports for youth with behavioral health needs and their families in alignment with key system of care values and approaches. Without careful attention to ensuring high quality workers are well trained in the competencies needed to work in multiple environments today, the task of implementing a high-quality service delivery system as part of the systems of care approach is almost impossible. Workforce training and development is one of the core strategies required for effective system of care expansion efforts. The Council understands critical partnerships have to be established to help build new competencies and capacity, structures and financing vehicles supporting workforce development. The Council recognizes the need to develop stronger relationships with higher education and related training programs. The Council supports

ongoing workforce development, training, education, services and supports to ensure a level foundation for infants and children.

Recommendation 5: Continue the Council on Children's Mental Health in the Sunset Review Process and revise the current reporting and planning structure for CCMH requiring biannual reports starting in July 2015. CCMH terminates June 30, 2014. Currently T.C.A. 37-3-115(b) requires the Council to submit this plan for statewide expansion of SOC on or before July 1, 2013. There are no statutory requirements for subsequent plans. The Council recommends an ongoing process to ultimately infuse System of Care Core Values and Guiding Principles into the state's current child and family services delivery system. Reporting on a biannual basis allows the Council to keep the General Assembly apprised of the progress to reach this goal. The Tennessee Department of Mental Health and Substance Abuse Services received a statewide expansion implementation grant lasting until 2016. The Council is specifically identified in the governance structure of this grant. The two year reporting timeline will allow the Council to make recommendations, implement these recommendations and learn from the outcomes to continually inform the planning process. The Council also reserves the right to submit interim reports if funding or policy changes are necessary.

Recommendation 6: Provide appropriate funding to sustain a System of Care Technical Assistance Center to serve as a support to statewide implementation of SOC approaches. The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) is in the process of creating a training and technical assistance center (SOCTAC) using federal grant funds. This center will be housed within TDMHSAS and may utilize contracted expertise for specific purposes. This center will provide training and technical assistance on a variety of topics including: family-driven and youth-guided services; wraparound services; family support provider certification; trauma-focused cognitive behavioral therapy and 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 SOCTAC will 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 the center created for this purpose by TDMHSAS as the federal funding will be insufficient to provide technical assistance and training at the levels needed to bring Systems of Care to scale statewide.

Recommendation 7: Expand use of the Child/Adolescent Needs and Strengths (CANS) Service Planning Tool to become a universally recognized service planning and communimetric tool among child-serving agencies, departments, providers, families and youth. As reported in the July 2010 and 2012 report from CCMH, CANS is currently being used or recommended for use by TDMHSAS, Department of Children's Services, Department of Education, and several juvenile courts across the state. 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. The Council will continue to examine how to expand the use of the CANS across contexts and modalities.

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-eight times between July 2008 and July 2013, 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. Meetings from February 2009 until June 2010 were detailed in the July 2010 report that can be found at http://www.tn.gov/tccy/ccmh-report10.pdf. Meetings from August 2010 until June 2012 were detailed in the July 2012 report that can be found at http://www.tn.gov/tccy/ccmh-report12.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 50 persons for the five Council meetings since July 2012. Over 50 percent of members in attendance at meetings have attended over three-fourths of the total number of meetings held.

A summary of CCMH meeting agendas and outcomes since the July 2012 report is included on page 45.

Steering Committee: Since its inception in October 2009, the Steering Committee has met 13 times with an average of 16 members at every meeting. A summary of agendas and outcomes of the Steering Committee and meetings of the workgroup co-chairs since the July 2012 report is presented in Table 2 on page 48.

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 2012 report. There are currently four workgroups providing recommendations and information about their respective topics and two advisory groups working to ensure each workgroup has family and youth engagement and remains culturally and linguistically competent. The workgroups, advisory groups and their individual foci are reflected in Table 3 on page 50. This table entitled CCMH Workgroup 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. The Council has continued to receive regular updates about these SOC initiatives and provide feedback as necessary. 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 Council reports, Tennessee's SOC experiences are summarized below in Table 1. Federally funded SOC grants were typically awarded for a five-year or six-year grant cycle with the possibility of an additional year no-cost extension if funding allows. The first full year of the grant cycle is considered a planning year for the initiative to organize, hire and train staff, develop the local governance structure, etc. Typically, sites do not begin serving children until the second year of funding. The newer SOC expansion implementation grant funding is for four years and has a statewide infrastructure focus. The federal expectation and understanding of the importance of sustainability planning and development for the demonstration sites also has relevance to the CCMH efforts for SOC across Tennessee.

July 2013 Report Table 1: Tennessee Current and Proposed System of Care Initiatives

PROJECT	STATUS	CHILDREN/FAMILIES* SERVED		SELECTED OUTCOMES
		# SVD	SELECTED CHARACTERISTICS	
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: 186	• 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 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 • Creation of additional support group models for youth and family members to address the diverse needs of this community related to dealing with the challenges of children's mental health issues (treatment access, stigma, cultural myths, etc.) and that will establish foundation for a local family run organization • Increased involvement of youth and parents/caregivers in the community evaluation process (Youth-Guided Empowerment Evaluation Camp (Y-GEEC), asset mapping and think tank activities)

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: 133
			• 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 Wraparound or WRAP services to remain independently in the community.
				Outcomes in addition to improved Clinical Outcomes:
				• Youth In Action Council established as community leaders and peer advocates
				  • An average of 25 youth regularly attend weekly youth council meetings. Youth have also started creating their own governance structure and have engaged in sustainability conversations focused on maintaining the influence of youth in the community and at the state-level.
				• Improved functioning in the home, school, and community
				HOME:
				  • According to the Behavioral Emotional Rating Scale (BERS) results, Caregivers

				report steady increases on the family involvement subscale between baseline, 6- and 12-month time. On the same measure and subscale, Youth also report steady increases during the same time points as caregivers. **SCHOOL:** • 8% fewer youth report having "missed school for any reason in the past six months" between baseline and one-year later. • Grades have also steadily improved for youth between baseline and the 12-month time-point (6.2% more B's, 12.5% more C's, and 12.5% fewer F's) **COMMUNITY:** • 18.7% FEWER youth reported hitting someone in the past six months between baseline and the 12-month time-point. 18.7% FEWER youth reported damaging property that did not belong to them between baseline and the 12-month time-point. • Successful transition into adulthood, per individual youth's definition. • One marker for this is successful graduation from K-Town. To date, K-Town has celebrated 32 youth who have graduated and met all of their personal goals established during their engagement in the Wraparound process.
Early Connections Network: Fulfilling the Promise Funding Request Over 6 Years:	Awarded: 10/2010 Anticipated End Date: 2016	Target: 400 Served to Date: 51 Enrollment	• Residents of Cheatham, Dickson, Montgomery, Robertson, and Sumner Counties; • Young children ages 0-5 and their families; • Emotional, behavioral or mental health	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

$9M Federal $8.5M Match Required**		Began: September 2012	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.	service providers • Increased number of early childhood specialists
Statewide System of Care Expansion Implementation Initiative (SOC-EXP) Funding Request Over 4 Years: $4M Federal $1.9M Match Required**	Awarded: 10/2012 Anticipated End Date: 2016	Target: TBD	• Population of focus to be determined by local announcement of funding recipients. (Examples include: child welfare; school-based; young children; juvenile justice involved, etc.)	PROJECTED OUTCOMES: • Implementation of state level policy, administrative and regulatory changes which promoted and sustained a statewide System of Care infrastructure. • Sustained SOC Technical Assistance Center • Development of Strategic Financing Plan • Facilitated increased access to effective, appropriate and coordinated mental health services for children • Increased family and youth involvement in system of care planning, implementation, evaluation and governance through the expansion of local and regional governance structures • Creation of a unique Tennessee SOC brand and centralized resource and education platform for data sharing and information dissemination

* 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 from graduated SOC initiatives in Tennessee to understand possibilities of the current federal initiatives to be sustained. The graduated SOC information is presented on the following page.

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.
Mule Town Family Network (now known as South Central System of Care (SCSC)) Funding Over 6 Years: $6.7M	Initiated: 2005 End Date: 2012	Target: 440 Total Served: 418	• 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%	• 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

Federal $6.7M Match Required**			at or near poverty; • 44% have IEP; • 49% have witnessed domestic violence; • 66% have lived with someone who was depressed; • 13% have attempted suicide; • 70% of caregivers report a family history of depression; • 62% of caregivers report a family history of substance abuse.	emotional strengths; • Over 95% of families reported positive experience on access to services, participation in treatment, cultural sensitivity, and satisfaction with services at both 6 and 12 month follow up.

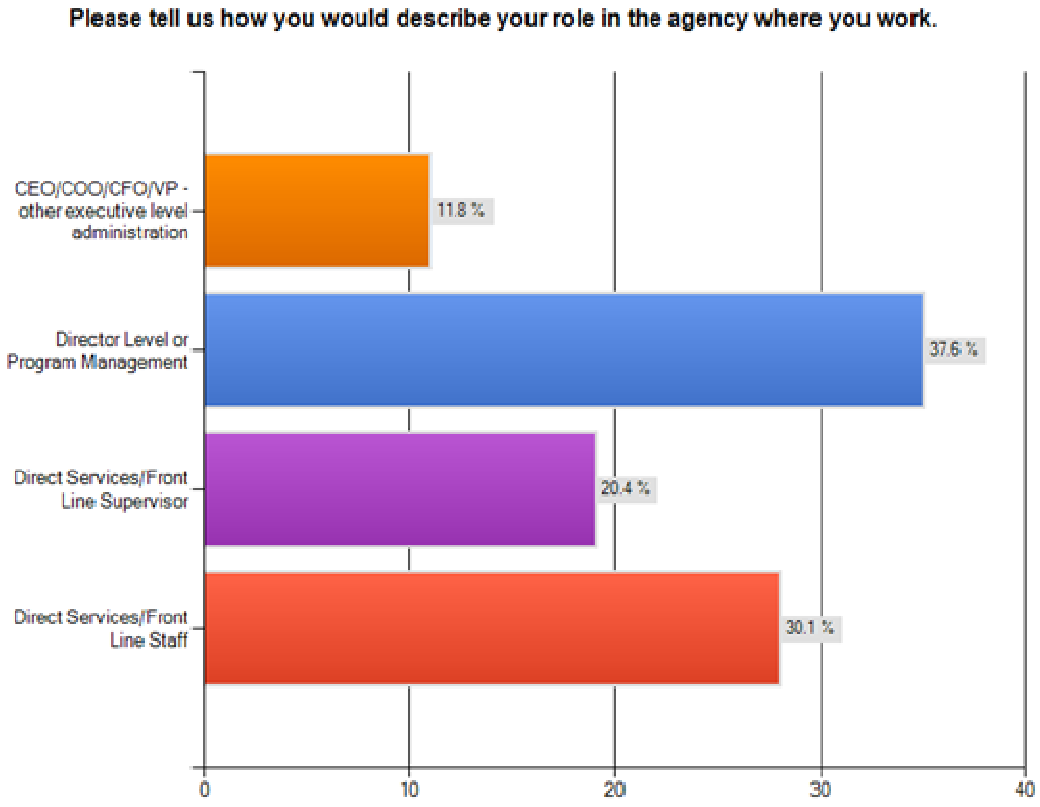
These initiatives provide an informative foundation for designing and planning for Systems of Care statewide, as required by T.C.A. 37-3-110 – 37-3-115.

II. SYSTEM OF CARE COMMUNITY READINESS

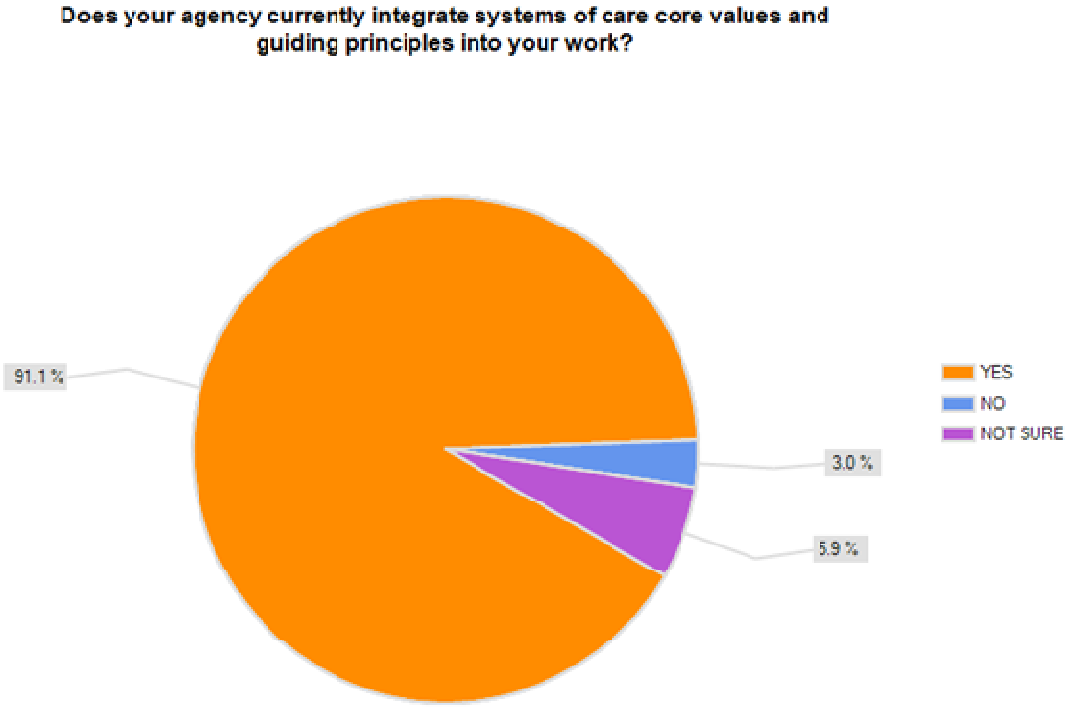
In an effort to determine the state's current use and integration of System of Care (SOC) Core Values and Guiding Principles, CCMH participants were asked to complete a baseline survey about their agencies perceived integration and use of SOC core values and guiding principles. This survey is helpful in determining future services, training and technical assistance to be provided to agencies across the state. Additional follow-up with agencies is planned based on the survey results. In future reports, more specific information about individual agencies and department may be provided; however, the information provided from this survey is in aggregate and encompasses all responses to the survey.

Representing a broad base of providers, advocates, and state departments, 101 People responded to the survey. When asked if participants were willing to work with CCMH and TDMHSAS in continuing to determine SOC readiness, over 95 percent of respondents stated they were interested in receiving more information.

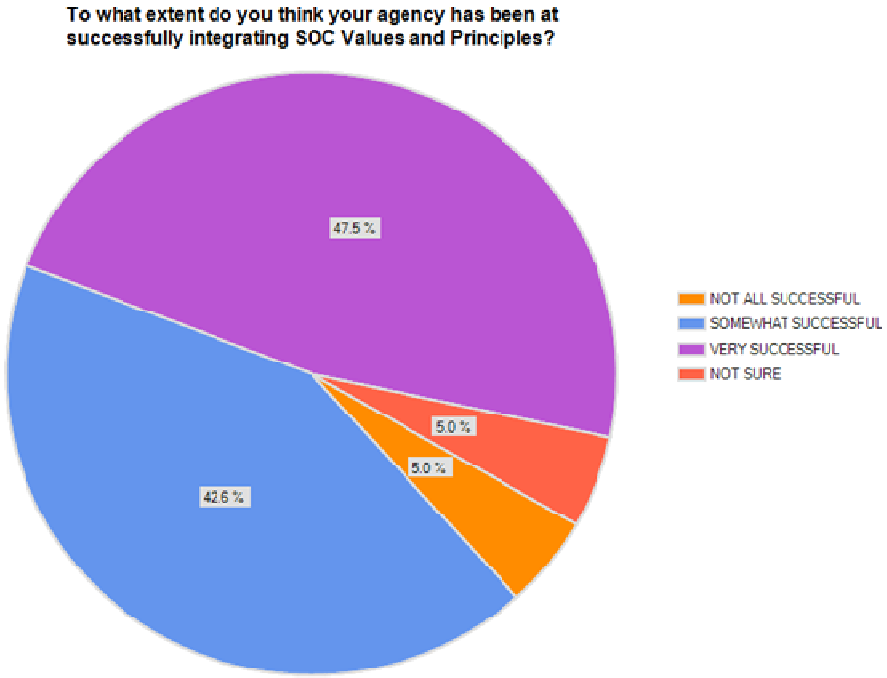
Agency staff at multiple levels (director, supervisor, and front line staff) completed a brief 12-question survey. The majority of respondents were director level/program management or direct services/front line staff. The following graph represents the complete breakdown of respondents by job role.



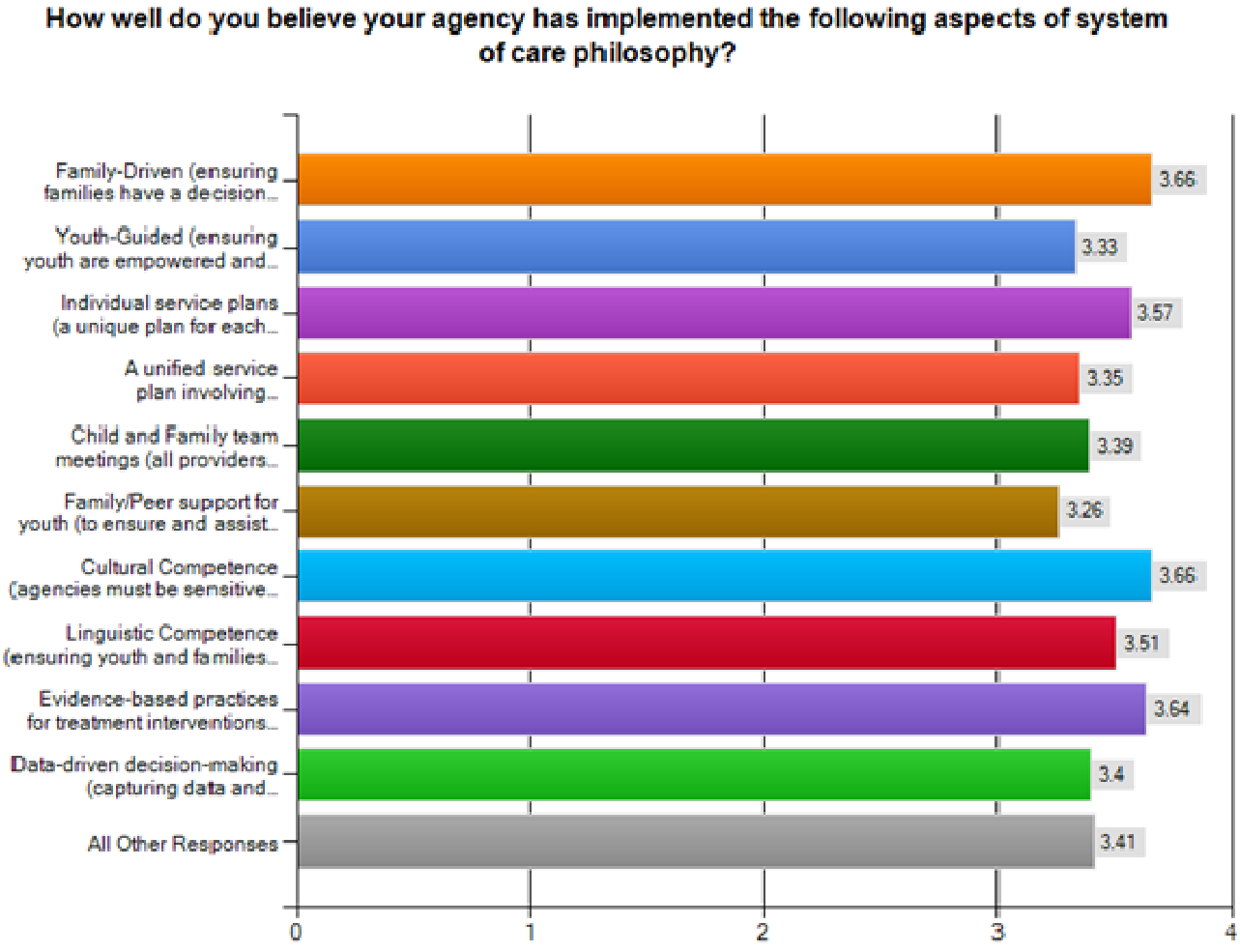
Current Overall Integration of SOC Values and Principles: Based on the self-reports of respondents, only three percent believe their agency does not currently integrate SOC values and principles into their work. The following graph displays the range of responses about current integration.



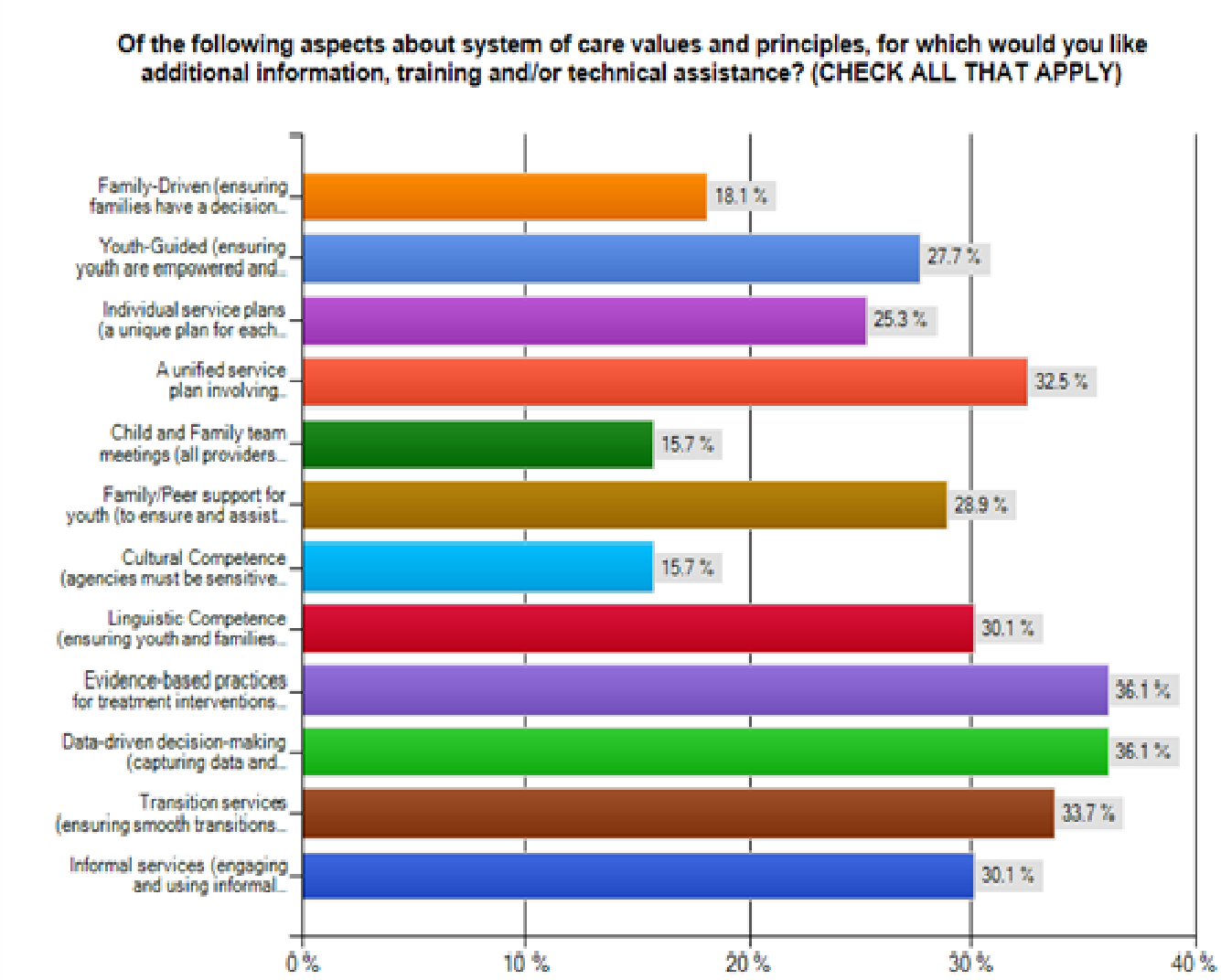
Over 90 percent believe their agency is at least somewhat successful in integrating values and principles. The following graph depicts the range of responses about the success of integration.



Implementing Specific Aspects: When asked how well their agencies had implemented specific aspects of SOC values and principles, respondents provided a more accurate portrait of strengths and weaknesses. Family-driven and cultural competence, two of the core values, received the highest average scores with peer and family support receiving the lowest. Additional follow-up surveys and interviews will be able to identify if all agencies are interpreting these concepts similarly. More formalized assessment measures have been used in other states to provide a more systematic way of determining successful implementation. The following graph represents how successful respondents believe their agency implements certain aspects SOC values and principles. Respondents were asked to rate their success on a scale from one to four, where one is not at all successful and four is very successful.



Additional Training and Technical Assistance: Despite receiving higher scores on the previous question, respondents stated needing the most assistance with evidence-based practices and data-driven decision making. As a System of Care Technical Assistance/ Center of Excellence is created, this information will serve as a foundation for the initial types of training and assistance provided. The following graph displays the average percentage of respondents indicating the need for training or assistance in a specific area.



III. LIST OF ALL PROGRAMS

CCMH has 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 developed using data from the resource mapping process for fiscal year 2011-2012. 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 Governor's Children's Cabinet is working to create a comprehensive online resource for Tennessee families which should be operational July 2013. 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.

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July 2013 Report Table 2: Departmental Service List

DEPARTMENT/AGENCY	PRIMARY PROGRAM SERVICE
Department of Children's Services	
	Assessment-Child Advocacy Center
	Mental Health-Sexual Abuse Counseling
	Placement-Continuum of Care
	Placement-Mental Health-Full Clinical Treatment
	Placement-Residential
	Support - Crisis Team Management
	Support - Custody Behavioral Services
	Support-Parenting Education
Department of Education	
	Coordinated School Health
Department of Health	
	Coordination-Early Childhood
	Education-Suicide Prevention
	Education-Tobacco Prevention
	Mental Health-Substance Abuse-Tobacco Cessation
Department of Mental Health and Substance Abuse Services	
	Administration-Assessment-Mental Health
	Administration-Behavioral Health-Safety Net
	Administration-Education-Mental Health
	Administration-Education-Mental Health-Suicide Prevention
	Administration-Emergency-Crisis Services-Child
	Administration-Mental Health-Early Childhood
	Administration-Mental Health-Forensic Services
	Administration-Mental Health-Inpatient
	Administration-Mental Health-Outpatient
	Administration-Mental Health-School Based Services
	Administration-Mental Health-System of Care
	Administration-Respite-Mental Health
	Administration-Support-Housing
	Administration-Support-Housing Subsidy
	Administration-Support-Mental Health
	Administration-Training-Mental Health
	Alcohol and Drug Abuse Prevention Services
	Alcohol and Drug Abuse Treatment Services
	Assessment-Mental Health
	Crisis Counseling
	Education-Mental Health
	Education-Mental Health-Early Childhood
	Education-Mental Health-Suicide Prevention

	Emergency-Crisis Services-Child
	Health and Wellness Initiative
	Mental Health-Early Childhood
	Mental Health-Home Based Services-Supportive Family
	Mental Health-Inpatient
	Mental Health-Outpatient
	Mental Health-School Based Services
	Mental Health-System of Care
	Respite-Mental Health
	Support-Housing
	Support-Housing Subsidy
	Support-Mental Health
	Support-Mental Health-Housing
	Training-Mental Health
Department of Safety	
	Education-Drug Abuse Resistance
Department of Transportation	
	Education-Safety-Alcohol Awareness
Office of Criminal Justice Programs	
	Mental Health-Drug Exposed Children
	Mental Health-Sex Offender Counseling
TennCare	
	Mental Health-In Home Services (includes case management and bundled services)
	Mental Health-Inpatient (includes residential treatment)
	Mental Health-Outpatient
	Mental Health-Partial Hospitalization
	Mental Health-Supported Housing (only includes youth aged 18-20)
	Pharmacy-Mental Health
Tennessee Commission on Children and Youth	
	Mental Health
	Mental Health-Custody Prevention
	Mental Health-Substance Abuse

IV. 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 for 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. This report presents information from fiscal year 2011-2012. Several tables and graphs detail funding for mental health and related services in the state. Mapping information for prior fiscal years was presented in previous reports.

Mental Health and Substance Abuse Resource Mapping Statewide Overview

Number of Agencies	**9**
Number of Data Records:	
FY 2011-2012	**367**
Total Expenditures:	
FY 2011-2012	**$450,508,554**

Source: Tennessee Commission on Children and Youth Resource Mapping Project

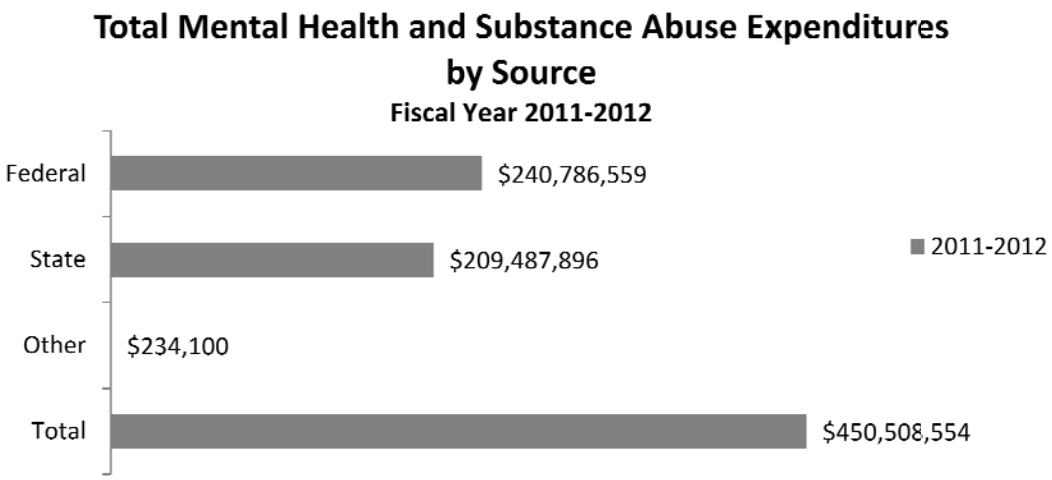
Total Expenditures and Funding Source: Mental health and substance abuse services accounted for less than 5 percent of the total funding allocated to children in Tennessee in FY 2010-2011. State funding is close to comprising half the funding for children's mental health services. TennCare is the largest 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

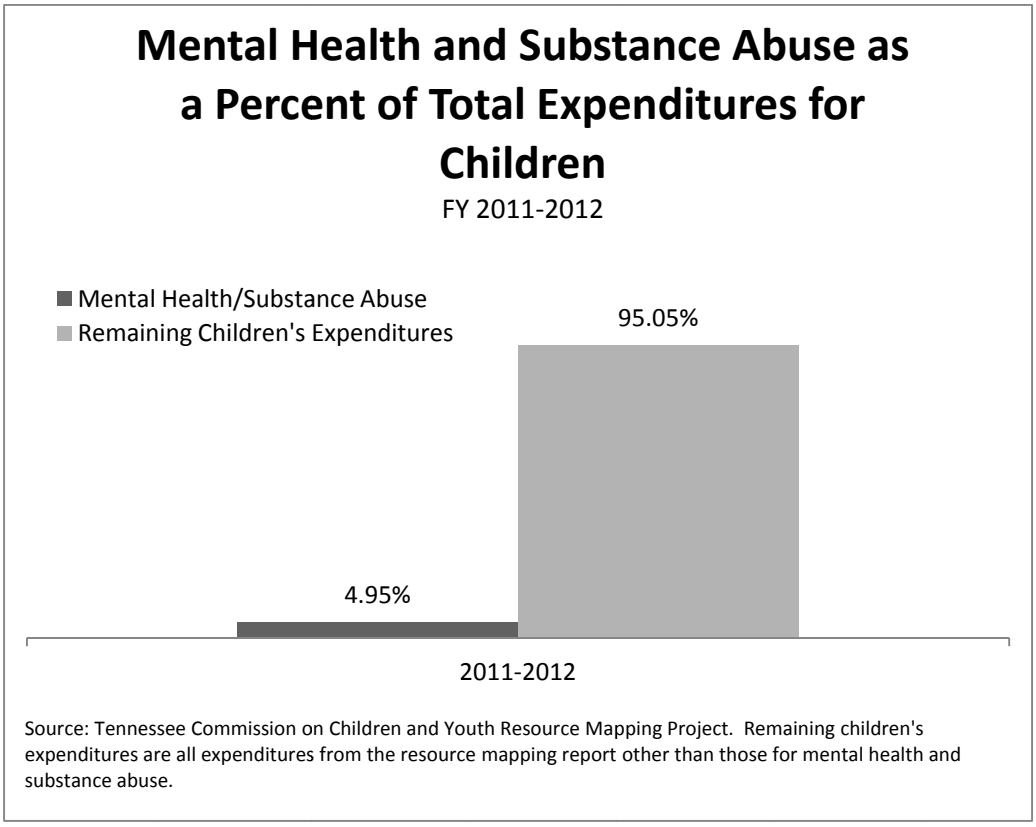
Fiscal Year	Federal	State
2011-2012	53%	47%

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

Source: Tennessee Commission on Children and Youth Resource Mapping Project



Source: Tennessee Commission on Children and Youth Resource Mapping Project



Source: Tennessee Commission on Children and Youth Resource Mapping Project. Remaining children's expenditures are all expenditures from the resource mapping report other than those for mental health and substance abuse.

Mental Health and Substance Abuse Expenditures by State Agency by Funding Source

FY 2011-2012

State Agency	Federal	State	Other	Total
Fiscal Year	**2011-2012**	**2011-2012**	**2011-2012**	**2011-2012**
Department of Children's Services	$80,202,800	$97,063,100	$46,600	$177,312,500
Department of Education	$0	$16,507,030	$0	$16,507,030
Department of Health	$514,900	$268,300		$783,200
Dept. of Mental Health	$20,687,632	$23,520,104	$0	$44,207,736
Department of Safety	$0	$868,098	$0	$868,098
Department of Transportation	$239,333	$0	$187,500	$426,833
Office of Criminal Justice Programs	$81,651	$447,954	$0	$529,605
TennCare	$138,886,506	$70,807,310	$0	$209,693,816
Tennessee Commission on Children and Youth	$173,736	$6,000	$0	$179,736
Grand Total	**$240,786,559**	**$209,487,896**	**$234,100**	**$450,508,554**

Source: Tennessee Commission on Children and Youth Resource Mapping Project

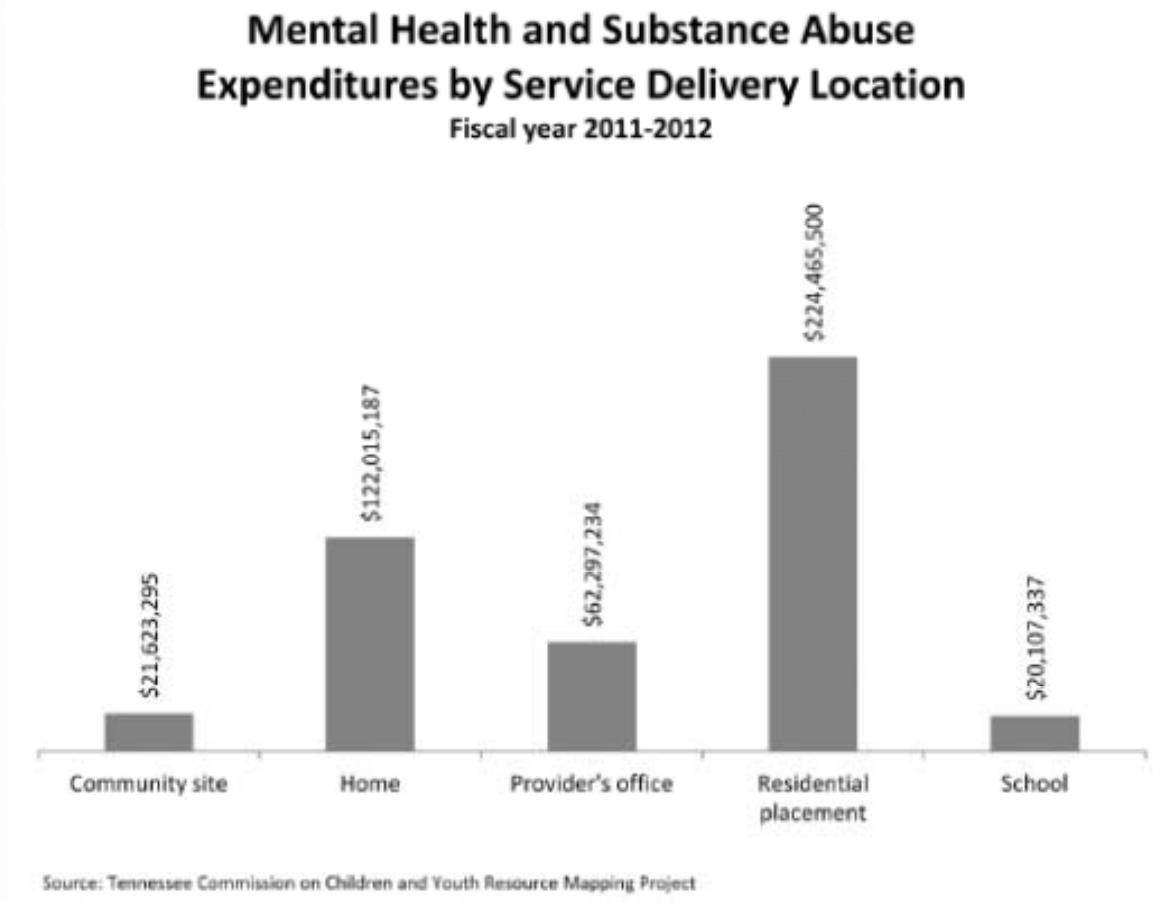
Both TennCare and the Department of Children's Service are affected by the return of the Federal Medical Assistance Percentage (FMAP) to its regular level, after having been increased by about 10 percent for nine quarters (October 2008 through December 2010) under the American Recovery and Reinvestment Act (ARRA) and by a smaller amount for an additional two quarters (January 2011 through June 2011) under P.L. 111-226.2. TennCare funding percentages are completely determined by the FMAP, but other agencies (such as DCS) are affected as well. Federal Medical Assistance Percentages (FMAPs), the matching rate the federal government pays as its share of a state's Medicaid benefit costs, is adjusted annually. A state's FMAP is based on its per capita personal income relative to the national average over three years.

TennCare Funding: As previously reported, TennCare is the largest source of mental health expenditures for children in Tennessee with total spending of $209,693,816. The federal portion of this (the Federal Medical Assistance Percentage—or FMAP) varies somewhat from year to year—it was 66.36 percent in FY 2012.

Service Delivery Location: Residential placement accounted for roughly 50 percent of funding in FY 2011-2012. All mental health expenditures for pharmacy are included in the service delivery location of *Home*. This represents over $113 million leaving roughly only $9 million in other mental health services provided in the child's home. 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 have those options available, especially children dealing with traumatic experiences. When properly diagnosed, these children are best served by other mental health services besides pharmaceutical interventions.

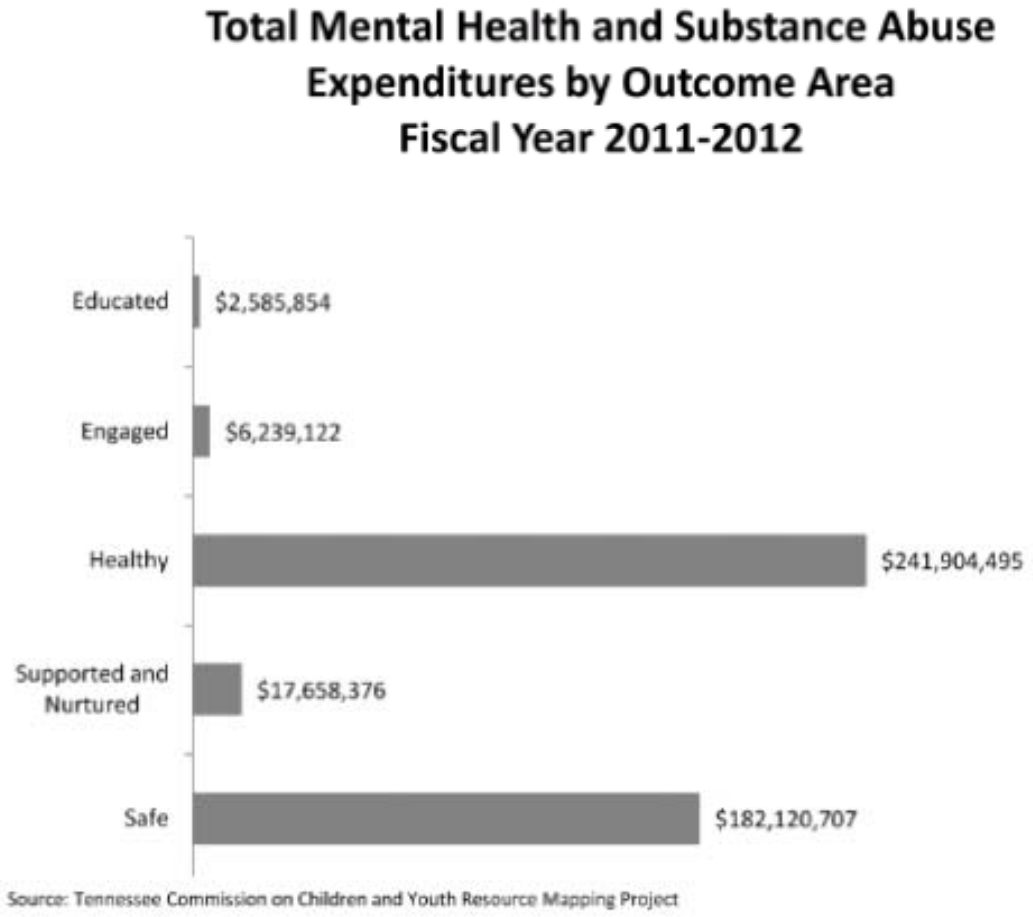
Location options included:

- Home;
- Community site;
- School;
- Provider's office; and
- Residential Placement (includes inpatient psychiatric care).



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).



***NOTE**: 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. Because of differences from year to year of reporting, this data may not be comparable to prior years of data.*

Inventory of Funds: Tennessee has historically relied heavily on federal funding for the provision of essential services and supports for children and families. Of the total mental health and substance abuse expenditures, the majority of funding continues to be federal dollars. However, more and more reliance is placed on state funding to close gaps in services as federal mental health funding declines. Many of the federal funding streams are reliant on matching funds. If substantial reductions are made in state dollars, this curtails the state's ability to continue to apply and receive certain federal grants, including

System of Care (SOC) Grants. Efforts should continue to be made to shift funding to cost-effective services to prevent the need for more restrictive and more costly services.

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.

V. 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.

Statutory 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, 2012 and 2013.

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.

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 professionals 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.

T.C.A. 33-1-401—Statewide Policy and Planning Council of the Department of Mental Health and Substance Abuse Services Children's Committee: This law requires the Department of Mental Health and Substance Abuse Services to convene a council of stakeholders, providers, family members, consumers and advocates to advise the department about the service system, policy development, legislation, budget requests, system evaluation and monitoring. The Council has several committees to

help inform the council's work. The Children's Committee assists in prioritizing the needs of children and youth and helps advocate those needs to the council as a whole and to the department.

Relevance to CCMH: Members participate in the work of the statewide policy and planning council and its children's committee. By continuing to provide input and recommendations to the department in this forum including stakeholders, providers, family members, consumers and advocates, the work of the department can be data-driven and consumer-informed. CCMH supports efforts that are family- and data-driven.

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

Best Practices – Behavioral Health Guidelines for Children and Adolescents: Birth – 17 Years of Age: The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) has updated and expanded its behavioral health best practice guidelines for children and adolescents. The guidelines, available online at http://www.tn.gov/mental/policy/best_pract_children.shtml, are intended 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.

As in the previous revision, the current guidelines include a section on Interagency Systems of Care (SOC) for Children's Mental Health. This section addresses the foundations and history of SOC core values and guiding principles. It further highlights the work of TDMHSAS in the development and implementation of federally funded SOC grants, many of which are operational presently. Update/revision of this section was spearheaded by the Director of the Council on Children's Mental Health (CCMH).

Relevance to CCMH: The overall purpose of the Council on Children's Mental Health (CCMH) is to expand SOC statewide. The fact that TDMHSAS included a section on Interagency Systems of Care (SOC) in its guidelines assists in validating SOC as a best practice and supports its expansion across the state. The guidelines are promoted for use by all practitioners that work with children and adolescents, especially when there is a behavioral health issue. Including CCMH and SOC in the guidelines further serves to encourage and strengthen the need for collaboration and coordination in work with children and adolescents with serious emotional disturbance (SED) and their families.

Centers of Excellence (COE) for Children in State Custody: The COEs, funded through TennCare and contracted with 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. 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 are based at East Tennessee State University (Johnson City); University of Tennessee Knoxville Cherokee Health Systems; University of Tennessee – Health Science Center Boling Center (Memphis); Southeast (Chattanooga) and Vanderbilt University (Nashville). In addition to the above referenced services, COEs have advanced the service delivery system through two major initiatives:

- **Learning Collaboratives**: 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 through the use of Learning Collaborative methodology, an evidence-based approach to train and support implementation and sustaining of new practices with fidelity.

This year the COE Best Practices Collaborative developed the Attachment, Self-Regulation and Competence (ARC) Learning Collaborative to train community mental health providers in the ARC model 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.

ARC builds upon the earlier Learning Collaboratives which implemented Trauma Focused Cognitive Behavioral Therapy (TF-CBT) in mental health centers, foster care continuums, and child advocacy centers across the state. Leadership for the project was 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 Collaboratives. Mental health agencies who were successful adopters of TF-CBT were invited to apply for inclusion in the ARC Learning Collaborative.

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 children and families with multiple complex problems and needs 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.

- **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.

CANS Consultants, who are staff of Vanderbilt University, are 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, 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.

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): The ECAC is a federal grant project awarded to the state in 2010. Under the leadership of the Children's Cabinet, goals under the ECAC grant include: 1) to align and enhance existing statewide early childhood system of care and education for children ages birth through five years, which promotes school readiness; 2) through a two-step process, to conduct a statewide needs assessment that identifies the availability 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; 3) to 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 4) to 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 to 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.

Governor's Children's Cabinet: Tennessee's children are a top priority for Governor Haslam and his administration. He created the Children's Cabinet in January 2012 by Executive Order (No. 10). With the Governor and First Lady serving as co-chairs, the Children's Cabinet consists of the Commissioners of six child-serving departments- Health, Mental Health and Substance Abuse Services, Children's Services, Human Services, Education, and TennCare. Each of these Commissioners brings rich experience and passion to their roles. Each is committed to children, public service, and committed to working together as a team. As a Cabinet, these Commissioners work together with an intentional focus of moving past the specific mission or function of each agency to find ways to tackle issues together. The purpose of the Cabinet is to coordinate, streamline, and enhance the state's efforts to provide needed resources and services to Tennessee's children.

Relevance to CCMH: Per Executive Order No. 10, the Children's Cabinet shall focus on a broad range of issues; including but not limited to children's: physical and mental health; education; safety; and overall well-being. The Council is working to coordinate services related to children's mental health including infant and early childhood services.

In-Home Tennessee: This initiative through the Department of Children's Services (DCS) seeks to strengthen and improve in-home services through the development of the In Home Tennessee (IHT) framework; the enhancement of an effective service array of services; and the engagement of children, youth, families, and community partners in service planning and delivery, to achieve safety, permanence and well-being. The In Home Tennessee initiative is included in the recommendations from the Governor's Top to Bottom review process. IHT is conducted on a region-by-region basis and continues to engage community partners, advocates, youth and their families in the process toward positive change to the child welfare system.

Relevance to CCMH: Services provided in the least restrictive environment, also seeking to keep children and youth with their families is a guiding principle of System of Care. Building a robust comprehensive service array is one avenue to achieving this principle. The Council supports efforts involving family-driven and youth-guided coordinated care as displayed in the In-Home Tennessee's Mission.

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 on 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.

State Policy Academy on Preventing Mental Health and Substance Abuse Disorders in Children and Youth: Chosen as one of six states to participate in SAMHSA's first state policy academy on prevention, TDMHSAS and other partners are working to identify children, youth, and young adults at risk for Mental, Emotional and Behavioral (MEB) disorders through universal screening. This screening would occur for individuals ages 13-21 in health care or other appropriate settings proactively. The

screening provider would also provide education and consulting for families and youth adults, and refer to appropriate services as needed.

Relevance to CCMH: The Council recommends early identification and effective intervention as the most cost effective and long-term beneficial course of action of children and youth. This project seeks to identify these youth in age appropriate settings and provide referral services as needed.

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. Trained 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 parent volunteers who assist with support groups and other family support activities. Hired for their experiences in navigating 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 nearly 150 councils, advisory groups, and policymaking committees each year, ensuring there is parent/family voice involved in decisions about services for children, as well as support other parents in becoming involved in these groups. 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 volunteer network of early childhood professionals, infant mental health experts, family advocates, managed care organizations, provider agencies, professional organizations, and state agency partners organized and facilitated by the Centers of Excellence for Children in State Custody (COEs). The goal 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 to develop the capacity to 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. 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. The pilot project established the screening process in eight juvenile courts across the state, with special emphasis on rural jurisdictions and the inclusion of females. The task force is now engaged in expanding the project to additional courts. This expansion will also include expansion of the Family Support Provider services 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, including the SAMHSA SOC site in Knoxville (K-Town Youth Empowerment Network), 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 has provided support for a local youth council and youth activities through the JustCare Family Network and has successfully 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.

SUMMARY

The Council on Children's Mental Health is pleased to report our accomplishments as well as our working plan noted throughout this July 2013 Report to the Legislature. Accomplishments of 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 an average attendance of 50 persons from all across the state.
2. Secured a four-year federal System of Care Expansion Implementation Grant.
3. Identified the CANS as a universal service planning tool and, in principle, CCMH members support the use of the CANS across departments and agencies.
4. Developed a Steering Committee to more efficiently provide governance for the CCMH and continued to update the workgroup structure and next steps to meet the changing needs of the Council.

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 and the importance of receiving the new System of Care Statewide Expansion Implementation grant under DMHSAS, which will continue to support the work of the Council moving forward.

July 2013 Report Document Group 1: Tables

Table 1: Summary of Council Agendas, Purposes and Outcomes

CCMH Meetings

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 24 08/23/12 10:00 A.M.-3:00 P.M	Legislative Update	Report about related children and youth legislation --Steve Petty, TCCY
	TCCY Children and Youth Budget Recommendations	Provide an overview of the budget recommendations made to the Governor by TCCY --Linda O'Neal, TCCY
	Infant and Childhood Mental Health Initiative Update	Provide an overview of infant and childhood mental health and related activities occurring in the state --Loraine Lucinski, TDOH
	Statewide Expansion Implementation Grant Application and SOC Site Status Update	Inform about the implementation grant application submitted in June 2012 and updates from the other SOC initiatives in the state. --Susan Steckel, TDMHSAS
	July 2012 Report Overview and Next Steps Planning	Review the July 2012 Report to the Legislature and discuss next steps for workgroups --Dustin Keller, TCCY
	Georgetown Training Institutes	Provide an overview of the institutes and sessions attended --Attendees

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 25 10/18/12 10:00 A.M.-3:00 P.M	Governor's Cabinet and Early Childhood Advisory Council	Provide an overview of the Governor's Children's Cabinet and the Early Childhood Advisory Committee Grant --Jude White, Governor's Office
	CCMH Workgroups and Next Steps Update	Discuss next steps for workgroups and the recent meeting of the Workgroup Co-Chairs --Dustin Keller, TCCY
	In Home-Based Services (CTT-CCFT) Study Continuation Update	Update the Council on the continuing around current home-based services provided in Tennessee --Mary Rolando, Vanderbilt Center for Excellence
	Prevention Policy Academy and State Prevention Enhancement Grants	Inform about the Prevention Policy Academy and the State Prevention Enhancement Grant received by TDMHSAS --Angie McKinney Jones, TDMHSAS
	Study of Disproportionate Minority Contact in the TN Juvenile Justice System	Present the recent study conducted by TCCY staff about DMC in Tennessee and discuss the relevance to the Council. --Dustin Keller, TCCY
	In-Home Tennessee – Department of Children's Services Initiative	Provide an overview of the In-Home Tennessee Initiative to the Council. --Jennifer Williams, TDCS

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 26 2/28/13 10:00 A.M.-3:00 P.M	Departmental Budget Updates	Provide a recent update on the state's budget and funding to mental health programs --Representatives of Child-Serving Departments
	CCMH Workgroup Next Steps Overview and Cafe	Allow committees to discuss the provided framework
	Community SOC Readiness Survey Results	Discuss the preliminary results from the Community SOC Readiness Survey --Susan Steckel, TDMHSAS --Dustin Keller, TCCY
	Data Dinner Theater	Review a recent play about the evaluation results of the K-TOWN Youth Empowerment Grant --Heather Wallace, K-Town
	SOC Grant Initiatives Update	Updates the Council about the SOC initiatives in the state. --Susan Steckel, TDMHSAS
	HEROES Initiative	Provide an overview of a school based mental health project in Northeast Tennessee --Greg Wallace, Johnson City Schools --Kathy Benedetto, Frontier Health
	Legislative Update	Report about related children and youth legislation. --Steve Petty, TCCY --Kurt Hippel, TDMHSAS

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 27 4/25/13 10:00 A.M.-3:00 P.M	School Climate Grant and School Safety	Update the Council about the School Climate Grant and the Office of School Safety --Mike Herrmann, TDOE --Pat Conner, TDOE
	CCMH Workgroup Updates	Allow reports from Workgroup Co-Chairs --Workgroup Co-Chairs
	Draft July 2013 Report to the Legislature Discussion	Provide an overview of the draft July 2013 report outline and discuss information needed --Dustin Keller, TCCY
	Youth Villages Crisis Services Update	Inform members about the statewide specialized crisis services --Dawn Puster, Youth Villages
	Co-Occurring Collaborative Update	Update about the Tennessee Co-Occurring Collaborative --Vickie Harden, Volunteer Behavioral Health Care Systems

	Prevention Policy Academy Update	Inform about the progress of the Prevention Policy Academy workgroup --Angie McKinney Jones, TDMHSAS
	Legislative Update	Report about related children and youth legislation. --Steve Petty, TCCY --Kurt Hippel, TDMHSAS

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 28 6/27/13 10:00 A.M.-3:00 P.M	Department of Children's Services Update	Provide an update from the Commissioner of DCS --Commissioner Jim Henry, TDCS
	CCMH Workgroup Updates	Allow reports from Workgroup Co-Chairs --Workgroup Co-Chairs
	Draft July 2013 Report to the Legislature Discussion and Approval	Provide an overview of the draft July 2013 report and secure Council approval to submit report to the legislature. --Dustin Keller, TCCY **ACTION: JULY 2013 REPORT TO THE LEGISLATURE APPROVED BY THE COUNCIL**
	Children And Youth Best Practices Guidelines	Inform about a recent revision to the TDMHSAS children and adolescent best practice guidelines --Edwina Chappell, TDMHSAS
	SOC Grant Initiatives Update	Updates the Council about the SOC initiatives in the state. --Susan Steckel, TDMHSAS
	SOC Primer Hands On Training Update	Provide an update about a recent training in Washington, DC. --Susan Steckel, TDMHSAS --Belinda Jones, K-TOWN --Dustin Keller, 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 10 9/5/12 2:00 P.M. - 4:00 P.M. Workgroup Co-Chair Meeting	Overview of Timeline and Requirements	Review the next steps document and the timeline needed to reach the July 2012 report submission
	Review of July 2012 Report Recommendations	Provide an overview of the previous report outline and items included
	Discussion of Structure Moving Forward	Discuss possible structure of workgroups and council to move forward from the July 2012 report.
	Roles and Responsibilities of Workgroup Co-Chairs	Decide on possible roles and responsibilities for Workgroup Co-Chairs to ensure work move forward.
	Next Steps	Review timelines and types of reports and items needed from workgroups

DATE/ TIME	AGENDA ITEM	PURPOSE
MEETING 11 02/04/13 2:00 P.M.- 3:30 P.M. Steering Committee	Dates for Next Steering Committee Meeting	Discuss possible dates for the next steering committee meeting
	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 12 03/25/13 2:00 P.M.- 3:30 P.M. Steering 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 13 05/20/13 2:00 P.M.-3:30 P.M. Steering Committee	Workgroup Discussions, Progress and Next Steps	Allow time for Workgroup Co-Chairs to discuss recommendations, feedback and comments from each Workgroup
	Review Draft Recommendations for the CCMH July 2013 Report to the Legislature	Provide an overview of the draft July 2013 report recommendations and discuss information needed
	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

Table 3: CCMH Workgroup Structure

STEERING COMMITTEE		
Objective	**Interfaces with Other Groups**	**Products or Outcomes**
Guidance and oversight for CCMH; serves as a gateway for ideas from Workgroup to CCMH; coordinates and creates the working agenda; and articulates the group's vision.	All workgroups; Governor's subcabinet groups; TDMHSAS 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.

WORKGROUPS	
Work Group	**Objective and Next Steps**
Collaboration and Adoption	Create a standardized training for CCMH, SOC, and other identified concepts; Develop bullet point talking points about what we doing and hope to achieve; and, Work with TA center and provide advisory oversight about products created including: Common Definitions; Brochures; and, Trainings.
Financing Strategies	Review and recommend what would need to be in the plan; Review current funding streams for aspects currently being funded in some way; and, Recommend how other aspects might be funded.
MIS & Accountability	Review what is needed to determine if the 'system' is functioning properly and providing intended outcomes for SOC youth and families; Review departments' and agencies' current database systems to determine if they can communicate or 'data-dump' in some meaningful way; Recommend how we gather, analyze and review this data on an on-going basis and not create our own system; and, Develop guidelines for System of Care Analytics - Tennessee (SOCA-TN).
Service Capacity and Readiness	Review readiness and fidelity assessments and make recommendations; Serve in an advisory capacity to the TA center around service capacity and readiness; Work with Community Outreach and Awareness workgroup to develop an SOC readiness toolkit; Review possibility of gathering information about local service array; and, Review regional aspects of SOC and what the state currently does well and needs to improve.

ADVISORY GROUPS	
Work Group	**Objective and Next Steps**
Cultural Linguistic Competency Advisory Group	Develop policies and protocols and provide representation to Council and workgroups to ensure cultural and linguistic competency; and, Provide orientation and on-going training to assist the Council and Council workgroups in ensuring cultural and linguistic competency.
Youth and Family Engagement / Advisory Group	Work with existing youth councils for input to the Council; Engage youth and families in the work and workgroups of the Council; Provide youth and family representation on the Council and other workgroups; and, Provide orientation and on-going training to assist family and youth in being engaged and active participants.