

**Senate Joint Resolution 799**  
**Final Report to the Tennessee General Assembly**  
**April 1, 2008**

Introduction:

This is the last of two reports required by Senate Joint Resolution 799 which was passed by the Tennessee State Legislature during the last term of the 104<sup>th</sup> General Assembly in 2006. SJR799 directed the Select Committee on Children and Youth to study the mental health needs of Tennessee's children and develop recommendations to improve the state's system of mental health care for children. A copy of SJR799 is included with this report as Attachment 1.

Pursuant to SJR799, an extensive study process has been conducted. The interim report, which was filed with the speakers of the Senate and of the House of Representatives on March 29, 2007 and was electronically distributed to all members of the legislature, describes the mental health needs of Tennessee's children and lays out a blueprint for a comprehensive, coordinated system of mental health care to address these needs. The resolution directs the second year of the study process to yield a report detailing a master plan whereby this system of mental health care for children can be developed and operationalized.

With submission of this, the final SJR799 report, the duties of the Select Committee on Children and Youth are hereby accomplished and completed as called for by this resolution. Contained herein is the master plan which the committee believes can successfully guide the development, steer the implementation, and determine the governance for support and maintenance of a comprehensive, coordinated, and effective mental and behavioral health care system for Tennessee's children and their families. However, in submitting this final report, the committee would like to make clear the following points:

- *This report sets forth a plan, however, the real work lies ahead and it will require tremendous commitment of governmental entities, communities and families all across this state to assure this work is carried out.*
- *The work to create a successful system of children's mental health care must be structured and sustained over a substantial period of time.*
- *Effective use of resources and delivery of quality care are must haves; additional resources for services are needed and better outcomes can be achieved through increased coordination and collaboration around the use of existing resources.*

This final report contains three (3) parts:

- I. Recommendations for Legislative Action to move forward with the work of developing a comprehensive, coordinated system of children's mental health care for Tennessee's children and youth,
- II. Findings of the SJR799 Study Process; and
- III. Activities of the SJR799 Study Process.

## I. Recommendations for Legislative Action

The completion of SJR799 directives wraps up the first phase of putting in place a comprehensive, coordinated system of mental health care for children. At this juncture, the Select Committee on Children and Youth recommends to the General Assembly that legislation be considered and passed in this session that establishes a structure for continuing the development and authorizes beginning the implementation of a system of children's mental health care. The purpose of legislation should be to place in Tennessee Code Annotated provisions that accomplish creation of the four (4) cornerstones of a system of mental health care for children which are:

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

The legislation should authorize an entity to address the findings of SJR799. A time-limited council should be statutorily established under the administrative direction of the Tennessee Commission on Children and Youth, and its work should be structured and led jointly by the Department of Mental Health and Developmental Disabilities and the Commission. In keeping with the involvement of a broad base of stakeholders that has begun under SJR799, the legislation should direct membership of the children's mental health care council to be representative of all stakeholder groups – public sector governmental agencies, state and local provider and advocacy organizations, and the consumer sector with representation of parents and caregivers as well as young adults who have experienced both needing and receiving mental health care.

The purpose of this council should be to continue the work of children's mental health care system development by detailing the master plan of the system and guiding a strategic plan for implementing demonstration sites according to an established schedule over the next three (3) to five (5) years. This second phase of the system development work should hold as its foundation a principles-based vision of effective and efficient mental health care delivery that centers on children and evidences strong partnerships with parents and caregivers.

A solid message which has come through the SJR799 study process is that interagency coordination in caring for children's mental health needs is weak. The legislation should create statutory mandates for state departments to coordinate and collaborate in support of designing and maintaining a comprehensive, coordinated system of children's mental health care. Provisions should be placed in all appropriate sections of Title 33 (Department of Mental Health and Developmental Disabilities) and Title 37, Chapter 3, Part 1 (Tennessee Commission on Children and Youth) that enable these entities to accomplish necessary steps to create and test the comprehensive, coordinated children's mental health care system. Furthermore, language should be placed in the general provisions in Tennessee Code Annotated of each of the following governmental entities requiring each to assist this children's mental health council in carrying out its duties and to include the council in development of interagency projects and programs as related to mental health care of children and their families: Council of Juvenile and Family

Court Judges, Department of Children’s Services, Department of Education, Department of Health, and Department of Human Services

Finally, the legislation should direct that the system of care, as it evolves over time and through demonstration sites around the state, must establish processes for determining how the most effective treatments and services can be identified and promoted. The system of care should strive to identify and incorporate services and programs that are informed by emerging science in the field of mental health and addictions treatment. Linking funding streams to research-informed practice is essential to increasing cost-effective use of dollars and to increasing the likelihood of better mental and emotional well-being treatment outcomes for our children and youth.

## II. Findings of the SJR799 Study Process

At the conclusion of the SJR799 study process, the Select Committee on Children and Youth is reporting to the General Assembly with confidence that the mental health needs of our children are great and that there is demonstrable need for improvement in the way that the state delivers services and supports to children and their families who are struggling with the effects of these kinds of problems.

- The interim report documented in great detail the kinds of mental health problems that exist among our children and youth. The prevalence of biologically-based mental illness among children and adolescents, typically referred to by the collective term “serious emotional disorders,” is significant and can be devastating to them and their families. Encouragingly, the availability of science-informed treatments and evidence-based interventions is increasing; however, people who work with children in various settings who need mental health services and supports report that it is extremely challenging and sometimes impossible to make this help available both timely and in therapeutically appropriate amounts to children who could very likely benefit and get better.
- Environmentally-induced stress compromises the mental well being of many young Tennesseans. The effects of safety concerns in their homes, schools, and communities result in both externalizing and internalizing behaviors that are debilitating to the mental wellness of many youngsters. Alcohol and drug use, addictions, depression, suicide, bullying, violence toward others, eating disorders, and self-injurious acts are all subsequent to mental health problems and often result because the need for treatment and intervention either goes unmet or is inadequately addressed. Prevention strategies for high-risk populations should be executed consistently in order to decrease the likelihood that these types of behavior-related problems will occur. Likewise, because no child or adolescent is immune to such problems, the importance of wellness education has been stressed as a core component of a truly comprehensive system of care. The screening, assessment, evaluation, diagnosis, treatment and management to recovery processes should be in place and readily executable from whatever venue a child or adolescent presents with suspected or known mental health needs of these types.
- Identifying mental health problems and knowing how to deal with those problems in a timely, appropriate way is a source of much concern and poises significant difficulty for parents and others who work with children. There should be a flow for the processes of screening, assessment, evaluation, diagnosing, intervening with treatment, and managing

care to stability or recovery within a mental health care system. The SJR799 study process has indicated we do not have this flow of processes in our state, and that the lack of such has resulted in such system failures as delayed identification of problems, diagnosing without proper assessment or thorough evaluation, treatment based on misdiagnosing, disruptions in continuity of care, and missed opportunities to support the maintenance of therapeutic progress. The lack of systematic procedure that spans identification through treatment and aftercare is problematic.

- Issues surrounding access to care were consistently raised across all venues of information gathering. Although the descriptive nature of the issues varied in different areas and among different informant groups, every facet of stakeholders report they experience challenges in accessing appropriate, timely mental health care to such a degree that their children's or clientele's well being has been compromised and the likelihood of good outcomes has been diminished.
- Access barriers emerged around several points: (1) geographic issues related to unequal distribution of resources, areas being underserved, and extensive travel time and lack of transportation limit access to care; (2) funding issues and disparity between reimbursement rates and cost of care limit access to care; and, (3) consumers, especially families and caregivers, indicate access is significantly limited by lack of a consistent source of accurate, reliable information about what services, supports, and specialty care providers are, in fact, available.
- Issues surrounding coordination and collaboration across agencies and child-serving settings were consistently raised. While some areas of the state are better than others, it is widely felt that processes are not in place to support care coordination and collaborative decision-making around case-specific or system's operations issues. It is unclear whether authority and mandate for interagency coordination and collaboration is statutorily explicit. Additionally, there is a lack of infrastructure in terms of identified personnel and policies and procedures to support the functions of interagency planning and care coordination, especially at the local level.
- A multitude of funding streams feed the work of various state departments, government funded entities, as well as medical and mental health treatment service delivery sites across the landscape of children and youth service settings. However, there is no comprehensive picture to show what all those funding streams are, how many dollars flow through them, or to where all the respective funds go. There is no comprehensive plan to assure that a core set of services and supports are provided and funded, nor is there a strategic process to assure that core services and supports are spread geographically across the state.
- People in communities around the state generally do not feel their voice is heard as it pertains to getting mental health care for children. Families, by and large, feel they need a greater input in the planning and tracking of progress in their children's care. Front-line personnel working with children in communities also indicated feeling that they have valuable knowledge about the adequacy of their mental health resources, but they have no systematic way to voice their information and influence improvements in the quality and/or quantity of available resources.

- Many Tennessee children need and access mental health services during childhood and adolescence, and essentially all children should be being touched by health education and prevention services – but we really don’t know what works. Strategies and processes need to be developed to better track children across time and service delivery settings, especially the higher-level users of mental health care, so the level of progress can be known and so the course of treatment and system involvement can be adjusted accordingly. Additionally, the state needs to figure out and put in place a procedural framework for identifying and promoting clinically effective treatments that are proven by evidence derived from scientific rigor and ethical practice.

### III. SJR799 Study Process

The findings documented herein have been gleaned from information-gathering done in a number of venues over the course of the 18-month long SJR799 study process. Diverse audiences that included people such as educators, juvenile justice and child welfare professionals, childcare providers, mental health professionals, parents and family members, and young people dealing with mental health problems have informed the SJR799 process through a variety of venues. Town hall meetings, a survey which was widely distributed across the state and the work products of five (5) topic-specific workgroups are the key sources of information this report is built upon. A steering committee comprised of representatives of organizations listed in SJR799 assisted staff of the Select Committee on Children and Youth in reviewing and processing the information collected.

#### Town Hall Meetings

During 2007, a series of ten (10) town hall meetings were held around the state, with the average attendance per meeting being approximately fifty-five (55) people. Most of the town hall meetings were video-taped and can be accessed for viewing by contacting Tennessee Voices for Children. A summary of the key issues in each of the meetings is included with this report as Attachment 2.

#### Children’s Mental Health Needs Survey

More than six hundred (600) completed survey forms were gathered from a wide range of stakeholder groups in 2007 and staff of the Vanderbilt Center of Excellence for Children in State Custody compiled the survey responses. A copy of the survey form and copy of the compilation of responses is included with this report as Attachment 3.

#### Core Issues Workgroups

During the fall of 2007, five (5) separate workgroups formed to delve into core system issues. Each group met multiple times and documented core issues relative to their topic. The groups were:

1. Service Array Workgroup
2. Interagency Collaboration Workgroup
3. Management Information System Workgroup
4. Funding Workgroup
5. Accountability Workgroup

The workgroups were convened and facilitated by a consultant with the Nashville-based Center for Non-profit Management (CNM), a support to the SJR799 study process provided by funding from the Vanderbilt Center of Excellence for Children in State Custody. A summary of the

workgroups' products and the support provided by CNM is included with this report as Attachment 4.

#### Summit Meeting

In order to re-engage all interested parties who had participated in any facet of the SJR799 study process to hear and respond to the sum total of information collected through the various venues described above, an open summit meeting was held in Nashville on November 27, 2007. The overarching purpose of the summit was to set forth the conceptual framework for the system of children's mental health care that has emerged through the study process. A copy of the document, **Legislative Cornerstones for a Children Mental Health Care System**, which was presented at the summit, is included in this report as Attachment 5.

Participants heard presentations on the results of the town hall meetings and a summary of information gathered through the survey process. On that day, presentations from each of the five (5) workgroups were open to all interested parties to hear and give comments. Subsequent to the summit, workgroups convened to refine their work products and determined next possible steps in the work of their respective topic areas that will enable and support the overall development of the state's system of mental health care for children. It is intended that these workgroups will support the next phase of system of care development.

#### Conclusion:

SJR799 has provided policymakers an important opportunity to get a broad and thorough look at the state of children's mental health needs in Tennessee. The subsequent conclusions to the findings of this work are that the needs are great and improvement is in order. The path to improvement is not easy and it is not quick. It will take a tremendous commitment from governmental entities, communities, and families all across this state to do the work of system reform. But the work needs to be done.

A bill currently making its way through the House and Senate, HB2502/SB2582, provides a vehicle for continuing the work of developing a comprehensive, coordinated system of children's mental health care that has begun pursuant to SJR799. The provisions of this legislation create a children's mental health council that would be duly authorized and enabled to carry out the strategic steps necessary for building out the framework of this system based on established principles of care. The council would guide the demonstration of the comprehensive, coordinated system of children's mental health care and the use of evidence-, research-, and theory-based over the course of a multi-year implementation process.

There is much yet to be learned about what can and will work to improve children's mental wellness and to address their mental health problems. Yet, what we do know at this juncture of study and system reform work is vital and needs to be used to form the launching pad for phase two of development of a comprehensive, coordinated system of mental health care for Tennessee's children and youth. It is important to provide these children and their families with opportunities for a brighter future, and it is important for the future of our state.

## Attachment 1

## **SENATE JOINT RESOLUTION 799**

**By Herron**

A RESOLUTION to declare an urgent need to thoroughly study all relevant issues pertaining to the extent and nature of mental health needs of Tennessee's children and youth.

WHEREAS, sound mental health and emotional well-being is vital to all of Tennessee's 1.4 million children and youth in order for them to attain their potential as citizens of this great State; and

WHEREAS, there is great disparity across Tennessee in the availability and accessibility of caring, competent, and able child and adolescent psychiatrists, psychologists, and clinical counselors to provide care for children who have mental and behavioral health care needs, and  
this disparity especially exists in rural and remote counties and communities; and

WHEREAS, it is estimated that almost 68,000 children in Tennessee meet the criteria to be diagnosed as having a serious emotional disturbance, and approximately 45,500 of those children are enrolled in TennCare; and

WHEREAS, within the State of Tennessee, suicide is the third leading cause of death for youths fifteen to twenty-four years of age, and within one-third of Tennessee's counties the suicide rate for this age cohort exceeds the national rate; and

WHEREAS, alcohol and substance use among Tennessee's children and youth is serious and significant, with results from the Youth Risk Behavior Survey revealing the following regarding Tennessee public high school students in 2005: seventy-five percent reported taking at least one drink of alcohol in their life; twenty-four percent reported taking their first drink of alcohol other than a few sips before the age of thirteen; forty-two percent reported having at least one drink, and twenty-five percent reported having five or more drinks, within a couple of hours within the past thirty days; and eleven percent reported driving a vehicle when they had been drinking alcohol within the past thirty days; and

WHEREAS, a fall 2003 study of youth in juvenile justice facilities in Tennessee documented at least fifty-three percent had mental health problems, forty-two percent had substance abuse problems, and thirty percent had co-occurring mental illness and substance use; and

WHEREAS, the 2004 Tennessee Commission of Children and Youth Children's Program Outcome Review Team review of children in the custody of the Department of Children's Services indicated fifty percent of all children in custody, sixty-nine percent of adolescents, and eighty-four percent of children adjudicated delinquent had a mental health diagnosis; the report further indicated forty-eight percent of adolescents, including seventy-two percent of children adjudicated delinquent, had substance abuse issues; and

WHEREAS, in 2004-2005, 175,692 Tennessee students were receiving special education services, of which 5,079 were seriously emotionally disturbed; and

WHEREAS, children and youth are not immune from debilitating trauma and psychological difficulties subsequent to the extraordinary tragic events such as occurred in our country on September 11, 2001, or the acts of violence at schools such as occurred at Columbine High School in Littleton, Colorado, at Campbell County Comprehensive High School in Jacksboro, Tennessee, at West Paducah High School in Paducah, Kentucky, and at a school bus stop in Cumberland City, Tennessee, or from their own personal experiences of abuse, neglect, or bullying, or even from the war-related death and mayhem seen on televisions in homes each day and night all across this country; and

WHEREAS, all children are at risk of threat of harm to their emotional stability and wellbeing because of tragic yet natural or accidental life occurrences, such as death of parents, siblings, extended family members, and friends, and may experience bouts of clinical depression, post-traumatic stress disorder, and behavioral problems; such children do, indeed, need professional mental health services to recover from such times, and without timely, highquality professional help may never recover; and

WHEREAS, Tennessee lacks a public children's mental health service delivery system that is sufficiently coordinated, comprehensive, and effective in identifying, assessing, diagnosing, treating, managing, and supporting children who have mental health care needs; and their families, and thus, the delivery system for services to meet their needs is greatly fragmented, too often inaccessible, and largely inadequate; now, therefore,

BE IT RESOLVED BY THE SENATE OF THE ONE HUNDRED FOURTH GENERAL ASSEMBLY OF THE STATE OF TENNESSEE, THE HOUSE OF REPRESENTATIVES

CONCURRING, that this General Assembly declares an urgent need to thoroughly study all relevant issues pertaining to the extent and nature of mental health needs of Tennessee's children and youth and how those needs can be thoroughly, competently, compassionately, and effectively addressed and met.

BE IT FURTHER RESOLVED, that the Select Committee on Children and Youth shall study the children's mental health system in Tennessee and develop recommendations for its improvement, and the Select Committee is authorized to establish a study committee of appropriate persons from whom it may obtain consultation and receive advisement in this effort.

BE IT FURTHER RESOLVED, that, as appropriate and upon request, representatives of the Office of the Comptroller of the Treasury, of the Departments of Mental Health and Developmental Disabilities, Children's Services, Education, Health, Human Services, of the Governor's Office of Children's Care Coordination, of the Commission of Children and Youth, along with individuals who have personal experience or expert knowledge pertaining to mental health care and service delivery to children, shall provide assistance in the study process.

BE IT FURTHER RESOLVED, that an interim report describing the mental health needs of Tennessee's children and youth, along with an initial blueprint for a comprehensive, coordinated, family-centered, and culturally responsive system for the mental and the behavioral health care of Tennessee's children and youth, be delivered to the legislature on or before April 1, 2007.

BE IT FURTHER RESOLVED, that a final report setting forth the master plan for development, implementation, and on-going oversight of such comprehensive, coordinated, family-centered, and culturally responsive system for mental and behavioral health care of the State's children and youth be delivered to the legislature on or before April 1, 2008.

## Attachment 2



# **Overview**

## **SJR799 Town Hall Meetings Comments**

**October 17, 2006**

**TVC Conference/Nashville**

Main Points/Recommendations:

1. Focus needs to be on prevention and early care.
2. Parents reflected on the need for someone to be there to help them. Programs and services need to be available so they can get help for their children when they need it.
3. Source of payment is often a barrier to accessing mental health care; lack of parity between medical and mental/behavioral health coverage exists within many insurance plans.

**January 16, 2007**

**Jackson Town Hall Forum**

Main Points/Recommendations:

1. The entire family needs to be involved in child's care.
2. Teachers need to be made aware of issues and need to know how to make referrals
3. School personnel are afraid to make referrals because they are afraid they will be financially responsible for services.
4. Parents need help with transition services from DCS.
5. Training for teachers about children's mental health issues and behavior management should be required; teachers should get this training through their undergraduate curriculum before they ever begin teaching; some periodic in-service training on dealing with children's mental health problems in classrooms and schools should also be required.
6. TennCare does not always cover treatment needs; provider networks are often not sufficient and geographic/distance barriers making accessing services very difficult in rural areas.

**March 29, 2007**

**Cookeville Town Hall Forum**

Main Points/Recommendations:

1. Lack of credible information and knowledge of where to find mental health professionals delays proper diagnoses being made and good treatment plans being developed and implemented.
2. When very young children (birth – 3 years old) are diagnosed with developmental disabilities they often will have emotional and mental healthcare needs later in life.
3. Interventions and treatment must happen in close time proximity to diagnoses being made (i.e. early on and quickly) in order to offset or minimize the degree of debilitation experienced later in life.
4. Foster children's mental health needs vary, and not all even have such needs. However, when mental healthcare is needed, thorough evaluations, proper diagnoses and individualized treatment plans should be guaranteed.
5. A significant number of children come into state custody due to their parents' mental health problems and unmet needs.
6. Children's mental health suffers when parents have substance abuse problems.
7. Gaps in services are especially pronounced in rural and remote areas such as the Upper Cumberland region; transportation is probably the single greatest barrier to available and accessible mental healthcare in this region.

**June 7, 2007**

**Knoxville Town Hall Forum**

Main points/Recommendations:

1. Parents and officials such as the justice system wait a long time to get the help that is needed for their children or the children they serve.
2. The greatest need articulated is for acute care services to quickly assess and thoroughly evaluate children evidencing mental health problems that threaten their safety and/or that of the community.
3. Courts need mental health coordinators, people who are responsible for knowing the milieu of mental health services and supports available; they should have the ability to access these resources as needed by children and juveniles who are before the court.
4. Early intervention is needed to keep children's problems and circumstances from growing worse over time because no one or no system acknowledges the problems and triggers appropriate assessment to occur.
5. Funds are needed to go with coordination of services so there is an existing and known source of payment; time is often lost while people are trying to figure out who can and will pay for what services and treatment.
6. Teamwork between agencies/departments needs to be a legislative mandate.
7. Children do not get the education or life preparation they need in terms of social skills, how to manage their own mental health needs, or how to recognize and accept diversity and differences among others.
8. Therapeutic after-school programs would be good for children; reinstating therapeutic preschool programs and nurseries would also be a valuable resource.

**July 9, 2007**

**Memphis/Shelby County Town Hall Forum**

Main points/Recommendations:

1. Child development is the foundation for community development.
2. Natural integration is key for children to live and function successfully in their communities.
3. Daycares need to be environments where staff know about and recognize children with developmental and emotional difficulties; these environments should be strengthened and properly resourced so they can be not only a learning environment for children but also a supportive environment for parents and caregivers.
4. Family support services need to be 'mother-friendly'.
5. Services need to be culturally relevant to the families and social institutions within the communities they serve.
6. Need sufficient payor response time; eliminate delays in receiving payor approvals in both public and private insurance programs, and provide for prompt appeal processes whenever possible.
7. Reimbursement restrictions of TennCare are greatly restricting access to mental health services esp. for non-custodial children.
8. Need for preventive mental health-focused training and support for children in daycare settings; recognize and structure this training and support to target and reach parents and caregivers.

**July 19, 2007**

**Nashville/Mid-Cumberland Town Hall Forum**

Main points/Recommendations:

1. Teacher training about children's mental health needs, and support from mental health professionals for teachers to effectively deal with and manage children with mental health problems while in the school setting is very much needed.
2. Make sure anti-bullying legislation is implemented and achieving the intended purpose.
3. Courts need the presence of mental health professionals to support the judicial process in terms of getting timely and appropriate services for children with mental health and/or drug problems.
4. Raise awareness about the need for trained, knowledgeable advocates for families.
5. Early Intervention is greatly needed.
6. Improve the quality of Alternative Schools; link mental health service delivery systems to Alternative Schools so that kids get the help needed to address precipitating problems and increase likelihood of successful transition back to regular school settings.
7. Promote practice of universal screening by pediatricians of all children beginning at very young age and periodically across the adolescent age span in order to detect and initiate therapeutic response to developmental and behavioral health problems.
8. Experience of trauma on children's mental health needs to be studied.
9. Have evidence-based programs as the core of the service array available for children and families.

10. Presence of Mental Health Liaisons in schools is proven effective for better outcomes for children with mental health needs; liaisons need to be spread throughout the school system as core staff.
11. Mandate mental health training for all education professionals working with children in schools.

**August 9, 2007**

**Columbia/South-Central Town Hall Forum**

Main points/recommendations:

1. Early identification and prompt, appropriate intervention are the keys to successfully dealing with children's mental health problems.
2. Identification and crisis stabilization has to go further; appropriate treatment for a sufficient period of time is necessary if level of functioning is to improve and/or recovery is to occur.
3. Providers who deliver quality child care should be required to integrate knowledge and practice of children's mental and emotional development into their program structure and content.
4. Integration of education and mental health care among preschool age children in service delivery systems such as TEIS and state-funded Pre-K classrooms is important.
5. Social and emotional support for families who have children with mental health problems is very much needed.
6. Waiting lists for mental health services causes delays in the juvenile courts being able to try and achieve the legal intent to treat and rehabilitate children who come in contact with the juvenile justice system.

**September 13, 2007**

**Martin/Northwest Town Hall Meeting**

Main points/recommendations:

1. Resourcefulness and strength of faith-based community is a strong point for this region; however there is definitely a need for more such support and for more churches to get involved helping young people.
2. Early identification with timely and appropriate intervention is a big challenge.
3. Comprehensive early-on assessments are so necessary but very hard to get.
4. The region has a dearth of resources — folks describe the northwest area as a 'resource desert'.
5. Funding: When insurance ends treatment and services stop, it doesn't matter whether the child is better or not. Just as much a problem, though, is even when funding is available there is a critical lack of competent providers.
6. No residential care in local area or region, closest residential placements are in excess of an hour away; distance and lack of transportation create tremendous barriers for families to visit and be involved in their children's treatment.

**September 19, 2007**

**Chattanooga/Southeast Town Hall Meeting**

Main points/recommendations:

1. Challenges of serving diverse population are significant and result in needs going unmet.
2. There is a real need to move mental health services into schools.
3. Delays in getting appointments – sometimes it takes months: This creates a significant barrier to timely onset of care.
4. TennCare rates are inadequate; this directly impacts availability and access to care because providers opt not to participate in MCO/BHO networks and see TennCare enrollee children.
5. In-patient resources are inadequate for children with serious mental health problems; however, some exceptional care for autistic children does exist.
6. There is great need for early identification of problems and proper diagnosis, and for timely access to services.
7. Agencies need to work together for children; coordination and communication between schools, courts, state and community-based services agencies, with parents and caregivers is greatly needed.

**September 26, 2007**

**Johnson City/Northwest Town Hall Meeting**

Main points/recommendations:

1. Kids are staying in DCS custody longer due to lack of mental health services.
2. Systems are working together well to intervene with and address needs of children who come before the court up until the point that residential/out-of-community treatment is needed, then geographic access factors create problems.
3. The DCS observation & assessment facility in Johnson City has noteworthy longevity in assessing children at risk of custody in a short-term residential setting, and has produced good custody-diversion outcomes among the population served; a 10-bed grant-funded observation & assessment facility is also operated in Kingsport by a community mental health services agency. This type of facility should be seriously considered for replication in other locations around the state where short-term/out-of-community assessment of juveniles with known or suspected mental health and/or co-occurring disorders is especially needed.
4. Training for professionals working with exceptional children, especially teachers, is needed.
5. Schools have great need for increased access to mental health services and supports. The school-based mental health service structure that is in place is considered very effective, the region just needs more funding to expand the structure and create more capacity so more children can be served.
6. Coordination and collaboration among agencies needs to be made a condition of funding.
7. Some means of reimbursement (\$\$ and process) for case management and care coordination activities needs to be put in place; school personnel and mental health professionals (psychiatrists, therapists, etc.) have no means of covering the cost of time spent interacting with systems representatives (DCS, courts, etc.) to create a coordinated course of action for a child and their family.
8. Payor/reimbursement rates for TennCare need to be increased, they do not cover anywhere near the cost of care.

This document has been prepared in the office of the executive director of the Select Committee on Children and Youth. The information contained herein is intended to give a general representation of the comments heard and received through a series of public meetings which were held for the purpose of gathering broad and diverse input to inform the SJR799 study process. If you have questions or would like to submit further comments you may call 1.800.449.8366, ext. 44831 or 44832.

## Attachment 3

The purpose of this survey is to gather information about services for children and youth with mental health needs in Tennessee. Please think about the services provided in your area and tell us what you want us to know by completing this survey.

The information from this survey will be summarized at a statewide and regional level for the purpose of informing the Select Committee on Children and Youth related to Senate Joint Resolution 799 of the current status of mental health services to children and youth in Tennessee.

1. Please indicate your County of Residence: \_\_\_\_\_

2. Are you a:

Youth

Parent

Parenting a child related to me – grandparent or other (please circle one)

DCS Case Manager

Mental Health Practitioner (social worker, psychologist, therapist)

Mental Health Administrator

Mental Health provider

Primary Care Provider (physician, pediatrician, etc.)

Juvenile Court Judge or staff

Child Advocate

Other, please list your role: \_\_\_\_\_

3. What aspects of children's mental health are most important to you?

Transportation

Access to appropriate mental health services

Access to appropriate treatment services

Access to qualified treatment personnel

Insurance coverage

Adequate Provider network

Program funding

Staff Training

Communication

Availability of Community Programs

Other, please list: \_\_\_\_\_

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4. What do you think are the strengths in children's mental health services in your community?

5. Is there a place to get mental health services for children and families in your community?

If not, how far do you have to travel for services?

6. What do you need help with the most for your child's or your own mental health needs, or for the mental health needs of the children and families you serve?

7. What do you consider to be the greatest barrier(s) to getting needed mental health services for children in your community?

**Instructions: Please indicate your level agreement or disagreement with the following statements.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
8 There are adequate mental health services for children in Tennessee.					
9 There are adequate mental health services for children in my community.					
10 There is good coordination of services between the agencies I utilize.					
11 Caregivers and family members are active participants in their loved ones' treatment planning.					
12 Caregivers and family members are active participants in their loved ones' treatment.					
13 Caregivers' and family members' participation is valued.					
14 In my community, it is difficult to access mental health services for children.					
15 In Tennessee, it is difficult to access mental health services for children.					

**Thank you for your assistance in completing this survey.**

Survey Site/Target Audience \_\_\_\_\_ date administered\_\_\_\_\_

**Please return completed surveys to:**

**[debbie.gazzaway@legislature.state.tn.us](mailto:debbie.gazzaway@legislature.state.tn.us) or fax to: 615-741-5471.**

## County

- 676 surveys
- Middle Tennessee had the highest number of returned surveys
- Top Five Counties
  1. Davidson 137 surveys (20%)
  2. Shelby 51 surveys (7.5%)
  3. Madison 32 surveys (4.7%)
  4. Knox 31 surveys (4.5%)
  5. Williamson 29 surveys (4.2%)

## Person Type

- Most respondents were professionals within the system (some respondents checked more than one category)
  - Professional 342 surveys (50.6%)
  - Family 96 surveys (14.2%)
  - Other 268 surveys (39.6%)

\* The “other” category likely included a large number of teachers

## Aspects that were important to respondents.

1. Access to appropriate MH services
2. Access to appropriate Treatment Services
3. Access to Qualified Treatment Personnel
4. Availability of Community Programs
5. Insurance

\*Very little variability by region or by type

## Strengths

1. Access to necessary services
2. None
3. Other
4. Committed Providers
5. Community Mental Health Centers

## Local Access

- Most people (81.5%) had access to mental health services in their community.
- Those who did not drove an average of 28.5 miles for services.

## What do you need help with most?

1. Access (13.2%)
2. Other (11.2%)
3. Insurance (7.5%)
4. Qualified personnel (7.3%)
5. Specialized services (6.9%)

## What do you consider the greatest Barriers?

1. Insurance (13.2%)
2. Educating Families (12.7%)
3. Access (11.6%)
4. Other (10.8%)
5. Funding for programs (10.8%)

### **Likert Questions**

There are adequate mental health services for children in Tennessee

- 63.31% either disagree (41.42%) or strongly disagree (21.89%)
- 21.75% either agree (20.56%) or strongly agree (1.18%)

There are adequate mental health services for children in my area

- 56.51 % either disagree (33.43%) or strongly disagree (23.08%)
- 25.15 % either agree (23.96%) or strongly agree (1.18%)

There is good coordination of services between the agencies I utilize

- 45.56% either disagree (32.40%) or strongly disagree (13.17%)
- 20.86 % either agree (18.79%) or strongly agree (2.07%)

In my community, it is difficult to access mental health services for children

- 26.63% either disagree (22.04%) or strongly disagree (4.59%)
- 40.68% either agree (24.56%) or strongly agree (16.12%)

In Tennessee, it is difficult to access mental health services for children

- 18.49% either disagree (14.64%) or strongly disagree (3.85%)
- 50.30% either agree (35.80%) or strongly agree (14.50%)

Caregivers and family members are active participants in their loved ones' treatment planning

- 30.77% either disagree (25.89%) or strongly disagree (4.88%)
- 24.11 % either agree (21.0%) or strongly agree (2.81%)

Caregivers and family members are active participants in their loved ones' treatment

- 29.59% either disagree (25%) or strongly disagree (4.59%)
- 23.82% either agree (21.45%) or strongly agree (2.37%)

Caregivers and family members' participation is valued

- 16.12% either disagree (11.98%) or strongly disagree (4.14%)
- 31.80% either agree (25.89%) or strongly agree (5.92%)

## Attachment 4

Service Array Workgroup

Service Array Workgroup

## **Eligibility for services and supports under SJR799:**

**Children and their families ages 0-24 that meet the following definition of emotional and behavioral:**

### **Those children at risk for:**

- Behavior that impairs their function at home, school and/or community and/or
- Meets the criteria for a Mental Health and substance abuse diagnosis by the DSM IV TR and/or
- Those children placed outside the home for treatment and/or
- Those children currently in inpatient care

Group discussion of “at risk”, meaning the opportunity exists for prevention/early identification

### **Children experience with:**

- sexual/physical abuse
- neglect
- lack of supervision
- school issues (e.g. truancy)
- health issues
- state custody
- aging out of foster care
- substance abuse issues
- trauma
- negative peers
- juvenile justice and the courts
- employment issues

### **Parents have experience with:**

- addiction
- mental health issues
- incarceration
- domestic violence
- poverty
- homelessness
- employment issues

**Mental Health Services**

Prevention  
Early Identification & Intervention  
Screening & Assessment  
Outpatient Treatment  
Home-Based Services  
Day Treatment  
Emergency Services  
Respite Care  
Therapeutic Foster Care  
Therapeutic Group Care  
Therapeutic Camp Services  
Transitional Living Services  
Independent Living Services  
Crisis Residential Services  
Inpatient Hospitalization  
Residential Treatment Services (short term)  
Aftercare

**Educational Services**

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

Tutoring and after school programs

**Substance Abuse Services**

Prevention  
Coordination  
Early Intervention  
Screening & Assessment  
Outpatient Services  
Day Treatment  
Detoxification  
Relapse Prevention  
Community Residential Treatment  
& Recovery Services  
Inpatient Hospitalization

**Recreational Services**

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

**Social Services**

Protective Services  
Financial Assistance  
Home Aid Services  
Respite Care  
Shelter Services  
Foster Care  
Adoption  
Aftercare

**Health Services**

Health Education & Prevention  
Screening & Assessment  
Primary Care  
Acute Care  
Long-term Care

**Vocational Services**

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

**Operational Services**

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

**Nontraditional Services**

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

Interagency Collaboration Workgroup

### **What is the capacity of an administrative entity?**

- Broad knowledge of mental health, education
- A sound understanding of SOC principles/philosophical framework
- Competency in integrating components of the system of services and supports
- Understanding of the culture of partnerships
- Sound business ethics
- History of strong administrative practices
- Ability to maximize revenue streams
- Ability to move systems forward
- Assure quality of services
- Ability to measure services and outcomes
- Ability to manage collaborations
- Facile in information management
- Ability to manage services and outcomes
- Authorized to hold all partners accountable for all collaboration and performance related activity in relevant program areas such as:
  - Intake
  - Transition
  - Data Sharing
  - Funding Streams
  - Services Planning
  - Policy Development

### **Definitions of areas of collaboration:**

#### Intake:

- No wrong door
- Points of entry
- Referral process
- Eligibility determination
- Communication with customers
- Outreach, notification of where to go next/next steps

#### Data sharing:

- For the purpose of seamless transition
- Resist duplication
- Increased coordination of services
- Inform accountability
- Sharing resources

Idea: leverage MRS system Local Advisory Councils(Community Advisory Boards – CABS) which is an example of what already exists in law and could be the infrastructure for this system (Referral, Intake, Data Sharing).

#### Service delivery:

- Plan implementation of appropriate services and supports at level indicated in the plan
- Services and supports are coordinated
- Transitions from one service to another
- Transitions from one system to another

... based on appropriate services and individualized needs (not on availability)

Service planning:

- Identifying and planning for services and supports
- Multiple stakeholders with one plan
- Incorporates services plans in place already and augment with components of system of services and supports

Idea: Decide critical criteria that meet System of Services and Support requirements; then each provider

uses their form as long as critical information needs are met.

Funding streams:

- Budgets are developed to align with relevant areas of services and supports
- Where are multiple funding streams with common purposes
- Leveraging funding where appropriate and available

Policy Development:

- Compatibility in laws, rules, regulations
- Simplified interagency agreements
- Keep child and family at the Center
- Mutual accountability
- Outcomes
- Management

**Vision:**

Tennessee will deliver a comprehensive, coordinated system of mental and behavior health services and supports to meet the needs of children ages 0-21 with children and their families as full partners. This will result in healthy social-emotional development of the child and family in the communities in which they live.

**Principles of service:**

In order to accomplish this vision, there will be one single entity with the infrastructure in place:

- to support coordination and collaboration on behalf of providers
- for early identification of behavioral and mental health needs
- to provide evidenced based proven practice and enforce accountability among all partners in the system

**Children ages 0-24:**

1. Have access to a comprehensive array of services and supports that address the child's physical, emotional, social and educational needs. These services are data-informed, based on promising and proven practices.
2. Receive individualized, community-based services and supports in accordance with the unique needs and potential of each child guided by an individualized service plan.
3. Receive services and supports within the least restrictive, most normative environment that is clinically appropriate
4. Are, along with their families and/or surrogate families, full participants in all aspects of the planning and delivery of services.
5. Receive services and supports that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Are provided with case management or similar mechanisms to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Experience early identification, intervention, and prevention in order to enhance the likelihood of positive outcomes.
8. Experience smooth transitions to the adult service system as they reach maturity.
9. Have the rights of protection and effective advocacy efforts.
10. Receive services and supports without regard to race, religion, national origin, sex, physical disability, or other characteristics; and services are sensitive and responsive to cultural differences and special needs.

This system leverages the resources of all public, private and nonprofit mental and behavior healthcare providers, supported across systems through finances, data and mutual accountability.

Management Information System (MIS) Workgroup

## Questions to ask:

1. Why do we need to collect data/information?
2. What are the characteristics of a data/information management system?
3. What should be collected?
4. How do systems talk to/work with each other? Where/how do they talk to each other?

### 1. Why collect data and information:

- To have real time care coordination at a local level
- To make data driven decisions
- To make good decisions about client, community needs
- To make projections based on data
- To correlate services to cost (cost/benefit for an economic argument)
- To correlate services to cost (cost/outcomes)
- So families don't have to tell their story over and over gain
- To correlate and coordinate services across systems
- To try to attain national outcome measures

### 2. Characteristics of a data and information management system:

- User friendly
- Readily available (ease of access inputting data and taking it out)
- "Need to know" controlled
- Find data and synthesize to make sense
- Updated in real time
- Able to access what you need to know and no more
- Uniform data elements
- Meets uniform standards in data dictionary across agencies
- Commitment/agreement regardless of auspice about the minimum data collected.
- Geo-coding/GIS capabilities, to map services and demographics
- Protects confidentiality and has consequences for violations and allowances for expungements and updating

### 3. What should be collected?

- Demand for services
- Identify services that are needed but not available
- Needed but intensity not available (How many, how much, how often)
- Waiting times for services
- Referral source and disposition
- Costs/methods of payment
- Aggregate demographic child/family information sufficient to address the level of intervention and funding source requirements
- Information critical to achieve/maintain state/local federal funding sources
- Information critical to demonstrate child/family's need related to outcomes inclusive of :
  - well-being
  - safety,
  - permanency,
  - education,
  - successful
  - behavior management and

- transitions at developmental and age appropriate milestones
- Information critical to achieve/maintain quality standards appropriate to the level of care (TCAHO/CARF/COIA, NOMS)
- Location of services/where services are rendered
- Housing/Placement (child and family information)
- Court involvement
- Inventory of all fund sources supporting the system:
  - Sources
  - Amounts/duration
  - Uses
  - Distribution
  - Outcomes
- Collection/capture of aggregated data regardless of pay or source/or no payment for services

5. How do systems talk to work with each other?

- A need for a data clearing house
- Systems need to talk to each other to share child specific data and global picture aggregated data
- Inventory state data systems to check compatibility
- What are the states current activities to develop MIS in Human services agencies?
- How do they accommodate the characteristics? (TEIDS/SSACWIS systems Edison, VIP etc.)

**Parking lot:**

- 4. What exists now? Continue to send information on existing data sets to identify information.
- 6. What are the state's current activities in Human Service Agencies to develop information management systems? Work on identification and compile.

## Funding Workgroup

**Funding Work Group:**

**Group approach to funding conversation:**

Look at the services off of the Service Delivery Workgroup's work.

Identify the ones that are:

- Federally required
- State required
- State chosen
- Public contracted
- State legislated

Begin with "core services" or those that have a legal requirement (federal, state, condition of funding, contract provision)

Identify and prioritize those that are federally required

**Services and supports reviewed for Funding sources:****Mental Health Services:**

TennCare Bureau, CoverKids, TCCY (respite with D of J funding)

TN Dept. of Children Services, Local courts (C/COO), TN Dept of Commerce and Insurance, TN Dept. of Education

Sources of information: TN State Departs, Youth Villages, TAMHO, Project Safe Schools, Judges Assn

Important to maximize coordination to prevent duplication (insurance funding as it relates to parity)

**Health Care Services:**

TennCare, FQHS, TN Dept. of Health, TN Depart. of Education (coordinated School care), CoverKids

Sources of information: TN State Departs

**Educational services:**

LEAs, TN Assoc. of School Boards, TN Dept of Education, Juvenile Courts (pre and post detention)

Sources of information: TN State Depts., Project Safe Schools, Judges Assoc, TN Assoc of School Boards,

**Substance Abuse Services:**

TennCare, TN Dept of Mental Health and Developmental Disabilities; Juvenile Courts (post adjudicated level 4), TN Dept. of Children Services

Sources of information: TN State Dept., TAMHO, Judges Assoc

**Vocational Services:**

TN Dept of Labor and Workforce Development, TN Dept. of Education , TN Dept of Human Services (TANF), TN Dept of Human Services (Voc Rehab), TN Dept of Mental Health and Developmental Disabilities, Tennessee Board of Regents (community colleges), TN Dept. of Children Services (Independent Living supports)

Sources of information: TN State Depts.

**Operational Services:**

Case Management: TN Dept of Health, TN Dept. of Children Services, TN Dept of Mental Health and Developmental Disabilities, TN Department of Mental Retardation, TN Dept. of Labor and Workforce Dev, TN Dept of Education (TEIS)

- What are special education components?
- Juvenile court: When it's the front door, make services follow, no case management services delivery capability

Sources of information: TN Depts, TN Association of School Boards, TennCare Bureau, TAMHO, Judges Assn

**Support Services:**

TN Dept of Mental Health and Developmental Disabilities, DMRS, TN Dept. of Children Services (adoption) Juvenile Courts, TN Dept of Human Services , TN Dept of Health, TN Dept. of Children Services/Chile Advocacy Centers's

**Transportation:**

TennCare, , TN Dept. of Children Services Dept. of Health, TN Dept of Human Services, Voc Rehab, Dept. of Finance and Administration

**Legal:**

Legal Aide, Disability law and advocacy Center, TJC, Law school clinics, Probation and aftercare, Juvenile Courts (youth services workers) County governments, TCCY (need case management role)

**Recreational:**

After school, 21<sup>st</sup> century, Dept of Ed

**Social Services:**

DHS (Homemakers, Home Health, Well Children, "Safe Place", FQHS, TN Dept. of Children Services (state and federal) Office of Criminal Justice (VOCA), TN Dept of Human Services (shelters)

**Nontraditional Services:**

Mentoring:

Big Brothers/big Sisters, 21<sup>st</sup> Century Schools, Independent Living (DCS), TN Dept of Ed, Governor's Mentoring Program (TN Dept. of Children Services)

Sources of information: TN Depts, TN Association of School Boards, TennCare Bureau, TAMHO, Judges Assn; United Way Assoc.

**Peer to Peer:**

Boys/Girls clubs, TN Dept of Mental Health and Developmental Disabilities – NAMI, Peer Support Services, TN Dept of Mental Health and Developmental Disabilities, TennCare, United Way

**Caregivers:**

Dept of Health, DHS, TN Dept of Mental Health and Developmental Disabilities (respite training), TennCare (MCCs and MH Association)

**Faith-based:**

All Federal Departments (unreachable in terms of identifying who got money in Tennessee)

**Flexible spending:**

TN Dept. of Children Services, TN Dept of Mental Health and Developmental Disabilities, Systems of Care (TN Dept of Mental Health and Developmental Disabilities) TennCare, Individual Services/Family Preservation, TN Department of Mental Retardation, Family support, each agency gives executives

**CCRR:**

TN Dept of Human Services

**Family support:**

TN Dept of Human Services (Day Care), TN Dept. of Children Services (Day Care)

**Family Resource Centers:**

TN Dept of Education.

**Systems of Care:**

Provide Part time engagement (TN Dept of Mental Health and Developmental Disabilities), SAMHSA

**Parking lot:**

How to deal with 3<sup>rd</sup> party community to maximize coordination of insurance funding..  
PARITY

Ask each funding entity for examples of how they use flex funding and how much (and the source)

What we want from state agencies:

- How much funding is available
- What are the categories of eligibility?
- Conditions of use of the funding
- (by allotment codes (programs))

Future: formalizing through contracts braiding/blending funding

Accountability Workgroup

## Accountability Workgroup

### **Definition of Accountability:**

Degree to which systems provide quality services defined as needed by individual services plans of children and families. Quality measures include:

- Accessibility and availability
- Outcomes

### **Principles of a system of accountability:**

- Standardized criteria are in place for tracking outcomes and progress (follow the child across systems)
- There are established levels of care and services across systems
- System is accountable for providing appropriate service
- There is a balance between “one size fits all” and expectations of criteria of services
  - Match up with service plan
  - Tie accountability to delivery of services
  - Monitor availability of services

**Top priority outcome/process measures and indicators already in place (*note: group agreed these outcomes need to be rolled up into higher level groupings of true outcomes, versus current mixture of measures and indicators*):**

DCS:

- Decrease in state custody
- Increase in family permanency

Juvenile Justice:

- Decreased recidivism
- Decrease placement in secured facilities

Dept of Mental Health and Mental Retardation

- Reduction of DMC
- Bring successful best and evidence based practice to scale

Dept. of Education:

- Increased graduation rates
- Increased academic performance
- Increased school attendance
- Decreased suspension/expulsion

DHS:

- Increased number of families leaving the roles (TANF) due to employment
- Increased level of employment

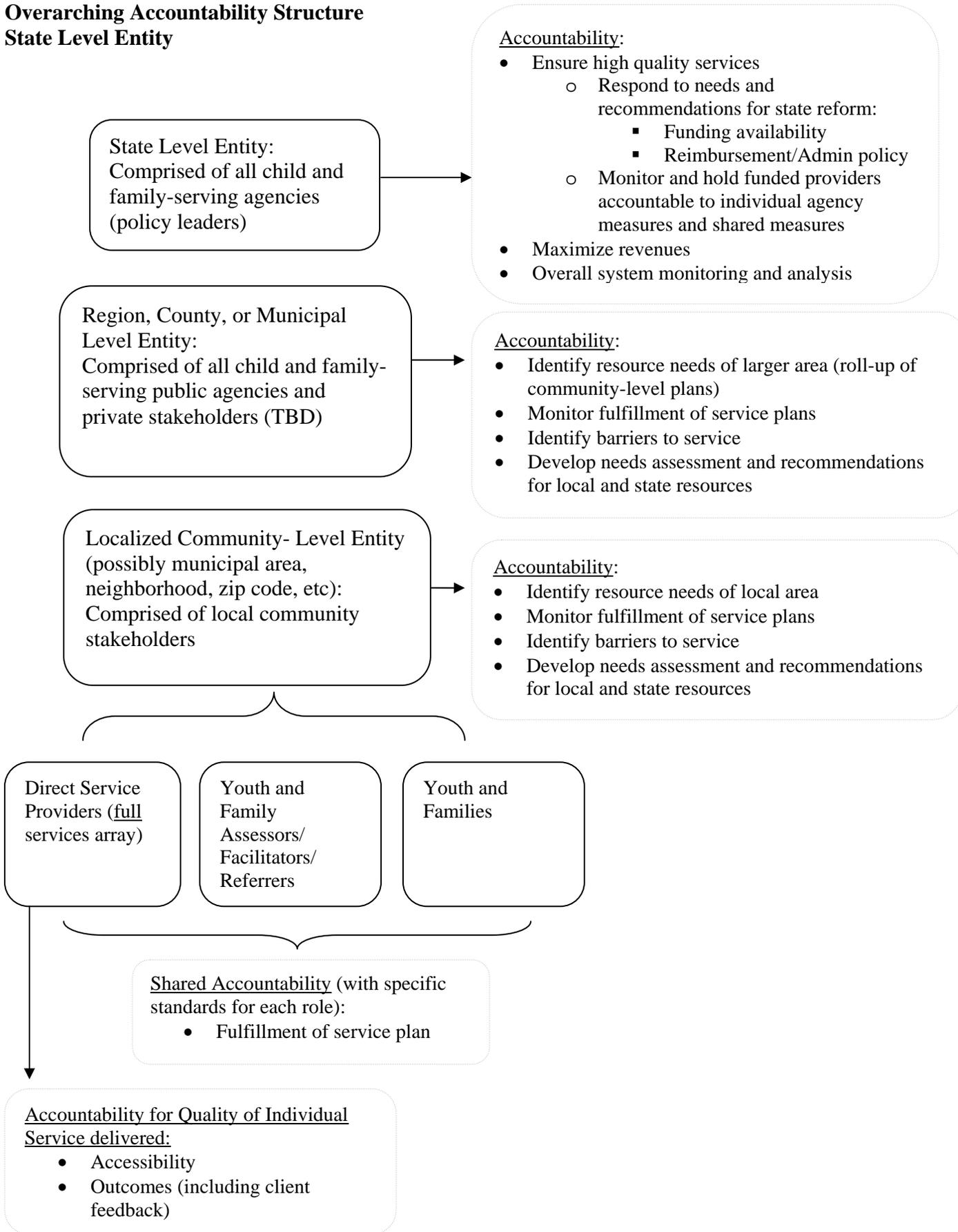
### **Mental Health and A&D:**

- Reduction in drug and alcohol abuse
- Reduction in suicide rates
- Decreased inpatient and residential treatment

Other:

- Increased access to services
- Increase family involvement in all levels of planning and implementation
- Increased cultural competencies
- Increased healthy lifestyle choices
- Decreased youth risk behaviors
- School readiness
- Improved birth outcomes
- Penetration of evidence-based treatment
- Decrease in youth with any Juvenile Court involvement
- Increased wellness, recovery, and resiliency
- Increased family self reliance
- Increased positive youth development
- Increased child safety
- Increased community involvement in well-being of children
- Increase in caring communities

**Overarching Accountability Structure  
State Level Entity**



## **Roles of State-level Accountability entity:**

Ensure adequate high quality, accessible resources to meet individualized need of youth and families across the state:

- Hold individual providers to meet needs
- System is accountable for aggregate
- Funding to meet the need
- Policy/reimbursement
- Support evidenced based practice
- Organized to perform these functions mandated through interagency collaboration
- Monitor and hold providers accountable
- Provide infrastructure to local communities to perform service delivery

Maximize revenue:

- Use leveraged funds first
- Use limited state funds next
- Identify and secure additional federal dollars

Gather, analyze and disseminate information for system's improvement and policy development (data informed decisions)

## **Building Blocks/Models:**

TEIS Service Monitoring System

- Single data base
- "need to know"
- Centralized access
- Suitable for community data complements
- On line

TOMS client/provider quality

- Planning tool
- On-line

CANS (DCS)

- Comprehensive planning tool
- Online

YRBS outcomes reporting

TADS and TADPOLES A & D outcome measures

## Attachment 5

## Legislative Cornerstones for a Children's Mental Health Care System

Prepared by Cindy Perry, Executive Director, Select Committee on Children and Youth  
November 27, 2007

The SJR799 study process is to culminate with recommendations to the General Assembly for improving the system of mental health care for children that will ultimately improve the mental and emotional well being of Tennessee's children. In considering the sum total of information and work that has gone on over the course of the study, four (4) distinct cornerstones of a system of mental health care have become clear.

### 1. Vision as a System Cornerstone

Tennessee should have a vision and a plan for a comprehensive, coordinated system of children's mental health care, and the law should articulate that vision. The vision should place families of children with mental health needs and the governmental agencies responsible for serving children in full partnership around the design, development, and governance of the mental health care system. The vision should state the intent of the state to strive to promote practice, deliver services, and operate programs that are reasonably expected to be effective based on emerging information and/or known evidence from the professional fields of medical and behavioral science, and based on family satisfaction with improvement in keys areas of the child's life functioning. The vision should obligate the state and other stakeholders to assure availability and access to a core set of services and supports to address the milieu of mental health needs that children and youth experience and that their families must address and manage. The vision should explicitly state that child-serving state agencies, advocacy organizations, and consumers shall have defined roles in the governance and oversight of the state's system of mental health care for children.

### 2. Interagency Coordination as a System Cornerstone

There should be statutory mandates and a systematic process that links together in decision-making and accountability all agencies and parties involved in a child's care and in the operation of the children's mental health care system. An entity within state government needs to exist and be vested with the authority for facilitation and governance of the children's mental health system of care. Across and within the network of agencies, both state government and community-based, the assurance of availability and access to the core set of services and supports needed to address and manage both biological- and behavioral-based mental health problems that manifest among children and youth should be made explicit. The collaboration of the system of care agents should produce a presence of infrastructure through which the work of the system is actualized. This infrastructure should be formed by two (2) component parts: First, there should be a sufficient presence of personnel with mental health expertise to direct assessment, evaluation, diagnosis, intervention/treatment planning and implementation, and progress monitoring to completion of care available to all communities and all settings where children are served, i.e. child care settings, schools, juvenile courts. Second, the core set of services and supports must be in place and monitored for sufficiency and effectiveness.

### 3. Quality of Care as a System Cornerstone

The degree of quality that mental health care produces should be evidenced first and foremost in outcomes that show improvement in the child's life functioning and success at accomplishing age-appropriate milestones and safe transition to adulthood. Families and children and the people working with them should all be valued and respected informants about the progress being achieved over the course of care. The state should endeavor to identify and promote clinically effective treatments that are proven by evidence derived from scientific rigor and/or ethical practice. Integrated data management systems that are intentionally structured to inform case-specific management processes as well as resource allocation and system management processes are vital to and predictive of the quality of care that emanates from the state's system of mental

health care for children. Timeliness in the onset of care is critical to increasing the likelihood of a successful course of care and good outcomes resultant from the care. The triggering of actions to initiate procedures of (1) screening for detection, (2) assessment of indicators, (3) evaluation of symptoms, (4) diagnosis of conditions, (6) treatment/intervention plan development and implementation, and (7) assertive case management to completion is vital to achieving the most cost-effective and socially beneficial outcomes for both the state and for the individuals. A core set of services and supports that is reasonably accessible (based on both conditions of eligibility and geographic location) and timely available (based on appropriateness of intensity and dosage) are absolutely necessary to the construction of a comprehensive, coordinate, and integrated system of mental health care for children that produces quality care.

#### 4. Workforce Development as a System Cornerstone

An infrastructure of human resources (i.e. personnel) must be available at the local and state levels to carry out the functions and operate the state's system of mental health care for children. The key functions are to (1) support the governance structure and (2) cause the system to act on behalf of individual children by triggering the initiation of basic processes and specific procedures for children who come to the system's attention. Strategic placement of the mental health system's personnel should be made, giving special attention that these personnel are linked to and work in support of both the education and the juvenile justice systems.

The state's mental health care system for children should develop and maintain effective linkages and relationships with the private clinical provider community. The professional preparation of teachers, social workers, and juvenile justice workers in under-graduate programs should include training in mental health knowledge; in-service development of these professionals should, likewise, be enriched with training in mental health knowledge.

There should be *centers for learning and excellence in children's mental health care* to (1) identify and promote effective practice in the field, and (2) accomplish the training of the children's mental health system's workforce in emerging knowledge of the professional arena.

The state can enrich and significantly supplement the children's mental health workforce by supporting the development and strengthening the capacity of family support organizations.

The state should align policies that assure parity of payment for mental health care; and, there should be a process whereby the state moves the public insurance rate structure toward reaching the cost of care consistent with the private insurance sector.

- ***This report sets forth a plan, the real work lies ahead.*** In order to address the findings, actualize the recommendations, and improve the outcomes for children with mental health needs in our state, it will take concerted, committed, and collaborative efforts of our executive and legislative leaders for a number of years to come, and the families of children and the youth with mental health needs must be partners in that system reform work.
- ***The work to create a successful system must be structured and sustained.*** A vision for health and wellness for all children must frame the work; it must be guided by principles that focus on children's needs, that respect and embrace their families and caregivers in the journey recovery and stability; it must recognize the diversity among those in need and respond accordingly; and, a strong, viable infrastructure through which the system plans, operates, and monitors the results of its output must be in place.
- ***The work must target effective use of resources and delivery of quality care.*** Means of early identification of needs and timely response with appropriate courses of care are essential system capacities that must be in place and functioning reliably in order for Tennessee's children to achieve better mental and behavioral health outcomes.