



The Advocate

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A newsletter on children's issues

April 2007



Contents

Mental Health page 1
 Select Committee Studies
 page 2
 Juvenile Justice page 4
 JustCare page 5
 Efforts/Systems of Care
 page 6
 MHDD Programs page 7
 RIP page 8

Calendar of Events

Events relating to helping children are available at:
www.tennessee.gov/tccy/webcalen.pdf.

TCCY

For more information on the Tennessee Commission on Children and Youth and its programs, check out the website at:
www.tennessee.gov/tccy.

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Mental Health: Most Important Child & Adolescent Health Factor

Recent events have underscored the need for identifying and addressing mental health problems early in order to prevent future problems.

Mental health problems frequently involve a complex interaction of biological, physical health, trauma and culture. Efforts to address it must be coordinated to respond to this complexity. An ongoing study by the Centers for Disease Control found that adverse childhood events affect lifetime health and mental health. This is reminder of the interactions between mental health and health and stress.

Unfortunately, half the children in state custody, who, by definition have risk factors, including loss of a parent, were found to have a mental health diagnosis in 2004.

Tennessee has a history of beginning successful mental health programs. The Regional Intervention Program, begun in 1969, has been shown to have long-term, even multi-generational effects. Recent efforts have also looked at the interrelations between agencies serving families and the families served, most specifically through systems of care. The Mule Town is a Tennessee systems of care currently operating.

The Department of Mental Health and Developmental Disabilities is also focusing on identifying and helping children early through its consulting program with day care providers and, in two counties, networks of providers. ■■

But children who have mental health needs do show up in every arena, every community, every school, every juvenile court across the state.

Select Committee on Children and Youth's Children's Mental Health Subcommittee
 Senate Joint Resolution 799 Interim Report, 2007

Select Committee Studies Children's Mental Health

A subcommittee of the Select Committee on Children and Youth recently issued an interim report to the Tennessee General Assembly. The report was the first fruits of a study conducted as required by Senate Joint Resolution 799, which was passed by the Legislature last year. The resolution called for the committee to study the problems of families with children who are mentally ill.

The committee will submit a final report with recommendations in April 2008. It is also in the process of setting up a broad-based task force of stakeholders. The task force has divided into work group.

In addition to documenting the extent of mental health issues in Tennessee's children, the report identifies some barriers to addressing them, the first of which is the lack of professionals to treat the problem. Current licensing data do not include information about how many of the state's licensed 1,244 psychologists and 634 psychological examiners have child-specific training or treat children. Fewer than 100 psychiatrists treat children and adolescents. Although it is reported use of psychotropic medications has increased in children and many of these, especially those for ADHD, are prescribed by pediatricians, most of the state's pediatric community is not properly trained to diagnose and manage serious mental illness, according to the report. Only two of the state's mental health institutes serve children. Children in Bristol without health care coverage and in need of inpatient treatment must travel nearly 300 miles from their home to receive help.

The professionals with the most frequent contact with children work in the school system. Controversy surrounds the use of screening tools in the schools, but, according to the report, "Parents express a desire for educators to be better trained, willing and able to more effectively work with children exhibiting anxiety, frustration or anger."

The Tennessee Commission on Children and Youth Cindy Durham, Chair Nashville	
Natasha Blackshear Nashville	Chey Korvandi-Geledar Brentwood
Sidney Bynum Nashville	Dana L. Lesley Chattanooga
Dennis Clark Chattanooga	Carlton Lewis Nashville
Beverly Cosley Chattanooga	Christy Little Jackson
Michelle Crowley Antioch	Jerry Maness Memphis
James B. Ford Franklin	Diane Neighbors Nashville
Susan Glassman Germantown	Sue Pilson Cookeville
Tim Goldsmith Memphis	Colonel J.A. Robbins Murfreesboro
Denise Hobbs Shelbyville	Dwight Stokes Sevierville
Marti Herndon Martin	Nancy Williams Memphis
Barbara Holden Memphis	Joetta Yarbro Dyersburg
Trudy Hughes Maryville	JoAnn Yates Lookout Mt.
Charles Hutchins Greeneville	Linda O'Neal Executive Director

- Teachers report a need for assistance in:
- Managing the symptomatic behavior, especially disruptive and crisis behavior;
 - Mental health consultation and assistance in developing and implementing child-specific instruction and behavior management plans;
 - Knowledge on appropriate community-based programs and services for referrals.

The study reports a pervasive sense of a lack of services and supports. This has been attributed to a lack of state funding and barriers to non-governmental funding, including a lack of parity between mental health and physical health funding. Parents who have exhausted insurance services still may not meet eligibility requirements for publicly funded programs, like TennCare.

The multiplicity of programs and regulatory responsibilities and the uneven geographic distribution of service providers indicate the need for better coordination.

Continued on Page 3.

Study Report

Continued from Page 2.

The subcommittee was chaired by Rep. Sherry Jones and included Sens. Diane Black, Charlotte Burks, Thelma Harper and Raymond Finney and Reps. John DeBerry, Beth Harwell, Richard Montgomery and Harry Brooks.

The Tennessee Department of Mental Health and Developmental Disabilities, Tennessee Voices for Children and TCCY are core partners with the Select Committee in the study process.

Throughout the first year of its study, the subcommittee held three hearings. A series of town hall meetings will be held across the state. The first was held in Nashville at the Tennessee Voices for Children Conference in the fall. A survey, available on the TCCY website at www.tennessee.gov/tccy/leg-sccy-mh.pdf, is being distributed to consumers, advocates and professionals. In addition, a task force of stakeholders will examine, analyze and make recommendations on the design of a statewide system of care. Task force plans would include designs for:

- Data collection and information management;
- Inventory of services and needs;
- Interagency framework of practice;
- Resource allocation;
- Accountability.

The Advocate is published by the Tennessee Commission on Children and Youth as an information forum on children's issues. The Tennessee Commission on Children and Youth, an independent state agency, serves as an advocacy agency and information resource for planning and coordination of policies, programs, and services on behalf of the state's children and youth. The 21-member Commission, appointed by the governor, works with other agencies and with regional councils on children and youth in each development district to collect information and solve problems in children's services. To receive *The Advocate*, sign up on the website at www.state.tn.us/tccy/listserv.html or contact Fay L. Delk, Publications Editor, Tennessee Commission on Children and Youth, 710 James Robertson Parkway, 9th Floor, Nashville, TN 37243-0800. Phone: (615) 741-2633. Fax: (615) 741-5956. E-mail: fay.delk@state.tn.us.

In addition to studying the problem, the subcommittee has been tasked with recommending legislation to set policy for a children's mental health service delivery system. Staff research has found two-thirds of states have legislation to create systems of care. System of care legislation:

- Sets a vision, values and principles to underlie the system;
- Identifies and defines supports and services;
- Identifies participants, including parents and families;
- Articulates roles of participants;
- Establishes clear expectations and a framework for interagency cooperation and coordination.

The report found that, in addition to the limited number of systems of care in Tennessee, the systems of care values and principles are not generally reflected in the child-serving departments and agencies. ■■

Tennessee Children's Mental Health Statistics

- 68,000 children meet diagnostic criteria of being seriously emotionally disturbed.
 - 1 in 5 children have a diagnosable mental disorder;
 - 50 percent of all children in state custody have a mental health diagnosis;
 - 69 percent of adolescents;
 - 84 percent of all adjudicated delinquents;
 - 5,232 Tennessee students received special education services because of a diagnosed emotional disturbance;
 - 28.2 percent of Tennessee students responding to the 2005 Youth Risk Behavior Survey reported feeling sad or hopeless almost every day for two weeks or more in a row;
 - One third of Tennessee counties have suicide rates for ages 10-19 exceeding the national rate;
 - 5 percent of youth (nationally) are currently medicated for ADHD;
 - 1 in 100 adolescent TennCare recipients had been prescribed an antipsychotic medication;
 - 48 percent of children in state custody have substance abuse issues;
 - 72 percent of delinquent children do;
 - 53 percent of youth in juvenile justice facilities canvassed in a 1-day census were experiencing mental health problems;
 - 15 percent were medicated for these problems;
 - Adolescents with serious emotional problems are nearly 4 times more likely to be dependent on alcohol and drugs.
- Senate Joint Resolution 799 Interim Report, 2007**

We are looking at a population who unfortunately seem to have a career pathway through the multiple public service systems, with the ultimate destination of the juvenile justice system. This career pathway begins with the identification of mental health needs by a child care teacher at age 5.

It continues with a referral for special education at age 7,

interaction with mental health and child welfare at age 9,

a placement out-of-home at age 11,

and inpatient psychiatric hospitalization at age 12.

The career pathway concludes with involvement in the juvenile justice system at age 14.

San Francisco Juvenile Probation, 2001, cited in Health Care for Our Troubled Youth

Mental Health and Juvenile Justice

There is a concern that the juvenile justice system is the system of last resort for children with mental health issues. It has been reported that a direct connection exists between lack of community services and entry into the juvenile justice system. The General Accounting Office reported 12,700 families relinquished custody of their children solely to gain mental health services in 2001. Nine thousand (71 percent) were placed in the juvenile justice system.

Most research suggests 70 percent of children and youth in juvenile justice facilities have a mental health diagnosis, and 20 percent have a serious mental illness. Youth in juvenile detention and correctional facilities are four times as likely to commit suicide as the general population. Substance abuse and dependence occurs at 10 to 20 times the general rate, and mood disorders at twice the rate.

Children in the juvenile justice system are also much more likely to have experienced trauma, including the estimated 25 to 32 percent who were either physically or sexually abused.

A high number of juveniles in training centers and detention are diagnosed with conduct disorders and oppositional defiant disorder. Many people view these diagnoses as just the same as saying a person behaves badly, but some studies have suggested that differing rates of diagnoses in White and African American children indicate that the same behaviors labeled ADHD in White children are labeled conduct disorder in African Americans. Also, a study found that a third of children who die by suicide had been diagnosed with a conduct disorder. At least one study found, in part because of the number of youth with multiple diagnoses, that even when conduct disorder was eliminated the percentage of youth with a mental health diagnosis was not significantly reduced.

The Washington State Institute for Public Policy evaluated evidence-based public policy options for reducing criminal justice costs. The evaluation compared costs to implement programs with benefits to crime victims and taxpayers as a result of reduced criminal behavior. Of the programs found to have sufficient research on which to base a judgment, it found that benefits ranged from \$77,798 from Multidimensional Treatment Foster Care to a loss of nearly \$15,000 because of the failure of Scared Straight programs. Multisystemic Therapy, used by Youth Villages in Tennessee, was found to have system benefits of \$18,213 based on 10 studies showing a reduction of crime by 10 percent.

Continued on Page 5.

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Juvenile Justice

Continued from Page 4.

The Department of Health’s Adolescent and Young Adult Health in Tennessee, 2006, calls mental health “arguably the most important aspect of adolescent health and well-being.”

Programs That Work for Juveniles

Program	% Change/ # of Studies	\$ Savings
Multidimensional Treatment Foster Care (v. regular group care)	-22.0% (3)	\$77,798
Adolescent Diversion Project (for lower risk offenders)	-19.9% (6)	\$40,623
Family Integrated Transitions	-13.0% (1)	\$40,545
Functional Family Therapy on probation	-15.9% (7)	\$31,821
Multisystemic Therapy	-10.5% (10)	\$18,213
Aggression Replacement Training	-7.3% (4)	\$14,660
Teen courts	-11.1% (5)	\$9,208
Juvenile sex offender treatment	-10.2% (5)	\$7,829
Restorative justice for low-risk offenders	-8.7% (21)	\$7,067
Interagency coordination programs	-2.5% (15)	\$5,186
Juvenile drug courts	-3.5% (15)	\$4,622

Source: Washington State Institute for Public Policy, 2006

JustCare for Kids

JustCare for Kids is a system of care project that began as a program of the Juvenile Court of Memphis Shelby County. The executive board has representation from 20 organizations and two parent representatives. The groups represented include the schools, community mental health centers, hospitals, Department of Children’s Services, juvenile court and residential and foster care programs for children.

According to the Interim Study Report by the Select Committee on Children and Youth’s mental health subcommittee, the Memphis Shelby County Juvenile Court administrator has stated that access to mental health services is the most significant barrier to being able to effectively divert children from the juvenile justice system. On one recent occasion, more than one-fourth of the juveniles detained securely had 10 or more prior complaints.

The organization originated as the Memphis/Shelby County Juvenile Justice Mental/Behavioral Health Collaborative, which came together in June, 2001. In 2004, it became a nonprofit agency. Its mission is to assure that children ages 0 to 18 with behavioral and mental health services have access to “appropriate, effective treatment that is family-centered and community-based.”

In addition to increasing cooperation among agencies serving children in Shelby County, the organization has conducted needs assessments and other reports. The program’s website includes a mechanism for reporting problems getting service.

Efforts to Build Systems of Care Continue

For many years the Tennessee Commission on Children and Youth has been supporting the creation of systems of care for families with children with mental and behavioral health issues in Tennessee. The concept of a system of care has been around for a while. In fact, the 20th Annual Research Conference—A System of Care for Children’s Mental Health: Expanding the Research Base—was held in March 2007.

Coordinating services to meet the goals of a system of care, including the “no wrong door” policy of funneling people to services they need no matter which agency they first contact, is complex. Overcoming agency and professional territorial defenses and integrating traditional funding streams is complex.

It makes sense that coordination among providers, ease of access and attention to input from consumers would create a more effective system. However, sometimes what makes sense does not survive objective evaluation. The system of care seems to have passed this test, also. A survey of literature reported in 2007 found:

- A consistent relative advantage of receiving services in a System of Care for reducing the risk of subsequent juvenile justice involvement;
- Education outcomes showed improvement over time in systems of care;
- Mental health outcomes showed improvement over time in systems of care, although relative effectiveness of systems of care compared to other programs was equivocal.

Other material submitted at the conference pointed out problems that interfere with use of services, including:

- Stressors associated with treatment;
- Beliefs about treatment (relevance) and causes of the problem;
- Poor relationship with therapist;
- Poverty, single-parent status and stress;
- Barriers such as time, transportation, child care and competing priorities;
- Previous negative experiences with mental health institutions;
- Changes in residential placement;
- Inconsistent primary care.

For more information on systems of care, see the January 2005 issue of *The Advocate*. 

Values and Principles of Systems of Care

Core Values

Systems of Care Are:

- Child-centered, family focused, and family driven;
- Community-based; and
- Culturally competent and responsive.

Principles

Systems of Care Provide for:

- Service coordination or case management;
- Prevention and early identification and intervention;
- Smooth transitions among agencies, providers, and to the adult service system;
- Human rights protection and advocacy;
- Nondiscrimination in access to services;
- A comprehensive array of services;
- Individualized service planning;
- Services in the least restrictive environment;
- Family participation in all aspects of planning, service delivery, and evaluation; and
- Integrated services with coordinated planning across the child-serving systems.

MHDD Programs for Children

Most research indicates early intervention is important in reducing the incidence and severity of mental health problems. The long-term success of the Regional Intervention Program (RIP) program is evidence of this. Research has also focused on quality early childhood education as having an important role in reducing problem behaviors, such as child abuse, and increasing positive behavior. The Institute of Medicine reported that from one in 10 to one in eight preschoolers had a diagnosable emotional or behavioral disorder.

Evidence suggests Tennessee early educators struggle with to deal with these children. A study of rates of children expelled from preschool found Tennessee was eighth highest in the nation.

The Department of Mental Health is addressing these concerns through three programs Early Childhood Networks, Project B.A.S.I.C. (Better Attitudes and Skills In Children) and the Child Care Consultation programs. The **Child care Consultation program**, staffed by Tennessee Voices for Children, provides mental health training and technical assistance to child care, Head Start and early childhood centers

The **Early Childhood Network** initiative is a local collaborative effort located in Maury and Rutherford counties to identify and address the mental health needs of preschool through third grade children using prevention and early intervention. Partners identify all resources available to address needs. As part of the collaboration, the Department of Mental Health and Developmental Disabilities funds a coordinator to facilitate the collaboration process and identify RIP, B.A.S.I.C., and Child Care Consultation programs and provides some funds to address identified gaps. This effort is intended to provide a seamless and comprehensive system to early identify and serve children in need of mental health services by networking with all local agencies that work with these children. Contact numbers for the two pilot programs are, for Rutherford County, (615) 849-8939, and, for Maury County, (913) 490-1566.

Project B.A.S.I.C. is a program that works through the schools with students from kindergarten to grade three. The program, which is available in 39 counties, is offered in schools that partner with a sponsoring mental health agency. It provides mental health education, early identification and intervention, teacher consultation, and school climate enhancement. This program and the Early Childhood Network is included in the state's Community Mental Health Services Block Grant funding.

Objectives of Project B.A.S.I.C. are:

- Identify and refer for treatment children with serious emotional disturbances;
- Enhance awareness and capacity for response of school personnel to the mental health needs of children;
- Assist children in the development of effective coping skills to deal with normative developmental crises and mental health risk factors; and
- Promote cooperation and coordination of effort between schools and community mental health service providers.

For further information regarding Project B.A.S.I.C. and the TDMHDD Children & Youth Services, please contact Louise Barnes, Ph.D. (louise.barnes@state.tn.us). 

Child Care Consultation

Population Served: 503 staff members of 83 early childhood centers received training and technical assistance, helping 12,822 children.

Early Childhood Network

Sites: 2
Population Served: 42 children in Rutherford County; 28 children in Maury County.

Project B.A.S.I.C.

Sites: 43 schools in 39 counties
Population Served: 15,041 children; 223 newly identified children with SED in FY 2006.

RIP: Nearly 30 Years of Building Better Futures

With an increased focus on best practice and evidence-based treatments, it is good to focus on one proven treatment that originated in Tennessee. The Regional Intervention Program, or RIP, began more than 30 years ago and has now moved across the country and even into other countries.

RIP is an intervention program for preschool children. It serves children with serious behavior or developmental concerns, including severe forms of aggression and antisocial behavior.

Graduates of the program, which involves early intervention, improved communication and rewards, have been studied up to 25 years later. In research reported in 2001, it was found that while in school participants' performances in class equaled those of other students who had not been identified as having aggressive behaviors. As adults, only one of the former clients studied was not employed or in graduate school. All but one had graduated from high school, and half completed college. No former client studied had reported instances of aggression or antisocial behavior, except for one minor property crime. This fact is especially impressive since the study cited an earlier study finding that aggression in young children is as stable over a 10-year period as is IQ.

RIP's great power is that it serves the family. Parents are trained to respond appropriately and effectively to their children on an ongoing basis. Using the old adage, instead of trying to give parents a fish by "fixing" their child, the program teaches them how to fish – to build a family parenting and communication system that continually responds to children as they grow.

Another source of power is the use of parents who have successfully completed the program as instructors for other parents. After completing their initial treatment, parents are required to "payback" by helping other parents go through the training. This serves to reinforce their learning and to use the power of peer support.

Recently, researchers and authors have begun to realize that efforts to discipline children fail if children do not have the necessary skills. The RIP program has worked well for 30 years by teaching parents and their children the skills they need to function. In fiscal year 2006, the program served 518 children from 469 families at 14 sites around the state. For more information about RIP, contact www.ripnetwork.org or call (615) 963-1177. 

Resources

Senate Joint Resolution 799 Interim Report to the Tennessee General Assembly, April 1, 2007, Select Committee on Children and Youth, www.legislature.state.tn.us/joint/Committees/children/reports/SJR799%20Interim%20Report.pdf.

Building Blocks for Youth, www.buildingblocksforyouth.org/mentalhealth/factsheet.html.

Center for the Promotion of Mental Health in Juvenile Justice, www.promotementalhealth.org.

Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates, Washington State Institute for Public Policy, 2006, www.wsipp.wa.gov/pub.asp?docid=06-10-1201.

Mental Health and Juvenile Justice: Moving Toward More Effective Systems Of Care. National Health Policy Forum, Issue Brief No. 805, 2005, www.nhpf.org/pdfs_ib/IB805_JuvJustice_07-22-05.pdf.

National Alliance on Mental Illness, www.nami.org

University of South Florida Research and Training Center for Children's Mental Health, <http://rtckids.fmhi.usf.edu/>. Youth with Mental Health Disorders: Issues and Emerging Responses. *Juvenile Justice Journal*. 7(1), 2000.

