Tennessee Moves to Improve Children's Mental Health Care
Creates Council on Children's Mental Health

Contents

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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Most families – either personally or through people they love – have suffered the pain of mental illness. The agony of experiencing or caring for someone with a severe emotional or mental disorder is not measurable, but other things are. An international evaluation found the costs of mental health disabilities were higher than those for any other condition.

During the past few years, Tennessee has begun a serious attempt to address children's mental illness. Under the leadership of Sen. Charlotte Burks and Rep. Sherry Jones, the legislature first called upon its Select Committee on Children and Youth to study the problem. With the support of the Tennessee Commission on Children and Youth (TCCY), the committee held forums across the state and surveyed stakeholders.

In 2008, the General Assembly passed legislation creating a Council on Children's Mental Health with TCCY and the Department of Mental Health and Developmental Disabilities as organizers. The council's mission is to develop a plan for an improved children's mental health system, around the core values of a system of care.

Efforts began immediately to gather experts and advocates together and organize the Council. Representatives from government departments, juvenile justice, nonprofit and advocacy organizations; legislators; educators; and parent advocates.

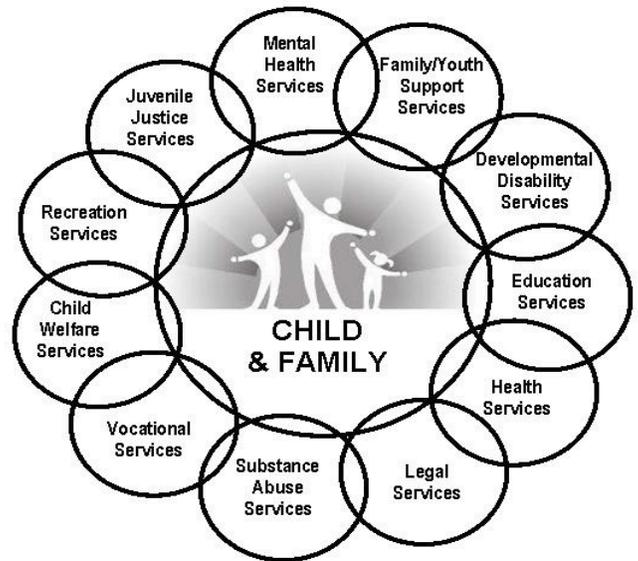The Council divided its membership into workgroups:
*   Accountability-MIS Workgroup;
*   Cultural and Linguistic Competency Workgroup;
*   Evidence-Based Services Workgroup;

- Interagency Workgroup;
- Service Array Workgroup;
- Service Integration;
- Funding Workgroup;
- Media Relations Workgroup.

The enabling legislation requires a preliminary report to the Legislature in February. This report will include an overview of the council's work and a timeline for future efforts to acheive a statewide system of care. The intervening economic turndown and state budget crisis have complicated the work of the Council, with the Tennessee Department of Mental Health and Developmental Disabilities, TCCY and virtually all other state agencies facing substantial budget cuts.

System Of Care

Core Values
✦ The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
✦ The system of care should be community based, with the locus of services as well as management and decision making responsibility resting at the community level.
✦ The system of care should be culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

Guiding Principles
✦ Children with or at risk for serious emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
✦ Children with or at risk for serious emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

Critical Requirements for a Implementing a System of Care

- Clear leadership and commitment at the top, as well as leadership and commitment at the community level;
- Adequate infrastructure;
- An adequate continuum of care and a sufficient array of services;
- Adequate funding;
- Blended/pooled/braided funding with flexibility to serve children who fall between the cracks;
- Adequate coordination of services;
- Incentives/statutory mandates for consistent coordination.
- Evaluation processes to monitor the system;
- Service testing/quality service reviews recommended methodology for evaluation.

Source: Unclaimed Children Revisited

Teach

If a child doesn't know how to read,
   we teach.
If a child doesn't know how to swim,
   we teach.
If a child doesn't know how to multiply,
   we teach.
If a child doesn't know how to drive,
   we teach.
If a child doesn't know how to behave, we…
   Teach?
   Punish?
***Why can't we finish the last sentence as automatically as
we do the others?***

John Herner, Counterpoint, NASDSE, 1998

Youth Suicide Prevention Gets Funding

Suicide is a leading cause of death in young people. It affects all groups and incomes. Tennessee has been a leader in responding to suicide and especially suicide in the young. Experts in suicide prevention, including Commissioner Gina Betts of the Tennessee Department of Mental Health and Developmental Disabilities, identify untreated or poorly treated mental illness as the primary cause of suicide.

This fall the Tennessee Department of Mental Health and Developmental Disabilities received $1.5 for the Tennessee Lives Count Project. This funding will expand the suicide prevention training to include peer training for young people. The program, which began in 2005, has been training adults who work with young people to recognize and respond to those at risk of suicide. The next phase of the project will focus on youth in the juvenile justice system, who will be trained in a peer suicide awareness program and a life skills/resiliency curriculum.

The TLC project teaches the warning signs for suicide among the youth population. The training includes information on appropriate responses to youth at risk of suicide.

For more information on Tennessee Lives Count, contact Dustin Keller at (615) 297-1077, dkeller@tspn.org or www.tspn.org/tlc#staff.

Complicated Causes, Complicated Solutions

Solutions to children's mental health problems must be coordinated because their causes are complex. According to the Substance Abuse and Mental Health Services Administration Mental Health Information Center, factors that contribute to mental health disorders in young people include:

- Exposure to environmental toxins, such as high levels of lead;
- Exposure to violence, such as witnessing or being the victim of physical or sexual abuse, drive-by shootings, muggings, or other disasters;
- Stress related to chronic poverty, discrimination, or other serious hardships; and
- The loss of important people through death, divorce, or broken relationships.

Changes in Juvenile Court Commitment Orders Process

New legal rulings about mental health screenings for children coming through the state's juvenile courts has resulted in changes in the way the screenings are done.

For a number of years the state-owned mental health hospitals and the juvenile courts had operated under rulings by the Tennessee Attorney General: Inpatient and outpatient mental health evaluations of youth charged with felonies were paid for by the state. Evaluations for children charged with misdemeanors were to be paid for by the referring county.

In 2001, a number of counties were billed for inpatient evaluations of youth charged with misdemeanors. Knox County, one of the counties, refused to pay and pushed its refusal all the way through a trial onto an appeal to the state's Court of Appeals. The county's decision to pursue the case resulted in the appeals court determinating all evaluation costs for children referred by the courts were to be paid for by the referring county or by the child's family.

The funding changes resulted in a reduction in inpatient evaluations. Agreements are being made to enable outpatient evaluations. However, clarifications are needed, and legislation may be filed in the 2009 session of the General Assembly on this issue.

Unclaimed Children Revisited Looks at National Progress in Serving Children with Mental Health Issues

A "shift in culture" has resulted in real efforts to improve mental health services for children, according to a new report. State policymakers surveyed for the publication reported success in serving many children with mental health concerns and are working to overcome barriers to complete success.

States made progress between 1982 and 2008, according to the report by the National Center for Children in Poverty, in making mental health service delivery more responsive to families and youth. States are also working toward making services more culturally and linguistically competent, but with more limited success.

All states are struggling to meet the needs of children mental health problems. Most states said they were serving some groups of children and youth with serious mental health problems well. However, a dozen states reported they failed to serve any seriously mentally ill children or youth well. Few states reported providing services statewide across the age-span, although most provided services for all age groups in some areas.

The 2008 report, *Unclaimed Children Revisited*, was an update of the Children's Defense Fund report from 1982. It also drew on the report by the 2003 President's New Freedom Commission on Mental Health and the 1999 Surgeon General's Report on Mental Health. These earlier reports had identified problems with the mental health systems.

Barriers

States wishing to improve services to children with mental health issues are boxed in by two barriers: lack of funding and lack of service capacity. Specifically, financing, especially Medicaid policy, workforce issues and cross system collaboration, were listed a major obstacles. A lack of funding for preventative services for young children and school-age children at risk but not yet diagnosed was identified. Medicaid regulations and state regulations indeed restrict some funding. Twenty-three states do not use Medicaid reimbursement to pay for services for youth in juvenile justice systems based on their interpretation of federal regulations.

One of the difficulties in evaluating the financial barriers is a lack of information about the actual amount being spent on children's mental health services. (*In addition to its efforts on behalf of the Council on Children's Mental Health, TCCY is also involved in addressing this issue in Tennessee through its resource mapping program.*)

Public Health Framework

A public health framework incorporates a continuum beginning with health promotion and education, through prevention and screening, to early intervention and appropriate treatment. Non-hospital and other settings where people live play a large role. Research underlies practice in a public health framework.

States are moving toward a public health framework for mental health services, but according to the National Center for Children in Poverty's research, state understandings of this vary. Mental health advocates' views of state public health framework efforts also differed from those of state policymakers.
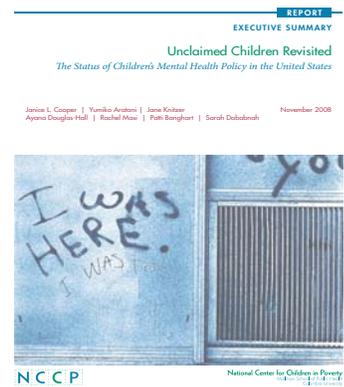
Age-Appropriate Services

In a program with age-appropriate services different services are offered for:
- ✦ Young children, ages birth to age 5;
- ✦ School-age children, ages 6 to 18;
- ✦ Youth transitioning to adulthood, ages 18 to 26.

According to the NCCP, only seven states support and fund statewide services across all childhood and youth ages.

Evidence-Based Practices

Most states said they support the use of evidence-based practices, but only a few mandate them. Tennessee law requires juvenile justice services to use evidence-based services.

Few family members or youth were aware of evidence-based programs, although community leaders were more likely to have heard of them.

Outcome-Based Decision Making

Despite federal initiatives, use of outcome-based decision making by states was in some cases rudimentary and less than might have been expected.

Cultural Competence

Children from minority groups or with limited English proficiency are less likely to get their mental health needs met and face disparities in access and outcomes.

Efforts to expand access for cultural and linguistic minorities need to occur on three levels:

✦ Systemic change alters the atmosphere in which all people function;
✦ Agency level guidelines establish performance standards;
✦ Workforce development strategies help build skills in individual providers.

Unclaimed Children Revisited recommended states:

✦ Embed multilingual, multicultural anti-stigma strategies in settings serving diverse groups;
✦ Document and review training programs and continue to fund competency-based training programs;
✦ Annually report detailed efforts to address disparities using national benchmarks;
✦ Publish an assessment of the level of cultural and linguistic competences of its children's mental health system.

Source: Cooper, J.L., Aratani, Y, Knitzer, J., Douglas-Hall, A et al. (2008). *Unclaimed Children Revisited: The Status of Children's Mental Health Policy in the United States*. New York: National Center for Children in Poverty. www.nccp.org/projects/unclaimedchildren.html

Signs of Youth Crying Out for Help
Evidence of Mental Health and Substance Abuse Concerns

A child or adolescent experiences big changes, such as:

- Showing declining performance in school;
- Losing interest in things once enjoyed;
- Experiencing unexplained changes in sleeping or eating patterns;
- Avoiding friends or family and wanting to be alone all the time;
- Daydreaming too much and not completing tasks;
- Feeling life is too hard to handle;
- Hearing voices that cannot be explained;
- Experiencing suicidal thoughts.

A child or adolescent experiences:

- Poor concentration and is unable to think straight or make up his or her mind;
- An inability to sit still or focus attention;
- Worry about being harmed, hurting others, or doing something "bad;"
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger;
- Racing thoughts that are almost too fast to follow;
- Persistent nightmares.

A child or adolescent behaves in ways that cause problems, such as:

- Using alcohol or other drugs;
- Eating large amounts of food and then purging, or abusing laxatives, to avoid weight gain;
- Dieting and/or exercising obsessively;
- Violating the rights of others or constantly breaking the law without regard for other people;
- Setting fires;
- Doing things that can be life threatening;
- Killing animals.

Federal Legislation on Mental Health

Mental Health Parity

The bad economy had a silver lining for mental health advocates. The "bailout" of financial markets was attached to a bill requiring mental health parity. Political pundits said the bailout supports dusted off an old mental health bill and added the financial provisions to it. Although the current bill had been passed by the U.S. House of Representatives in March, versions of the bill had been introduced every year since 1996 to improve provisions of the original Mental Health Parity Act of 1996.

Substance abuse coverage was added in the new act, which went into effect for most plans on January 1, 2009.

According to the American Psychological Association Practice Organization, equity in coverage applies to all financial requirements and to all treatment limitations, including:
- Lifetime and annual dollar limits;
- Deductibles, copayments, coinsurance, and out-of-pocket expenses;
- frequency of treatment;
- number of visits;
- Days of coverage, and;
- Other similar limits.

Federal requirements trump state requirements unless state requirements require greater parity.

Bill to Permanently Block 2007 Medicaid Regulations Introduced

A bill designed to address the regulatory issues that triggered fears of cutbacks at DCS in 2008 has been introduced in Congress. The federal Centers for Medicaid and Medicare Services (CMS) proposed regulatory changes this spring that were delayed by Congress. The bill (S. 3611, the Medicaid Services Restoration Act of 2008) makes the delays permanent.

The bill did not make it through the legislative process before the end of the of the 110th Congress; it will have to be reintroduced in the next one. The incoming administration may rescind the proposed regulations.

For more information on mental health-related legislation see National Alliance on Mental Illness at http://capwiz.com/nami/issues/bills/