



STATE OF TENNESSEE
COUNCIL ON CHILDREN'S MENTAL HEALTH

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Council on Children's Mental Health
January 22, 2009
10:00 a.m. – 3:00 p.m.
Junior League of Nashville

MEETING SUMMARY

Participant List:

Susan Adams
Carla Babb
Mark Baldwin
Sumita Banerjee
Heather Baroni
Kathy Benedetto
Bonnie Beneke
Gina Betts
Colleen E. Bohrer
Kathryn Bowen
Pam Brown
Charlotte Bryson
Charlotte Burks
Tiffany Cheuvront
Nicole Cobb
Michelle Covington
Emel Eff
Bruce Emery
Mary Beth Franklyn
Deborah Gatlin
Melissa Gordon

Nneka Gordon
Sharon Green
Veronica Gunn
Vickie Harden
Raquel Hatter
Mike Herrmann
Denise Hobbs-Coker
Jennifer Houston
Robbie R. Hutchens
Jeanne James
Petrina Jesz
Shay Jones
Dustin Keller
Richard Kennedy
Paul Lefkowitz
Ann Lowe
Jules Marquart
Rob Mortensen
Elvira Newcomb
Linda O'Neal
Freida Outlaw

John Page
Laine Peeler
Cindy Perry
Steve Petty
Sue Pilson
Mary Rolando
Sara Smith
Steve Sparks
Debrah Stafford
Susan Steckel
Millie Sweeney
David Switzer
Linda Tift
Pat Wade
Denise M. White
Ellyn Wilbur
Kristie Wilder
Stephanie Young

Welcome and Introductions – Commissioner Virginia Trotter Betts and Linda O'Neal

Commissioner Betts:

- Right now is a complicated time in the legislature in terms of turning in the 2/1/09 report because of the changes to leadership and committee assignments.

- I have heard a lot from all of you about our work around system of care and the need for more resources.
- In systems of care all problems are seen as the community's problem, not just one agency's or department's problem.
- I hope we will problem solve together to make sure the financial issues in our state do not disproportionately fall on the most vulnerable population in our state.
- I'm so glad you all are here and doing such terrific work at the end of the day.

Linda O'Neal:

- Thank you to all who have contributed to the report, especially Mary Rolando who is working on the report and Sukey Steckel who has contributed to the report and prepares the meeting summaries.
- Recognition of members who had notified O'Neal they could not attend today's meeting.

Juvenile Court Commitment Orders (JCCO)

Dr. Jeff Feix, Department of Mental Health and Developmental Disabilities: Presented history of TDMHDD involvement with JCCOs

- *See Handout: "Summary Fact Sheet Juvenile Court-Ordered Mental Health Evaluations"*
- Group of children who fall between the cracks because they do not fit in many of the regular categories.
- All evaluations include general mental health issues and committability. Courts can also order a juvenile court evaluation to determine competency to stand trial, drug and alcohol issues, psycho-sexual evaluations, IQ; courts can order evaluation on specific questions.
- Statewide contracts to conduct outpatient evaluations can be one mental health center per juvenile court or several courts for one center.
- Before Court of Appeals decision, inpatient evaluations were performed at 5 locations across the state, two hospitals and three private mental health centers.
- County had to pay if it is a misdemeanor charge, as confirmed by an Attorney General's opinion
- Courts most often ordered inpatient evaluations – 90% of the time, as reported in chart on back of meeting handout.
- TDMHDD attempted to change disparities by scheduling meetings with the Administrative Office of the Courts (AOC) and Tennessee Council of Juvenile and Family Court Judges (TCJFCJ). Parties agreed to draft new model court orders.
- TDMHDD approached all outpatient centers to determine whether or not the centers were experiencing capacity issues.
- TDMHDD and AOC agreed with legislature to try to support a 50/50 ratio for inpatient/outpatient, but were not sure how to go about this because there is no scientific evidence to support this ratio.
- The AOC distributed new court orders and TDMHDD distributed letters to all providers to begin to coordinate communication between clerks and providers.
- In Re: J.B. changes everything.

- Court ruled counties have to pay for all evaluations regardless of misdemeanor or felony charge.
- TDMHDD had to terminate all contracts for inpatient evaluations.
- After negotiation, TDMHDD no longer pays for inpatient evaluations, but can contract with Community Mental Health Centers to provide outpatient evaluations.
- On September 1, 2008, TDMHDD stopped paying for inpatient evaluations. (Updated information since the CCMH meeting, only four inpatient evaluations have been ordered since then to Youth Villages and Youth Villages billed the county directly at a negotiated rate between the Youth Villages and the county, and three inpatient evaluations have been conducted at MTMHI.)

David Haines, J.D., Administrative Office of the Courts:

TCJFCJ has had legislation filed to bring us back to where we thought we were with the state paying for felony evaluations before the JB decision came down.

- We need to fill the gaps in the system. Our goal is to put together a system that will work in the Juvenile Justice arena. We need to work together, especially with TennCare, to build the system working with what already exists.

Questions/Discussion from the Council Re: JCCO Issues:

- Lack of knowledge of resources for juvenile court judges was expressed.
- Q: As a result of the inpatient JCCOs dropping off, how has that impacted the DCS census and admission to DCS custody? A: We have not seen a correlation with admission to DCS custody as a result of this change. *Refer to data handout from meeting from DCS.*
 - AOC Representative referred to study handout from 2005.
- Q: Are outpatient evaluations being done prior to the court order? A: The answer is that they are not available for a variety of reasons.
- To be fair, some jurisdictions have ordered very few inpatient evaluations. Observation Center (Johnson City) is for children who have been adjudicated delinquent.
- Q: Do we have a reliable estimate of the number of youth who actually need inpatient evaluations? How would you answer that? A: There is not data to currently support that, no scientific data. Providers would estimate less than half, which became the unscientific basis of the 50:50 ratio agreed between TDMHDD and the General Assembly's Fiscal Review Committee as a goal.
- Q: Do you have community liaisons in the court to determine if the evaluation should be inpatient or outpatient? A: Not really; judge said you work with the information that you have and go from there.
- Q: Is there no standard? A: There is generally an intake process, but beyond that there is very little consistency in terms of intake questions, etc. You have 95 counties doing 95 different things. Who would do mental health evaluations for every child moving through the juvenile justice system?
 - One thing that we need to do is to formalize our relationship with the juvenile justice system (from the Community Mental Health Center

- perspective). Formalize agreements and contracts with the court to ensure mental health evaluations are available and at a lesser cost.
- Commissioner Betts referred again to the bottom chart on the handout and said we were “Throwing the baby out with the bathwater.” She expressed it was most troublesome we have gone from 700 inpatient evaluations to none and said we need to find a place in the middle.
 - Sen. Burks added the same thing has happened with adult protective services. Last year we passed legislation that stymied the Adult Protective Service workers hands and we are no longer able to help the older adults being abused.
 - The need for a continuum of options for the children that need evaluations was expressed.
 - There is the issue of children presenting at the hospital after they have been riding in the back of a police car for two hours. Evaluations need to be available through crisis services at the court house and there is the need for trained crisis personnel to be available.
 - Deb Gatlin, DCS: Need to remember the difference between a medical need for care and a JCCO. The Council needs to be mindful of the difference in need. JCCOs answer “forensic” questions for the court while mental health screening and assessment answer only questions about the need for treatment for the person being evaluated. Are we having negative effects from not having any inpatient evaluations since September? Are children committing more crimes at homes, etc.?
 - Charlotte Bryson: We have known for years most of these children do not need such restrictive, expensive evaluation services.
 - Does the judge keep up with the data as far as what happens to the child after the evaluation? The court tracks the disposition of each case but neither the evaluator nor TDMHDD knows the outcome.
 - Kathy Benedetto reported admissions at Frontier were higher than they have ever been in the month of October and in December for alcohol and drug admissions.
 - Elvie Newcomb: Judges need alternatives, particularly for youth who may pose a risk to themselves or others if released to the community, but who don’t meet involuntary commitment criteria.
 - Commissioner Betts: Mobile Crisis needs to be available to the judges.
 - Shay Jones, DCS crisis management team leader: DCS court liaisons statewide work the system while the child is in crisis. The liaisons have become very well trained in the last few months to find alternatives to state custody and inpatient JCCOs.
 - Commissioner Betts: Mobile Crisis services use a broader model than just evaluating for the need for inpatient.
 - O’Neal: Need a CCNH workgroup around this issue. Asked for volunteers, sign up sheet in back. JCCO Workgroup needed.
 - Betts: very important to remember what Deb Gatlin said, difference between medical need and JCCOs.
 - Youth Villages Representative: Carla Babb provided an explanation of Youth Villages services and stated they are focused on a continuum of services and options.

Impact of Current Economic/Funding Situation on Community Mental Health Centers (CMHC)

- Kathy Benedetto, Frontier Health – Northeast (NE)
 - Commented about the Behavioral Health Organization (BHO) contracts. As of January 1, 2009, we are now operating with children who do not know which BHO is assigned to them via their TennCare participation.
 - We do use blended funding. Right now for our venture program we are getting BHO approval for 10 days, which is less than what it has been and what the court has been requesting.
 - Negotiated BHO rates are not where they need to be but are keeping us operational.
 - At the same time we are being asked to provide evidenced-based services.
 - It's hard to find a child-trained psychiatrist or psychiatric nurse practitioner in Northeast.
 - There is a need for CMHCs to have interdisciplinary options including psychologists, psychiatry, social work, family therapy, etc.

- John Page, Centerstone – 27 counties in Middle Tennessee
 - Things are not as bleak as they were in December 2008 when I spoke before. We have successfully negotiated our BHO contracts.
 - We are getting people in within four days; emergency services are provided the same day.
 - Fee for service staff are more motivated and busier.
 - We have lost some of the reserves we have and are not able to subsidize some of the services, such as the Regional Intervention Program (RIP), as we were able to in the past.

- Vanderbilt, Kathy Gracey – Vanderbilt
 - We are trying to look at establishing more intensive outpatient programs (IOPs) so children can stay where they live and be served by a community-based IOP. Juvenile sex offenders typically require 12-14 weeks IOP.
 - We are looking to establish a trauma IOP in the next 6 months.

- Vickie Harden, Volunteer Behavioral Health Care System – 31 counties in Middle and East Tennessee
 - The CMHCs have overall continued to serve with the faith we will at some point be paid.
 - With the impending budget cuts, it is reasonable to expect a change in the landscape of available services.
 - We are here advocating for us and our services and we are willing to blend funds and do what it takes to continue to provide services in the schools and courts.

- Commissioner Betts: I want to say something about West Tennessee providers. The negotiations are still unfolding for West Tennessee with the new integrated model. We are struggling to make sure attention is given to specialty mental health services within

the integrated model, so the promise of an integrated model is fulfilled. For example, when you go to a primary care setting, you can get a mental health referral. We need to make sure mental health is fundamental because a health condition of mental illness or substance abuse is going to affect any health treatment plan outcome. In general, state Medicaid programs are focused on children and youth and their mothers.

- Colleen Bohrer: I believe some of the confusion around the insurance cards was that people did not understand about the integration and people still think they should be getting two cards, not the one.

Impact of Current Economic/Funding Situation on Other Private Non-Profit Agencies

- Raquel Hatter, Family and Children's Services
 - Thank you for everyone who filled out the surveys.
 - We determined at the beginning we were not going to be depressed by looking at the economy and what we are leaning about what the impact is going to be. We subsidize almost every program we have, so we are getting hit on both sides.
 - We wanted to be solution focused.
 - Noted that services for children and families have already decreased since the CCMH began last year.
 - Surveys were simple, focused on collaboration, etc.
 - Impact of compassion fatigue on front line staff.
- Bonnie Beneke, Tennessee Chapter, Children's Advocacy Centers, reporting survey responses:
 - 1) What are the priority services provided by the agency? (7 responses)
 - Range of services
 - 2) If you provide mental health services, what cuts do you anticipate?
 - Too early to know.
 - We may know there is a need, but we are hesitant to hire personnel to work in an area because we are unsure of funding availability.
 - Trying to cut costs.
 - Center for Non-Profit Management (CNM) suggested to all non-profits to cut their budgets by 10-20 percent. Agencies are cutting cleaning costs, renegotiating rental agreements, rethinking capital campaigns.
 - We don't want to cut direct services to children, but things like transportation and phone calls.
 - If your agency advocates for families, will you continue to do so?
 - Yes, but require data to show there is a need.
 - Not reducing overall services, but reduction in tangible services such as food, etc.
 - Looking to work with retired baby-boomers who have time to work and collaborate with agencies and use their professional skills.
- Millie Sweeney, Tennessee Voices for Children, reporting survey collaboration responses:

- What other types of agencies do you expect to collaborate with and are you willing to do so?
 - Agencies are willing, but are unsure of the opportunities to do so;
 - Need for communicating needs with other agencies;
 - Need for collaboration to build a true system of care;
 - Need for collaboration through grants and other opportunities;
 - Attempts at collaboration are met with financial resistance;
 - Collaboration exists across all systems.
 - Key is collaboration in trying economic times.
 - There is an emphasis on collaboration at the local level, but encourage collaboration at the state level as well.
 - CNM assumes a 25 percent cut in budgets and grantors are requiring revised financial plans along with their requests for funding.
- Colleen: From a parent's point of view, I have seen less of an availability of service for my family's needs and those other families I know. People have been calling and not able to receive services. Because everyone has to cut back and take on more work, people are struggling to do their jobs because they are stretched too thin.
 - Commissioner Betts: Update on budget reductions, Governor's request. Agencies have been asked to make Tier one and Tier 2 cuts at 7.5 percent for each tier. TDMHDD has only three ways to reduce its budget: 1) Cuts to contracts and grants to vendors; 2) Cuts to hospitals; and 3) Cuts to central office expenses. These are not recommendations; they are options for cuts made out of necessity. TDMHDD is also picking up expenses previously in TennCare's budget and is currently working on another 5 percent cut (Tier 3). In December 2008 at the National Association of State Mental Health Program Director's meeting, six states had improving budgets, but all other states were having to make cuts. Potential 25 percent cut to TDMHDD budget. With an increase in the Federal Medical Assistance Program (FMAP), as proposed by President Obama's new administration stimulus package, these funds will first go to TennCare. Federal Mental Health Parity legislation passed and will be implemented in 2010. This will mean everyone's insurance will include a mental health and substance abuse component. The Governor is scheduled to release his final budget on February 9th. [Update since January: Governor Bredesen's budget is now schedule to be released in late March in order to consider the impact of the Federal stimulus legislation, the American Recovery and Reinvestment Act (ARRA).]
 - The Governor has said he wants to minimize cuts to Education, Mental Health, DCS, and Transportation, according to Senator Burks who had a recent conversation with him.

Policy Academy Plans – Freida Outlaw, TDMHDD

- Refer to National Federation of Families 2009 Policy Academy handout.
- Need for a catchy state motto – need some input from Council members.
- We will work there, but it does not end there. We will have more work to do when we get back.

K-Town System of Care Application, Freida Outlaw, DMHDD

- Refer to K-Town Youth Empowerment Network handout.
- Notice of Award to be made September 2009.

Discussion of Draft Preliminary Report to the Tennessee General Assembly – Mary Rolando

- Refer to Draft of PC 1062 report.
- Report follows the requirements of the law in addition to related considerations.
- Mary asked all Council members to give the report a critical review and let her know if there are any changes that need to be made or items that need to be included.
- Need to review Council and Workgroup active participant lists.
- Report to be turned in Friday, January 30, 2009.
- Edits are due to Mary by close of business on Monday, January 26th.

Discussion of Plans for Next Steps for the Council on Children's Mental Health

- Time line – frequency of future meetings. Final report due July 2010 (17 months).
 - Technical Assistance training to be held April 23rd and 24th
 - Next CCMH meeting scheduled for March 5th (subsequently changed to March 13).
 - Council meetings will be every other month beginning in June 2009.
- Reports and topics to be presented/points of concern to be addressed at future meetings:
 - Media release around the report. Need to educate legislators about the work of the Council.
 - Volunteers for Media Relations Work Group: Colleen Bohrer, Jill Hudson, DMHDD, Linda O'Neal.
 - March meeting: budget update from all child-serving departments; Policy Academy update, MCO presentation (Dr. James to coordinate presenters); JCCO Workgroup update
 - Sara Smith: what can the Commissioners on the Council do in collaboration with the Governor's Children's Cabinet?
 - Betts suggested to copy the Children's Cabinet on the report submitted to the legislature.
 - When the MCOs come, provide an overview of outpatient, evidence-based practices that are producing positive results.

Acceptance of Meeting Summaries for July 22, August 28, October 21 and December 5, 2008 CCMH Meetings

- Mary Rolando moved that all the meeting summaries be accepted, seconded by Pam Brown. All Council members present voted unanimously to accept the meeting summaries.

Other Business

Workgroup Meetings, if time permits

- Work groups met to review their section of the report.

Meeting Summary completed March 4, 2009 by Susan Steckel, Tennessee Department of Mental Health and Developmental Disabilities.