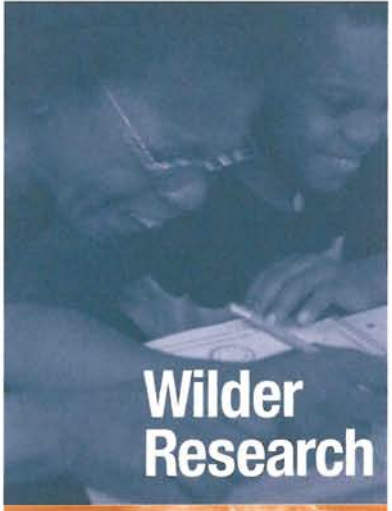

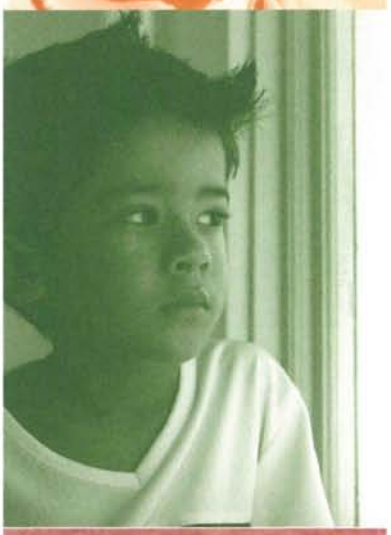

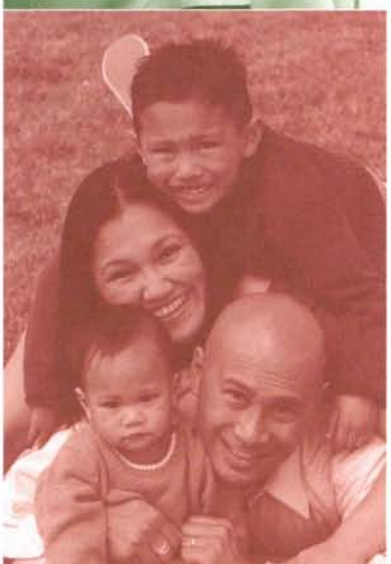

Hennepin County Children's Mental Health Collaborative

Annual Report for Year One of the Solicitation of Interest (SOI) Grantees (July 2008-June 2009)

SEPTEMBER 2009

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September 2009

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Background

Overview of all Solicitation of Interests (SOIs) and Evaluation Process

In 2007, the Hennepin County Children's Mental Health Collaborative (HCCMHC) issued five Solicitations of Interest (SOIs) that were developed to address key concerns regarding the existing Hennepin County children's mental health system and reflect the Collaborative's current priorities. The SOIs focused on four topic areas: juvenile justice (two separate solicitations), uninsured/underinsured youth, primary care, and school-based mental health services. In each SOI, funded programs were required to conduct evaluations in order to examine their effectiveness and allow the Collaborative to understand their impact on the children's mental health system in Hennepin County. In some of the SOI programs, the HCCMHC identified specific evaluation measures that grantees would be expected to collect and report. In other programs, specific evaluation measures were not identified and therefore developed by the programs.

Under contract with the HCCMHC, Wilder Research staff worked with program representatives and Collaborative members to develop a coordinated evaluation plan for programs funded within the four topic areas. These evaluation plans were designed to provide the Collaborative with information about the aggregate impact of the program in addressing current needs in Hennepin County. The final evaluation plans of each SOI program contain many common evaluation components, but include differences that reflect unique aspects of each program's target population and program structure.

This report summarizes the aggregate data reported across programs from the first year of funding (reporting dates vary based on each agency's contract period, for more details see the Financials section in the Appendix). The report is followed by an Appendix that offers a more in-depth look at each specific SOI area (juvenile justice, uninsured/underinsured youth, primary care, and school-based mental health services).

This annual report addresses the following questions:

- Are the funded programs reaching their anticipated target population?
- How many, and what are the characteristics of, children are being served through programs funded by the Collaborative?
- What common challenges have the programs faced in implementing their programs? What successful strategies have been used to overcome these barriers?

- Are youth experiencing improved outcomes as a result of the services they receive?
- What key lessons have been learned through this grantmaking initiative?

Readers of this report are encouraged not to make comparisons between programs, despite the fact they are reporting on common measures. There are a number of differences between programs, including their intended target population and service delivery approach. Therefore, the conclusions that could be made through direct comparisons are quite limited.

The report provides a summary of the population served by all programs, and identifies common implementation challenges and early lessons learned. Examples from individual programs are used to highlight these themes to illustrate the unique aspects of providing services in a specific setting or to meet the needs of a specific target population.

Evaluation process

Wilder Research plays a different role in each of the four SOI programs. In addition to providing sample data collection templates/tools and protocols to each program, Wilder Research provides limited technical assistance to the juvenile justice and uninsured/ underinsured programs, including:

- Offering training to the programs on reporting requirements and completion of reporting tables; and
- Submitting a brief summary to the HCCMHC describing the activities and lessons learned of the SOI programs.

For the primary care programs, Wilder Research is the contracted external evaluator and works throughout the data collection, analysis, and reporting process with both funded programs. The school-based mental health programs used their first-year evaluation funding to develop a shared database for tracking service provision and client outcomes.

Although each area is different, most programs are responsible for collecting demographic information. Some are also charged with providing additional data to Hennepin County (the juvenile justice programs in order to obtain recidivism data), analyzing data, preparing semi-annual and annual reports, and distributing reports to both to Wilder Research and Hennepin County.

Overview of programs

Twenty-three programs were funded by the Hennepin County Children's Mental Health Collaborative in 2008. Figure 1 provides a brief overview of each project by SOI group (juvenile justice, uninsured/underinsured, primary care, and school-based mental health).

1. Overview of the programs

Juvenile Justice	
Amicus-Radius	Serves girls in the juvenile justice system in North Minneapolis by offering groups, individual counseling, restorative justice support circles, staff referrals, and support to additional resources.
Amicus-Radius-North Vista (was Bren)	Serves girls at the North Vista Education Center by offering groups, individual counseling, restorative justice support circles, staff referrals and support to additional resources.
Emerge/Streetwerks	Serves at-risk North Minneapolis youth by expanding the existing StreetWerks summer employment program and ensuring culturally appropriate services, job placement services, and educational services.
Family and Children Services: My Life, My Choice	Serves at-risk teen girls by providing prostitution prevention groups and individual case management to youth who are involved in prostitution.
Family and Children Services: Youth Connections	Serves at-risk youth and their families by providing professional screening, case management, holistic service planning, and resources.
Genesis II for Families, Inc.	Serves youth who are in or have experienced out of home placement with 10 weeks of group training on life skills of employment, education, housing, transportation, a transition portfolio, and medical/ mental health.
HIRED	Serves youth who are involved in the juvenile justice system by providing personalized and innovative work solutions such as job readiness training, placement in post-secondary career training opportunities, job placement, and job coaching and job retention.
Relate Counseling Center	Serves youth experiencing chemical health issues by providing mental/chemical health assessment, counseling, and education support.
SEARCH	Serves Somali youth by providing intensive case management, career development, parent counseling, and recreational activities for immigrant youth and their families.
Stadium View School	Serves youth in the BETA program at the JDC by developing intensive, coordinated mental health, social and educational support utilizing an ecological analysis/assessment establishing base lines to inform the development of a transition planning process.

1. Overview of the programs (continued)

Uninsured/Underinsured	
Baby Space	Serves Native American children ages 0-9 who reside in the Little Earth of United Tribes Housing Development or attend Baby Space/Tatanka Academy. Provides preventative classroom interventions to all children enrolled in the school and further assessment and therapeutic interventions to youth exhibiting social-emotional or behavioral difficulties.
Family Children Services	Serves young children (ages 3-5) enrolled in PICA HeadStart. Provides on-site mental health screening, assessment, intervention, and consultation services to children who have, or at risk of developing, a diagnosable mental health concern.
La Familia Guidance Center	Serves Latino youth, emphasizing youth from immigrant families who are often ineligible for insurance. Provides culturally-competent outreach, screening, and intervention services, including Functional Family Therapy, through Southside Community Health Services' Green Central Clinic.
Mental Health Collective	Serves East African youth and families living in South Minneapolis. Provides mental health and cultural competency resources with staff, education and outreach programs for use in schools, and culturally-competent mental health services.
YouthLink	Serves primarily transition-age youth (18-21) experiencing homelessness. Provides case management, group education, advocacy, and support to youth who visit their drop-in center. This program does not provide on-site mental health services, but helps youth access services from local providers.
Primary Care	
Partners in Pediatrics	Provides co-located mental health services at their Maple Grove Clinic in collaboration with Pediatric Consultation Specialists. Social-emotional screening occurs at all well-child visits, with the mental health professional located on at the clinic one day each week to provide consultation to medical providers, immediate mental health triage services, and further assessments.
St. Joseph Home for Children	Provides intake and shelter services for Hennepin County children removed from their homes due to abuse or instability. Social-emotional screening is incorporated into the health assessments conducted when youth enter the program. Children with an elevated screen are referred to the behavioral health clinic for further assessment and intervention services, as appropriate. A care coordinator serves as a liaison between behavioral health staff, residential counselors, and families.

1. Overview of the programs (continued)

School-based Mental Health	
CLUES/Richfield School District	Serves youth in Richfield High Schools by providing mental health services to Latino youth and their families.
Family Networks/ Robbinsdale Area Schools	Serves youth with a mental health diagnosis by increasing the accessibility for uninsured and underinsured children to mental health services and improving the identification of mental health issues for youth.
Minneapolis Department of Health and Family Support	Serves a multicultural group of youth at Roosevelt High School by providing prevention, assessment, and intervention services to youth through therapy.
St. Anthony School District/ Nystrom and Associates	Serves youth at the St. Anthony-New Brighton School district by providing assessments, individual and family therapy, groups and educational groups to students with a mental health diagnosis.
The Storefront Group/Anoka Hennepin School District	Serves adolescents through educational training related to mental health by providing consultation for prevention services and crisis intervention to the school staff and faculty.
Washburn Center for Children/Eden Prairie	Serves youth in the Eden Prairie School district school linked children's mental health services for Eden Prairie students by providing individual and family therapy on site in the school setting, office visits and/or home visits.

Implementation status

During the first six months of this initiative, grantee contracts were finalized, evaluation plans were developed in coordination with the funded programs in each topic area, and all but three programs began providing services. Programs that were not fully implemented in 2008 experienced delays in the contracting process or turnover of key staff.

During the last six months (January – June 2009), most programs felt they had been successful in reaching their target population and enrollment goals. Four programs (Family and Children Services: My Life, My Choice, HIRED, La Familia Guidance Center, St. Joseph's Home for Children) identified turnover of key staff or agency-level restructuring as a challenge faced during the past six months. Despite this challenge, the programs had continued to provide services and have resolved, or have a plan to resolve, these issues.

A number of programs identified ways they were fine-tuning their service delivery approaches and program models. Program staff from Family & Children Services (FCS) recognized that some HeadStart teachers were hesitant to make referrals for mental health services. As a result, they plan to develop a "CARES team" to offer reflective coaching for teachers and provide additional classroom-based services. My Life, My Choice mentioned that after the revamping of their partnerships was completed, their group therapy structure was redesigned to incorporate individual safety planning. The primary care grantees were pleased with the degree to which they had established positive relationships between mental health and primary care providers and both programs identified strategies they planned to use to further enhance those relationships.

A few data collection and evaluation challenges were also identified during the first year of the program. There are limited outcome data available for youth served by juvenile justice and uninsured/underinsured grantees. Because of this issue, two uninsured/underinsured grantees (BabySpace and Family & Children Services) plan to administer data collection instruments more frequently to improve their ability to assess changes in youth outcomes. The juvenile justice grantees are not required to report recidivism data until the next annual report, and therefore have limited information about their discharged clients.

More significant changes were made to the primary care evaluation plan. The original plan incorporated follow-up telephone interviews with parents of children who had been screened in the primary care setting. However, for a variety of reasons (described in greater detail in the Appendix), this data collection strategy was not effective. As a result, the evaluation plan was changed to exclude the parent interviews, but incorporate more detailed key informant interviews with project stakeholders.

Characteristics of youth served

Demographic data describing characteristics of youth served were captured for all primary care, juvenile justice, and uninsured/underinsured programs. Data from the school-based programs are not included in this report, but will be available after the database is fully operational in September 2009. The demographic data included in this report describes the characteristics of youth served by each program. However, it is important to keep in mind that each program defines its services differently. Most, but not all, programs consider screening as the initiation of services. Detailed information about individual SOI programs can be found in the Appendix.

A total of 882 children, youth, and young adults were served by Collaborative-funded programs between October 2008 and June 2009. Across all program types (primary care, uninsured/underinsured, juvenile justice), males and females were fairly equally served. When combined, approximately half of all the youth served were male (50%) (Figure 2). The youth served ranged in age from 0-21 years old, with exactly half between the ages of 9 and 17 (50%). Less than 1 percent of the youth in the juvenile justice programs were under the age of 9, while uninsured/underinsured programs had a focus on early childhood populations. The populations served by each program type vary by race and gender, but overall, very few Asian-American (5%) and transgender (less than 1%) youth were served by any of the SOI programs.

2. Demographic characteristics of youth served (N=882)

	Primary Care		Uninsured/ underinsured		Juvenile Justice		TOTAL	
	N=301	%	N=232	%	N=349	%	N=882	%
Gender								
Male	133	44%	129	56%	179	53%	441	50%
Female	166	55%	101	44%	170	47%	437	50%
Transgender	0	0%	2	1%	0	0%	2	0%
Unknown	2	1%	0	0%	0	0%	2	0%
Age								
0-5 years	47	16%	94	41%	0	0%	141	16%
6-8 years	43	14%	34	15%	0	0%	77	9%
9-11 years	40	13%	8	3%	2	1%	50	6%
12-17 years	89	30%	18	8%	277	79%	384	44%
18-21 years	80	27%	76	33%	70	20%	226	26%
Unknown/missing	2	1%	2	1%	0	0%	4	0%
Race								
Black/African American	100	33%	94	41%	217	62%	411	47%
Native American	9	3%	70	30%	12	3%	91	10%
Asian/SE Asian	7	2%	0	0%	38	11%	45	5%
White/Caucasian	156	52%	11	5%	50	14%	217	25%
Bi- or multi-racial	16	5%	14	6%	26	7%	56	6%
Other	6	2%	33	14%	11	3%	50	6%
Ethnicity								
Hispanic	5	2%	56	24%	29	9%	90	10%
Non-Hispanic	149	50%	158	68%	316	91%	623	71%
Unknown/missing	2	1%	18	8%	0	0%	20	2%

There are obvious differences between programs in their target population. A number of juvenile justice and uninsured/underinsured programs focus on serving youth of specific ages (early childhood and transition-age youth), cultural groups (Native American, Hispanic, and East African youth), or other key characteristics (homeless youth). The unique distinctions between programs are described in the topic-specific reports in the Appendix.

Because participant outcomes are reported so differently across each type of program, this information is not reported in aggregate, but outcomes for individual programs are included in the Appendix. One of the key measures reported by the primary care programs are the number of youth screened and subsequent referrals made for youth with elevated screening scores. Among the uninsured/underinsured grantees, programs report the number of youth who met all treatment goals at discharge and pre-post measurements are used to assess changes in youth functioning. However, at this point in the evaluation, there is limited outcome data available across programs.

The key measure the juvenile justice grantees were asked to report on was recidivism. Recidivism is defined as any youth who committed a delinquent act or petty offense and were charged by the County Attorney's Office and entered the juvenile justice system or were sent to out of home placement for intervention services and/or disciplinary action six months after discharge. The grantees will not be reporting recidivism data until next year since they needed at least six months from discharge before the recidivism could be assessed. The school-based grantees have been asked to report on improvement for child-function outcomes (e.g., CASII, SDQ, attendance, academic performance, and academic placement) as well as parent/client satisfaction.

Key observations and next steps

In the Appendix, key themes across programs and specific examples of program strengths, challenges, and lessons learned are highlighted. However, there are a few broad themes that emerged during the last year that might guide future work with all projects and enhance the processes used by the Collaborative during future funding cycles. Wilder Research has highlighted a few key observations made while developing the coordinated evaluation plan and working with grantees during the first funding period for the Collaborative to consider:

- **When asked to identify the early successes of the program, many grantees reported improved cross-disciplinary collaboration and accessibility of services.** Among uninsured/underinsured and primary care grantees, programs reported improved partnerships across agencies and among staff. These improved relationships allowed program staff to collaborate more effectively. In addition, program staff felt these partnerships and the use of co-located mental health services in locations familiar to families increased accessibility of services. However, stakeholders from a number of programs also recognized that considerable time and effort is needed to build and maintain these relationships. Stakeholders from both primary care programs felt a combination of formal and information communication strategies were needed to support and sustain new cross-disciplinary partnerships.
- **Key informant interviews with project staff may be an effective way to identify common lessons learned across all projects.** While all grantees are asked to respond to a series of questions in the report narrative, the depth of reporting varies considerably by program. The evaluation plan for the primary care grantees included a series of key informant interviews with stakeholders from each project. The benefit of this data approach has been the ability to gather more comprehensive data from a range of staff, including project managers and direct service staff. To provide the Collaborative with more in-depth information about the challenges experienced by each program, perceived benefits of the service, and plans for sustainability, it may be helpful for the Collaborative to consider incorporating key informant interviews with all programs into the data collection strategies for the next annual report.
- **While programs have been successful in reporting information for youth at intake, outcome data has been more difficult to collect.** Because the uninsured/ underinsured programs serve hard to reach populations, a number of grantees have experienced challenges collecting outcome data. Two programs plan to gather outcome data at more frequent intervals to improve their ability to capture outcome data if participants are likely to leave services abruptly. More frequent assessment may be necessary in order for the Collaborative to receive enough data to understand the impact of services.

Appendix

Juvenile Justice

Uninsured/underinsured youth

Primary care

School-based mental health

Financials

Juvenile Justice

Background

To reduce or prevent youth involvement with the juvenile justice system, Hennepin County Mental Health Collaborative funded 10 programs who work with youth involved to some degree in the system. The funded Juvenile Justice-SOI programs (JJ-SOI) were directed to build/continue relationships with community-based organizations, law enforcement, human services, schools and corrections. Additionally, their programs were to incorporate best practices and provide supplemental services to youth who are involved in the system.

The goals for all but one of the programs within the Juvenile Justice group are to:

- Improve overall service coordination, communication and outcomes in the juvenile justice system.
- Improve service delivery of prevention or intervention services for youth at risk of involvement or currently involved in the juvenile justice system.

Amicus' Radius North Vista program's focus takes a systems-level approach. They are charged with changing and improving mental health and chemical dependency intervention services for youth involved in the juvenile justice system (Figure A1).

A1. Overview of Juvenile Justice Programs

Amicus-Radius	Serves girls in the juvenile justice system in North Minneapolis by offering groups, individual counseling, restorative justice support circles, staff referrals, and support to additional resources.
Amicus-Radius-North Vista (was Bren)	Serves girls at the North Vista Education Center by offering groups, individual counseling, restorative justice support circles, staff referrals and support to additional resources.
Emerge/Streetwerks	Serves at-risk North Minneapolis youth by expanding the existing StreetWerks summer employment program and ensuring culturally appropriate services, job placement services, and educational services.
Family and Children Services: My Life, My Choice	Serves at-risk teen girls by providing prostitution prevention groups and individual case management to youth who are involved in prostitution.
Family and Children Services: Youth Connections	Serves at-risk youth and their families by providing professional screening, case management, holistic service planning, and resources.
Genesis II for Families, Inc.	Serves youth who are in or have experienced out of home placement with 10 weeks of group training on life skills of employment, education, housing, transportation, a transition portfolio, and medical/mental health.

A1. Overview of Juvenile Justice Programs (continued)

HIRED	Serves youth who are involved in the juvenile justice system by providing personalized and innovative work solutions such as job readiness training, placement in post-secondary career training opportunities, job placement, and job coaching and job retention.
Relate Counseling Center	Serves youth experiencing chemical health issues by providing mental/chemical health assessment, counseling, and education support.
SEARCH	Serves Somali youth by providing intensive case management, career development, parent counseling, and recreational activities for immigrant youth and their families.
Stadium View School	Serves youth in the BETA program at the JDC by developing intensive, coordinated mental health, social and educational support utilizing an ecological analysis/assessment establishing base lines to inform the development of a transition planning process

Staffing and implementation status

As they were asked to do in the semi-annual reports, all agencies were asked to give details about their implementation and staffing status in their annual report. Of the ten JJ-SOI agencies, all but one was fully staffed by the end of this reporting period and eight were being fully implemented. Family and Children Services: My Life, My Choice described their implementation status as "in process," but felt they would be able to meet all of the goals required through their contract because they received an extension through December 31, 2009. HIRED reported that there was restructuring at the Home School, and therefore the implementation process was taking longer (NOTE: HIRED did not begin their contract until January 1, 2009).

Characteristics of youth served

Youth demographic information was gathered by each agency's staff and submitted to Wilder Research in July 2009. The data included in this report describe characteristics of youth screened from October 2008-July 2000. A total of 349 youth received services during this timeframe (Figure A2).

A2. Number of youth who were served by agency

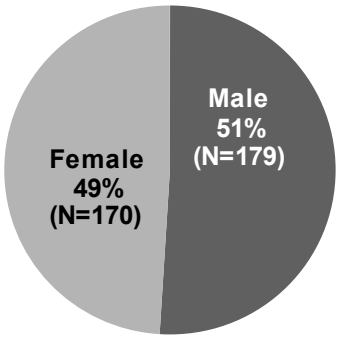
Provider	Youth who began receiving services within the reporting year
Amicus Radius	24
Amicus Radius-North Vista	16
Emerge/Streetwerks	30
Family and Children Services: My Life, My Choice	50
Family and Children Services: Youth Connections[1]	15
Genesis	104
HIRED[2]	4
Relate	23
SEARCH	53
Stadium View	30
TOTAL SERVED	**349**

1 *Because of a late start, data collection did not occur during the first reporting period.*

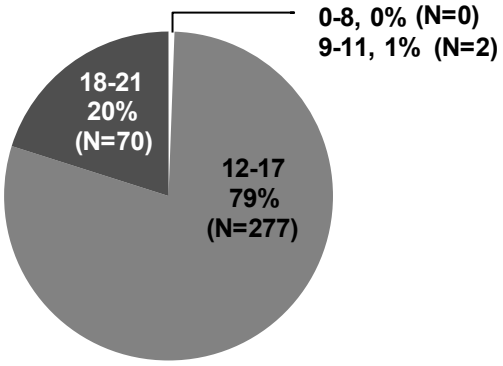
2 *Because of a late start, data collection did not occur during the first reporting period.*

Approximately half of the youth served were male (51%) ((Figure A3). There were no youth served between the ages of 0-8, which would be expected of youth involved in the juvenile justice system. Approximately four-fifths of the youth served were between the ages of 12-17 (79%) (Figure A4). Over half of the youth served by the juvenile justice agencies were African American/Black (62%) (Figure A5). Of the 217 African American/ Black youth, 12 percent identified as African-born (e.g., new immigrants, refugees) (Figure A5). Nine percent of the youth identified as Hispanic (Figure A5).

A3. Gender of youth receiving services



A4. Ages of youth receiving services



A5. Race/ethnicity of youth receiving services

	N=349	%
Race		
Black/African American	217	62%
Of the total number of African American children (question 4a), how many are African-born (new immigrants, refugees)?	25	12%
Native American	12	3%
Asian/SE Asian	38	11%
White/Caucasian	50	1%
Bi- or multi-racial	26	7%
Other	11	3%
Ethnicity		
Hispanic	29	8%
Non-Hispanic	316	91%
Unknown/missing	4	1%

System-change feedback

Providers were asked about their perceptions of system changes that have occurred because of the grant. Specifically, agencies were asked which program strategies have been the most helpful in decreasing the number of youth who get involved with the juvenile justice system, if coordination of services have improved as a result of the grant, and if improvements to service delivery (of prevention or intervention services) have been made for the youth they serve.

Which program strategies have been most helpful in decreasing the number of youth who get involved with the juvenile justice system?

Providers felt that consistency in the staff their clients work with is helpful and that they can benefit by having a specific person who can provide them with the education and support needed. Providers also felt that incorporating a number of learning styles is important when working with these youth and that the grant has provided the opportunity to develop new types of learning approaches in the services offered. Some also noted that having a designated person to do outreach was really helpful in increasing referrals.

Has coordination of services improved as a result of this project, and if so, how? (What types of problems has the project encountered when providing coordinated care and how have those barriers been addressed?)

In terms of coordination, most of the providers mentioned that during the grant period, resources have grown more scant "and are still vastly underresourced." Others reported that there is a lot of work that needs to be done to get more referrals. One agency noted that their outreach efforts were almost nullified because of prior commitments to other partners/agencies, "We later learned that another officer in the department had agreed to allow an agency that does street counseling to be present at the curfew sweeps and that agency objected to Youth Connections being allowed to join."

What improvements to service delivery of prevention or intervention services have been made for youth at risk or currently involved in the juvenile justice system?

Providers felt that the grant did improve service delivery overall. Some of the ways they mentioned it helped were:

- Increasing follow-up to maintain connection and provide ongoing case management to the youth and parents.
- Accompanying youth and parents to court.
- Providing translation services.
- Offering early access to services (early intervention).
- Having one person responsible for coordinating services (to build rapport with the youth).
- Increasing the ability to follow-up with youth (to maintain connection and provide ongoing case management to youth and parents).

Satisfaction feedback

Programs were required to report participant (youth) satisfaction data for the evaluation and some agencies also reported on parent/caregiver satisfaction (although it is not required since all of the JJ-SOI Programs do not work with parent/caregivers). Different methods were employed by the agencies. Some agencies conducted surveys or interviews, while others facilitated focus groups. Some agencies collected information from their partner/referring agencies in addition to the parent and/or youth data.

Overall, the agencies reported that participants were generally pleased with the services that were provided, especially when it came to the relationship with the agency staff (e.g., case worker, facilitator). One agency noted "…the school and support staff members made the program work." The agencies that work with girls exclusively reported that the youth enjoyed their group sessions (e.g., Amicus Radius, Amicus Radius-North Vista). Of the agencies that provide career development activities, youth reported that they liked these services and found them helpful.

Some of the agencies mentioned that participants were limited in their ability to participate because of financial constraints. It was also mentioned that the participants did not enjoy the group setting or the weekly meetings that were mandated by the agencies (e.g., Genesis, SEARCH. Additionally, the frequency and amount of time of the sessions were bothersome to some youth and others were dissatisfied because were forced to go to the program (by the juvenile courts).

Some agencies reported that they had trouble getting youth and parents to participate in data collection. As one agency reported, "It has not been very workable to get the youth and parent to come for a second meeting to complete follow-up surveys when a second face-to-face session is not a typical component of the agency."

Intake/Discharge information

In their annual reports, most agencies tracked their intake and discharge numbers (Figure A6).

A6. Program' Discharge Data

Provider	Intake: How many data collection instruments were completed at intake?	Discharge: How many data collection instruments were completed at discharge?
Amicus Radius	6 youth	4 youth
Amicus Radius-North Vista	4 youth	4 youth
Emerge/Streetwerks	30 youth	13 youth
Family and Children Services: My Life, My Choice	*Did not report*	*Did not report*
Family and Children Services: Youth Connections	15 youth	0 youth
Genesis	23 youth	20 youth
HIRED	4 youth	0 youth
Relate	9 youth	7 youth
SEARCH	37 youth	14 youth
Stadium View	12 youth	11 youth
TOTAL	**140 youth**	**73 youth**

Future evaluation activities

To demonstrate the effectiveness of services, the juvenile justice grantees have been asked to report on recidivism. Each agency will give the County participant names, date of birth, gender, and MNSIS ID (if available) to monitor if the youth commit a delinquent act or petty offense and are charged by the County Attorney's Office and/or enter the juvenile justice system six months after they have completed the agency. Since recidivism data cannot be collected immediately after agency completion, recidivism data was not required for this report, but will be presented in the next annual report.

Providers have been given the following guidance for reporting recidivism, along with a spreadsheet.

- Fill in the spreadsheet provided to collect a list of youth who have completed the program. When completed, the spreadsheet will be used to determine if the youth has reoffended (defined as committing a delinquent act or petty offense and charged by the Hennepin County Attorney's Office and enter the juvenile justice system or are sent to out of home placement for intervention services and/or disciplinary action).

- The recidivism data will be given to Sue Sinna via email every SIX months and then returned to the programs to analyze for their annual report. To emphasize, reporting of the recidivism data is required on an annual basis, but Hennepin County requests that each program turn in their spreadsheets twice a year to ease the workload of the data collection process.

- Some programs are prevention-focused (where the youth may not have any prior adjudications), while others are intervention-centered (where the youth may have prior adjudications). For those who are mostly prevention-oriented, the recidivism data may be used to show whether or not the youth you have been working with was charged with committing a delinquent act or petty offense after your prevention services. On the other hand, those programs who are more intervention-oriented may find the recidivism data useful in determining if the youth continued to reoffend even after your services.

As a reminder, the recidivism data should be included in only the annual reports (Figure A7).

A7. Data collection due dates

Range of dates youth completed program	Due date to send spreadsheet to county	Data returned to program from county	Include in annual report due
Oct 08-Mar 09	Oct 31, 2009	Nov 30, 2009	July 2010
Apr 09-Sep 09	Apr 30, 2010	May 31, 2011	July 2010
Oct 09-Mar 10	Oct 31, 2010	Nov 30, 2010	July 2011
Apr 10-Sept 10	Apr 30, 2011	May 31, 2011	July 2011

Although they were not required to do so, one of the agencies did report recidivism data (Figure A8).

A8. Stadium View's Recidivism Data

Provider	Over the past 6 months, how many of the youth who have completed the agency have committed a delinquent act or petty offense and were charged by the County Attorney's Office and entered the juvenile justice system?	Over the past 6 months, how many of the youth who have completed the agency was sent to out of home placement for intervention services and/or disciplinary action?
Stadium View	5 youth (45%)	6 youth (55%)

Next steps

In their annual reports, agencies noted their planned steps for the next six months (Figure A9). Some agencies still mentioned that they wanted to increase referrals and outreach. Two agencies did not specify any new next steps.

A9. Program's next steps

Provider	Next steps
Amicus Radius	Increase interest in a Graduate's Group for agency participants.
Amicus Radius-North Vista	Implement family counseling/supports for girls and their families.
Emerge/Streetwerks	Continue to work with the 30 active students until they get a job.
Family and Children Services: My Life, My Choice	Meeting goals of the contract despite the revamping of their partnership with Minneapolis YWCA.
Family and Children Services: Youth Connections	*Nothing noted.*
Genesis	*Nothing noted.*
HIRED	Provide job readiness skills, develop employment plans, collaborate with other community agencies and collaborate with probation officers were some of the next steps mentioned.
Relate	Add a truancy group for youth and connecting with schools.
SEARCH	Recruit a Latino agency to collaborate and reinforce relationships with current partners and establish new partnerships
Stadium View	Seek funding to replicate the agency with a selected group within the juvenile justice system.

Key observations

- **Implementation can be difficult when the unexpected happens (echoed from the semi-annual report).** Staffing issues, organizational changes, relocating services, and financial constraints are some of the factors that have affected the implementation and/or number of youth that some agencies have served.

- **Building relationships with youth is important in satisfaction.** Providers felt their clients yearn for respect and that it is important for youth to feel that they are a part of something. Having a consistent person at the agency that they can build rapport with is important. Further, satisfied youth often were those who had a staff person that they could trust to share their feelings and/or give input.

- **Many of the agencies had trouble filling out all components of the report.** A few were confused about the demographic chart and when the recidivism data was due. Others were unclear that they needed to complete section 5 (which was to be included in the annual year-end reports only). Wilder Research has revised the reporting template and will distribute it to the Juvenile Justice agencies in Fall 2009.

Uninsured/underinsured youth

Background

The purpose of this funded group is to improve access to mental health services among youth who are uninsured or underinsured. The grantees have used a broad definition of underinsured populations, including youth who have no insurance due to their legal status, inadequate coverage, or burdensome co-pays or deductable plans. In addition, each of the funded projects also emphasize reaching a unique target population that, for a variety of reasons, is often underserved in the current mental health system (Figure A10).

A10. Overview of Uninsured/Underinsured Programs

Baby Space	Serves Native American children ages 0-9 who reside in the Little Earth of United Tribes Housing Development or attend Baby Space/Tatanka Academy. Provides preventative classroom interventions to all children enrolled in the school and further assessment and therapeutic interventions to youth exhibiting social-emotional or behavioral difficulties.
Family & Children Services	Serves young children (ages 3-5) enrolled in PICA HeadStart. Provides on-site mental health screening, assessment, intervention, and consultation services to children who have, or at risk of developing, a diagnosable mental health concern.
La Familia Guidance Center	Serves Latino youth, emphasizing youth from immigrant families who are often ineligible for insurance. Provides culturally-competent outreach, screening, and intervention services, including Functional Family Therapy, through Southside Community Health Services' Green Central Clinic.
Mental Health Collective	Serves East African youth and families living in South Minneapolis. Provides mental health and cultural competency resources with staff, education and outreach programs for use in schools, and culturally-competent mental health services.
YouthLink	Serves primarily transition-age youth (18-21) experiencing homelessness. Provides case management, group education, advocacy, and support to youth who visit their drop-in center. This program does not provide on-site mental health services, but helps youth access services from community-based providers.

Staffing and implementation status

Four of the five programs (BabySpace, Family & Children Services, La Familia Guidance Center, and YouthLink) reported their programs were fully implemented and felt they were successfully reaching their target population. The Mental Health Collaborative has encountered some challenges reaching their target population (Somali youth) because of difficulties partnering with a local mosque. Recent concerns about recruitment of Somali youth through mosques led to a need to spend more time building trust with Somali community and spiritual leaders.

La Familia Guidance Center lost a key staff member within five months of the programs initiation, and will be working to hire a Mental Health Worker soon. The program utilized three community mental health interns to support the project during the last year. Although these students have completed their internship, the program plans to hire at least one intern student this Fall.

Characteristics of youth served

Youth demographic information was gathered by each program's staff and submitted to Wilder Research in January 2009. The data included in this report describe characteristics of youth served from October 2008 through June 2009.

During the first year of the program, a total of 232 youth received screening and/or therapeutic intervention services (Figure A11). The number of youth served by each program varied. The two programs who served fewer programs had experienced delays in the contracting phases of the project (La Familia Guidance Center) or as a result of staffing changes as the project began (Mental Health Collective).

A11. Number of youth served, by program

Provider	Youth who began receiving services within the reporting year
Baby Space	72
Family & Children Services	53
La Familia Guidance Center	27
Mental Health Collective	5
YouthLink	75
TOTAL SERVED	**232**

When combined, the uninsured/underinsured programs served a diverse population. Nearly half of all program participants were between the ages of 0 and 5 years (45%), while one-third were young adults, age 18 to 21 (33%) (Figure A12). However, individual programs served very different targeted populations. The Mental Health Collective and YouthLink both focus on serving young adults, while BabySpace and Family & Children Services programs have an early childhood focus. Nearly three-quarters of the youth served were African-American (41%) or American Indian (30%), while one-quarter of the youth were identified as Hispanic/Latino (24%). Most participants (81%) spoke English as their primary language at home.

A12. Demographics of youth served (N=232)

	N	%
Age		
0-3	40	17%
4-5	64	28%
6-8	24	10%
9-11	8	3%
12-17	18	8%
18-21	76	33%
Unknown	2	1%
Gender		
Male	129	56%
Female	101	44%
Transgender	2	1%
Race		
African American	94	41%
African-born (refugee, immigrant)	*6*	
Asian-American	0	0%
American Indian	70	30%
White/Caucasian	11	5%
Bi-/multi-racial	14	6%
Other	33	14%
Ethnicity		
Hispanic/Latino	56	24%
Non-Hispanic/Latino	158	68%
Unknown	18	8%
Primary language spoken in home		
English	188	81%
Spanish	36	16%
Somali	3	1%
Other	5	2%

Most program participants (81%) had insurance through a public plan. Fewer participants were without insurance at intake (9%) or ineligible for insurance coverage (3%) (Figure A13).

A13. Insurance status at intake (N=232)

	N	%
No insurance	20	9%
Public insurance plan/program	187	81%
Private insurance plan	3	1%
Not eligible for insurance	6	3%
Unknown	17	7%

Screening and service utilization data

The screening tools used by each program vary, and include the Ages and Stages Questionnaire-Social Emotional version (ASQ:SE – BabySpace), Strengths and Difficulties Questionnaire (SDQ - LaFamilia, BabySpace), Devereux Early Childhood Assessment Clinical Form (DECA-C – Family & Children Services), Infant Toddler Social Emotional Assessment (ITSEA - Family & Children Services), and Behavior Assessment System for Children (BASC-2 - Family & Children Services). YouthLink also uses a general Health and Wellness assessment to determine the need for additional services. The Mental Health Collaborative had planned to use the SDQ, but are interested in using different tools appropriate for young adults (ages 18-21) and culturally-specific. According to program staff, the Somali language does not include words to describe mental or emotional health. As a result, some of the questions on standard mental health screening assessments cannot be clearly understood by Somali parents and youth.

The screening, assessment, and referral approaches used by each program vary considerably. BabySpace, for example, screens all children and often provides prevention-focused classroom services to children who may be exhibiting behaviors or other problems in the classroom, regardless of the screening score. However, fewer children receive a formal diagnostic assessment or therapeutic services. A number of youth referred for diagnostic assessments did not have elevated screening scores, but were referred following observations by classroom teachers and staff. In contrast, all children referred for services from Family & Children Services receive a diagnostic assessment, regardless of whether their screening score is elevated.

Nearly half of youth screened (49%) had an elevated score, indicating potential behavioral or mental health issues (Appendix A14). Among participants referred for a diagnostic assessment, very few refused the service. In all, one-third of the youth (33%) were diagnosed with a mental health or social-emotional disorder as a result of the services provided by the program.

A14. Screening, assessment, and referral outcomes for youth

	BabySpace	Family & Children Services	La Familia Guidance Center	Mental Health Collective	YouthLink	Total
Screening summary						
Number of youth screened	72	53	26	5	75	231
Number of youth with an elevated screening score	13 (18%)	21 (40%)	20 (77%)	5 (100%)	54 (72%)	113 (49%)
Number of youth referred for a diagnostic assessment	13 (18%) [a]	53 (100%) [b]	20 (77%)	5 (100%)	18 (24%)	84 (36%)
Number of youth who received a diagnostic assessment	11 (15%)	46 (87%)	3 (12%)	5 (100%)	17 (23%)	82 (35%)
Number of youth who refused a diagnostic assessment	0 (0%)	5 (9%)	0 (0%)	0 (0%)	0 (0%)	5 (2%)
Number of youth who received a mental health/social-emotional diagnosis	10 (14%)	42 (79%)	3 (12%)	5 (100%)	16 (21%)	76 (33%)

[a] *Nine children who did not have elevated screening scores were also referred for a diagnostic assessment.*

[b] *Diagnostic assessments are conducted for all youth who exhibit behavioral concerns in the PICA classroom, including those who do not have an elevated screening score.*

Discharge data

When data from all programs are combined, nearly one-quarter of the children/youth (21%) were discharged after successfully completing the program (Figure A15). Services ended for fewer families due to refusal of services (15%), the family moving (9%), or referrals to a more intensive treatment setting (6%). The reasons for discharge for YouthLink participants are quite different than for other programs. Young adults who turn 22 years old are not eligible for continued services at YouthLink and receive only short-term transitional services before discharge. Young adults may also choose not to focus on accessing mental health services in their interactions with staff when other crisis issues are more pressing or when adequate community-based services are already in place.

A15. Reasons for discharge from mental health services

	BabySpace (N=1)	Family & Children Services (N=13)	La Familia Guidance Center (N=2)	Mental Health Collective (N=5)	YouthLink (N=12)	TOTAL (N=33)
Successful completion of program	0	2	1	3	1	7 (21%)
Service refused (early termination of services	0	4	1	0	0	5 (15%)
Child referred to another agency	1	1	0	0	0	2 (6%)
Child/family moved	0	3	0	0	0	3 (9%)
Other	0	2 [a]	0	2	11 [b]	15 (45%)

[a] *Two youth were discharged because they had lost funding to participate in the HeadStart program.*

[b] *Some youth were discharged because they aged out of the program (N=4). Other youth were not eligible for the program because they did not want to address those issues (other crises may have required attention) nor had adequate mental health services in place without assistance from staff.*

Staff from most programs reported the degree to which youth participants completed their individual treatment goals at discharge. Because BabySpace is integrated into full-day year-round child development center, the program uses a different approach, reviewing treatment goals regularly and making appropriate changes to the intensity of services provided to the child. When data from all programs are combined, over half of the youth served (58%) partially met their individual treatment goals (Figure A16). Fewer were successful in meeting all treatment goals (16%) or experienced major disruptions in treatment, such as moving away from services or experiencing crises (14%).

A16. Completion of treatment goals at discharge

	BabySpace[a] (N=11)	Family & Children Services (N=13)	La Familia Guidance Center (N=2)	Mental Health Collective (N=5)	YouthLink (N=12)	Total (N=43)
Successfully met all treatment goals	3	2	1	0	1	7 (16%)
Partially met treatment goals	7	11	1	0	6	25 (58%)
Experienced major disruptions in meeting treatment goals	1	0	0	0	5	6 (14%)
Data not reported	0	0	0	5	0	5 (12%)

Note: *Percentages are not reported for calculations involving groups with fewer than 10 participants.*

[a] *BabySpace is a program embedded into a school setting. Treatment goals are reviewed on a regular basis, but most children are not formally discharged from the program when this occurs.*

To assess changes in youth functioning, each program was asked to administer a youth outcome measure at intake and every six months or discharge (depending on the length of the program). The programs were encouraged, but not required, to use the Strengths and Difficulties Questionnaire (SDQ) as an outcome measure. Three programs reported using the SDQ as an outcome measure (BabySpace, FCS, and La Familia Guidance Center). FCS also uses the Behavioral Assessment System for Children (BASC-2). YouthLink also uses a general Health and Wellness assessment to determine the need for additional services.

Only a small number of youth completed were discharged from most programs, and outcome measures were completed for very few of these participants during the first year of the program. Some of the reasons staff were unable to assess changes in outcomes included: some youth did not receive screening at intake (BabySpace); outcome measures could not be administered due to abrupt or unpredictable ends to program participation (YouthLink); outcome measures were only administered to youth who successfully completed all treatment goals (FCS); and staff did not administer the measure at discharge due to paperwork burden (La Familia Guidance Center). In order to improve reporting on outcome data across all programs, barriers to completing this component of the evaluation will be discussed at a meeting scheduled with all grantees in August 2009.

YouthLink did administer a satisfaction survey to seven young adults who participated in their program. Across all items, most participants (N=6 or 7) "strongly agreed" or "agreed" they were satisfied with their relationship with staff, the accessibility and quality of services, and overall impressions of the program. Possible service improvements identified by participants included additional support addressing transportation and housing concerns.

Outreach is a key component of the program developed by La Familia Guidance Center. In 2009, they provided 30 presentations to providers and parents at local agencies, churches, schools, and events. Forty-four families, with a total of 111 children, attended these presentations. Most of the families who attended the presentations (73%) were Spanish-speaking.

Next steps and key observations

All grantees were asked to identify next steps they planned to focus on during the next six months. Specific program goals were identified by three of the funded programs (Figure A17).

A17. Program's next steps

Provider	Next steps
Baby Space	To improve their system for obtaining screening data by offering space and time for parents to complete the forms and having staff available for assistance. Offer Parent-Child Interaction Therapy and Filial Therapy to children and families, as appropriate. Consider offering mental health services to families not enrolled in Tatanka Academy.
Family Children Services	Administer outcome measures every three months, instead of discharge to collect pre-post measures on a larger percentage of participants.
La Familia Guidance Center	None identified in program report.
Mental Health Collective	Pilot a prevention-focused parenting education program. Develop broad intervention approaches, rather than focusing on individualized therapy or services. Establish new partnerships with a community high-rise building to reach more youth and families.
YouthLink	To improve the referral process and offer more groups to current and potential clients on topics that are important to them. Continue to improve and streamline the process, especially for youth aging out of services in need of short-term assistance.

When writing their reports, all uninsured/underinsured grantees are asked to reflect on the data they report and identify any results they felt were surprising. Some of the key observations highlighted by program staff or identified by Wilder Research are listed below:

- **Program staff feel ongoing, informal communication with program participants and community members can lead to increased utilization of services.** All grantees felt their services were effective in engaging youth and families by taking time to develop relationships with parents and teachers, providing services in a non-clinical setting, and being flexible with families who engage in treatment for only short periods at a time. Across programs, staff felt families seldom sought mental health services as a primary focus, but were willing to participate in treatment when staff could explain how various interventions could address areas of concern identified by the parent or young adult (such as improved behavior in the classroom, or ability for homeless youth to secure their basic needs) and a trusting relationship was established.

Program staff at BabySpace, for example, were surprised to observe most youth referred for assessment and treatment are not identified through the screening process, but through ongoing contact and communication with family, teachers, and mental health staff. They hypothesized that parents may be more comfortable discussion their concerns with staff after developing a relationships than when completing a screening measure. La Familia Guidance Center has also found their group presentation format to be an effective, non-threatening way to share information about mental health and behavioral issues with parents in their primary language. Although the program has not tracked how many families seek services after attending a presentation, they feel it has been a successful way to reach out to the Chicano-Latino community.

- **Multiple strategies may be needed to encourage parents to complete screening instruments in a non-clinical setting.** At BabySpace, a number of strategies have been used to ensure a high percentage of parents complete the screening instruments distributed by classroom teachers. The mental health providers have developed scripts for staff to use when introducing the instruments, offered incentives (donations for donated items) to parents who return the instruments, and hosted coffee and doughnut mornings for parents to allow them time and space to complete the instruments. Similar strategies may be helpful to other programs, as well.

- **Although most program participants had insurance at intake, program staff described reasons their target population has had difficulty accessing mental health services in other settings.** Staff from BabySpace feel their ability to slowly build relationships with staff through their consistent involvement in the learning center has allowed parents to feel more comfortable sharing concerns with staff and the services available. Parents have not refused the services offered by the mental health providers at BabySpace. Similarly, by providing co-located services at the HeadStart site, FCS can help reduce barriers around transportation, co-pays for weekly services, or resistance to working with mental health providers in an unfamiliar setting. At YouthLink, staff feel their flexible approach to services is essential to reach this highly-mobile population. While many traditional programs require participants to regularly attend weekly sessions, YouthLink is more flexible. Their goal is to identify other community-based providers who are also willing to take a more flexible approach when providing services to expand the number of options available to homeless youth.

- **Supplemental data may be needed to demonstrate the impact of services.** All grantees had difficulties collecting and reporting outcome data, as many youth do not officially "discharge" from services. Wilder Research plans to meet with each program to review their evaluation plan and consider supplemental information that can be gathered to further describe the impact of the services provided.

Primary Care

Background

Two programs, Partners in Pediatrics (PIP) and St. Joseph's Home for Children (St. Joe's) received funding to provide co-located mental health services and primary care clinics. Although both programs have similar goals of increasing the use of mental health screening and improving access to care, they vary in regard to program structure and target population (Figure A18).

A18. Overview of Primary Care programs

Partners in Pediatrics	Partners in Pediatrics entered a collaborative arrangement with Pediatric Consultation Specialists to provide co-located mental health services at their Maple Grove Clinic. Through this arrangement, the mental health providers can offer Behavioral-Express Care (BE-Care) appointments for children and families with behavioral concerns. Social-emotional screening occurs at all well-child visits, with the mental health professional located on at the clinic one day each week to provide consultation to medical providers, immediate mental health triage services, and further assessments.
St. Joseph Home for Children	St. Joseph's Home for Children's provides intake and shelter services for Hennepin County children removed from their homes due to abuse or instability. Social-emotional screening is incorporated into the health assessments conducted when youth enter the program. Children with an elevated screen are referred to the behavioral health clinic for further assessment and intervention services, as appropriate. A care coordinator serves as a liaison between behavioral health staff, residential counselors, and families.

Implementation status

Both programs were fully implemented since 2008. However, St. Joe's has experienced staff turnover in key positions, including the clinical director and behavioral health therapists. At this point, the behavioral health clinic is only staffed three of five days each week.

Characteristics of youth served

The data included in this report describe characteristics of youth screened between October 2008 and June 2009. Demographic information was gathered at different points of the screening and assessment process in 2008. The information reported by St. Joe's includes information from all youth screened, while PIP data includes only youth screened and referred to the mental health provider for additional services.

When data from both programs were combined, a total of 346 children/youth received mental health screening services. The populations served by the two programs are very different. Over half of youth screened at St. Joe's (53%) were age 15 or older, compared

to only 1 percent of youth served at PIP (Figure A19). Most youth served at St. Joe's (66%) were African American, while PIP served a primarily White/Caucasian patient population (89%) (Figure A20).

A19. Ages of youth served

	St. Joe's (N=148)		PIP (N=153)	
	N	%	N	%
0-5	0	0%	47	31%
6-8	2	1%	41	27%
9-11	10	7%	30	20%
12-14	56	38%	33	22%
15-18	78	53%	2	1%
Unknown	2	1%	0	0%

A20. Race/ethnicity of youth served

	St. Joe's (N=148)		PIP (N=153)	
Race	N	%	N	%
African-American	98	66%	2	1%
Asian-American	3	2%	4	3%
American Indian	9	6%	0	0%
White/Caucasian	20	14%	136	89%
Bi-/multi-racial	10	7%	6	4%
Unknown	1	1%	5	3%
Ethnicity				
Hispanic/Latino	7	5%	2	1%

Note: *Ethnicity data was not captured by St. Joe's in November, 2008.*

Screening and referral outcomes

St. Joe's

Most youth (97%) received mental health screening at St. Joe's. Among the 143 youth with a competed screen, nearly 89 percent had elevated scores. While the percentage of youth with potential mental health concerns is considerably higher than expected in the general population, it is likely an accurate reflection of population seen at St. Joe's.

Youth come to St. Joe's in crisis situations where there are concerns about child abuse or neglect. The act of moving to St. Joe's for temporary housing in itself is also a stressful and traumatizing event for the youth seen. According to staff, most youth also have a long history with Hennepin County child welfare, juvenile justice, or children's mental health systems.

A total of 140 youth were seen in the Integrated Care Clinic, with only four youth refusing services. In December, St. Joe's began tracking the types of referrals made by the behavioral health clinicians. Referrals by the behavioral health clinician were tracked for 121 youth, with some youth receiving multiple referrals. Nearly half of these youth (49%) were referred for follow-up appointments with the behavioral health therapist, while others were referred for new or continuing community-based mental health services (22%) (Figure A21). While the referrals documented for a few youth specified continued work with the unit therapist, it is important to note all youth staying in the shelter work with a unit therapist. However, the degree to which ongoing coordination between the behavioral health clinicians and unit therapists may vary. Among youth referred to "other" services, referrals were made to asthma camp, mentoring services, school, primary care services, and a parenting group.

A21. Referrals made by behavioral health clinicians, St. Joe's (N=121)

	N	%
Follow-up appointment with behavioral health therapist	59	49%
Community-based mental health services	21	17%
Continue working with unit therapist	8	7%
Mental health diagnostic assessment	7	6%
Continue current therapy services	6	5%
Psychiatry (medication management or neuropsych evaluation)	3	2%
Other	5	4%

Some tracking of referral outcomes has been done while youth reside at St. Joe's. Of the 64 youth referred for additional mental health services, nearly half (48%) attended a follow-up appointment with the behavioral health clinician or community-based provider, while one-quarter (27%) did not. It was not known whether the remaining youth attended a follow-up appointment. A challenge faced by St. Joe's is that many children leave the shelter before additional services can be initiated. For example, referrals for mental health diagnostic assessments are typically relayed to the child's social worker, but it is not known how many of these youth received the assessment after leaving St. Joe's.

PIP

Screening outcomes. In order to examine screening and referral patterns for the general clinic populations, documentation of screening results and referral outcomes are captured by the Maple Grove PIP clinic once a week. Between October 2008 and May 2009, the results from 361 youth who had appointments at the Maple Grove Partners in Pediatrics clinic were included in this sample of patients. Most of these patients seen were children less than two years of age (Figure A22). Screening instruments were used during most pediatric appointments (89%).

A22. Ages of children/youth screened at Maple Grove PIP clinic (N=361)

Age	N	%
0-2	205	57%
3-5	51	14%
6-9	31	9%
10-12	34	9%
13-15	17	5%
16-18	23	6%

Among the 323 youth screened, nearly one in every five (17%) had elevated screening scores. While this percentage seems high for the population served, it may be a reflection of the sensitivity of the screening instruments used by PIP to identify potential social-emotional and behavioral concerns. For example, while some screening instruments incorporate a threshold to differentiate between general concerns (non-elevated scores) and potentially greater social-emotional concerns (elevated scores), on the Pediatric Symptom Checklist (PSC) the score is considered to be elevated if a parent identifies any behavioral concerns when completing the instrument.

The referral outcomes for most youth with elevated screening scores were not documented. Within this sample, less than 10 percent of youth with elevated screening scores were revered to BE-Care for additional services (Figure A23). Among youth who were not referred following an elevated screen, the provider often offered guidance or counseling to the parent or felt the concern was related to a medical issue. However, without additional information it is not possible to determine the general patterns in the types of referrals that occur after behavioral concerns are identified through the screening process.

A23. Referral outcomes among youth with elevated screening scores, PIP (N=56)

Screening results	N	%
Referred to BE-Care clinic	5	9%
Not-referred to BE-Care clinic	17	31%
Identified as a medical issue	5	9%
Pediatric guidance provided	5	9%
Counseling for age provided	3	5%
Medical issue, pediatric guidance provided	3	5%
Already seeing therapist	1	2%
Referral outcome unknown	33	59%

BE-Care outcomes. Additional information was collected to describe the referrals made for youth who attended BE-Care appointments. Just over 10 percent of patients referred for mental health triage were seen by PCS on the same day as the pediatric appointment (Figure 24). Youth were more likely to be seen in the week (41%) or 8 to 14 days (22%) following the pediatric appointment. A few patients were seen by the mental health triage provider more than a month after being referred by the pediatrician (7%). Most of the appointments (92%) were held at the BE-Care clinic location, rather than the PCS office.

A24. Length of time between PIP pediatric visit and mental health triage appointment

	N	%
Same day	17	11%
1-7 days	62	41%
8-14 days	34	22%
15-30 days	20	13%
More than one month	10	7%
Unknown	10	7%
Total	45	100%

Nearly three-quarters of the children who attended a triage mental health visit received some type of education (72%), while referrals for psychotherapy (55%) were also common. Approximately one in every five children seen by the mental health professionals were referred for additional psychological testing (17%) (Figure A25). Other types of referrals and supports provided by the mental health providers included outreach to the child's school or preschool (N=7), books or handouts (N=5), and parenting guidance (N=4).

A25. Referrals made by triage mental health provider, PIP

	N	%
Education provided	110	72%
Psychotherapy	87	57%
Psychological testing (diagnostic assessment)	26	17%
Physical/occupational therapy	5	3%
Speech therapy	1	1 %
Back to pediatrician	2	1%
Other	43	28%

Note: *Children may have received multiple referrals/services during the triage mental health visit.*

As described previously, parents of children who are referred for additional mental health services are given a list of mental health providers, including PCS, they may contact for future visits. Since the project began, 13 youth who were referred for additional testing or therapeutic services attended future appointments at PCS. Most of these youth (92%) were diagnosed with conditions related to anxiety, depression, ADHD, and adjustment disorders.

Next steps and key observations

During the next year, both programs plan to work toward sustainability of their model, which may require modifications to their current service-delivery or billing approaches. In addition, St. Joe's would like to explore how successfully they are able to help youth connect with community-based mental health services, and consider whether other screening instruments may be more appropriate with this population. PIP is interested in assessing patient satisfaction with BE-Care services and considering strategies to provide reimbursable services to youth from a variety of health care plans.

A series of focus groups was conducted with stakeholders from both projects, including pediatricians, mental health providers, and billing managers. Despite the vast differences in the population served by each site and implementation of the initiative in their unique settings, both programs felt the initiative had led to greater collaboration across staff and improved access to mental health services for the youth served through the program. However, each program identified unique staffing, implementation, and sustainability challenges. Some of the key observations made by program staff and Wilder Research during the first year of services are listed below:

- **Both programs felt it took longer than expected for the project to build relationships across staff and a common understanding of the program goals.** Both projects had hired all staff and had started serving youth in 2008. However, in

retrospect, program stakeholders felt it took longer than expected to develop cross-disciplinary relationships and build consensus on the goals of the project. At PIP, the mental health providers found it difficult to develop relationships with over 30 different medical providers located in five clinic locations. In addition, additional time was needed to familiarize staff with BE-Care, and recognize which children who would most benefit from a referral to this service. At St. Joe's, the project was without key leadership for a 3-month period, making it difficult for staff to address implementation challenges early in the project. Program stakeholders are currently engaged in a series of discussions to determine how to modify the integrated care model they were trained on to best address the concerns of the high-need population they serve.

- **Insurance coverage and reimbursement has been identified as the most significant challenge faced by PIP stakeholders.** The degree of coverage for mental health services varies considerably by insurance plan, but providers seldom know in advance which types of services will be covered. In addition, PCS is part of the Blue Cross Blue Shield provider network, but is not accepted into other plans. With grant funds, PIP has been able to supplement the costs of services so that families pay only a $30 co-pay. However, when funding ends, there will be no option to supplement payment for families who attend BE-Care appointments and are covered through other health insurance plans.

- **Care coordination is seen as a critical element of both projects, but difficult to sustain.** In order to ensure communication occurs between the mental health providers, medical staff, families, and other agencies (including schools, child protection, juvenile justice), both programs have developed some type of care coordination role. At PIP, the mental health providers take time to communicate their recommendations to the pediatricians through written progress notes or telephone calls. However, these hours are not billable. At St. Joe's a portion of grant dollars is used to fund the care coordinator position. Though both programs find this role to be extremely important, it will be difficult to sustain when grant funding ends.

School-based mental health

To remove barriers to learning and promote the social and emotional development of children, the Hennepin County Mental Health Collaborative funded six programs that work with schools and their students. The funded school-based mental health programs were directed to better assess and treat student's mental health concerns and improve the student access to mental health services within Hennepin County schools. The funded agencies are Storefront, Washburn Center for Children, Family Networks, Clues, Nystrom and Minneapolis Department of Health Family Support (Figure A26).

A26. Overview of School-Based Mental Health Programs

CLUES/Richfield School District	Serves youth in Richfield High Schools by providing mental health services to Latino youth and their families.
Family Networks/ Robbinsdale Area Schools	Serves youth with a mental health diagnosis by increasing the accessibility for uninsured and underinsured children to mental health services and improving the identification of mental health issues for youth.
Minneapolis Department of Health and Family Support	Serves a multicultural group of youth at Roosevelt High School by providing prevention, assessment, and intervention services to youth through therapy.
The Storefront Group/Anoka Hennepin School District	Serves adolescents through educational training related to mental health by providing consultation for prevention services and crisis intervention to the school staff and faculty.
St. Anthony School District/ Nystrom and Associates	Serves youth at the St. Anthony-New Brighton School district by providing assessments, individual and family therapy, groups and educational groups to students with a mental health diagnosis.
Washburn Center for Children/Eden Prairie	Serves youth in the Eden Prairie School district school linked children's mental health services for Eden Prairie students by providing individual and family therapy on site in the school setting, office visits and/or home visits.

During the summer of 2008, some of the school-based mental health staff met to discuss the need for a more streamlined and integrated approach to tracking school-based mental health services. They determined an integrated data management system would provide several important benefits, including: 1) reducing the need for agencies to develop individual (redundant) data management systems; 2) assisting programs in meeting grant reporting requirements; and 3) using system-level data to better understand the potential benefits of school-based mental health services, identify strategies for enhancing programming, and build a case for program sustainability

Five of the six agencies (Minneapolis Department of Health and Family Support is not a database partner) contributed at least $3,000, in addition to the same contribution from other community-based agencies (that are not part of the school-based mental health SOI

programs). With supplemental financial support from Hennepin County, a plan for the development of a database emerged late in 2008. Wilder Research is serving as the program manager of these efforts. In this capacity, we have convened workgroups to finalize the database content and structure and create all user policies. We are not creating the actual database, but have contracted with an external vendor, Internet Exposures, a Minneapolis-based web design firm. We are working closely with the vendor throughout the database construction to ensure that the resulting database will meet the needs/ expectations of the partnering agencies.

The MN Kids Database (which is the name of the web-based database) is in its final stages of development and nearing completion. The database should be "live" at the end of August as the final features are being added. As it becomes finalized, agencies were given an extension to turn in their data (due August 31, 2009).

In the meantime, three clinician trainings have been completed and user agreements are being collected. Additionally data from agencies who are interested in importing last year's data is in the process of being coded and cleaned so it can be "dumped" into the database.

Once the database is officially up and running, demographic, staffing, and programmatic information will be analyzed by Wilder Research and the data will be added to the Collaborative Report.

Overview of MN Kids' Database

The MN Kids' Database is web-based, allowing users to enter data or run reports at any location with Internet access. It is an integrated data management system developed to assist clinicians and providers better track and report information, including (but not limited to):

- Provider/school/agency identifiers
- Student background, such as identification numbers, name, gender, grade, race/ ethnicity, date of birth, and special education status
- Parent/guardian contact information
- Insurance information and billable/non-billable status
- Referral information, including the date referred to service, history of mental health service, and presenting problems

- Information about services provided (session-specific), including date, type of service (individual therapy, family therapy, etc.), length of service, location of service
- Student assessment results, using the Strengths and Difficulties Questionnaire (SDQ) and the Child and Adolescent Service Intensity Instrument (CASII)
- Documentation of reasons why students may have never been seen and reasons for discharge
- Documentation of school-wide services provided, including date, type, and length of service

Features of the MN Kids' Database

- The database is web-based, allowing users to enter data or run reports at any location with Internet access.
- The database is secure, housed on a secure server with access limited to authorized users.
- Authorized users are able to run a number of simple reports through the database. For more complex analysis/reporting needs, data can be downloaded into a spreadsheet format suitable for importing into other database or statistical analysis software.
- The database is scalable, allowing additional partners to be added as needed over time. The application is developed to accommodate future enhancements where possible.
- The database has reporting features designed to help participating agencies meet the reporting requirements of several funding sources, including the DHS school-based mental health grants and the Hennepin County Children's Mental Health Collaborative school-based mental health grants.

Note: It would be optimal for the database to interface directly with information management systems at partner agencies – this would allow users to transfer information directly across the databases, eliminating any need for duplicate data entry. Due to the diverse array of partners, with different existing in-house systems, complete integration is not possible. We have made every effort possible to minimize the need for duplicate data entry and to ensure that data downloaded from the system can be integrated as easily as possible with other agency-specific information (such as billing records).

Project timeline of MN Kids' Database

The database project began early in 2008. Over the past year, Wilder Research has worked with the advisory group and database partners in completing Step 1-4 (see Figure A27 below). The live version of the MN Kids' Database is scheduled to launch September 11, 2009.

A27. Database Timeline

Advisory Group of the MN Kids' Database

An advisory group has been established and has convened many times over the past year to oversee the MN Kids' Database. The advisory group is charged with reviewing database items, providing feedback to the vendor, revising user agreements, approving new contracts, and handling any written complaints by clients (e.g., students, parents) that are not resolved at the agency level. Currently, the advisory members are:

- Brad Kopecky, Storefront
- Cheryl Holm-Hansen, Wilder Research
- Cindy Slowiak, Hennepin County
- Ginnee Engberg, Family Networks
- Jim Johnson, Minneapolis Public Schools
- Julie Atella, Wilder Research
- Linnea Swanson, Guadalupe Alternative Programs
- Mark Sander, Hennepin County
- Melodie Hanson, Robbinsdale Area Redesign

- Tom Steinmetz, Washburn Center for Children

Next steps and key observations

The process of creating a database to be used by a variety of programs, some that can be very different from one another, takes time and consideration. The monthly meetings held to discuss database content, operationalization of data points, and various administration tasks were time consuming, but crucial. Despite these challenges, the partnership has created a database that should provide important information about school-based mental health. Over time, the database should not only provide useful information to individual clinicians (i.e., for case management/monitoring), but will also guide larger policy- and system-reform efforts.

Financials

Primary Care Agencies	Contract Period	Year 1 Budget	Year 1 YTD Payment	Year 2 Budget	Year 2 YTD Payment	Year 3 Budget	Year 3 YTD Payment	Total Budgeted Funding
Pediatric Consultation Specialists	8/1/08-7/31/11	20,300	12,708	19,300	0	18,900	0	**$ 58,500**
St. Joseph's Home for Children	8/1/08-7/31/10	35,400	15,000	29,600	0	0	0	**$ 65,000**

Juvenile Justice MH Systems Change Agency	Contract Period	Year 1 Budget	Year 1 YTD Payment	Year 2 Budget	Year 2 YTD Payment	Year 3 Budget	Year 3 YTD Payment	Total Budgeted Funding
Amicus	9/1/08-8/31/10	33,794	26,775	33,794	0	0	0	**$ 67,588**

Juvenile Justice Prevention and Intervention CMH Correction Agencies	Contract Period	Year 1 Budget	Year 1 YTD Payment	Year 2 Budget	Year 2 YTD Payment	Year 3 Budget	Year 3 YTD Payment	Total Budgeted Funding
Amicus	9/1/08-8/31/09	30,000	27,753	0	0	0	0	**$ 30,000**
HIRED	1/1/09-12/31/09	50,000	9,264	0	0	0	0	**$ 50,000**
Emerge	9/1/08-8/31/09	30,000	25,986	0	0	0	0	**$ 30,000**
Family & Children's (Youth Connections)	9/1/08-8/31/09	30,000	19,253	0	0	0	0	**$ 30,000**
Family & Children's (My Life My Choice)	9/1/08-8/31/09	30,000	22,848	0	0	0	0	**$ 30,000**
Genesis II	9/1/08-8/31/09	30,000	30,000	0	0	0	0	**$ 30,000**
Relate	9/1/08-8/31/09	30,000	18,400	0	0	0	0	**$ 30,000**
Stadium View School	9/16/08-8/31/09	60,000		0	0	0	0	**$ 60,000**
SEARCH	9/16/08-9/15/09	60,000		0	0	0	0	**$ 60,000**

Uninsured/Underinsured Agencies	Contract Period	Year 1 Budget	Year 1 YTD Payment	Year 2 Budget	Year 2 YTD Payment	Year 3 Budget	Year 3 YTD Payment	Total Budgeted Funding
Baby's Space	9/1/08-8/31/11	35,000	25,463	36,400	0	37,856	0	**$ 109,256**
LaFamilia	11/25/08-12/31/11	40,000	25,463	40,000	0	40,000	0	**$ 120,000**
MH Collective	9/1/08-8/31/11	40,000	29,848	40,000	0	40,000	0	**$ 120,000**
Family & Children's PICA	10/1/08-9/30/11	40,000	32,607	40,000	0	40,000	0	**$ 120,000**
YouthLink	9/1/08-8/31/11	40,000	8,569	40,000	0	40,000	0	**$ 120,000**

School-based Mental Health Agencies	Contract Period	Year 1 Budget	Year 1 YTD Payment	Year 2 Budget	Year 2 YTD Payment	Year 3 Budget	Year 3 YTD Payment	Total Budgeted Funding
Nystrom	8/12/08-7/31/11	27,000	27,000	27,000	0	27,000	0	**$ 81,000**
Mpls. Dept. of Health	2/10/09-1/31/12	30,000	0	30,000	0	30,000	0	**$ 90,000**
Washburn Center for Children	9/1/08-8/31/11	30,000	30,000	30,000	0	30,000	0	**$ 90,000**
Family Networks	9/1/08-8/31/11	27,000	30,000	27,000	0	27,000	0	**$ 81,000**
CLUES	9/1/08-8/31/11	27,000	21,542	27,000	0	27,000	0	**$ 81,000**
Storefront	8/12/08-7/31/11	27,000	0	27,000	0	27,000	0	**$ 81,000**
TOTALS		**$ 802,494**	**$ 438,479**	**$ 447,094**	**$ -**	**$ 384,756**	**$ -**	**$ 1,634,344**