Hennepin County Children's Mental Health Collaborative

Semi-annual report

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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 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). While programs collected similar demographic information for this report, it is imperative not to make comparisons between programs. Due to the differences in each program's target population and service approach, comparisons would be limited at best. This semi-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?

- What key lessons have been learned through this grantmaking initiative?

The annual reports for all funded programs will include outcome data to examine changes in youth outcomes and other key measures. A brief summary of the additional evaluation components that will be reported on by each SOI group are included in the Appendix. Additionally, the Collaborative has provided an overview of the financials for each program which can also be found in the Appendix.

Evaluation process

Wilder Research plays a different role in each of the four SOI programs. Wilder Research provides sample data collection templates/tools and protocols to each program (with the exception of the school-based mental health programs). 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;
- Reviewing all programs' reports; 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 are using 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 that funded by the Hennepin County Children's Mental Health Collaborative in 2008. Figure 1 is provides a brief program overview 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/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 programs began providing services. While all programs are currently moving ahead with their work, they experienced a few challenges that led to delays. Funding issues beyond the control of the Collaborative disrupted project timelines. While these delays were inconvenient, most programs were still able to fully implement their programs. Overall, the majority of programs were operational at the end of 2008. Three programs were not fully operating by the end of the first reporting period, due to delays in the contracting process (HIRED and La Familia Guidance Center) and hiring of staff (Family and Children Service: Youth Connections). Based on the information included in the semi-annual reports, a few programs also experienced delays in implementation due to staffing issues or site changes in 2008. It may be helpful to encourage programs to involve multiple staff in future grantee meetings to ensure information is not lost if staff turnover occurs.

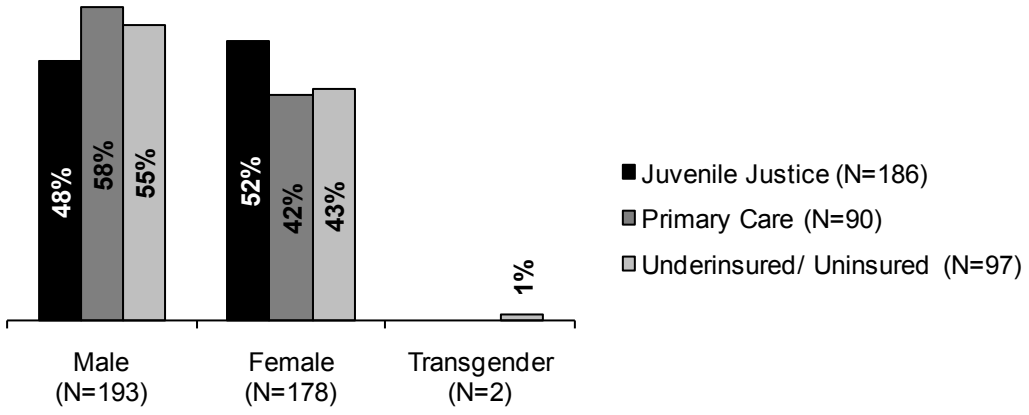
Most programs had also fully implemented the evaluation plan at the end of 2008. A number of programs were late submitting their semi-annual reports, most often because of confusion regarding reporting timelines. In addition, a few programs had questions about the report template or asked for clarification on specific evaluation measures. To avoid potential problems with the annual report, Wilder Research plans to be proactive with grantees to identify any questions related to reporting outcome measures.

Characteristics of youth served

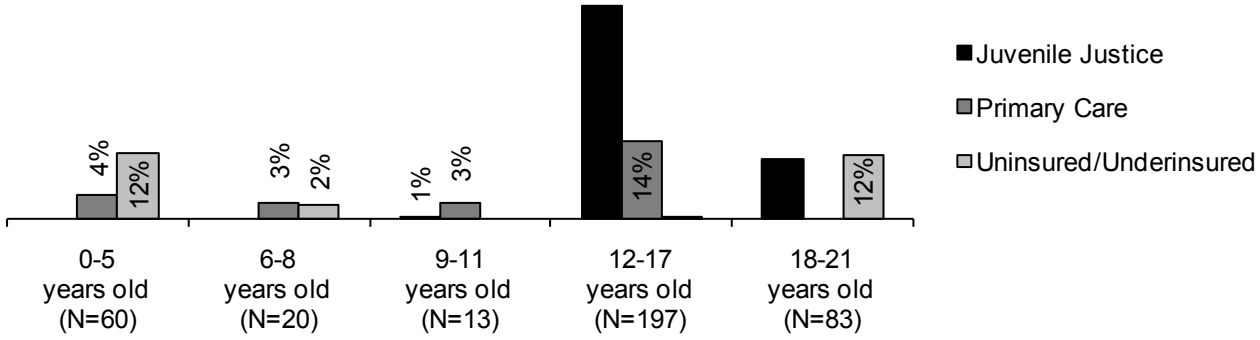
Demographic data describing characteristics of youth served were captured for 15 of the 23 funded programs. A few of the programs did not report any of this descriptive information because they were not fully implemented in 2008. The school-based programs are also not included in this report; data regarding the characteristics of youth served will be reported in July 2009 (once their database is operational). Each program may have had a slightly different way of counting their participants because of the different point of entry involved. For instance, in primary care, one of the programs counted youth screened while the other counted youth referred for mental health triage. Detailed information about individual SOI programs can be found in the Appendix.

A total of 373 youth were served during the period of October-December 2008 for the SOI programs providing information. Approximately half of the youth served were male (52%). The youth served during this period ranged in age from 0-21 years old, with half falling between the ages of 12 and 17 (54%). None of the youth in the juvenile justice programs were under the age of nine. Half of the youth identified as African-American/ Black (53%). Within this group, nearly 1 in 10 identified as African-born (8%). Very few Asian-Americans (3%) were served by any of the SOI programs. One-quarter of the youth served were Hispanic (25%) (Figures 2-5).

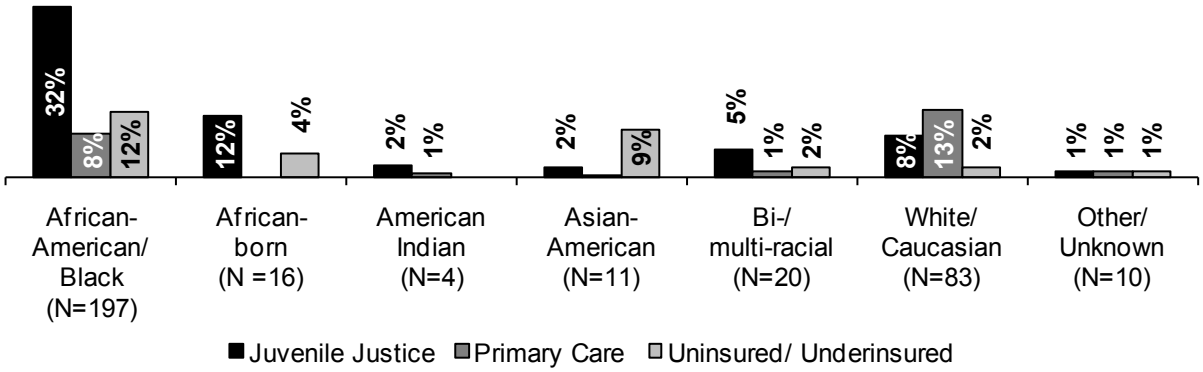
2. Gender of youth served



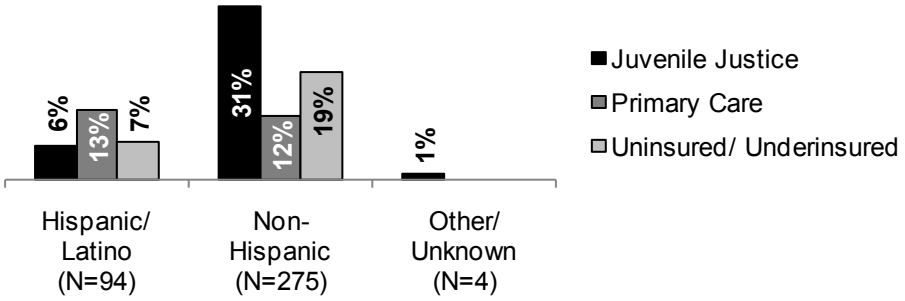
3. Age of youth served



4. Race of youth served



5. Ethnicity of youth served



Overall, the programs report the have been successful in reaching their anticipated target populations. 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) and 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.

Key observations and next steps

There are a few key lessons learned 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:

- **Clearly describing evaluation expectations to all potential grantees during the SOI process may lead to the use of more consistent outcome measures.** Although the final evaluation plan captures consistent demographic information across all SOI programs, it was more difficult to identify common outcome measures. While it can be challenging to identify meaningful measures that can be used across different target populations, it may have been easier to reach consensus if each SOI explicitly described the evaluation requirements to potential grantees. If a similar proposal process is used in the future, it may be helpful for the Collaborative's Measuring Success sub-committee to become engaged in developing the evaluation plan before the SOI is posted, and to provide a menu of specific outcome measures each grantee will be expected to report, if they receive funding.

- T**he development of a coordinated grantmaking approach and evaluation plan requires frequent and different levels of communication with programs, both through group discussions and with individual technical assistance to programs.** Despite attempts to ensure clear communication throughout the development of the evaluation plan, some information was not clearly understood by all stakeholders. To ensure consistent information sharing with potential grantees, there should be frequent communication between representatives from the Collaborative, County grant managers, and Wilder Research staff. This may help minimize confusion regarding requirements and ensure all grantees hear consistent information about the process used to finalize contracts, develop and implement the evaluation, and begin services. In addition, it is important to offer grantees individual technical assistance to help them incorporate data collection activities into their work, define each measure based on their program structure, and address any program-specific questions that arise. To enhance future communication with grantees, Wilder Research will not only continue to respond to questions from individual programs, but actively offer support to grantees before the annual reports are due.

- **Additional discussions will be needed throughout the course of the evaluation to ensure the information gathered is useful to all stakeholders.** In recent conversations with the Measuring Success committee, some key evaluation questions of interest to the Collaborative were identified. This type of information will help shape the content of future evaluation reports. In addition, it may also be helpful to consider how this summary information will be shared with all funded programs, which additional process evaluation questions may be helpful to discuss with program representatives during future evaluation meetings, and whether it is appropriate for Wilder Research and/or the Collaborative to use information from the semi-annual reports to provide individual programs with suggestions or recommendations to improve 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 programs 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.

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.
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

All programs were asked to report about their implementation and staffing status. Of the ten JJ-SOI programs, all but two were fully staffed by the end of the reporting period and eight were being fully implemented. SEARCH described their implementation status as "in process." Youth Connections had a late start implementing their program, which was dormant for part of the reporting period. As of December 2008, they had hired staff. HIRED, on the other hand, did not begin their contract until January 1, 2009, so reporting about their staffing will occur during the next reporting cycle.

Some programs did not have any implementation concerns or issues. Those who faced challenges mentioned staffing changes, low referrals, poor school attendance rates, and changing sites.

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 screened from October-December 2008. Two of the 10 programs did not begin providing services during this reporting period (HIRED and Youth Connections); therefore, the demographic information in this section includes only eight of the Juvenile Justice programs. A total of 186 youth received services during this timeframe (Figure A2).

A2. Number of youth who were served by program

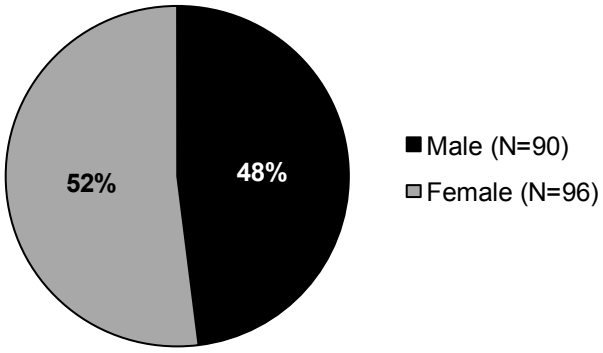
Agency	Youth who began receiving services within the data collection period
Amicus Radius	10
Amicus Radius-North Vista	8
Emerge/Streetwerks	13
Family and Children Services: My Life, My Choice	45
Family and Children Services: Youth Connections[1]	-
Genesis	70
HIRED[2]	-
Relate	14
SEARCH	16
Stadium View	10
TOTAL SERVED	**186**

[1] *Because of a late start, data collection did not occur during this reporting period.*

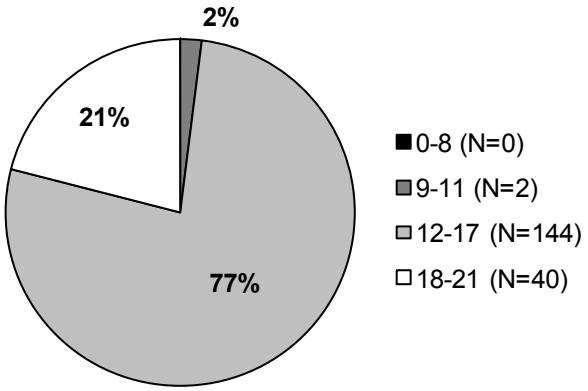
[2] *Because of a late start, data collection did not occur during this reporting period.*

Approximately half of the youth served were female (52%). There were no youth served between the ages of 0-8, which would be expected of youth involved in the juvenile justice system (Figure A4). Approximately three-fourths of the youth served were between the ages of 12-17 (77%). Most youth served by the juvenile justice programs were African American/Black (65%) (Figure A5). Of the 120 African American/Black youth, 11 percent identified as African-born (e.g., new immigrants, refugees) (Figure A6). Twelve percent of the youth identified as Hispanic.

A3. Gender of youth receiving services



A4. Ages of youth receiving services



A5. Race/ethnicity of youth receiving services

Race	N	%
African American/Black	120	65%
African-born	*14*	*11% of African-American/Black*
Asian American	8	4%
American Indian	7	4%
Bi-/multi-racial	20	11%
White/Caucasian	29	15%
Other	2	1%
Ethnicity		
Hispanic	22	12%
Non-Hispanic	160	86%
Unknown/Missing	4	2%

Future evaluation activities

To demonstrate the effectiveness of services, the juvenile justice grantees have been asked to report on recidivism. Each program 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 enter the juvenile justice system six months after they have completed the program. Since recidivism data cannot be collected immediately after program completion, the first annual report may have limited recidivism data to discuss. Programs are also required to report participant (youth) satisfaction data for the evaluation. Programs may also report on parent/caregiver satisfaction data, but it is not required (since all of the JJ-SOI Programs do not work with this group).

Next steps and key observations

In their semi-annual reports, programs noted their planned steps for the next six months (Figure A6). Many programs wanted to work on increasing referrals. Others mentioned planning trainings and outreach.

A6. Program's next steps

Agency	Next steps
Amicus Radius	Increase referrals.
Amicus Radius-North Vista	Implement family support/counseling for girls and their families.
Emerge/Streetwerks	Reach enrollment capacity, conduct survey and focus group, and enroll students in summer employment opportunities.
Family and Children Services: My Life, My Choice	Conduct trainings and awareness campaigns about social networking technologies and internet safety.
Family and Children Services: Youth Connections	Implement program.
Genesis	Start/open another Group Life Skills class.
HIRED	Implement program.
Relate	No changes planned.
SEARCH	Formalize partnerships and refer more youth to CSCM.
Youth Connections	Fully implement the procedures with 33 additional youth.

When writing their reports, all juvenile justice grantees are asked to reflect on the data they reported. Some of the key observations highlighted by program staff and Wilder Research are listed below:

- **Implementation can be difficult when the unexpected happens.** Amicus Radius-North Vista initially planned on working in the Bren, but had to change their location to North Vista midway through the reporting period. Likewise, staffing issues prevented HIRED and Youth Connections from implementation.

- **New programs are slow to get referrals from other agencies.** A few programs wanted to formalize partnerships and strengthen their referral base in order to serve more youth. SEARCH and Emerge/Streetwerks noted that they wanted to increase their numbers by spending time interacting with other agencies.

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 broach 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 A7).

A7. 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 local providers.

Staffing and implementation status

All programs were asked to report about their implementation and staffing status. Of the five uninsured/underinsured programs, four were fully staffed by the end of the reporting period. The Mental Health Collective and La Familia Guidance Center experienced delays in implementing their program. La Familia Guidance Center received their contract late in 2008 and did not serve any youth during the reporting period. The Mental Health Collective experienced staff turnover in 2008 and served only three youth during the reporting period. However, they had not anticipated having services fully implemented until 2009.

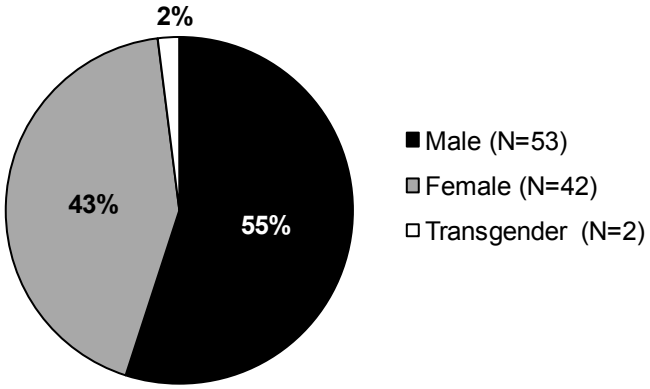
The Mental Health Collective reported unique staffing challenges due to the high degree of stigma around mental health issues in the East African community. Although the program has developed strong partnerships with other agencies, staff who left the project stated they experienced more resistance from community members than they anticipated. While all staffing positions are currently filled, stigma is likely to continue being a significant challenge for this program.

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 screened from October-December 2008.

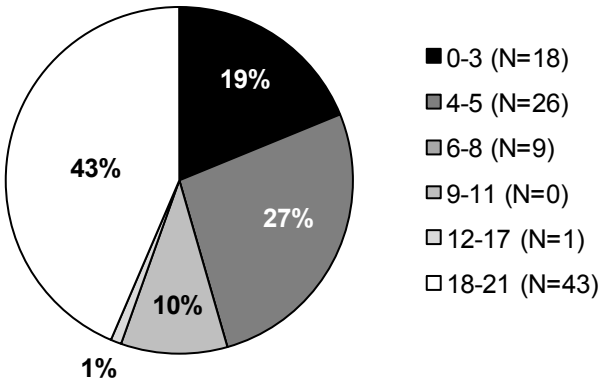
During the first three months, four of the five SOI-funded grantees began offering services to youth. A total of 97 youth received screening and/or therapeutic intervention services during this timeframe. Approximately two-thirds of the youth receiving services are male (55%) (Figure A8).

A8. Gender of youth receiving services



Youth ranged in age from 0-21 years old (Figure A9). The data included in this report came primarily from three programs that have a specific age focus (Baby Space, FCS, and YouthLink). Nearly half of the children served/assessed were 0-5 years old (46%), while slightly fewer (44%) were transition-age youth, ages 18-21.

A9. Ages of youth receiving services



Over 90 percent of youth served by uninsured/underinsured programs were identified as individuals of a "minority" cultural group. Nearly half of the youth served (47%) were African American/Black. Of the 46 African American/Black youth, 2 percent were identified as African-born (new immigrants, refugees). In addition, without including any data from La Familia Guidance Center, nearly one-quarter of youth served (24%) were Hispanic.

A10. Race/ethnicity of youth receiving services (N=109)

Race	**N**	**%**
African American/Black	46	47%
African-born	*2*	*Less than 1% of African-American/Black*
Asian American	0	0%
American Indian	33	34%
Bi-/multi-racial	7	7%
White/Caucasian	7	7%
Other	4	4%
Ethnicity	N	%
Hispanic	25	24%
Non-Hispanic	72	76%
Unknown/Missing	0	0%

Over 80 percent of the youth who received services were insured through a public program, such as Medical Assistance (MA) or MinnesotaCare (Figure A11). Fewer youth did not have insurance, either because they were ineligible (1%) or for another reason (9%).

A11. Mental health insurance coverage at intake

No insurance coverage	10 (9%)
Insured through public program (MA, MinnesotaCare)	85 (88%)
Insured through private insurance	2 (2%)
Not eligible for insurance	1 (1%)
Unknown	1 (1%)
Total	97 (100%)

Screening and service utilization data

When combined, a total of 97 youth were screened for mental health or behavioral issues during the reporting period. Nearly half of youth screened (48%) had an elevated score, indicating potential behavioral or mental health issues. Although the screening, assessment, and referral data included in this report are preliminary and should be interpreted with caution, they also indicate unique differences in program approach and characteristics of the target population (Figure A12).

The screening tools used by each program vary, but include the Ages and Stages Questionnaire-Social Emotional version (ASQ:SE – BabySpace, Family & Children Services) and Strengths and Difficulties Questionnaire (LaFamilia). YouthLink also uses a general Health and Wellness assessment to determine the need for additional services.

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. In contrast, all children referred for services from Family & Children Services receive a diagnostic assessment, regardless of whether their screening score is elevated.

A12. Screening, assessment, and referral outcomes for youth (N=97)

	BabySpace	Family & Children Services	Mental Health Collective	YouthLink
Screening summary				
Number of youth screened	33 (100%)	20 (100%)	3	41 (100%)
Number of youth with an elevated screening score	10 (30%)	3 (15%)	3	31 (76%)
Referral summary: Among youth with elevated screening score, how many:	**N=10**	**N=3**	**N=3**	**N=31**
Received a referral for a diagnostic assessment?	4 (40%)	20[a]	3	18 (58%)
Did not receive a referral?	6 (60%)	0	0	13 (42%)
Diagnostic assessment summary: Among youth referred for a diagnostic assessment, how many:	**N=4**	**N=20**	**N=3**	**N=18**
Received a diagnostic assessment?	3	20	3	15 (83%)
Refused the assessment?	0	0	0	0
Unknown/missing	1	0	0	3 (17%)
Among youth who received a diagnostic assessment, how many were diagnosed with a mental health/social-emotional problem?	3	20	3	12 (80%)
Therapeutic intervention summary: Number of youth who received:				
Therapeutic services (post-diagnostic assessment)	3	20	3	12
Another type of referral (speech, special education, OT/PT)?	1	0	0	2
No services (was already receiving services)	2	0	0	10

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

[a] *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.*

Future evaluation activities

All grantees are asked to report additional evaluation components, including youth outcome data, on an annual basis. To assess changes in youth functioning, each program will 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. In each annual report, all projects will be required to report basic information about the number of children/caregivers with scores in the clinical range at intake and discharge, and a brief description of changes in scores over time.

Programs are also required to gather stakeholder and staff feedback to gather information about barriers and lessons learned. Projects are not required to report satisfaction data in their reports. However, they have been encouraged to gather this information.

Next steps and key observations

In their semi-annual reports, all grantees were asked to identify next steps they planned to focus on during the next six months. Most programs identified specific service enhancements they planned to implement during the next six months, while La Familia Guidance Center provided a timeline on the steps they planned to take in order to fully implement their program by March 2009 (Figure A13).

A13. Program's next steps

Agency	Next steps
Baby Space	To improve their system for obtaining screening data and to increase the assessment measure to include ITSEA and CBCL.
Family Children Services	To move into Project Secure (four classrooms for children whose families live in Minneapolis family shelters) and implement the evaluation tool.
La Familia Guidance Center	To begin screening, conducting diagnostic assessments, and providing mental health intervention services, including FFT, to youth. The programs plans to have all service and evaluation processes fully implemented by March 2009.
Mental Health Collective	To offer regular meetings for planning groups, prevention and screening at Umatal Islam, implement partnering group, and finalize the resource manual.
YouthLink	To improve the referral process and offer more groups to current and potential clients on topics that are important to them, such as anger management groups, grief and loss, healthy relationships, trauma issues and/or diet/mood.

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 and Wilder Research are listed below:

- **Post-screening follow-up can be difficult when housing instability is an issue.** YouthLink staff were surprised to note that over 40 percent of youth with elevated screens (N=13) did not receive a diagnostic assessment. They realized that a number of youth may receive one-time or infrequent services from the drop-in center, and those youth are less likely to receive any follow-up services.

- **A number of children served were receiving mental health services from other agencies when screening occurred.** Both BabySpace and YouthLink noted that some of the children they served were already receiving mental health services or other types of supports when they became involved with their projects. In these situations, referrals for diagnostic assessments and therapeutic services were not made in order to avoid unnecessary duplication of services.

- **Over 80 percent of youth who received services did have health insurance through a public program.** Overall, only 10 youth served did not have any health insurance. Additional conversation with program grantees may be helpful to understanding whether each program is successfully reaching families who may otherwise not be able to afford the cost of mental health services. It may be that program staff may have provided families with assistance in applying for publically-funded insurance or that office co-pays and other deductibles have been barriers to services for other families.

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 A14).

A14. 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. 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.

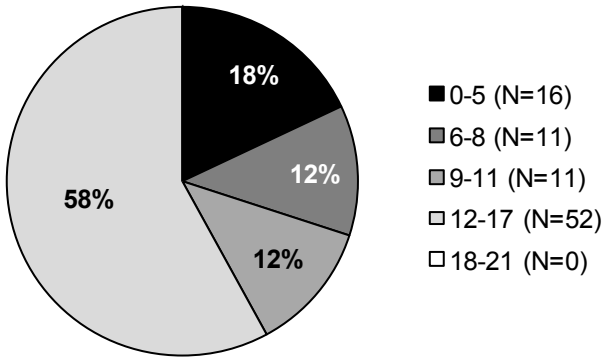
Implementation status

Both programs began screening youth during the last reporting period and implementing data collection components of the evaluation. Although the Clinical Director left St. Joe's, program implementation continued to move forward. A new Clinical Director was hired in March 2009.

Characteristics of youth served

The data included in this report describe characteristics of youth screened between October and December 2008. 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 90 youth received social-emotional screenings as part of a primary care visit. Over half of the youth screened (58%) were between the ages of 12 and 17 (Figure A15). The gender of children served was only reported by St. Joe's in 2008. Among the 45 youth screened, over half (58%) were female.

A15. Ages of youth served



The two primary care programs serve very different cultural groups. While over 90 percent of youth screened at the Maple Grove clinic are White/Caucasian (91%), St. Joe's participants are more likely to be African-American (69%) (Figure A16). In both programs, very few participants were identified as Hispanic.

A16. Race/ethnicity of youth served

	PIP (N=45)		St. Joe's (N=43)	
Race	**N**	**%**	**N**	**%**
African-American	0	0%	31	69%
Asian-American	1	2%	2	4%
American Indian	0	0%	1	2%
White/Caucasian	41	91%	6	13%
Bi-/multi-racial	1	2%	3	6%
Unknown	2	4%	0	0%
Ethnicity				
Hispanic	0	0%	2	4%

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

Screening and referral outcomes

St. Joe's

One child was not screened at St. Joes, but was referred for mental health services by a nurse practitioner. Of the 44 youth screened, most (91%) had elevated screening scores. Of the 40 youth with elevated screening scores, most (93%) were seen in the behavioral health clinic. Three youth refused additional assessment and therapeutic services at the behavioral health clinic.

In December, St. Joe's began tracking the types of referrals made by the behavioral health clinic. Of the 21 youth who were screened and seen by the behavioral health clinic during the month, over half (57%) were referred for a diagnostic assessment or therapeutic services. Youth and families also received referrals to an asthma camp (N=1) and parenting support group (N=1). Future reports will look specifically at how often diagnostic assessments are recommended by staff and obtained.

PIP

In 2008, PIP began collecting data describing the results of all children screened during well-child visits one day each week. However, this data was not gathered consistently and is not reported here. Future reports will provide a snapshot of screening and subsequent referrals or other recommendations given by pediatricians.

Less than 10 percent of patients referred for mental health triage were seen by PCS on the same day as the pediatric appointment (Figure A17). Youth were more likely to be seen in the week (31%) or 8 to 14 days (29%) 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 (9%). However, most of these appointments (93%) were held at the PIP clinic location, rather than the PCS office.

A17. Length of time between pediatric visit and mental health triage appointment at PIP

	N	%
Same day	4	9%
1-7 days	14	31%
8-14 days	13	29%
15-30 days	7	16%
More than one month	4	9%
Unknown	3	7%
Total	45	100%

Over half of the children who attended a triage mental health visit received some type of education (67%) or referrals for psychotherapy (55%) (Figure A18). Referrals for additional assessment were made for less than one-third (29%) of youth. According to PCS, additional assessment guides the therapeutic treatment plan, and is assumed to be a component of the services youth and families receive when they are referred for psychotherapy.

A18. Referrals made by triage mental health provider

	N	%
Education provided	30	67%
Psychotherapy	25	55%
Psychological testing (diagnostic assessment)	13	29%
Books/handouts provided	4	9%
Pediatrician	3	7%
Church/support group	2	4%
Divorce group	1	2%

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

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. During the first three months of the project, two children who received referrals for psychotherapy or a diagnostic assessment returned to PCS for additional assessment.

Future evaluation activities

All grantees are asked to report additional evaluation components, including youth outcome data, on an annual basis. To assess how well the services provided by the primary care grantees have led to increased access to services, Wilder Research will collect with a sample of parents or caregivers approximately three months after the child is screened and to additional services. The survey will ask parents/caregivers to share their overall perceptions of the screening process, identify any barriers to following through with the referral recommendation, and assess overall satisfaction with the types of services received by the child and family. Due to financial constraints, these follow-up interviews will only be conducted in English.

Qualitative information will also be gathered from staff involved in the screening process to explore perceived barriers to and benefits of screening and coordinated care. Mental health professionals, pediatricians, and other project staff will also be asked to share feedback about their comfort discussing screening results with families, lessons learned, and ideas to improve the screening and referral process.

Next steps and key observations

Both programs plan to continue enhancing communication between mental health and primary care staff during the next six months. Evaluation components not fully implemented during the first few months of services will also be incorporated into their data collection procedures in 2009.

Some of the key observations made by program staff and Wilder Research during the first few months of services are listed below:

- **Potential improvements could be made at both program sites to enhance their screening procedures.** Many youth enter St. Joe's because of concerns of abuse or other issues in the home. As a result, their parents may not be involved during the intake process. The Strengths and Difficulties Questionnaire (SDQ) is currently used as a screening instrument by St. Joes. It is completed by the child if he/she is 11 years of age or older, but is completed by staff 10-14 days after the child enters the program if it is not possible to gather parent feedback. Program staff will be monitoring the effectiveness of this approach to identify potential mental health issues.

- At PIP clinics, a variety of screening instruments are used to identify potential behavioral/mental health issues at all well- child visits. Pediatricians administer the Parents' Evaluation of Developmental Status (PEDS) to parents of children ages 0-5, and the Pediatric Symptom Checklist (PSC) to parents of children ages 7-18. A youth version of the PSC (the PSC-Y) is also administered to youth patients ages 10-18 at well-child visits. When anxiety or depression concerns arise, pediatricians may also administer the Screen for Child Anxiety Related Emotional Disorders (SCARED), Children Depression Inventory (CDI) and Beck Depression Inventory (BDI), as needed. In the PIP Uptown clinic, a pilot will begin administering the Brief Infant Toddler Social Emotional Assessment (BITSEA) to parents of 12- and 15-month patients seen by one pediatrician. Limiting the number of screening instruments used and adopting screening timelines to administer instruments at recommended developmental stages may reduce burden on staff and parents.

- **Less than 10 percent of youth screened at the PIP clinic received same-day mental health services.** There are a number of reasons few families receive on-site mental health triage services. Although the mental health provider is located on-site at one clinic once a week, screening and referrals may come from any PIP clinic location throughout the week. As a result, same-day triage services are not available to all families. In addition, according to program staff, many families do not have enough time available to attend a second appointment with the co-located mental health staff after attending a pediatric appointment.

- **A viable reimbursement code is needed to sustain co-located services at the PIP clinic locations.** An early implementation challenge identified by the program is finding a reimbursement code or other sustainable funding source (beyond grant funds) for the co-located mental health service. The co-located mental health practitioner in the Maple Grove clinic is a psychologist, and therefore, cannot use a Medical Assistance (MA) consultation code. They considered using a diagnostic interview code for services in the PIP clinic, but then would not be able to bill for a full diagnostic evaluation if they were referred to PCS. Despite discussions about this billing issue, a viable reimbursement code has not been identified.

- **Short lengths of stay at St. Joe's can make it difficult to offer additional services to all youth screened.** Although over half of youth referred to the behavioral health clinic receive additional assessment or intervention services, program staff were initially surprised by the number of youth who did not receive referrals for additional services. Although some children leave the shelter before additional services can be initiated, service refusals were not consistently tracked throughout the reporting period. Improvements to the current data collection procedures will be made to clearly identify reasons additional mental health services are not received.

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, Family Networks, Clues, Nystrom and Minneapolis Department of Health Family Support.

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

All six of the agencies 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. 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.

Due to the planning of the database, agencies were not required to turn in any semi-annual data. They will be responsible for reporting at the end of year one of this grant period, though. The following information will provide a summary of the database program's implementation status.

A19. 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/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.

Database overview

To address the aforementioned needs of community agencies and schools, a shared integrated database is in development to track the following types of information (not a comprehensive list of variables):

- 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

The database will have the following features:

1. The database will be web-based, allowing users to enter data or run reports at any location with Internet access.

2. The database will be secure, housed on a secure server with access limited to authorized users.

3. Authorized users will be 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.

4. The database will be scalable, allowing additional partners to be added as needed over time. The application will be developed to accommodate future enhancements where possible.

5. 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, this integration is not possible. We will make 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).

6. The reports will be 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.

Advisory Board

An advisory board to oversee the database has been establish and has convened. The Collaborative Database's 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 that are not resolved at the agency level.

Next steps and key observations

The process of creating a database to be used by programs can be very different from one another takes time and consideration. Having monthly meetings to discuss database content, operationalization of data points, and various administration tasks was time consuming, but crucial.

Once the database is up and running, demographic, staffing, and programmatic information will be collected. Wilder Research will prepare an aggregate report at the end of the first year. Once the database is in operation, an evaluation plan for the school-based mental health grantees will be developed that will include what outcomes will be reported and analyzed.

Financials

CMH SOI LCTS Grants to Providers
Schedule of Contract Commitments

		Budgeted				Actual + Projection					
Provider	**Contract period**	**Year 1 Funding**	**Year 2 Funding**	**Year 3 Funding**	**Total Funding**	**2008 Funding**	**2009 Funding**	**2010 Funding**	**2011 Funding**	**2012 Funding**	**Total Funding**
Primary Care MH System Change											
Pediatric Consultation Specialists	8/1/08 - 7/31/11	20,300	19,300	18,900	58,500	8,458	19,883	19,133	11,025		58,500
St. Joe's/Catholic Charities	8/1/08 - 7/31/10	35,400	29,600		65,000	14,750	32,983	17,267			65,000
Juvenile Justice MH Systems Change					**123,500**						
Amicus (JJ MH Systems Change)	9/1/08 - 8/31/09	33,794	33,794		67,588	11,265	33,794	22,529			67,588
Juvenile Justice Prevention & Intervention					**67,588**						
CMH Corrections Funds											0
Amicus (JJ Prevention)	9/1/08 - 8/31/10	30,000			30,000	10,000	20,000				30,000
HIRED (HC Home School - Futures Forward)	1/1/09 - 12/31/09	50,000			50,000		50,000				50,000
Emerge Community Development	9/1/08 - 8/31/09	30,000			30,000	10,000	20,000				30,000
F&C Svc (Youth Connections)	9/1/08 - 8/31/09	30,000			30,000	10,000	20,000				30,000
F&C Svc (My Life My Choice)	9/1/08 - 8/31/09	30,000			30,000	10,000	20,000				30,000
Genesis II	9/1/08 - 8/31/09	30,000			30,000	10,000	20,000				30,000
Relate	9/1/08 - 8/31/09	30,000			30,000	10,000	20,000				30,000
Stadium View School	9/16/08 - 8/31/09	60,000			60,000	17,500	42,500				60,000
SEARCH	9/16/08 - 9/15/09	60,000			60,000	17,500	42,500				60,000

CMH SOI LCTS Grants to Providers
Schedule of Contract Commitments

		Budgeted				Actual + Projection					
Provider	**Contract period**	**Year 1 Funding**	**Year 2 Funding**	**Year 3 Funding**	**Total Funding**	**2008 Funding**	**2009 Funding**	**2010 Funding**	**2011 Funding**	**2012 Funding**	**Total Funding**
Underinsured/Uninsured MH Services					**350,000**						
Baby's Space	9/1/08 - 8/31/11	35,000	36,400	37,856	109,256	11,667	35,467	36,885	25,237		109,256
MH Collective / African Aid	9/1/08 - 8/31/11	40,000	37,100	35,300	112,400	13,333	39,033	36,500	23,533		112,400
F&C Svc (PICA)	9/1/08 - 8/31/11	40,000	40,000	40,000	120,000	13,333	40,000	40,000	26,667		120,000
YouthLink	9/1/08 - 8/31/11	40,000	40,000	40,000	120,000	13,333	40,000	40,000	26,667		120,000
School Based MH Initiatives					**461,656**						
Nystrom & Assoc./St. Anthony Schools	8/12/08 - 7/31/11	30,000	30,000	30,000	90,000	11,250	31,250	30,000	17,500		90,000
Mpls Health Dept./Mpls Schools	2/10/09 - 1/31/12	27,000	27,000	27,000	81,000		27,000	27,000	24,750		81,000
Washburn/Eden Prairie Schools	9/1/08 - 8/31/11	30,000	30,000	30,000	90,000	10,000	30,000	30,000	20,000		90,000
Family Networks/Robbinsdale	9/1/08 - 8/31/11	30,000	30,000	30,000	90,000	10,000	30,000	30,000	20,000	2,250	90,000
CLUES/Richfield Schools	9/1/08 - 8/31/11	30,000	30,000	30,000	90,000	10,000	30,000	30,000	20,000		90,000
Storefront Group/Anoka Hennepin	8/12/08 - 7/31/11	30,000	30,000	30,000	90,000	11,250	31,250	30,000	17,500		90,000
					531,000						
Totals		**771,494**	**413,194**	**349,056**	**1,533,744**	**233,640**	**675,661**	**389,315**	**232,879**		**1,533,744**
				1,533,744						**2,250**	