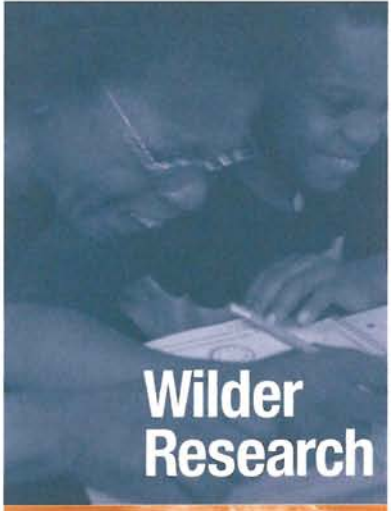

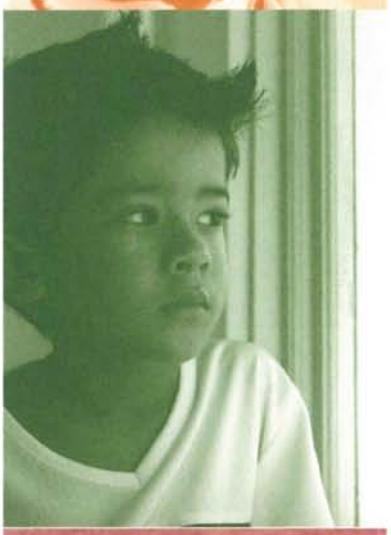

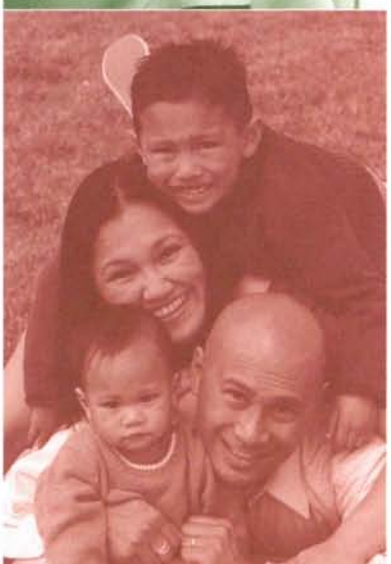

Hennepin County Children's Mental Health Collaborative

System of care assessment

JANUARY 2010

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System of care assessment

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Summary

The system of care approach to serving youth with mental health needs emphasizes coordinating services to best meet the individualized needs of each child and their family. While expansion or enhancement of clinical services is a common feature in systems of care, the primary focus is on creating an infrastructure to coordinate these services. Both the services and the infrastructure should reflect a number of established principles, such as being family-driven, culturally competent, coordinated, and individualized to meet the needs of each youth and family. Research has found that a system of care approach can lead to improved outcomes, especially for youth with higher needs.

The Hennepin County Children's Mental Health Collaborative has expressed interest in strengthening the children's mental health system of care, including a possible proposal for system of care funding through the Substance Abuse and Mental Health Services Administration (SAMHSA). With oversight from the Measuring Success work group, Wilder Research assessed the Collaborative's current readiness for this funding and to guide other mental health systems reforms.

Information was derived from the following sources: (1) a review of the system of care literature; (2) analysis of publicly available data regarding the Hennepin County children's mental health system; (3) an online survey with 43 mental health service providers in Hennepin County; (4) interviews with 21 mental health system leaders, representing the State, county Human Services and Juvenile Justice departments, school districts, mental health providers, and advocates; (5) interviews with the directors of three graduated system of care sites; (6) an online survey with 31 Collaborative stakeholders, representing Collaborative committees, the Alliance for Families and Children, and several special education directors; and (7) one 90 minute focus group with 16 County parents/caregivers caring for a child receiving mental health services.

System of care values

The Substance Abuse and Mental Health Services Administration (SAMHSA) has adopted a number of values and principles to guide service delivery and broader system reforms. The system of care assessment conducted for the Hennepin County Children's Mental Health Collaborative focused on five of these values: cultural competence, family involvement, accessibility, care coordination, and effective services.

Cultural competence. SAMHSA expects significant efforts to promote cultural competence in systems of care. Communities may adopt a wide array of strategies based on local needs and priorities and are encouraged to consider not only the needs of specific

racial/ethnic groups, but also traditionally underserved populations (i.e., homeless or impoverished families and gay, lesbian, bisexual, and transgendered youth).

The assessment identified challenges related to cultural competence. One concern is the shortage of trained staff to serve children/families, especially providers of color. Many stakeholders identified a need for more trained professionals who represent the local population and can offer services in multiple languages. Addressing this issue is likely to require long-term efforts, such as tuition reimbursement, internship programs, and retention incentives. Some stakeholders suggested more immediate efforts to increase workforce diversity, such as the use of paraprofessionals and support for new agencies interested in providing culturally-specific mental health services.

Efforts to promote competence should not focus exclusively on workforce diversity. Some stakeholders, including parents, felt that other staff traits were more important than the match between providers and clients. Other recommendations were also made, such as training staff regarding culturally competent approaches and increasing availability of culturally specific and relevant assessments and tools. It is also important to consider a broad definition of diversity. In addition to race/ethnicity, locally there may be a need for enhanced focus on issues related to sexual orientation and gender identity.

Family involvement. SAMHSA has a high standard for family involvement, promoting the concept of "family driven care." In family-driven care, parents not only choose their services/supports, but are involved in system-level efforts to design and implement programs, evaluate outcomes, and make funding decisions.

Locally, stakeholders were supportive of efforts to increase family involvement. While providers generally felt that family members were involved in treatment decisions, some parents felt devalued in their interactions with providers. Most agencies do not include parents in leadership roles. The Collaborative has invested in parent leadership, but these efforts are relatively new and will require additional time to determine success.

The lack of an established parent advocacy or support group in Hennepin County was regularly identified as a gap in the mental health system. While state-level advocacy organizations support parents, there is not a single strong voice able to represent the perspectives of parents in the County.

There can be significant challenges in increasing parent leadership. Efforts to increase involvement will require improved strategies for sharing information about service options, peer support, and advocacy training. This need is greater for parents of children of color who may feel uncomfortable seeking services or marginalized through past negative experiences with child-serving agencies. Strategies to engage and support

families experiencing significant life challenges/stresses may also be needed, such as providing in-home services, flex funds, and child care and stipends for families.

Accessibility. While the children's mental health system was consistently recognized by stakeholders as having a wide array of available services, they also had several significant concerns related to accessibility. Physical location and transportation issues currently pose a significant barrier. Services were seen as poorly distributed across the County, compounding the difficulty to find and receive services. Stakeholders recommended offering more services in nontraditional locations that are convenient for youth and families (including home, school, and community settings) and providing transportation.

Issues related to health plans and insurance also limit access to services and impede coordination efforts**.** Financial barriers, such as high cost of insurance and out-of-pocket costs of services, were mentioned. Providers also highlighted the negative impact of health plans and insurance on broader goals (i.e., no reimbursement for interagency coordination or collaboration). Many requested reforms to increase reimbursement rates, make it easier for families to receive services, and promote collaboration.

Services should be available on a timely basis, with no (or at least a short) waiting period. While many providers actively promote access, including offering services on weekends or during evenings, waiting lists were described as a barrier.

Service coordination. While their involvement may vary based on the needs of the target population, there should be representation from multiple fields, such as mental health, human services, juvenile justice, and schools. Agency representatives should participate in community decision-making and coordinate services at the individual level. Stakeholders expressed a need for greater coordination, while identifying barriers such as difficulty paying for staff time to participate in meetings.

Stakeholders felt that accessibility and coordination varied widely, depending on the specific individuals and agencies providing services. Without consistent expectations for interagency collaboration, it is difficult for providers, case managers, and other formal and informal supports to ensure service coordination.

Effective services. Little information is centrally available regarding the effectiveness of services in Hennepin County. SAMHSA does not require specific interventions, but does encourage the use of evidence-based practices within systems of care. Eight in 10 providers said that their agency implements evidence-based practices, such as Functional Family Therapy, Trauma Focused Cognitive Behavioral Therapy, and Dialectical Behavior Therapy. Many providers value evidence-based practices, listing benefits such as higher quality services, better client outcomes, and alignment with funder interests.

They also identified challenges, such as concerns about appropriateness for cultural communities or clients with complex needs, logistical barriers (i.e., paperwork, funding, training time), and restrictiveness (i.e., emphasis on fidelity over clinical judgment).

To increase effectiveness, stakeholders suggested a variety of training topics, such as family engagement, early childhood mental health, evidence-based practices, specific presenting issues (i.e., trauma, dual disorders, autism spectrum), and other skills (case management, diagnostic assessment, clinical supervision). They also recommended post-training supports, such as high-quality ongoing supervision and consultation.

Readiness for system of care efforts

A greater understanding of implementation issues can inform efforts to create and sustain mental health systems of care. While many issues are important, this assessment focused on three aspects emphasized by stakeholders representing funded systems of care: planning and shared vision, relationships and leadership, and funding.

Planning and shared vision. Significant planning is required before launching system reform. Funded communities had a common vision and goals before seeking funding, including defined target populations, key partners, and service approaches. While local stakeholders felt the County has been working on important initiatives in partnership with schools and juvenile justice, they did not feel a shared vision for the children's mental health system has been articulated. Stakeholders recommended that planning focuses on long-term goals, rather than short-term adjustments.

Relationships and leadership. Representatives from funded communities described their initiatives being built upon pre-existing relationships across multiple child-serving agencies or using deliberate processes to build trust and collaboration across state and local agencies. In Hennepin County, there are examples of strong collaboration across agencies. However, greater efforts are needed to expand the range of partners, however, especially parents, service providers, cultural communities, physicians, and health plans.

One study involving 25 funded communities found that positive relationships across partners strongly influenced sustainability. This included consistent leadership, ongoing use of inclusive decision-making, and a shared vision of the system. Training new staff in leadership roles was an important strategy to sustain efforts. Conversely, changes in key leadership, including policy-makers, had a negative impact on sustainability.

Stakeholders had positive feedback regarding County and Collaborative leaders, though many are concerned about leadership. While many stakeholders described County administrators as advocates for children's mental health, repeated restructuring efforts

have led to confusion and to concerns that the County would be unable to sustain leadership of a reform initiative. The Collaborative was seen as influential in bringing stakeholders together, but lacking the infrastructure to lead a system-wide reform effort.

Funding. From the beginning, each funded community interviewed focused on finding sustainable funding streams to maintain their efforts, including pooling funding across agencies, capturing new Medicaid dollars, and reallocating cost savings from deep-end services to other community-based services. They also saw their funding as a way to build an infrastructure to support system reform, not as a way to fund specific services.

Local stakeholders, as well as representatives from graduated systems, stressed the importance of focusing on initiatives that can be sustained. Local stakeholders indicated a need for the County and agencies involved in planning for a grant application to clearly communicate how priorities were identified and to assure stakeholders that funding would be used to build a sustainable system, not to address current budget shortfalls. The most effective strategies used to sustain systems of care are increasing levels of Medicaid reimbursement and obtaining new or increased levels of state funding.

System sustainability

After funding ended, many sites successfully maintained their work in a number of areas, including reducing the number of youth in overly restrictive settings and developing a shared understanding of system values. Sites were less successful in maintaining coordinated system management, ensuring adequate service capacity, maintaining a family-run organization or peer supports, and using evaluation.

When availability of services was assessed after funding ended, many communities saw increased availability of transition services for youth leaving residential placements, as well as more behavioral aides, therapeutic group homes, and substance abuse treatment options. However, services without a direct funding source were more difficult to maintain, including flex funds, transportation services, family support services, respite care, and recreational activities for youth and families.

Funded communities found data to be essential to increasing buy-in across agencies and sustaining their program. While some communities found clinical outcome data particularly useful, others focused on cost-benefit analyses to describe how funds used for out-of-home placements could be reallocated to community-based services. Evaluation data helped them obtain additional funding and demonstrate the effectiveness of their work to new policy-makers and agency leadership.

Service utilization and gaps

Systems of care are expected to have an array of services in place to meet the needs of their target population. Communities may need to inventory services to determine whether they are readily available to families, and identify gaps. Stakeholders identified a number of significant service gaps, such as limited options for psychiatry, hospitalization, residential services, crisis support, and transition services for young adults leaving the children's mental health system. Others mentioned the need to provide support to meet broader family needs, and to ensure services for youth who are uninsured or underinsured.

Four in five Collaborative survey respondents (83%) felt that the system serving children/ youth with mental health issues was "somewhat effective." When asked what the Collaborative could do to help the system better meet the needs of youth, stakeholders provided a range of suggestions, such as supporting prevention, engaging parents and cultural communities, expanding school-based services, promoting community awareness of services, lobbying/advocating for improved funding, and using social marketing to reduce stigma about mental health.

Collaborative functioning

In 2001, an extensive review of the literature led to the identification of factors that influence the success of collaboration. Some of the most important factors that may be relevant to the Children's Mental Health Collaborative can be grouped into five main categories: purpose, representation, communication, decision-making, and resiliency.

Purpose. Collaborative partners share a vision that extends beyond the mission or purpose of any single agency. The commitment of partners to serve a specific population is one of the most important factors. By focusing on potential changes in the target population, members are less likely to focus on individual benefits for their organization. As the collaborative defines its purpose, it is important that concrete, attainable goals and objectives are identified and clearly understood by partners.

Half of the survey respondents "strongly agreed" that they have a clear understanding of what the Collaborative is trying to accomplish (compared to 13% in 2008) and most (79%) felt that the Collaborative was "somewhat successful" in achieving its mission to "serve as the catalyst within Hennepin County for best/promising practices and outcome-based applications and system enhancements within the spectrum of children's mental health services and practices." Respondents made suggestions to increase the Collaborative's success in fulfilling its mission, such as using data more systematically, improving

communication and visibility, increasing the diversity of partners, and focusing efforts on improved accessibility and quality of care.

Representation. Successful collaboration requires representation from all groups who will be affected by its activities. Successful collaboratives regularly reassess their membership and consider whether to bring in new groups. Key representatives should include individuals with important influence on the issue being addressed by the partnership. Most survey respondents (95%) agreed "somewhat" or "strongly" that their agency has something to gain from being involved; the percentage that agreed "strongly" increased from 39 percent in 2008 to 65 percent in 2009. Most also agreed that the Collaborative represents a good cross-section of the mental health system; the percentage that agreed "strongly" increased from 23 percent in 2008 to 48 percent in 2009.

Communication. Successful collaboratives use frequent and open communication to keep all partners informed and discuss possible approaches to addressing problems. Many collaboratives rely on a blend of formal and informal communication strategies to enhance existing partnerships and strengthen coordination across agencies. Most survey respondents agreed that they are updated often about what goes on in the Collaborative; the percentage agreeing "strongly" increased from 25 percent in 2008 to 58 percent in 2009. Almost half of the respondents (46%) agreed "strongly" that they have informal conversations with others involved in the Collaborative.

Most survey respondents provided positive ratings of Collaborative partners. All agreed "somewhat" or "strongly" that the appropriate people are involved in the process (compared to 64% in 2008). Ninety-four percent agreed that partners have a clear sense of their roles and responsibilities, have respect for one another, communicate openly with one another, and have a high level of commitment (compared to 58%-88% in 2008).

Decision making. Successful collaboration relies on joint decision-making authority about the rules and standards that govern the behavior of the group. A lack of input from all partners can lead to decisions that do not adequately address all aspects of a problem. Just as it is important to gather input from agencies and organizations, it is also essential to ensure the perspectives of families are represented so that the impact of any decision is understood from the perspective of those who will ultimately receive services.

Most (88%) of the Collaborative survey respondents agreed "somewhat" or "strongly" that there is a clear method for making decisions among members (compared to 54% the previous year). The percentage of respondents agreeing that all members have a voice in decision making increased from 54 percent to 72 percent. More than 80 percent agreed that the partners make decisions using input from each other, are open to different

approaches about how the work should be done work together to achieve group goals, and fully participate in the group process.

Other feedback. Respondents gave mixed ratings regarding the Collaborative's success. Most (74% to 86%) agreed "somewhat" or "strongly" that the Collaborative has created appropriate multi-disciplinary community workgroups, improved communication among agencies, effectively integrated efforts from multiple sectors to enhance children's mental health services, developed clear recommendations and strategies for increasing service coordination, strengthened working relationships among agencies, and increased access to a continuum of appropriate and effective community mental health services. They were least likely to agree that the Collaborative increased access to family support services and successfully raised funds to enhance children's mental health services in Hennepin County. In general, ratings were higher than those provided in 2008.

Respondents felt that workgroups had clear roles and meetings were effectively facilitated. When asked to identify the most positive thing resulting from the Collaborative, respondents often mentioned the improved services facilitated through the SOI, especially school-based services. Others appreciated the Collaborative's role in bringing stakeholders together, and providing opportunities for parental involvement. Respondents suggested, increased communication and visibility and strengthened participation of parents/parent advocacy organizations. Others recommended that the Collaborative focus more on increasing the accessibility and effectiveness of services.

Recommendations

The results of this assessment suggest a wide array of short-term and long-term strategies for enhancing the children's mental health system and strengthening the role/functioning of the Children's Mental Health Collaborative. They also indicate that Collaborative partners are engaged and willing partners in pursuing these recommendations. The following strategies are recommended, given their importance in promoting effective collaboration, strengthening systems of care, and enhancing outcomes for youth and families:

1. Create a short- and long-term plan to address the shortage of mental health professionals of color and increase cultural competency in Hennepin County.

2. Develop strategies to engage families in system-level decision making processes and sustain their involvement over time.

3. Increase linkages between the children's mental health system and other systems serving children and families, including access to adult services and family supports.

4. Develop model for care coordination and pursue funding strategies, such as increased support through County contracts and private health plans.

5. Develop a workforce development initiative that establishes training priorities and provides high-quality training and consultation.

6. Work with the County and local stakeholders to develop consistent ways to identify, map, and reassess service gaps.

7. Address stakeholder concerns regarding leadership, and identify individuals and agencies willing to guide system of care reform efforts.

8. Gather available information related to effectiveness of services for children, and identify strategies to improve outcomes as necessary.

9. Establish Collaborative goals and success indicators for the coming year, with an emphasis on improving the system of care for children/youth with mental health issues in Hennepin County.

Project background

Mental health systems of care

It is estimated that 10 to 20 percent of children in the United States have significant emotional and behavioral disturbances, and only one in five of these children receive care. While many children do not receive any supports, others may receive multiple services in school, community-based agencies, and other settings. These services are often not coordinated, with providers unaware of the full array of services a family is receiving and, in some cases, working towards inconsistent and potentially conflicting goals.

In an effort to replace this patchwork approach with a more integrated one, some communities have moved towards a system of care approach. Generally speaking, "system of care" refers to a coordinated array of services to meet the needs of children with emotional/behavioral problems and their families. Over the past few decades, this term has been defined more specifically as an organizational philosophy and approach.

It is important that children receive high-quality mental health and support services. These services should be appropriate based on the child's need, developmental level, and cultural background. While expansion or enhancement of clinical services is a common feature in systems of care, the primary focus is less on the direct provision of services, and more on creating an infrastructure to coordinate these services. Both the services and the infrastructure should reflect a number of established system of care principles, such as being family-driven, culturally competent, coordinated, and individualized to meet the specific needs of the youth and family.

Pre-post outcome measures have been used most often to demonstrate the effectiveness of system of care efforts. These outcomes studies have consistently shown system of care initiatives leading to increased access to mental health services, greater interagency collaboration, increased satisfaction among families, reductions in restrictive psychiatric services, and cost reductions in deep-end services (i.e., out-of-home placements in the child welfare and juvenile justice system) (Duchnowski, Kutash, & Friedman, 2002). Positive youth outcomes, including improved child functioning, reduced problem behaviors, and improved school performance, have also been reported consistently (Center for Mental Health Services, 2007). However, very little research has examined the effectiveness of system of care efforts compared to other types of interventions for youth with behavioral disorders. Preliminary data suggests a system of care model may be most beneficial for youth with higher needs, such as youth involved in the juvenile justice system (Center for Mental Health Services, 2007).

Purpose of this assessment

The Hennepin County Children's Mental Health Collaborative has expressed interest in strengthening the children's mental health system of care, including a possible proposal for funding through the Comprehensive Community Mental Health Services for Children and their Families Program (commonly referred to as system of care funding) administered through the Substance Abuse and Mental Health Services Administration (SAMHSA). Based on input provided by the Collaborative's Measuring Success work group, Wilder Research conducted a special project related to systems of care for the Collaborative in 2009. The purpose of the assessment was to assess the Collaborative's current readiness for this funding and to guide other mental health systems reforms.

This multi-faceted project was designed to answer a variety of questions, such as:

- What are the current strengths and weaknesses of the current mental health care system for children in Hennepin County?
- What factors should communities consider prior to submitting an application for funding?
- How closely does the current mental health system exhibit the principles expected from funded system of care communities (e.g., cultural competence, care coordination, family-driven care, accessibility)?
- How well is the Collaborative functioning? What do stakeholders feel about its current structure and leadership?
- Is the necessary infrastructure in place to support a system of care application?

Methodology

Information from this report was derived from the following sources:

- **Literature review:** The published literature regarding the system of care model was reviewed, including a number of journal articles and research reports.
- **Secondary data analysis:** Publicly available data regarding the children's mental health system in Hennepin County was obtained and reviewed.
- **Provider survey:** An online survey was conducted with mental health service providers in Hennepin County. All providers on the Collaborative's email listserv were invited to participate; recipients were also encouraged to forward the email

invitation to others in their agencies. A total of 43 people participated in the survey. Respondents included agency administrators (51%), supervisors (40%), and direct service providers (37%). Individuals could select more than one role. Respondents represented a variety of agencies located in or serving Hennepin County. Key findings from the survey are embedded throughout the report; a full set of data tables can be found in the appendix.

- **Interviews with local stakeholders**: Key informant interviews were conducted with 21 Hennepin County mental health system leaders, representing perspectives from the State, Hennepin County Human Services and Juvenile Justice departments, school districts, mental health providers including individuals capable of representing the perspectives of cultural communities, and family advocates. Most key informants had a long history of involvement with the Hennepin County children's mental health system, though some were relatively new to their positions. The protocol used to interview the key informants can be found in the appendix.

- **Interviews with other funded system of care representatives:** Key informant interviews were conducted with project directors of three graduated system of care sites: Santa Cruz (funded in 1989), Wraparound Milwaukee (funded in 1994), and PACT 4, located in southern Minnesota (funded in 1999). These sites were selected because of their success in maintaining services following system of care funding. Two of the communities are large and diverse urban centers, both somewhat smaller than the population found in Hennepin County. The third community, PACT 4, is the only graduated system of care site in Minnesota. During the 60-minute interview, the project directors were asked to share their experiences preparing their grant proposals and sustaining their efforts following their funding periods. The informants were also asked to identify ways the system of care grant requirements both enhanced and impeded their work. Common themes were identified from the interviews conducted, and site-specific examples were used to highlight key findings.

- **Collaborative survey:** A total of 88 Collaborative stakeholders were invited to respond to an online survey to assess the functioning and status of the Hennepin County Children's Mental Health Collaborative. The survey was similar to one conducted in 2008, and was designed to examine a variety of factors that are key indicators of successful collaborative efforts. A total of 31 stakeholders completed the survey, for a response rate of 35 percent. The list of potential respondents was developed by combining the following membership lists: standing Collaborative committees (governance board, executive group, providers group, and all other work groups), the Alliance for Families and Children, and several Minneapolis Public Schools special education directors. The respondents represented school districts (26%), non-profit agencies (23%), county government (16%), other collaborative/coalitions (16%), parent

organizations/parents (7%), and mental health providers (3%). Key findings from the survey are embedded throughout the report; a full set of data tables can be found in the appendix.

- **Parent focus group:** One 90-minute parent focus group was convened, with recruitment assistance provided by the Collaborative. A total of 16 parents and caregivers participated in the focus group, 10 of whom had received Hennepin County case management services. All participants lived in Hennepin County suburban communities, but were diverse in terms of their age and length of time their family had received services through Hennepin County. The focus group was conducted in English, and included parents representing communities of color. While parents were not asked to share their child's diagnoses, information volunteered during the focus groups indicates that their children had wide-ranging mental health needs. While attempts were made to coordinate additional parent focus groups in partnership with the school district, advocacy organizations, and Hennepin County providers, these could not be completed within the time frame for the project.

While efforts were made to gather opinions of a wide range of stakeholders, there are several limitations of this assessment. First, it is important to note that Hennepin County includes a diverse array of stakeholders and opinions. It was not possible in this project to gather all possible opinions. Some perspectives are notably absent. For example, relatively few service providers completed the Collaborative survey, making it difficult to assess how they may perceive the Collaborative structure or leadership. While there was diversity among the parent focus group participants, none had primary languages other than English and none lived in Minneapolis. The key informants interviewed were all nominated by the Collaborative's Measuring Success committee, but do not include all important voices within the Collaborative. Several informants invited to participate did not respond to requests for interviews or did not wish to participate.

System of care values

The system of care values and principles adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) were developed through a series of reports that criticized the overreliance of communities on residential placement, the failure of providers and policy-makers to recognize families as important partners in helping their children, and the lack of awareness of the culture of the child and family (Kutash, Duchnowski, & Friedman, 2005). The system of care values and principles that were developed in response to these criticisms focused on individualized services, family involvement, collaboration across systems, and coordination of services. A full list of system of care values and principles can be found in the appendix. The system of care assessment conducted for the Hennepin County Children's Mental Health Collaborative focused on five key values: cultural competence, family involvement, accessibility, care coordination, and individualized, effective services.

The degree to which these system of care values are demonstrated through the services provided in the County was addressed in varying degrees in the key informant interviews conducted with county stakeholders, the parent focus group, and the provider survey.

Cultural competence

According to the National Center for Cultural Competence, "cultural competence requires that organizations: (1) have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally; (2) have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge and adapt to diversity and the cultural contexts of the communities they serve; and (3) incorporate the above in all aspects of policy making, administration, practice, service delivery and systematically involve consumers, key stakeholders, and communities."

There are cultural disparities in access to mental health services. Nationally, there are well-documented disparities between cultural groups in regard to access to youth mental health services, involvement in the juvenile justice system, and academic success. These disparities were also noted by Hennepin County stakeholders, who identified a need for greater outreach and accessibility of culturally-appropriate/specific services for youth of specific cultural communities (including African American, American Indian, Latino, and new immigrant/refugee populations).

SAMHSA expects significant efforts to promote cultural competence in funded systems of care. Their focus on cultural and linguistic competency for all system of care grants is intended to address the mental health disparities that result from reduced access to, and availability of, mental health services for people of color and other underserved cultural groups. SAMHSA encourages communities to define cultural and linguistic competency locally, allowing local stakeholders to consider not only the needs of specific racial and ethnic groups, but also traditionally underserved populations, such as homeless or impoverished families and gay, lesbian, bisexual, and transgendered youth.

While communities can adopt a wide range of strategies to increase cultural competence, it is expected that these practices impact all levels of the system, from individual service delivery to system governance and policy-making. In 2008, a set of recommendations was developed to help system of care communities operationalize cultural and linguistic competency in their governance structure, services and supports, planning and quality improvement initiatives, cross-disciplinary collaborative efforts, communication, and workforce development (Martinez & Van Buren, 2008). This toolkit identifies effective strategies used by communities to increase cultural competence, resources and tools that may be helpful in adopting a strategy, and suggested performance indicators. The wide variety of strategies identified in the toolkit demonstrates that cultural competence may be approached differently to reflect on the needs of the community and locally-identified cultural competence priorities.

There is a shortage of trained staff to serve children/families, especially providers of color. There is consensus across stakeholder groups that, although Hennepin County has a number of culturally-specific mental health providers, there is a need for more professionals who represent the diversity of the Hennepin County population and are able to offer services in multiple languages. Many service providers felt that the greatest barrier to cultural competence was a lack of qualified staff representing the cultural/linguistic background of the populations served. The shortage of mental health professionals representing communities of color is acknowledged not only as a challenge in Hennepin County, but across the state and nation.

Providers recommended both long-term and short-term strategies for increasing the diversity of staff. Providers suggested a number of efforts to increase the diversity of licensed staff, such as tuition reimbursement, internship programs, and retention incentives. While system-level changes are needed to recruit more individuals of color into the field and retain these mental health professionals over time, some stakeholders also suggested more immediate efforts to increase diversity within the workforce. Some encouraged the use of paraprofessionals who provide support services or mental health professionals who work under the supervision of licensed practitioners. Other potential strategies included increased use of community health workers and cultural liaisons who

represent specific cultural communities, and increased technical assistance and support for new agencies interested in providing culturally-specific mental health services, but who need support to develop the billing mechanisms needed to sustain services.

Stakeholders disagree about the importance of a cultural/linguistic match between providers and youth. While there was overall agreement that efforts should be made to increase the diversity of the workforce, a number of stakeholders recognized that this strategy alone would not be sufficient to increase cultural competency in Hennepin County. According to one stakeholder, with the rapid growth of our cultural community, "it is in our best interest to help build the capacity of all providers to improve care."

Stakeholders have varying perspectives about the degree to which White mental health professionals can and should provide culturally-appropriate services to youth and families of color. On the one hand, linguistic-competency was considered necessary to provide appropriate services, especially for new immigrant populations. However, some providers felt there was too much emphasis placed on the cultural or ethnic "match" between providers and youth, rather than characteristics that lead to a strong and effective therapeutic relationship. Research on cultural match between providers and clients suggests that match may help increase initial client engagement and retention, but does not lead to better outcomes or satisfaction for youth receiving mental health services.

Parents of color who participated in the focus group, as well as those who were White, also stressed the importance of finding the "right" case managers and providers who could build a trusting relationship with their child and family and offer the right services to meet their needs. According to one parent, "having a therapist who shares the same [cultural background] can be nice, but we can find ways to meet that need in other ways. As long as the therapist works well with my child, I don't care [about his/her cultural background]. I want to find ways to help my child improve his behavior."

More immediate enhancements to the system may be necessary to ensure adequate linguistic competency to provide effective services to youth and families. A shared understanding of youth behavior must be developed in partnership with new immigrant and refugee communities to work effectively with families from cultures who do not identify or discuss mental health as defined in Western cultures. While a number of efforts have been made throughout the state to increase workforce capacity and provide translated materials in a variety of commonly-spoken languages (including Spanish, Somali, and Hmong), it is also important to remember additional efforts may be needed to meet the needs of smaller cultural communities in Hennepin County.

In addition to the lack of mental health professionals of color, providers recognized a number of challenges to providing culturally-appropriate services. First, there was recognition that mental health is not a concept recognized by some cultures, especially new immigrant/refugee populations. Developing a shared vocabulary to discuss the social-emotional needs of youth and behavioral issues with parents has been an ongoing challenge for providers. There is a need to develop an array of culturally-specific tools and measures, including curricula, screening, assessment, and outcome measures. Providers also recognize that a traditional therapeutic approach does not always work well with populations who are not comfortable with disclosing concerns with a therapist. Some providers noted insurance issues, such as a lack of funding to support collaboration and coordination efforts and an over-reliance on a medical model approach. The increased emphasis on using evidence-based practices also poses challenges for some providers who feel additional information is needed to determine how to best adapt these practices to work with specific cultural communities. A few stakeholders suggested greater outreach through cultural liaisons would help develop a shared language around mental health, build trust, and ultimately bridge the gap between cultural communities and providers, schools, and county services.

Additional training is needed to develop a shared definition and framework for cultural competence and increase capacity throughout the county. One of the strengths and challenges within Hennepin County is the diversity of its population. According to one stakeholder, responsibility for culturally-competent services has often been delegated to culturally-specific providers charged with the responsibility of "serving their own." While some stakeholders recognized that historically the need for culturally-competent providers has been an issue in Minneapolis, the changing demographics in suburban communities has made cultural competency an important issue to address throughout the county. Some providers requested general training in areas such as cultural sensitivity and awareness, while others suggested more in-depth support in areas such as culturally-competent diagnostic assessments, language skills, and appropriate service models.

Some lessons in providing culturally competent services can be gleaned from local initiatives and the common experiences of cultural groups. Beginning in 2008, the Cultural Providers Network, a partnership between the University of Minnesota and community providers, has worked to identify culturally-specific practices and methods to evaluate the effectiveness of these approaches. The group's work is intended to bridge the gap between research and practice and identify both evidence-based practices that can be modified to meet the needs of various cultural communities, and practice-based strategies that can inform mental health interventions. While many providers are involved in this initiative, there may be opportunities to share lessons learned by this group with more Hennepin County stakeholders. One stakeholder also felt there are important opportunities to share lessons learned across cultural communities. For

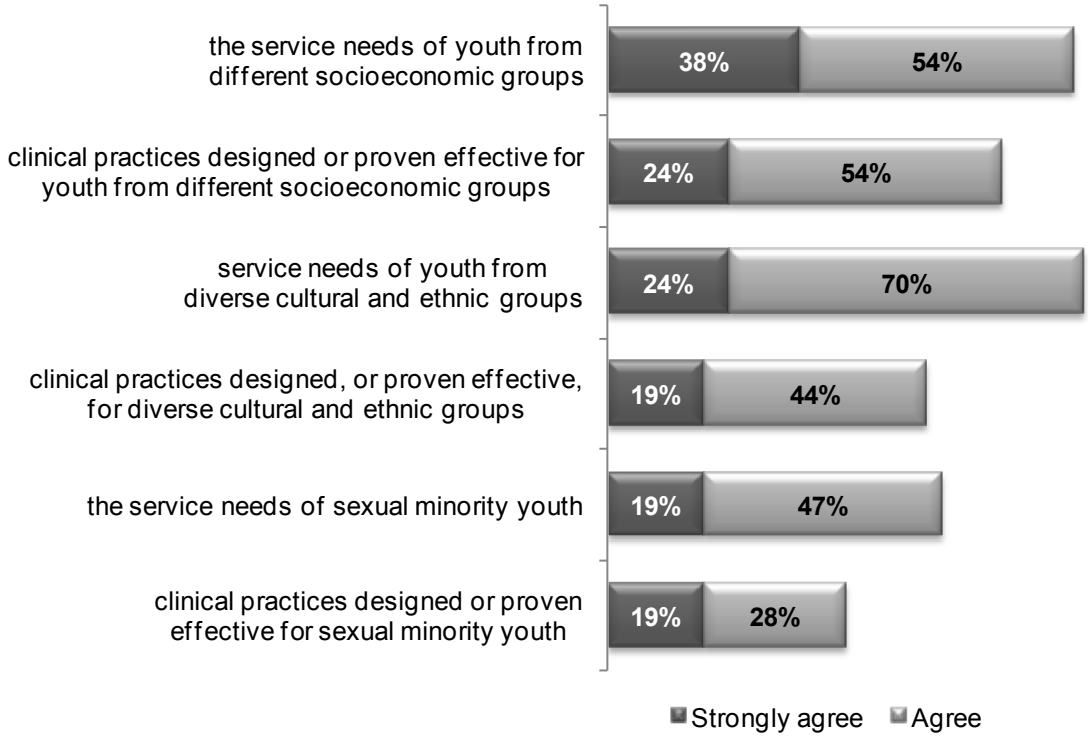
example, the experiences of the African American community in trying to maintain a strong cultural identity in the midst of stress may be useful to share with new immigrant and refugee populations.

It is important to consider elements of diversity other than race/ethnicity, especially sexual orientation and gender identity. Some providers mentioned the importance of thinking more broadly than racial/ethnic/linguistic competence, to consider other definitions of "culture" (i.e., political, socioeconomic, religious, sexual orientation). Several felt that it is important to acknowledge within-group diversity, and the fact that many people represent more than one cultural group. Providers were most likely to "agree" or "strongly agree" that they are knowledgeable about the service needs of youth from diverse ethnic (94%) and socioeconomic (92%) groups. Fewer "agreed" or "strongly agreed" that they know about clinical practices designed, or proven to be effective, for these groups (63%-78%). Providers were least likely to "agree" or "strongly agree" with items related to sexual minority youth, including knowledge about service needs (66%) and knowledge of effective practices (47%) (Figure 1).

Nationally, there has been a growing awareness of the importance of addressing the gay, lesbian, bisexual, and transgender (GLBT) youth population. It has been estimated that at least 5 percent of all youth identify as a sexual minority. Research has found that these youth are at higher risk for a variety of outcomes, including attempting suicide, using drugs or alcohol, experiencing school problems, and being a victim of violence. Of the 43 providers who completed the online survey, only three said that their agency has expertise serving GLBT youth. Higher numbers of providers reported that their agency has expertise serving Chicano/Latino/Hispanic youth (N=17), African American youth (N=15), African/Somali youth (N=10), Native American youth (N=7), and Hmong/ Southeast Asian youth (N=7).

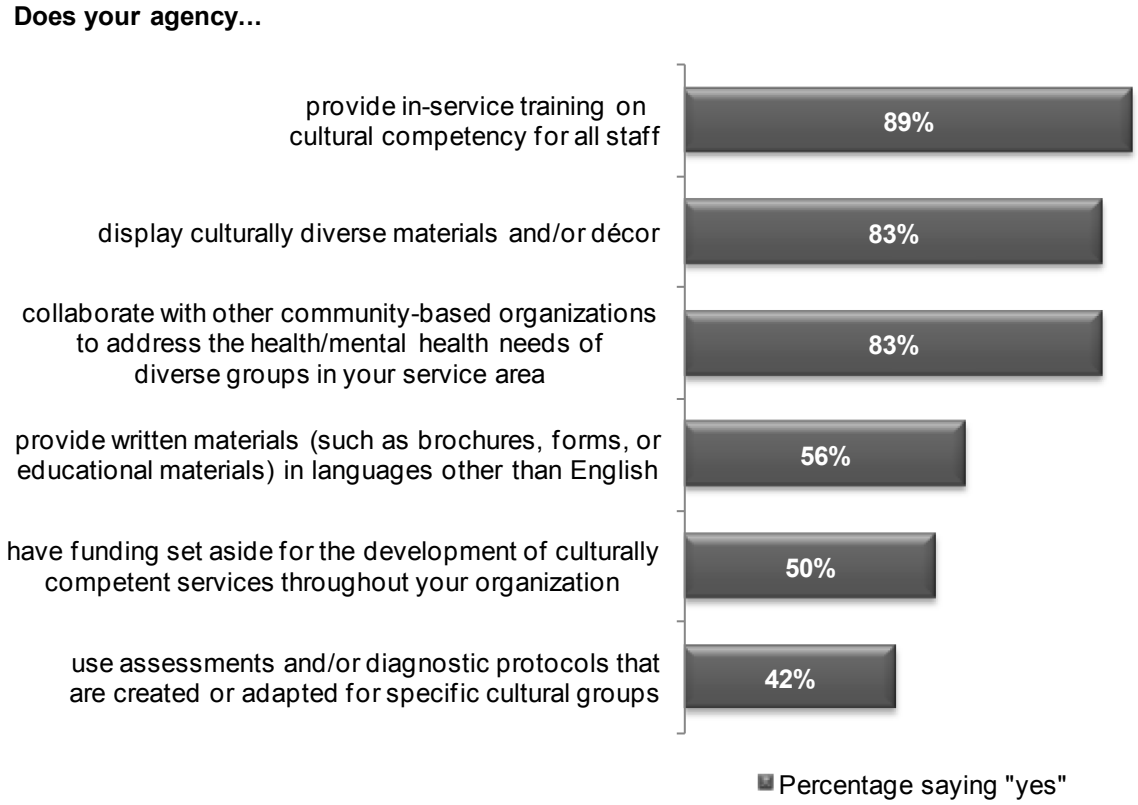
1. Provider survey – Knowledge working with culturally specific populations (N=43)

I am knowledgeable about...



In addition to training, other steps could be taken to enhance cultural competence. Most providers (83%-89%) said that their agency provides cultural competence in-service training, collaborates with community-based organizations to address the needs of diverse groups, and displays culturally diverse materials and/or décor. Fewer (42% to 56%) have funding set aside to develop culturally competent services, provide written materials (such as brochures, forms, or educational materials) in languages other than English, and use assessments and/or diagnostic protocols created or adapted for specific cultural groups (Figure 2).

2. Provider survey – Agency efforts to support cultural competence



Agencies varied in the extent to which culturally relevant resources are integrated into treatment plans. Most providers (94%) "frequently" include natural or informal supports, such as friends or family members. Fewer "frequently" include culturally-specific providers (49%), bilingual service agencies (34%), traditional healers/cultural health care providers (20%), or faith-based agencies/religious or spiritual leaders (11%).

Family involvement

SAMHSA has a high standard for family involvement in mental health systems of care, promoting the concept of "family driven care." According to the National Federation of Families for Children's Mental Health, family-driven care means "families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, territory, and nation." This means families are involved in choosing the services and supports they receive, setting goals, designing and implementing programs, evaluating outcomes, and partnering in funding decisions.

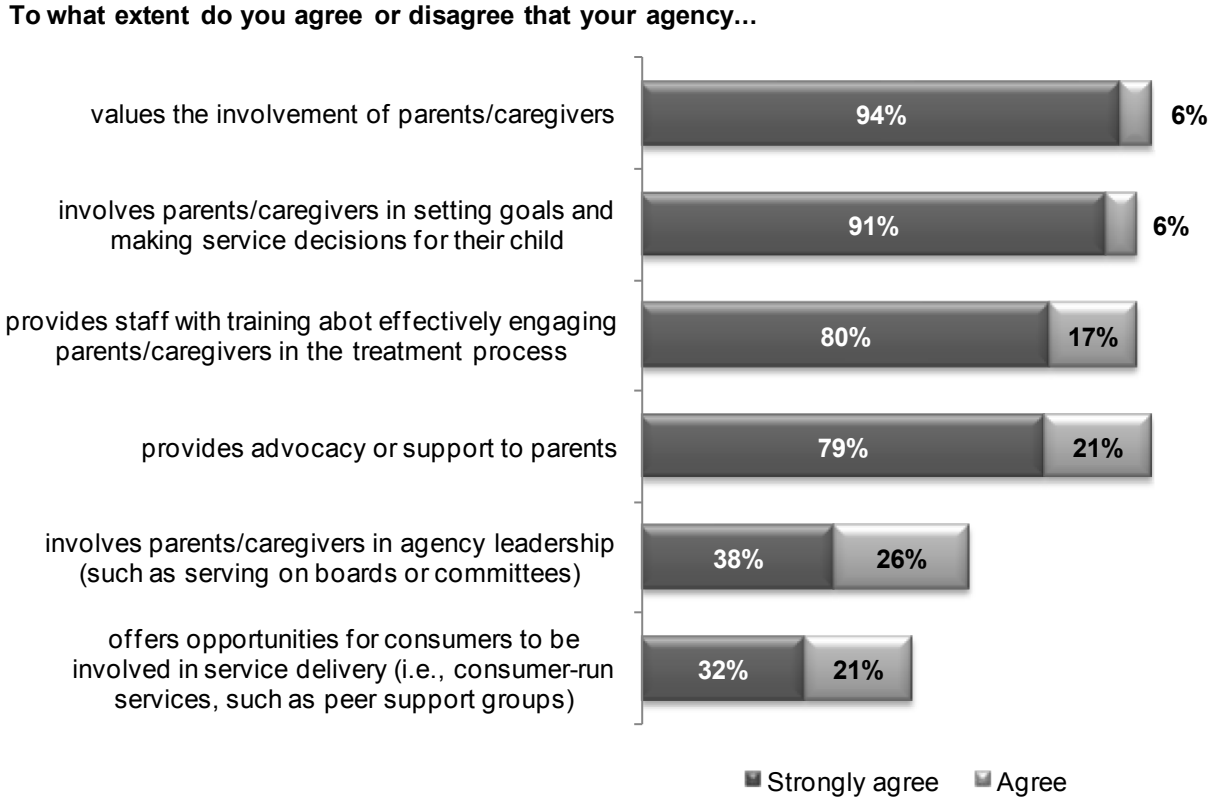
When systems fully involve families, a number of changes can occur. For example, parents and caregivers become actively involved in decision-making and governing bodies, not just as an advisory group, but as committee representatives with the same voting power as mental health professions and policy makers. Peer support services may become available in the community to meet the needs of parents and families. Services may be offered outside of traditional work hours or in locations that are more comfortable for families. Treatment plans are developed in coordination with parents and reflect not only the needs and strengths of the family, but also the formal and informal services the family plans to utilize in order to address their needs.

Representatives from previously-funded system of care communities involved families in different ways. Family involvement reflected not only the unique characteristics of each site, but also the changing priorities of SAMHSA. While all projects considered family decision-making and peer support to be important aspects of their services, there was less emphasis on family involvement in all levels of system of care activities when some of the first communities were funded. Currently, it is expected that all funded communities not only engage families in service planning, but have parents actively involved in evaluation, social marketing, and policy-making decisions. Across all system of care funded sites, family involvement initiatives have incorporated a range of different approaches, reflecting the local needs and interests of each community. While some communities have focused their efforts on developing a strong family-run organization with an emphasis on developing peer support services, other communities have established paid positions for family members to work as interviewers on the evaluation team, provide care coordination services, or train agency and county employees about ways to work more effectively with families. Communities have also utilized a variety of strategies to engage parents in decision-making at all levels of the system.

Previously funded communities were more successful engaging families in making care decisions than in promoting system-level governance. All communities felt they successfully engaged parents and caregivers in developing service plans for their individual children. However, they had mixed experiences having parents fully engaged in other aspects of the system of care. One community stated that the key to involving parents in system decision-making was to work with existing parent leaders who were already active and involved. Another community found that they only had token representation of parents on their governance board and other policy-making bodies, but found parents were extremely involved in training staff about parent involvement and providing peer support to other caregivers. To find the best way to involve parents in the system, each community needed to know the strengths and interests of those caregivers already involved and build on those assets.

While most local service providers value parent/caregiver involvement in service planning, many do not currently include them in leadership roles. Similar to the experience of system of care representatives, most local service providers completing the online survey "strongly agreed" or "agreed" that their agency values the involvement of parents/caregivers and involves them in setting goals and making service decisions for their child (97% to 100%). Approximately one in four or five providers (18% to 24%) "disagreed" or "strongly disagreed" that their agency involves parents/caregivers in agency leadership (such as serving on boards or committees) and offers opportunities for consumers to be involved in service delivery (i.e., consumer-run services, such as peer support groups) (Figure 3).

3. Provider survey – agency efforts to promote family involvement



The lack of a well-established parent advocacy or support group in Hennepin County was regularly identified as a gap in the children's mental health system. While state-level advocacy organizations (i.e., NAMI, MACMH, PACER, and others) provide support to parents who live in Hennepin County, and efforts are being made to build the capacity of the Parent Support Group through the Collaborative, there is not a single strong voice able to represent the perspectives of parents in the county. Efforts

have been made to increase parent involvement through the County, but advocates felt these initiatives have been short-term opportunities. For parents to be actively involved in decision-making and developing effective family involvement, they need training and support to develop the advocacy skills needed to represent the perspectives of parents in different settings. This process takes time and ongoing support, two factors that advocates felt had not necessarily been provided by the County.

In addition, the lack of an established parent-run organization in the county can make it difficult for parents to easily find local support services. Parents who participated in the focus group felt the connections they made with state-level advocacy organizations and local support groups were very important to increasing their knowledge of the system, developing advocacy skills, and connecting with local parent groups and services. However, it was difficult for some to learn about various opportunities for involvement in the county. Parents also identified a number of helpful workshops, conferences, and programs that are offered in the county, but felt it may be useful to develop a more centralized way to share these opportunities with parents.

There are unique barriers to family involvement in school-based services. Across stakeholder groups, there was consensus that the degree to which children's mental health services are family-driven in Hennepin County varied widely by school district, provider agency, and individual provider or case manager. While many stakeholders felt the efforts made by Minneapolis Public Schools to integrate school-based mental health services was positive, parents and advocates described mixed experiences with schools. Many parents felt teachers had inadequate training and districts were too likely to use in-school or out-of-school suspension in response to behavioral issues, rather than developing an individualized plan to help the child improve his or her classroom behavior. Representatives from the school acknowledged that it can be difficult to provide family-driven services in schools, as it requires a shift in philosophy from an education-focused approach guided by consistent district standards and driven by school staff, to a family-focused approach engaging caregivers and using individualized goals.

Some parents felt devalued in their interactions with professionals. When asked how providers, case managers, and other staff could demonstrate their commitment to working with families as partners, parents who participated in the focus group said that they wanted to be treated as experts in understanding their child's needs. Although some parents described very productive relationships with staff who serve their child and family, many felt that their opinions were dismissed by professionals. One parent stated, "As parents, we are the best advocates these kids are ever going to have. We know what each look means. But when I share a concern and then have the case manager or provider tell me that my son is okay, it just shows they aren't valuing my opinion." Parents also

described situations when they felt blamed for their child's behaviors or felt professionals implied their parenting skills were inadequate.

Parents, as well as other county stakeholders, felt that a lack of information about available services limited family opportunities for decision-making. Although parents recognized that there are a number of mental health providers and services available in the county, they found it difficult to gather and compare information about programs. Providers and stakeholders also felt parents may not be able to make fully-informed choices about the types of services their child receives if they do not receive adequate information about the types of services and choices they have. The need for more information about service options, peer support, and advocacy training may be even more pronounced among parents of children of color who have not been comfortable seeking mental health services or who have already felt marginalized through past negative experiences with various child-serving agencies.

There should be more outreach to and support of families. Providers identified a number of other family barriers that limit engagement and access to services, such as stigma, a lack of trust of providers or the system, and other life challenges or stressors. A lack of child care for other children not receiving services was also frequently cited as a barrier. Providers made a number of suggestions, such as disseminating information about available services (in multiple languages), providing in-home services, and offering child care and stipends for families.

Accessibility of services

System of care communities are expected to have an array of appropriate services in place to meet the needs of their target population. Communities may need to inventory services to determine whether they are readily available to families, and identify any service gaps that exist. Implementing sustainable programs to address these identified unmet needs is one important way to increase accessibility of services.

In addition, each system should have policies and practices that ensure these services are accessible to youth and families. This could result in mental health services being offered in nontraditional locations that are convenient for youth and families, such as schools or primary care clinics. Improved accessibility could also result from better transportation services or providers offering extended evening and weekend hours.

While a broad array of services exists, services are not equally available across the county. A strength of the Hennepin County children's mental health system consistently recognized across stakeholder groups is the number and diversity of available services. However, there is acknowledgement that there are still gaps in services and geographic

areas where services are less accessible to youth and families. Some stakeholders described urban and suburban divisions in accessibility of services, including limited service options in the northern Hennepin County suburbs. While there are greater public transportation options in Minneapolis, it can be difficult for families throughout the county to travel to services. Tied into concerns related to cultural competency within the county, some stakeholders also felt there were few culturally-specific services available in areas that have experienced recent increases in new immigrant or refugee populations.

Physical location and transportation issues currently pose a significant barrier to access. Service providers emphasized the importance of offering services in convenient locations (including home, school, and community settings) and providing transportation when necessary. Geographic barriers and the lack of transportation were commonly identified barriers to access. While many providers said that their agency provides services in non-clinic community locations (82% do this "a lot," 10% do this "a little"), fewer provide transportation (10% do this "a lot," 69% do this "a little").

Some services are limited or difficult to access. Parents and other stakeholders also identified a number of services that were limited or otherwise difficult to access in the county. Due to a lack of residential options, many Hennepin County youth with conduct disorders and highly aggressive behaviors are placed out of state in Eau Claire Academy or other residential facilities. Stakeholders identified a lack of transition services, including services focused on skill-building, for young adults leaving the children's mental health system as a gap. Parents were interested in having greater access to mentoring services and respite care, and an expansion of school-based mental health services to more schools across the county.

While crisis services were seen as a strength in the county by many stakeholders, some felt these services were fairly limited and available only to families in the midst of a crisis. Parents felt there were few options available to them when their child was starting to experience problems. Although they could anticipate a crisis situation emerging in the future, they found it difficult to find services to address these escalating problems proactively.

Issues related to health plans and insurance limit access to services and impede coordination/collaboration efforts. One core element of accessibility as defined by providers is cost, with services needing to be affordable to the family. Financial barriers, such as the high cost of insurance and out-of-pocket costs of services were frequently mentioned. Providers also highlighted the negative impact of health plans and insurance on broader system goals (i.e., policies that do not allow reimbursement for interagency coordination or collaboration). Many requested reforms that would increase reimbursement rates, make it easier for families to receive services, and promote

collaboration. These concerns were also raised by other stakeholders. Some stakeholders felt that reimbursement drove the types of services provided in the county, rather than community needs. As a result, there may be considerable competition across providers offering some types of services, while gaps are present in other areas.

Service timeliness and convenience could be improved. A common definition of accessibility given by providers is that services should be available on a timely basis, with no (or at least a short) waiting period. Many providers actively promote access, including offering services on weekends (61%) or during evenings (97%) at least "a little." Waiting lists were described as a barrier. Only one-third of the providers surveyed said that their agency generally does not have a waiting list; others generally did (23%) or said that it depended on the type of service (36%). When asked how long children usually stay on the waiting list, responses varied, with most providers estimating that it was generally a few weeks to a few months.

Parents and advocates recognized a need for greater access to flex funds and informal supports that help stabilize the family. According to one stakeholder, there was once an initiative where families could request a small amount of money to get things they needed to help their child remain in the home. Families requested a variety of things that would not otherwise be covered through traditional service plans. For example, a family requested money for a lock, phone, and second phone line so that the sibling of their aggressive child could feel safe and seek help if her brother became aggressive. That inexpensive intervention allowed the child to remain in the home and provide support to the entire family. For some families, these additional supports are the pieces that are missing and difficult to access through the county.

Service coordination

System of care communities are expected to work across disciplines to provide the appropriate array of services to youth. While the extent to which various partners are involved in the system may vary based on the needs of the target population served, there is an expectation that there is representation from multiple fields, including mental health, human services, juvenile justice, and schools. Other partners that may be involved include early childhood services, substance abuse treatment providers, representatives from faith-based organizations, and adult mental health.

Representatives from involved agencies should be involved in the community's governance board or other decision-making bodies and work collaboratively to coordinate the financing and delivery services to meet the needs of families. Service coordination should also occur on an individual level, such as through a coordinated treatment plan or participation in the Wraparound process.

Parents had positive experiences with Wraparound services. A few parents who participated in the focus group had been involved with the Hennepin County system when Wraparound was used by case managers. They spoke very positively about this approach, and felt it helped the case manager and team better meet child's needs. There was some recognition that Wraparound requires significant time. However, they felt the process could still be cost effective if work is divided across team members and out-of-home placements are avoided. There was strong agreement within the focus group that Wraparound, or a similar approach involving coordination of services and regular meetings with the child's team of formal and informal supports, would be a positive change in the county. Parents also suggested a need for greater care coordination as youth return from an out-of-home placement to ensure a smooth transition for the child and family.

Stakeholders expressed a need for greater coordination of services, while identifying a number of barriers. Service providers identified limited funding as a barrier to care coordination. While they can seek reimbursement for the therapeutic services, it is more challenging to find a way to pay for staff time to participate in meetings. Stakeholders felt the degree to which care coordination occurred in Hennepin County likely varies considerably. For example, some stakeholders felt coordination between schools and mental health providers were strong when school-based mental health providers were present. However, in districts without these services, coordination was perceived as limited. Several stakeholders acknowledged that Wraparound is likely to be most beneficial for youth and families who have higher needs, and not a cost-effective option for all youth receiving case management services.

Parents and advocates described frustrations with a perceived lack of coordination within the county, especially when first seeking help. While the single phone line is a concept most parents and advocates thought could be helpful, many described delays in hearing back from the County or finding it difficult to determine who to contact when problems arise. While some parents felt they started the intake process in a timely manner, they did not receive clear information about the types of services available to them, and the process they could expect in order to begin receiving Hennepin County services. Parents who participated in the focus group described a need for a "navigator" to help families better understand the mental health system and choose appropriate services.

Overall, a number of stakeholders identified the Hennepin County system as "fragmented" or "inconsistent." Stakeholders felt that service accessibility and coordination varied widely, based on the individual characteristics of individuals and agencies providing services to the family. Without a consistent set of expectations for interagency collaboration across the system, it is difficult for service providers, case managers, and other formal and informal supports to adopt practices to ensure service coordination occurs at an individual level.

Individualized, effective services

In addition to ensuring the appropriate mix of services is available to youth and families in the community, services and supports should also be coordinated at the individual level. Individualized treatment plans should incorporate both formal services and informal supports, based on the needs of the youth and family. Many communities use flex funds as a way to provide unique supportive services to youth and families that may not be included in standard treatment.

While there have been some recent efforts to explore the use of various evidence-based practices within system of care communities, there are not requirements to implement specific interventions. Rather, communities are encouraged to focus on building a comprehensive array of effective services available to youth and families.

Eight in 10 providers (82%) said that their agency is implementing evidence-based practices. A wide range of practices were reported, including Functional Family Therapy, Trauma Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Eye Movement Desensitization Reprocessing, Parent Child Interaction Therapy, Aggression Replacement Training, and Motivational Interviewing.

Many providers value evidence-based practices, but face implementation challenges. Providers implementing these practices identified benefits, such as more consistent and higher quality services, resulting in better outcomes and client satisfaction. Others valued the training or consultation offered by the model developers, or felt that it satisfied funder interests. They also identified a number of challenges, such as concerns about models' appropriateness for cultural communities or clients with complex needs, logistical barriers (i.e., training time, increased paperwork, funding), and restrictiveness (i.e., more emphasis on fidelity than on clinical judgment).

Neither the key informant interviews nor parent focus groups focused on specific evidence-based practices or service models that were needed in the county. However, there was general concern by a few providers that the fee-for-service reimbursement strategy left providers with less flexibility to incorporate care coordination and unique, individualized treatment approaches (i.e., animal therapy) into their service packages. While there is growing awareness and utilization of evidence-based practices, no consistent policies are in place to standardize these practices across the county.

Providers identified a number of areas where training, and post-training supports, would be helpful. Training recommendations emerged throughout the provider survey. Training to enhance cultural competence was mentioned most frequently, including cultural values and effective practices. Other common topic suggestions included:

strategies for engaging/working effectively with families, early childhood mental health, evidence-based practices, approaches for addressing specific presenting issues (i.e., trauma, dual disorders, autism spectrum), and other skills (case management, diagnostic assessment, clinical supervision).

In addition to identifying training topics, providers offered a number of suggestions related to improving the quality of training. When asked to identify the greatest barriers to improved quality of clinical services, providers most often mentioned difficulty finding time and money to train and support staff. Providers also recommended post-training supports, such as high-quality and ongoing supervision and consultation. A number of providers mentioned the need for ongoing training, such as refresher training and conferences. Other recommendations included engaging parents and providers in the planning, making it realistic (i.e., requirements, paperwork, time), and ensuring that it is useful to providers.

Readiness for system of care efforts

Although system of care efforts have been occurring for over 20 years, much of the research has focused on youth outcomes, rather than understanding the factors that lead to system-level reform. There is growing recognition that a greater understanding of implementation issues can inform efforts to create and sustain mental health systems of care. Important implementation issues include governance, financing, theories of change, strategies to develop an expanded provider network, planning, and management information systems (Kutash, et al., 2005). In this report, several key factors related to system readiness and sustainability were identified through available literature and interviews with three graduated system of care communities: Santa Cruz (funded in 1989), Wraparound Milwaukee (funded in 1994), and PACT 4, located in southern Minnesota (funded in 2003).

Representatives interviewed from three system of care communities described a number of factors that helped them successfully implement their programs. While the perspectives of these individuals may not fully represent the experiences of all system of care communities, they do represent the views of three diverse communities who have been successful in sustaining their efforts.

Planning and shared vision

Significant planning is required before launching a system of care reform. According to one funded community representative, "The trick is to know what you're doing before you begin." Although each grant includes a one-year planning period, all communities felt they had a well-defined target population, set of key partners, and approach to service delivery before applying for the grant. All partners had developed interagency relationships through work on past initiatives, and were able to build on these relationships to create a common vision and consensus around the project goals.

While local stakeholders felt the county has been working on important initiatives in partnerships with schools and juvenile justice, they did not feel a shared vision for the children's mental health system has been clearly articulated. This lack of clarity, combined with the perceptions of unnecessary competition between providers and agencies in some areas, led stakeholders to generally agree that any vision of a children's mental health system was not shared across stakeholder groups and historical geographic divides in the county.

When asked to identify strategies the County could use to build a shared vision of what the children's mental health system should look like in the future, stakeholders felt any planning process should focus on long-term goals rather than short-term adjustments.

Concerns raised by stakeholders about many recent reorganizing efforts made by the County and perceptions of a lack of follow-through on these initiatives indicated a need for deliberate relationship-building efforts by the County and across system stakeholders. According to one stakeholder, "There needs to be a new level of trust…a commitment to the long-term plan needs to be there."

Stakeholders generally support the system of care principles, but do not share a vision of how to implement them system-wide. Stakeholders perceive system of care values (i.e., cultural competency, family involvement, accessibility, coordination) are practiced to varying degrees throughout the children's mental health system. While there are examples of effective approaches to service delivery and interagency coordination, there is not a common vision of how these values should be integrated into the children's mental health system. Strong partnerships with schools and juvenile justice present opportunities for growth through a system of care grant, but additional work is needed to bring other stakeholders to the table in meaningful ways. Families do not have a strong voice in the current system, especially in communities of color historically underserved by the children's mental health system.

Relationships and leadership

Successful systems of care built on and enhanced pre-existing relationships. Representatives from the three funded system of care communities all described their initiatives being built upon pre-existing relationships across multiple child-serving agencies or using deliberate processes to build trust and collaboration across state and local agencies. PACT 4, for example, is a Collaborative with a long history of working together to develop effective service models using Local Collaborative Time Study (LCTS) funds. Stakeholders in Milwaukee rallied around a need to address growing out-of-home placement costs. To demonstrate how their coordinated approach would lead to improved outcomes for youth and lead to cost-savings across agencies, they conducted an initial pilot with 25 youth in out-of-home placements to demonstrate how a Wraparound approach could be used to bring successfully bring youth back into their homes.

In Hennepin County, there are examples of strong collaboration across agencies, as well as areas where greater collaboration is needed. Stakeholders identified partnerships to build school-based mental health services within the Minneapolis Public Schools as an area of strength and a strong example of partnerships between the schools and community-based providers. Services have also been developed through the schools to expand substance abuse prevention and intervention activities. A number of stakeholders also felt there was energy around JDAI efforts and opportunities to increase partnerships to

improve the availability of community-based services for youth with high needs and transition services for youth returning from residential placements.

Greater efforts are needed to expand the range of participating partners, including parents, service providers, physicians, and health plans. Stakeholders felt that family involvement in system-level policy development and decision-making needs to be enhanced. Others felt that while there is a strong provider network in place to advocate jointly for funding or various changes in policies and practices, providers do not necessarily work together to coordinate their efforts to provide a continuum of services. Greater coordination across providers may help establish a more robust continuum of services in the county, based on community needs. A few stakeholders also identified a need for greater collaboration with primary care physicians and health plans. Within the county, an opportunity to better coordinate early intervention services across all child-serving departments was also identified.

Many stakeholders identified the county's strong provider network as a strength of the system and felt it was essential to engage this group in the planning process. While a number of stakeholders could identify mental health providers who were engaged in the county system and perceived as leaders, families were not identified as having influential roles. The lack of a local family-run organization has made it difficult for families to have a shared voice in county-level decisions. While statewide advocacy organizations have been active in supporting Hennepin County parents, they do not feel well-connected to County departments.

To increase buy-in and implement their initiatives, funded communities built on existing system reform initiatives or efforts to address the mental health needs of youth. One system of care community representative said that efforts are often led primarily by one agency, but that partnerships need to grow over time so that all agencies own pieces of the system and continue to share a common vision. A challenge to long-term sustainability is maintaining this vision and buy-in across agencies as key representatives and agency leadership changes over time. All communities spoke directly or indirectly about the need to clearly identify how all agencies would benefit by being involved in the system of care in order to build partnership. One representative spoke of not only looking for win-win scenarios that were part of their implementation plan, but compromising to create greater incentives for agencies to participate in the system and adjust their practices to improve the way services are delivered to youth.

Systems of care adopt a number of leadership structures to guide their initiatives. In some communities, leadership occurs through top agency representatives, while others are led by lower-level management across agencies that are highly invested in cross-disciplinary collaborative work. While there is no single structure that makes a system of care

community successful, the representatives interviewed all had built their initiative on existing collaborative efforts. One community felt State-level support was essential to their work, especially as they focused their efforts on developing sustainable funding streams.

While stakeholders saw key county administrators as advocates for children's mental health, concerns were raised about the County's ability to lead reform efforts. Repeated restructuring efforts have led to confusion about who to contact for specific questions at all system levels, from individuals seeking services to Department of Human Services staff working on specific statewide initiatives. In addition, some stakeholders do not trust the County to pursue and sustain this work, as multiple restructuring efforts have occurred during a short period of time. Stakeholders wanted to see children's mental health having a consistent "home" in the County system, with dedicated staff who could work in the area long-term.

While the Collaborative was seen as having an influential role in bringing a broad array of stakeholders together and encourage new initiatives, stakeholders did not believe this group had the infrastructure to lead a system-wide reform effort. One stakeholder also pointed out that there are a number of Family Services Collaboratives in place throughout the County, competing directly or indirectly with the Children's Mental Health Collaborative for limited dollars.

Positive partnership is one of the best predictors of system of care sustainability. In a study involving stakeholders from 25 communities who received the earliest rounds of system of care funding, one of the factors that had the most influence on sustainability was positive relationships across partners (SAMHSA, 2005). This included consistent leadership over time, the ongoing use of inclusive decision-making approaches, and maintenance of a shared vision of the system. As described by the communities interviewed, training of new staff in leadership roles was an important strategy to sustain efforts. Conversely, changes in key leadership, including policy-makers, had a negative impact on sustainability.

Funding

Recent funding cuts have led to reductions across all County child-serving divisions. Overall, the county is expecting the proposed unallotments made after the 2009 Legislative Session to result in a $4 million reduction in funding, with another $7 million reduction in the following year. These reductions in funding have led to a hiring freeze during the last two years, as well as job reductions in child welfare and other child-serving divisions. Over the past 12 months, the children's division has been reduced by approximately 90 staff.

Smaller agencies may need assistance to survive funding challenges. While a strength of the Hennepin County system is its breadth of providers, some stakeholders feel that a number of smaller providers are in jeopardy as future funding cuts occur. Smaller agencies may not have the infrastructure to maximize reimbursement for the services they provide or seek other revenue through grants, and may not have other funding streams to tap into, such as funding from private donors. There was some agreement that there was a need to build provider capacity to ensure services are created or sustained in key areas of the county, but not a clear vision for how this work could take place.

From the beginning, each funded community focused on finding sustainable funding streams to maintain their efforts, including developing pooled funding based on capitated rates across agencies, capturing new Medicaid dollars, and reallocating cost savings from deep-end services to other community-based services. One community representative stated efforts need to be made to build expertise across system partners and community agencies to understand how funding is currently allocated and develop strategies to shift funding to support the full initiative.

Representatives from each community also very clearly articulated that they saw their system of care funding as a way to build an infrastructure to support system reform efforts, not as a way to fund specific services. It is important to note that the current SAMHSA collaborative agreements are much more defined now than in earlier years of the federal program. A number of specific positions must be filled by each grantee community to build an infrastructure to support the implementation of system of care principles. Further, because of the complexity of the required evaluation and additional administrative data collection activities, multiple staff members throughout the system have responsibilities outside of their primary service delivery roles. These additional responsibilities can be cumbersome for employees unless there is support for these initiatives across management levels.

Local stakeholders, as well as representatives from graduated systems of care, stressed the importance of focusing any system of care grant application on initiatives that can be sustained over time. Representatives from funded communities pointed out that while the funding amount available through these grants is large, there are a number of infrastructure and evaluation requirements in place that use a considerable amount of the total funding. While past communities had been successful in obtaining new grants because of their success with their system of care efforts, new dollars coming to their system were used to further expand or enhance services, not to sustain services created while the collaborative agreement was in place. Feedback from local stakeholders indicated the need for the County and agencies involved in the planning for a grant application to use a very transparent process to clearly communicate how priorities were identified, and deliberate efforts to ensure stakeholders how the grant would be used to

build a sustainable system, not address budget shortfalls currently being faced by the County.

The two most effective financing strategies used to sustain established systems of care were found to be increasing the ability of agencies and providers to obtain Medicaid reimbursement and obtaining new or increased levels of state funding. While the communities interviewed felt their success in obtaining a system of care grant helped them secure other funding, these additional dollars were considered ways expand or enhance their efforts, not as a primary strategy to maintain specific services. Other funding options, including the use of more efficient operating strategies and creating partnerships outside of the mental health system, were identified as less successful sustainability strategies. Changes to the federal, state, or local economic climate often had a negative impact on sustainability.

Other perspectives of local stakeholders

There was excitement among some stakeholders to pursue a system of care grant, but also concerns about the level of overall system readiness. While stakeholders identified existing interagency partnerships between children's mental health and schools or juvenile justice as initiatives that could be further expanded through a system of care grant, a number of different target populations and service gaps were identified by stakeholders. Despite many ideas about ways to improve services, there was not a clear and common vision of what an effective children's mental health system should look like in Hennepin County.

Interviews with stakeholders indicate a level of weariness and distrust across the system resulting from ongoing restructuring efforts by the County. To build consensus around this initiative, stakeholders felt the County needs to be transparent in its planning process and deliberate in developing a long-term, sustainable proposal. Strong efforts also need to be made in order to engage families in the planning process and consider how to build and expand parent support services in order to develop a competitive grant application.

Stakeholders felt the system of care grant could provide the County with an opportunity to build a more integrated system and address gaps in the continuum of care. While a number of stakeholders identified a need for improved services for youth with highly aggressive behaviors in the County, including a need for more local residential treatment options, more intensive community-based alternatives to placements, and improved transition services for youth leaving residential placements, other stakeholders identified gaps in early childhood, prevention and early intervention services, culturally-specific services, and services for young adults transitioning from the children's mental health system to adult services. A challenge identified by stakeholders is to increase

service availability throughout the county in a way that improves access to all youth, including cultural communities currently underserved (i.e., American Indian, African American, and Latino youth, recent immigrant and refugee populations, families living in poverty) and geographic areas of the county where services are currently lacking.

While many stakeholders were excited by the opportunities that could come through a system of care grant, a number of reservations and concerns were also raised. A number of stakeholders felt the efforts to increase school-based mental health services in the Minneapolis School district were a strong example of interagency partnerships that could be built upon in a system of care grant. Hennepin County's current Juvenile Justice Detention Alternatives Initiative (JDAI) efforts have focused on developing recommendations to develop community-based alternatives to out-of-home placements, with the goal of limiting the length of residential stays to less than nine months and avoided repeated out-of-home placements. Whereas the school-based efforts in Minneapolis have been implemented, these juvenile justice efforts are in earlier planning phases. Although stakeholders were optimistic about the opportunities to develop better coordinated services for youth involved in the juvenile justice system, it seemed fewer were as familiar with the work being planned through this initiative. Additionally, many stakeholders felt that a closer collaboration between school-based mental health programs and juvenile corrections may be helpful in providing services.

System sustainability

While there is growing interest and exploration into the factors that lead to sustainability of system of care efforts, the information currently available is somewhat limited. The literature cited in this report focuses on identifying factors that lead to system sustainability and determining how well different types of services are maintained after the funding period ends. Additional examples from the three communities interviewed are also included, when relevant.

Communities are somewhat successful in sustaining system of care elements once funding ends. In a study of 25 graduated system of care sites, some common findings emerged describing how well specific services and system of care values were maintained after the cooperative agreement with SAMHSA ended (SAMHSA, 2004). While many sites were successful in maintaining their work in a number of goal areas, including reducing the number of youth in overly restrictive settings and developing a shared understanding of system of care values, sites were less successful in maintaining a shared focal point for coordinated system management, ensuring adequate service capacity, maintaining a family-run organization or peer supports, and using evaluation.

When the availability of specific services was assessed after funding ended, many communities saw increases in the availability of transition services for youth leaving residential placements, as well as more behavioral aides, therapeutic group homes, and substance abuse treatment options for youth. However, services without a direct funding source were more difficult to maintain, including flex funds, transportation services, family support services, respite care, and recreational activities for youth and families.

While the national evaluation requirements were described as an implementation challenge, representatives from funded communities found the use of data to be essential to increasing buy-in across agencies and sustaining their program. While some communities found clinical outcome data to be particularly useful in describing the effectiveness of their efforts, other communities have focused more heavily on cost-benefit analyses, particularly to describe how dollars formerly spent to fund out-of-home placements could be reallocated to fund community-based services that support youth in their homes. They found the use of evaluation data helped them obtain additional funding from other sources and a way to demonstrate the effectiveness of their work to new policy-makers and agency leadership.

Service utilization and gaps

Approximately one in five Minnesota youth have a diagnosable mental health condition. Nearly 24 percent (or 684,000) of Minnesota residents are under the age of 18. According to Kids' Count data (2000), approximately 145,000 youth have a diagnosable mental or emotional disorder in Minnesota (2001). The most frequently diagnosed mental disorders were anxiety disorders (13%), disruptive disorders (10%), mood disorders (6%) and addictive disorders (2%). In addition, nearly 70,000 youth have a functional impairment due to their mental illness. An estimated 13,000 youth in Hennepin County have some type of diagnosable mental health condition, with over 1,000 youth experiencing functional impairment. However, mental health issues are more common among various high-risk populations. The county's juvenile probation department, for example, determined that more than half (51%) of their youth were diagnosed with at least one mental health issue.

> *At the Hennepin County Home School, a state-licensed residential correctional treatment center for juveniles ages 13 to 19, more than 70 percent of the youth have some psychiatric diagnosis, including attention-deficit hyperactivity disorder, bipolar disorder, post-traumatic stress, and depression. Left untreated, these youth are at high risk for a lifetime of institutionalization.*
>
> Hennepin County, 2007.

Parent or caregiver reports of youth mental health issues may be somewhat lower. In 2006, Hennepin County's Survey of the Health of All the Population and the Environment (SHAPE) collected information from parents and caregivers regarding perceptions of their children's health. When asked if their child had any physical, behavioral, or mental conditions (that they expect will last 12 months or longer), 4.8 percent of the county's sample reported yes. Rates varied some by race/ethnicity, ranging from 2 percent for African born youth to 7 for Hispanic/Latino youth.

Of the parents who indicated that their child had a condition, most (51%) reported the condition was physical only. The remaining parents described the condition as behavioral/mental only (27%) or both physical and behavioral/mental (22%).

Hennepin County data

In 2003, approximately 2,400 youth received services (such as outpatient services, case management, and residential treatment) from the county's unit and a number of contracted providers, costing approximately $23.5 million. Seven out of every 10 children served by the county's mental health unit were male. Nearly two-thirds of the youth were between the ages of 12 and 17. Most were African American or White (43% and 42% respectively), while fewer were identified as as Latino (6%) or Asian (2%).

Most youth who receive targeted case management services have insurance coverage through a public plan. In 2008, 300 youth received CMH-TCM from 24 Hennepin County social workers. Over 80 percent of these services were paid for through Medical Assistance fee for service or managed care plan (Prepaid Medical Assistance Program or PMAP) (Figure 4). Less than 20 percent of youth case management services were paid for through private insurance plans. The payments for these contract providers came from a variety of sources as noted in Figure 4.

4. Payment source for CMH-TCM contracted providers

	Total Number	Percent
Medical Assistance-Fee For Service	363	40.07%
PMAP-Medica	169	18.65%
Private/Commercial Insurance	154	17.00%
PMAP-U-Care	58	6.40%
PMAP-MHP	53	5.85%
PMAP-Health Partners	45	4.97%
Uninsured	43	4.75%
Unknown	21	2.32%
Totals	906	

Hennepin County, 2009.

There are a number of community based providers in Hennepin County that offer services to youth with mental health issues. Among them are Community University Health Care Center, Family and Children's Services, Family Networks, Fraser, LaFamilia Guidance Center, Power of Relationships, Reach for Resources, St. David's Center, St. Joseph's Home for Children, The Storefront Group, Volunteers of America and Washburn Center for Children. Figure 5 details Hennepin County's utilization services for each provider in 2008 on a given day.

5. CMH-TCM Contracted Providers Capacity on any given day

	Capacity	2008 Utilization
Community University Health Care Center	45	45
Family and Children's Services	15	8
Family Networks	141	43
Fraser	105	Not Available
LaFamilia	45	6
Power of Relationships	195	257
Reach for Resources	30	41
St. David's Center	45	70
St. Joseph's Home for Children	30	36
The Storefront Group	144	102
Volunteers of America	113	116
Washburn Center for Children	96	134
Totals	1,004	899* 89.5%*

Hennepin County, 2009.

* *2008 Utilization Data does not include Fraser's capacity.*

Statewide service gaps

Statewide data reveal a number of significant service gaps, such as limited options for hospitalization, residential services, psychiatry, and crisis support. According to Kids Count, over 20,000 children in Minnesota received some type of mental health service (emergency, outpatient, day treatment, residential treatment, hospital inpatient, case management, and professional home-based family treatment) in 2002. However, there are a number of service gaps evident throughout the state. In 2008, the Minnesota Department of Human Services convened a workgroup to examine children's mental health needs in Minnesota and to develop recommendations on how to meet these needs. According to their report, 12 crisis teams serve youth in 57 counties and 4 tribes (through the Children's Mental Health Division on Mobile Crisis Response Services). Overall, the DHS report noted very few spaces available for youth who are in need of hospitalization due to mental health concerns, especially acute conditions. They found that there are 157 hospital beds for children and adolescents in 6 hospitals with either separate or combined (child/adolescent and adult) units and 120 spaces in nine partial hospitalization programs, located and administered by either hospitals or community mental health centers. A total of 17 residential facilities are certified to provide mental health treatment for 585

children/youth, and there are 121 credentialed Children Therapeutic Services and Supports (CTSS) programs.

The workgroup reported a list of problem areas in the current system in their 2009 report in terms of access, service availability and coordination. The report denoted the following problems with the current system:

- Lack of access or ability to access hospitals beds
- Lack of intensive alternative services for youth
- Lack of knowledge about crisis teams and referrals to them
- Lack of coordination between emergency responders, crisis teams and hospitals
- Need for improved discharge planning out of ERs and hospitals to prevent re-admission
- Need for longer term residential services for a specific group of children and adolescents
- Lack of child and adolescent psychiatrists available for consultation and ongoing treatment

Minnesota has one of the poorest student to school counselor ratios in the country. Ten percent of students who took the Minnesota Student Survey in 2001 reported high levels of stress. As reported in *Diagnostic Predictive Scales (DPS) Twin Cities Pilot Project Diagnostic* by Prairie St. John's, the President of the American School Counselors Association (Jim Bierma) noted that Minnesota ranked 49th out of 50 states in terms of the student to school counselor ratio (800:1) in 2007 (Jensen, et al, 2008). The national average is one school counselor to every 488 students.

Stakeholder perspectives

Stakeholders identified a number of unmet needs for children/youth with mental health issues in Hennepin County. As part of the Collaborative survey, local stakeholders were asked to identify the most pressing unmet needs of children/youth with mental health issues in Hennepin County. Some providers mentioned a general lack of timely access to services for children, while others mentioned specific shortages (such as school-based services and psychiatry). Others mentioned the need to provide support to meet broader family needs, and to ensure services for youth who are uninsured or underinsured.

Four in five Collaborative survey respondents (83%) felt that the system serving children/youth with mental health issues was "somewhat effective." Most of the remaining respondents felt that the system was "not at all effective." When asked what the Collaborative could do to help the system better meet the needs of children/youth with mental health issues, stakeholders provided a range of suggestions. Recommendations included supporting prevention efforts, engaging parents and cultural communities, supporting school-based services, promoting community awareness of available services, lobbying/advocating for improved funding, and using social marketing strategies to reduce stigma about mental health.

Collaborative functioning

A significant body of literature identifies the key characteristics of successful collaboration, common barriers to collaborative efforts, and strategies to prevent or minimize the impact of these challenges. There are many similarities in how collaboration is approached across disciplines, providing examples of effective partnerships both within and beyond the field of children's mental health. This summary utilizes this framework to highlight key strategies to achieve collaboration, including examples of practices and policies that have been successful approaches for existing collaborations and strategies that increase a collaborative's resiliency.

Challenges to collaboration

Collaboration is difficult to achieve. Often, collaborative efforts are initiated in response to a complex problem that a single agency cannot address alone, a need to provide integrated services to address a target population's broad range of needs, or a perceived opportunity to make significant changes and improvements to existing systems. Regardless of whether the collaborative is formed to respond to a crisis or opportunity, the work of the group to address these broad issues is often complicated and time-consuming. Although a number of stakeholders may be interested in working together to address a shared concern, many groups find it difficult to enter true collaborative partnerships where there are common goals, mutually-understood relationships, and sharing of decision-making authority, accountability, and resources.

Research highlights a number of common challenges that must be overcome before effective collaboration can occur. In a study of children's mental health collaborations, the four barriers most often identified by collaborative partners included: (1) varying commitment to collaborative efforts; (2) distrust among partners; (3) resistance to change; and (4) concerns regarding time requirements (Hodges et al., 1999). Although all partners may enter the collaboration at different stages of readiness or comfort working with others, it is essential that there are processes in place to address these barriers by building trust and developing shared expectations and accountabilities across all partners.

Characteristics of successful collaboration

In 2001, an extensive review of cross-disciplinary literature describing effective collaboration was conducted, leading to the identification of 20 factors that influence the success of collaboration (Mattessich, et al., 2001). Although each of these factors is important, the unique characteristics of each collaborative require a different blend of strategies to strengthen current partnerships and address barriers that are impeding the work of the collaborative. Some of the most important factors that may be relevant to the Hennepin County Children's Mental Health Collaborative (HCCMHC) can be grouped into five main categories: (1) purpose; (2) representation; (3) communication; (4) decision-making; and (5) resiliency.

Purpose

A key distinction made between true collaborative efforts and other, less integrated partnerships, is the relationship between mutual benefits and individual gains. When agencies choose to partner, they negotiate strategies that are beneficial to themselves and the mission of their agency. However, collaborative partners share a vision that is shared by all partners and extends beyond the mission or purpose of any single agency. The mission and goals of the collaborative are identified as one source as the group's "sphere of activity" (Mattessich, et al., 2001). Although this sphere may overlap with the goals and mission of a partner organization, it should also contain components that are shared by other organizations or unique to the collaborative itself.

One of the most important factors that help collaboratives stay together is the commitment all partners have in serving a specific target population (Thomson & Perry, 2006). By focusing on the larger issues being addressed by the collaborative, individual members may be less likely to focus on the individual benefits they hope their organization will gain through the collaborative and instead, consider ways in which their participation in the collaboration will result in changes that positively impact the target population.

As the collaborative defines its purpose, it is important that concrete, attainable goals and objectives are identified and clearly understood by all partners (Mattessich, et al., 2001). By identifying both short- and long-term goals, the collaborative will have opportunities to building on early successes and maintain enthusiasm for the more challenging long-term goals.

Survey respondents generally felt that the role of the Collaborative was to bring partners together to coordinate and enhance children's mental health services in Hennepin County. Several respondents focused predominantly on the convening role,

while others emphasized the concept of service coordination. Most respondents focused on broad concepts, such as "making systemic improvements," "supporting children's mental health," "providing resources," and "ensuring access." Some focused on more specific roles, such as community education or supporting Wraparound services.

Most Collaborative survey respondents (79%) felt that the Collaborative was "somewhat successful" in achieving its mission to "serve as the catalyst within Hennepin County for best/promising practices and outcome-based applications and system enhancements within the spectrum of children's mental health services and practices." Eight percent felt that the Collaborative was "very successful," while 12 percent s aid that the Collaborative was "not at all successful."

Respondents made a number of suggestions for increasing the Collaborative's success in fulfilling its mission. Several mentioned that the Collaborative was making progress and should continue its current efforts. Other recommendations included: (1) using data more systematically, such as service and outcome data of partners; (2) improving communication and visibility, especially with community partners such as school staff; (3) increasing the diversity of partners, especially parents and representatives of cultural communities; and (4) focusing more efforts on improving the accessibility and quality of care in Hennepin County, including the use of evidence-based practices.

Half of the 2009 collaborative survey respondents "strongly agreed" that they have a clear understanding of what the Collaborative is trying to accomplish, compared to only 13 percent the previous year. Almost one-quarter of the respondents disagreed "somewhat" or "strongly" with this item, however.

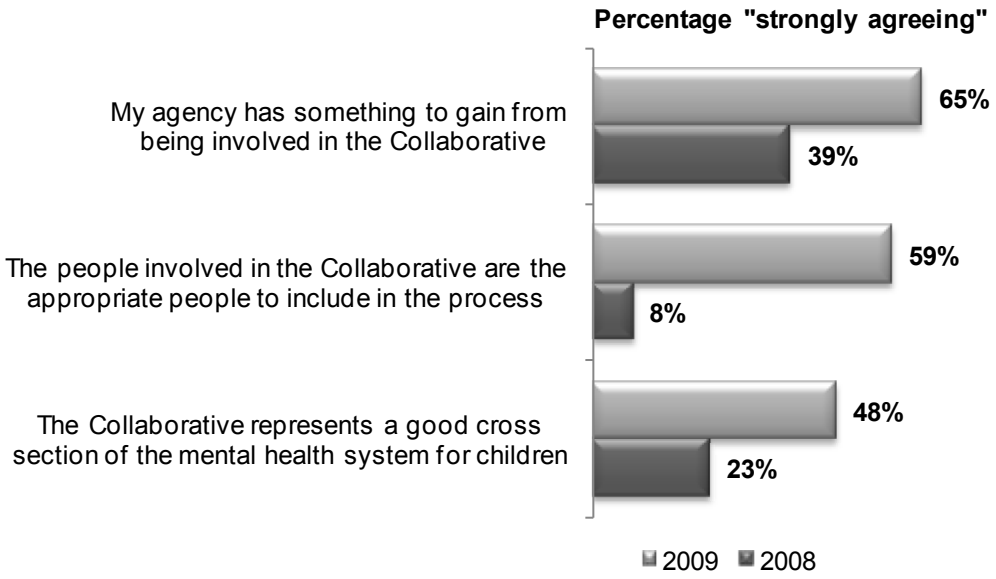
Representation

Successful collaboration requires representation from all community stakeholder groups who will be affected by its activities. Although the collaborative membership must be large enough to allow for representation of all perspectives, it is important that the size of the collaborative does not become so great that it becomes burdensome to make decisions and otherwise unmanageable (Mattessich, et al., 2001). Successful collaboratives regularly reassess their membership and consider whether new groups should be brought into the partnership. Key representatives to the collaborative should include individuals who have important influence on the issue being addressed by the partnership. If identified stakeholders are not interested in participating in the collaborative directly, it may be helpful to identify other ways to inform these key individuals of the collaborative's work and consider other opportunities for stakeholder involvement (Mattessich, et al., 2001).

Although collaboration between competing organizations is possible and can lead to successful outcomes, it may not be advisable to have competing players at the table if the goals of the collaborative mirror the goals and activities of individual organizations (Mattessich, et al., 2001). This may lead to "turf wars" or other disagreements among partners who feel too much of their agency's work is at stake. To avoid this type of conflict between partners, there must be clear understanding of the services each type of agency provides, how they currently coordinate with other organizations to meet the needs of children and families, and consensus on the best ways for the collaborative to address existing service gaps (Darlington & Feeney, 2008).

Most collaborative survey respondents were invested in the collaborative and felt the right partners were involved. Most 2009 survey respondents (95%) agreed "somewhat" or "strongly" that their agency has something to gain from being involved in the Collaborative; the percentage that agreed "strongly" increased from 39 percent in 2008 to 65 percent in 2009. Fewer, though still the majority, agreed that the Collaborative represents a good cross-section of the mental health system for children; the percentage that agreed "strongly" increased from 23 percent in 2008 to 48 percent in 2009 (Figure 6).

6. Collaborative ratings of representation



Communication

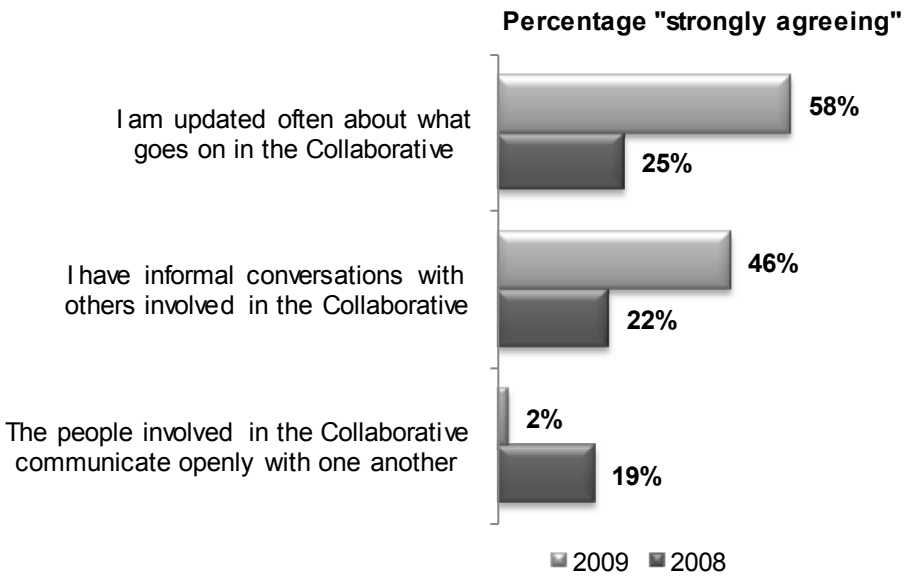
Successful collaboratives utilize frequent and open communication to keep all partners informed and discuss possible approaches to addressing problems. Although it is important to use a variety of communication strategies to reflect the preferences of the group, it is important that these different approaches are offered as communication strategies to all members. If different communication occurs with various types of collaborative partners, such as oral communication only being used for meetings with a small group of stakeholders, splintering of the group may occur (Mattessich, et al., 2001). Effective communication strategies should be encouraged throughout the collaborative, with all partners having the opportunity and responsibility of providing feedback to discussions and decisions. Most survey respondents agreed that they are updated often about what goes on in the Collaborative; the percentage agreeing "strongly" more than doubled from 25 percent in 2008 to 58 percent in 2009 (Figure 7).

Many collaboratives rely on a blend of formal and informal communication strategies to enhance existing partnerships and strengthen coordination across agencies (Darlington & Feeney, 2008). Although relationships between individual partners are essential, communication strategies that rely on the characteristics and effort of individuals can be difficult to maintain through transitions in staffing or other barriers. Therefore, it is also important to establish common expectations among all collaborative partners and develop consistent communication processes. Almost half of the 2009 survey respondents (46%) agreed strongly that they have informal conversations with others involved in the Collaborative; another 38 percent agreed "somewhat."

For open, honest dialogue to occur, there must be trust among all collaborative partners. Successful collaboratives often hold individual meetings with potential and existing partners to build personal relationships outside of regular group meetings (US Department of Health and Human Services, 2002). This not only creates an opportunity to build trust between partners, but also allows individuals to discuss and resolve issues they may not feel comfortable discussing in large group settings.

Most survey respondents provided positive ratings of the Collaborative partners. In 2009, all respondents agreed "somewhat" or "strongly" that the appropriate people are involved in the process (compared to only 64% in 2008). Ninety-four percent agreed that partners have a clear sense of their roles and responsibilities, have respect for one another, communicate openly with one another, and have a high level of commitment to the process (compared to 58%-88% in 2008).

7. Collaborative ratings of communication



Decision-making

There are three major types of decision-making structures: autocratic systems where one person makes the decision; democratic systems where all partners have a vote on each issue; and a diffused system where small groups have autonomy to make decisions assigned to them (Ray, 2002). These different types of structures are appropriate to collaborations at varying levels of maturity, however different situations may require a unique type of decision-making approach.

Successful collaboration relies on partners having joint decision-making authority about the rules and standards that govern the behavior of the group and relationships between agencies (Thomson & Perry, 2006). A successful governance structure is one that shares decision-making authority and responsibility for adhering to decisions across the entire group. Although it is essential that agreement is reached when decisions are made, this does not mean that each decision will be identified as the best possible solution for each individual agency.

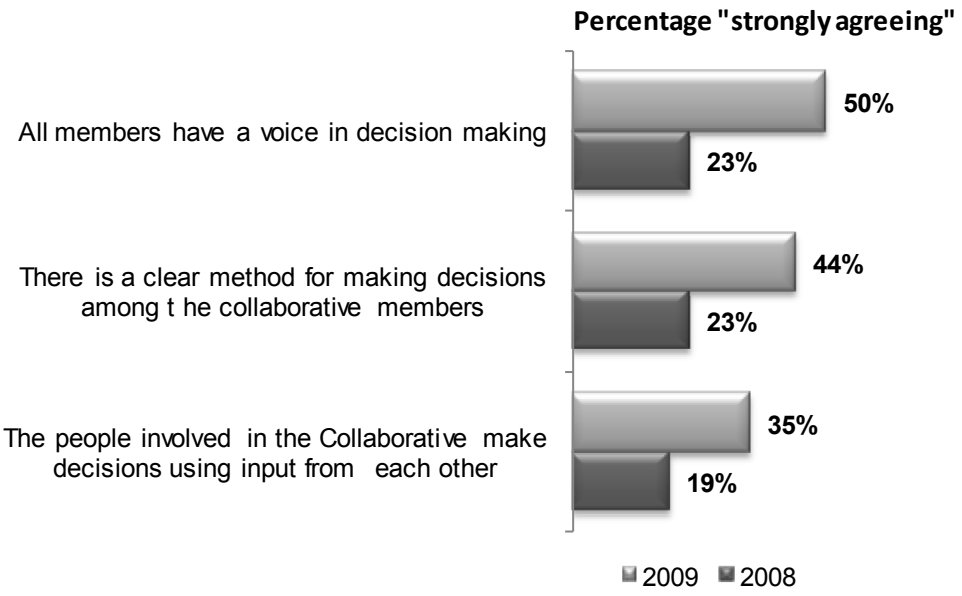
A lack of input from all collaborative partners can lead to decisions that do not adequately address all aspects of a problem. Although program administrators may have greater clout in developing policies or securing funding, successful collaboratives also include representatives that understand how broad policy decisions will impact day-to-day service delivery, such as direct service staff and service recipients (Hodges, et al., 1999). Some collaborative groups have also found it useful to rotate leadership roles

when multiple agencies are involved to promote shared ownership across all partners (Armstrong & Evans, 2006).

Just as it is important to gather input from agencies and organizations, it is also essential to ensure the perspectives of families are represented so that the impact of any decision is understood from the perspective of those who will ultimately receive services. Family advocates argue that without ongoing communication and opportunities for family feedback "ineffective and inadequate services and supports are designed and implemented" (Federation of Families for Children's Mental Health, 1998).

Ratings of Collaborative decision making increased between 2008 and 2009. In 2009, 88 percent of the Collaborative survey respondents agreed "somewhat" or "strongly" that there is a clear method for making decisions among members (compared to 54% the previous year). The percentage of respondents agreeing that all members have a voice in decision making increased from 54 percent to 72 percent. The percentage of the respondents who "strongly agreed" with these two items increased from 23 percent to 44 percent and from 23 percent to 50 percent respectively. More than 80 percent agreed that the partners make decisions using input from each other, are open to different approaches about how the work should be done, work together to achieve group goals, and fully participate in the group process.

8. Collaborative ratings of decision making



Success of the Collaborative in reaching goals

Survey respondents gave mixed ratings regarding the Collaborative's success in meeting goals. Collaborative survey respondents were asked to rate the success of the Collaborative in meeting a number of goals. Most agreed "somewhat" or "strongly" that the Collaborative has created appropriate multi-disciplinary community workgroups (86%) and increased or improved communication among agencies (85%). Approximately three-quarters of the respondents agreed that the Collaborative effectively integrated efforts from multiple sectors to enhance children's mental health services (77%), developed clear recommendations and strategies for increasing service coordination (77%), strengthened effective working relationships among agencies (76%), and increased access to a continuum of appropriate and effective community mental health services (74%).

They were least likely to agree that the Collaborative increased access to family support services (57%) and successfully raised funds to enhance children's mental health services in Hennepin County (50%). In general, ratings were higher than those provided in 2008.

Other feedback regarding the Collaborative

Survey respondents felt that workgroups had clear roles and meetings were effectively facilitated. All survey respondents agreed "somewhat" or "strongly" that meetings are facilitated effectively (compared to 75% in 2008). Most agreed that the meeting agendas reflect the priorities of the group members (82%). The percentage of respondents agreeing that the roles of standing groups are clear increased from 58 percent in 2008 to 88 percent in 2009.

When asked to identify the most positive thing resulting from the Collaborative, survey respondents often mentioned the improved services facilitated through the SOI, especially school-based services. Others appreciated the Collaborative's role in bringing diverse stakeholders together, and providing opportunities for parental involvement in the system. Several mentioned that the new workgroups and organization were positive, and would lead to significant benefits for the Collaborative.

Survey respondents made a number of suggestions for the Collaborative, including increasing communication and visibility of the collaborative and strengthening the participation of parents/parent advocacy organizations. Other respondents recommended that the Collaborative focus more on increasing the accessibility and effectiveness of services. Several specifically suggested that the Collaborative pursue a SAMHSA system of care grant.

Recommendations

The results of this assessment suggest a wide array of possible short-term and long-term strategies for enhancing the children's mental health system and strengthening the role/functioning of the Children's Mental Health Collaborative. Wilder Research recommends the following strategies be given strong consideration, given their importance in promoting effective collaboration, strengthening the system of care, and enhancing outcomes for children and families:

1. Create a short- and long-term plan to address the shortage of mental health professionals of color and increase cultural competency in Hennepin County.

2. Develop strategies to engage families in system-level decision making processes and sustain their involvement over time.

3. Increase linkages between the children's mental health system and other systems serving children and families, including access to adult services and family supports.

4. Develop a model for care coordination and pursue funding strategies, such as increased support through County contracts and private health plans.

5. Develop a workforce development initiative that establishes training priorities and provides high-quality training and consultation.

6. Work with the County and local stakeholders to develop consistent ways to identify, map, and reassess service gaps.

7. Address stakeholder concerns regarding leadership, and identify individuals and agencies able to guide system of care reform efforts.

8. Gather available information related to effectiveness of services for children, and identify strategies to improve outcomes as necessary.

9. Establish short-term and long-term Collaborative goals and success indicators, with an emphasis on improving the system of care for children/youth with mental health issues in Hennepin County.

Appendix

System of care values and principles

Key informant interview protocols

Provider survey results

Collaborative survey results

References

System of care values and principles

Core Values

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

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive planning services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.

9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

- Stroul, B & Friedman, R., 1986

Key informant interview protocols

HCCMHC – SOC assessment
Key informant interviews

NOTE: The draft questions frequently ask about perspectives of the County, but will be changed as appropriate, to be relevant to each key informant. This document describes the type of questions that will be asked of key stakeholders. Prior to each interview, an condensed interview guide, containing key high-priority questions from this list, will be developed.

Background

- How do you define the Hennepin County Children's Mental Health system? Which agencies are involved? Are all agencies equal participants? Are there agencies/organizations/stakeholders that should be part of the system but seem less connected to the system?
- What is your role in the Hennepin County Children's Mental Health system?
- What areas of the local system are you most familiar with and feel comfortable speaking about?

System strengths, weaknesses

- What are the current strengths of the Hennepin County children's mental health system? (Are these recent changes or long-standing system strengths?) *NOTE: Probe for specific information about agencies/organizations that are involved in these areas.*
- What are the current weaknesses of the Hennepin County children's mental health system? Are any efforts underway to address these issues?

Target populations

- Has the County identified any specific populations they are trying to find better ways to serve? What activities are currently planned/underway?
- Are there any specific populations that you feel are currently underserved by the Hennepin County system? *NOTE: Probe for populations underserved due to lack of access to services, need for specialized/specific services in the area, stigma, etc.*

Alignment with system of care principles

NOTE: To discuss these elements, may need to develop a grid to send to key informants prior to each interview, so they are familiar with these terms and have an opportunity to think about local examples.

- What is this concept as defined/understood by local stakeholders? Is the local definition consistent w/ the system of care principles, as defined by SAMHSA?
- From your perspective, how well does the local system of care embody this principle? *NOTE: Probe for examples of successful incorporation of the principle, examples where the concept is misunderstood or has been difficult to achieve*
- Is the County currently involved in any initiatives to work on these concepts? (What types of barriers has the County encountered in the particular area? Where has the County experienced success? Are there any long-term initiatives that may complement/conflict with a system of care initiative?)

Infrastructure

- Where are decision-making points in the local system of care? Who are the key decision-makers? What partners have strong influence on decisions about service delivery and enhancement of services in the County?
- The SAMHSA-funded system of care requires
    - Collaborative governance structures and decision-making processes (i.e., a Governing Body with strong parent representation and input, representatives of all key agencies) – are these collaborative decisions currently being made in the County? What barriers would need to be overcome to move towards this collaborative process?
    - Movement towards seamless financing (need to define this in greater detail)
    - Coordinated training efforts to build workforce capacity. What training initiatives are currently in place/being considered? What successes/issues have come out of past workforce training initiatives?
    - A comprehensive continuum of services to be available in the County (or through partnerships, new efforts). Where are there current gaps in the service delivery system? Are there efforts to currently address this gap?
    - A fiscal host and principle investigator able to meet the requirements of the grant. Where would a SAMHSA-funded grant likely be housed? Are there leaders in place to fill key roles to implement grant activities?

Overall assessment

- What are the implications on recent budget cuts to the children's mental health system? Are there services at risk? How are these issues being addressed?
- Based on your understanding of the current mental health system, what are the biggest barriers to local system change? What are the strengths the County can build on when working towards system change?
- Are there other important factors the County should consider before submitting an application for funding?
- From your perspective, what steps need to happen for Hennepin County to build consensus around key system change priorities and increase support on these issues?

Other resources/contacts

- Are there any key stakeholders you would also suggest we talk to?
- If any important resources/potential sources of secondary data were discussed during the interview - request copies.

Provider survey data tables

A1. Role of survey respondents (N=43)

What best describes your role? Check all that apply.	N	%
Agency administrator	22	51%
Supervisor	17	40%
Direct service provider	16	37%
Other	3	7%

Cultural competence

A2. Open-ended question: How do you define "culturally competent" mental health services for children/youth?

How do you define "culturally competent" mental health services for children/youth?
A service provided by a mental health provider who is of the same culture as the client and/or by a provider who has been trained and has the experience in a specific culture.
Ability to communicate fluently in the language of the client. Know intimately their culture and be able to assist the client in their successful assimilation to the US culture.
Able to provide services proficiently for a variety of cultural/racial/ethnic backgrounds.
Bilingual, bicultural. An awareness and understanding of one's culture and worldview.
Cultural and linguistic match is desired but not always possible. Providers should demonstrate open minds, curiosity, relational acumen, and respect.
Culturally competent does not mean that just because you speak the language you are covered. You need to have knowledge of the breakdown of each community. For example, to speak Spanish does not mean you are competent in the Latino community because we are at least 16 communities in our own. Same thing for the Asian and African communities.
Culturally competent services are services provided by a staff with understanding and respect to the child's culture and ethnic background.
Culturally competent services are those in which the provider has an understanding of, and interest in, other cultures and how a person's culture, impacted by the dominant culture, impacts their mental health services.
Culturally competent services encompasses an understanding of all dimensions of a client's culture and an ability to interface in ways that engender the client experiencing respect, understanding and ability to move forward without barriers in regard to race, ethnicity, language, socioeconomic and familial context, etc.
Delivered by staff who have knowledge about the culture of the child and family, are respectful towards members of that culture, understand the idiosyncrasies of the members of the culture and have a particular interest in working with members of that cultural group.
Delivered in an ethnically sensitive environment, respectful of family culture by therapists who preferably speak the common language.

A2. Open-ended question: How do you define "culturally competent" mental health services for children/youth? (continued)

How do you define "culturally competent" mental health services for children/youth?
Different language capacities. Providers that represent the cultures served or demonstrate an understanding of how to work across cultures. Services that address culture and build a connection to culture and to protective factors.
I define it as attitudes, beliefs and behaviors that are culturally appropriate.
It goes beyond knowing facts about countries and culture to having an open attitude and getting out of your own box to see things from others perspective.
Knowing the cultures that you are working with so that you are aware of the differences and can adjust as needed.
Language appropriate, holistic, family involvement, values aware, community based.
Mental health services in which there are providers fluent in different languages and educated in different cultures. Ideally there would be providers who are themselves from different cultures and originally from a country other than the United States to provide mental health services for children and youth.
Not sure. Competent is defined as having suitable or sufficient skill, knowledge, experience, etc., for some purpose. Having enough skill should come from training. Having enough knowledge would come from book learning and enough assessment time to determine what the individual's culture is. Experience would come from years of practice with clients who would share cultural similarities. Culture is really about knowing an individual and the multiple cultures that the individual navigates. Knowing what is a cultural value and what is a universal human truth. Just being from a culture may not make you competent but may make you blind to a cultural value that conflicts with a universal truth. The culturally competent provider would be able to help the individual work within their belief system to be able to see another alternative. Cultural competence in mental health is particularly difficult because our clients live in multiple cultural groups. Providing culturally competent services to a 14 year old female, Native American and African American young woman who presents herself as bisexual from a mother with high socioeconomic status and a father who has a substance abuse pattern from a low socioeconomic level who is going to a highly Christian school, with Goth friends, whose aunt committed suicide but the family was unwilling to talk about her mental health, whose grandmother is a pagan and she personally identifies herself as a vampire, and does not even want to talk about the baby-daddy present with so many cultural issues that it is hard to attend to them all. The provider would just have to be willing to open themselves up to hear a culture from the client's perspective. Most frequently we talk about the color of people's skin or language as being the most defining cultural issues but frequently this isn't even scratching the surface.
Providers that have knowledge and experience working with cultures other than their own. Providers who are sensitive, aware and accepting that differences exist between people from different cultures.
Services provided by a provider who speaks the language and has the cultural background of the youth/family being served. Or a provider who has training and experience working with specific populations of color/ethnicity.
Services provided with knowledge of the role of culture in people's lives, sensitivity to cultural differences, and appropriate knowledge about the specific culture of a client to the degree possible.
Services that are effective in meeting the cultural needs of children and families must be timely.

A2. Open-ended question: How do you define "culturally competent" mental health services for children/youth? (continued)

How do you define "culturally competent" mental health services for children/youth?
Services that are offered in ways that are responsive to all cultures and provided by staff who are culturally diverse. All services need to respect cultural differences and be available in a variety of ways to make them more accessible to people from different cultures. Language needs to be clearly understood. Awareness of possible cultural differences has to be a high priority.
Services that are provided with attention, respect, and consideration to the cultural needs and background of a client. While the provider may not know all that each culture entails, it is important for the provider to identify this need and complete the necessary research involved. This is also an area that needs to be shared within the client-provider relationship as it affects the relationship and the client may share their knowledge, experience and expertise in a particular culture(s).
Services that take into account the cultural background of the children/youth and their families. They are informed by best practices as related to culture, and as a part of the service, has a feedback loop that ensures children and families are receiving culturally appropriate services.
Someone able to understand, empathize and be able to understand what the world looks like from an 'other than what the clinician culture' looks like.
Strong knowledge or cultural factors and influence upon individual and family seeking services. Speak language of client you are serving.
That the provider has adequate knowledge base, comfort and experience with the culture.
The capacity to work with effectively with people from a variety of ethnic, political, economic, and religious backgrounds. It is being aware and respectful of the values, beliefs, traditions, customs and parenting styles of those we serve. It requires flexibility in service delivery and understanding how we are different from one another.
The provision of culturally and linguistically appropriate and accessible mental health services regardless of race, gender, age, disability, sexual orientation, national origin, language, religion or socioeconomic status challenges state mental health agencies to develop, expand, and evaluate effective, culturally competent services and treatment methods. Ideally, services that can be provided in client's primary language by a provider who can understand and relate to the clients cultural world view. Next best option, needed paperwork provided in client's primary language, and providers that understand that alternate world and cultural views impact a clients perspective and having providers that have an understanding of what some of those perspectives may be through education on cultures frequently served by an agency and providers that are willing to understand the perspective of the client they serve.
The services are delivered in a method/process that respects the family's ethnicity/culture. Language, location, who participates, and who provides the service, are all factors. I do not believe that any one of these factors is more important than the others.
Understanding and respect for cultural differences, interpreter services or people who speak the language providing service.
We've used the DHS definition.

A2. Open-ended question: How do you define "culturally competent" mental health services for children/youth? (continued)

How do you define "culturally competent" mental health services for children/youth?
We agree with the following: "Cultural competence is the capacity to work effectively with people from a variety of ethnic, cultural, political, economic, and religious backgrounds. It is being aware and respectful of the values, beliefs, traditions, customs, and parenting styles of those we serve, while understanding that there is often as wide a range of differences within groups (e.g., Native Americans) as between them. It is being aware of how our own culture influences how we view others. Cultural competency is about developing skills. This includes improving your ability to control or change your own false beliefs, assumptions, and stereotypes; to think flexibly; to find sources of information about those who are different from you; and to recognize that your own thinking is not the only way." Jordan Institute for Families, 1999.
When, as often as possible, the practitioner reflects the cultural identity of the client. When this is not possible, a practitioner who has experience and knowledge working with that specific population. It also includes linguistic appropriateness.

A3. Agency expertise providing culturally competent mental health services for specific populations

Does your agency have expertise providing culturally competent mental health services for any specific populations?	N	%
Yes	26	61%
No	2	5%
It depends on the type of service	6	14%
Not sure	1	2%
Not applicable	1	2%

A4. Open-ended question: Please identify any specific cultural populations your agency has expertise serving.

Please identify any specific cultural populations your agency has expertise serving	N
Chicano/Latino/Hispanic/Spanish speaking populations	17
African American	15
African/Somali	10
Native American	7
Hmong/Southeast Asian/Cambodian	6
Lesbian, gay, bisexual, transgender (LGBT)	3
Deaf/hard of hearing	2
Those living in poverty/low SES	2
Caucasian	2
Homeless youth	1
Uninsured youth	1
Other	3

A5. Provider knowledge of cultural needs and appropriate practices

How much do you agree or disagree with the following items?	N	Strongly agree	Agree	Disagree	Strongly disagree	Not sure/not applicable
I am knowledgeable about the service needs of youth from diverse cultural and ethnic groups.	37	24%	70%	0%	0%	5%
I am knowledgeable about clinical practices designed, or proven to be effective, for diverse cultural and ethnic groups.	36	19%	44%	8%	3%	25%
I adequately address the needs of youth from diverse cultural and ethnic communities.	36	16%	56%	3%	0%	25%
I am knowledgeable about the service needs of sexual minority youth.	36	19%	47%	14%	0%	19%
I am knowledgeable about clinical practices designed, or proven to be effective, for sexual minority youth.	36	19%	28%	22%	0%	31%
I adequately address the needs of sexual minority youth.	36	16%	38%	15%	0%	31%
I am knowledgeable about the service needs of youth from different socioeconomic groups.	37	38%	54%	0%	0%0	0%
I am knowledgeable about clinical practices designed, or proven to be effective, for diverse socioeconomic groups.	37	24%	54%	3%	3%	16%
I adequately address the needs of youth from diverse socioeconomic groups.	37	35%	51%	0%	0%	13%
I am able to engage parents/families from different cultural backgrounds.	37	35%	51%	0%	0%	13%

A6. Fluency of clinical staff

Are any of the clinical staff in your agency fluent in languages other than English?	N	%
Yes	29	78%
No	7	19%
Not sure	1	3%

A7. Open-ended question: What languages?

What languages?	N
ASL/sign language	5
Spanish	14
French	4
Somali	5
Hmong	4
Khmer	1
Nigerian	1
Liberian	1
Cambodian	1
Oromo	1
Arabic	1
Thai	1
Lao	1
Russian	2
Vietnamese	1
Swahili	1

A8. Access to qualified interpreters

Does your agency have adequate access to qualified interpreters?	N	%
Yes	21	58%
No	8	22%
Not sure	2	6%
Not applicable	5	14%

A9. Agency-level cultural competency efforts

Does your agency...	N	Yes	No	Not sure/not applicable
have funding set aside for the development of culturally competent services throughout your organization?	36	50%	31%	19%
collaborate with other community-based organizations to address the health/mental health needs of diverse groups in your service area?	36	83%	11%	6%
display culturally diverse materials and/or décor?	36	83%	11%	6%
provide written materials (such as brochures, forms, or educational materials) in languages other than English?	36	56%	39%	5%
use assessments and/or diagnostic protocols that are created or adapted for specific cultural groups?	36	42%	33%	25%
provide in-service training on cultural competency for all staff?	36	89%	3%	8%

A10. Inclusion of culturally-relevant resources in service plans

How often are the following service providers and/or agencies integrated in the development of treatment/service plans for children or youth?	N	Frequently	Occasionally	Never	Not sure/not applicable
Traditional healers or cultural health care providers	35	20%	46%	6%	29%
Faith-based agencies/religious or spiritual leaders	35	11%	63%	3%	23%
Bilingual service agencies	35	34%	57%	0%	8%
Natural supports or informal supports (friends, family members)	35	94%	4%	0%	3%
Culturally specific agencies	35	49%	46%	0%	6%

A11. Open-ended question: What are the greatest barriers to providing culturally competent services?

What are the greatest barriers to providing culturally competent services?
The Medical Assistance/HMO model. Lack of resources to help families with practical problems of everyday living. Fragmented services.
A lack of qualified mental health professionals from various cultures who are willing to work for non-profit rates.
Attitudes on part of clinicians that their view is the best view.
Bi-lingual therapists; assessment tools normed for multiple cultures.
Emphasis on licensure.
Finances and staff trends.
Finding and maintaining qualified staff and providing ongoing training and best practices.
Finding qualified staff.
Funding for collaboration and coordination efforts that are not billable services. Funding for training. Although we have some training, budget it is not adequate. Funding for psychological test kits that are culturally appropriate. Funding for culturally appropriate books, tools, games etc. to help providers work with culturally specific groups.
Lack of a diverse trained pool of licensed mental health professionals.
Lack of agencies available to provide services.
Lack of awareness and training – funding.
Lack of bicultural staff and insensitivity to culturally diverse clients.
Lack of knowledge, rigid attitudes.
Lack of mental health providers available for hire that are from minority cultures or are bi-lingual.
Lack of trained mental health professionals from minority backgrounds.
Language and use of interpreters.
Location of services, public transportation.
Money for training, salaries, etc.
Most licensed MH professionals are still from the dominant culture. Some cultures understanding mental health issues and being open to seeking help for such issues.
Not being able to speak in the client's language. Not having intimate knowledge of the client's culture.
Provider experience, time to ask the questions is needed. Reimbursement for time to find out what the culture of the client is. It is not a skill that the provider is providing and it is not part a of CBT (cognitive behavioral therapy?) so it is not very reimbursable.
Resources – money and time.
Small cultural diversity in our catchment area. Very low need equals very low need for services.
Sometimes the biggest barrier is the client themselves in regards to trust. It can be difficult for some families to trust providers of different cultures.
Staff time for training; more providers of service from diverse cultural groups.

A11. Open-ended question: What are the greatest barriers to providing culturally competent services? (continued)

What are the greatest barriers to providing culturally competent services?
Stigma of receiving mental health services. Getting the word out and letting communities of color know that we provide culturally competent services.
The lack of common definition for what this means. If it means language, then the shortage of licensed folks who speak more than English is difficult. If it is cultural background, then the lack of licensed/trained folks who have spent "meaningful" time living in the culture.
The number one barrier is being required to use the medical model exclusively with children and families. Medical Assistance, PMAP's and the more traditional plans are Caucasian based. They believe in the concept of the "identified client" which opposes the communal nature of non-Caucasian cultures. Many Non-Caucasian cultures are distrustful of the medical model and view it as pathologizing vs. strength based. The advent of forcing service providers to move families into these systems of care in early 2000 in Hennepin County directly contradicts participatory action research done in the 1980's which resulted in the family preservation movement. Family preservation is about open and more flexible service delivery systems in which respect for and work with families, extended families, and community is viewed as essential. Increased flexibility in systems of care allows practitioners to help families and children with psychosocial stressors that impact ability to effectively engage in mental health services. Low income and non-Caucasian families struggling day in and out with psychosocial stressors are looking first for practical help vs. engagement in diagnostic assessments, clinically based treatment plans and traditional therapies. Denials and threats of denials of payment for services straying from the medical model have created disincentive for service providers to provide culturally competent services.
The variety of cultures that we work with necessitate ongoing training and learning that there is often not enough time or funding to provide to staff. Hiring and retaining a diverse staff is also difficult, but crucial to providing culturally sensitive services. Language can also be a barrier especially when some families do not want an interpreter from their culture due to privacy concerns.
We as an agency do not have a barrier in providing services to the Chicano Latino community because this is who we are. But, we don't provide services to other cultural communities because we don't speak the language and don't believe in having interpreters in session, just not correct.

A12. Open-ended question: What resources and or training would help staff at your agency enhance their ability to provide culturally and/or linguistically competent services?

What resources and or training would help staff at your agency enhance their ability to provide culturally and/or linguistically competent services?
Additional human resources that are bilingual, Spanish/English.
Again, it is really about money.
Again, resources to help people of color move up the licensure pipeline.
Agencies willing to consult with others.
Bringing in someone who has been providing services to the Chicano Latino community and he or she could share with us what they see coming down the road.
Continued cultural sensitivity training.
Funding for trainings or free trainings related to cultural competency specifically related to mental health would be helpful.
Having the staff who have the skill and want to be hired for what the position pays. Paid training time, free for the staff and the agency is paid for the time for the staff to not see clients. A complete list of services that is centralized and some accounting for the financial costs of staff's time to access and utilize the information.
I think we do a pretty good job here.
Increased access to affordable and knowledgeable trainers to educate staff on cultural issues AND how this interacts with mental health needs.
Language support classes, tuition reimbursement, and funding to pay bilingual staff.
MA rates that near the cost of providing services – this is not said lightly; many clients from minority cultures have MA or no insurance. If reimbursement were reasonable, lots of other stuff would fall into place, like training, interpreter services, etc.
Mental health service providers working with families and children involved in County systems of care need more flexible service models and/or resources to provide therapeutic recreation and psychosocial support within residing communities. In-services on working with diverse populations are always valuable. Our agency knows little about working with the Somali population. It is great learning about how to provide culturally competent services and frustrating working in systems of care that don't allow it.
Money – more access to training programs that could send interns who then could be hired on.
More training is always good. If the training is done from the perspective that we are improving the ability to deliver meaningful services than everyone benefits.
NA
Not sure.
Obtaining more staff fluent in other languages than English.
Ongoing culturally competent in services and trainings. Though this too has been hard. The last 2 persons (Somali and Latino given from a reliable referral source) never returned multiple phone calls, where messages were left with comments their trainings would be financially reimbursed. This is not an unusual problem for us.

A12. Open-ended question: What resources and or training would help staff at your agency enhance their ability to provide culturally and/or linguistically competent services? (continued)

What resources and or training would help staff at your agency enhance their ability to provide culturally and/or linguistically competent services?
Resources to mentor individuals from minority groups to become mental health providers in our agency. Staff training on site in how to work with members of various groups.
See above. (2 respondents)
Staff training development program.
Support language and cultural training (i.e., pay for it).
Training that goes beyond basic diversity training and addresses the concepts above – culturally competent DA's (that still meet DHS guidelines), how mental health is viewed by various cultures and how they respond to those issues/needs, etc.
Unsure.
We do a pretty good job of providing staff trainings in regard to culturally competent services. Outside training is always welcome and is difficult to find.

Family involvement

A13. Open-ended question: How do you define "family driven" mental health services for children/youth?

How do you define "family driven" mental health services for children/youth?
1) Focus on children's needs within the family. 2) How to address those needs through a systems approach viewing the adult(s) in the child's life as central to the solution. 3) Adapting to family's needs according to what they bring in, culturally, developmentally, spiritually and in accordance with presenting issues. 4) Looking at them in terms of larger contexts e.g., work, education, employment/earnings, faith community, health and so on, and working with that in mind.
Actively involve families in the treatment process. Building the goals, objectives and interventions on the treatment plan WITH the family to best understand what they are wanting and needing for their child and family so that the focus will be on what the family needs.
Addressing clinical issues from an understanding that the condition of one member impacts and can be impacting to all other family members.
Based on research and statistics obtained from mental health consumers (the children and guardians) input has resulted in mental health services specifically offered as helpful based on the results from this data.
Child (if an appropriate age) and family members/care givers are a part of the development of the treatment plan, and the review of treatment progress.
Collaborate with parents to define treatment goals and evaluate "success" – involvement of family members in treatment (i.e., reshaping the family environment).

A13. Open-ended question: How do you define "family driven" mental health services for children/youth? (continued)

How do you define "family driven" mental health services for children/youth?
Families need to be involved in developing and carrying out treatment plans. Parents need to trust and partner with providers. Parents' values and culture must be taken into account in describing, offering, and providing mental health services to children/youth.
Family as key and full partner and driver of treatment and care plan.
Family driven mental health services would seem to be services that are delivered with the family's choices respected in regards to providers and treatment preferences.
Family driven practitioners view the system (whatever it may be) as the client vs. primary focus on an "identified client." Prognosis for increased functioning is improved by leveraging the family system rather than working with an individual in isolation. If you can move the system forward by reducing psychosocial stress, you are able to address mental health issues more effectively.
Family driven services are those that recognize that all children are part of a family that need to be respected partners in the treatment process.
Family identifies what they find effective, how they can access the services, at what pace, with what interventions, where, and toward what goals.
Family is involved in setting goals for child and family and then participates where needed.
Focusing on a family, "systems" approach as opposed to individual work with youth. Engaging the family and involving them in treatment.
Having the focus be on what the family is wanting.
I really hate all the trendy language. I have ALWAYS tried to involve family as much as possible, keeping in mind that when dealing with an adolescent vs. a young child, it may not be in the adolescent's best interest to let family "drive" the treatment. I see our work with families as a collaboration.
If mom and dad have equal say in the treatment of their child and that all communications is done in their language without an interpreter.
Inclusion of extended family and recognition of import of family unit.
Involves parents/caregivers as knowledgeable about children. Engages parents in goal-setting and in skill building. Engages parents as partners. Gives parents resources and teaches them to advocate. Considers non-traditional family structures. Allows family to define itself.
Mental health services from a systems perspective.
Never heard this term – prefer "relational and systemic."
Parents are involved in planning their participation in services from Intake on; parents involved in deciding what services are appropriate and involved in measuring treatment effectiveness as well as deciding discharge.
Services that engage the guardians of the children served and incorporate the aims, wishes and goals of the guardians into treatment planning.
Services that initiate full involvement of child and family in planning services.
Services that respond for full family dynamics and engage the full family in services.

A13. Open-ended question: How do you define "family driven" mental health services for children/youth? (continued)

How do you define "family driven" mental health services for children/youth?
Services where parents and/or caregivers are empowered to express their needs and lead the team in developing the treatment plan for their child.
Services where the family is the primary decision maker on the treatment plans.
The family is empowered to identify and express their needs and goals are developed around such.
The family is involved, to the ability, in all aspects of the process. This includes education about services, education about service providers, education and input on treatment plan, ongoing input into the services process, ongoing education about what is being provided and how the services should be impacting the child/family.
The services are strength based and inclusive of family members!

A14. Agency efforts to promote family involvement

To what extent do you agree or disagree that your agency	N	Strongly agree	Agree	Disagree	Strongly disagree	Not sure/not applicable
involves parents/caregivers in setting goals and making service decisions for their child?	34	91%	6%	0%	0%	3%
values the involvement of parents/caregivers?	35	94%	6%	0%	0%	0%
provides staff with training about effectively engaging parents/caregivers in the treatment process?	35	80%	17%	3%	0%	0%
provides advocacy or support to parents?	34	79%	21%	0%	0%	0%
involves parents/caregivers in agency leadership (such as serving on boards or committees)?	34	38%	26%	15%	3%	18%
offers opportunities for consumers to be involved in service delivery (i.e., consumer-run services, such as peer support groups)?	34	32%	21%	24%	0%	24%

A15. Open-ended question: What are the greatest barriers to meaningfully involving parents/caregivers in mental health services for children/youth?

What are the greatest barriers to meaningfully involving parents/caregivers in mental health services for children/youth?
Availability of hours working parents can be seen. Day care for siblings of children in treatment.
Being able to contact/connect initially with the parents/care givers.
Budgets are developed based on fee for services and a high percent of staff productivity. If there is no revenue for a particular service it is not given a high priority. There is no funding to have a staff assigned to develop and support a meaningful parent advocacy/support program.
Family situations; transportation; availability of support to families so they can participate – issues related to stigma of mental health.
Getting parents to trust agencies and institutions that impact their lives.
Involvement.
Lack of information or access, lack of interest, various stressors that impede family involvement.
Lack of transportation, money, childcare, parent can't get off work, parent simply wants us to "fix" the child, chaotic families with numerous problems.
Language, cultural understanding and consideration that family should be included in the diagnostic and treatment process.
Medical Assistance requires the identified client to be present when engaging in services. This rule took away our ability to work with parents alone prior to children transitioning from out of home placements. Very often parents need a great deal of individual work not appropriate for inclusion of children in order to be more effective. Although there are ways to get around this at times by working with them through their own systems of care, services become fragmented with more minutia and less client contact.
No funding for talking with the parent by phone for 30 minutes. Significant restrictions on how to involve family in services. For example, family skills requires child to be present at all times – sometimes, that is not what is best for the child.
Parent availability during program hour.
Parent have transportation barriers, they have their own mental health issues that impact their involvement.
Parents are often stressed and do not have the financial or time to participate.
Parents are overwhelmed, looking for help/support from outside provider. Parents are aware of some services but not aware of the whole continuum of available services.
Parents are overwhelmed.
Parents not making their children's mental health a priority.
Parents' time.
Parents' willingness and availability to be involved.
Parents work schedules. Parents transportation options. Not having daycare for younger children.
Psychologists and the DSM.

A15. Open-ended question: What are the greatest barriers to meaningfully involving parents/caregivers in mental health services for children/youth? (continued)

What are the greatest barriers to meaningfully involving parents/caregivers in mental health services for children/youth?
Some parents do not have the energy or willingness to be involved at any level. Many parents are difficult to reach and their children are seen without parents being there (school settings). There are sometimes language barriers and some parents have their own mental health issues that keep them from participating fully.
Sometimes parents don't want to be involved or sometimes, they want things or resources that are difficult to provide. We have had parents who won't sign treatment plans even though we have revised them several times to the parents' wishes.
That parent's work two jobs and can't make appointments.
The complexity of our client needs.
Their income levels preclude their spending much time; physically getting to the meeting place.
Their time.
Time. Location. Busy family schedules. Preoccupation with basic needs/survival.
Time restraints of parents.
Transportation. Stigma. Overcoming parents being undervalued by other systems.
When children are identified as the patient, they are often referred in that context because parents see the child as the problem. Doing this keeps them from looking at their culpability in the problem (if they have been part of the problem), and therefore reduces their need to see themselves as part of the solution. Targeting the kid as the problem keeps them from looking at themselves. This answer is from a strictly clinical "I have a child in my office and this is the presenting problem and family context I need to address right now" point of view. Other issues pertinent to the question but not necessarily clinical are those already described in this survey, money, insurance, transportation, buy in and so on.
Work schedule of parents, frustration level of parents, parent's previous experience with providers, and parent's lack of involvement with their child.

A16. Open-ended question: What resources and/or training would help staff at your agency enhance their ability to involve parents/caregivers in mental health services for children/youth?

What resources and/or training would help staff at your agency enhance their ability to involve parents/caregivers in mental health services for children/youth?
Again, MA rates that cover the cost of services.
Again, resources to sustain services that are accessible (i.e., in-home, etc.).
Better funding for in-home services.
Continue to train staff on ways to partner with families to elicit the highest involvement possible from the parents/caregivers.
Continued cultural competency training.
Continued mental health education/training specifically regarding youth and their families.
Don't think it would be an agency enhancement – need more support to parents in being able to physically access services and have time and energy to do so.
Either the systems of care need to change to include the entire family as the client and allow for more flexibility, or resources need to be built into contracts for providers to work with primary care givers.
Funding.
Help with transportation and childcare, providing services in places besides the clinic, such as at school.
How to engage clients at the beginning and deal with ambivalence.
I think we do this area pretty well but could always benefit from this training.
NA.
Not sure.
Onsite daycare option. Transportation reimbursement.
Ongoing trainings on blended family work and how to get parental buy in, especially when the child is seen as the problem by them. Working with parent's resistance born out of their own shame/guilt. Working with the chemically problematic family (teens present with chem. issues, but upon further investigation it's found that parents have significant CD problems themselves and in too many cases not just model poor chemical health behaviors, but actually nurture that with their children). Working with divorced parents with very different child rearing philosophies and unresolved anger/hurt/etc. issues between them, where the child becomes or is the pawn in the middle.
Provide trainings in Spanish for parents and not use an interpreter.
Staff training dollars.
Stress importance of parental involvement.
This is a strength for our agency; our primary license is LMFT – this is their training.
Training on how to engage difficult families.
Training on new or more effective ways to engage "resistant" parents beyond the intense efforts staff are already doing to engage parents.
Transportation. Stipends.
Unsure.

Accessibility

A17. Open ended question: How do you define "accessible" mental health services for children/youth?

How do you define "accessible" mental health services for children/youth?
"Accessible" mental health services are those services that a family can gain access to despite their circumstances (home-bound, low SES, lack of transportation, etc.).
Affordable, in most cases with Hennepin County CTSS clients it needs to be free of charge. Providers who acknowledge and accommodate for transportation challenges. Timely response from service provider. Respectful, engaging, culturally competent service providers. Recognition and attention to practical needs of everyday living that impact client's ability to engage in mental health services. Health maintenance programs that remain stable over time vs. shifting from one month to the next.
Access or ability to receive competent mental health services within reasonable distance and at reasonable cost for parent/caregiver.
Access to services that are where the children are, make it easy for the family/child to receive services, (i.e., in-home or on-site where the children attends an early childhood program), are relevant to the family in terms of how the service is delivered, and is a good "fit" for the family in terms of all dimensions of cultural understanding and context.
Accessible meaning: affordable, location that can be reached without much difficulty, appointments that can be made without a long wait, language and culturally competent.
Affordable (that often means free or paid for by the county, PMAP, etc.), timely (meaning they don't have to wait a month), respectful services that accommodate the child's/youth's and their family's needs, which may include in-home, non-traditional, and time intensive services, covering a multiplicity of issues.
Affordable services. Resources when they can't afford their co-pays and co-insurances. Quick response from a provider when requesting a mental health services. Services from a provider who understands their culture. An appointment within a reasonable time frame, one to two weeks.
Appropriate services are available and affordable with a reasonable waiting time.
Availability of scheduled times, and locations that clients can be seen as well as accessible in terms of style that engages youth at an appropriate developmental level, accounting for cultural competence.
Available to all children without regard to funding, located within a half hour of the child's home, and available within a month's time from request for service.
Clinic is located geographically accessible, including by bus. Clinic(s) accept all forms of insurance, including MA. Clinic has a waiting time of no more than 4 weeks for assessment, psychiatric evaluation, and therapy.
Define accessible as being available.
Easy to access (get service needs define, begin treatment) as early as need is identified...minimal financial, transportation, cultural, scheduling, or 'off-putting' (e.g., not comfortable with provider or concerned about stigma) barriers.
Free or very low-cost. No waiting list or a very short waiting list. Easy to get to in terms of transportation.

A17. Open ended question: How do you define "accessible" mental health services for children/youth? (continued)

How do you define "accessible" mental health services for children/youth?
Information is readily available and available in different languages to better serve the multicultural community. Contact information is also readily available making it easy for client's to call and speak to someone about services or a referral.
It means that all families can get mental health services in their own language and are treated equal like all families. That agencies don't put up road blocks, i.e., government and non profits. That payment is not the main issue in getting help.
Physically accessible, affordable and culturally competent. Physically includes a location that is easily accessible by public transportation as well as car and that can comfortably accommodate a wide variety of physical and emotional handicaps and could include on-site services at home or other community based settings.
Prepared educationally and experientially to meet the specific clinical needs. Able to meet with them where they are, which may mean school or home as well as in the clinic setting. Able to communicate to them in their language and with an intimate understanding of their culture.
Rapid response, prompt intake, personal (rather than automated), prompt communication of status and changes, culturally appropriate, community based, integrated, collaborative.
Readily available mental health services within 2 weeks for non crisis issues and immediately for crisis situations. Linguistically and appropriate mental health services to all populations seeking.
Reduced or 'no' barriers to service. Barriers include income, insurance coverage, the ability or lack thereof to pay deductibles and co-pays, transportation, stigma, parental disagreements for services for a child. There are more, but this will give the reader an idea of what the writer is intending.
Service that are close to the client and are available when needed.
Services in which children/youth and their guardians are able to get the mental health services they need in a timely manner dependent on the level of severity of their needs at the time of the request.
Services located where kids spend their time (i.e.,. schools, home), are culturally respectful, are affordable, timely.
Services provided in settings in which they already participate/reside; no "red tape"; no "middle people" – they can walk it, ask for it, get it; as close to 24/7 as possible.
Services that are affordable, geographically convenient, and often with minimal parental involvement (parent lack of availability). They also need to be available quickly after referral and happen at convenient times.
Services that are available in their community if possible, and that families can financially afford. A range of services is needed, one size does not fit all.
Services that are available in the child's community e.g., at a clinic, school or home. Services that affordable e.g., for those without insurance.
Services that are available to meet clients needs that are effective, of high quality, and easily made available without undue bureaucracy, etc.

A17. Open ended question: How do you define "accessible" mental health services for children/youth? (continued)

How do you define "accessible" mental health services for children/youth?
Services that children/youth can use at times that are reasonable, in settings that are appropriate to their needs, provided by professionals who have skills in addressing their mental health needs while competent in addressing cultural and spiritual variables. Additionally, accessible services also mean that service providers are able to appropriately consult with others involved in the child/youth's care – parents, educators, psychiatrists and other services providers.
Services that are offered/delivered in a way that makes sense for each individual's situation.
Services that are located in a child's community and that are flexible with hours. Services should also be flexible with the location and with funding/payee sources.
Services that are community based culturally competent and effective.
That the service is available immediately in a time, location and language that is comfortable for the participant.
Short waiting period to get an appointment, crisis services, interpreter services, in-school and in home services.
Services that families can receive within normal standards for timeliness and with as few barriers as possible, cultural, linguistic, transportation, financial.
The services are affordable, offered at locations the person/family can get to with a minimal amount of effort. The services are provided in a method that is effective for the child and family.

A18. Agency efforts to promote accessibility

Does your agency….	N	A lot	A little	Not at all	Not sure/not applicable
Offer any services in non-clinic community locations, such as schools or community centers?	39	82%	10%	8%	0%
Provide transportation for families wishing to receive services at your agency?	39	10%	59%	31%	0%
Offer any services during evening hours?	38	47%	50%	3%	0%
Offer any services on weekends?	39	23%	38%	38%	0%
Provide crisis support to families outside of business hours?	39	18%	51%	31%	0%
Offer any services for free?	39	21%	49%	25%	5%
Offer any services on a sliding fee scale?	39	33%	44%	23%	0%
Provide child care for families while they are participating in services?	39	3%	33%	61%	3%
Offer any direct services or referrals to help families meet other needs (such as housing, clothing, basic needs, or services to parents)?	39	72%	18%	10%	0%
Have reception staff who can greet clients in languages other than English?	39	23%	18%	56%	3%

A19. Types of insurance accepted by providers

What types of insurance are accepted at your agency? (check all that apply) (N=43)	% accepting insurance
Straight MA	84%
MHP	79%
UCARE	79%
Medica	79%
Blue Cross/Blue Shield	74%
Health Partners	70%
Other HMO	49%
Other non-HMO	47%
Not sure	5%
Not applicable	2%

A20. Prevalence of waiting lists

Does your agency generally have a waiting list for children/youth?	N	%
It depends on the type of service	14	36%
No	14	36%
Yes	9	23%
Not applicable	2	5%
Not sure	0	0%

A21. Open ended question: What is the average number of days that children/ youth usually stay on the waiting list?

What is the average number of days that children/youth usually stay on the waiting list?
1-2 weeks. (4 respondents)
1-3 months. (4 respondents)
Around 3 weeks. (2 respondents)
Depends on program/services. (4 respondents)
Depends on the program; for day treatment 90-120 days.
Depends on the service: 7 days for services, 90 for evaluations.
Don't know/not sure. (2 respondents)
Homeless youth shelter can have waiting lists on occasion, don't know average length, highly dependent on the week.
Varies by program – from a few weeks to a few months.
Varies by program area – it can be as little as a week and as long as several months (day treatment).

B22. Open ended question: What are the greatest barriers to accessibility of mental health services for children/youth?

What are the greatest barriers to accessibility of mental health services for children/ youth?
Transportation. Lack of trust and "buy in" from children's primary care givers (e.g., the clinical, symptom focused nature of the MA/medical model is not easily trusted or understood and is often viewed as impractical and pathology based). This is especially prevalent for non-Caucasian families and children. Struggles managing problems of everyday living. Lack of information (e.g., where to find a culturally competent provider, how to access services, what to expect from receiving services). Ever decreasing amounts of support and accountability from Child Protection, Juvenile Probation and Children and Family services due to budget constraints dating back to 2002. Fragmented services: MA model is fragmented, e.g., disallows transitional work when kids and families are separated from each other and reuniting. The MA model focuses on "identified clients" and disallows systems work identified as vital through research in the 80's resulting the the family preservation movement. The concept of "identified clients" does not acknowledge the importance of community for non-Caucasian culture's.
Lack of dependable transportation. Lack of information. Lack of trust of traditional medical model service delivery format. Psychosocial stressors. Frequently changing health plans (e.g., month to month). Lack of ability for service providers to work with parents. Lack of ability in health plans to work systemically and eco-systemically with families.
Access points, payment structures, lack of parental consent or follow through once child is identified as in need of mental health intervention.
Appropriately trained providers; lack of common sense when it comes to confidentiality in schools; emphasis on licensed providers.
Availability of needed service and funding for them.
Child care for adults during appointments is a significant challenge, the financial burden, and stigma associated with going to a mental health clinic.
Clinics not accepting MA.
Current reimbursement rates don't allow for much flexibility or provision of services in a variety of settings. For example, while most clinicians want to be able to consult with various service providers involved in the child's care, there is no reimbursement for that service and the rates barely cover the cost of the sessions themselves.
Difficulty with transportation, parent can't get off work, lack of childcare for other kids, lack of provider availability.
Financial/Insurance. Transportation. Language barriers.
Financial issues. Cultural barriers.
Financial obstacles, transportation and general commitment.
Financial resources, family and child is overwhelmed and not able to make all the connections necessary to get the services going/continuing. Families/child are resistant/uneasy about services, family resistant to completing paperwork needed to provide services.
Financial, many families cannot afford co-pays and deductibles. Transportation.
Generally speaking, this does not necessarily refer to the services offered at my clinic. A lack of funds to provide services to those that cannot afford them. Services accessible in clients language.

B22. Open ended question: What are the greatest barriers to accessibility of mental health services for children/youth? (continued)

What are the greatest barriers to accessibility of mental health services for children/ youth?
Greatest barrier is inadequate payment for services; if payment was adequate there would be more services available for children and families. Licensed clinicians from some cultural communities.
Having enough providers, cost, location, culturally appropriate.
Inadequate services for youth needing more intensive care e.g., day treatment, residential treatment, inpatient hospitalization.
Income, insurance or the ability to pay co-pays/deductibles and geographical distance to clinic/ transportation.
Information not available (or not available in their language) to families on what services are out there and how to access them. Transportation can be a barrier for some families. No insurance and unable to self-pay for services can be a barrier.
Insurance not having it or not wanting to fill out form because of status.
Insurance, waiting lists, no transportation.
Lack of bilingual/ bicultural staff, lack of health insurance, transportation, cost.
Lack of funding. Lack of transportation. Lack of motivation (court involvement, consequences for not participating, etc.). Lack of trust. Poor previous experiences in the mental health field. Lack of service providers of color.
Lack of qualified providers, especially psychiatrists. Transportation. Stigma.
Lapses in, or no insurance. Caregivers that may not be consistent in arranging visits for child or they do not show for appointments.
Location – culturally appropriate. Lack of integration/coordination. Confusing systems. Lack of uniformity, re: referral process.
Location/transportation, times of availability.
Long waiting time for services, few coordinating opportunities, lack of providers of color.
Not enough practitioners to meet the need, especially child and adolescent psychiatrists.
Parents that are unwilling to provide the services and make them accessible to youth.
Payment for services. Location of services. The need for parent involvement and parent permission. Transportation.
Professional staff with credentials to do the treatment work; transportation; adequate payment for in-home services.
Stigma that impacts families' willingness to seek help. Limited backgrounds of our therapists – have Spanish speaking therapists but have not been able to hire therapists of other ethnic backgrounds. Transportation is another significant barrier. We offer sliding scale and other no fee programs so affordability is not an issue for us but I believe it generally is.
Transportation or willingness by caregiver to supply or help orchestrate transportation.

A23. Open ended question: What resources and/or training would help staff at your agency enhance the accessibility of mental health services for children/youth?

What resources and/or training would help staff at your agency enhance the accessibility of mental health services for children/youth?
Transportation provided for clients or pay providers to transport clients to appointments. Open systems of care vs. fragmented services (e.g., building resources in service delivery to allow providers to provide mental health services and help families with practical problems of everyday living. Allowance of resources for and acknowledgment of the critical role therapeutic recreation has for families and children. Open service models to include systems/community work with families and children (e.g., more work with extended families, schools, probation officers, child protection workers and any other child and family serving agencies clients are involved with).
Transportation. Resource allocation for mental health providers to help families with psychosocial stressors. Uniform/standardized health plans. Trainings from representatives of health plans to learn how to navigate service delivery systems. More frequent, efficient and meaningful correspondence with representatives from medical assistance, PMAP's and other health plans. More flexible health plans allowing for systemic/eco-systemic work with families and children.
Bilingual brochures, pamphlets of information. Knowledge on transportation resources for our client's to help them get to and from appointments. More support for in-school service, because I have found that most of the youth our agency serves in the schools, would most likely not be receiving that service if we were not right there in the school to provide the service.
Communicating with families about the need for services can always be improved. Financial resources may help but that is more speculative at this point. We have never provided transportation so I am not sure the impact that would have.
County operated vans at numerous pickup sites. Training of more therapists from ethnic and immigrant populations by graduate schools of social work and other counseling programs to develop a larger core of therapists from diverse backgrounds.
DBT training, DC 0-3 training, increased financial support, clinical supervision, and tuition reimbursement.
Familiarity with available services – contact person for questions.
Grants for funding support. Bi-lingual services. Ability to provide transportation access.
Greater resources to implement third party billing structures into a community social service setting, training regarding systems of care and coordination.
Higher salaries; more staff with license to practice independently.
I feel we are well prepared to serve our target population of Latino youth and families.
Improved financial support to help absorb rising transportation costs and bad debt.
Increased funding for low/no income, or the no or underinsured.
Knowing what services are available and funding for them.
Meaningful cultural diversity training, re: needs of various groups.
Mental health training practitioners on new methods and intervention.
Not sure. (2 respondents)

A23. Open ended question: What resources and/or training would help staff at your agency enhance the accessibility of mental health services for children/youth? (continued)

What resources and/or training would help staff at your agency enhance the accessibility of mental health services for children/youth?
Payment for coordination and consultative services. Only getting paid for fee for service doesn't allow staff to be able to spend adequate time in services that are non billable but essential – such as coordination and consultation with others to assist clients.
Resource guide for children's services that includes psychiatric care, agencies working with children/families, community resources.
Resources for the un-insured or under insured. Greater availability of diverse staff with higher levels of training. Increased insurance rates for staff have put barriers on getting into schools. The low rate of reimbursement makes agencies/professionals less likely to go in home for THERAPY since the therapist's time is paid at a travel rate versus paid at a therapy rate plus travel. Cost of high no show rates makes clinics less flexible in offering accessible services, because frequently the more flexible the higher the no shows. Training on engaging clients is needed, how to view no shows are part of the diagnostic picture and use it to engage clients more successfully.
Resources to support clinicians moving up the licensure continuum, particular people of color.
Speak the language of the population you are servicing.
The type of resource we would need is payment for providing the non-billable services and also offsetting the cost of no-show appointments. Families in distress are often not able to have consistent follow through – even when services are provided in their homes. However, agencies that rely on 3rd party funding often find themselves having to discharge families who repeatedly no-show because they offset the costs of not billing.
These items are NOT the issue for accessibility.
Third party billing is a nightmare.
Third party reimbursement levels do not cover the cost of providing services. Closing programs limits the availability of services and impacts waiting lists, locations, etc. Decisions made by other stakeholders regarding things like transportation (bus) also impact our ability to provide services like day treatment. It is hard to get past the financial viability issues.
Training in cultural competency would be valuable in understanding where people are coming from, what they value, what they believe in. Better, more effective work can be done, and stronger relationships can be built when there is an understanding and respect for another's culture. I believe this would help in retaining clients and getting them the help they need.
Training is not the issue what it comes down to is money for agencies to provide the direct services.
Transportation services.
We could use childcare and transportation help.
We have provided mental health education training to provider and member services staff, outreach, and office specialist staff. We also have with some provider agencies the ability to receive quick access for our members for certain mental health services.

Staff training and use of evidence-based practices

A24. Number of clinical staff

How many clinical staff do you have who work with children/youth? (number of FTEs or full-time equivalents)	N
Don't know	2
5 or fewer	4
6 to 10	6
11 to 15	3
16 to 20	3
More than 20	9

A25. Clinician training in children's mental health

Do clinicians at your agency have specific training in providing mental health services to children/youth?	N	%
Yes, all of them	24	69%
Yes, some of them	10	29%
No, none of them	0	0%
Not sure	1	2%

A26. Respondent training in children's mental health

Do you have specific training in providing mental health services to children/youth?	N	%
Yes	29	88%
No	4	12%

A27. Type of training received by respondents

How did you obtain that specific training? (check all that apply)	N	%
Degree program	27	63%
Certificate program	27	63%
Coursework	24	56%
Independent study	18	42%
Workshops, trainings, and in-services	26	61%
Professional experience	28	65%
Other	2	5%

A28. Agency use of established evidence-based programs

Is your agency implementing any established evidence-based programs?	N	%
Yes	28	82%
No	2	6%
Not sure	4	12%

A29. Open-ended question: What evidence-based programs are being implemented?

What evidence-based programs are being implemented?
Aggression Replacement Training. (ART)
Culturally competent services, quality driven outcomes.
Dialectical behavior therapy (DBT). (3 respondents)
Motivational interviewing. (2 respondents)
Eye movement desensitization reprocessing (EMDR). (2 respondents)
EBP.
Use of assessment tools at intake (PHQ-9, SDQ etc.).
Diabetes care, depression care, SPMI.
Trauma Focused Cognitive Behavior Therapy (TFCBT). (4 respondents)
Functional Family Therapy (FFT). (3 respondents)
PMTO (Parent-Skills).
Respect.
Parent Child Psychotherapy.
Yoga Calm. Not sure which ones the school linked programs are using, it is through the state.
Relationship based program for children with autism spectrum disorders; 0-3 evaluation tool.
State training Early Childhood Initiative.
Parenting Through Change Child Development Policing Program (no longer offered due to funding).
Two of us (supervisors) were trained as part of a state grant in evidenced based practices for children and youth. We participate in twice monthly consultation calls regarding cases where we are utilizing evidenced based practices.
Variety of therapies.
We are implementing evidence-based training for our adult programs and would like to do this for our children's programs as well.
We are participating in the MN DHS Children's Mental Health Division Evidenced-based Practices training, implementation and data base. We also participate in the Practice Based Evidence efforts at the University of Minnesota. This is primarily focused on working with individuals in cultural and ethnical minority groups.
We have started the DHS sponsored Evidence Based Practice model with children and adolescents.
Parent Child Interaction Therapy (PCIT). (2 respondents)

A30. Open-ended question: What have been the benefits/advantages of using evidence-based programs?

What have been the benefits/advantages of using evidence-based programs?
Being able to confer with developers of the model re fidelity to the model; consultation with experts.
Consistency in programming. Quality of results.
Don't yet have clinical data.
EBP data base. Specific tools and resources for interventions and outcome measurement.
Effectiveness.
Excellent training.
Funding sources like it; better services.
I'm sure there's a plus side somewhere, but mostly it's restrictive, bureaucratic, and not logistically viable. Often, it doesn't make sense culturally.
Increased knowledge and ability to use CBT in treatment with youth.
New knowledge, expertise for clinical staff. Increased treatment of child trauma. Creation of a more professionally stimulating environment for staff and interns.
Proven effectiveness.
Provides for increased structure and direction for the therapist, some funding has been related to offset costs of learning. Therapists have been more thoughtful about planning sessions.
Satisfies the third party payers.
Setting clearer goals, achieving customer satisfaction.
Third party payers are less able to restrict coverage and like seeing results of research in services that have proof. Client satisfaction and improvements.
Too early to tell.
We have had to make adjustments because the evidence based program did not take into consideration the culture of client.
We have just started to use this and have not measured benefits yet.
We prefer an emphasis on practice-based evidence; common factors approach.

A31. Open-ended question: What have been the challenges/disadvantages of using evidence-based programs?

What have been the challenges/disadvantages of using evidence-based programs?
Adds to paperwork and thus administrative cost.
Challenges adhering to data and consistently reviewing outcomes and training.
Don't know yet.
Engaging clients, parents inconsistency/ambivalence.
Funding. Training. Staff turnover.
Funding for continued training.
Funding to support full implementation.
Just getting folks trained, making sure it's recorded effectively in the chart, demonstrating how it's shown to 3rd party payers and so on.
Keeping exact fidelity to the model, as one's own experience often leads one to divert from the model.
Manualized programs are just that; they are the antithesis of culturally competent.
Many clients have multiple disabilities and diagnosis. Many clients have mental health and chemical health disorders. Many of the EBP are based on studies on children with less complex issues than the ones that we work with.
Securing resource to effectively train, supervise and provide ongoing consultation for staff. Determining which children/families might benefit from an EBP.
See above.
Some rigidity that interferes with clinician's best instincts.
Staying updated on preferred practices as they are identified.
The systems are not culturally competent and they do not measure quality of service but outcomes.
The training is long and only one or two staff can be trained every six months, so it will be a long process to implement.

A32. Open-ended question: What are the priority areas for skill development for you and/or the other staff at your agency?

What are the priority areas for skill development for you and/or the other staff at your agency?
Trainings on working with Somali, Nigerian, Hmong, Hispanic and GLBT populations.
Adolescent and parent DBT programming and interventions that are adherent to DBT practices. Cognitive Behavioral Training – specifically Exposure. 0-3R infant and young child mental health. Motivational Interviewing. Working with dual disordered adolescents.
Assessment, trauma treatment, DC:0-3.
Child and adolescent development. Attachment theory. Trauma based work. DBT or other similar interventions.
Client driven is number one.
Continued education regarding current mental health practices for youth.
Cultural competency. Evidence based practice. Early childhood interventions.
Cultural competence is important. My division often has staff new to the field so there is much focus on service provision, compliance, and client/family engagement, and growing clinical skills in practice. Beyond that focus on ethics, new data as it relates to diagnoses we serve, and systems approaches within a family and the community.
Cultural competence, competencies in autism and other special needs.
Culturally competent services for Hispanic children. Additional training on GLBT youth.
Develop as therapists, build language/cultural skills.
Diagnostic assessments/treatment plans/case notes/billing.
Early Childhood.
Early childhood mental health.
Excellent diagnostic assessments. Improved case formulation. Integrating TFCBT into ongoing practice.
Family systems, and DBT.
Gang related training.
Implementing the 0-3 model for more children; expertise in assessment and treatment with children on the autism spectrum; skills training.
Increased cultural competency, use of play therapy, implementation of evidenced based practices across the agency.
it depends on the staff and their level of expertise. For the newer "greener" staff, general case management skills need to be developed. Or training on how to access appropriate referrals. For more established staff, they need to continue to develop their case management skills and learn more about how to help families who may at times appear to be "difficult."
My own priority is learning Spanish so I can work without an interpreter. Agency-wide I'm not sure.
Not sure what you are asking. We have a wide variety of skills that we are developing within the agency. Our diversity is more active, we have the evidence based practices that we are incorporating and also lately training on attachment.
Our agency gives therapists freedom to develop their own areas of interest. My area of interest is divorce therapy. My agency gives freedom to take trainings as part of the work day, but will not pay for the training, but will pay for your time.
Staff training and client satisfaction and outreach.
Youth transitions.

A33. Agency participation in training initiatives

Is your agency currently participating, or considering participating in, any training initiatives?	N	%
Yes	18	56%
No	4	31%
Not sure	10	13%

A34. Open-ended question: What successes have come out of these initiatives?

What successes have come out of these initiatives?
Clients successfully completing treatment.
Enthusiastic providers; more competent providers; more successful outcomes.
Great success and strong outcomes with adolescent and family DBT programming. Too soon to know the successes from involvement in EBP training.
Improved effectiveness of treatment and ability to treat youth in milieu settings e.g., Head Start.
Knowledge often leads to more effective therapy.
Not sure what is meant by this question. When we train others or are trained by others, of course the community benefits from increased knowledge and we benefit by a larger tool box into which we can reach for better services.
People of color heading towards licensure.
Recent efforts have not been measured yet.
Too early to assess.
Too soon to tell.
We have 12 staff trained in EMDR and using it in their practice. More than 20 staff have been trained in TFCBT and are using it. All Day Treatment staff have been trained in a developmental repair model, and a training manual was written. Strengthened the agency as a training site for graduate to post doctoral interns/fellows.
Yearly training and advanced knowledge and leadership.

A35. Open-ended question: What are the greatest barriers to improving quality of clinical services? How can these challenges be overcome?

What are the greatest barriers to improving quality of clinical services? How can these challenges be overcome?
Decreased staffing at agencies. Increase staffing levels, assess quality of services based on audits. With data results from these audits use to develop quality improvement initiatives.
Difficulty hiring therapists of color. Improved salaries and increased training opportunities for employees.
Emphasis on diagnosis; lack of emphasis on prevention, early intervention.
Financial/funding barriers. Navigating the web of becoming 3rd party billers.
Funding.
Funding for staff to participate. Both the cost of the training itself and then the lost productive time when staff attend and participate in the training. We need more grants and funding to support staff being trained in the best practices approaches and skills.
I don't see barriers at my agency.
Information (feedback) gathering from clients and referral sources as to what could be done to improve our services and then making needed changes in a timely manner while balancing that with staying in quality compliance with state and certification boards.
Knowledge and funding.
Lack of funding and commitment by leadership.
Lack of funding for staff development and training. Free trainings and stipends.
Lack of funding.
Limits of staff who are bi lingual.
Massive amounts of paperwork (mostly related to payment for services) takes a lot of time away from providing services. Training is expensive and takes more time away from providing services. The County and State could lead the way in decreasing the amount of paperwork they require. There could be more collaborative trainings provided for groups of agencies.
Money – pay, training, etc. More money.
Money. Training is expensive and time consuming.
Not enough trainings research/trainings promoting cultural competence.
Often staff leave after they have received a lot of training from us, have worked a couple of years for us (a not for profit) and then once licensed move on to more lucrative positions elsewhere. We do difficult work with young staff that we often have to provide a lot of guidance, training and supervision for.
Retention of qualified staff is one barrier. Budget constraints have made retaining/hiring staff more difficult. Staff turnover negatively impacts quality of care for children. Additional staff support and acknowledgement is being used to improve job satisfaction other than financial.

A35. Open-ended question: What are the greatest barriers to improving quality of clinical services? How can these challenges be overcome? (continued)

What are the greatest barriers to improving quality of clinical services? How can these challenges be overcome?
Right now is money. We are in a situation where most of our funders are pulling out or reducing contributions. We have to increase productivity, and still conform to all quality assurance issues. Staff has less time to think creatively, organize fund raisers, or go into the community to promote services. Staff is really stretched. Administrative staff are spending more time writing grants with less or poorer results. Scrambling for money takes front seat to things like trainings, time to think creatively and develop programs and so on.
That we look at quality of service in all aspects of delivering of service. I mean the area of interpreters we believe this is a barrier from the clients side. Everyone knows that this is not correct but we need to address it from a system side.
There are significant time and resource limitations to training and consultation – staff need to do billable services for agency to survive and even when training or training money is available it is challenging to free staff up and lose revenue from billable services.
Time and money.
Time and money. Reinvestment from the county level instead of shifting all the funds to the insurance companies. They need to financially partner.
Time constraints, not enough people to serve the demand, we are lacking the space to add staff, integration of care with schools, medical providers, other child providers.
Training, staff development.

A36. Open-ended question: What resources and/or training would help staff at your agency enhance their ability to involve parents/caregivers in mental health services for children/youth?

What resources and or training would help staff at your agency enhance their ability to involve parents/caregivers in mental health services for children/youth?
Adequate funding.
Again more education regarding youth mental health issues and how to interact with youth experiencing mental health issues and how to interact with their parents/caregivers.
All training that is culturally specific is helpful. Conversing with other clinicians that serve the same population always adds value.
Billing training, treatment planning training, diagnostic training and tuition reimbursement.
Funding for parent groups, parenting workshops and general education.
Greater resources and expectations by management about it's importance.
MA rates would be the major; next best would be categorical funds for travel, family involvement, training, etc.
Money and access to expertise.
Money so that we can bring in someone to help train our staff in the coming trends in our community.
More training in early childhood.
Not sure. (3 respondents)
Our agency does a fairly decent job at this already.
Provide psycho-educational information in order to reduce the stigma regarding mental health services.
Staff and the agency culture clinical culture is well versed in involving parents and caregivers in mental health services.
This is my agency's particular strength.
Training on family systems work. Increased understanding of the challenges faced by parents e.g., employment, housing.
Training on how to engage parent. Skills is not able to meet with the parent without the child for hardly any time at all and this is counterproductive as the parent needs to be engaged without the child present as the parents authority is circumvented when the parent is redirected in front of the child.
We do a lot of this already, finding time when there are productivity expectations is often a barrier to more staff training.

A37. Open-ended question: What kinds of post-training supports are needed for implementation of new strategies in everyday practice?

What kinds of post-training supports are needed for implementation of new strategies in everyday practice?
Agencies to be willing to pay for training or part of and also being willing to let clinicians leave work for training without penalties.
An accessible manner to receive feedback to questions as they arise during implementation.
Conferences where several staff attend together are often ways to enthuse staff about particular modalities.
Consultation and supervision, refresher trainings.
Don't know. (3 respondents)
Financial.
Follow-up by agency supervisors.
Funding for strong clinical supervision and clinical supervision groups.
Good clinical supervision.
Local trainings for evidenced based practices.
Not sure that I understand this question. If understood correctly, it would be important to have ongoing training in best practices, money to train clinicians in this, and ongoing moneys for services provided.
Not sure this is necessary.
Ongoing resources with staff trainers.
Ongoing training for supervisors to support the follow-up with providers.
Perhaps support and consultation groups which cross agency boundaries so that resources and intervention strategies can be shared.
Reflective practice opportunities.
Review of outcomes after implementation of new strategies, possibly within the first 3 months initially. With the outcome results determine what is working well, what needs to be changed for improvement and implement these changes.
That the system understand what is needed in one community may not be needed in another.
Training for supervisors in supporting new practices. Ongoing consultation to support the implementation and effective use of the training received.
Training time and financial support for that training time. Most want additional training but cannot afford to go and afford to not see clients during that time.

A38. Open-ended question: As part of their strategic plan, the collaborative is considering designing a quality improvement initiative. Do you have any recommendations or suggestions for them to consider as they conduct their planning?

As part of their strategic plan, the collaborative is considering designing a quality improvement initiative. Do you have any other recommendations or suggestions for them to consider as they conduct their planning?
Am not familiar enough with the collaborative to make a suggestion.
Be very careful – small, short term poorly funded initiatives will have little or no impact on practice.
Continue to talk with providers. Hopefully parents and providers are actively involved in the collaborative. Take a close look at the discrepancy in salary scales between county clinical leadership and staff and non-profit agency leadership and clinical staff.
Focus on rates that meet the cost of proficient service delivery.
Help agencies maximize use of technology to conduct it's clinical work. Provide leadership training for it's "leaders."
Honestly, a therapist worth her/his salt, is already cognizant of the importance of remaining culturally competent and continually building/honing clinical skills to best serve those receiving services. The only concrete area I would consider for quality improvement is the use of interpreters. With the availability of competent therapists speaking the language of immigrant communities, why are interpreters still being used, unless a practitioner is providing some especially unique service which cannot be found elsewhere? In other words, why is it still ethically viable not to refer, given the opportunity, when a therapist is available who speaks the client's native language? This may be unrelated to what your planning here, but I find it amazing this is still being practiced to such an extent.
Identifying what quality means, best ways to gather information, implement new ideas, and track the progress.
Instead of designing more paperwork and surveys, let's put money towards helping our clients get into the clinic, help develop child care on site so I don't have to do a psych eval on one child with 2 or 3 other little siblings in the same room.
Make it realistic for providers to implement. Recently, DHS sent out their mandate for CASII and SDQ. However, there is no recognition that the amount of documentation is already overwhelming and no willingness to pay for the activities to any of it well.
Make sure that whatever is developed is useful at a practical level and not just something that looks good on paper but will not be useful.
No/not at this time. (6 respondents)
The whole area of interpreters, the system okays this both county and state but that does not mean that it is correct, but they feed off of each other.
When measuring treatment effectiveness, use multiple measures: some standardized measures, some parent or child reports and some measures of treatment goal attainment.

Outcome monitoring/quality assurance

A39. Agency monitoring of client outcomes

Does your agency routinely collect information on the outcomes of mental health services for children/youth?	N	%
Yes	30	91%
No	2	6%
Not sure	1	3%

A40. Agency use of a quality assurance process

Does your agency have an established quality assurance process where outcomes of services are reviewed and used to guide service enhancements?	N	%
Yes	23	70%
No	5	15%
Not sure	5	15%

Collaborative survey data tables

Description of survey respondents

A41. Type of agency represented

What type of agency do you represent?	2008 N	2008 %	2009 N	2009 %
School district	21	31%	8	26%
Non-profit agency	17	25%	7	23%
County government	13	19%	5	16%
Mental health provider	11	16%	1	3%
Another collaborative or coalition	8	12%	5	16%
Parent organization/parent	0	0%	2	7%
Other	7	10%	4	14%

2008 "other" responses included the State, Collaborative staff, Family Service Collaborative, City Public Health, medical clinics, health plan, and contracted by CMHC. 2009 "other" responses included educational institution, family, HCCMHC staff, and managed care organization.

A42. Familiarity with the Collaborative

How familiar are you with the Hennepin County Children's Mental Health Collaborative?	2008 N	2008 %	2009 N	2009 %
Not at all familiar	4	6%	1	3%
Somewhat familiar	39	57%	12	39%
Very familiar	25	37%	18	58%

Note: *Only those individuals who indicated that they were "somewhat familiar" or "very familiar" with the Collaborative were asked to continue with the survey.*

Perceived purpose of the Collaborative

A43. Open-ended comments: Perceived purpose of the Collaborative (2009)

How would you describe the purpose of the Collaborative?
A partnership of resources for addressing children's mental health needs in the community.
A way to coordinate children's mental health services county wide.
Bring all mental health providers, consumers, policy makers, families, to work together to ensure efficiencies of the systems of care and improve where we have weaknesses, fill in the gaps, and ensure families are empowered to care and nurture their children in the community. Educate the community to accept and encourage children with mental Illness.
Bring folks together.
Bring together providers, schools, county staff, juvenile justice and parents to seek systemic improvements to children's mental health system in Hennepin County.
Coordination, communication, resource allocation, mobilizing community resources.
Promote collaboration among systems providing MH services to children, and provide a vehicle that is required by law to enable Hennepin to receive LCTS funds.
Provide outreach and resources to parents of children with mental illness.
Provide resources for the mental health needs of children in Hennepin County.
Support children's mental health in Hennepin County.
Support wrap-around services for students and families in Hennepin County.
The Hennepin Children's Mental Health Collaborative is a partnership between Hennepin County, school districts, parents, friends, and family, service providers, and other community members. It is a way of bringing together all the people, services and supports children with severe emotional disturbances and their families need to improve their care and quality of life. They use a wrap around method and services are focused on the family.
The Hennepin County Children's Mental Health Collaborative's purpose is to improve resources, increase access to providers, and to ensure that funding is used to provide high quality, evidence based practices to build a systems of care model for mental health services for all children in Hennepin County.
The purpose of the Collaborative is to pull area agencies, families, and children together in an effort to provide the best possible support to children (and their families) with emotional disabilities.
To assess and review individuals and agencies requests for grant funding from the Collaborative for Behavioral Health Education or projects in which Behavioral Health Services for individuals will be improved. The Collaborative also assesses on an on-going basis the progress being made by the individuals and agencies in which grant funding has been given and if the objectives and goals are being met as proposed.
To assist in managing the needs and resources to provide mental health services to children in Hennepin County. To help develop a sustainable county plan to meet the needs.
To assist providers, schools, and county government to provide mental health services to the children of Hennepin County.
To bring together agencies in a community to support healthy youth and families.

A43. Open-ended comments: Perceived purpose of the Collaborative (2009) (continued)

How would you describe the purpose of the Collaborative?
To coordinate efforts and allocate shared resources to improve children's mental health in Hennepin county.
To coordinate mental health initiatives/services within Hennepin County. To bring together a wide variety of folks who work with children or have children focusing on improving the mental health of the children in the County.
To coordinate MH services across various disciplines and identify gaps and needs.
To ensure that all children in Hennepin County have access to effective mental health services.
To ensure the maximization and effective coordination of mental health services utilized by children and families in Hennepin County.
To serve as a convener of systems within Hennepin County on behalf of children with mental health issues; to serve as a catalyst in creating necessary change in systems operations on behalf of children and families.
To serve children in Hennepin County with a dual diagnosis.
Work with community on mental health supports.

Success of the Collaborative in reaching goals

A44. Perceived success of the Collaborative

How much do you agree or disagree with each of the following statements? The Collaborative…		N	Disagree strongly	Disagree somewhat	Agree somewhat	Agree strongly
Disseminates information to the mental health community related to evidence-based and "promising" practices	2008	44	23%	25%	45%	7%
	2009	23	13%	22%	39%	26%
Effectively integrates efforts from multiple sectors (county, schools, health organizations, providers, parents, collaborative, and community organizations) to enhance children's mental health services	2008	52	11%	27%	37%	25%
	2009	22	4%	18%	36%	41%
Provides a continuum of services for children and youth ranging from prevention through treatment	2008	51	22%	29%	31%	18%
	2009	23	13%	26%	52%	9%
Has increased access to a continuum of appropriate and effective community mental health services	2008	50	20%	28%	34%	18%
	2009	23	0%	26%	48%	26%
Has increased access to family support services	2008	45	11%	31%	49%	9%
	2009	21	5%	38%	38%	19%
Has successfully raised funds to enhance children's mental health services in Hennepin County	2008	48	17%	29%	42%	12%
	2009	22	14%	36%	27%	23%
Has developed clear recommendations and strategies for increasing system coordination	2008	47	21%	28%	40%	11%
	2009	22	0%	23%	45%	32%
Has effectively used research to guide recommendations for service and system enhancements	2008	39	5%	28%	44%	23%
	2009	21	9%	24%	43%	24%
Has created appropriate multi-disciplinary community workgroups	2008	48	8%	15%	50%	27%
	2009	22	0%	14%	41%	45%
Has strengthened effective working relationships among agencies	2008	49	10%	16%	53%	20%
	2009	21	0%	24%	33%	43%
Has increased or improved communication among agencies	2008	50	14%	18%	50%	18%
	2009	20	10%	5%	40%	45%
Has increased the cultural competence of services to children	2008	45	16%	38%	42%	4%
	2009	21	14%	24%	43%	19%
Meaningfully engages parents as partners to guide the mental health system	2008	48	17%	42%	29%	12%
	2009	21	5%	24%	52%	19%
Provides resources to support mental health services, such as funding and leadership	2008	45	9%	31%	40%	20%
	2009	22	0	4	10	8

Success in achieving mission

A45. Collaborative success in achieving mission

		N	Not at all successful	Somewhat successful	Very successful
The mission of the Collaborative is "to serve as the catalyst within Hennepin County for best/promising practices and outcome based applications and system enhancements within the spectrum of children's mental health services and practices." How successful has the Collaborative been to date in achieving its mission?	2008	58	26%	71%	3%
	2009	24	12%	79%	8%

A46. Open-ended comments: Suggestions for increasing the Collaborative's success in fulfilling its mission (2009)

What suggestions do you have for increasing the Collaborative's success in fulfilling this mission?
Actively seek funding; increase diversity at every level, which may mean replacing sacred "cows" with new energy; create space for all voices to be heard; too much decision making done in small group at the top.
Advocate for streamlining access to mental health services in Hennepin County.
Be more visible and clear about its work with its funding partners. Needs to provide regular reports and statistics of client success including complete demographic information.
Better communication with all stakeholders.
Collaborative needs to be more visible with better communication and marketing of the purpose of the collaboration.
Continue the direction and keep the connection with Wilder to get better data on progress.
Continue to build on progress made over the last 10 months. Continue to increase visibility of group and its goals.
Continue to move in this direction, this is a slow process.
Create a greater systemic focus on services, best practice, use of research etc. – things that actually would make a difference in the lives of children.
I think the Collaborative needs to stress more the continuum of children's mental health services within Hennepin County (no matter the funding base); more focus on evidence based practice; continue the systems building work.
I think there needs to be more publicity in the communities and participating agencies related to the Collaborative. As a school social worker, I don't feel like I have been made aware of the Collaborative much at all. I would really appreciate being offered more information about how I can utilize this resource and when to refer families to it.
More funding! Also, should incorporate some of the functions of an advisory committee such as review of service data re: mental health services provided to kids.

A46. Open-ended comments: Suggestions for increasing the Collaborative's success in fulfilling its mission (2009) (continued)

What suggestions do you have for increasing the Collaborative's success in fulfilling this mission?
More networking amongst members. Develop relationships with parents at all levels and cultures for input.
None.
Not sure.
Stronger communication/outreach to school staff that clearly articulates how to interface/refer with the collaborative.
The collaborative is on the right track and has done a very good job of outlining its goals and objectives. My suggestion is that it needs to step the work up a notch to a better definition of what it means by best practices and evidence based practices so that all members are in agreement on the common goals. It is one thing to use the words that are most "popular" in the lingo of mental health, but another to define and address what it means by evidence based and ask the collaborative how it intends to actually implement evidence based practice and what specific evidence based practices are they referring to. SAMHSA has labeled a number of programs as best practice, yet has the collaborative actually tried to choose and use specific models of evidence based practice. I suggest that this is the next step in the collaborative's work.
The HCCMHC needs to take a look at it's self and see how for real we bring in more people of color to the decision making of the collaborative and more parent's of color.
To continue assessing the progress of agencies and individuals goals as described in the request for funding once they have received them. Possibly require outcome statistics at set times as a stipulation with agencies prior to giving out grant funding.
Unfortunately, I do not receive information or am I aware of how to access this service. What type of situation is best to refer to the collaborative. I know this service has been around for some time but have lost touch with their purpose and how to access their services.
Work on the goals that have been set by work groups and parents.
Working together with all providers, DHS and families to ensure a continuum of care for children with mental health illness.

Agency investment/interest in the Collaborative

A47. Agency investment/interest in the Collaborative

How much do you agree or disagree with each of the following statements?		N	Disagree strongly	Disagree somewhat	Agree somewhat	Agree strongly
My agency has something to gain from being involved in the Collaborative	2008	54	4%	6%	52%	39%
	2009	23	0%	4%	30%	65%
The Collaborative represents a good cross section of the mental health system for children	2008	51	6%	16%	55%	23%
	2009	21	0%	14%	38%	48%
I have a clear understanding of what the Collaborative is trying to accomplish	2008	53	11%	34%	42%	13%
	2009	24	8%	17%	25%	50%
I am updated often about what goes on in the Collaborative	2008	55	17%	25%	33%	25%
	2009	24	17%	12%	12%	58%
I have informal conversations with others involved in the Collaborative	2008	54	7%	13%	57%	22%
	2009	24	12%	4%	38%	46%
What we are trying to accomplish through the Collaborative would be difficult for any one agency to achieve by itself	2008	52	0%	2%	29%	69%
	2009	21	0%	5%	29%	67%

Ratings of Collaborative operations

A48. Frequency of meeting attendance

		N	Never	Rarely	Sometimes	Often
How frequently do you attend Hennepin County Children's Mental Health Collaborative meetings (Operations group, Governance Board, Provider's Group)	2008	48	29%	21%	22%	28%
	2009	24	8%	17%	25%	50%

A49. Ratings of Collaborative operations

		N	Disagree strongly	Disagree somewhat	Agree somewhat	Agree strongly
How much do you agree with each of the following statements about the collaborative?						
There is a clear method for making decisions among the Collaborative members	2008	26	11%	35%	31%	23%
	2009	18	0%	11%	44%	44%
All members have a voice in decision making	2008	25	15%	31%	31%	23%
	2009	18	0%	28%	22%	50%
Meetings are facilitated effectively	2008	28	4%	21%	46%	29%
	2009	17	0%	0%	29%	71%
The roles of standing groups (operations, governance, providers) are clear	2008	26	15%	27%	39%	19%
	2009	17	0%	12%	29%	59%
Meeting agendas reflect the priorities of the group members	2008	27	4%	19%	70%	7%
	2009	17	0%	18%	35%	47%
Parents are fully included in Collaborative meetings	2008	24	21%	42%	29%	8%
	2009	16	12%	12%	50%	25%
To what extent do you agree that that the people involved in the Collaborative:						
Are the appropriate people to include in the process	2008	25	4%	32%	56%	8%
	2009	17	0%	0%	41%	59%
Have a clear sense of their roles and responsibilities	2008	26	4%	38%	50%	8%
	2009	17	0%	6%	65%	29%
Have respect for one another	2008	26	0%	19%	42%	39%
	2009	17	0%	6%	59%	35%
Communicate openly with one another	2008	26	0%	23%	58%	19%
	2009	16	0%	6%	69%	25%
Make decisions using input from each other	2008	26	4%	19%	58%	19%
	2009	17	0%	12%	53%	35%
Have a high level of commitment to the process	2008	25	0%	12%	68%	20%
	2009	17	0%	6%	65%	29%
Are open to different approaches about how the work should be done	2008	25	4%	24%	56%	16%
	2009	16	0%	12%	63%	25%
Work together to achieve group goals	2008	26	0%	27%	54%	19%
	2009	17	0%	18%	41%	41%
Fully participate in the group process	2008	26	0%	27%	54%	19%
	2009	16	0%	19%	44%	38%

Most positive features of the Collaborative

A50. Open-ended comments: Most positive thing resulting from the Collaborative (2009)

What is the most positive thing you have seen resulting from the Collaborative?
A focus on children's mental health.
Bringing people into the same room.
Continued availability of LCTS funding.
Effective parent involvement.
Funding is being used more effectively and efficiently.
Good use of resources and good clear communication.
I'm not sure, as I have had very little experience with the Collaborative.
I am impressed by Curt Peterson's work in communicating and reaching out to members. He does an excellent job of responding to all concerns and informing members about all of the activities of the collaborative.
I do not attend meetings of the CMHC because I do not know when the Governance and other committee meet. They do not publish meeting dates, agendas or meeting minutes directly to their funding partners. We still struggle to get measurable outcome information and demographic information, who is being served and where do they live in Hennepin County, on a regular basis from the CMHC.
I remember learning about the service several years ago but have since lost touch with what is available to families. In theory, the collaborative sounds very supportive but cannot specifically talk about what I have experienced.
I think the efforts being put toward educating the community on the systems of care philosophy and the SAMSHA systems of care grant.
Inclusion of parents in the Children's Mental Health partnership.
Individuals and agencies working towards positive outcomes through the grant funding in accessing/improving mental health services for children.
Like all the new work groups – like to see more real work getting done.
Much better organization.
People from various perspectives getting to know each other and the array of services in Hennepin County.
Providers coming together for support/resources; SOI process; plan and work groups.
Secured YES grant and FASD Court grants to support children's mental health initiatives in Hennepin County.
Strengthening relationships and communication among county, school systems, and providers.
That we are making progress in the elementary schools.
The improvement of directions and focus over the past 12 months.
The requirement that agencies work together for the greater good of the youth/families in the county.
Variety of participation amongst groups; schools, agencies, professionals, etc.
Work around school linked mental health services and the uninsured.

Suggestions for change

A51. Open-ended comments: Suggestions for changing the Collaborative (2009)

What things would you change about the Collaborative?
Better communication.
Concentrate on increasing ready access to mental health services and lobbying for funding parity.
Continue to work at transparency and group decision-making; work together on increasing funding (SAMSHA).
DON'T change the facilitator - very good!
Don't know.
Elaborate structure could be simplified so actual services could be enhanced. Need to cut down on intake time and expand collaboration with its funding partners.
Give it money to administer.
Give it time before more change. Do a work group to get the Systems grant done.
I am not sure if I would change the actual operation of the collaborative, but just ask them to consider how they will fulfill the guiding principle of incorporation of evidence-based practices. Perhaps this has already been addressed. If so, I would like it to be addressed at the governance meeting so members who have questions can learn more about how it is being implemented.
I think it is going to take time to change some of the negative baggage some members of the Collaborative bring to the present work of the Collaborative – it tends to interfere with the current work of the Collaborative when some folks hold onto these past resentments and disappointments.
I think it needs to be better promoted and publicized within the community, particularly in school districts. I don't feel like I've been given much of any information about the Collaborative.
Information regarding services, referral process, who can receive the services.
It should be more visible so that all of the partners know about the collaborative and participate.
More discussion of issues at meetings – not just reports and updates. Some way to create and focus on a clinical core – leadership (Curt, Jamie, etc. have no background in this).
More parent, caregiver feedback on services, funding.
More parental involvement.
Necessary organization.
Need to continue to educate about mission, recruit members and raise quality and effectiveness of collaborative meetings and actions.
Not much.
Nothing at this point.
Parent involvement.
Strengthen participation of parents/parent advocacy organizations.
We need to be more transparent with regards to financials of the HCCMHC, at every meeting of full collaborative there is not a report of finances it only happens once or twice a year.
Work for change.

Functioning of the mental health system

A52. Open-ended comments: Most pressing unmet needs of children/youth (2009)

In your opinion, what are the most pressing unmet needs of children/youth with mental health issues in Hennepin County?
Access to child and adolescent psychiatrists for evaluation and if indicated medication management.
Access to services, knowledge of resources.
Access, clinical excellence from providers, cultural competence from providers.
Addressing needs of culturally specific populations.
Children's needs are not being address in a timely manner. System is too complex. SOI grantees appear to not be required to work collaboratively with others within the community they serve.
Children who don't have advocates or involved parents/families are unserved.
Connecting children and their families in need to the correct level of service and the best provider for them.
Day treatment for young children.
Finding treatment resources for 16-21, getting appointments with psychiatrists for any age and finding support groups for kids with various types of mental illness.
Funding issues associated with Children's Mental Health.
I believe the most pressing unmet need is for a strong mental health component in all schools and in the juvenile justice programs. Hennepin County has so many young people that are caught up in gangs, prostitution, violence, and criminal activity due to poverty and the pressures of the urban way of life. We need to provide strong adult outreach to create a safety net for our youth. Brainerd, MN has a very excellent model of school based mental health in which there is a large strong team of mental health workers in their schools. Hennepin County teachers have expressed frustration with how little help there is for their students. With so many schools in one county, the numbers needed to serve Hennepin County would be huge, but would provide prevention and early intervention to keep youth on the right track.
I think case management and support services for students struggling with truancy is an under-funded area in which students' needs are not being met currently.
Kids needs are woefully unmet.
Low income families with little to no support – financial, housing, etc.
Maintaining access to high quality, affordable mental health services in a time of economic stress in all systems involved in delivering children's mental health services.
Preventive services for all kids.
Resources, but we are using all that we have access to.
School based mental health services.
Service provision to meet needs of ALL children/youth (we are satisfied with counting number of schools with a provider without asking the question – does that take care of the need in the school?); lack of emphasis on working with the child in the context of their family.

A52. Open-ended comments: Most pressing unmet needs of children/youth (2009) (continued)

In your opinion, what are the most pressing unmet needs of children/youth with mental health issues in Hennepin County?
Sustainable funding for school based mental health services, child psychiatry services, better school support for ADHD kids.
The continuum of services to a child with mental illness. If one service goals are met another is there to continue the goals for the child.
The issue that MH services are voluntary and often parents won't do what is needed for the youth, as well as the 18-21 age group is seriously underserved.
Under insured children not getting service and no equal access across the county.
Underinsured children. There also is still not a huge amount of trust in the system. The County should work more closely with community to guide the process.

A53. Perceived effectiveness of the children's mental health system

		N	Not at all effective	Somewhat effective	Very effective
In your opinion, how effectively is the system serving children/youth with mental health issues?	2008	49	22%	78%	0%
	2009	23	13%	83%	4%

A54. Open-ended comments: What could the Collaborative do to help the system better meet the needs of children/youth with mental health issues? (2009)

What could the Collaborative do to help the system better meet the needs of children/ youth with mental health issues?
Again, work to remove access barriers.
Be more transparent. Require that any organization that receives county dollars must engage collaboratively with organizations across the county not just in Minneapolis.
Comprehensive web site of resources by area. Advocate for better 3rd party coverage of mental health visits.
Continue to promote promising practices help develop better payment structures for school based mental health and first-line counseling.
Continue to work both on systems change and meeting immediate needs. There needs to be a focus on both.
Do a better job of making itself known to area school social workers and service providers.
Fund more school based mental health services.
Given the funding limitations, the HCCMHC does the best it can.
Have more muscle to take on Hennepin County. County leadership is not supportive of collaborations...so we will always be limited in our overall effectiveness.
Help the provider's with funding so that they can provide preventive mental health services and not have to wait until child is in trouble.
I think the Collaborative has done a lot of good work in the past year of bringing the systems together and trying to address the needs of children/youth at a systemic level; I believe continued work in needed in getting parents to the table and engaging people of color.
I think the collaborative needs to focus on early intervention and prevention by promoting mental health screenings, early childhood mental health support for all families, not just those who are failing. Mental health needs to be addressed like physical health, as something we all possess and as human beings with emotions and minds, we all need to have a mental health "check-up" to stay healthy. Hennepin County needs to use social marketing to overcome stigma and needs to continue to bring people together with the common goal of improving the mental health of our youth.
Identify real changes that need to be met.
Let agencies continue to fund prevention and help them access resources for that work.
Listen to parent/foster parent/caregiver feedback and do something about it accept talk. Take and the research by Wilder and devise a plan and then implement it to improve system in short.
Lobby with officials to cover funding youth 18-21 in Hennepin County with MH needs.
Look more broadly at the mental health system in Hennepin, and not just those things funded by the collaborative.
Parent involvement, provide information on resources available for children and their families, do more outreach.
Pulling together for the SAMSHA grant would be an example of what I think the Collaborative should do.
See #7 and #13 above.
Work more closely with the agencies in the community – not just the large agencies, but all agencies. Create strong systems of care, support networks in the community that reduce stigma, improve early identification of warning sign and enhance accessibility.

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