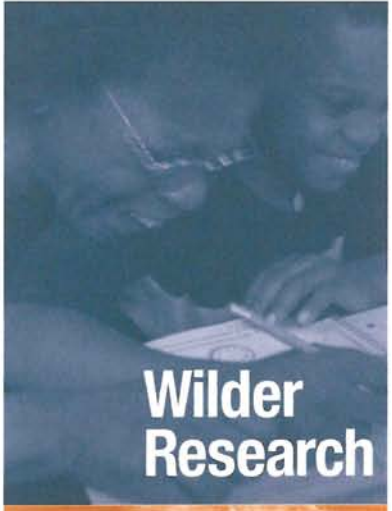

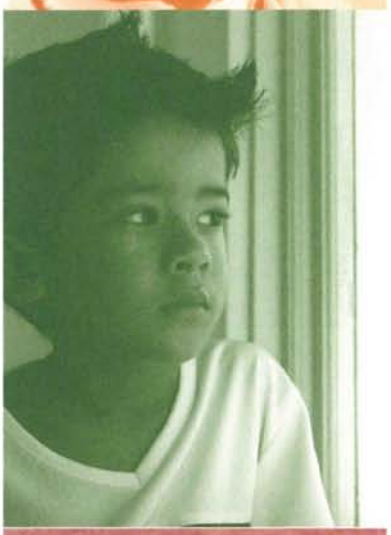

Hennepin County Children's Mental Health Collaborative

Annual report

OCTOBER 2010

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Prepared by:
Julie Atella, Melanie Ferris and Cheryl Holm-Hansen

Wilder Research
451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700
www.wilderresearch.org

Contents

Figures

Acknowledgments

Wilder Research contributors include:

Jackie Campeau
Louann Graham

The information included in this report was provided primarily from the program evaluators and/or executive directors of each funded project. Our appreciation is extended to the Evaluation subcommittee of the Hennepin County Children's Mental Health Collaborative members, who provided oversight and support.

Background

Overview of all Solicitation of Interests (SOIs) and evaluation process

In 2007, the Hennepin County Children's Mental Health Collaborative (HCCMHC) issued five Solicitations of Interest (SOIs) that were developed to address key concerns regarding the existing Hennepin County children's mental health system and reflect the Collaborative's current priorities. The SOIs focused on four topic areas: juvenile justice (two separate solicitations), uninsured/underinsured youth, primary care, and school-based mental health services. In 2009, a fifth topic area, parent involvement, was added. In 2010, two new juvenile justice programs, through the Juvenile Detention Alternative Initiatives (JDAI), were funded. In each SOI, funded programs were required to evaluate their effectiveness and allow the Collaborative to assess their impact on the children's mental health system in Hennepin County. In some of the SOI areas, the HCCMHC identified specific evaluation measures that grantees would be expected to collect and report. In other areas, specific evaluation measures were not identified in the SOIs and were left to applicant programs to develop.

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

This report summarizes key findings and recommendations across programs followed by an Appendix that offers a more in-depth look at each specific SOI area (juvenile justice and JDAI, uninsured/underinsured youth, primary care, school-based mental health services, and parent involvement). While programs collected similar demographic information for this report, it is imperative not to make comparisons between programs in terms of effectiveness. Due to the differences in each program's target population and service approach, conclusions made through direct comparisons between programs would be quite limited. This annual report addresses the following questions:

- Are the funded programs reaching their anticipated target population?
- How many, and what are the characteristics of, children are being served through programs funded by the Collaborative?

- What common challenges have the programs faced in implementing their programs? What successful strategies have been used to overcome these barriers?

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

A summary of the additional evaluation components that were reported on by each SOI group are included in the Appendix. An overview of the financial data for each program, provided by the Collaborative, can also be found in the Appendix.

Evaluation process

Wilder Research plays a different role in each of the five SOI programs. Wilder Research provides sample data collection templates/tools and protocols to each program (with the exception of the school-based mental health programs). Wilder Research provides limited technical assistance to the juvenile justice/JDAI, uninsured/underinsured, and parent involvement programs, including:

- Offering training to the programs on reporting requirements and completion of reporting tables;

- Reviewing all programs' reports; and

- Submitting a brief summary to the HCCMHC describing the activities and lessons learned of the SOI programs.

For the primary care program, Wilder Research is the contracted external evaluator and works throughout the data collection, analysis, and reporting process. Five of the six school-based mental health programs applied their evaluation funding towards the development of a shared database for tracking service provision and client outcomes, with Wilder Research providing some basic reporting assistance.

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

Overview of programs

There have been 26 programs funded by the Hennepin County Children's Mental Health Collaborative since 2008, including the addition of the Minnesota Association for Children's Mental Health (MACMH) in 2009 and Youthline and DOCCR in 2010. Figure 1 provides a brief program overview by SOI group (juvenile justice, uninsured/ underinsured, primary care, school-based mental health, and parent leadership). Some programs are no longer receiving funding because their contract has ended or because the program or Collaborative has decided to end their contract early.

1. Overview of the programs

Program	Description	Current contract status
Juvenile Justice		
Amicus-Radius	Serves girls in the juvenile justice system in North Minneapolis by offering groups, individual counseling, restorative justice support circles, staff referrals, and support to additional resources.	Funded
Amicus-Radius-North Vista (was Bren)	Serves girls at the North Vista Education Center by offering groups, individual counseling, restorative justice support circles, staff referrals and support to additional resources.	No longer funded – contract ended
Emerge/Streetwerks	Serves at-risk North Minneapolis youth by expanding the existing StreetWerks summer employment program and ensuring culturally appropriate services, job placement services, and educational services.	No longer funded – contract ended
Family and Children Services: My Life, My Choice	Serves at-risk teen girls by providing prostitution prevention groups and individual case management to youth who are involved in prostitution.	No longer funded – contract ended
Family and Children Services: Youth Connections	Serves at-risk youth and their families by providing professional screening, case management, holistic service planning, and resources.	No longer funded – contract ended
Genesis II for Families, Inc.	Serves youth who are in or have experienced out of home placement with 10 weeks of group training on life skills of employment, education, housing, transportation, a transition portfolio, and medical/mental health.	No longer funded – contract ended
HIRED	Serves youth who are involved in the juvenile justice system by providing personalized and innovative work solutions such as job readiness training, placement in post-secondary career training opportunities, job placement, and job coaching and job retention.	No longer funded – contract ended
Relate Counseling Center	Serves youth experiencing chemical health issues by providing mental/chemical health assessment, counseling, and education.	No longer funded – contract ended
SEARCH	Serves Somali youth by providing intensive case management, career development, parent counseling, and recreational activities for immigrant youth and their families.	No longer funded – contract ended
Stadium View School	Serves youth in the BETA program at the JDC by developing intensive, coordinated mental health, social and educational support utilizing an ecological analysis/assessment establishing base lines to inform the development of a transition planning process.	No longer funded – contract ended

1. Overview of the programs (continued)

Program	Description	Current contract status
Juvenile Detention Alternatives Initiative (JDAI)		
Hennepin County DOCCR-JDAI intern[a]	Funds an intern who is responsible for assisting the Department of Community Corrections and Rehabilitation with creating JDAI media and promotional materials, reporting to funders, preparing for committee meetings, and developing/working on a juvenile resource database.	Funded
Minneapolis Parks and Recreation[a]	Serves youth who are referred by Hennepin County's juvenile probation by providing fiscal management services for the Basic & Supplemental Needs & Incentives (BSNI) program implemented in conjunction with the Youthline Outreach Mentorship Program.	Funded
Uninsured/Underinsured		
Baby Space	Serves Native American children ages 0-9 who reside in the Little Earth of United Tribes Housing Development or attend Baby Space/Tatanka Academy. Provides preventative classroom interventions to all children enrolled in the school and further assessment and therapeutic interventions to youth exhibiting social-emotional or behavioral difficulties.	Funded
Family Children Services	Serves young children (ages 3-5) enrolled in PICA HeadStart. Provides on-site mental health screening, assessment, intervention, and consultation services to children who have, or at risk of developing, a diagnosable mental health concern.	Funded
La Familia Guidance Center	Serves Latino youth, emphasizing youth from immigrant families who are often ineligible for insurance. Provides culturally-competent outreach, screening, and intervention services, including Functional Family Therapy, through Southside Community Health Services' Green Central Clinic.	Funded
Mental Health Collective	Serves East African youth and families living in South Minneapolis. Provides mental health and cultural competency resources with staff, education and outreach programs for use in schools, and culturally-competent mental health services.	Funded
YouthLink	Serves primarily transition-age youth (18-21) experiencing homelessness. Provides case management, group education, advocacy, and support to youth who visit their drop-in center. This program does not provide on-site mental health services, but helps youth access services from local providers.	Funded

1. Overview of the programs (continued)

Program	Description	Current contract status
Primary Care		
Partners in Pediatrics	Provides co-located mental health services at their Maple Grove Clinic in collaboration with Pediatric Consultation Specialists. Social-emotional screening occurs at all well-child visits, with the mental health professional located on at the clinic one day each week to provide consultation to medical providers, immediate mental health triage services, and further assessments.	Funded
St. Joseph Home for Children	Provides intake and shelter services for Hennepin County children removed from their homes due to abuse or instability. Social-emotional screening is incorporated into the health assessments conducted when youth enter the program. Children with an elevated screen are referred to the behavioral health clinic for further assessment and intervention services, as appropriate. A care coordinator serves as a liaison between behavioral health staff, residential counselors, and families.	No longer funded – contract voluntarily terminated by grantee
School-based Mental Health		
CLUES/Richfield School District	Serves youth in Richfield High Schools by providing mental health services to Latino youth and their families.	Funded
Family Networks/ Robbinsdale Area Schools	Serves youth with a mental health diagnosis by increasing the accessibility for uninsured and underinsured children to mental health services and improving the identification of mental health issues for youth.	Funded
Minneapolis Department of Health and Family Support	Serves a multicultural group of youth at Roosevelt High School by providing prevention, assessment, and intervention services to youth through therapy.	Funded
St. Anthony School District/ Nystrom and Associates	Serves youth at the St. Anthony-New Brighton School district by providing assessments, individual and family therapy, groups and educational groups to students with a mental health diagnosis.	Funded
The Storefront Group/Anoka Hennepin School District	Serves adolescents through educational training related to mental health by providing consultation for prevention services and crisis intervention to the school staff and faculty.	Funded
Washburn/Eden Prairie	Serves youth in the Eden Prairie School district school linked children's mental health services for Eden Prairie students by providing individual and family therapy on site in the school setting, office visits and/or home visits.	Funded
Parent Involvement		
Minnesota Association of Children's Mental Health (MACMH)	Provides leadership training to core group of Hennepin County parents through the Family Catalyst program and expands the Collaborative's Parent Leadership Group (PLG).	Funded

Characteristics of youth served

Demographic data are described in the Appendix. Some agencies appeared to report only the current reporting period's data, while others reported all data from July 2009-June 2010. Additionally, some agencies only reported the number of youth referred, while other agencies reported the number of youth receiving services. These factors made it difficult to create an aggregate chart of youth served since October 2008. But, unlike other reporting periods, all of the agencies who were funded during the period of January through June 2010 turned in a report.

As was true in past reports, there are obvious differences between programs in their target population. The school-based programs serve youth of all ages (preschool to transition), while the uninsured/underinsured programs focus on youth of specific ages (early childhood and transition-age youth). Additionally, some of the juvenile justice and school-based groups have a focus on specific cultural groups (Native American, Hispanic, and East African youth), or other key populations (homeless youth). In general, the programs report they have been reaching their anticipated target populations. The unique distinctions between programs are described in the topic-specific reports in the Appendix.

Key observations and next steps

Through the funded projects, the Collaborative is reaching a diverse population and providing services otherwise unavailable in Hennepin County (e.g., additional screening and diagnostic assessments for youth in primary care, working with uninsured/ underinsured youth, providing mental health services to students through the school-based programs). Wilder Research has highlighted a few key observations while analyzing the second year's annual data for the Collaborative to consider.

Overall

- **Consider reconvening grantees to discuss key lessons learned and sustainability efforts.** Programs should have considerable insight about the implementation process, as well as advice and comments about the evaluation and overall SOI process. Most important, understanding if and how the SOI funding has helped with sustainability would be helpful to uncover. Gathering some or all of this information may be very useful if a similar grantmaking process is used by the Collaborative in the future. Since we do not have the capacity or funding to conduct in-depth interviews with the programs, it may be useful to ask programs to respond to a brief survey or email to gather some of their feedback.

- **Timeliness of reporting is less of an issue overall than it has been in the past, but clarity of what data are being reported and training about how to fill out the reporting templates is necessary.** Currently, programs are asked to collect the data needed for their reports. Based on this round of reports, some agencies may have been confused or misunderstood the reporting template. When checking numbers against past reports, not all of the data added up as it should. It appears that agencies either reported their data inconsistently across reporting periods, or were unclear about what to report (referred youth, served youth, or both). As a result, it was difficult to report the aggregate data. It may be necessary to provide a webinar or other training before the next report to assure that data are being reported correctly and consistently.

- **As was true in past reports, a blend of common and program-specific measures is likely needed to report information across sites.** Evaluation plans were developed to promote consistency in reporting across grantees. While common measures can provide some general shared indicators across projects, program-specific data should also be collected to provide the Collaborative with the necessary depth of information. Grantee-specific reporting leads to some challenges, but may be a more appropriate approach to take if a similar grantmaking process is used by the Collaborative in the future.

Appendix

Juvenile Justice and JDAI

School-based mental health

Uninsured/underinsured youth

Primary care

Parent Involvement

Financials

Juvenile Justice and JDAI

Background

To reduce or prevent youth involvement with the juvenile justice system, Hennepin County Children's Mental Health Collaborative has funded 12 programs that work with youth involved to some degree in the system. In addition to the 10 Juvenile Justice programs that were funded in the first round of SOIs, funding for two Juvenile Detention Alternative Initiative (JDAI) programs began in this reporting period (Figure A1). Funding went to support an internship in Hennepin County's Department of Community Corrections and Rehabilitation (DOCCR) and the Youthline Outreach Mentorship Program of the Minneapolis Parks and Recreation Board. Funding for most of the first round of Juvenile Justice programs ended in 2009. There was only one program that was still funded in June 2010, which was Amicus' Radius program.

The DOCCR intern's report details the percentage of time spent on activities, including grant writing, committee meetings, and resource database management (40%), in addition to data analysis/research (25%) and updating department policies, practices and procedures (25%). The report also highlights barriers and key lessons learned.

The funded Juvenile Justice-SOI programs (JJ-SOI) are directed to build/continue relationships with community-based organizations, law enforcement, human services, schools and corrections. Additionally, their programs were to incorporate best practices and provide supplemental services to youth who are involved in the system.

A1. Overview of Juvenile Justice and JDAI Programs

Currently Funded Program	Description
Amicus-Radius	Serves girls in the juvenile justice system in North Minneapolis by offering groups, individual counseling, restorative justice support circles, staff referrals, and support to additional resources.
Hennepin County DOCCR-JDAI intern	Funds an intern who is responsible for assisting the Department of Community Corrections and Rehabilitation with creating JDAI media and promotional materials, reporting to funders, preparing for committee meetings, and developing/working on a juvenile resource database.
Minneapolis Parks and Recreation Youth Outreach Mentorship Program - Youthline	Serves youth who are referred by Hennepin County's juvenile probation by providing fiscal management services for the Basic & Supplemental Needs & Incentives (BSNI) program implemented in conjunction with the Youthline Outreach Mentorship Program.
Previously Funded Program	**Description**
Amicus-Radius-North Vista (was Bren)	Served girls at the North Vista Education Center by offering groups, individual counseling, restorative justice support circles, staff referrals and support to additional resources.
Emerge/Streetwerks	Served at-risk North Minneapolis youth by expanding the existing StreetWerks summer employment program and ensuring culturally appropriate services, job placement services, and educational services.
Family and Children Services: My Life, My Choice	Served at-risk teen girls by providing prostitution prevention groups and individual case management to youth who are involved in prostitution.
Family and Children Services: Youth Connections	Served at-risk youth and their families by providing professional screening, case management, holistic service planning, and resources.
Genesis II for Families, Inc.	Served youth who are in or have experienced out of home placement with 10 weeks of group training on life skills of employment, education, housing, transportation, a transition portfolio, and medical/mental health.
HIRED	Served youth who are involved in the juvenile justice system by providing personalized and innovative work solutions such as job readiness training, placement in post-secondary career training opportunities, job placement, and job coaching and job retention.
Relate Counseling Center	Served youth experiencing chemical health issues by providing mental/chemical health assessment, counseling, and education support.
SEARCH	Served Somali youth by providing intensive case management, career development, parent counseling, and recreational activities for immigrant youth and their families.
Stadium View School	Served youth in the BETA program at the JDC by developing intensive, coordinated mental health, social and educational support utilizing an ecological analysis/assessment establishing base lines to inform the development of a transition planning process

Staffing and implementation status

Both Amicus Radius and Youthline were asked to report about their implementation and staffing status. Both reported they were fully staffed. Radius hired a program counselor who provides both therapeutic services and case management for the program. Additionally, they have a Community and Family Connections Manager who offers mentoring services, resource referrals and general support to the girls' group.

The implementation of the contract took longer than anticipated for Youthline, who is still working on the referral process for their program. Reporting that their partnership is fully implemented, there has been some disconnect between probation and Youthline's staff, making the referrals limited. The process of referring youth from probation to the program has been more complicated than expected, which has affected the number of youth referred. To address this barrier, program staff and probation officers attended a meet and greet hosted by the Minneapolis Park and Recreations Board to discuss the referral process and build relationships.

Characteristics of youth served July 2009-December 2009

Youth demographic information was gathered by each program's staff and submitted to Wilder Research in July 2010. The data included in this report describe characteristics of youth screened between January-June 2010. Figure A2 gives an overview of the totals provided by Radius and Youthline. During January-June 2010, 19 youth were served. The majority of the youth were female (74%) (Amicus Radius serves only girls), in the age range of 12-17 years old (79%) and were African-American (95%) and non-Hispanic (95%).

A2. Number of youth served by program

	Juvenile Justice and JDAI groups January-June 2010 Data	
	Amicus Radius	**Youthline**
Ages of youth served		
0-3	0	0
4-5	0	0
6-8	0	0
9-11	0	4
12-17	14	1
18-21	0	0
Unknown/missing	0	0
Total served	14	5
Race		
Black/African American	14	4
African (African-born)	0	0
Asian/SE Asian	0	0
Native American	0	0
White/Caucasian	0	0
Bi- or multi-racial	0	0
Other	0	1
Unknown/missing	0	0
Total served	14	5
Ethnicity		
Hispanic	0	1
Non-Hispanic	14	4
Unknown/missing	0	0
Total served	14	5
Gender		
Male	0	5
Female	14	0
Transgender	0	0
Total served	14	5

Recidivism for the Juvenile Justice group

To demonstrate the effectiveness of services, all of the juvenile justice grantees who were funded in round one were asked to report on recidivism. Six agencies gave the County the data necessary to obtain recidivism data (Amicus Radius, Emerge, Genesis, My Life/My Choice, SEARCH, and Youth Connections). For the purposes of this report, recidivism is defined as it is for the County contracts and occurs:

- If the youth commit a delinquent act or petty offense and are charged by the County Attorney's Office and enter the juvenile justice system six months after they have completed the program.
- If the youth commit a delinquent act or petty offense and are placed in out of home placement six months after they have completed the program.

Since recidivism data cannot be collected immediately after program completion, the recidivism data has not previously been reported. The County was unable to provide any baseline recidivism statistics, so the numbers provided cannot be used to determine if there has been a reduction in criminal activity. Not all of the agencies provided the information needed to collect recidivism data, therefore or the 417 total youth reported in the Juvenile Justice group since October 2008, only 26 percent (N=109) of the youth's juvenile justice histories were reviewed (Figure A3).

It is important to note that Stadium View collected its own recidivism data and reported that five youth had committed a delinquent act or petty offense, were charged by the County Attorney and entered the juvenile justice system within six months of completing the program. They also reported that there were six youth who were placed in out of home placement within six months of completion. These data were not included in Figure A3 since they did not report what level of offense was committed and because the data was not reviewed by the County in the same manner as the other agencies data.

A3. Recidivism of 109 youth

	N	P
Adjudicated for 1+ offenses	18	17%
Adjudicated for misdemeanor	5	6%
Adjudicated for gross misdemeanor	4	4%
Adjudicated for felony	8	7%
Send to out of home placement	11	10%

Key findings

- **Require programs to submit list of youth served to have a more complete overview of recidivism.** Because there was a period of time between when a youth was discharged and when they may have recidivated, some programs were no longer funded and therefore did not turn in the list of youth served and discharged to the county. Other programs collected the data internally, but did not report it in the same manner as the county did.

School-based mental health

To remove barriers to learning and promote the social and emotional development of children, the Hennepin County Children's Mental Health Collaborative funded six programs that work with schools and their students. The funded school-based mental health programs were directed to better assess and treat student's mental health concerns and improve the student access to mental health services within Hennepin County schools. The funded agencies are CLUES, Family Networks, Minneapolis Department of Health and Family Support, The Storefront Group, Nystrom and Associates, Washburn Center for Children (Figure A4). The grantee's goals are to increase access, improve child functioning and increase daily learning.

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

Five of the six funded agencies are part of the MN Kids Database that emerged from this collaborative discussion. Each of the five agencies has contributed at least $6,000 towards the database to date. With supplemental financial support from Hennepin County and other partner agencies, the database is now operational. Wilder Research is serving as the program manager and oversees the administrative and fiscal needs of the database. Internet Exposure, a Minneapolis-based web design firm, is the subcontracted vendor that developed the website. Wilder Research is working closely with them to ensure that the resulting database will meet the needs/expectations of the partnering agencies.

A4. Overview of School-Based Mental Health Programs

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

Characteristics of youth served

During the database planning phase, agencies were not required to submit data. Now that the MN Kids' Database has been built, data are being reported. The data included in this report describe characteristics of youth served between January-June 2010. All six agencies reported data. A total of 218 children/youth received mental health services. Most of the youth were 12-17 years old (56%) or 9-11 years old (20%); age information was not provided for more than one-quarter of the youth (28%) (Figure A5).

Most of the youth served were Caucasian (59%), followed by Other (21%). Some programs categorized their Hispanic youth, which represented a quarter (25%) of youth served, as "Other" for race. This may account for many of the youth in the Other category. More females (54%) than males (46%) were served. Less than half of youth served (49%) spoke English as their primary language in the home.

A5. Demographic characteristics of youth served

	MDHFS N=33		Family Networks N=17		Storefront N=28		Nystrom N=47		CLUES N=15		Washburn N=78		Total N=218	
	N	%	N	%	N	%	N	%	N	%	N	%	N	P
Ages of youth served														
4-5	0	0%	0	0%	0	0%	0	0%	0	0%	6	8%	**6**	**3%**
6-8	0	0%	0	0%	0	0%	0	0%	0	0%	15	19%	**15**	**7%**
9-11	0	0%	0	0%	0	0%	0	0%	17	36%	26	33%	**43**	**20%**
12-17	22	67%	16	94%	28	100%	15	100%	11	23%	31	40%	**123**	**56%**
18-21	11	33%	1	6%	0	0%	0	0%	10	21%	0	0%	**22**	**10%**
Unknown/missing	0	0%	0	0%	0	0%	0	0%	9	19%	0	0%	**9**	**4%**
Race														
Black/African American	2	6%	7	41%	0	0%	0	0%	0	0%	10	13%	**19**	**9%**
Asian/SE Asian	0	0%	1	6%	0	0%	0	0%	0	0%	2	3%	**3**	**1%**
Native American	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
White/Caucasian	1	3%	7	41%	27	96%	4	27%	36	77%	54	69%	**129**	**59%**
Bi- or multi-racial	0	0%	0	0%	0	0%	1	7%	7	15%	0	0%	**8**	**4%**
Other	30	91%	0	0%	1	4%	10	67%	3	6%	1	1%	**45**	**21%**
Unknown/missing	0	0%	2	12%	0	0%	0	0%	1	2%	11	14%	**14**	**6%**
Ethnicity														
Hispanic	30	91%	2	12%	1	4%	10	67%	7	15%	5	6%	**55**	**25%**
Non-Hispanic	3	9%	15	88%	27	96%	5	33%	25	53%	73	94%	**148**	**68%**
Unknown/missing	0	0%	0	0%	0	0%	0	0%	15	32%	0	0%	**15**	**7%**

A4. Demographic characteristics of youth served (continued)

	MDHFS N=33		Family Networks N=17		Storefront N=28		Nystrom N=47		CLUES N=15		Washburn N=78		Total	
	N	P	N	P	N	P	N	P	N	P	N	P	N	P
Gender														
Male	12	36%	7	41%	9	32%	7	47%	22	47%	43	55%	**100**	**46%**
Female	21	64%	10	59%	19	68%	8	53%	25	53%	35	45%	**118**	**54%**
Transgender	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Unknown/missing	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Primary language spoken in home														
English	5	15%	0	0%	27	96%	5	33%	0	0%	69	88%	**106**	**49%**
Spanish	27	82%	0	0%	1	4%	10	67%	0	0%	1	1%	**39**	**18%**
Somali	0	0%	0	0%	0	0%	0	0%	0	0%	1	1%	**1**	**0%**
Other	0	0%	0	0%	0	0%	0	0%	0	0%	1	1%	**1**	**0%**
Missing	1	3%	17	100%	0	0%	0	0%	47	100%	6	8%	**71**	**33%**
4-5	0	0%	0	0%	0	0%	0	0%	0	0%	6	8%	**6**	**3%**

Insurance Status

Of the 218 students served, over one-third (39%) were insured through private insurance. Sixteen percent of the students had no coverage at all. One in five (22%) students served was insured through public programs, such as MA or MinnesotaCare (Figure A6).

A6. Mental health insurance status at intake

	MDHFS N=33		Family Networks N=17		Storefront N=28		Nystrom N=47		CLUES N=15		Washburn N=78		Total	
	N	P	N	P	N	P	N	P	N	P	N	P	N	P
No insurance coverage	7	21%	4	24%	3	11%	3	6%	13	87%	5	6%	35	16%
Insured through public program	8	24%	5	29%	3	11%	4	9%	0	0%	29	37%	48	22%
Insured through private insurance	14	42%	8	47%	22	76%	39	83%	2	13%	44	57%	85	39%
Unknown/ Missing	4	13%	0	0%	0	0%	1	2%	0	0%	0	0%	5	2%
Total	33	100%	17	100%	28	100%	47	100%	15	100%	78	100%	218	100%

Types of activities and services provided

A total of 9,065 services were provided by the agencies during the period of January-June 2010. This number is over 6 times larger than was reported for October 2008-December 2009. It is unclear exactly why the total services provided increased so much, but it may be largely due to the fact that there was data merged into the database after the last reporting period. Consistent with the previous reporting period, the most common service was individual therapy lasting 30 to 90 minutes (3,073 sessions). Other common services included Care Coordination (n=1,319) and Parent Consultation (n=1,007), and Child specific consultation to support staff (n=1,003) (Figure A7).

A7. Services provided

	MDHFS	Family Networks	Storefront	Nystrom	CLUES		Total
Building crisis management		-	-	-	-	-	**4**
Care coordination	47	70	7	20	1	1,174	**1,319**
Child specific consultation to administration	3	-	5	10	1	76	**95**
Child specific consultation to support staff	-	18	113	-	10	862	**1,003**
Child specific consultation to teachers	-	-	-	9	-	868	**879**
Child specific observation	-	-	-	5	-	-	**5**
Classroom presentation	-	-	-	-	-	6	**6**
Consultation (not student specific)	13	-	2	-	-	235	**250**
Diagnostic assessments (intakes)	22	20	9	23	12	131	**217**
Family therapy w/ client	-	1	-	64	-	158	**223**
Family therapy w/o client	-	-	-	47	-	146	**193**
Group psychotherapy	-	-	67	-	-	-	**67**
Group skills training	-	-	-	36	-	86	**122**
Individual skills training	-	-	-	-	-	299	**299**
Individual therapy 30 min	-	-	-	48	-	1,810[a]	**1,858**
Individual therapy 60 min	117	226	284	550	28	5	**1,210**
Individual therapy 90 min	-	-	3	2	-	-	**5**
Mental health case management	-	-	16	-	-	-	**16**
Parent consultation	5	-	12	5	-	985	**1,007**
Phone parent consultation	14	-	17	38	5	-	**74**
Program development/planning categories	1	-	-	-	-	149	**150**
School conferences	-	-	2	-	-	46	**48**
Screening	-	-	-	1	-	-	**1**
Training for staff	-	4	-	-	-	8	**12**
Travel	-	-	2	-	-	-	**2**
Total services	**222**	**339**	**545**	**858**	**57**	**7,044**	**9,065**

[a] *Many of the 30 minute Individual therapies for Washburn may be 60 minutes, but due to an issue with the data merging which is being resolved with MKD, they are mostly categorized as 30 minutes for this report.*

Time between referral and 1st meeting

Programs were asked to calculate the average time between a student's referral to the program and their first meeting with a clinician. The way in which some of the agencies reported this varied from the way they had reported it in the past future. Storefront, Nystrom and Washburn reported a percentage rather than an average (Figure A8). Because the reporting is not consistent across agencies, it is not possible to provide an overall average. In the future, using the MN Kids Database to report this data is favored since it automatically calculates this figure. Changing the county's reporting template to reflect this may be appropriate, as well.

A8. Time between referral and 1st meeting

	MDHFS	Family Networks	Storefront	Nystrom	Clues	Washburn
Average time between referral and 1st meeting	7 days	9 days	54% same day	96% same day	3 days	89% 0-7 days

Child functioning

All of the programs reported on the required child functioning variables (Figure A9), except Nystrom who did not report their CASII outcome. All programs have reported 100% parent satisfaction. Programs reported improved or maintained SDQ scores range for 50-90% of youth served. Because of the way school data is shared by the districts, agencies were required to report attendance, academic performance and academic placement to the county in October 2010. While some of the agencies reported these data anyway, they were not included in the figure below because it was not always clear how these data were measured.

A9. Child functioning

	MDHFS	Family Networks	Storefront	Nystrom	Clues	Washburn
Improved/Maintained CASII Score	69%	68%	89%	N/A	100%	73%
Improved/Maintained SDQ Score	50%	68%	65%	67%	90%	81%
Improved/Maintained Attendance	n/a	n/a	n/a	n/a	n/a	n/a
Improved/Maintained Academic Performance	n/a	n/a	n/a	n/a	n/a	n/a
Improved/Maintained Academic Placement	n/a	n/a	n/a	n/a	n/a	n/a
Positive Client/Parent Satisfaction with the Program	100%	100%	100%	100%	100%	100%

Key findings

- **Operationalize the child functioning outcome measures so that it can be consistently measured across programs.** There is still concern about reporting child functioning variables (improved/maintained CASII, SDQ, attendance, performance and placement), which are requirements of their County contracts and Collaborative reports. Agencies are likely measuring these outcomes inconsistently. Agencies expressed unease about the data being used to compare one program to another because of the different ways each measured the outcomes. Additionally, agencies were not clear about the consequence of being below the targeted goal and impact on future funding.

Uninsured/underinsured youth

Background

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

A10. Overview of Uninsured/Underinsured Programs

Program	Description
Baby's Space	Serves Native American children ages 0-8 who reside in the Little Earth of United Tribes Housing Development or attend Baby Space/Tatanka Academy. Provides preventative classroom interventions to all children enrolled in the school and further assessment and therapeutic interventions to youth exhibiting social-emotional or behavioral difficulties. *Target population: American Indian children residing on the Little Earth reservation and surrounding neighborhood and/or enrolled in Baby's Space/Tatanka Academy*
Family & Children Services (FCS)	Serves young children (ages 3-5) enrolled in PICA HeadStart. Provides on-site mental health screening, assessment, intervention, and consultation services to children who have, or at risk of developing, a diagnosable mental health concern. *Target population: Uninsured/underinsured Hennepin County children who are diagnosed or at risk of diagnosis with an emotional/behavioral disturbance and attending one of seven PICA service sites*
La Familia Guidance Center	Serves Latino youth, emphasizing youth from immigrant families who are often ineligible for insurance. Provides culturally-competent outreach, screening, and intervention services, including Functional Family Therapy, through Southside Community Health Services' Green Central Clinic. *Target population: Uninsured and underinsured Latino youth in need of mental health services in Hennepin County*
Mental Health Collective	Serves East African youth and families living in South Minneapolis. Provides mental health and cultural competency resources with staff, education and outreach programs for use in schools, and culturally-competent mental health services. *Target population: Uninsured/underinsured East African children and families*
YouthLink	Serves primarily transition-age youth (16-21) experiencing homelessness. Provides case management, group education, advocacy, and support to youth who visit their drop-in center. This program does not provide on-site mental health services, but helps youth access services from community-based providers. *Target population: Uninsured/underinsured homeless youth ages 16-21 who are residents of Hennepin County*

Staffing and implementation status

All of the projects are currently fully staffed, but four of the five (Baby's Space, FCS, Mental Health Collective, and YouthLink) did experience changes in staffing during the past six months. Baby's Space hired a new full-time Licensed Psychologist and experienced "significant turnover" in their teaching staff. Their report states they were able to address these changes to minimize disruption for children and families. FCS and YouthLink both noted changes in clinician staffing during the past six months. YouthLink was without a second mental health practitioner for three months, and it is unclear whether staffing changes at FCS resulted in reduced capacity for part of the reporting period. The Mental Health Collective (MHC) reported their outreach position for African Aid and clinical practitioner position at the MHC was understaffed for much of the Spring. Their report states individuals held these positions, but did not have the skill set to complete all project tasks. Two Somali women have recently been hired to fill these roles.

All projects are fully implemented, but a few have made recent enhancements or changes to their program. Key activities or accomplishments included in each grantee report are highlighted below.

- Baby's Space continues to provide monthly Family Nights, as well as other formal and informal outreach activities, to engage parents in the services their child receives. During the past six months, an average of 28 families participated in Family Night activities (65% of families enrolled).

- The MHC has focused their work on piloting the Tree of Life Curriculum to a total of 75 youth. The curriculum is intended to help students identify life goals and appreciate resources available to them, rather than focusing on past negative experiences. They also expanded their partnerships with community-based organizations to offer youth groups to Somali youth at three different locations, with a fourth planned for the Fall. They have also been approached to hold 6-week group sessions at three community locations and one additional school.

- LaFamilia Guidance Center has given a number of presentations to community stakeholders during the past year (reported in more detail later in the report) and noted they have experienced an increase of inquiries from schools in Richfield, Brooklyn Center, Brooklyn Park, Bloomington, and South Minneapolis who wish to refer youth without insurance who are in needs of mental health services.

- FCS reduced the number of children they serve, but increased the intensity of services each child receives. Children now receive support twice a week, and most of this skill development is done in the classroom, rather than in individual sessions.

- YouthLink continues to offer groups on topics of interest to the youth they serve. This Spring, they completed a 6-week anger management session, an 8-week grief and loss group, and implemented a new curriculum on healthy relationships developed specifically for homeless youth. One of their mental health practitioners received training in Eye Movement Desensitization and Reprocessing (EDMR), and is providing that intervention to youth who receive therapy services through YouthLink.

Characteristics of youth served

Youth demographic information was gathered by each program's staff and submitted to Wilder Research in a series of semi-annual reports. The data included in this report describe characteristics of youth served by the projects during the past year. It should be noted that Baby's Space provides services to a consistent cohort of students enrolled in Tantaka Academy.

When combined, the uninsured/underinsured programs served a diverse population of children and youth in Hennepin County. Approximately one-quarter of all program participants were between the ages of 0 and 5 years (29%) or young adults, age 18 to 21 (24%) (Figure A11). However, individual programs served very different targeted populations. For example, YouthLink has a large focus on young adults, while Baby's Space and Family & Children Services programs work exclusively with early childhood programs. A third of youth served were Hispanic/Latino (33%). Over one-quarter of the youth served was African American (27%), with large population of American Indian (15%) children and youth also served. Nearly two-thirds (67%) of the children spoke English as their primary language at home.

A11. Demographics of youth served (N=262)

	N	%
Age		
0-3	42	16%
4-5	33	13%
6-8	29	11%
9-11	18	7%
12-17	76	29%
18-21	63	24%
Unknown	0	0%
Gender		
Male	141	54%
Female	120	46%
Transgender	1	>1%
Unknown		

A11. Demographics of youth served (N=363) (continued)

	N	%
Race		
African American	70	27%
African-born (refugee, immigrant)	38	15%
Asian-American	3	1%
American Indian	39	15%
White/Caucasian	15	6%
Bi-/multi-racial	43	16%
Other	48	18%
Unknown/missing	6	2%
Ethnicity		
Hispanic/Latino	87	33%
Non-Hispanic/Latino	161	61%
Unknown	14	5%
Primary language spoken in home[a]		
English	200	76%
Spanish	34	13%
Somali	23	9%
Other	5	2%

[a] *This refers to the primary language spoken at home by the child. "Other" responses included bilingual (Spanish, English), and one unspecified response.*

Although these grantees were funded to serve children and youth who were unable to access care due to insurance barriers or other reasons, two-thirds of the program participants (65%) had insurance through a public plan. Fewer participants were without insurance at intake (20%) or insured through a private plan (2%) (Figure A12). As described previously, the grantees noted the populations they serve are underrepresented in the mental health system. However, with the exception of some Hispanic/Latino children who are ineligible for insurance because they are undocumented, simply obtaining insurance is not a barrier for most families served.

A12. Insurance status at intake (N=262)

	N	%
No insurance	53	20%
Public insurance plan/program	169	65%
Private insurance plan	6	2%
Unknown	34	13%

[a] *Sixteen of the youth were ineligible for insurance because they were undocumented. The reasons for insurance ineligibility for other youth are unknown.*

Screening and service utilization data

As described in previous reports, the screening, assessment, and referral approaches used by each program vary considerably. Screenings is not used by the Mental Health Collective until they have established a strong relationship with the family and know the youth is likely to continue mental health services. In contrast, all children referred for services from Family & Children Services receive a diagnostic assessment, regardless of whether their screening score is elevated.

Because the screening process occurs somewhat differently in each project and some children may be screened multiple times, this report includes screening results reported during the past year. During that time, approximately half of the children or youth screened (53%) had an elevated score, indicating potential behavioral or mental health issues (Figure A13). In all, 89 youth (40% of youth screened by the projects during the past six months) were diagnosed with a mental health or social-emotional disorder as a result of the services provided by the program.

A13. Screening, assessment, and referral outcomes for youth (July 2009 – June 2010)

Screening summary	Baby's Space	Family & Children Services	LaFamilia Guidance Center	Mental Health Collective	YouthLink	Total
Number of youth screened	55	48	29	15	78	225
Number of youth with an elevated screening score (percentage of youth screened)	16 (29%)	16 (33%)	23 (79%)	15 (100%)	50 (64%)	120 (53%)
Number of youth referred for a diagnostic assessment	9	48	22	15	36	130
Number of youth who received a diagnostic assessment	7	47	15	15	8	92
Number of youth who refused a diagnostic assessment	0	0	3	15	9	27
Number of youth who received a mental health/social-emotional diagnosis	6	46	15	15	7	89

Discharge data

When data from all programs are combined, nearly one-third of the children/youth (31%) were discharged after successfully completing the program (Figure A14). Services ended for fewer families due to refusal or early termination of services by the family (20%), the family moving (5%), or referrals to another agency (3%). The discharge reasons for YouthLink participants are quite different than for other programs, and influence the aggregate reasons for discharge. Young adults who turn 22 years old are not eligible for continued services at YouthLink and receive only short-term transitional services before discharge. Young adults may also choose not to focus on accessing mental health services in their interactions with staff when other crisis issues are more pressing or when adequate community-based services are already in place.

A14. Reasons for discharge from mental health services, July 2009-July 2010

	Baby's Space (N=1)	Family & Children Services (N=21)	La Familia Guidance Center (N=24)	Mental Health Collective (N=4)	YouthLink (N=25)	Total (N=75)
Successful completion of program	1	8	10	3	1	23 (31%)
Service refused (early termination of services)	0	3	10	0	2	15 (20%)
Child referred to another agency	0	0	2	0	0	2 (3%)
Child/family moved	0	1	1	0	2	4 (5%)
Other	0	5[a]	1	1	17[b]	24 (32%)
Missing	0	4	0	0	3	4 (5%)

[a] *Five were discharged because they transferred to Kindergarten.*

[b] *Some youth were discharged because they aged out of the program. Other youth were not eligible for the program because they did not want to address those issues (other crises may have required attention) or felt they had adequate mental health services in place without assistance from staff*

Outcome data

Each grantee is asked to report two types of outcome data in their annual reports to the County and Collaborative: 1) changes in child functioning over time using a standardized assessment tool, and 2) progress towards treatment goals at the time of discharge. This information has proven to be difficult for programs to track and report. As indicated in the figure below, most youth do not have a completed assessment instrument at discharge (Figure A15). Programs identify difficulty getting discharge information because some youth discontinue services unexpectedly and it was not possible to meet with parents to have them complete a discharge assessment.

A15. Assessment results at discharge, July 2009-July 2010

Assessment results	Baby's Space (N=1)	Family & Children Services (N=21)	La Familia Guidance Center (N=24)	Mental Health Collective (N=4)	YouthLink (N=25)
Youth/caregivers who completed screen at discharge	0	10	3	Missing	0
Number of youth with scores in the clinical range at discharge	0	3	0	Missing	Unknown
Number of youth with improvement in scores from intake to discharge	0	7	3	Missing	Unknown

The programs were also asked to report the child's progress on meeting various treatment goals at discharge. Based on the data submitted, a majority of the youth (58%) served had partially met their treatment goals when services ended (Figure A16). Fewer of the youth (18%) had successfully met all treatment goals at discharge.

A16. Progress towards treatment goals, October 2008-July 2010

	BabySpace[a] (N=12)	Family & Children Services (N=34)	La Familia Guidance Center (N=5)	Mental Health Collective (N=5)	YouthLink (N=37)	Total (N=93)
Successfully met all treatment goals	4	8	4	0	1	17 (18%)
Partially met treatment goals	7	25	1	0	21	54 (58%)
Experienced major disruptions in meeting treatment goals	1	1	0	0	12	14 (15%)
Data not reported	0	0	0	9	3	12 (13%)

[a] *BabySpace is a program embedded into a school setting. Treatment goals are reviewed on a regular basis, but most children are not formally discharged from the program when this occurs. Data is reported for more children than who have been discharged from the program.*

Additional program-specific information

Because each program is unique, their reports include additional information describing key program activities that are not part of the standard reporting template used by all uninsured/underinsured grantees. Wilder Research has worked with the MHC and LaFamilia Guidance Center to incorporate their outreach activities into a modified reporting template. The other grantees are encouraged, but not required, to provide additional information about the services they provide. Highlights from the submitted reports are included below:

- The Mental Health Collective modified their reporting in January 2010 to include participation in parent and youth group activities and involvement with the outreach worker. During the past six months, a total of 38 parents attended at least one of three parent groups and 75 youth attended at least one of 10 youth groups which used the Tree of Life Curriculum, with 74 participating in at least three of the sessions. The outreach worker was approached by 7 parents and 9 youth, and offered proactive outreach to 5 families. As a result of the outreach activities, referrals were made to mental health services (N=2) and other community resources (N=7), while 7 youth received additional information about a prevention activity.

- La Familia Guidance Center provided outreach at nine different events/locations during the past year, reaching 269 families with a total of 561 children. The report also states 39 presentations were given to professional and community groups, including social services, school representatives, and clergy members during the past year. In all, 43 youth were referred to LaFamilia for services through these activities, with most referrals (N=21) coming from schools.

Next steps and key observations

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

A17. Program's next steps

Provider	Next steps
Baby's Space	Continue to identify strategies to encourage parents to complete screening instruments. Although still interested in offering Parent-Child Interaction Therapy and Filial Therapy to families in the future and expanding services to youth not enrolled in Tatanka Academy, these are on hold due to changes in the mental health professional position.
Family Children Services	Identify cultural consultants/liaisons and resources to better understand cultural values and practices of families served.
La Familia Guidance Center	Continue to improve consistency, completeness, and timeliness of data collection.
Mental Health Collective	Provide youth groups in new community locations. Schedule meeting with mental health professionals who work with the Somali community to share lessons learned. Address program sustainability in partnership with African Aid. Requested consideration for HCCMHC to accept a request to extend the program until the fall, using unspent funds from the first two years of the grant.
YouthLink	Continue to provide more topic-specific groups for youths and explore use of trauma-focused services. Improve consistency of transition plans for 20-year old participants. Continue to improve and streamline the referral process to avoid unnecessary waits for services. (All goals were continued from the semi-annual report.)

When writing their reports, all uninsured/underinsured grantees are asked to reflect on the data included in the report and work over the last year to identify key lessons learned. Some of the observations and concerns highlighted by program staff are listed below:

- Parent engagement strategies, such as using prepared scripts, offering assistance with the form, and offering food treats and other incentives did not increase the survey completion rate. (Baby's Space)

- Classroom observation and parent concerns are more likely to lead to referrals for diagnostic assessments than screening scores. (Baby's Space)

- Flexible appointment scheduling has been key to providing mental health services to homeless youth. (YouthLink)

- Changes to the General Assistance Medicaid (GAMC) program may have a significant impact on the availability of services to young adults without insurance. New strategies may be needed to address service gaps. (YouthLink)

- Low-income families may be unable to afford the insurance premiums for public programs. Extended hours (evenings and weekends) for clinics and public programs could improve the accessibility of services for Hispanic/Latino youth who have parents working multiple jobs. (LaFamilia Guidance Center)

- In classroom therapeutic interventions have been beneficial to children and have strengthened relationships between teachers, administrators, and therapists. (FCS)

- Proactive outreach explaining the youth group curriculum and inviting questions has helped build rapport between program staff and parents. (Mental Health Collective)

The following recommendations, developed using information included in this report and summary reports completed by each program, offer the Collaborative with suggestions to consider in future grantmaking efforts:

- **Pursue different strategies to ensure completion of discharge data.** The populations served through these programs are difficult to reach and are often discharged early from services. As a result, it is difficult to capture data that describes changes in child outcomes using parent-report assessment tools. While not ideal, it may be more useful to collect discharge data exclusively from program staff so that information can be reported for all youth served.

Primary Care

Background

Two programs, Partners in Pediatrics/Pediatric Consultation Specialists (PCS) and St. Joseph's Home for Children (St. Joe's) received funding to provide co-located mental health services and primary care clinics (Figure A18). As described in the HCCMHC Semi-Annual report (April 2010), St. Joe's encountered a number of challenges staffing their program and voluntarily terminated their contract with Hennepin County in November 2009. This report only includes data for the ongoing PCS project.

A18. Overview of Primary Care programs

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

Implementation status

PCS has been fully staffed and continues to provide on-site services (BE-Care) at the Maple Grove PIP clinic location one afternoon (approximately five hours) each week. A new licensed social worker has been hired to provide these onsite services, but no other staffing changes have been made.

Characteristics of youth served

The data included in this report describe characteristics of youth who attended a BE-Care appointment between October 2008 and June 2010. Since the program began, a total of 311 youth have been seen for a BE-Care appointment. The youth range in age from 1 to 19 years of age, with approximately one-third of the youth age 5 or younger (Figure A19). Most youth were White (86%) and non-Hispanic (96%).

A19. Demographic characteristics of youth served

	PIP (N=311)	
	N	%
Age		
0-5	99	32%
6-8	84	27%
9-11	59	19%
12-14	63	21%
15-18	6	2%
Unknown	0	0%
Gender		
Male	176	57%
Female	132	42%
Unknown/missing	3	>1%
Race		
African American	7	2%
Asian American	12	4%
American Indian	0	0%
White/Caucasian	267	86%
Bi-/multi-racial	11	4%
Unknown	14	5%
Ethnicity		
Hispanic/Latino	2	>1%
Non-Hispanic/Latino	300	96%
Unknown	9	3%

Timeliness of services

Fewer patients received a BE-Care appointment within a week of referral during the second year of the project. During the past 12 months, 43 percent of patients attended a BE-Care appointment within one week of being referred by the pediatrician, compared to 52 percent of patients in the first year of the project (Figure A20). According to program stakeholders, same day appointments are rare because most parents have not set aside additional time to participate in a BE-Care appointment after the child's visit to the pediatrician. Without additional information, it is not clear whether appointment dates are somewhat later due to parent preference or other factors. Most of the appointments (94%) were held at the BE-Care clinic location, rather than the PCS office.

A20. Length of time between pediatric visit and mental health triage appointment (N=311)

	Year 2: July 2009-June 2010 (N=158)		Year 1: October 2008-June 2009 (N=153)	
	N	%	N	%
Same day	9	6%	17	11%
1-7 days	59	37%	62	41%
8-14 days	39	25%	34	22%
15-30 days	29	18%	20	13%
More than one month	11	7%	10	7%
Unknown	11	7%	10	7%

Types of referrals made

Over half of patients seen at BE-Care are referred for mental health therapeutic services. Patients referred to BE-Care receive a 40-minute referral to discuss their concerns. During the past 12 months, most patients (83%) receive education during that appointment, while fewer are referred to additional services, including psychotherapy (58%), psychological testing (20%), and physical/occupational therapy (2%) (Figure A21).

A21. Referrals made by triage mental health provider

	N	%
Education provided	110	83%
Psychotherapy	77	58%
Psychological testing (diagnostic assessment)	26	20%
Physical/occupational therapy	2	2%
Other	8	6%

Note: *Children may have received multiple referrals/services during the triage mental health visit. "Other" referrals included referrals for support services (N=2), referrals for meds (N=1), and unspecified services (N=5).*

It is not known whether most parents actually seek the services they are referred to following BE-Care appointments. BE-Care is a service available to all patients, regardless of insurance, for a $30 co-pay. Although PCS providers staff BE-Care, patients who receive a referral for mental health services are given a more comprehensive list of mental health providers in the area and may select a provider of their choice. Some families do continue their care with PCS, but the provider group has only sought a service contract through Blue Cross Blue Shield. Five of the youth who had a BE-Care

appointment during the past 12 months did receive follow-up mental health services from PCS. All participated in a diagnostic assessment and received a mental health diagnosis. However, it is not known how many other families pursued additional services.

Parent satisfaction

Parents who completed a satisfaction survey were satisfied with the services they received. Satisfaction surveys were completed by approximately 30 percent of the patients seen during the past six month (N=26). Results from the satisfaction survey were overwhelmingly positive for most items. When asked to consider how the services they received helped them understand and respond to their child's behavior, all parents felt the service helped them understand the types of resources or services available for their child. While still positive, fewer reported they know what to do if problems arise with their child and understand their child's behavior better after the initial BE-Care appointment. When asked for suggestions to improve the service, a number of parents suggested longer appointment times and expanded clinic hours/locations.

Other activities

PCS has continued to provide monthly webinars focused on topics of interest to the PIP providers. These presentations are done for providers at the Maple Grove clinic and recorded so they can be watched live or at a later date by providers from all PIP locations. Recent training topics have included information on the similarities and differences between school IEP and 504 plans, Asperger's Syndrome, pediatric headaches, and encopresis (soiling after potty training has been completed). As a result of the encopresis webinar, a team approach was developed to refer patients to PCS for a series of appointments to help parents address the psychological aspects of the conditions while the PIP provider addresses the concern from a medical perspective.

Sustainability

Although PCS has been able to staff BE-Care at adequate levels, the provider group is not credentialed by all major health plans. To address this issue, PCS hired a licensed social worker as an independent contractor who could become credentialed individually by multiple health plans to provide services at BE-Care. Although this individual is credentialed through Blue Cross Blue Shield, PCS has encountered a number of challenges in working with the other three health plans that insure most of their patients. This credentialing process is considered essential by PCS to maintain staffing at BE-Care. Although there are multiple challenges in this approach, it continues to be the best way project staff have found to ensure project sustainability. Co-pays will be necessary to supplement staff expenses at BE-Care, but PCS will be able to avoid billing patients the full costs of BE-Care appointments by credentialing a new staff member.

The relationships developed between PIP and PCS have led to opportunities to expand co-located mental health services outside of the scope of the grant. A PCS staff member is now leasing office space and providing on-site therapy at the PIP clinics in Rogers and Brooklyn Park. According to PCS staff, the medical providers feel more comfortable referring patients to an organization they are familiar with, and parents appreciate attending appointments at a familiar location.

Next steps and key observations

According to PCS staff, no significant program changes are planned during the next year. They will be continuing to work with insurance plans to attain certification for their mental health staff to ensure the project can be sustained over time. Using the data from this report, Wilder Research also recommends PCS consider the following next steps during their final year of grant funding:

- **Continue to monitor which providers refer patients to BE-Care, in order to assess changes in referral patterns over time.** During the past six months, PCS began tracking which providers refer patients to BE-Care. By reviewing this information regularly, PCS can identify changes in referral patterns and providers who have not referred patients for this service.

- **Work with providers and scheduling staff to identify parents who may need a longer intake appointment than offered at BE-Care.** Although parent satisfaction was overwhelmingly positive, a few parents did feel a longer BE-Care appointment was needed. Continuing to work with providers and scheduling staff to assess the needs of the family and immediately referring parents to a longer intake appointment when necessary, will help ensure referrals are appropriate and meeting the family's expectations.

- **Consider the need for additional informational materials and resources that can be made available to parents.** A few parents reported they were not sure whether they understood their child's behavior better after attending a BE-Care appointment. It may be helpful to reassess the types of information and materials available for parents and develop fact sheets or other brief informational packets for parents who want additional information about their child's behavior at the time of the appointment.

Parent Involvement

Background

In late August 2009, the Hennepin County Children's Mental Health Collaborative contracted with the Minnesota Association of Children's Mental Health (MACMH) to provide leadership training to core group of Hennepin County parents and expand the Collaborative's Parent Leadership Group (PLG). Parent training, focused on helping parents develop skills to work collaboratively and constructively as decision-makers, was provided through MACMH's Family Catalyst Project. MACMH was also charged with helping the PLG develop a strong infrastructure, expand its size, and coordinate with Collaborative workgroups and committees to ensure the perspectives of parents are heard and parents are engaged at decision-making throughout the Collaborative.

Since the initiative began in 2009, MACMH trained 12 parents through the Family Catalyst Project. However, less effort was put towards the formalization and expansion of the PLG. A single group, now called the Parent Catalyst Leadership Group, currently involves parents who have been trained as Family Catalysts. A parent support group will begin to meet monthly during the next reporting period.

Implementation status

Two full days of training (16 hours) were provided to parents in the Family Catalyst Program during the first quarter of the project and additional trainings are planned for late 2010. Because it has been challenging to find days that work for all parents, MACMH planned to offer alternate training dates to parents who have been unable to attend all training sessions. MACMH reported their program is fully staffed and being implemented as planned. However, activities related to infrastructure development of the PLG were not fully reported and were not met within the timeframe established in collaboration with the Collaborative.

Characteristics of families involved

To date, a total of 12 parents were identified as members of the Family Catalyst Program. This includes the 10 parents trained during the first 6 months of the program and 2 parents who joined during the last reporting period (Figure A22). This same group of parents also comprised the Parent Leadership Group, referred to in the report as the Parent Catalyst Leadership Group (PCLG). MACMH reports they are pleased with the diversity of the group and have met their recruitment goals for the first year of the program.

A22. Demographic characteristics of parents involved in the Family Catalyst Program/Parent Leadership Group (N=12)

	N	%
Gender		
Male	0	0%
Female	12	100%
Race		
African American	4	20%
Asian American	0	0%
American Indian	2	20%
White/Caucasian	4	30%
Bi-/multi-racial	2	20%
Ethnicity		
Hispanic/Latino	2	10%

Note: *One African-American group member was identified as African-born.*

Recruitment strategies

As reported in the 2010 semi-annual report, in August and September 2009, MACMH distributed 1,500 flyers and applications for the Family Catalyst Program to a variety of organizations throughout Hennepin County, with specific emphasis on culturally-specific service agencies. Four parents became involved with the PLG through written materials, while others were already involved (N=3) or referred to the group by a service provider (N=4) or other PLG member (N=1) (Figure A23). MACMH planned to recruit another 10-12 parents to the Family Catalyst Program this Fall, including four parents who have already been identified.

A23. Routes to parent involvement in the Family Catalyst Program

	N	%
Parent/caregiver was involved in the PLG prior to the Family Catalyst Program initiative	3	25%
Referred by school staff, service provider	4	33%
Referred by a friend, PLG member	1	8%
Attended an event/presentation	0	0%
Received a newsletter/flyer/other written materials	4	33%
Other reason	0	0%

According to MACMH, none of the parents initially recruited to participate in the Family Catalyst Program dropped out. However, four of the parents were involved less frequently in meetings in recent months. Staff recognize that when parents are dealing with their own child's mental health concerns or other family issues, their involvement in the program will decrease. To ensure all parents receive the same level of training, they considered refresher training sessions or inviting current PLG parents to participate in training sessions with the new cohort of Family Catalyst Program participants expected to begin this Fall.

Recent activities

Training

During the past year, Family Catalysts participated in a number of training sessions to enhance personal and professional growth. The titles of the training sessions include: Parent Support Group Facilitator Training, Introduction to Public Policy, Understanding the Parent Role, the Power of Telling Your Own Story; Protective Factors for Strengthening Families; Developing Mission, Vision, and Goals; Enhancing Personal and Professional Potential; Meeting Protocol and Mock Meeting with Role Playing; and Understanding the Purpose, Goals, and Structure of Meetings. The Family Catalysts also attended the MACMH 2010 Conference. Additional details describing the content of each training session have not been provided.

Parent involvement in workgroups, initiatives

Beginning in January 2010, Family Catalysts began to work within a variety of workgroups and initiatives, including the following:

- Special Education Advisory Council (State and local level)
- Center for Excellence in CMH- Cultural Providers Network
- DHS State Operated Services Workgroup
- HCCMHC School Based Mental Health Workgroup
- HCCMHC Governance Board
- Juvenile Justice Coalition Substance Abuse Workgroup
- Juvenile Justice Diversion Workgroup
- Juvenile Justice Training Adolescent Brain Development

- SECAC Parent Mentoring Program
- Hennepin South Services Collaborative
- MDH Health Care Home Workgroup

The level of involvement parents have in these workgroups is not known. According to MACMH's annual report, parents and caregivers have been warmly welcomed in all workgroups and committees. The program continued to be interested in seeking new opportunities to involve parents.

Outreach

According to the report written by MACMH, the Parent/Caregiver Leadership Group (PCLG) continued to distribute informational postcards and applications for the Family Catalyst Program at mental health clinics, schools, and other sites in Hennepin County likely to serve families of children with mental health disorders throughout the first year of the project. The PCLG also plans to distribute materials for a back-to-school Children's Mental Health Resource Fair to be held on August 24th.

Through the project, MACMH planned to convene monthly Parent Support Group meetings that will be open to any caregivers interested in attending. In their January 2010 report, MACMH stated the Parent Support Group will begin in May 2010. Based on the information received to date, it is not clear whether these meetings have started or how many parents have attended any meetings outside of the trained group of Family Catalysts.

Additional observations

When asked to describe how the program has affected their knowledge, confidence, support system, and ability to network, all parents had very positive things to say about the program's impact. MACMH's August 2010 report included a number of quotes from parents who are involved in the Family Catalyst program. A number of parents described how the training and networking with other parents has given them confidence and skills to be effective advocates. The program was described as an opportunity for both professional and personal growth, which helped them build knowledge in new areas and a stronger personal support network. One parent also noted it was interesting to be involved in a program with such cultural diversity and different views about mental health.

Family Catalysts identified needs for greater mental health training for school staff and expanded service options for youth in Hennepin County. In their reports, MACMH was asked to relay concerns expressed by Hennepin County parents that arise

during trainings and other interactions with parents. Some of the issues identified by Hennepin County parents during the past year include: access to school-based mental health services and the need for more classroom accommodations; a need for crisis response and de-escalation training for school staff; limited insurance coverage for mental health services; a need for ongoing therapy throughout recovery; identification of programs offering "best-practices" services; and greater services for transition-age youth, especially in entering post-secondary education or the job market.

The following observations emerge from the existing information:

- **Expectations regarding growth of the Parent Leadership Group need additional clarification.** The expansion and sustainability of the Parent Leadership Group (PLG) is a high priority for the Collaborative, and a primary reason for funding a project in this area. Although MACMH has consistently reported they are meeting the goals and objectives of the project, the Collaborative envisioned the PLG including a larger number of parents outside of the Family Catalyst Program. Further discussion may be needed to clarify how any parent training program will engage Hennepin County parents in the PLG and support parent involvement in Collaborative-level decision making.

- **Develop tracking approaches to document and report the number of Hennepin County parents who participate in the Parent Support Group.** Based on the report, it seems the Parent Support Group is intended to be an open group for any Hennepin County parent interested in joining. The evaluation plan did not include any information to track the project's outreach activities and overall growth in the support group. Minor changes could be made to the report template to track and report this information without substantially increasing data collection burden among project staff.

- **Consider strategies to assess and report the degree to which workgroups and committees involve parents in decision-making.** During the past six months, the Family Catalysts began to participate in a variety of workgroups and committees, primarily outside of the Collaborative. There are a number of efforts organizations can take to encourage parent involvement and support parents who participate in meetings, such as holding meetings at times that are convenient to parents, offering stipends for meeting attendance, involving multiple parents (rather than a single parent representative), and ensuring parents have decision-making roles. In order for the Collaborative to have a better sense of how parents are involved in workgroups and committees in Hennepin County, it may be helpful to develop some data collection strategies to better understand the decision-making roles parents have in each of these workgroups.

Financials

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

Provider	Contract Period	Budgeted Year 1 Funding	Budgeted Year 2 Funding	Budgeted Year 3 Funding	Budgeted Total Funding	Actual 2008 Funding	Actual 2009 Funding	Projected 2010 Funding	Projected 2011 Funding	Projected 2012 Funding	Total Funding
Underinsured/Uninsured MH Services					**350,000**						
Baby's Space	9/1/08 - 8/31/11	35,000	36,400	37,856	109,256	11,667	35,467	36,885	25,237		109,256
MH Collective/African Aid	9/1/08 - 8/31/11	40,000	37,100	35,300	112,400	13,333	39,033	36,500	23,533		112,400
F&C Svc (PICA)	9/1/08 - 8/31/11	40,000	40,000	40,000	120,000	13,333	40,000	40,000	26,667		120,000
YouthLink	9/1/08 - 8/31/11	40,000	40,000	40,000	120,000	13,333	40,000	40,000	26,667		120,000
School Based MH Initiatives					**461,656**						
Nystrom & Assoc./ St. Anthony Schools	8/12/08 - 7/31/11	30,000	30,000	30,000	90,000	11,250	31,250	30,000	17,500		90,000
Mpls Health Dept./ Mpls Schools	2/10/09 - 1/31/12	27,000	27,000	27,000	81,000		27,000	27,000	24,750	2,250	81,000
Washburn/Eden Prairie Schools	9/1/08 - 8/31/11	30,000	30,000	30,000	90,000	10,000	30,000	30,000	20,000		90,000
Family Networks/ Robbinsdale	9/1/08 - 8/31/11	30,000	30,000	30,000	90,000	10,000	30,000	30,000	20,000		90,000
CLUES/Richfield Schools	9/1/08 - 8/31/11	30,000	30,000	30,000	90,000	10,000	30,000	30,000	20,000		90,000
Storefront Group/Anoka Hennepin	8/12/08 - 7/31/11	30,000	30,000	30,000	90,000	11,250	31,250	30,000	17,500		90,000
					531,000						
Parent Leadership Support Contract											
MCMHA	Approved 4/10/09			60,000	60,000		16,567				60,000
Totals		**771,494**	**413,194**	**409,056**	**1,593,744**	**233,640**	**692,228**	**389,315**	**232,879**	**2,250**	**1,593,744**
				1,593,744							