Hennepin County Children's Mental Health Collaborative

2016 Annual Metrics Report

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Introduction

This report provides the Hennepin County Children's Mental Health Collaborative (HCCMHC) with a summary of information related to their 2016 funded programs and other HCCMHC initiatives.

The report summarizes the HCCMHC's "success metrics" for 2016. These metrics have been reported annually since 2008, though they have undergone a number of revisions. These metrics were informed by the HCCMHC's strategic plan and include measures of HCCMHC functioning, work groups, system-level improvements, and funded services. The report also incorporates supplemental information about funded services, including the number of people served, implementation strengths and challenges, and other lessons learned.

Success in HCCMHC functioning

The first category of HCCMHC success metrics is the quality of relationships among partners and the overall functioning of the HCCMHC. The Collaborative conducts biannual surveys of its members, with the most recent survey conducted in late 2016. Nine survey items were originally selected to reflect the overall success of the HCCMHC. Four items were removed in 2014 and another four were removed in 2016, leaving one core measure (Figure 1).

The percentage of stakeholders rating the HCCMHC as "very successful" in achieving its mission has varied over the previous survey administrations, with an increase from 25 percent in 2014 to 54 percent in 2016. The HCCMHC mission has evolved over time, which may contribute to the variability in ratings.

1. Metrics related to success in HCCMHC functioning

How the HCCMHC functions	2012 (N=31-35)	2013	2014 (N=15-16)	2015	2016 (N=13)
% of stakeholders who rate the HCCMHC as "very successful" in achieving its mission	40%	-	25%	-	54%

Note. Results come from surveys conducted with HCCMHC stakeholders. Surveys were not conducted in 2013 or 2015, per the Governance Board's decision to collect surveys every other year. In 2014, four measures were removed from the list of core metrics, including the percentage of stakeholders who strongly agreed that: 1) they have a clear understanding of what the CMHC is trying to accomplish; 2) parents have a leadership voice in work groups; 3) the people involved in the CMHC work together to achieve group goals; and 4) effective communication strategies are being used to share information about CMHC activities. In 2016, four additional measures were removed: (1) the CMHC represents a good cross-section of the mental health system for children; (2) all members have a voice in decision making; (3) parents are fully included in CMHC meetings; and (4) diverse communities are represented among all work groups.

Success in work groups and work plans

The second category of HCCMHC success addresses the implementation of the HCCMHC work plans. In 2016, there were six active work groups (governance, executive, evaluation, provider, school-based services, and education). Information was gathered from one or more leaders from each group to explore the status of each work group in terms of establishing and implementing their work plans. Two metrics that relied on stakeholder survey responses were eliminated in 2016.

As reported by work group leaders, the groups' main successes and challenges include:

- **Executive and governance committees** - The Executive Committee and the Governance Committee's work in 2016 was in accordance with the approved work plans. They ensured that the funded service projects were meeting the stated goals specific to increasing the relational competence of providers with non-majority populations, with a continuation of an early childhood screening initiative, with continued supporting of community corrections projects focused on mental health support for juvenile girls, and with school based projects that assist with mental health support that leads to successful graduation. The provider competence work wrapped up showing strong results as compared to the developed outcomes. The early childhood screening project has been very successful, resulting in the project being incorporated (services, staffing and support) at the initial location. With this development, the number of screenings being completed has grown, as have the number of FTEs providing screening. This success has also led to expansion of the program to additional clinical sites. The committees continued to look for areas of need and opportunity specific to children's mental health. The committees received initial information regarding current children's mental health service provider locations in the county. The initial report generated significant discussion regarding geographic gaps, the difficulty of accurately accounting for providers, and the challenge of establishing criteria for inclusion of providers. The committees saw great potential in the information and committed to thorough discussion, investment, and collaboration to continue to improve the accuracy and uses of the data. All CMHC groups continued to focus on completing work plans as efficiently as possible.

- **Evaluation -** The evaluation committee met as needed through 2016. Through this period, the committee continued to work with funded programs on their evaluation efforts. The committee also oversaw the preparation of the 2015 summary reports related to the funded programs and to the HCCMHC's metrics of success, provided guidance and support related to the evaluation of the DOCCR initiatives, supported the completion of a qualitative project related to school-based mental health, and oversaw the development and completion of a map of children's mental health providers in Hennepin County.

- **Provider -** The provider group met once in April of 2016. Quarterly meetings were scheduled, with meetings taking place when members felt there were appropriate agenda items or education topics of interest. The meeting in 2016 focused on Changes to Minnesota Data Sharing Laws from the 2015 Legislative Session, presented by Jamie Halpern. The meeting also covered important updates and a confirmation of provider leadership seats on the various CMHC committees. The group will continue to set quarterly meeting dates but only meet when the group identifies a topic. There will not be a formal work plan in 2017.

- **School-based mental health -** The Hennepin County school mental health work group continues to meet regularly focused on understanding, improving and expanding school mental health in Hennepin County. There were four main areas (three were similar to last year) that group dedicated time to in their 2016 meetings and work: 1) discussing evaluation and outcomes; 2) summer programming; 3) looking to the future and 4) planning for the 2017 legislative session. Some group members worked with Wilder Research on developing and implementing the 2016 qualitative study of school mental health in Hennepin County. Over the summer, Wilder Research finished the study and presented the findings to our workgroup in the fall of 2016. Second, the work group spent several meetings exploring summer program ideas and reviewing some summer pilot projects that emerged from last year's discussions in this group. Third, over the course of last year, the group spent time discussing the future of school mental health. These discussions led to the restructuring of some of our meetings so that they were more applicable to school stakeholders. In the Spring of 2016, the group had a meeting specifically focused on getting more school district feedback and ideas about how to better integrate school mental health with different educational initiatives, such as Positive Behavior Interventions and Supports (PBIS) and Multi-tiered Systems of Support (MTSS). The group plans to focus at least 3-4 meetings per year to have agendas and discussions of interest to school stakeholders. Fourth, the group spent a number of meetings developing some common talking points related to school mental health and had Sue Abderholden attend one of the meetings to talk about the 2017 legislative sessions and how members of the school mental health group could prepare to be

supportive of any school mental health legislative activity. Finally, the group successfully submitted a proposal to the HC CMHC Scholarship fund to send over 50 clinicians to the 1st Annual MN School Mental Health conference.

- **Education -** The CMHC education committee reviews all requests for scholarships and training support. The group does its work in a virtual capacity, reviewing approximately 30+ requests a year. Working from a core budget of $18,000, the group awarded $17,394.62 in 2016. They awarded an additional grant of $7,880 for school based training to mental health providers, for a total of $25,275. Over 555 individuals attended trainings sponsored by the CMHC in 2016.

2. Metrics related to work groups success

How the work groups function	2012	2013	2014	2015	2016[b]
Number of active work groups	8	8	8	6	6
Number of work groups with an established work plan[a]	3/8	7/8	6/8	4/6	4/6
Number of work groups making significant progress toward their goals [a]	7/8	7/8	7/8	6/6	5/5

[a] Metric derived from the information provided by group leaders. The workgroups have moved towards an approach of setting responsive agendas, rather than having formally established work plan. As a result, this metric will be removed beginning in 2017.

[b] Information about one work group was not available at the time the report was prepared

In 2016, two metrics were removed: (1) % of stakeholders "strongly agreeing" that the roles of standing work groups are clear; and (2) % of stakeholders "strongly agreeing" that the roles of the standing work groups are appropriate.

Success in funded programs/services

Overview of funding efforts and evaluation process

Continuing the efforts that began in 2007, the Hennepin County Children's Mental Health (HCCMHC) funded five entities in 2016 to address key concerns regarding the existing Hennepin County children's mental health system. Three juvenile justice programs, one early childhood program, and one parent leadership group received funding.

Under contract with HCCMHC, Wilder Research staff worked with program representatives and HCCMHC members to develop a coordinated data collection effort for funded programs to provide information about the aggregate impact of the programs in addressing current needs in Hennepin County. HCCMHC identified specific evaluation measures that grantees were required to collect and report to Wilder Research, demonstrating their program's reach.

This section of the report summarizes key metrics collected by the programs during 2016. It also includes highlights from a focus group and summary reports that were collected by Wilder Research.

This section of the report addresses the following questions:

- Who were the youth served through HCCMHC funded programs in 2016?
- What were their experiences with implementation?
- What are some lessons learned and suggestions for 2017?

Evaluation process

In 2016, Wilder Research continued to support HCCMHC's evaluation efforts by conducting a focus groups with the juvenile justice programs that were working directly with youth to collect information about implementation and sustainability. The juvenile justice programs also collected data that was reported in an online reporting template.

Summary reports were also submitted to Wilder Research by the Hennepin County Birth to 5: Watch Me Thrive program and the Parent Catalyst Leadership Group (PCLG), both of which provided information about their progress, successes, and barriers.

Overall success in funding services

Figure 3 provides an overview of the success metrics collected over the past five years. In 2016, 92 percent of the HCCMHC stakeholders "strongly agreed" that funding is allocated appropriately (an increase from 34% in 2012 and 53% in 2014).

The number of projects funded through the HCCMHC increased from 10 in 2011 to 18 in 2013, before declining to 9 in 2014, 7 in 2015, and 5 in 2016. The number of youth served by these programs showed a related increase from 669 in 2011 to 1,422 in 2013, before declining to 631 in 2014, 580 in 2015 and 92 in 2016. While at least 48 percent of the youth served each year have been from communities of color, 2016 had its highest percentage (86%) of youth from communities of color. Across each of the past five years, all of the funded programs have been fully implemented.

In addition to the youth served, the HCCMHC's funding to the PCLG was used to train 64 parents in 2016 (a decrease from 104 in 2015).

3. Metrics related to success in funding services

Success in funding services	2012	2013	2014	2015	2016
Number of projects funded	12	18	9	7	5
% of projects fully implemented at the close of the funding year	100%	100%	100%	100%	100%
Number of youth served annually	745	1,422	631	580	92
% of youth served from communities of color	48%	56%	60%	67%	86%
Number of parents reached through training/support	N/A	N/A	143[a]	104	64
% of projects that have reported improved youth outcomes					
School-based services	6/6	6/6	N/A	N/A	N/A
Juvenile justice	a	a	a	a	a
Uninsured/underinsured	N/A	N/A	N/A	N/A	N/A
Early childhood	N/A	N/A	1/1	1/1	N/A
Number of trainings offered by the cultural competence programs	N/A	58	151[b]	N/A	N/A
Number of people trained by the cultural competence programs	N/A	915	1060[b]	N/A	N/A
% of stakeholders who "strongly agreed" that funding is allocated appropriately	34%	N/A	53%	N/A	92%

[a] Recidivism data were collected but not reported due to the low number of youth in most of the programs.

[b] These data have been updated since the last annual report. The final report can be found in the Appendix.

The following section summarizes information collected about the funded programs. This information has historically been presented as a separate annual report to the Collaborative.

Description of youth served in 2016

A total of 92 new youth were served in 2016 by the juvenile justice programs. These efforts reached a culturally diverse sample of children and youth in Hennepin County. All but one of the youth served by the juvenile justice programs were between 12 and 17 years (there was one person whose age was not known. Nearly two in three youth served were black or of African ancestry (61%). Fourteen percent were white/Caucasian. One in ten youth were biracial/ multiracial (11%) or Native American (9%). Nearly one in six youth were of Latino/Hispanic (13%) ancestry. Nearly all youth served were female (91%) (Figure 4).

4. Demographics of youth served (N=92) (2016 aggregate totals)

Age	N	%
0-5 years old	-	-
6-9 years old	-	-
10-11 years old	-	-
12-17 years old	91	99%
18 or older	-	-
Unknown/not available	1	1%
Race		
Asian/Southeast Asian	-	-
Biracial/Multiracial	10	11%
Black/African ancestry	56	61%
Native American	8	9%
Other/Unknown	5	5%
White/Caucasian	13	14%
Ethnicity		
Latino/Hispanic	12	13%
Non-Latino/Hispanic	80	87%
Gender		
Male	7	8%
Female	84	91%
Transgender/other	1	1%

All funded agencies who served school-aged youth were required to track which school districts youth were enrolled in at the time of intake. Nearly one in three of the youth (29%) were enrolled in Minneapolis Public Schools. One in ten of the youth (21%) were not enrolled in school. (Figure 5).

5. Youth served by school district (N=92) (2016 aggregate totals)

	Juvenile justice (N=92)	
District	**N**	**%**
Anoka-Hennepin	3	3%
Bloomington	3	3%
Brooklyn Center	7	8%
Hopkins	1	1%
Minneapolis	27	29%
Intermediate School District 287	4	4%
Osseo	7	8%
Richfield	2	2%
Robbinsdale	3	3%
St. Anthony	1	1%
St. Louis Park	1	1%
Wayzata	1	1%
Charter school	8	9%
Other school not listed above	13	14%
Not enrolled in school	10	11%

Description of funded entities

In 2016, three juvenile justice programs and one early childhood program were funded by the Hennepin County Children's Mental Health HCCMHC (HCCMHC). Additionally, the Parent Catalyst Leadership Group (PCLG) received funding from HCCMHC. The following sections briefly describe their major activities and outcomes.

Juvenile justice

The purpose of this funded group is to reduce or prevent youth involvement with the juvenile justice system. These programs are funded to coordinate efforts and/or provide better access to mental health services. Some of the programs incorporate emerging or best practices and provide trauma-informed services to youth who are involved in the juvenile justice system. The goals of the programs include: 1) improving overall service coordination, communication, and outcomes in the juvenile justice system; and 2) improving delivery of prevention or intervention services for youth at risk of involvement or currently involved in the juvenile justice system. The type of services provided by the juvenile justice agencies include gender-based individual counseling and groups, gender-based equine therapy model, and hospital-based model with services by Advanced Practice Nurses (Figure 6).

6. Overview of funded juvenile justice programs

Program	Description
Girls Circle H.E.A.R.T.	The YMCA runs Girls Circle H.E.A.R.T., a gender-responsive curriculum, for Hennepin County involved adolescent girls. It includes a 16 week curriculum that provides recreational, individual and group learning experiences; community support through individual and family support, crisis intervention, transportation, and trauma-informed resources and referrals; as well as educational support through coordinating support services, monitoring attendance and attending school meetings.
Hold Your Horses	Cairns Psychological Services provides gender-responsive equine-assisted group psychotherapy through their Hold Your Horses program. The equine therapy treatment model focuses on assisting youth in developing skills to improve their adaptive functioning. Horses assist in the development of these skills by focusing on mindfulness, self-regulation, self-soothing and self-awareness. Group takes place for two hours, one time per week, for 10 consecutive weeks.
Runaway Intervention Program (RIP)	Midwest Children's Resource Center's RIP program provides community visits and group counseling. An advanced practice nurse-led initiative to help severely sexually assaulted or exploited girls reconnect to family, school and health care resources. The two components of the program are: 1) the initial complex health and abuse assessment at the hospital-based Child Advocacy Center; and 2) ongoing care through health assessments, medical care, treatment for post- traumatic stress disorder and depression, and ongoing access to confidential reproductive health care for 12 months.

Findings from focus groups with juvenile justice program staff

A focus group was conducted in December 2016 with representatives from the three funded agencies, along with a staff member from the Positive Opportunities for Women of Every Race (POWER) program. A few themes emerged regarding implementation and sustainability, including:

- **A need for clarity about the programs' purposes and services.** As stated in past focus groups, program staff believe that some county referral sources may be unclear about what the programs have to offer or how they run. To help deal with this, program staff shared that they continue to provide presentations helping to create awareness of their programs.
- **Continued inconsistent relationships with county and social workers.** Some programs reported challenges with not having a specific point person at the county who is dedicated to working with them. These inconsistent working relationships create barriers to effective collaboration and communication between the program and the county. One of the four program did not experience this barrier.
- **County reporting requirements.** Some programs shared that they spend a significant amount of time reporting to the county. Additionally, some program staff felt that timelines for reporting are not always reasonable and are often requested with a sense of urgency. Programs with fewer staff and limited capacity felt that these requests were demanding of their time.

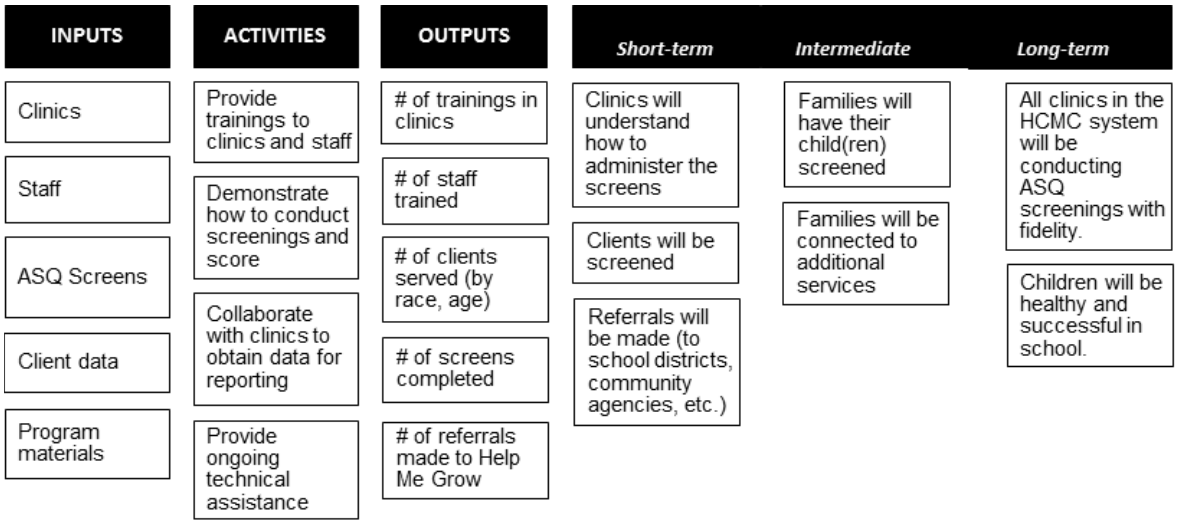
Additional information about the focus group and findings from the 2016 evaluation, as well as information about the 2017 evaluation, can be found in the Appendix.

Early childhood

The purpose of this funded area is to increase social-emotional screening of infants at Hennepin County Medical Center (HCMC). In 2016, the program changed their model and instead of administering the Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) for social-emotional screening[1], they trained the Hennepin County Medical Clinic (HCMC) clinics to conduct the screenings themselves and meet with the family.

[1] The purpose of this first-level screening tool is to identify children who may be at risk for social or emotional difficulties and refer them for ongoing supports and services.

Wilder Research worked with the program to build a logic model that would capture the components of the program model, which is illustrated here:



The Hennepin County Birth to 5: Watch Me Thrive (Birth to 5) staff conducted trainings with the following HCMC clinics:

- Peds Primary (downtown)
- Richfield
- Brooklyn Park
- St. Anthony Village
- Golden Valley
- East Lake
- Whittier

A total of 145 individuals took part in the trainings, which included approximately 20 initial trainings and 11 follow up support sessions. Besides going over the administration of the ASQ:SE, the Birth to 5 staff also provide training around the following areas:

- **Tips** for determining age in months and adjusting for prematurity
- **Guidelines** for how to introduce screening to family and discuss results and referrals
- **Instruction** on using the tool to determine the score scoring the tool

- **Guides** for how to interpret and document results
- **Information** about referrals and follow ups
- **Suggestions** for identifying and delegating roles/tasks

Staff from Birth to 5 reported the ASQ yielded more age-appropriate and directive information than the previous developmental screening tool being used in the clinics allowed. This meant the screening provided better picture of overall child development and areas of concern or delay.

It was reported that trained clinics face some complexities which make conducting the ASQ challenging at times. These included:

- Working with interpreters and families whose primary language isn't English, as well as working around the literacy level of families (so they can fill out the ASQ with fidelity).
- Facing time constraints of clinic appointments in which to implement screening.
- Establishing the most effective ways that each clinic can partner with other community programs.

Birth to 5 also reported it was sometimes difficult rolling out the program model to other clinics because approaches can vary (between the way Birth to 5 approaches the work and other systems' processes). Additionally, the clinicians and staff being trained were sometimes not notified (by their clinic) that the new model was being rolled out in advance of the training, and there was often a short timeframe between when the training occurred and the implementation of the new procedures.

Birth to 5 staff reported they have plans to partner with the Domestic Abuse Project (DAP) and will be meeting with Wilder Research in early 2017 to discuss implications for their evaluation and reporting to HCCMHC in future years.

Parent involvement

The HCCMHC provides administrative, financial, and structural support, as well as coordination services to the Parent Catalyst Leadership Group (PCLG). The vision of the PCLG is that all families of children with mental health needs in Hennepin County have the support and resources to advocate and create a united voice in decision-making processes at all levels of the children's mental health systems of care. The mission of this initiative was to prepare PCLG members to become leaders in policy-making, advocacy, education, and support in order to empower Hennepin County families and create community awareness of children's mental health. This initiative supports parents to accomplish a number of activities including attendance of monthly training and support group meetings, and meeting with other parents of children with mental health concerns.

Characteristics of families involved

In 2016, a total of nine parents are identified as members of the PCLG. All parents attended at least one of the PCLG's monthly support group meetings. The parent group noted that because of the complicated and stressful lives of the parents and the fact that many work full time, it is difficult to find parents who are available during the weekdays.

Two-thirds of the participating parents (67%) are white, 33 percent are African American, and one parent (11%) is of Hispanic ethnicity (Figure 7). Most of the parents (N=8) live in suburban Hennepin County cities.

7. Demographic characteristics of parents involved in 2016 (N=9)

	N	%
Gender		
Male	1	11%
Female	8	89%
Race/Ethnicity		
African American	3	33%
Asian American	-	-
American Indian	-	-
White	6	67%
Bi-/multi-racial	-	-
Hispanic/Latino	1	11%

Overview of other metrics and activities reported in 2016

- The PCLG held 12 parent support group meetings in 2016.
- The PCLG held 9 meetings, trainings, and forums which were attended by 64 parents.
- Parents from the PCLG were involved in 14 outreach activities which involved nearly 800 people. These outreach activities included resource fairs and tables, as well as participation in panels and other type of outreach meetings.
- PCLG members are involved in 22 workgroups and committees.
- The PCLG Facebook support group has 62 members.

More detailed information can be found in the full report, located in the Appendix.

System-level success

The fourth category of HCCMHC success is the overall functioning of the children's mental health system. Most of the information related to this area comes from the survey of HCCMHC stakeholders, which was conducted most recently in 2016 (Figure 8).

In 2016, most stakeholders (92%) "strongly agreed" that LCTS funds enhance children's mental health services in the community, an increase from 67 percent in 2014. The percentage of stakeholders who "strongly agreed" that the CMHC spends an appropriate amount of resources on children's mental health increased from 53 percent in 2014 to 69 percent in 2016, while the percentage "strongly agreeing" that the CMHC funds the appropriate kinds of activities decreased from 73 to 54 percent.

8. Metrics related to system-level success

System-level success	2012 (N=31-32)	2013	2014 (N=12-15)	2015	2016 (N=13)
% of stakeholders "strongly agreeing" that the CMHC spends an appropriate amount of its resources on children's mental health services.	56%	-	53%	-	69%
% of stakeholders "strongly agreeing" that the CMHC funds appropriate kinds of activities.	59%	-	73%	-	54%
% of stakeholders "strongly agreeing" or "agreeing" that LCTS funds enhance children's mental health services in our community[a]	N/A	-	67%	-	92%

Notes. Results come from surveys conducted with HCCMHC stakeholders. Surveys were not conducted in 2013 or 2015, per the Governance Board's decision to collect surveys every other year.
Seven metrics were removed in 2016, including: (1) the % of stakeholders rating the system serving children/youth with mental health issues as either "somewhat effective" or "very effective"; (2) % of stakeholders rating the system serving children/youth with mental health issues as "very effective"; (3) the % of stakeholders "strongly agreeing" that the CMHC had a positive impact on the overall system of care for children; (4) % of stakeholders "strongly agreeing" that the CMHC engages and sustains parents in systems-level participation and leadership; (5) % of stakeholders "strongly agreeing" that the CMHC increases access to children's mental health services; (6) % of stakeholders "strongly agreeing" that the CMHC improves the quality of children's mental health care (i.e., evidence-based care, trauma-informed services, etc.); and (7) % of stakeholders "strongly agreeing that the CMHC supports culturally and gender responsive services.

Considerations

The number of youth served directly is lower this year, but programs funded by HCCMHC continued to serve a large, diverse group of youth and youth-serving agencies. HCCMHC funding increased accessibility to mental health services for youth and their families. For some agencies, the funding enhanced services they were already providing, and for others the funding made services possible.

Given the feedback we received from the three programs that were working with youth directly, the collaborative can look for ways for the system to **better understand systemic trauma and oppression.** Program staff pointed to a need for more understanding of how youth experience trauma from being involved in the justice and human service systems. In addition to the likelihood of having adverse childhood experiences (ACEs), the systemic racism and experience of being involved in the justice system furthers exacerbate the mental health issues of youth. Staff pointed to systemic issues as being interrelated with adverse childhood experiences (ACEs) and their impact on youths' mental health. **HCCMHC may want to consider additional funding for programs to expand the training and capacity of the system.**

PCLG members still face challenges with **transportation** (to get to the meetings) and **schedules** (to attend the meetings). They are also still not sure how much impact they have on changing the system. **HCCMHC may want to work with the leadership group to explore other meeting options, including offering virtual meetings.**

Finally, funding for special projects (e.g., cross-cultural work, early childhood, and juvenile justice) has generated knowledge and lessons. Methods to share findings should be expanded beyond the annual report. **HCCMHC could work with these agencies and programs to determine different ways to share and celebrate the successes of these projects.**

Appendix: Funding information

Funding information

In 2016, the Hennepin County Children's Mental Health HCCMHC (HCCMHC) funded a number of programs and activities. Below is a brief overview of the programs and scholarships that were funded. The programs and efforts were funded jointly by HCCMHC, Hennepin County's Department of Community Corrections and Rehabilitation (DOCCR), Intermediate School District (ISD) 287, and/or Local HCCMHC Time Study (LCTS). The programs also may have funding from other sources.

I. Programs funded by HCCMHC/LCTS funds – Total $128,544

Parent support and programming of the Parent Catalyst Leadership Group (PCLG) used $12,170 in LCTS funds this year. The HCCMHC scholarship program was available to individuals living within Hennepin County and/or employees or volunteers who work at nonprofit agencies for publicly announced and credentialed children's mental health conferences or trainings. $17,100 was paid in scholarship support for approximately 32 individuals (in individual scholarships) and 416 individuals (in agency and event scholarships). The early childhood program was funded by HCCMHC and LCTS funds and billed $99,274.

II. Programs funded by HHCCMHC/LCTS/DOCCR funds – Total $337,777

Three juvenile justice programs were funded collectively by HCCMHC, LCTS, and DOCCR funds in the amount of $337,777.

III. Programs funded by HCCMHC funds – Total $149,333

ISD 287 received funding for two of their programs. One was the Diploma On! program (Figure A3). Diploma On! was previously named the Drop Out Prevention Program (DOPP), and is offered to ten area school districts, including Brooklyn Center, Eden Prairie, Hopkins, Orono, Osseo, Richfield, Robbinsdale, St. Louis Park, Wayzata, and Westonka. The other is the Restorative Justice project, which provides training for staff in restorative justice practices to reduce behavioral incidents. The total amount used in HCCMHC funds was $149,333.

Parent Catalyst Leadership Group (PCLG) year-end report

HCCMHC Parent Involvement Report

This report template should be completed annually to describe the goals, activities, and impact of parent involvement activities funded by the Hennepin County Children's Mental Health Collaborative (due January 31 of each year). Information from this report will be used by Wilder Research to prepare a report summary of all Collaborative-funded projects/initiatives.

Status of contract goals

Table 1: Status on progress toward goals

Contract goal	Brief description of progress towards goal since last report	Current status (Not started, in progress, on hold/delayed, completed)
Maintain catalyst base and recruit new members.	• In 2016, 2 catalysts stepped away due to other increased commitments in their lives. We have not added any new parents this year. We have maintained a base of 9.	Goal in progress (moving target)
Establish and work towards outreach targets (this can include geographic and diversity goals).	• Currently, the PCLG is racially, ethnically and socioeconomically diverse, but could benefit from participation from some currently underrepresented groups, such as Native Americans and recent immigrants. • PCLG continues to extend its reach by presenting and doing outreach at events and offering social media, a blogsite, a new online Facebook support group, and a monthly newsletter to our expanding email base.	Goal in progress.
All CMHC work groups' roster should include active and consistent membership from the PCLG.	• All CMHC work groups are being attended by an involved parent representative and there are formal alternate assignments for each committee. Meeting attendance has been very consistent.	Goal met
Strengthen alliances with school groups	• PCLG has had active outreach to and communication with the Parents of Tradition group at Minneapolis Public Schools. • Many parents are regular attendees at their school district's special education advisory group (SEAC/ SECAC) are working on issues such as improving academic opportunities and outcomes for students in EBD programs; and expanding inclusion, vocational and extracurricular opportunities for students in special education. • PCLG members regularly participate in special education and school resource fairs. • PCLG has produced and offers resource materials for schools to encourage them to offer more mental health awareness programming.	Goal met

Table 1: Status on progress toward goals (continued)

Contract goal	Brief description of progress towards goal since last report	Current status (Not started, in progress, on hold/delayed, completed)
Provide 9-12 parent training sessions/ year	• 9 PCLG meetings this year.	Goal met
Provide 9-12 monthly support groups per year	• PCLG had 12 support group meetings this year. • PCLG added a Facebook Support Group so that parents can have more support "on demand" and we can reach more parents.	Goal met
Co-sponsor trainings for a larger audience at least twice per year.	• PCLG gave presentations and hosted information tables at various parent meetings and other mental health events. (see list below) • PCLG hosted a workshop with Dr. Elizabeth Reeve: "Parenting Challenges: Taking Care of Yourself."	Goal met.

Q1. Please describe any barriers you have encountered in working towards the contract goals and steps you are taking/plan to take to address these challenges.

- Our parents have extremely complicated and stressful lives and we meet only monthly, so it is difficult to make steady progress on our goals.
- It continues to be challenging to find a variety of parents who are available during the weekdays to attend HCCMHC meetings. More PCLG parents are working full time. Parents of younger children have trouble finding childcare during the after school hours.

Parent Catalyst Leadership Group activities

Table 2: Description of Parent Catalyst Leadership Group participants

a. Number of parents/caregivers currently involved in the PCLG	9
b. Number of trained catalysts currently involved in the PCLG	9
c. Number of parents who have completed PCLG training (January 2011 – current)	9
Diversity within the PCLG	
Race	
a. Black/African-American	3
b. African (African-born)	0
c. Native American	0
d. Asian/SE Asian	0
e. White/Caucasian	6
f. Bi- or multi-racial	
g. Other (please describe below) – *one white parent is a parent of biracial children*	
h. Unknown/missing	
Ethnicity	
a. Hispanic	1
b. Non-Hispanic	
c. Unknown/missing	
Gender	
a. Male	1
b. Female	8
City of residence	
a. Minneapolis (North)	1
b. Suburban cities (please list cities where PCLG members live: Bloomington. Brooklyn Center, Hopkins, Minnetonka, New Hope, Plymouth, St. Louis Park)	8

Table 3: Parent Catalyst Leadership Group training meetings and events

Date	Description	Trainer/Guest speaker (If conducted by external trainer)	Number attended
1/9/2016	Co-chair nominations & election; FB support group discussion; workplan review; Mapping project discussion – members committed to review provider information offered online through private and public insurance		7
2/20/2015	Meeting updates; "Parents of Tradition" connection and upcoming education event; Discussion of ways to improve support group; Insurance search engines report		8
3/12/2015	Signup for outreach events; Meeting updates; Follow up on provider searches; Review draft of parent survey		8
4/30/2016	Meeting updates; Sharing resources from MACMH; Scheduling meetings and outreach activities; Fall event planning;		7
6/25/2016	Meeting updates; More fall event planning; Review of survey revisions; In depth discussion: "Why does Karen's dog get more follow through on his dental appointment from her vet than children who are discharged from MH hospitalization get?" How can we help change the system to get parents the follow through and help that they actually need?		9
8/20/2016	Meeting updates; Fall event updates; Workgoup/workplan – refocusing and refining goals for fall;		5
9/17/2016	Meeting updates; area workshops; Fall event updates; Follow up on contacts and potential collaborations; Facilitated discussion: How do we prioritize PCLG efforts?		6
10/15/2016	"Mental Health: Yours, Mine and Ours" film showing and focus group; PCLG updates	Deb Cavitt; Cari Michaels	8
11/19/2016	Event review and future planning; Conversation with Wilder re: addressing the information/access gap for parents. How can we best connect parents to information and new research findings?	Cheryl Holm Hanson, Wilder	6

Outreach Activities and Panel/Focus Group Participation (estimated audience)

- Beacon Academy Special Education Resource Fair Participation/Presentation (40)
- American Indian Engagement Event resource table (45)
- Outreach meeting: NAMI Hennepin County and Minneapolis ASD Support Group Leaders (6)
- Meeting with ASD Parents in Minneapolis (5)
- Parents of Traditions trainings (4 meetings – 30 attendees total)
- Fidgety Fairy Tales Resource Tables @ 4 HC libraries; (150)
- Minneapolis Public Schools Special Education Resource Fair (100)
- MNAdopt Resource Fair (120)
- Meeting with MOFAS leaders to increase collaboration (3)
- Meeting with MNAdopt staff to increase collaboration (4)
- Presentation to MPS Native American special ed parents (7)
- Outreach meeting: Plymouth Area ANSWER Support Group (6)
- JFCS Mental Health Event resource table (250)
- PCLG Panel Participation: University of MN presentation to nursing students (20)

PCLG member involvement in workgroups, committees

Table 4: Description of parent involvement in workgroups, committees

Name of organization. (Specify name of committee, and/or workgroup, if applicable)	MM/YY involvement began	MM/YY involvement ended	Frequency of meetings	Description of involvement
HC CMHC –Executive Committee	Pre 2011	Still Attending	Bi-monthly	1 Voting Member
HC CMHC –Governance Committee	Pre 2011	Still Attending	Bi-monthly	2 Voting Members
HC CMHC –School-based Mental Health	Pre 2011	Still Attending	Monthly	Active Member
HC CMHC –Evaluation Committee	Pre 2011	Still Attending	As Needed	Active Member
HC CMHC –Provider	Pre 2011	Still Attending	As Needed	Active Member
LCTS	2011	Still Attending	Annually	Active Member
State Advisory Council on Mental Health **1) Subcommittee on Children's Mental Health 2) Schools and Mental Health Workgroup**	2014	Still Attending	Monthly	Active Member
Metro CCS: Policy Committee and Leadership Teams	July 2013	Still Attending	Monthly	2 Active Members

Table 4: Description of parent involvement in workgroups, committees (continued)

Name of organization. (Specify name of committee, and/or workgroup, if applicable)	MM/YY involvement began	MM/YY involvement ended	Frequency of meetings	Description of involvement
Metro Area IEIC	Pre 2011-June 2016	Phasing off	Quarterly	Active Member
Cultural Providers Network	2011	Attending	Monthly Sept-June	Active Member
Statewide Independent Living Council (SILC)	Pre 2011	Still Attending	Monthly	Active Member
Bloomington Special Education Community Advisory Council (SECAC) and Pathways to Graduation	Pre 2011-June 2016	Phasing off	Monthly Sept-June	Active Member
Hopkins Special Education Advisory Committee (SEAC)	Pre 2011	Still Attending	Monthly, Sept-May	Active Member
Lionsgate Special Education Advisory Committee (SEAC)	2013	Still Attending	5X/year	Active Member
Minneapolis Public Schools Special Education Advisory Council (SEAC)	Pre 2012	Attending	Monthly Sept-May	Active Member
Osseo/Maple Grove Special Education Advisory Council (SEAC)	2014	Attending	Monthly Sept-May	Founding Member
Wayzata Special Education Advisory Council (SEAC)	2014	Attending	Monthly Sept-May	Active Member
Wayzata Partners for Healthy Kids	2015	Attending	Monthly Sept-May	Active Member
African American Advisory Council	2016	Attending	As Needed	Active Member
School Mental Health Task Force	2015	Attending	As needed	Active Member
Harrison School Site Council	2016	Attending	As Needed	Active Member
MACMH Board Member	May 2013	Still Attending	Bi-Monthly	Active Member
MACMH – Parent Support Provider Program	Sept 2013	Still Attending	Monthly	5 Active Members

Parent Support Group activities

Table 5: Parent Support Group

Parent support group involvement	Number attended
a. Number of parent support group meetings held in past 12 months	12
b. Number of non-PCLG parents (total, unduplicated) who have attended a parent support group meeting since January 2016	8
c. Number of PCLG members (total, unduplicated) who have attended a parent support group meeting since January 2016	7
d. Number of PCLG Facebook support group members	62

Q1. Is parent participation for the parent support group at the level you expected it would be? If not, please describe any barriers to increasing participation in the support group and how you plan to address these challenges.

While we were able to attract new attendees, many of our guests seemed to visit for just a one to three visits when they felt most in crisis, and then stopped attending after their crisis had been resolved. 2016 has had generally lower attendance than 2015 and we are exploring new locations and new ways to attract parents. We plan to hold a joint support group meeting in 2017 with an existing St. Joan of Arc mental health support group.

Our Facebook online support group has 62 members and we get positive feedback about the group.

Table 6: Parent Support Group topics

Date	Description	Number catalysts + guests
1/2014	Resource Activity	5+0
2/2014	Taking Care of Self/	4+1
3/2014	Siblings	3+1
4/2014	Medication	5+0
5/2014	Getting the services your child needs	4+2
6/2014	Recreational activities	5+2
7/2014	Summer check in	4+0
8/2014	Crisis and the criminal justice system	3+2
9/2014	Back to School – struggles and successes	4+1
10/2014	Building on your child's strengths	2+0
11/2014	Transgender; Depression	3+1
12/2014	Holidays	4+1

Lessons learned

Q1: What have been the major barriers to increased parent involvement in Collaborative workgroups/committees? What steps can the Collaborative take to address these barriers?

Scheduling: As stated above, one of the primary barriers is the timing of collaborative committees. Many meet at 2:30 or 3:00 pm on weekdays, which makes it challenging both for our full-time working parents as well as those who are picking up kids after school.

Impact and Knowledge: Some parents who serve on HCCMHC committees question how much actual impact they have in changing the system. Even long-serving committee members don't feel as if they have much influence, stating that ideas they share tend to be dismissed or ignored.

It might be helpful if some committee meetings had some time for an open forum when miscellaneous issues could be raised, rather than those that pertain directly to the traditional agenda of evaluations, contracts and grants.

Q2: Have Parent Catalysts faced any challenges/difficulties in becoming involved with community workgroups/organizations? How can these challenges be addressed?

Transportation: Several of our parents do not have cars, so transportation and rotating meeting sites can present a significant barrier for them.

Scheduling: With the economy improving, more of our parents are working full time and they simply aren't available during the weekdays to participate in many of these committees. In addition, our parents spend a great deal of time navigating the system and dealing with family emergencies, so it is difficult for them to take on more involvement. Many of these community workgroups seem to compete for the same parents, ones who check multiple boxes (race, poverty, geographic region, etc.) at the same time. Options to call in, flexible scheduling, better outreach and stipends for childcare or travel all increase the likelihood of involvement.

Skill Set: Many of the truly disadvantaged parents who these organizations could benefit most from hearing from are the ones who are least likely to be included because they lack the education or English speaking ability to be able to be considered a peer and listened to on many of these committees. Organizations should put more effort into outreach for parents who are newer to the system, but who could benefit from learning about programming, challenges, and resources.

Q3: What concerns have been identified as parents (Parent Catalysts/parent support group & Facebook group participants) that may be helpful for the Collaborative to try to address?

- "Where do I start?" – Parents still report feeling lost and not knowing what to do when they are concerned about their child. They report that schools try to avoid doing evaluations, particularly if the student is bright and not yet failing classes. They often don't know how to go about finding a therapist and they are frustrated by how many phone calls they have to make and how hard it is to find anyone who has availability.
- "What do I do when I take my child to the ER but they say they won't hospitalize him?"
- Frustration that there is no follow up for families from the hospital after a child has been released.
- Frustration about lack of day treatment availability.
- Frustration that an adolescent with mental health and substance abuse problems needs to be referred to juvenile justice in order to get the services he needs.

- "Will I be able to keep my same providers when Medica MA changes are made in May?"
- "How will TEFRA be affected?" Complaints about high TEFRA fees.
- "What will happen with the ACA and mental health treatment?"
- Shared sentiment that calling Front Door isn't helpful, particularly for parents who don't qualify for services and who are seeking information about navigating the system.
- "Cultural impasse" between parents and providers, where parents have a strong tendency to feel blamed and providers tend not to recognize the complexity of parents' lives and the *cumulative* burden when they perceive that parents are not doing enough to help their child.
- Lack of sufficient cultural providers.
- Too many arrests of students with mental health needs in schools.
- Parents, particularly low income families, struggling to work and also take a child with mental health needs to appointments, therapy, and deal with school problems as well.

Appendix: Completed reports since the last annual report

Below are links to three reports that were completed since last year's report.

Evaluation of School-based Mental Health Services in Hennepin County: Understanding the Impact of Services on Students: http://www.hccmhc.com/wp-content/uploads/2010/09/HCCMHC_SchoolBasedMentalHealth_Hennepin_9-16.pdf

Hennepin County Children's Mental Health Collaborative Cross Cultural Agencies Report to the collaborative 2013-2015: http://www.hccmhc.com/wp-content/uploads/2010/09/HCCMHC-Cross-Cultural-findings-2013-2015.pdf

Hennepin County's Department of Community Corrections and Rehabilitation (DOCCR) 2015: http://www.hccmhc.com/wp-content/uploads/2010/09/DOCCR-Programs-2015.pdf

Appendix: Collaborative survey

Since 2008, the Hennepin County Children's Mental Health Collaborative has conducted periodic assessments of their functioning and status. Surveys of Collaborative members were conducted annually from 2008-2010, then moved to a biannual schedule. The current survey was conducted in late 2016.

Description of survey respondents

A total of 27 Collaborative stakeholders were invited to respond to the survey. Up to four invitations were sent to each potential respondent. Thirteen people (48%) completed the survey. Respondents represented a range of agencies, with most representing school districts (31%), non-profit agencies (23%), county government (23%), and parents (23%). Respondents also represented mental health providers (15%) and other coalitions or collaboratives (15%). Seventy-seven percent of the respondents described themselves as "very familiar" with the Collaborative; the rest described themselves as "somewhat familiar." Most respondents (85%) "often" attend Collaborative meetings (such as the Governance Board or work groups/committees). Others attend meetings "sometimes" (15%).

A1. Type of agency represented

	2012 (N=36)		2014 (N=19)		2016 (N=13)	
What type of agency do you represent?	**N**	**%**	**N**	**%**	**N**	**%**
School district	7	19%	6	32%	4	31%
Non-profit agency	15	42%	5	26%	3	23%
County government	3	8%	5	26%	3	23%
Mental health provider	8	22%	-	-	2	15%
Another collaborative or coalition	1	3%	3	16%	2	15%
Parent organization/parent	3	8%	1	5%	3	23%
Other	3	8%	1	5%	-	-

Respondents were instructed to check all that apply, so totals may exceed 100%. In 2014, the one person who responded "other" identified him/herself as a consumer.

A2. Familiarity with the Collaborative

How familiar are you with the Hennepin County Children's Mental Health Collaborative?	2012 (N=36)		2014 (N=19)		2016 (N=13)	
	N	%	N	%	N	%
Not at all familiar	1	3%	1	5%	-	-
Somewhat familiar	13	36%	6	32%	3	23%
Very familiar	22	61%	12	63%	10	77%

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

A3. Frequency of meeting attendance

How frequently do you attend Hennepin County Children's Mental Health Collaborative meetings (such as the Governance Board or work groups/ committees)?	2012 (N=36)		2014 (N=19)		2016 (N=13)	
	N	%	N	%	N	%
Never	4	11%	1	5%	-	-
Rarely	6	17%	4	21%	-	-
Sometimes	5	14%	3	16%	2	15%
Often	21	58%	11	58%	11	85%

Key findings

Success in achieving mission

All respondents felt the Collaborative was at least "somewhat successful" in achieving its mission, with the percentage rating it as "very successful" increasing between 2014 and 2016. Fifty-four percent of respondents said that the collaboration was "very successful" (54%) or "somewhat successful" (46%) in achieving its mission. The percentage who rated the Collaborative as "very successful" decreased from 40 percent in 2012 to 25 percent in 2014, before increasing to 54 percent in 2016. The mission statement was revised in both 2012 and 2014[2], making it difficult to assess trends over time. Changes in ratings may be due to the fact that the Collaborative has had varying levels of success achieving various iterations of the mission.

[2] In 2014, respondents were asked to rate the Collaborative's success in their mission "to improve access to and resources for high-quality, trauma-informed mental health services for children, youth, and families in Hennepin County."

A4. Collaborative success in achieving mission

How successful has the Collaborative been to date in achieving its mission?	2012[1] (N=35)		2014[2] (N=16)		2016[2] (N=13)	
	N	%	N	%	N	%
Not at all successful	1	3%	1	6%	-	-
Somewhat successful	20	57%	11	69%	6	46%
Very successful	14	40%	4	25%	7	54%

[1] "To serve as the catalyst for improving children's lives by serving as a convener, coordinator, advisor and advocate for community efforts to increase access to and resources for high quality mental health services for children and families."

[2] "To improve access to and resources for high-quality, trauma-informed mental health services for children, youth, and families in Hennepin County."

Success of the Collaborative in reaching goals

Collaborative partners were asked to rate the success of the CMHC in a number of ways. One set of questions assessed the Collaborative's success in carrying out core intended activities, while a second set asked about success in reaching key intended impacts. A few of these items were also included in the 2012 survey, but most were added in 2014 to reflect the revised goals that emerged during the CMHC's visioning process early in the year.

In 2016, members were asked to rate the Collaborative's success in carrying out six core activities. Members were most likely to "strongly agree" that the Collaborative involves leadership Coalition/stakeholders (54%) and has increased linkages between the children's mental health system and other systems (61%); most other members "agreed somewhat" with these items. Most also "agreed strongly" (31%) or "agreed somewhat" (54%) that the Collaborative offers supportive and proactive training and that the Collaborative uses assessments and research to drive the work plan/funding.

Ratings were lower for the other two items, with fewer Collaborative members "agreeing strongly" (23-31%) or "agreeing somewhat" (23-38%) that the Collaborative has identified gaps in children's mental health services and works towards consistent inclusion of youth voice and perspective. Forty-six percent of the respondents "disagreed strongly" (23%) or "disagreed somewhat" (23%) that the Collaborative works towards consistent inclusion of youth; 23 percent also "disagreed somewhat" that the Collaborative has identified gaps in children's mental health services (Figure A5).

A5. Perceived success of the Collaborative in carrying out key activities

How much do you agree or disagree with each of the following statements? The Collaborative…	Year	N	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Involves leadership Coalition/ stakeholders	2016	13	54%	38%	8%	-	-
Has used assessments and research to drive work plan/funding.	2014	16	44%	37%	-	6%	13%
	2016	13	31%	54%	8%	-	8%
Has increased linkages between the children's mental health system and other systems (schools, primary health care providers, corrections, early childhood, etc.)	2014	16	50%	31%	-	6%	13%
	2016	13	61%	31%	-	-	8%
Has worked towards consistent inclusion of youth voice and perspective in all CMHC work	2014	16	19%	12%	31%	19%	19%
	2016	13	23%	23%	23%	31%	-
Has identified gaps in the children's mental health services (i.e., for early childhood, children of color, children living in poverty, youth who are exploited, GLBT youth, youth transitioning to adult mental health system).	2014	16	31%	44%	13%	-	13%
	2016	13	31%	38%	23%	-	8%
Offers supportive and proactive training	2016	13	31%	54%	8%	-	8%

The survey respondents were also asked a second set of questions regarding the Collaborative's success in achieving their core goals. Members were most likely to rate the Collaborative as successfully allocating LCTS funding within core areas (69% "agreeing strongly," 23% "agreeing somewhat"). Most respondents also "agreed strongly" (54%) or "agreed somewhat" (31%) that the Collaborative promoted system building and support, though 15 percent of the respondents also "disagreed somewhat" with this item.

Ratings were somewhat lower for other items. Thirty-one to 38 percent of respondents "agreed strongly" that the Collaborative advocated around core principles or policy areas, convened informational meetings for all entities and stakeholders in support of children's mental health, and built collaborative systems and structures in support of children's mental health. Most other respondents "agreed somewhat," though a few disagreed with some items.

The lowest rated item related to the Collaborative's success in educating by disseminating best and promising practices. Twenty-three percent of respondents "agreed strongly" with this item, and 46 percent "agreed somewhat." Three respondents (23%) "disagreed" with this item, either "strongly" or "somewhat" (Figure A6).

A6. Perceived success of the Collaborative in meeting goals (2016)

How much do you agree or disagree with each of the following statements? The Collaborative…	N	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Allocated LCTS funding within core areas	13	69%	23%	-	-	8%
Advocated around core principles or policy areas	13	38%	46%	8%	-	8%
Convened informational meetings for all entities and stakeholders in support of children's mental health	13	31%	61%	8%	-	-
Educated by disseminating best and promising practices	13	23%	46%	15%	8%	8%
Built collaborative systems and structures in support of children's mental health	13	38%	54%	-	-	8%
Promoted system building and support	13	54%	31%	15%	-	-

Note. Several additional questions were included in the previous surveys. Only questions included in 2016 are reflected in this figure.

Importance of a collaborative approach

Collaborative members were asked two items in 2016 related to the importance of a Collaborative approach. All respondents either "agreed strongly" (46%) or "agreed somewhat" (54%) that the Collaborative represents a good cross-section of the mental health system for children. They all also either "agreed strongly" (77%) or "agreed somewhat" (23%) that what they are trying to accomplish through the Collaborative would be difficult for any one agency to achieve by itself (Figure A7).

A7. Importance of a collaborative approach

How much do you agree or disagree with each of the following statements?	Year	N	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
The Collaborative represents a good cross section of the mental health system for children	2012	32	34%	53%	9%	3%	-
	2014	15	47%	40%	-	13%	-
	2016	13	46%	54%	-	-	-
What we are trying to accomplish through the Collaborative would be difficult for any one agency to achieve by itself	2012	32	78%	19%	3%	-	-
	2014	14	71%	14%	14%	-	-
	2016	13	77%	23%	-	-	-

CMHC funding

In 2016, the CMHC continued to invest LCTS funds with the following priority areas: school-based mental health services, cultural competence training for mental health professionals, early childhood mental health screening in primary health care settings, juvenile corrections-based mental health services (through JDAI), shared social worker projects (through District 287), emergency support, and scholarship and training support for mental health training opportunities. Survey respondents were asked a variety of questions about these funding priorities.

Ninety-two percent of stakeholders "agreed strongly" that LCTS funds enhance children's mental health services in the community (an increase from 67% in 2014). Eighty-five percent of the survey respondents "agreed strongly" that they were aware that funding had been allocated in these areas (an increase from 60% in 2014).

Ratings were somewhat lower for the other three items, although most respondents still agreed strongly that the CMHC spends an appropriate amount of its resources on children's mental health services (69%), allocates funding appropriately across priority areas (61%), and funds appropriate kinds of activities (54%).

A8. Ratings of CMHC funding decisions

Please indicate whether you agree or disagree with the following items.	Year	N	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
I was aware that the funding had been allocated by the CMHC in these areas	2012	32	59%	22%	12%	6%	-
	2014	15	60%	27%	13%	-	-
	2016	13	85%	-	8%	-	8%
The CMHC is spending an appropriate amount of its resources on children's mental health services	2012	32	56%	34%	6%	-	3%
	2014	15	53%	27%	-	-	20%
	2016	13	69%	23%	8%	-	-
The CMHC is funding appropriate kinds of activities	2012	32	59%	28%	9%	3%	-
	2014	15	73%	20%	-	7%	-
	2016	13	54%	38%	-	-	8%
Funding is allocated appropriately across priority areas	2012	32	34%	53%	3%	6%	6%
	2014	15	53%	20%	7%	7%	13%
	2016	13	61%	31%	-	-	8%
LCTS funds enhance children's mental health services in our community.	2014	15	67%	26%	-	7%	-
	2016	13	92%	-	-	-	8%

A9. Open-ended comments: Other key priority areas for funding

Are there any key priority areas for children's mental health services that are not represented in the funding decisions? If so, what?

2014
I feel all the areas are represented in theory; however, the actual work is not as well defined or executed.
Transition age youth.
2016
More focus on: LGBTQ community and transition (from education to workplace).
The work of the Hennepin County CHMH may be very good. When I talk about the Collaborative, most people in the county do not know what the Collaborative is doing, nor do they have a point of reference for the priorities, spending and services provided by the Collaborative.
It would be nice to see an emphasis on including student voice – if even in the format of an annual conference for youth that could be in partnership with MN Alliance With Youth, NAMI MN Youth and other partners. This would help gain youth voice in the process.
Emergency management in the event of a mass trauma event. In the event of disaster the county, hospitals, and the school districts have plans and processes in place, but to my knowledge, there is no coordination between the providers in the collaborative with these systems. Some time and effort spent considering how the children's mental health providers would respond in advance of a large-scale event would be prudent.
From my perspective the HCCMHC has always been open in considering project funding request which meet CMHC priorities.

Coordination team

In 2016, a series of 15 new questions were added to assess the success of the Collaborative's coordination team. While most respondents at least "agreed somewhat" with each item, the percentage who "agreed strongly" varied widely. Survey respondents were most likely to "agree strongly" that the coordination team effectively oversaw the CMHC training and scholarship program (69%), managed the collaborative timeline through the year (69%), provided efficient and timely communications on any and all aspects of the working of the collaborative (61%), oversaw all LCTS funding protocols and strategies (61%), and provided oversight and management of general LCTS financial information that is secured through Hennepin County (61%).

For six items, approximately half of the respondents provided ratings of "agree strongly." Fifty-four percent of the respondents "agreed strongly" that the coordination team effectively completed DHS Annual Reports and Hennepin County spending reports; assisted with the completion of all legal document updates as needed; assisted with other projects or initiatives as requested; ensured that meetings of the full board and executive committee were well thought-out, prepared, supported and executed; and worked with board and executive committee on expanding stakeholder representation on the CMHC board. Forty-

six percent "agreed strongly" that the coordination team effectively conducted CMHC strategic planning updates as needed or requested.

The lowest rated item related to the coordination team's success in effectively sharing and disseminating studies or data that can help identify existing community needs, barriers, opportunities or other relevant strategic issues (23% of stakeholders "agreed strongly"). Other items with relatively low ratings (38% "agreeing strongly") addressed the Collaborative's success in working with the Board and executive committee on establishing agendas, reports, and other needed action steps to meet stated goals; representing CMHC at community meetings that connect with their mission and purpose; and responding to parent and community member's requests for information. It should be noted that 38-54 percent of respondents indicated that they "did not know" how to rate these last two items (Figure A10).

A10. Coordination team success

In 2016, the coordination team effectively…	N	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Ensured that meetings of the full board and executive committee were well thought-out, prepared, supported and executed	13	54%	38%	-	-	8%
Provided efficient and timely communications on any and all aspects of the workings of the collaborative	13	61%	31%	-	-	8%
Worked with Board and executive committee on establishing agendas, reports, and other needed action steps to meet stated goals	13	38%	38%	-	-	15%
Shared and disseminated studies or data that can help identify existing community needs, barriers, opportunities or other relevant strategic issues	13	23%	54%	15%	-	8%
Provided oversight and management of general LCTS financial information that is secured through Hennepin County.	13	61%	31%	8%	-	-
Responded to parent and community member's requests for information	13	38%	8%	-	-	54%
Oversaw all LCTS funding protocols and strategies	13	61%	31%	-	-	8%
Oversaw the CMHC training and scholarship program	13	69%	23%	-	-	8%
Conducted CMHC strategic planning updates as needed or requested	13	46%	23%	8%	-	23%

Note. Several additional questions were included in the previous surveys. Only questions included in 2016 are reflected in this figure

A10. Coordination team success (continued)

In 2016, the coordination team effectively…	N	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't know
Worked with board and executive committee on expanding stakeholder representation on the CMHC board	13	54%	15%	8%	-	23%
Represented CMHC at community meetings that connect with our mission and purpose	13	38%	23%	-	-	38%
Completed DHS Annual reports and Hennepin County spending reports, and any other reports as required or requested from DHS and Hennepin County	13	54%	15%	-	-	31%
Managed collaborative timeline throughout year	13	69%	15%	-	-	15%
Assisted with the completion of all legal document updates, as needed	13	54%	15%	-	-	31%
Assisted with other projects or initiatives as requested	13	54%	23%	-	-	23%

Note. Several additional questions were included in the previous surveys. Only questions included in 2016 are reflected in this figure.

In 2016, survey respondents were asked to answer two open-ended questions about the Collaborative's current coordination team. Three people provided responses when asked about the most helpful benefits of the coordination team. These responses focused on services such as convening and holding well-organized meetings (Figure A11). Two people made recommendations related to how the coordination team could improve. One person suggested sharing meeting minutes with other Collaborative members and the other recommended broader communication strategies and mental health supports for youth in foster care (Figure A12).

A11. Open-ended comments: Positive aspects of the coordination team

What do you find most helpful/beneficial regarding the performance of the current coordination team? What benefits are they providing to the Collaborative?

2014

I think the structure of the coordination team is very helpful. It is important to have a leadership team who works to oversee and link the work of the collaborative.

Knowledgeable, professional, good communications, long track record with collaborative.

Involving parents. Effective use of funding.

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Good and efficient meetings, good consultation on programs and evaluation.

Very organized.

A core team of decision makers and coordinators to improve efficiency and effectiveness.

A11. Open-ended comments: Positive aspects of the coordination team (continued)

What do you find most helpful/beneficial regarding the performance of the current coordination team? What benefits are they providing to the Collaborative?

2016

The HC CMHC serves as a cross-county convening group for sharing, reflection, advocacy, action and response. Thank you for this work.

Well organized meetings. Clearly stated strategic plan.

The current Coordination Team does a fine job of organizing and overseeing all aspects of the HCCMHC. Job well done...

A12. Open-ended comments: Recommendations for improving the coordination team performance

Do you have any suggestions for ways that the coordination team could improve?

2014

I am not sure, but feel some sort of "independent" quality assurance (i.e. a way that other collaborative members could voice concerns anonymously).

No

??

More communication and transparency to the rest of the collaborative.

2016

Perhaps minutes from their meetings could be available to other Collaborative members as requested.

Expand communication, as resources are available -- not to each other, but to the broader public, families, individual students and youth – even groups such as grandparents raising grandchildren. I would like to see an initiative where everyone works to identify additional mental health supports for children in Foster Care, as their care coordination team identifies [what] is needed. I think there is a lot that could be done in this area in coordination with schools, Foster Care parents and CMHC.

None

Overall perspectives about the Collaborative

The final two questions asked respondents to share some overall thoughts about the Collaborative. Nine people described the most positive thing that they have seen resulting from the Collaborative. These respondents identified a number of different benefits, such as parent participation, funding for early childhood and school-based services, and supporting collaboration (Figure A13). Eight people made suggestions for improving the Collaborative. Several suggested increasing participation of parents, representatives of community mental health initiatives or advocacy groups, people of color, and youth. Others suggested more focus on the "outside world" of children's mental health, increased visibility, more thought about building Collaborative relationships; and increased LCTS funding (Figure A14).

A13. Open-ended comments: Most positive thing resulting from the Collaborative

What is the most positive thing you have seen resulting from the Collaborative?

2014

The grant opportunities they provide to partner and support minority communities in the area of children's mental health.

Support of school based mental health; early childhood project; scholarship dollars.

School Based Mental Health work. Integrating funding streams in this priority has aligned so nicely with the CMH/FSC legislation.

It's good for people from different backgrounds and knowledge based to come together. There are many systems to touch on and no one person/system understands it all.

Expansion of resources to primary settings for children including school and healthcare clinics.

Many new and innovative projects.

2016

Constant participation by parents.

Expansion of early childhood services.

Investment is school mental health, building a camaraderie among collaborative participants.

Support for the key priority areas.

The supportive community and school based early intervention, screening and supports. Thank you to the PLCG for their work -- amazing support and outreach activities.

Collaboration and a place for coordination. Scholarships for agencies.

Early Childhood Screening for children's mental health.

School based mental health stands out as a one of the more tangible things.

Members of the HCCMHC have been good stewards of public LCTS Funds. The Collaborative has maintained true to its mission & goals.

A14. Open-ended comments: Suggestions for changing the Collaborative

What things would you change about the Collaborative?

2014

Instead of the "appearance" that all members have an equal (and respected) voice, it would be nice to really including parents in more leadership roles.

Orientation of new members; recruitment of new members, particularly from ethnic and cultural minority communities because several "insiders" see each other at other meetings, it can seem like decision are made elsewhere among an inner circle keep working on transparency and inclusion.

It would be good to have the website more clearly communicate opportunities for training, etc. Perhaps a constant contact email list serve or something where blasts are sent to individuals, staff, support staff. It would be good to offer a summer session where the school based therapists could have networking time -- kind of a seminar for the therapists working in schools. It would be good to have the HIPPA/FERPA training for the therapists again. Would love to see additional weaving of supports for families (DD parents who are parenting children with mental health). Would love to see the Collaborative bring cultural leaders to the table in our meetings -- help send the message and reduce stigma.

More youth and diversity presence. An orientation to roles and expectations for new members and perhaps a mentor to update on what's happening now and how we can best participate.

Would like more informal meetings to get to know fellow members and understand everyone's role/representation. More parent and consumer involvement.

More diversity.

Form a subcommittee of young people who are struggling with mental illness and siblings of children struggling with mental illness. This would give a voice to the kids that are the subject of this committee (collaborative). Form a sub committee to examine the links between mental illness in young people and the sex trafficking and or sexual abuse of these kids. Especially in the case of Native American girls. The sexual exploitation of minors, especially those with another level of vulnerability (a mental illness) must be of great concern to this committee.

2016

Parents having more "ACTIVE" roles (i.e. chair of one of the committees). This has been done on state and local councils.

Reduce HC members and increase members from community mental health initiatives or advocacy groups.

Need to focus more on the outside world of CMHC, not just what the collaborative does itself.

Involvement of more people of color

More visibility.

Expand to include youth voice at the table and in review of funding allocations/strategies, when possible.

More thought around building relationships within the Collaborative.

More LCTS funding, if that were possible.

None