Evaluation of Children's Mental Health Grants: Building Service Capacity 2014-2015

Children's Mental Health Division
November 1, 2016

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Legislative Report

Minnesota Department of **Human Services**

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LB3-0001 (3-13)

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I. Executive summary

Children's Mental Health Capacity Grants provide funding to build the clinical and administrative infrastructure necessary for delivering effective mental health care to children with severe mental illnesses. Such capacity development includes hiring clinical staff, training, clinical supervision for interns, and other start-up costs for a new clinical venture. In addition, these grants cover direct services to children without insurance and children whose family insurance does not cover necessary mental health services or ancillary supports.

With $10.9 million annually for Mental Health Initiative Infrastructure Development Grants, the 2007 Legislature began to rebuild state support for children's mental health services, lost in 2003, with reallocation of the annual $21.7 million of children's mental health services grants to other programs. In subsequent years, the Legislature's support increased—and as of SFY 2017 stands at $24.3 million, slightly higher than 2003.

State General Fund Appropriations for Children's Mental Health Grants

State Fiscal Year	2014	2015	2016	2017
School-Linked Infrastructure Development	7,065,000	9,554,000	9,554,000	9,587,000
Crisis Response Services	2,904,000	2,924,000	4,924,000	5,424,000
Respite Care Services	1,024,000	1,024,000	1,274,000	1,524,000
Early Childhood Mental Health Infrastructure	1,024,000	1,024,000	1,024,000	1,024,000
Cultural and Ethnic Minority Infrastructure	300,000	300,000	300,000	300,000
Evidence-Base Practices Training Capacity	750,000	750,000	750,000	750,000
Child Welfare/Juvenile Justice Screening	4,332,000	4,332,000	4,412,000	4,412,000
First Episode Psychosis Response	0	0	0	177,000
Text 4 Life	625,000	625,000	1,125,000	1,125,000
Children's Mental Health First Aide Training	22,000	23,000	23,000	23,000
Total Annual Children's Mental Health Grants	**18,046,000**	**20,556,000**	**23,386,000**	**24,346,000**

Financial Summary of CMH Grants during the 2014-2015 reporting period

	Appropriated	Expended	Unspent	% Unspent
All Children's Mental Health Grants SFY 2014	17,599,000	16,819,460	779,540	4%
All Children's Mental Health Grants SFY 2015	19,988,000	19,289,099	698,901	3%

A detailed report on each grant is presented in the body of the report, which includes appropriations, expenditures, and unspent funds.

II. Legislation

Minnesota Statutes 2016, section 245.4889, subdivision 3.

Subd. 3. **Commissioner duty to report on use of grant funds biennially.**

By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) The amount of funding for children's mental health grants, what programs and services were funded in the previous two years, and outcome data for the programs and services that were funded; and
(2) The amount of funding for other targeted services and the location of services.

III. Introduction: Purpose and Organization of this Report

This is the first biennial report to the Legislature's health and human services finance and policy committees to evaluate the use of children's mental health grant funds, appropriated pursuant to Section 245.4889. The Department of Human Services, Children's Mental Division, prepares this report to inform the Legislature regarding:

(1) The amount of funding for children's mental health grants, what programs and services were funded in the previous two years, and outcome data for the programs and services that were funded; and
(2) The amount of funding for other targeted services and the location of services.

The report was prepared using fiscal data from the State's accounting system (SWIFT) and outcomes data from the Division's Mental Health Information System (MHIS) and the Minnesota Outcomes Reporting System, with aggregations of client-specific treatment information.

This report is submitted to the Minnesota Legislature pursuant to Minnesota Statutes 2016, section 245.4889, subdivision 3.

This report presents information on State-appropriated grants benefiting children with serious mental health disorders and their families. The intent of the report is to provide sufficient information on grant-funded program to allow the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under Section 245.4889.

Services and programs funded by the federal-state Medical Assistance, MinnesotaCare and other federal appropriations are beyond the scope of this report.

First, this report introduces the focused capacity-building strategy of the children's grants program and summarizes component grants in *Children's mental health programs and services funded by State-appropriated grants*. Second, the report evaluated each of the seven grant programs, describing its purpose; two-year funding and history of the Legislature's financial support; outcomes and demographics of children and youth served by the grants; and evaluative conclusions.

IV. Children's mental health grants: a strategy for statewide access

The Children's Mental Health Infrastructure Development Grants are designed bring effective care to every community in Minnesota. All of Minnesota—including Greater Minnesota and cultural minority communities—need access to the latest proven treatments; to coordinated care; to individualized and efficiently-administered service delivery.

When the 2007-2008 Legislature and the Department of Human Services Children's Mental Health Division launched the grant program, the purpose was not to sponsor a random patchwork of projects, but to begin a long-term, strategic initiative that would build a statewide provider network with the capacity to meet the needs of children and adolescents with complex conditions. It was and continues to be a growing population with increasingly serious needs. While funds were targeted to specific service gaps, the strategy was—and continues to be—to create effective clinical and administrative capacity throughout Minnesota.

Historically, access to effective and age-appropriate mental health treatment and support services had been severely limited in many Minnesota communities—both geographic and demographic. Beginning in 2008, the Minnesota Legislature launched a long term capacity-building effort to bring quality mental health care to a greater number of high-needs children in natural environments; to measurably improve the clinical effectiveness of services; and to connect children with the right service, at the right time, and at the right level of intensity to make a difference. Efforts have included reducing cultural disparities and geographic disparities by making services earlier available, easier to access, and effective in their delivery.

With the Legislature's support, the Department of Human Services has achieved significant results in seven grant programs, during the 2014-15 biennium. Each program is evaluated, here, in the order of largest-to-smallest appropriation. The legislature's support continued in the 2015 and 2016 sessions and the results of those investments will be reflected in future reports.

The strategy for statewide infrastructure development is the voice of stakeholders speaking to the State: a series of listening sessions, work groups, and task forces between 2005 and 2015.

Future Report revisions. Changes will be made for the next biennial Children's Mental Health Grants Report, due to the Legislature in November 2018.

(1) Grantees will be required to submit data as a condition of payment. A substantial number of grantees failed to deliver outcomes data requested by DHS—or delivered incomplete data or delivered in a format that made it difficult to compile accurately.
(2) DHS is evaluating the need to change the instruments used to measure individual treatment outcomes. Clinical review of the 2014-2015 outcomes suggest that current measurement tools are insufficiently sensitive to clients' treatment progress. New instruments have emerge, which may be more reliable indicators changes in symptomology. One such tool is currently being piloted that has been validated for children from birth to age 5. The Child Behavior Check List (CBCL), for children ages 1½ to 5 years of age, is part of a series tools, validated to age 90-plus, the Achenbach System of Empirically Based Assessment (ASEBA), which is standard outcome measure used to develop evidenced-based interventions.

A. School-Based and School-Linked Mental Health Services Grants

1. Grant purpose and funded activities.
School mental health services are provided by community mental health agencies: most often they are co-located in schools. Services sometimes are "school-linked," provided in the child's home or a community setting for greater effectiveness, family preference, or lack of space in school buildings; and often during summer and holiday breaks when schools are closed.

Objectives of the grant design are to:

- Identify as early as possible a child's emerging mental health needs. (For pre-K through Grade-12 students, mental health conditions emerge at different stages of development.)
- Improve individual treatment success and ability to function in school and community.
- Increase access by offering a "normal" (non-stigmatizing) setting, where a child routinely spends the day, thereby avoiding family disruption and transportation demands.
- Increase access for uninsured and under-insured children/youth.
- Develop and maintain long-term clinical, administrative, and fiscal infrastructure to sustain services beyond grant funding.
- Deliver medically-necessary clinical and rehabilitative services to treat diagnosed mental and chemical health conditions.
- Build local mental health service infrastructure by funding training and the clinical supervision required for mental health professional licensure candidates.

Diagnostic Assessment. Thorough diagnosis and functional assessment is foremost in the school-based mental health approach—so that children receive the appropriate intervention, at the right time, and at the right level of intensity. The Diagnostic Assessment used in school-based mental health is the same comprehensive assessment used in the Minnesota Health Care Programs (Medical Assistance and MinnesotaCare) and it includes screening for alcohol and/or chemical use. Additionally, the diagnostic assessment guides the development of a child's Individual Treatment Plan.

Continuum of services. The assessment process further determines medical necessity for a full range of non-residential mental health services, which are covered by the family's public or private insurance when available, and covered by the Grant when the family lacks insurance coverage. Covered services include the following:

- Individual, Group, and Family Therapy
- Individual, Group, and Family Skills Training
- Crisis Intervention Services at school
- Clinical Care Consultation
- Psychoeducation Services
- Psychiatric Consultation Services
- Medication Management Services

Ancillary and Supportive Services. Ancillary and Supportive Services are paid by the Grant since most private and public insurance plans do not cover them. They include the following:

- Treatment related consultation with teachers/student support staff
- Family contacts/consultations
- Attendance at IEP and other schools meetings as requested by host schools

- Up to three (3) Pre-Diagnostic Assessment sessions with parents when needed for cultural considerations and/or other concerns parents have around "informed consent"
- Care Coordination
- Translation and/or Interpreter Services.
- Staff transportation to schools and/or homes to provide grant services.
- Staff transportation to three statewide Grantee Meetings held each year in St. Cloud.
- Staff time to coordinate information and paperwork needed for third party billing (insurance) and a multitude of other "infrastructure development" fiscal activities to support the families and partners of the grant program, and to work towards long-term financial sustainability of program services.

Training. In-Service training for educators, student services staff, and school nurses serves not only the extant students but enhances the long-term capacity of the local system to serve more and future students. Commonly-funded staff training regards mental health conditions; ways to decrease stigma; culturally-sensitive treatment interventions and supports; identifying students who may benefit from grant services; information about grant services and referral policies including parental consent and data privacy requirements; and collecting data for state-determined outcome measures.

Family insurance obligations. Grant contracts require that services, which may be billed to MA or other insurance, must be billed. For families with commercial insurance, the Grant pays for insurance-related, out-of-pocket expenses, as a result of the federal ***Free Appropriate Public Education Act*** (FAPE) law that requires schools to provide services written into a child's Individual Education Program (IEP) to the student without cost to the family. These obligations commonly include:

- Co-Pays for clinical and rehabilitative services (if a barrier to parental consent).
- Deductibles for high cost-sharing insurance plans (if a barrier to parental consent, especially in geographic locations where few families are eligible for public insurance).

Without grant funds, a school may not acknowledge mental health needs in students' IEPs. Thus, the Grant ensures access to mental health care even for students covered by commercial health insurance.

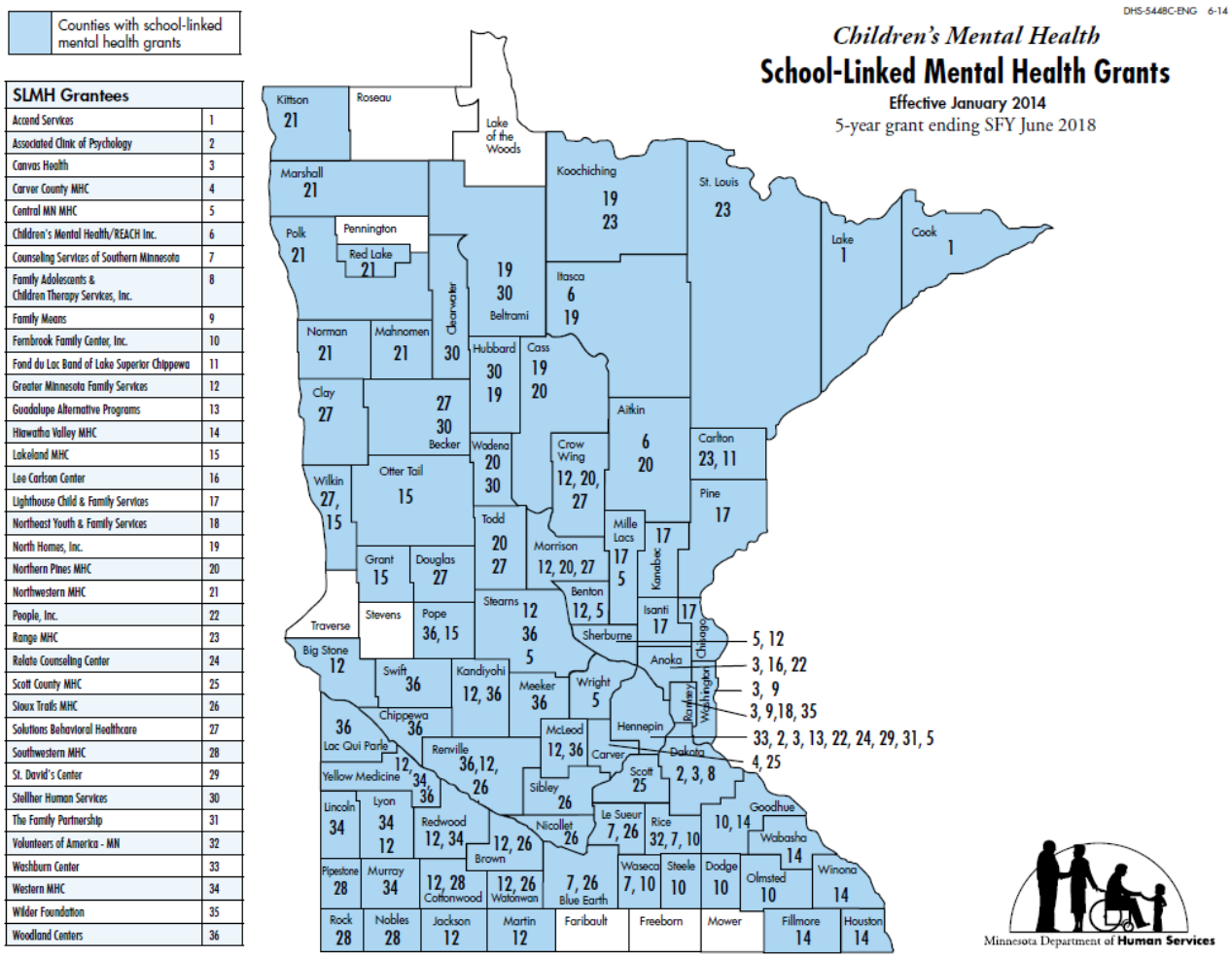
2. Financials.

	Appropriated	Expended	Unspent	% Unspent
State Fiscal Year 2014	7,064,965	6,857,963	207,002	3%
State Fiscal Year 2015	9,554,000	9,553,924	76	0%

History of funding. Originally funded with a base appropriation of $4,777,000 per fiscal year in 2008, the 2013 Legislature increased the Fiscal 2014 base by $2,388,000 and the Fiscal 2015 base by an additional $2,389,000 for an annual base of $9,554,000 in SFY 2016. The Legislature again increased its support for the 2018-19 Biennium to an annual base of $11,004,000, a 230 percent increase since the inception of the program.

3. Outcomes. Demographics; Locations; Treatment outcomes

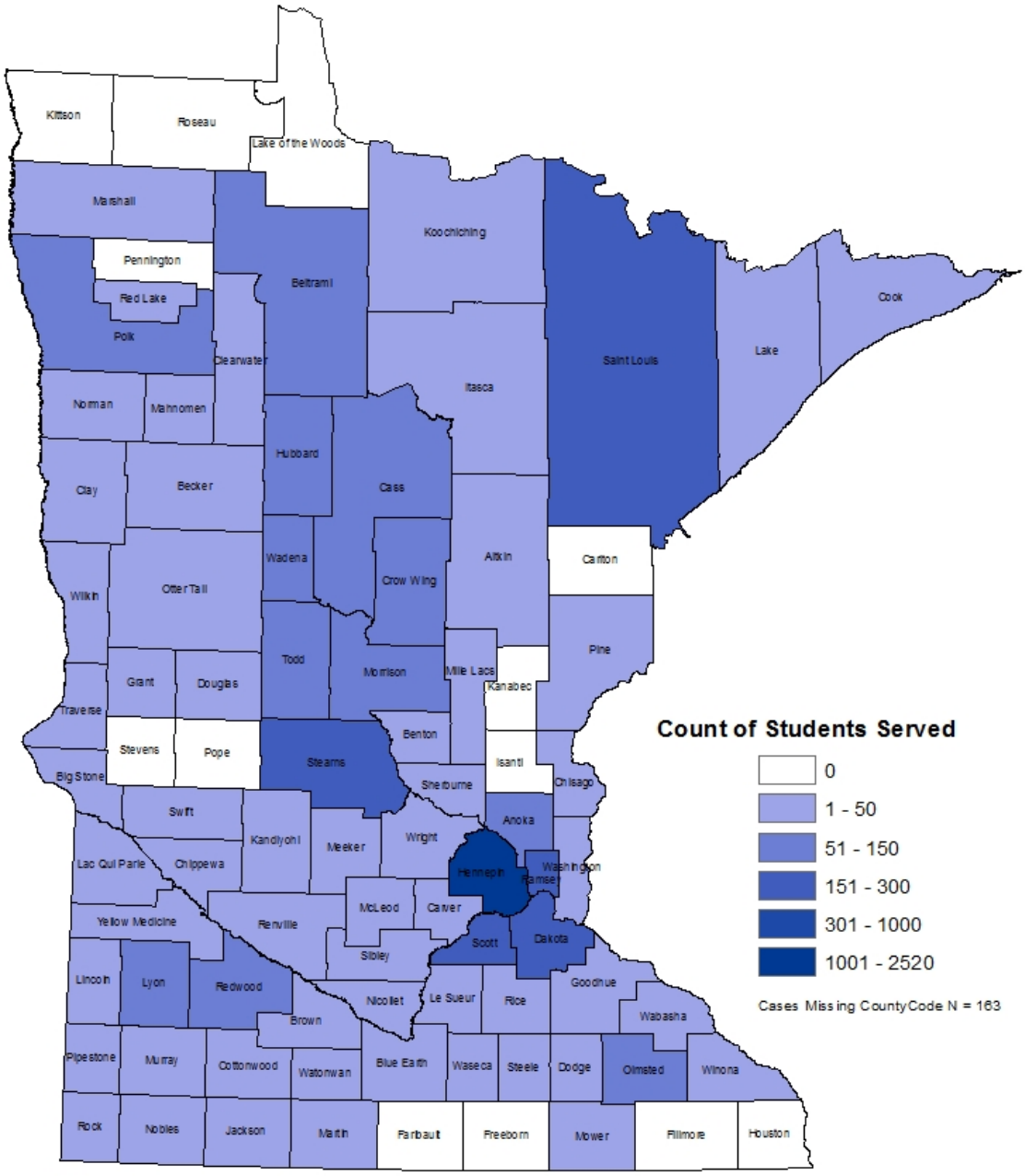
The School-Linked Mental Health Grant has 36 grantees, serving 79 counties of Minnesota.



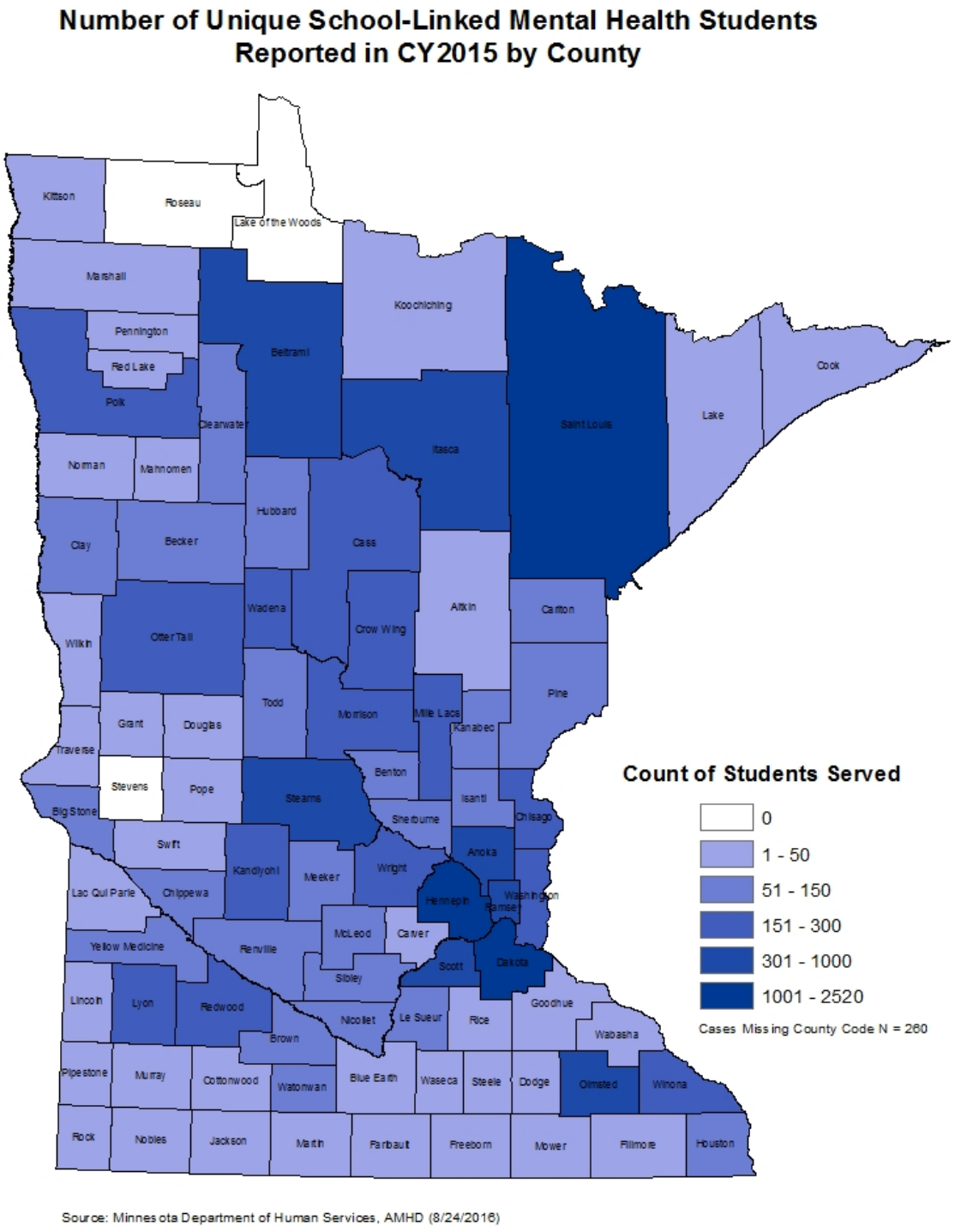
The total number of unique children served by the SLMH grant in 2014 was 4,591; the total in 2015 was 14,277[1].

[1] Student data was only collected for the final quarter of 2014 and one of the grantees did not begin serving students until the start of 2015.

Number of Unique School-Linked Mental Health Students Reported in CY2014 by County



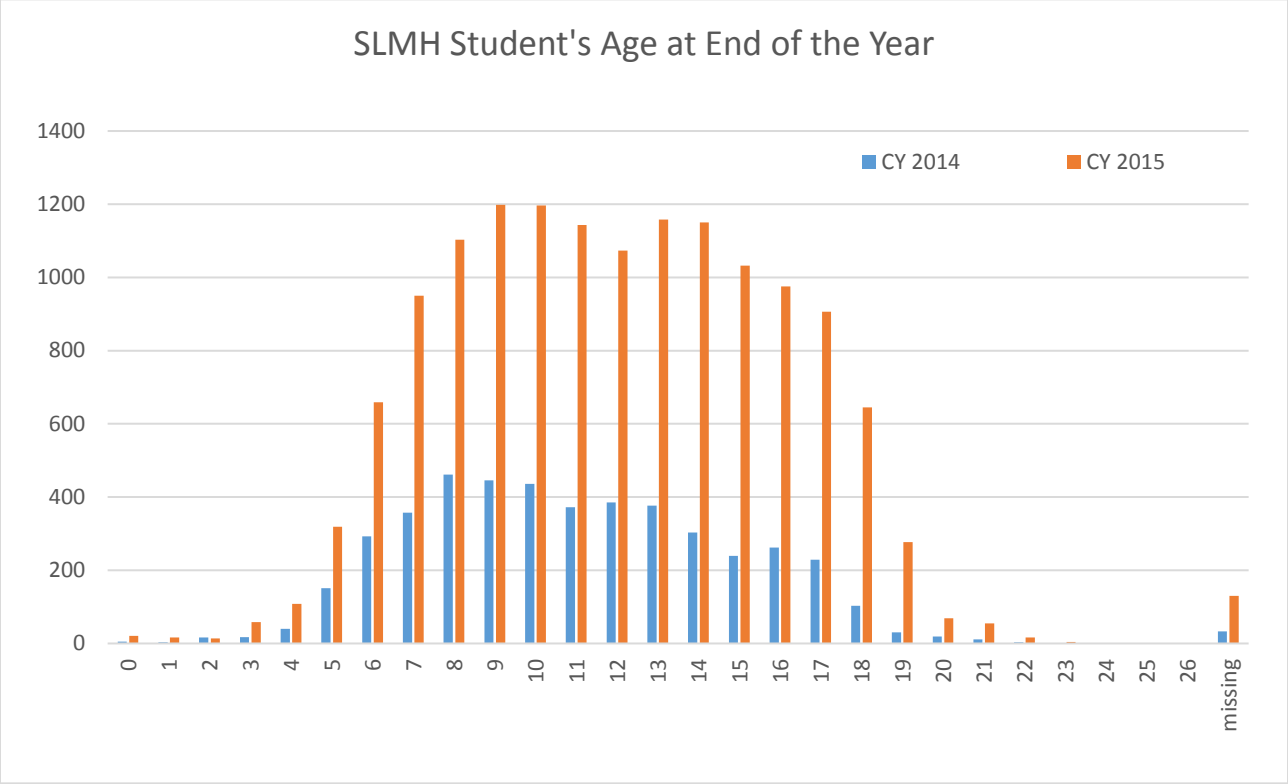
Source: Minnesota Department of Human Services, AMHD (8/24/2016)


Number of Unique School-Linked Mental Health Students
Reported in CY2015 by County
Kittson
Roseau
Lake of the Woods
Marshall
Koochiching
Pennington
Beltrami
Red Lake
Polk
Clearwater
Itasca
Saint Louis
Lake
Cook
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Wadena
Crow Wing
Aitkin
Carlton
Wilkin
Otter Tail
Todd
Morrison
Mille Lacs
Kanabec
Pine
Grant
Douglas
Traverse
Benton
Stevens
Pope
Stearns
Isanti
Big Stone
Sherburne
Chisago
Swift
Anoka
Kandiyohi
Meeker
Wright
Lac Qui Parle
Chippewa
Hennepin
Washington
Ramsey
McLeod
Carver
Yellow Medicine
Renville
Scott
Dakota
Sibley
Lincoln
Lyon
Redwood
Nicollet
Le Sueur
Rice
Goodhue
Wabasha
Brown
Pipestone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
Count of Students Served
0
1 - 50
51 - 150
151 - 300
301 - 1000
1001 - 2520
Cases Missing County Code N = 260
Source: Minnesota Department of Human Services, AMHD (8/24/2016)

Number of Children served by county, by year

	2014	2015
Atkin	2	39
Anoka	70	353
Becker	9	74
Beltrami	64	338
Benton	44	140
Big Stone	33	74
Blue Earth	33	50
Brown	48	111
Carlton	0	80
Carver	22	46
Cass	94	254
Chippewa	24	102
Chisago	1	264
Clay	33	102
Clearwater	38	79
Cook	8	26
Cottonwood	26	38
Crow Wing	116	182
Dakota	276	1321
Dodge	2	33
Douglas	27	31
Faribault	0	1
Fillmore	0	12
Freeborn	0	5
Goodhue	2	4
Grant	3	12
Hennepin	1131	2520
Houston	0	83
Hubbard	80	120
Isanti	0	118
Itasca	49	387
Jackson	35	50
Kanabec	0	97
Kandiyohi	29	166
Kittson	0	9
Koochiching	2	41
Lac Qui Parle	3	19
Lake	13	44
Lake of the Woods	0	0
Le Sueur	42	116
Lincoln	6	14
Lyon	119	290
Mahnomen	35	60
Marshall	2	19
Martin	15	21
McLeod	5	40
Meeker	35	121
Mille Lacs	5	181
Morrison	109	199
Mower	4	22
Murray	19	45
Nicollet	40	72
Nobles	44	17
Norman	4	34
Olmsted	93	310
Otter Tail	13	157
Pennington	0	1
Pine	5	122
Pipestone	11	5
Polk	84	170
Pope	0	13
Ramsey	283	886
Red Lake	2	33
Redwood	114	182
Renville	38	103
Rice	18	50
Rock	16	10
Roseau	0	0
St. Louis	278	1023
Scott	188	440
Sherburne	4	79
Sibley	26	51
Stearns	160	448
Steele	2	14
Stevens	0	0
Swift	2	30
Todd	68	134
Traverse	1	2
Wabasha	1	40
Wadena	109	181
Waseca	8	39
Washington	23	267
Watonwan	41	89
Wilkin	3	8
Winona	4	205
Wright	3	181
Yellow Medicine	29	73
Transient/homeless	1	1
Out of state	1	3
Missing	161	251
TOTAL:	459 1	1427 7

Age of Children Reported by SLMH



Gender of Unique Children Reported by SLMH[2]

	2014	Percent of 2014	2015	Percent of 2015
Female	1959	43%	6244	44%
Male	2579	56%	7902	55%
Unknown	0	0%	4	<.5%
Missing	53	1%	127	1%
Total:	4591	100%	14,277	100%

Race of Unique Children Reported by SLMH[3]

	2014	Percent of 2014	2015	Percent of 2015
White	2637	57%	9446	66%
Black/African American	614	13%	1593	11%
Asian	89	2%	241	2%
American Indian/Alaskan Native	180	4%	738	5%
Native Hawaiian/Pacific Islander	11	<.5%	50	<.5%
Other	133	3%	543	4%
Biracial/multiracial	265	6%	817	6%
Unknown	99	2%	353	2%
Missing	563	12%	496	3%
Total:	4591	99%[4]	14,277	99%[5]

Ethnicity of Unique Children Reported by SLMH[6]

	2014	Percent of 2014	2015	Percent of 2015
Latino	439	10%	1444	10%
Somali	12	<.5%	41	<.5%
Hmong	28	1%	84	1%
None	1772	39%	7700	54%
Other	277	6%	690	5%
Missing	2063	45%	4318	30%
Total:	4591	101%[7]	14,277	100%

[2] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.

[3] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.

[4] Percentages do not add to exactly 100% due to rounding errors.

[5] Percentages do not add to exactly 100% due to rounding errors.

[6] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.

[7] Percentages do not add to exactly 100% due to rounding errors.

Insurance Status of Unique Children Reported by SLMH[8]

	2014	Percent of 2014	2015	Percent of 2015
MHCP	2514	55%	7721	54%
Private/commercial	1245	27%	3925	27%
Both	356	8%	892	6%
None	417	9%	1352	10%
Unknown	18	<.5%	99	1%
Missing	41	1%	288	2%
Total:	4591	100%	14,277	100%

First Mental Health Service for SLMH Student?[9]

	2014	Percent of 2014	2015	Percent of 2015
Yes	1955	43%	6724	47%
No	2107	46%	7384	52%
Unknown	16	<.5%	21	<.5%
Missing	513	11%	148	1%
Total:	4591	100%	14,277	100%

ED/SED[10] Status for SLMH Students Reported

	2014	Percent of 2014	2015	Percent of 2015
ED	1790	39%	6775	47%
SED	1884	41%	5431	38%
None	261	6%	1051	7%
Unknown	99	2%	473	3%
Missing	557	12%	547	4%
Total:	4591	100%	14,277	99%[11]

Individualized Education Plan (IEP) Status for SLMH Students Reported

	2014	Percent of 2014	2015	Percent of 2015
IEP, does not include MH	1149	25%	3405	24%
IEP, w MH Services from school or other provider	77	2%	367	3%
IEP, w MH services from SLMH	319	7%	1024	7%
No IEP	2846	62%	9113	64%
Unknown	11	<.5%	30	<.5%
Missing	189	4%	338	2%
Total:	4591	100%	14,277	100%

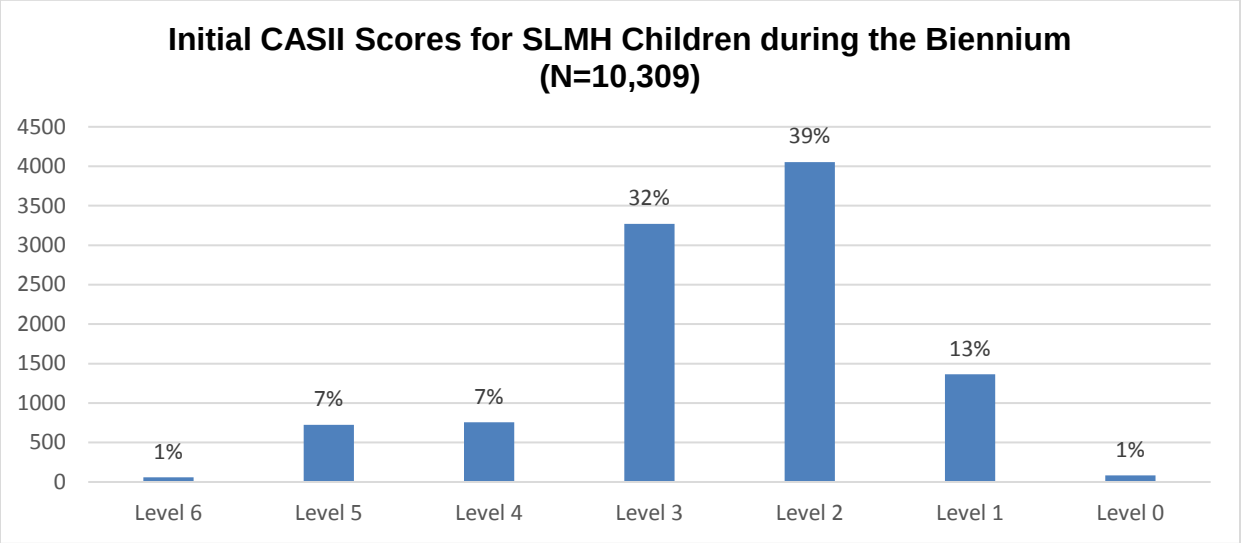
Outcomes data (CASII/SDQ)

[8] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[9] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[10] Emotional disability/Serious emotional disability
[11] Percentages do not add to exactly 100% due to rounding errors.

The *Child and Adolescent Service Intensity Instrument* (CASII) is a tool to evaluate the service intensity needs of children and youth. The CASII evaluates the youth's functioning across six environmental dimensions and combines that with necessary resource/service variables: care environment, clinical services, support services, crisis stabilization and prevention services. This generates a Level of Service Intensity recommendation. (See Levels Below). The CASII has been validated for children and adolescents ages 6 through 18 years

Key to CASII Levels of Service Intensity
Level 0: Basic Services.
Level 1: Recovery Maintenance and Health Management.
Level 2: Outpatient Services.
Level 3: Intensive Outpatient Services.
Level 4: Intensive Integrated Service without 24-Hour Medical Monitoring.
Level 5: Non-Secure, 24-Hour, Medically Monitored Services.
Level 6: Secure, 24-Hours, Medically Managed Services.

Minnesota's public mental health system uses the *Strengths and Difficulties Questionnaire* (SDQ) in conjunction with the CASII to monitor the overall clinical functioning of children receiving mental health services. The SDQ is a 25-item questionnaire that may be completed by caregivers, teachers, and youth (over the age of 10). It can be used for children and youth ages 2 through 17 years. The SDQ evaluates symptoms on 5 scales: (1) emotional symptoms, (2) conduct problems, (3) hyperactivity/inattention, (4) peer relationship problems, and (5) prosocial behavior. Scales 1 through 4 are added together to generate a total difficulties score. Scale 5 generates prosocial behavior score.



Change in CASII Scores (2,572 children measured)

Children with more than one assessment were measured for the change from first assessment of biennium to last of biennium (at least 5mo apart).] Lower numbers are better. Those shaded yellow are counts for children who improved. White values stayed the same. The fields shaded grey show the number of scores that became worse.

This table shows that:

- Scores improved for 894 children (scores above the shaded diagonal),
- Scores remained the same for 1,105 children (scores in the shaded diagonal of cells), and
- Scores worsened for 573 children (scores below the shaded diagonal).

		Level of Care at Time 2						
Level of Care at Time 1		**6**	**5**	**4**	**3**	**2**	**1**	**0**
	6	0	1	2	6	5	1	0
	5	5	37	32	52	52	17	1
	4	2	23	64	86	31	8	0
	3	5	44	71	335	269	71	1
	2	0	24	21	213	517	218	19
	1	1	3	3	34	111	150	22
	0	0	2	0	1	5	5	2

Initial SDQ score for child during the biennium

(A child may be represented by all three categories although self-assessment is only children over 11.)

	Parent (N=4356)			**Teacher (N=1460)**			**Self (N=1431)**		
	Normal scores	Mean	SD	Normal scores	Mean	SD	Normal scores	Mean	SD
Emotional Symptoms	0-3	4.33	2.54	0-4	3.73	2.73	0-5	4.90	2.66
Conduct Problems	0-2	3.72	2.43	0-2	3.40	2.70	0-3	2.98	1.90
Hyperactivity-Inattention	0-5	5.93	2.70	0-5	6.21	2.91	0-5	5.34	2.18
Peer Problems	0-2	3.32	2.14	0-3	3.56	2.21	0-3	3.33	1.99
Total Difficulties[12]	0-13	17.30	6.49	0-11	16.91	6.79	0-15	16.55	5.84
Prosocial Behavior[13]	6-10	7.00	2.17	6-10	5.57	2.58	6-10	7.25	2.00
Impact Score[14]	0	3.79	2.73	0	2.91	1.89	0	2.57	2.42

[12] Total difficulties is the sum of Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention, and Peer Problems.

[13] Higher scores indicate stronger prosocial skills.

[14] Impact score is only available for those who completed the extended form. It addresses if the respondent thinks the child has a problem and, if so, how much of the child is impaired/burdened as a result. (Parent N=4095, Teacher N=1314, Self N=1305)

Number of SLMH Students in Each of the 4-band Categories

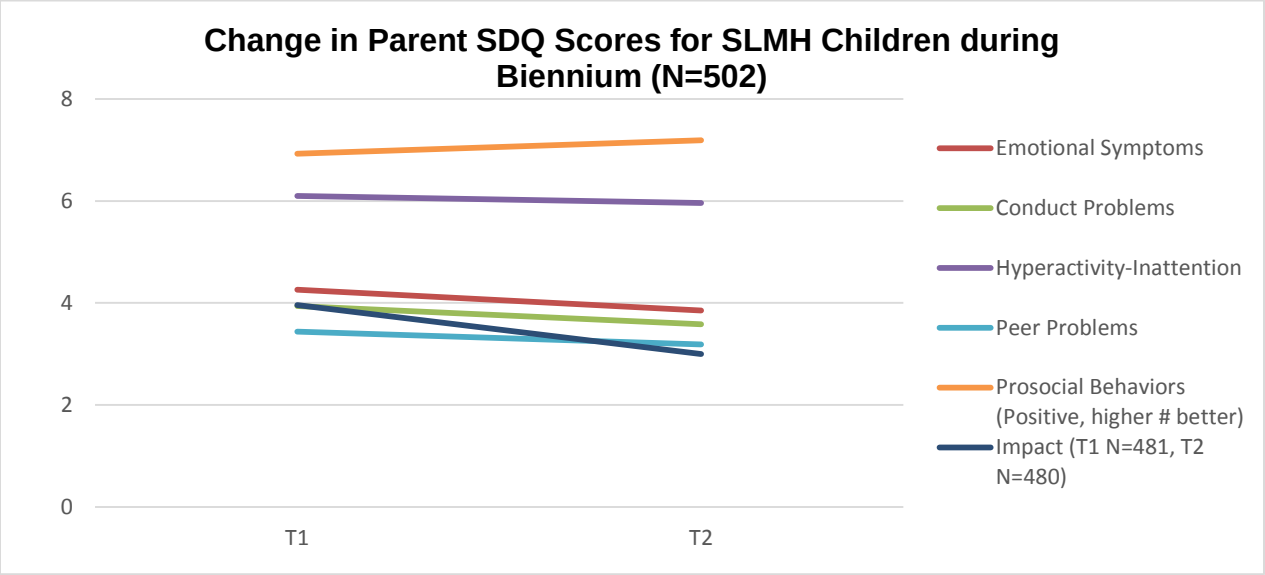
	Normal Range[15]	Slight Risk of Mental Health Concern	High Risk of Mental Health Concern	Very High Risk of Mental Health Concern
Parent completed SDQ (N=4356)				
Total difficulties	1277 (29%)	707 (16%)	734 (17%)	1638 (38%)
Emotional problems	1743 (40%)	616 (14%)	1079 (25%)	918 (21%)
Conduct problems	1499 (34%)	659 (15%)	1191 (27%)	1007 (23%)
Hyperactivity	1890 (43%)	1059 (24%)	494 (11%)	913 (21%)
Peer problems	1665 (38%)	723 (17%)	731 (17%)	1237 (28%)
Prosocial[16]	1959 (45%)	624 (14%)	655 (15%)	1118 (26%)
Impact (N=4095)	602 (15%)	367 (9%)	478 (12%)	2648 (65%)
Teacher completed SDQ (N=1460)				
Total difficulties	311 (21%)	288 (20%)	248 (17%)	613 (42%)
Emotional problems	741 (51%)	171 (12%)	149 (10%)	399 (27%)
Conduct problems	621 (43%)	175 (12%)	165 (11%)	499 (34%)
Hyperactivity	587 (40%)	302 (21%)	168 (12%)	403 (28%)
Peer problems	495 (34%)	482 (33%)	191 (13%)	292 (20%)
Prosocial	701 (48%)	288 (20%)	174 (12%)	297 (20%)
Impact (N=1314)	195 (15%)	143 (11%)	206 (16%)	770 (59%)
Self-completed SDQ (N=1431)				
Total difficulties	532 (37%)	266 (19%)	178 (12%)	455 (32%)
Emotional problems	643 (45%)	183 (13%)	163 (11%)	442 (31%)
Conduct problems	903 (63%)	228 (16%)	144 (10%)	156 (11%)
Hyperactivity	738 (52%)	259 (18%)	189 (13%)	245 (17%)
Peer problems	502 (35%)	300 (21%)	242 (17%)	387 (27%)
Prosocial	926 (65%)	217 (15%)	159 (11%)	129 (9%)
Impact (N=1305)	372 (29%)	166 (13%)	181 (14%)	596 (45%)

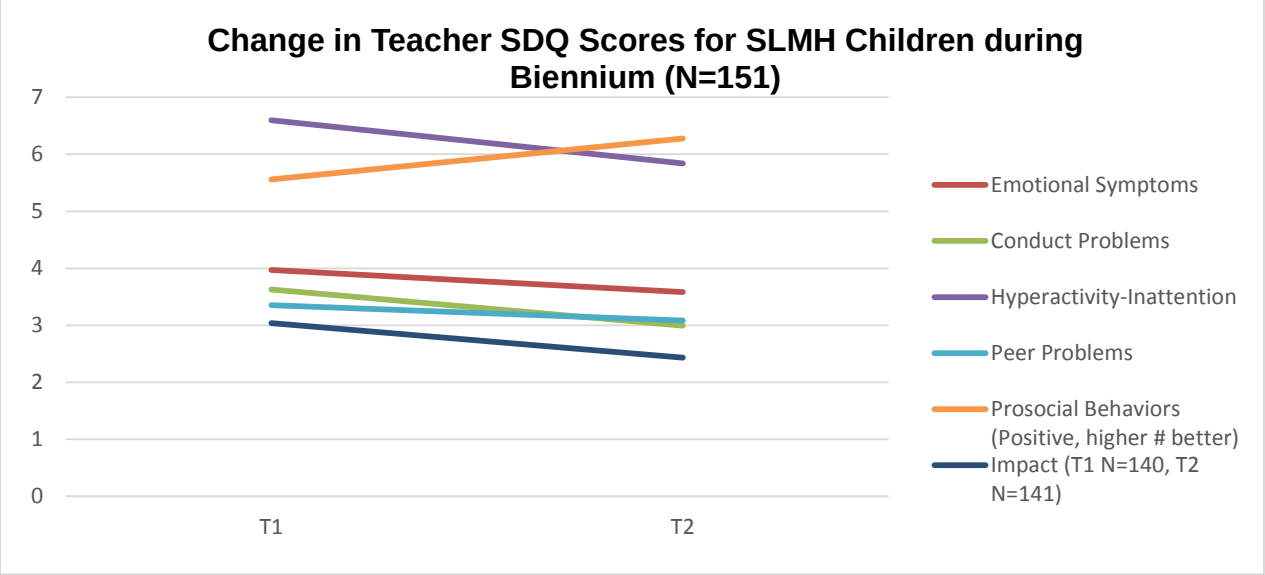
[15] The categories are based on population norms. Close to Average (Normal) is 80% of the population, Slightly Raised/Lowered (Slight Risk) is 10% of population, High/Low (High Risk) is 5% and Very High/Very Low (Very High Risk) is 5%.

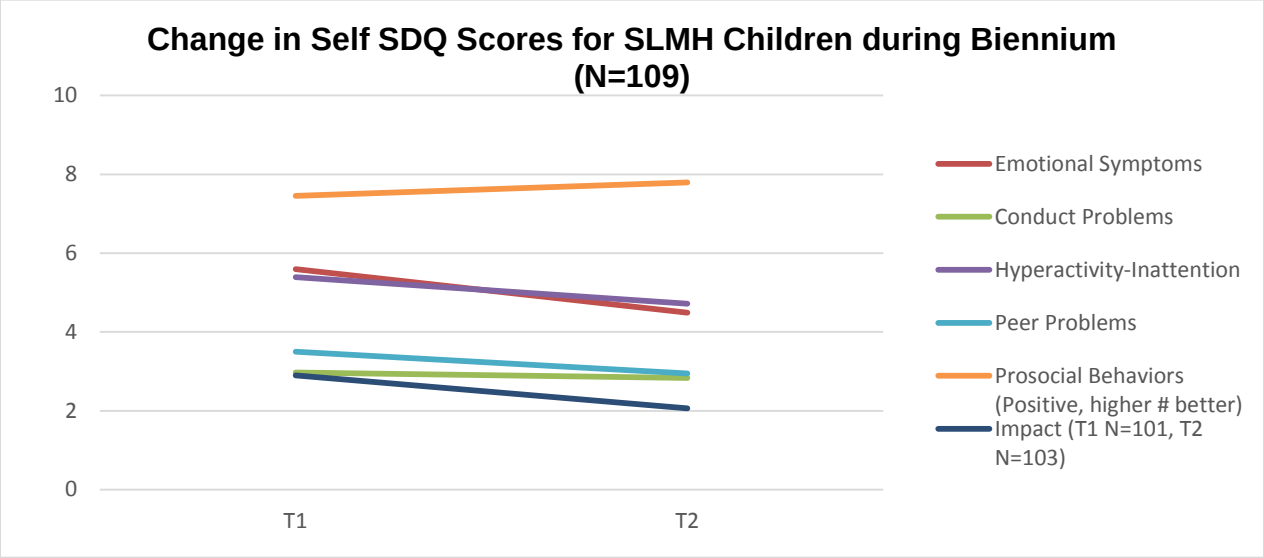
[16] Higher scores indicate stronger prosocial skills.

Change in SDQ scores for child during the biennium

Shows children with more than one assessment completed by the same role-player (parent/teacher/self), change from first assessment of biennium to last of biennium (at least 5 months apart).







4. Conclusions and Evaluation.

Schools, where children spend a better part of their lives, have proven to be an effective—and popular—setting for the expansion of Minnesota's mental health infrastructure. School is a normal, non-stigmatizing, place for a child to be. The school setting allows services to be incorporated into a daily routine and allows a child to slip discreetly into a treatment session. School does not disrupt a family's normal routine, require (often unaffordable or unavailable) transportation, or force a child to stand out as abnormal to siblings and peers. While it may be intuitive that a setting, which avoids adding more disruption to a child's life, would produce superior treatment results, the data supports this as well. The individual outcomes data shows improvement over this two-year period on five out of six outcomes measurement scales.

Minnesota's capacity to provide mental health care in school has broadened to 79 of 87 counties and deepened to a greater number of children per county. Just from 2014 to 2015, many counties saw significant increases, doubling or quadrupling the number of children served.

Providing mental health services in a school setting continues to find children with mental health conditions that otherwise would have "fallen through the cracks" in the system. In 2014, 43 percent of student served by a school-linked mental health grant received their first-ever mental health service. The number was even higher in 2015, with 47 percent receiving their first mental health service.

A large majority (60 percent) of children receving mental health services through the grant do not have special education programs. The data does not reveal whether conditions treated through the grant would, or would not, meet special education criteria requisite to generate an Individual Education Programs (IEP). DHS staff, along with the Department of Education, have conducted both formal and informal training with local school districts to identify state and federal education resources for students with mental health needs.

B. Children's Mobile Crisis Intervention Grants

1. Grant purpose and funded activities.
Mobile crisis response teams are the front-line safety net for children in psychiatric crisis. The goal of this grant is to ensure that every Minnesota child and family has access to timely intervention by trained mental health responders.

A mobile crisis team can go anywhere a chld or adolescent experiences a psychiatric crisis. Trained mental health crisis reponders de-escalate the situation, calm the person, and intercede with other affected people at the scene. For a team without a licensed mental health professional at the scene, clinical advice must be no more than a phone call away.

Capability of Children's Mobile Crisis Response Teams. Local mental health crisis programs provide 24-hour crisis hotlines, supervised by licensed mental health professionals, with the ability to dispatch mobile crisis response teams. More than half of the programs have 24/7 mobile coverage, with the rest of the programs having after-hours phone support, after normal business hours, weekends and holidays.

2. Financials.

(Awards to Counties)	Appropriated	Expended	Unspent	% Unspent
State Fiscal Year 2014	2,904,035	2,904,035	0	0%
State Fiscal Year 2015	2,924,000	2,924,000	0	0%

History of funding. Originally funded in 2008 at an annualized base of $1,024,000, the 2013 Legislature provided expansion grants—awarded to counties—to expand mobile crisis services throughout the state, starting in SFY 2014. DHS awarded funds to develop adult and children's mobile crisis response services in areas that were still lacking the services: a total of 13 multi-county crisis programs provided crisis services in 59 counties.

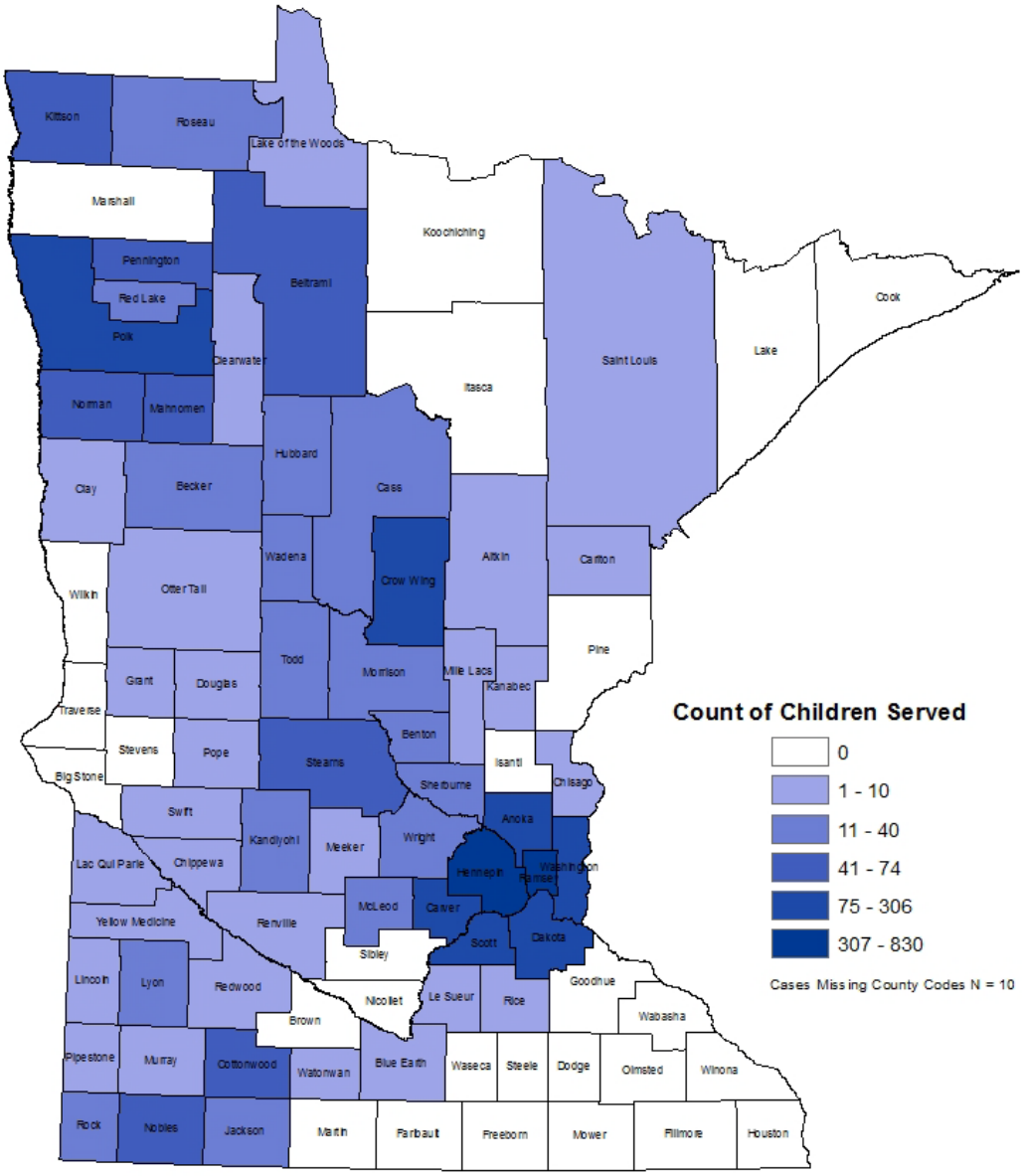
Expansion of mobile crisis teams to a greater number of communities began with the infusion of crisis expansion grants starting in state fiscal year 2014. Further support, starting in SFY 2016, resulted in at least one mobile crisis team is every Minnesota county. By SFY 2020, mental health crisis intervention teams are expected to be available 24-hour-per-day, seven days per week.

In CY2015, an additional 25 counties were funded increasing the crisis programs to fifteen (15) providing crisis services in 85 of Minnesota's 87 counties.

3. Outcomes. Demographics; Locations; Treatment outcomes
The Mobile Crisis grant has 21 grantees. In 2014, grantees served 3123 children with a total of 3888 crisis events. During 2015, the grantees reported serving 3101 children[17] who experienced 3783 crisis incidents.

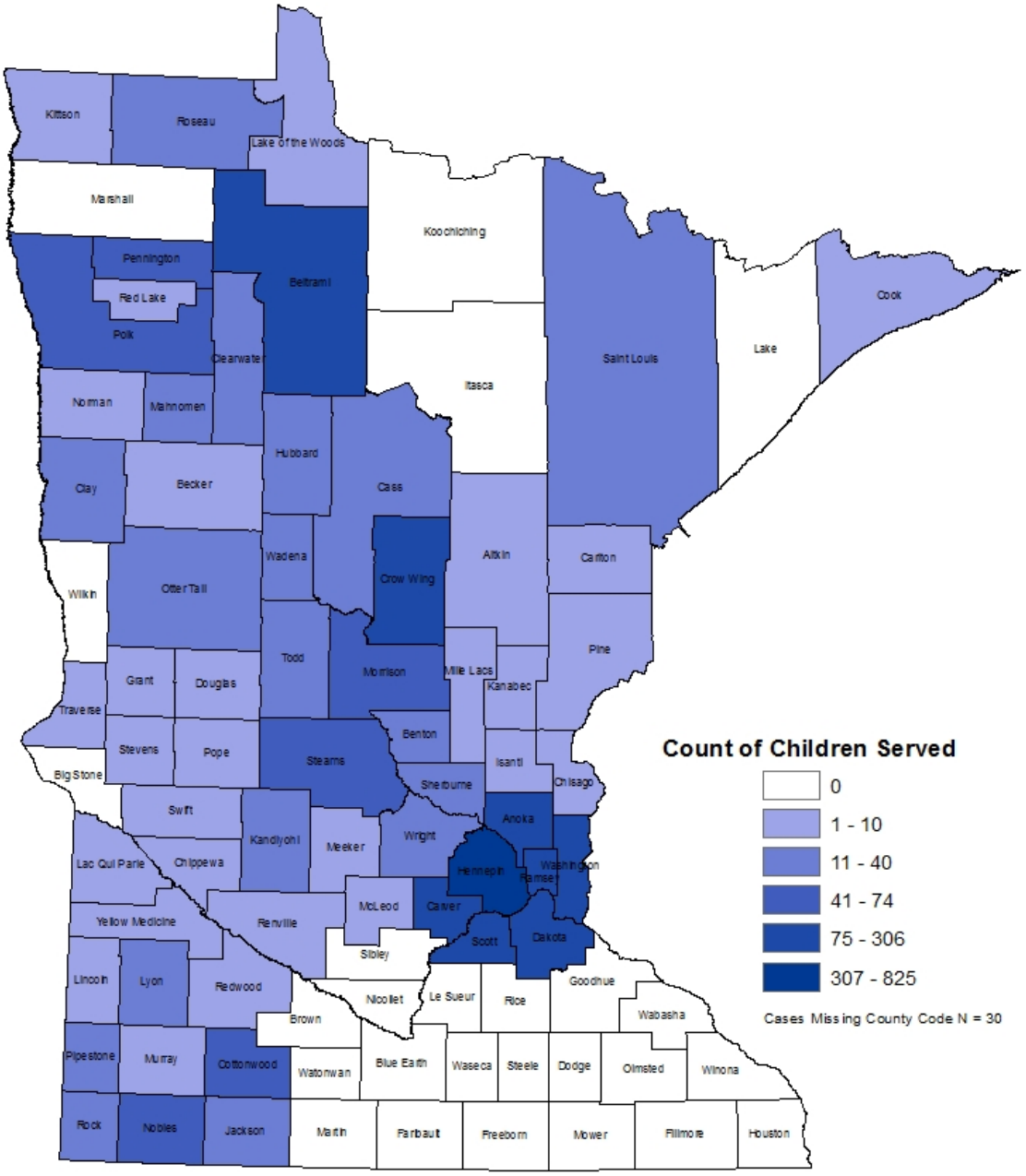
[17] Numbers are likely much higher as we are missing 10 of 42, 24%, of the reports for 2014 and 8 of 42, 19%, of the reports for 2015.

Number of Unique Mobile Crisis Children Reported in CY2014 by County

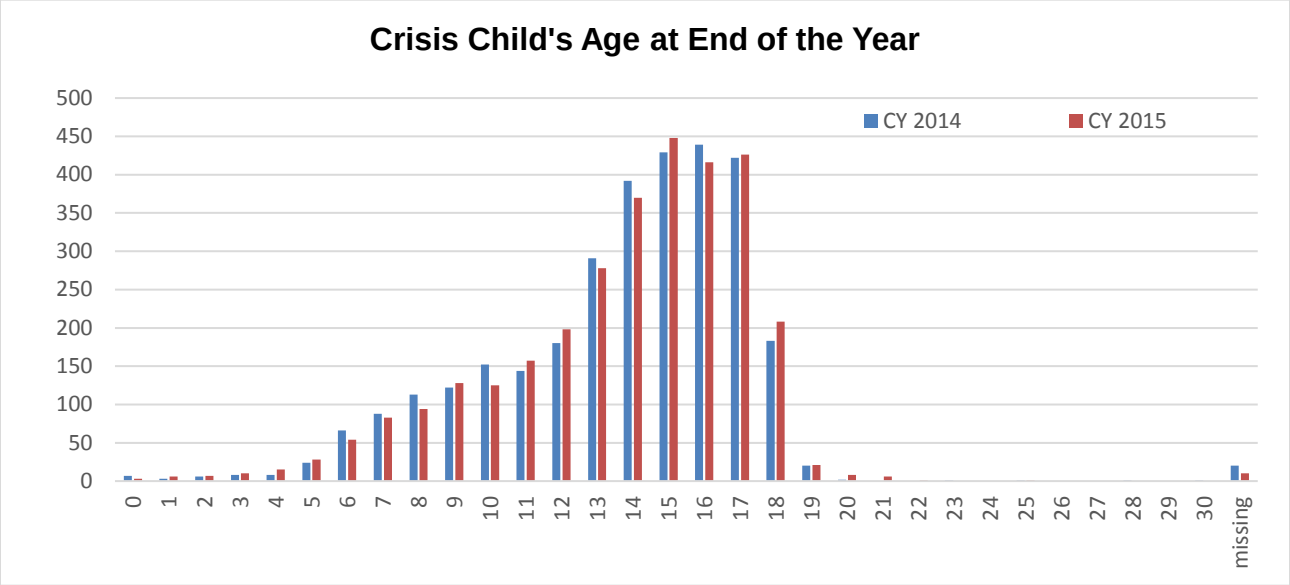


Source: Minnesota Department of Human Services, AMHD (8/24/2016)

Number of Unique Mobile Crisis Children Reported in CY2015 by County



Source: Minnesota Department of Human Services, AMHD (8/24/2016)



Gender of Unique Children Reported by Mobile Crisis[18]

	2014	Percent of 2014	2015	Percent of 2015
Female	1681	54%	1654	53%
Male	1441	46%	1444	47%
Missing	1	<.5%	3	<.05%
Total:	3123	100%	3101	100%

Race of Unique Children Reported by Mobile Crisis[19]

	2014	Percent of 2014	2015	Percent of 2015
White	1735	56%	1679	54%
Black/African American	463	15%	468	15%
Asian	54	2%	75	2%
American Indian/Alaskan Native	152	5%	169	5%
Native Hawaiian/Pacific Islander	3	<.5%	8	<.5%
Other	94	3%	19	1%
Biracial/multiracial	103	3%	83	3%
Unknown	494	16%	505	16%
Missing	25	1%	95	3%
Total:	3123	101%[20]	3101	99%[21]

[18] The number of children served are unique to the year but the same child may have been served in 2014

[19] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.

[20] Percentages do not add to exactly 100% due to rounding errors.

[21] Percentages do not add to exactly 100% due to rounding errors.

Ethnicity of Unique Children Reported by Mobile Crisis [22]

	2014	Percent of 2014	2015	Percent of 2015
Latino	277	9%	269	9%
Somali	18	1%	19	1%
Hmong	20	1%	27	1%
None	1638	52%	1350	44%
Other	136	4%	126	4%
Unknown	299	10%	340	11%
Missing	735	24%	970	31%
Total:	3123	101%[23]	3101	101%[24]

Primary Language of Unique Children Reported by Mobile Crisis [25]

	2014	Percent of 2014	2015	Percent of 2015
English	2918	94%	2953	95
Spanish	92	3%	91	3
Hmong	13	<.5%	11	<.5%
Other	10	<.5%	9	<.5%
Unknown	2	<.5%	10	<.5%
Missing	88	3%	27	1
Total:	3123	100%	3101	99%[26]

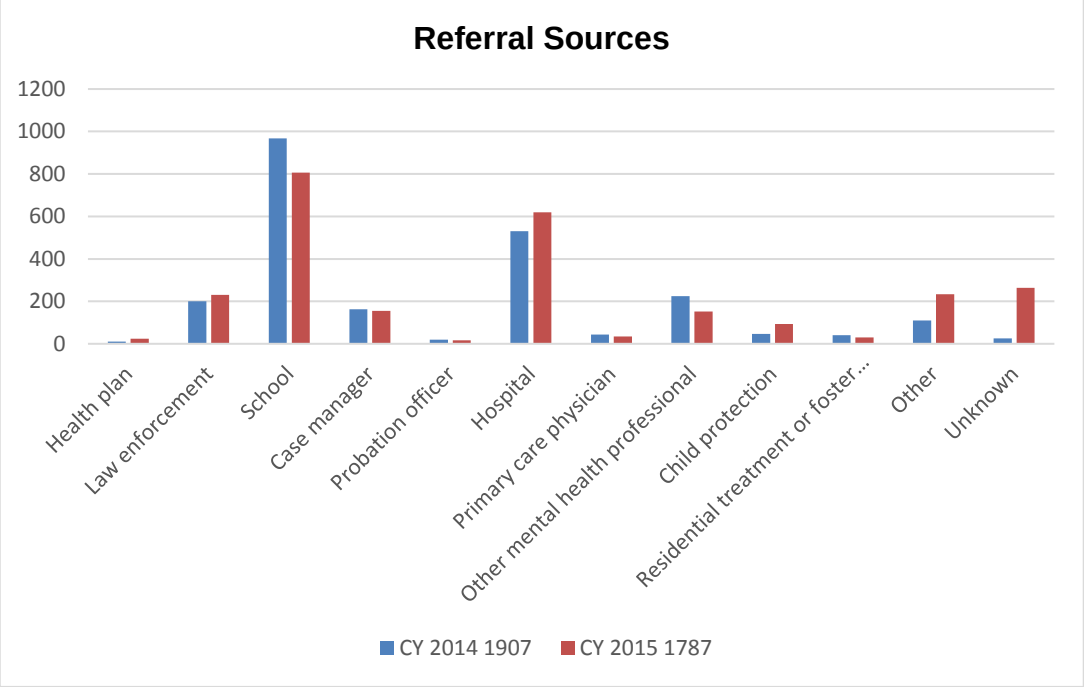
Insurance Status of Unique Children Reported by Mobile Crisis [27]

	2014	Percent of 2014	2015	Percent of 2015
MHCP	1313	42%	1430	46%
Private/commercial	688	22%	749	24%
Both	1	<.5%	2	<.5%
None	422	14%	502	16%
Unknown	559	18%	320	10%
Missing	140	4%	98	3%
Total:	3123	100%	3101	99%[28]

[22] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[23] Percentages do not add to exactly 100% due to rounding errors.
[24] Percentages do not add to exactly 100% due to rounding errors.
[25] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[26] Percentages do not add to exactly 100% due to rounding errors.
[27] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[28] Percentages do not add to exactly 100% due to rounding errors.

Referral Source to Mobile Crisis[29]

	2014	Percent of 2014	2015	Percent of 2015
Self, family, friend	1907	44%	1787	40
Health plan	11	<.5%	24	1
Law enforcement	201	5%	230	5
School	967	23%	806	18
Case manager	163	4%	155	3
Probation officer	20	<.5%	16	<.5%
Hospital	530	12%	619	14
Primary care physician	44	1%	35	1
Other mental health professional	224	5%	152	3
Child protection	46	1%	94	2
Residential treatment or foster care provider	41	1%	30	1
Other	110	3%	233	5
Unknown	26	1%	264	6
TOTAL:	**4290**	**100%**	**4445**	**99%[30]**



The following show all crisis calls during the year. It includes duplication across children that use the services for multiple crises.

[29] Totals are greater than the number of crisis incidents because more than one referral source was permitted.
[30] Percentages do not add exactly to 100% due to rounding errors.

Crisis Plan Status for Crisis Grant Incidents Reported

	2014	Percent of 2014	2015	Percent of 2015
(A)Available and used	261	7%	130	3%
(E)Exists but not accessible	84	2%	97	3%
(N)Does not exist	2112	54%	1992	53%
(Y)Available but not used	926	24%	795	21%
(U)Unknown	459	12%	331	9%
Missing	46	1%	438	12%
Total:	3888	100%	3783	101%[31]

Was Call the Initial Contact or Repeated Crisis Contact?[32]

	2014	Percent of 2014	2015	Percent of 2015
Initial crisis contact	1840	47%	2257	60%
Repeat crisis contact	1334	34%	1196	32%
Unknown	95	2%	291	8%
Missing	619	16%	39	1%
Total:	3888	99%[33]	3783	101%[34]

Primary Reason Reported for Crisis Call

	2014	Percent of 2014	2015	Percent of 2015
1 Suicidal ideation	1148	30%	1243	32%
2 Suicide attempt	164	4%	180	5%
3 Depression	244	6%	257	7%
4 Anxiety/panic	171	4%	173	5%
5 Self-injurious behavior[35]	196	5%	174	5%
6 Aggressive/threatening behavior	288	7%	384	10%
7 Trauma (assault, abuse, loss)	91	2%	75	2%
8 Challenging, disruptive, out of control behavior	1008	26%	829	22%
9 Situational crisis	358	9%	270	7%
10 Psychotic/delusional behavior[36]	29	1%	22	1%
11 Other reason	174	5%	165	4%
Missing	17	<.5%	11	<.5%
Total:	3888	99%[37]	3783	100%

[31] Percentages do not add exactly to 100% due to rounding errors.
[32] The number of children served are unique to the year but the same child may have been served in 2014 and 2015. Repeated contact means that the child has had a face-to-face contact with crisis response program prior to the call.
[33] Percentages do not add exactly to 100% due to rounding errors.
[34] Percentages do not add exactly to 100% due to rounding errors.
[35] Non-suicidal
[36] Child is not threatening to self or others.
[37] Percentages do not add exactly to 100% due to rounding errors.

Secondary Reason Reported for Crisis Call[38]

	2014	Percent of 2014	2015	Percent of 2015
1 Suicidal ideation	133	5%	165	7%
2 Suicide attempt	17	1%	23	1%
3 Depression	491	19%	509	22%
4 Anxiety/panic	198	8%	164	7%
5 Self-injurious behavior[39]	125	5%	135	6%
6 Aggressive/threatening behavior	323	13%	278	12%
7 Trauma (assault, abuse, loss)	44	2%	83	4%
8 Challenging, disruptive, out of control behavior	259	10%	261	11%
9 Situational crisis	335	13%	237	10%
10 Psychotic/delusional behavior[40]	11	<.5%	9	<.5%
11 Other reason	623	24%	467	20%
Total:	2559	100%	2331	100%

Alcohol/Drug Use at Time of Crisis Assessment

	2014	Percent of 2014	2015	Percent of 2015
Yes	130	3%	147	4%
No	3740	96%	3228	85%
Unknown	11	<.5%	7	<.5%
Missing	7	<.5%	401	11%
Total:	3888	99%[41]	3783	100%

Stabilization Services Provided

	2014	Percent of 2014	2015	Percent of 2015
Yes	1156	30%	1227	33%
No	2170	56%	2103	53%
Missing	562	14%	543	14%
Total:	3888	100%	3783	100%

Outcomes

Status at End of Crisis Event

	2014	Percent of 2014	2015	Percent of 2015
C Remained in Current Home	3052	78	2747	73%
E Emergency Foster Care	15	<.5%	8	<.5%
H Hospitalized	463	12	497	13%
O Other	114	3	102	3%
S Shelter Placement	141	4	178	5%
T Temporary Residence	61	2	43	1%
Unknown	0	0	9	<.5%
Missing	42	1	199	5%
Total:	3888	100%	3783	100%

[38] Entering a secondary reason for the call was optional.

[39] Non-suicidal

[40] Child is not threatening to self or others.

[41] Percentages do not add exactly to 100% due to rounding errors.

		PRIMARY REASON										
		Suicidal ideation	Suicide attempt	Depression	Anxiety/ panic	SIB	Aggressive	Trauma	Out of control	Situational crisis	Psychotic/ delusional	Other
CY 2014		Count	Count	Count	Count	Count	Count	Count	Count	Count	Count	Count
End Status	Remained in current	824	73	224	154	166	208	74	875	295	18	138
	Emergency foster care	4	0	0	0	1	0	1	3	5	0	1
	Hospitalized	244	86	7	5	9	49	0	44	1	6	11
	Other	36	3	5	5	7	12	1	30	6	2	7
	Shelter	20	2	1	6	5	11	5	37	41	2	11
	Temporary family/friends	17	0	4	0	6	7	3	11	10	0	3

		PRIMARY REASON										
		Suicidal ideation	Suicide attempt	Depression	Anxiety/ panic	SIB	Aggressive	Trauma	Out of control	Situational crisis	Psychotic/ delusional	Other
CY 2015		Count	Count	Count	Count	Count	Count	Count	Count	Count	Count	Count
	Remained in current	857	83	231	149	144	290	60	693	133	11	100
	Emergency foster care	1	0	0	0	0	0	1	3	1	0	2
	Hospitalized	279	89	7	5	11	46	3	36	4	8	9
	Other	26	2	3	2	8	10	1	21	5	0	23
	Shelter	18	0	4	8	1	13	9	7	115	0	2
End Status	Temporary family/friends	16	2	3	0	1	4	1	8	6	0	2
	Unknown	2	0	0	0	0	0	0	1	1	0	5

4. Conclusions and Evaluation.

A large majority of Minnesota's children and adolescents who experience a mental health crisis are able to stay in their homes—avoiding hospitalization or emergency foster placement. In 2014, that amounted to 78 percent of those who received intervention from a mobile crisis team— more than 3,000 people. It was 73 percent in 2015, or almost 2,800 children.

Slightly fewer children received Crisis Response serve in 2015, compared to 2014. Predictably, adolescents received crisis intervention in greater numbers than their younger peers. The peak was age 15, an age that is known to experienced clinicians as a common period for the onset of new mental illnesses. Fewer of these individuals in 2015 had Crisis Plans in place at the time of the psychiatric crisis, a trend that was slight worse than a year earlier.

The portion of white versus racial/ethnic minority children receiving Crisis services was unchanged during this two year period.

Calls for help were most often initiated by self, family, or friend; with the child's school being a distant second in the number of referrals. Hospital were close behind schools. Five percent of calls to mobile crisis teams came from law enforcement agencies, a rate that was steady over the two years.

Between 42 and 46 percent of children and adolescents receiving crisis intervention had Medical Assistance or MinnesotaCare insurance. Because Crisis Response is a covered service and this Grant has greatly expanded local crisis response capacity, demand for grant funding is likely to decrease for assisting publicly-insured families. However, about one-quarter of individuals receiving crisis services during this period were covered by commercial insurance, which commonly does not cover psychiatric crisis response unless a medical emergency unit is called. As a result, demand for state grant dollars is likely to continue indefinitely to pay for privately insured individuals unless private insurance plan begin to provide necessary coverage.

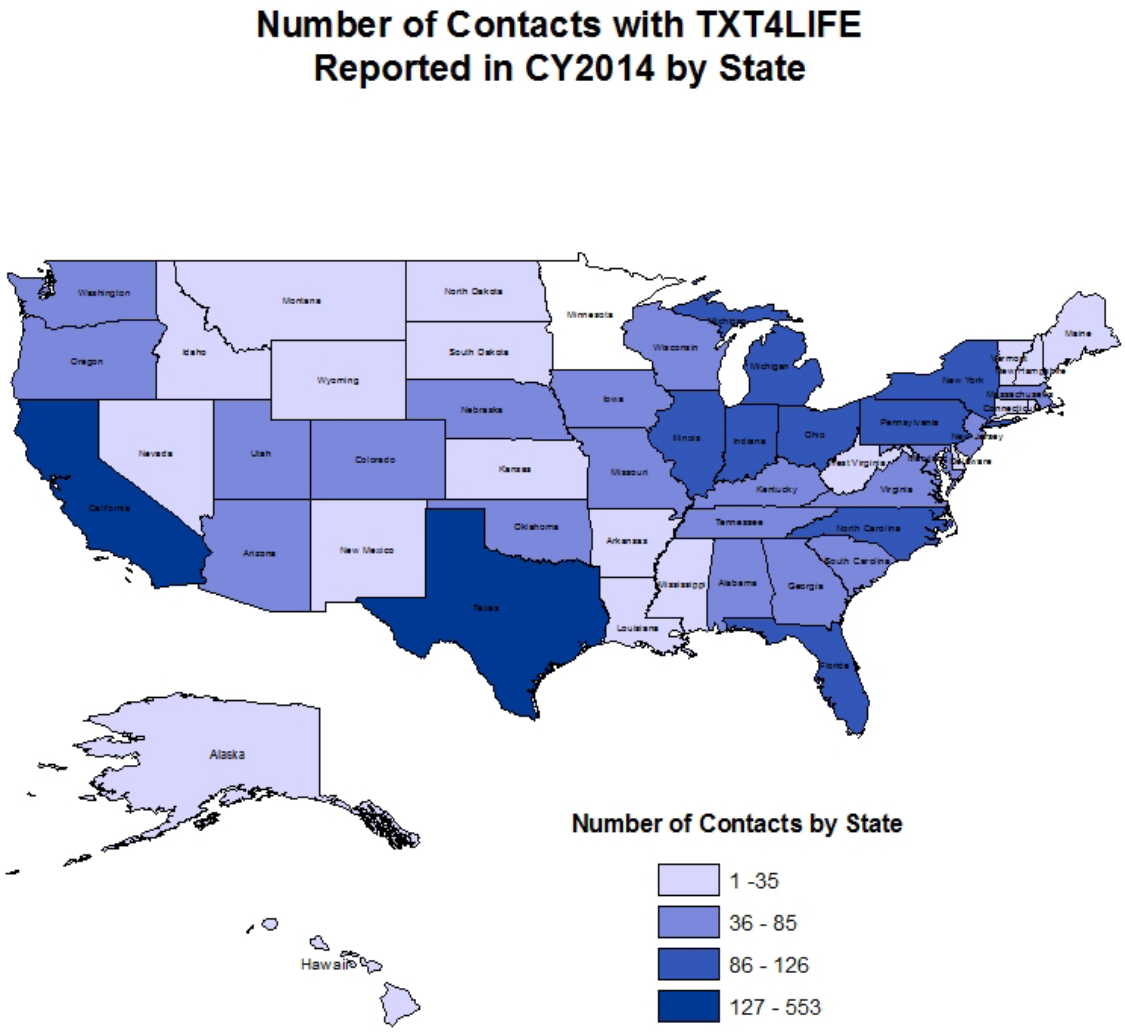
Additionally, approximately 15 percent of calls for mobile crisis intervention came from children with no insurance. These numbers are far greater than the portion of uninsured children in Minnesota's overall population (4%). This suggests that children without routine insurance coverage are far more likely to experience a psychiatric crisis.

TXT4LIFE

In 2014, there were a total of 5,658 completed text sessions; 2015 saw an increase to 9,968 text contacts. There may be duplication in the people served as the same person might reach out for help on more than once occasion so numbers are only for the contacts and not for individuals served. At the beginning of each texting session, the person texting for support is asked for gender, age, race/ethnicity, and zip with the self-reported data included below.

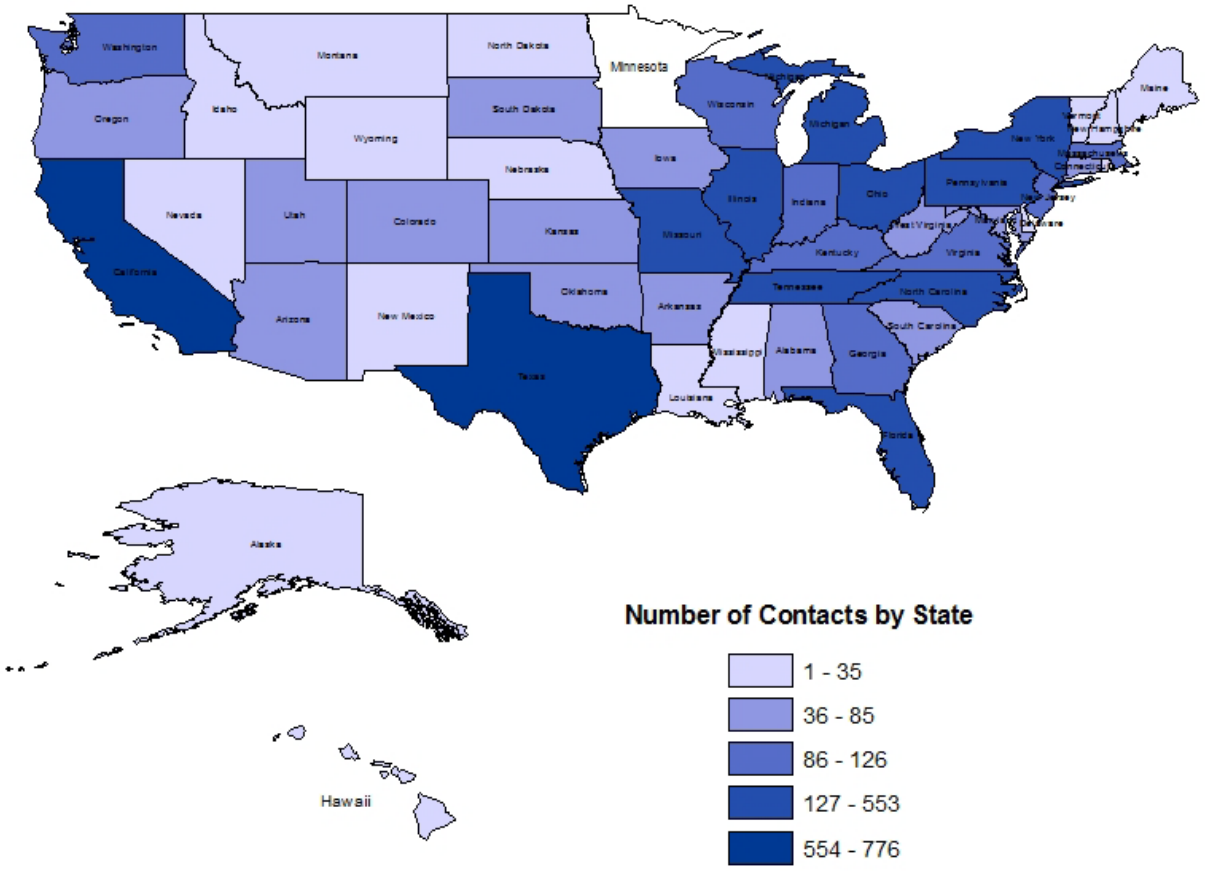
Canvas Health operates the TXT4LIFE program in Minnesota, but receives contacts from across the U.S. DHS administers the grant. The Legislature has not requested outcomes from DHS, but Canvas collects data from the program.

Location of People Outside of Minnesota Served by TXT4LIFE[42]

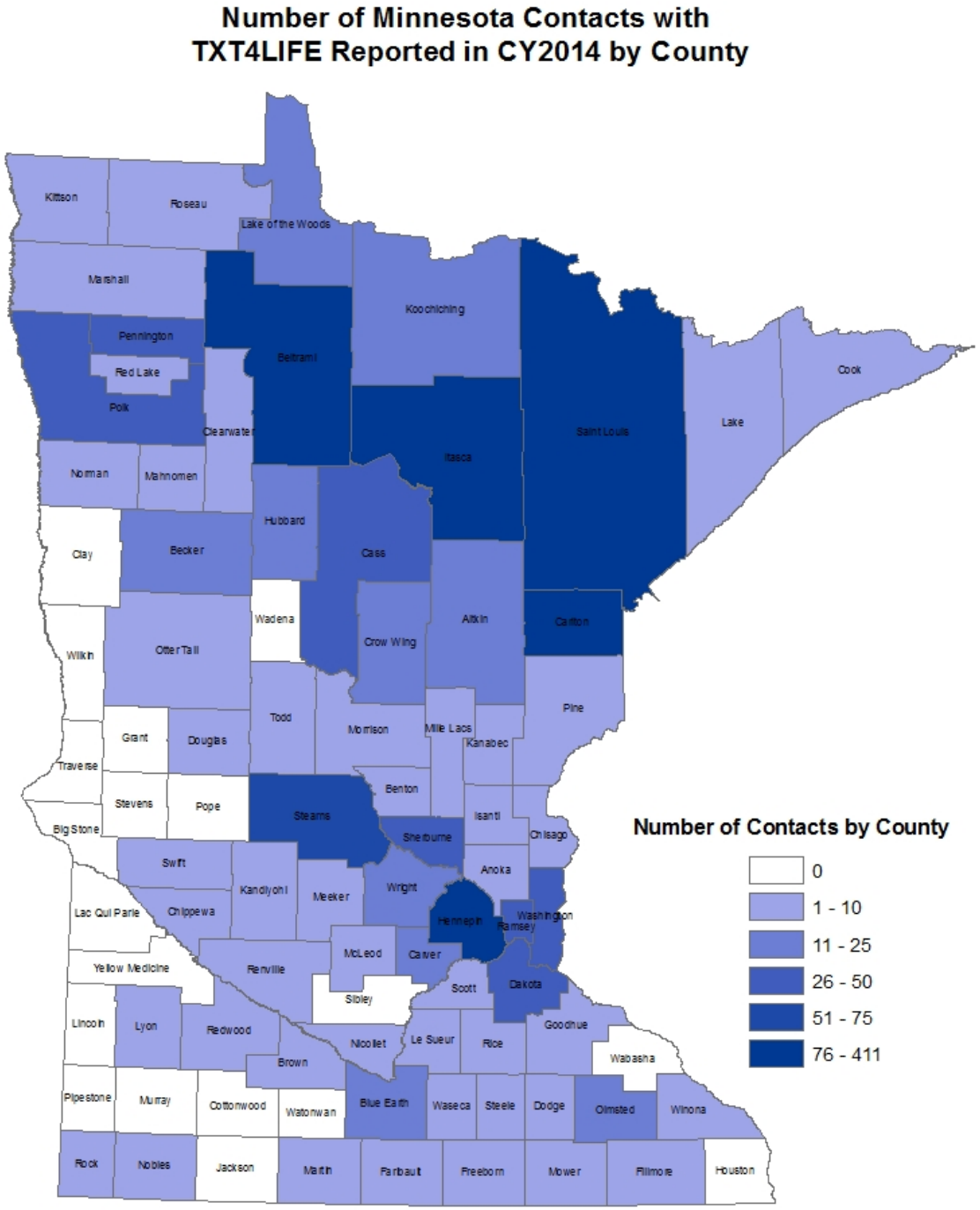


[42] Minnesota data is shown on its own graph, broken down by county.

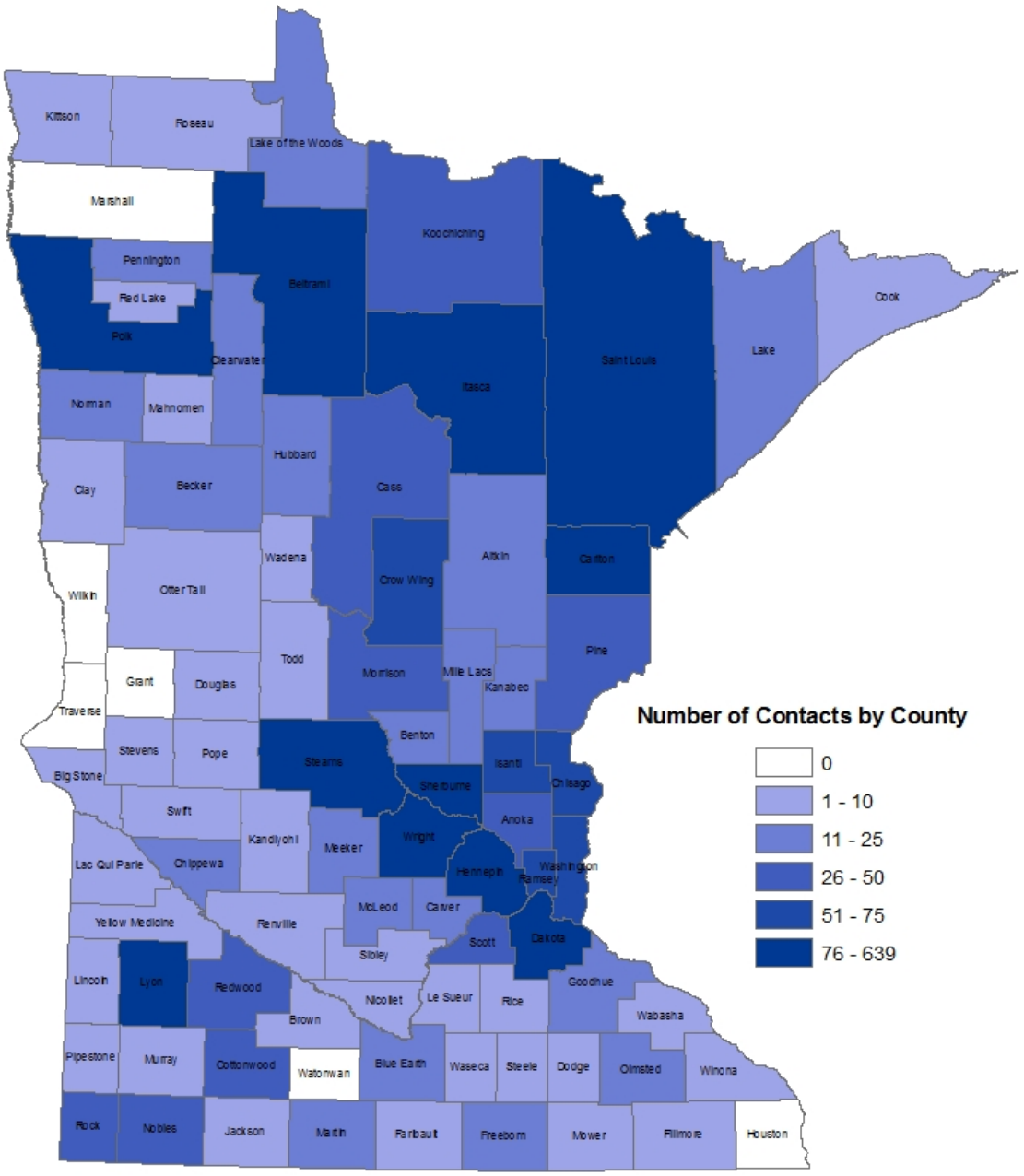
Number of Contacts with TXT4LIFE Reported in CY2015 by State



State/Territory	CY 2014	CY 2015
Alabama	60	70
Alaska	14	7
Arizona	49	77
Arkansas	20	37
California	408	776
Colorado	54	54
Connecticut	28	41
Delaware	6	12
DC	5	5
Florida	120	218
Georgia	73	102
Hawaii	1	4
Idaho	8	19
Illinois	126	165
Indiana	98	116
Iowa	56	80
Kansas	18	59
Kentucky	62	98
Louisiana	35	35
Maine	9	13
Maryland	45	74
Massachusetts	42	120
Michigan	104	165
Minnesota	2141	4746
Mississippi	27	27
Missouri	79	216
Montana	13	19
Nebraska	51	26
Nevada	30	32
New Hampshire	4	20
New Jersey	44	99
New Mexico	20	19
New York	123	165
North Carolina	99	163
North Dakota	27	25
Ohio	123	189
Oklahoma	52	42
Oregon	76	66
Pennsylvania	120	146
Puerto Rico	4	2
Rhode island	4	4
South Carolina	57	40
South Dakota	25	43
Tennessee	75	145
Texas	553	684
Utah	47	43
Vermont	1	29
Virgin Islands	1	0
Virginia	57	111
Washington	52	103
West Virginia	20	38
Wisconsin	85	107
Wyoming	4	5
Unspecified	203	286
TOTAL:	5658	9987


Number of Minnesota Contacts with
TXT4LIFE Reported in CY2014 by County
Kittson
Roseau
Lake of the Woods
Marshall
Koochiching
Pennington
Beltrami
Red Lake
Polk
Clearwater
Itasca
Saint Louis
Lake
Cook
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Wadena
Crow Wing
Aitkin
Carlton
Wilkin
Otter Tail
Todd
Morrison
Mille Lacs
Kanabec
Pine
Grant
Douglas
Traverse
Benton
Stevens
Pope
Stearns
Isanti
Big Stone
Sherburne
Chisago
Swift
Kandiyohi
Meeker
Wright
Anoka
Lac Qui Parle
Chippewa
Hennepin
Washington
Ramsey
McLeod
Carver
Yellow Medicine
Renville
Scott
Dakota
Sibley
Lincoln
Lyon
Redwood
Nicollet
Le Sueur
Rice
Goodhue
Brown
Wabasha
Pipestone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
Number of Contacts by County
0
1 - 10
11 - 25
26 - 50
51 - 75
76 - 411

Number of Minnesota Contacts with TXT4LIFE Reported in CY2015 by County



	2014	2015
Atkin	20	15
Anoka	10	28
Becker	20	21
Beltrami	95	147
Benton	9	24
Big Stone	0	3
Blue Earth	15	18
Brown	2	6
Carlton	105	138
Carver	19	12
Cass	49	44
Chippewa	1	11
Chisago	7	58
Clay	0	5
Clearwater	2	12
Cook	2	9
Cottonwood	0	37
Crow Wing	20	54
Dakota	48	92
Dodge	3	1
Douglas	2	4
Faribault	7	1
Fillmore	1	1
Freeborn	1	25
Goodhue	5	18
Grant	0	0
Hennepin	377	639
Houston	0	0
Hubbard	17	24
Isanti	2	64
Itasca	114	114
Jackson	0	7
Kanabec	3	14
Kandiyohi	2	9
Kittson	4	10
Koochiching	15	35
Lac Qui Parle	0	1
Lake	8	11
Lake of the Woods	24	15
Le Sueur	1	10
Lincoln	0	3
Lyon	2	94
Mahnomen	5	11
Marshall	3	2
Martin	3	0
McLeod	1	14
Meeker	4	18
Mille Lacs	3	20
Morrison	6	33
Mower	2	3
Murray	0	3
Nicollet	3	1
Nobles	1	27
Norman	4	11
Olmsted	12	13
Otter Tail	4	2
Pennington	27	17
Pine	5	34
Pipestone	0	4
Polk	32	77
Pope	0	2
Ramsey	29	72
Red Lake	3	1
Redwood	8	41
Renville	1	1
Rice	7	9
Rock	1	43
Roseau	2	9
St. Louis	411	560
Scott	4	42
Sherburne	49	95
Sibley	0	5
Stearns	52	321
Steele	10	8
Stevens	0	2
Swift	1	7
Todd	1	1
Traverse	0	0
Wabasha	0	6
Wadena	0	10
Waseca	5	2
Washington	42	70
Watonwan	0	0
Wilkin	0	0
Winona	2	2
Wright	11	139
Yellow Medicine	0	7
Unspecified	375	1167
TOTAL:	2141	4746

Age	2014	Percent of 2014	2015	Percent of 2015
10-11	201	4%	110	1%
12-13	453	8%	1052	11%
14-15	947	17%	1941	19%
16-17	789	14%	1430	14%
18-19	341	6%	744	7%
20-21	339	6%	380	4%
22+	731	13%	2002	20%
Unknown/declined	1603	28%	1694	17%
Missing	254	4%	615	6%
Total reported:	5658	100%	9968	100%

Gender of People Reported Served by TXT4LIFE Sessions[43]

	2014	Percent of 2014	2015	Percent of 2015
Female	2888	51%	5860	59%
Male	965	17%	1564	16%
Transgender	32	1%	67	1%
Non-conforming	26	<.5%	59	1%
Unknown/declined	911	16%	1577	16%
Missing	836	15%	841	8%
Total reported:	5658	100%	9968	101%[44]

[43] There may be duplication because it is possible that the same person texted for assistance more than once in the same year or across years.

[44] Percentages do not add exactly to 100% due to rounding errors.

Race/Ethnicity of People Reported Served by TXT4LIFE Sessions[45]

	2014	Percent of 2014	2015	Percent of 2015
White	557	13%	2194	23%
Black/African American	278	6%	599	6%
Asian	185	4%	196	2%
American Indian/Alaskan Native	38	1%	154	2%
Hispanic/Latino	72	2%	473	5%
Unknown/declined	3210	74%	6080	63%
Total race/ethnicities reported:	4340	100%	9696	101%[46]

Services Provided During TXT4LIFE Sessions[47]

	2014	Percent of 2014 Total Services	2015	Percent of 2015 Total Services
Crisis counseling	996	12%	3850	20%
Emergency intervention[48]	80	1%	196	1%
Information/referral	3039	38%	7401	39%
Supportive listening/texting	3979	49%	7773	40%
Total services:	8094	100%	19,220	100%

Summary of Reasons for Contacting TXT4LIFE and Outcome

	2014	Percent of 2014 Total Text Sessions	2015	Percent of 2015 Total Text Sessions
Suicide risk but deescalated	693	12%	2324	23%
Primary issue: Mental Health	1518	27%	2303	23%
Referred to MH related services	3297	58%	7323	73%

[45] There may be duplication because it is possible that the same person texted for assistance more than once in the same year or across years. Additionally, some people identified more than one race so there may be overlap and it is impossible to tell the numbers that may be missing.

[46] Percentages do not add exactly to 100% due to rounding errors.

[47] Total numbers add to more than the total number of people served due to the possibility of multiple services being provided during an incident.

[48] Emergency intervention: Contact and referral made to 911 or local police due to imminent risk to texter.

C. Children's Respite Care Services Grants

1. Grant purpose and funded activities.

Raising a child with a severe psychiatric illness challenges a family's ability to survive. The unique stresses of the child's special needs and his challenging—often dangerous--behavior takes a toll on parents and siblings. Without relief, the family can break apart, leaving both the child with mental illness and his siblings more vulnerable; and leaving parents unable to care for their children.

Child Respite Care is short-term care provided to children with emotional disturbance due to temporary absence or need for relief of those persons normally providing care. Respite care may be provided—in the form of either planned or emergency respite—during the day or overnight; in the individual's home or in an out-of-home setting; from one hour to several days. This includes crisis nursery services and respite provided in a foster home.

Respite care supports the resilience and stability of families by providing relief to children, caregivers and their families. Providing respite care for the child offers parents a chance to recuperate; to regain the strength necessary to support and care for the child. Respite care can be critical to the child's and the family's success.

Families of children receiving county, county-contracted, or tribal Children's Mental Health Case Targeted Management services, and who are caring for children with a severe emotional disturbance are eligible for Respite Care. Respite care services are a frequently requested support service for these families. While respite is considered an important support service for families with children who have a severe emotional disturbance, Medical Assistance cannot be used for long-term sustainability, since Respite Care is not coverable under federal Medicaid law. State funding will remain necessary in the foreseeable future.

DHS expects this services will result in improved child functioning and diversion from out-of-home placements and hospitalizations. Additionally, DHS expects that a majority of children and families will report satisfaction with respite care services received. The child, parents, guardians, and family members are viewed as partners in the planning and provision of respite care services for their family.

DHS awarded grants to 72 counties in 2016—an increase from 54 in 2015—and served 6,800 children. Of the counties receiving grants in previous years, none saw a reduction of monies, and additional counties received 80 percent of their requests. A stakeholder group comprising counties, advocacy groups, and parents, in the spring of 2016, designed a new "Respite Methodology" to guide funding decisions in future years. This included underspent and overspent funds. Counties contract with private providers to deliver respite care.

A request-for-proposals was in issued in fall of 2016 to provide facilitation and coordination of all meetings pertaining to the Children's Mental Health Respite study, working under the guidance of the Children's Mental Health Division. This contract is still in negotiations. The contractor will provide project management, guidance, coordination, and facilitation for stakeholder engagement related to Children's Respite Services with input from Children's and Family Services Administration's Child Welfare team.

2. Financials.

	Appropriated	Expended	Unspent	% Unspent
State Fiscal Year 2014	1,024,000	1,024,000	0	0%
State Fiscal Year 2015	1,024,000	1,024,000	0	0%

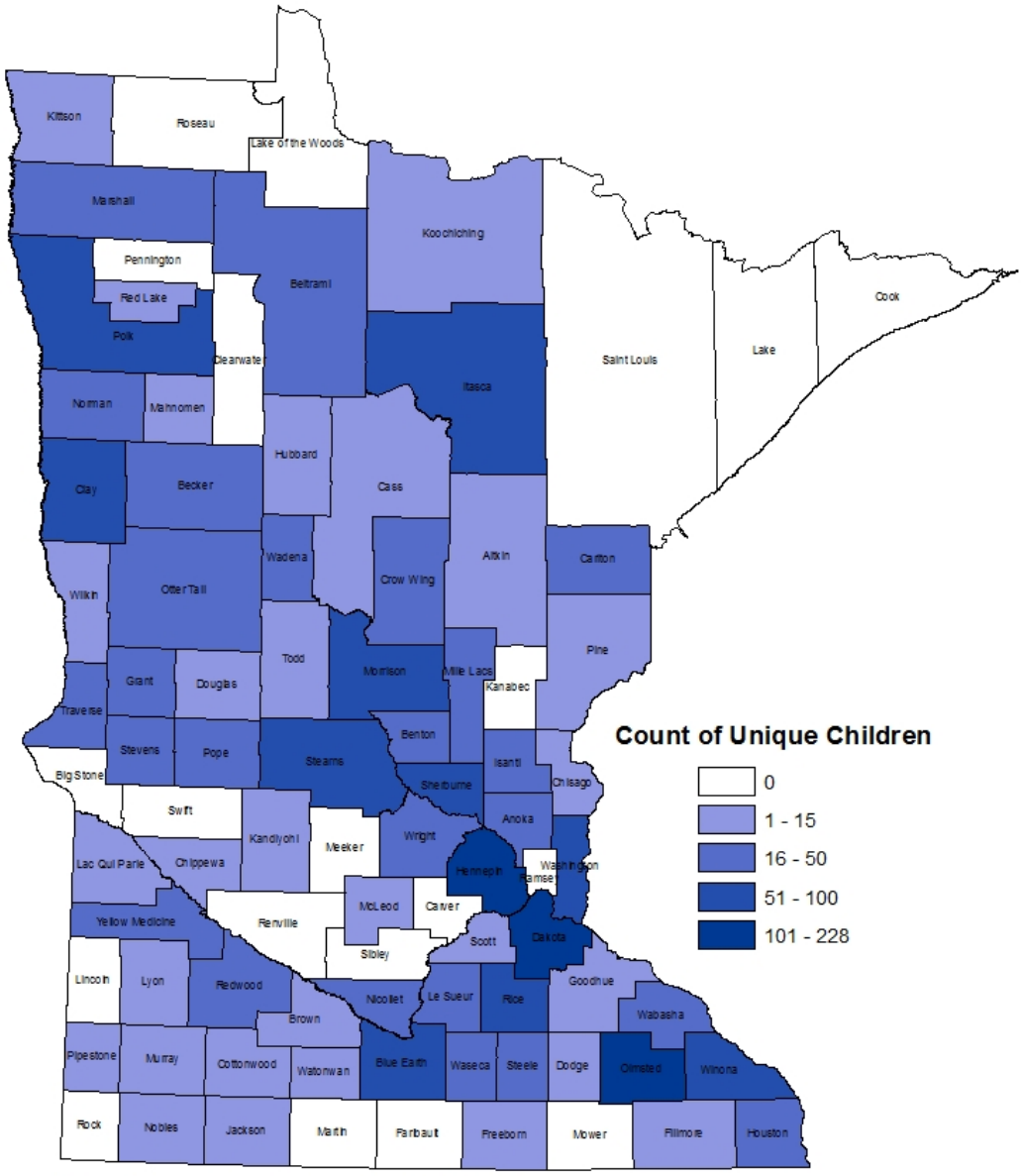
History of funding. State appropriations for Respite Care services have held steady, since the program's SFY 2008 inception, at $1,024,000 each fiscal year.

Future funding. Respite Care Services will require state grant funding for the foreseeable future. Respite Care for children with mental health needs is not an eligible Medicaid State Plan service under federal statute. Medicaid is a potential payer only under an approved Section 1915 Home and Community-Based Services waiver. However, the current federal administration is approving few state waiver applications and, instead, is directing states to cover new benefits for children under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) authority—which is limited to services that are coverable under the federal Medicaid (State Plan) program benefits set.

3. Outcomes. Demographics; Locations; Treatment outcomes

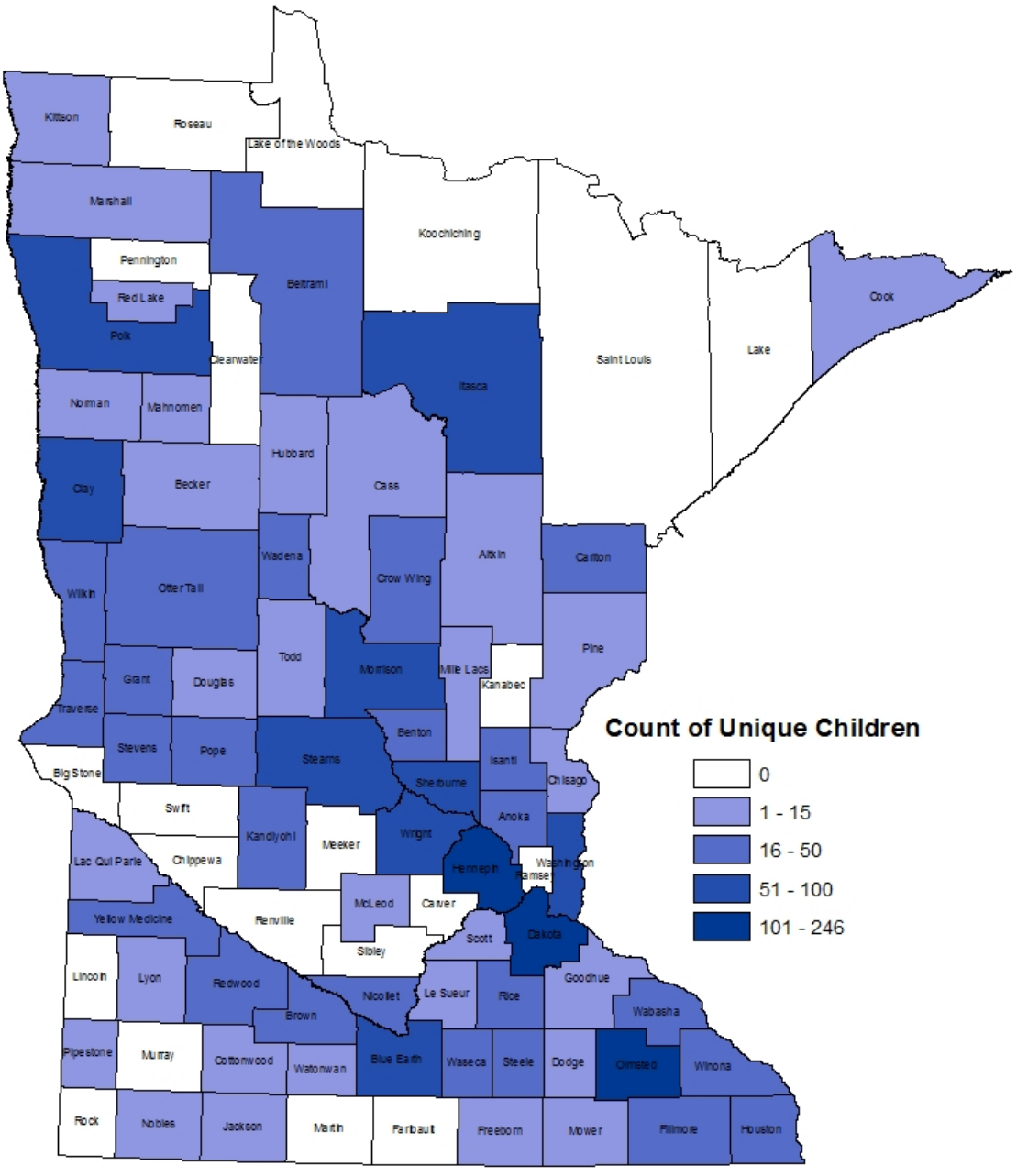
In 2014, 2,109 children were served by 9344 payments from the Respite grant. In 2015, 2,140 children were served, utilizing 8,780 Respite visits.

Number of Unique Children Receiving Mental Health Respite Grant Payments for CY2014 by County



Source: Minnesota Department of Human Services, AMHD (10/4/2016)

Number of Unique Children Recieving Mental Health Respite Grant Payments for CY2015 by County



Source: Minnesota Department of Human Services, AMHD (10/4/2016)

Number of children for whom Respite payments were made, by county, by year.

	2014	2015
Atkin	6	7
Anoka	19	29
Becker	20	12
Beltrami	21	21
Benton	31	27
Big Stone	0	0
Blue Earth	70	93
Brown	11	27
Carlton	45	47
Carver	0	0
Cass	9	11
Chippewa	1	0
Chisago	11	5
Clay	93	76
Clearwater	0	0
Cook	0	1
Cottonwood	6	4
Crow Wing	19	29
Dakota	149	125
Dodge	2	2
Douglas	5	4
Faribault	0	0
Fillmore	12	24
Freeborn	3	1
Goodhue	2	1
Grant	25	25
Hennepin	228	246
Houston	47	36
Hubbard	2	5
Isanti	37	31
Itasca	89	65
Jackson	12	7
Kanabec	0	0
Kandiyohi	15	26
Kittson	2	1
Koochiching	1	0
Lac Qui Parle	11	12
Lake	0	0
Lake of the Woods	0	0
Le Sueur	18	13
Lincoln	0	0
Lyon	6	10
Mahnomen	11	10
Marshall	4	6
Martin	16	13
McLeod	0	0
Meeker	0	0
Mille Lacs	16	10
Morrison	78	86
Mower	0	7
Murray	1	0
Nicollet	44	42
Nobles	2	4
Norman	20	13
Olmsted	101	124
Otter Tail	41	41
Pennington	0	0
Pine	4	3
Pipestone	1	2
Polk	62	77
Pope	33	33
Ramsey	0	0
Red Lake	2	1
Redwood	22	19
Renville	0	0
Rice	56	46
Rock	0	0
Roseau	0	0
St. Louis	0	0
Scott	15	8
Sherburne	68	61
Sibley	0	0
Stearns	51	53
Steele	45	47
Stevens	23	26
Swift	0	0
Todd	1	4
Traverse	20	18
Wabasha	20	21
Wadena	17	16
Waseca	32	31
Washington	85	73
Watonwan	1	1
Wilkin	15	23
Winona	67	44
Wright	46	66
Yellow Medicine	24	16
Total:	2072	2068

Demographic data was identifiable for 2,072 unique children served by the Respite Grant in SFY 2014; unique children receiving services in 2015 numbered 2,068.

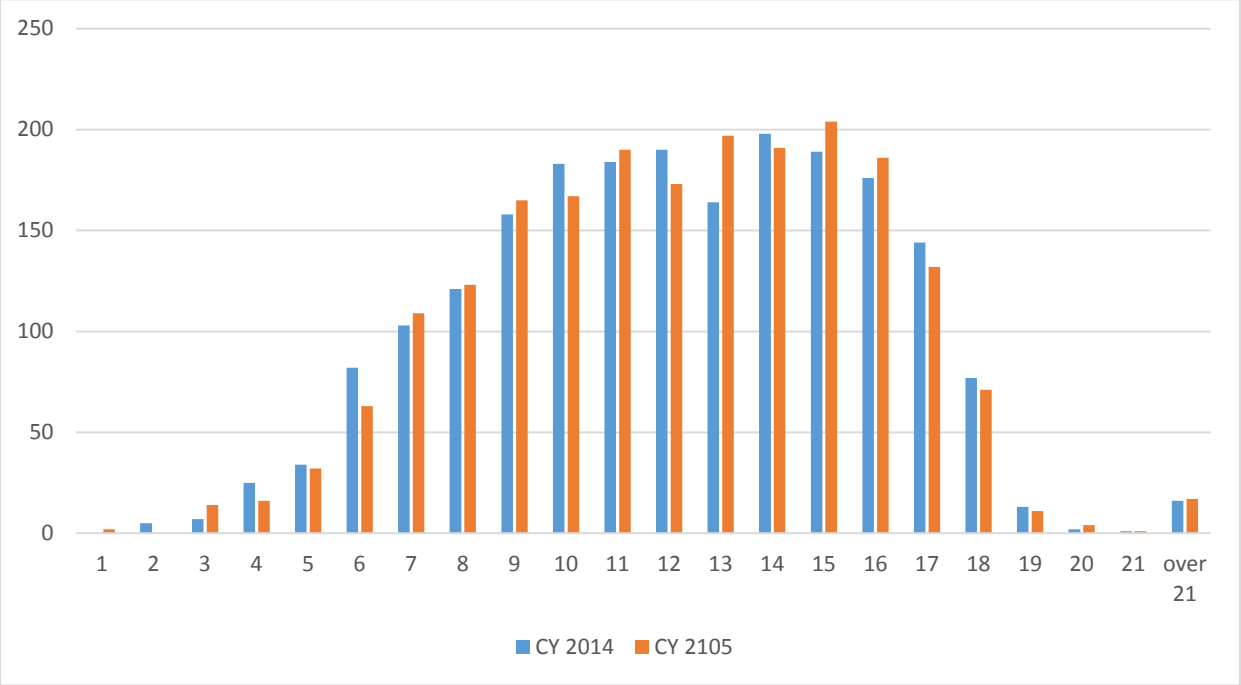
AGE	CY 2014	CY 2105
1	0	2
2	5	0
3	7	14
4	25	16
5	34	32
6	82	63
7	103	109
8	121	123
9	158	165
10	183	167
11	184	190
12	190	173
13	164	197
14	198	191
15	189	204
16	176	186
17	144	132
18	77	71
19	13	11
20	2	4
21	1	1
over 21	16	17
Total:	2072	2068

Primary Language of Unique Children Reported by Respite Grant [49]

	2014	Percent of 2014	2015	Percent of 2015
English	1507	73%	1476	71
Spanish	10	1%	20	1
Other	12	<.5%	12	<.5%
Unknown	5	<.5%	9	<.5%
Missing	538	26%	551	27
Total:	2072	100%	2068	99

[49] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.

Age of People Served by Respite Grant



Gender of Unique Children Reported by Respite Grant[50]

	2014	Percent of 2014	2015	Percent of 2015
Female	845	41%	868	42%
Male	1227	59%	1200	58%
Total:	2072	100%	2068	100%

Race of Unique Children Reported by Respite Grant[51]

	2014	Percent of 2014	2015	Percent of 2015
White	1590	77%	1593	77
Black/African American	280	14%	280	14
Asian	29	1%	22	1
American Indian/Alaskan Native	141	7%	127	6
Pacific Islander	4	<.5%	7	<.5%
Declined	0	0%	1	<.5%
Unknown	23	1%	28	1
Missing	5	<.5%	10	<.5%
Total:	2072	100%	2068	99%[52]

[50] The number of children served are unique to the year but the same child may have been served in 2014 and 2015

[51] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.

[52] Percentages do not add exactly to 100% due to rounding errors.

4. Conclusions and Evaluation on Respite Care Grants.
The statewide number of children receiving Respite Care stayed even from 2014 to 2015, with boys using significantly more than girls.

English-speaking children uses more than 70 percent of Respite Care covered by the grants in the two-year period, though primary language was not reported for a quarter of children served. The second largest language group were Spanish speakers, though they represented only 1 percent of users.

Use of Respite Care is fairly even across children ages 7 to 17. Data shows tapering utilization at both ends of the age range.

Future funding needs. Respite Care Services will require state grant funding for the foreseeable future. Respite Care for children with mental health needs is not coverable under federal Medicaid law as a State Plan benefit. Respite Care could be sustained with Medicaid funding under an approved 1915(i) state plan waiver. However, federal Medicaid administrators, in recent years, have been denying state waiver applications and, instead, are directing states to cover new benefits for children under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) authority—which limits services to those coverable under State Plan program benefits.

D. Early Childhood Mental Health Capacity Grants

1. Grant purpose and funded activities.
The purpose of the Early Childhood Mental Health grant is to build the statewide infrastructure to ensure that all children under age-five with mental health conditions, regardless of their insurance status, receive evidence-based early childhood mental health services from highly trained early childhood mental health professionals.

The grants fund:

- clinical services for the uninsured and underinsured children ages birth to five;
- training for early childhood mental health professionals in three evidenced based interventions and in early childhood assessment:
    - Parent Child Interaction Therapy
    - Incredible Years Parenting Group
    - Trauma Informed Child Parent Psychotherapy
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R, to be updated to DC:0-5 in December 2016);
- foundational child development expertise (which is not provided in most clinical training programs) by sending clinicians from each grantee provider agency to the University of Minnesota's Infant and Early Childhood Mental Health Certification Program.

Mental health care for toddlers looks very different than care for older children or adults. It's about healthy cognitive and emotional development for every child. It's about ensuring healthy attachment between mother and infant, without which the child faces poor lifelong outcomes. It is overcoming barriers to development—like a traumatic environment or a parent's own mental illness. Early childhood mental health is the foundation necessary for learning well before young children tackle their numbers and letters.

Most children develop well in all cultures and with all kinds of families. However, children are at higher risk of problems as they grow older when they have specific cognitive or sensory impairments, when they live in chaotic or unpredictable environments, or when they experience difficulty in establishing loving, stable relationships with caring adults. Long-lasting difficulties can include behavioral problems, poor coping skills, inability to concentrate, decreased self-esteem, and an inability to share or react appropriately to others. Often such difficulties mean that children start kindergarten noticeably behind their peers. Many then struggle to catch up throughout their entire school careers.

Identifying difficulties early, before age 5, and providing families with the proper assessments and interventions make a difference in a child's earliest years and for many years thereafter.

For 2015-2016, following the period covered by this report, the Early Childhood Mental Health Grant program re-focused its emphasis to these goals:

- to grow a statewide early childhood mental health workforce with the capacity to provide clinical, medically necessary, mental health services to children ages birth to five years old and their families;
- to develop the regional capacity across the state to engender more early childhood mental health professionals through formal practicum and internship sites;

- to develop the regional capacity to provide evidence-based early childhood mental health consultation to early childhood programs such as childcare and Head Start; and
- to develop an early childhood mental health consultation system for childcare centers, family childcare, and Head Start.

The shift acknowledges the broader coverage now available for basic mental health care under state and federal healthcare reform and concentrates resources on growing providers in every part of the state in evidence-based practices and trauma-informed care.

2. Financials.

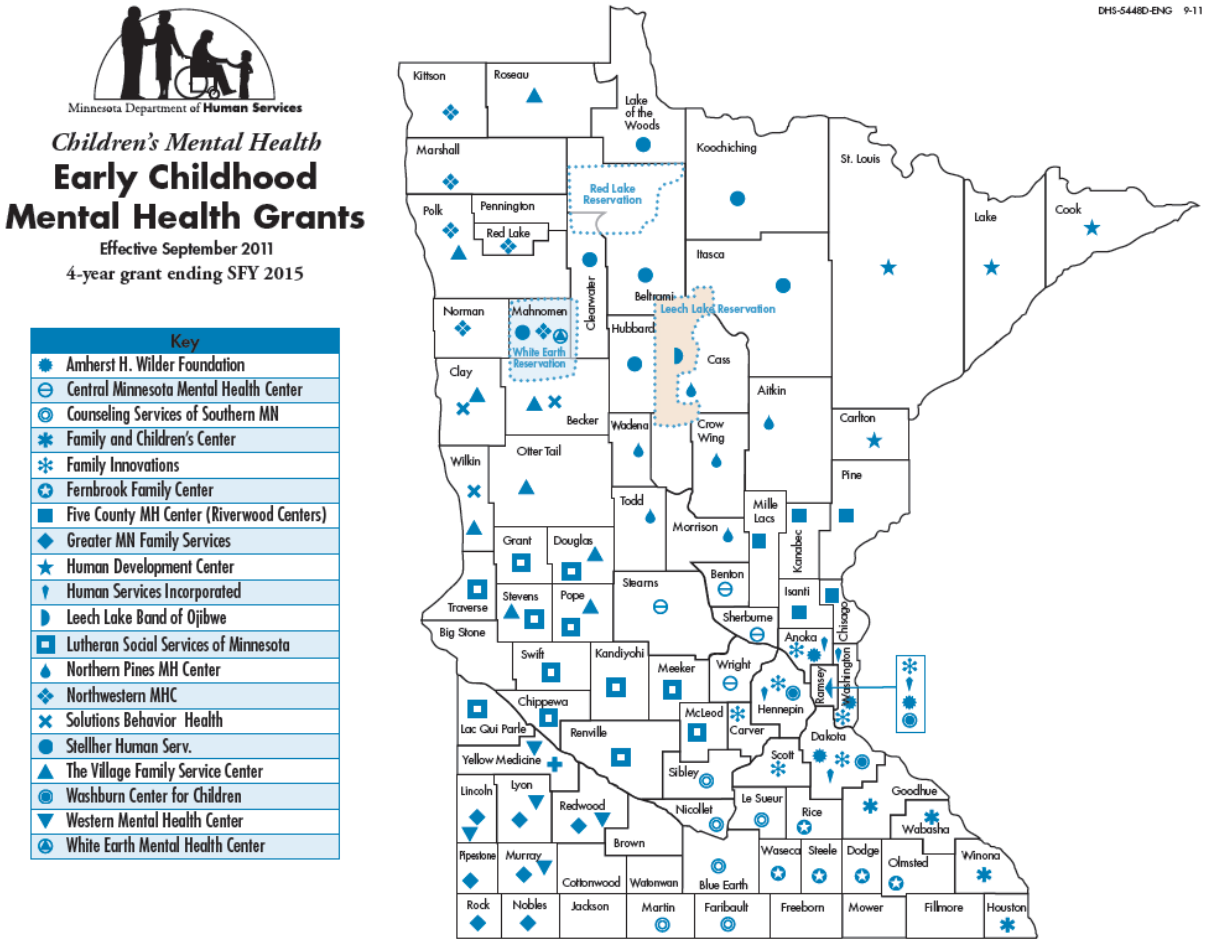
	Appropriated	Expended	Unspent	% Unspent
State Fiscal Year 2014	1,024,000	906,615	117,385	11%
State Fiscal Year 2015	1,024,000	458,320	565,680	55%

Unspent funds. During the 2012-2015 grant cycle, contracts required grantees to dedicate half of their budgets to services for uninsured and underinsured. As a result of federal and state health care reform during that period, fewer children lacked insurance than was projected at the beginning of the grant period. DHS found that most children covered by the grant were well-insured and, thus did not need grant coverage for direct services; this resulted in a high level of underspending in the *direct services* category; while the *infrastructure development* category was fully expended. To remedy this issue, the next round of grants (for SFY 2016-2020) removed the direct services requirement and re-focused funds on training a statewide network of providers.

History of funding. The Legislature's support for this grant is unchanged from its initial base of $1,024,000 each year.

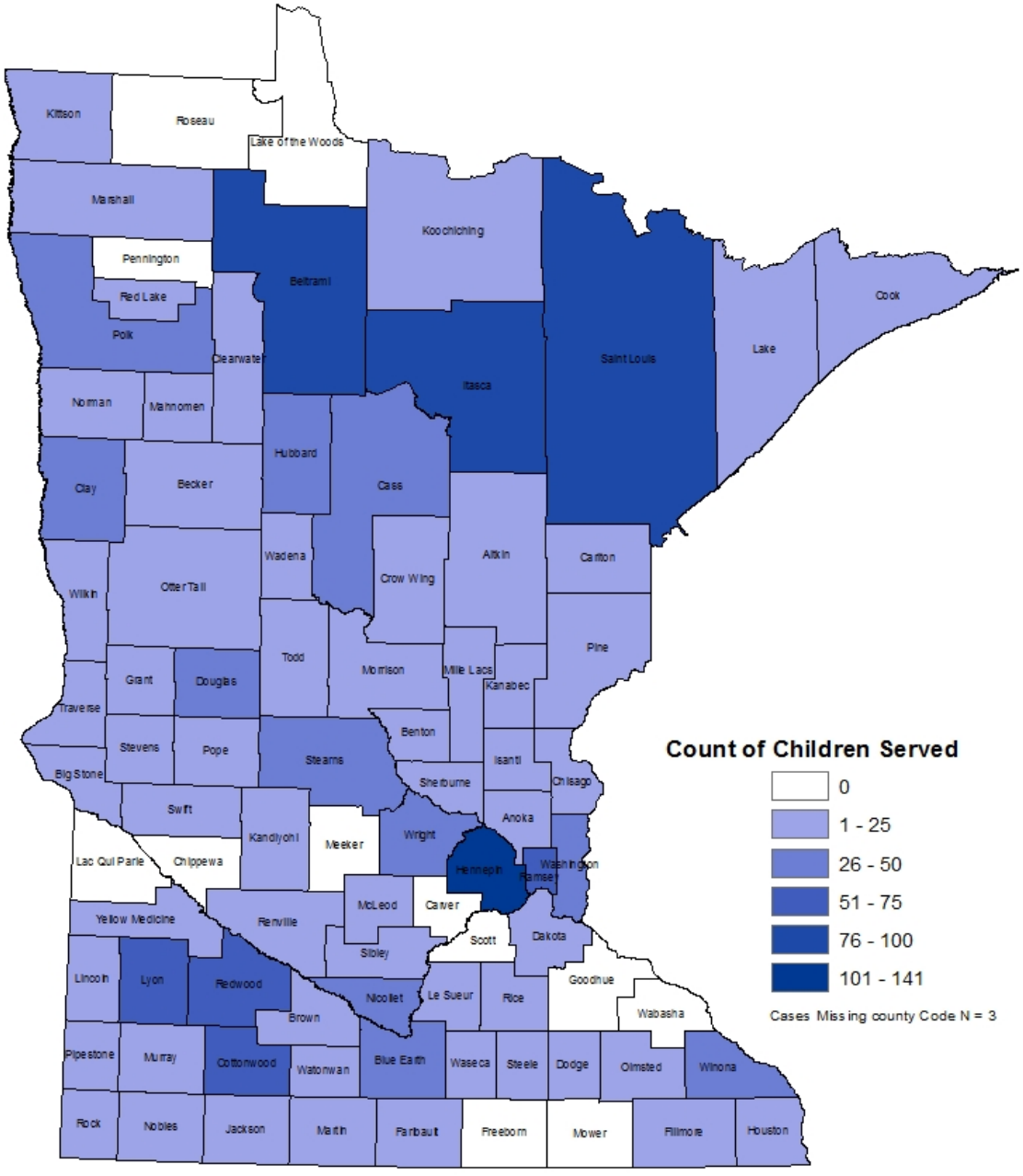
3. Outcomes, Demographics, Locations, and Treatment outcomes

The Early Childhood Mental Health Grant funded 20 providers serving 78 counties in Minnesota during the two year period. Results are shown in maps, tables, and charts below:



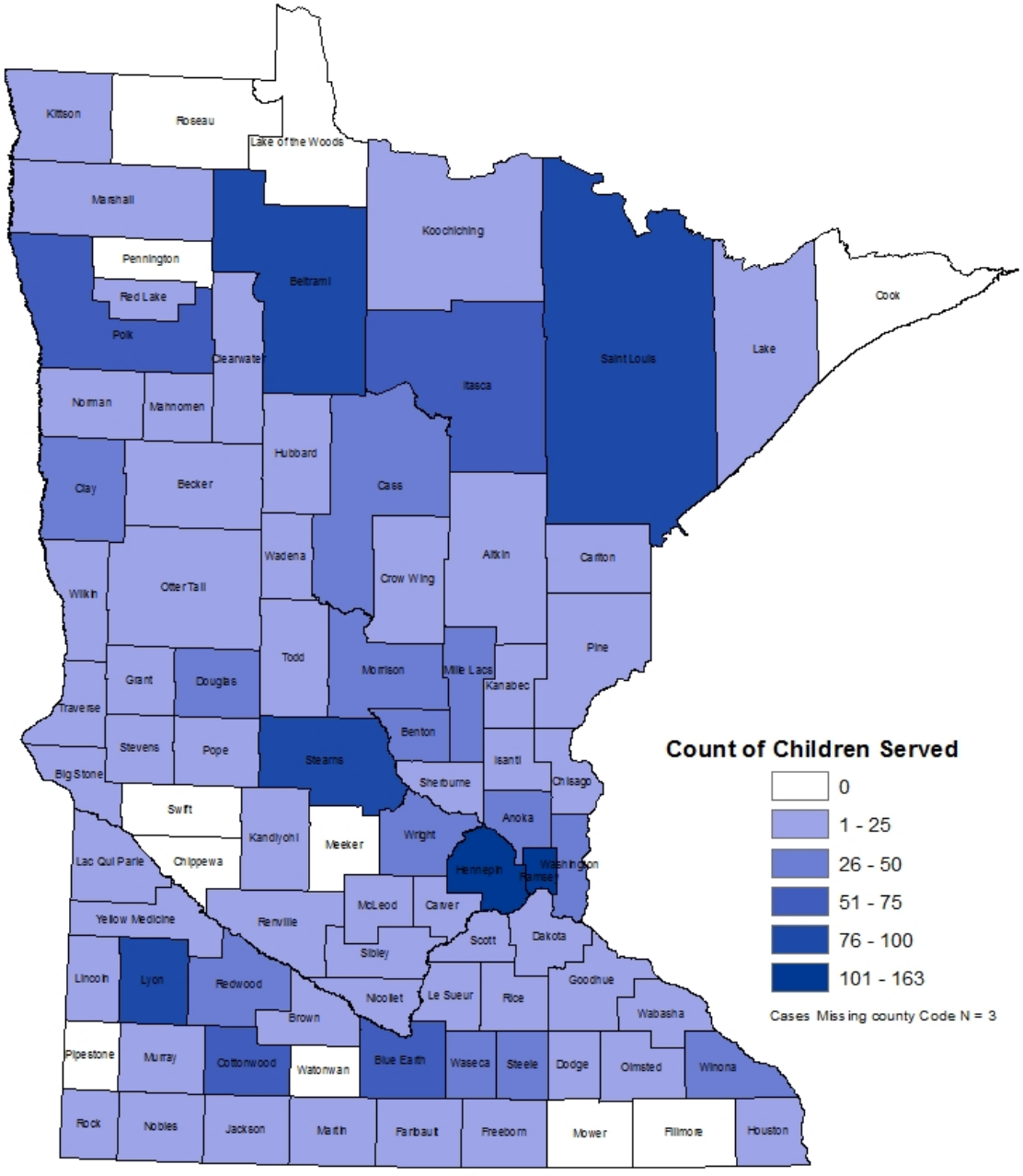
In 2014, a total of 1,543 children were served; during 2015 that number increased to 1,720.

Number of Unique Early Childhood Mental Health Children Reported in CY2014 by County



Source: Minnesota Department of Human Services, AMHD (8/24/2016)

Number of Unique Early Childhood Mental Health Children Reported in CY2015 by County

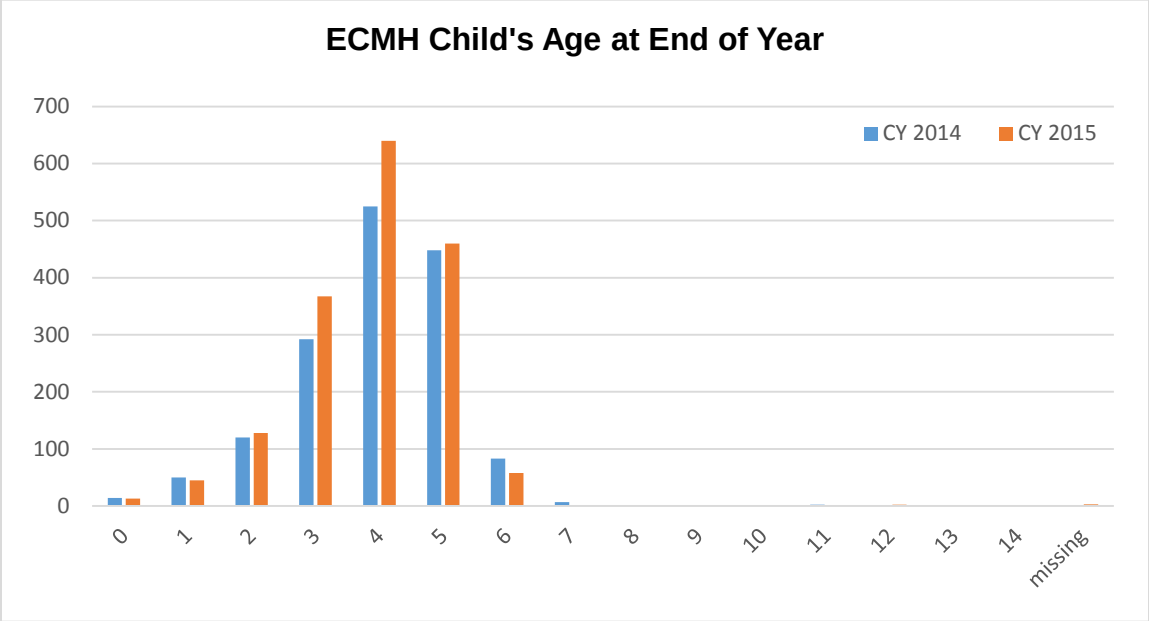


Source: Minnesota Department of Human Services, AMHD (8/24/2016)

Number of children served by Early Childhood Mental Health Grants, by county, by year

	2014	2015
Atkin	2	1
Anoka	6	27
Becker	6	10
Beltrami	88	90
Benton	16	28
Big Stone	4	2
Blue Earth	38	51
Brown	5	1
Carlton	14	7
Carver	0	6
Cass	31	35
Chippewa	0	0
Chisago	18	3
Clay	32	33
Clearwater	13	8
Cook	1	0
Cottonwood	62	70
Crow Wing	25	21
Dakota	12	16
Dodge	3	3
Douglas	48	44
Faribault	5	9
Fillmore	1	0
Freeborn	0	1
Goodhue	0	1
Grant	10	6
Hennepin	141	163
Houston	11	6
Hubbard	35	20
Isanti	7	11
Itasca	86	72
Jackson	16	19
Kanabec	5	8
Kandiyohi	18	13
Kittson	2	5
Koochiching	15	19
Lac Qui Parle	0	1
Lake	2	3
Lake of the Woods	0	0
Le Sueur	22	24
Lincoln	7	4
Lyon	70	83
Mahnomen	20	7
Marshall	9	7
Martin	7	5
McLeod	1	3
Meeker	0	0
Mille Lacs	22	32
Morrison	18	37
Mower	0	0
Murray	13	5
Nicollet	38	25
Nobles	7	6
Norman	6	8
Olmsted	7	11
Otter Tail	4	5
Pennington	0	0
Pine	22	9
Pipestone	1	0
Polk	40	60
Pope	4	7
Ramsey	66	107
Red Lake	2	4
Redwood	55	47
Renville	9	9
Rice	17	19
Rock	4	2
Roseau	0	0
St. Louis	83	81
Scott	0	2
Sherburne	3	14
Sibley	2	3
Stearns	35	77
Steele	15	27
Stevens	4	1
Swift	2	0
Todd	1	13
Traverse	6	3
Wabasha	0	2
Wadena	8	5
Waseca	15	26
Washington	37	38
Watonwan	1	0
Wilkin	1	1
Winona	35	35
Wright	32	39
Yellow Medicine	11	11
Out of state	0	1
Missing	3	2
TOTAL:	1543	1720

Age of Children Served by ECMH



Age	CY 2014	CY 2015
0	14	13
1	50	45
2	120	128
3	292	367
4	525	640
5	448	460
6	83	58
7	7	1
8	0	0
9	0	0
10	0	0
11	2	1
12	1	2
13	0	1
14	0	1
missing	1	3
TOTAL:	1543	1720

Gender of Unique Children Reported by ECMH[53]

	2014	Percent of 2014	2015	Percent of 2015
Female	554	36%	678	39%
Male	982	64%	1036	60%
Missing	7	<.5%	6	<.5%
Total:	1543	100%	1720	99%[54]

Race of Unique Children Reported by ECMH[55]

	2014	Percent of 2014	2015	Percent of 2015
White	1008	65%	1095	64%
Black/African American	84	5%	154	9%
Asian	23	1%	25	1%
American Indian/Alaskan Native	139	9%	130	8%
Native Hawaiian/Pacific Islander	9	1%	3	<.5%
Other	22	1%	13	1%
Biracial/multiracial	221	14%	241	14%
Unknown	13	1%	40	2%
Missing	24	2%	19	1%
Total:	1543	99%[56]	1720	100%

Ethnicity of Unique Children Reported by ECMH[57]

	2014	Percent of 2014	2015	Percent of 2015
Latino	124	8%	127	7%
Somali	3	<.5%	6	<.5%
Hmong	14	1%	9	1%
African	18	1%	44	3%
Karen	-[58]	-	5	<.5%
None	975	63%	1173	68%
Other	16	1%	28	2%
Missing	393	25%	328	19%
Total:	1543	99%[59]	1720	100%

[53] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[54] Percentages do not add to exactly 100% due to rounding errors.
[55] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[56] Percentages do not add to exactly 100% due to rounding errors.
[57] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[58] The Karen category was not added to the data collection until 2015.
[59] Percentages do not add to exactly 100% due to rounding errors.

Primary Language of Children Reported by ECMH[60]

	2014	Percent of 2014	2015	Percent of 2015
English	1486	96%	1642	95%
Spanish	36	2%	28	2%
Hmong	10	1%	5	<.5%
Karen	-[61]	-	3	<.5%
Somali	2	<.5%	9	1%
Other	7	1%	3	<.5%
Missing	2	<.5%	30	2%
Total:	1543	100%	1720	100%

Program Types Reported by Children in ECMH[62]

	2014	Percent of 2014	2015	Percent of 2015
Licensed child care[63]	285	15%	354	17%
Family, friend and neighbor care[64]	161	9%	174	8%
Head Start	354	19%	368	18%
Early childhood special education	295	16%	312	15%
General preschool	166	9%	218	10%
School based program	44	2%	83	4%
Therapeutic preschool/Day treatment	139	8%	166	8%
Other	95	5%	97	5%
No program[65]	268	15%	236	11%
Missing[66]	41	2%	80	4%
Total:	1848	100%	2088	100%

[60] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[61] The Karen category was not added to the data collection until 2015.
[62] Up to 2 programs may be reported for each child.
[63] These include any licensed child care providers, family, or center.
[64] Does not include parent or legal guardian care
[65] Child does not participate in any Early Childhood programs.
[66] Children for whom nothing was reported on program type

Insurance Status of Children Reported by ECMH[67]

	2014	Percent of 2014	2015	Percent of 2015
MHCP	1137	74%	1316	77%
Private/commercial	234	15%	235	14%
Both	63	4%	76	4%
None	99	6%	81	5%
Unknown	3	<.5%	2	<.5%
Missing	7	<.5%	10	1%
Total:	1543	99%[68]	1720	101%[69]

First Mental Health Service for Unique ECMH Children Reported?[70]

	2014	Percent of 2014	2015	Percent of 2015
Yes	1289	84%	1471	86%
No	223	14%	174	10%
Missing	31	2%	75	4%
Total:	1543	100%	1720	100%

ED/SED[71] Status for Unique ECMH Children Reported[72]

	2014	Percent of 2014	2015	Percent of 2015
ED	548	36%	519	30%
SED	648	42%	829	48%
None	69	4%	64	4%
Unknown	85	6%	74	4%
Missing	193	13%	234	14%
Total:	1543	101%[73]	1720	100%

[67] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[68] Percentages do not add to exactly 100% due to rounding errors.
[69] Percentages do not add to exactly 100% due to rounding errors.
[70] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[71] Emotional disability/Serious emotional disability.
[72] The number of children served are unique to the year but the same child may have been served in 2014 and 2015.
[73] Percentages do not add to exactly 100% due to rounding errors.

Special Education Plans for ECMH Children Reported

	2014	Percent of 2014	2015	Percent of 2015
Individual Education Plan	285	18%	333	19%
Individual Family Support Plan	118	8%	112	7%
Individual Interagency Intervention Plan	2	<.5%	1	1%
Blank (None or missing)	1138	74%	1274	74%
Total:	1543	100%	1720	101%[74]

Outcomes data using the Early Childhood Service Intensity Instrument (ECSII) and the Strengths and Difficulties Questionnaire (SDQ)

The ECSII was developed to provide a structured tool to help providers and clinicians from multiple agencies serving children from ages 0-5 to assess what intensity of services are needed and to develop comprehensive, integrated service plans.

The ECSII is based on the concept of Service Intensity (SI) as opposed to "level of care" that is utilized in outcome measures for school-aged children and adolescents (as described in this report as CASII measures). Traditionally, level of care has implied facility-based programs with ascending levels of restrictiveness. Since young children and their families often require services in multiple contexts, the breadth of the service plan may be more important than restrictiveness. We believe that Service Intensity best captures this concept. Service intensity involves multiple factors, not only the frequency and quantity of services, but also the extent to which multiple providers or agencies are involved, as well as the level of care coordination required.

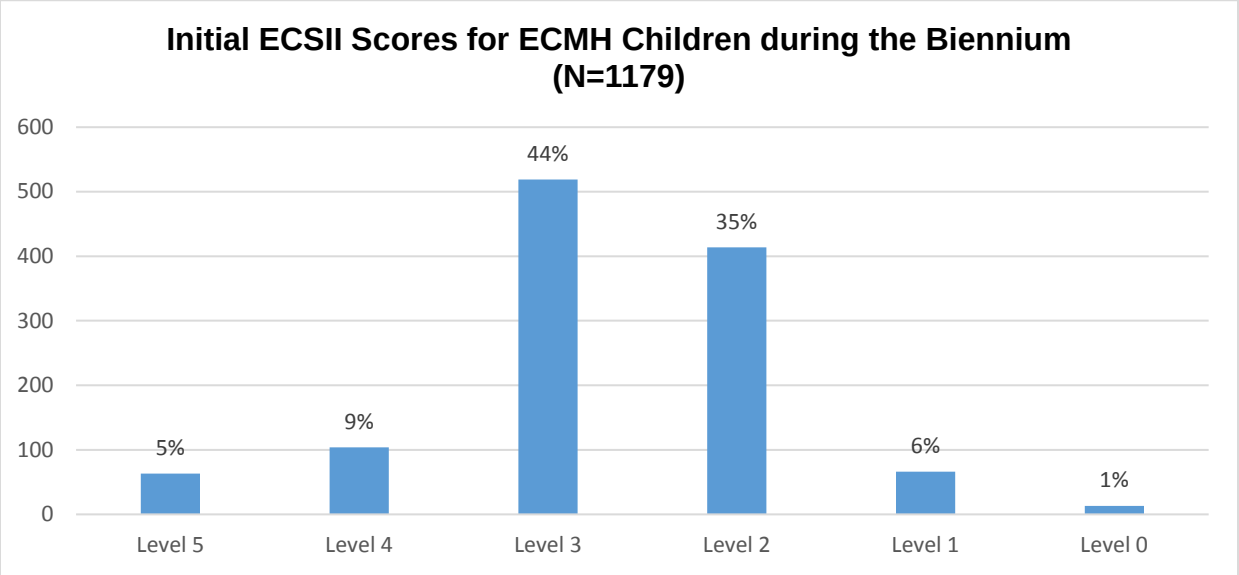
The ECSII is based on a developmental perspective that recognizes the changing capacities and needs of the child over this rapid period of development, as well as the considerable individual variations in normal development. The ECSII emphasizes the dynamic interplay of risk and protective factors with the child's temperament and developmental capacities. It also emphasizes the central importance of significant relationships in the development of young children. The

The ECSII can help identify compromise or insecurity in the child's significant relationships, and guide selection of services and supports to address these concerns in order to mitigate current and future developmental, psychological, or behavioral problems. The ECSII also approaches each child's "caregiving system" as an ecosystem in which extended family and other supports in the community and system of care have the potential to play an important role. It evaluates the caregiving ecosystem including relationships between the child and parents or significant caregiver (dyadic relationships); the child and other adults; and the relationship between primary caregivers.

ECSII evaluations are based on measurements in five levels in five life domains. A score, in any domain, of Level 4 for example, indicates a need for "high service intensity" in that domain. The key below describes the five levels that are used in the summary tables that follow.

[74] Percentages do not add to exactly 100% due to rounding errors.

Key to ECSII Service Intensity levels
Level 0: Basic Health Services.
Level 1: Minimal Service Intensity (Beginning Care).
Level 2: Low Service Intensity.
Level 3: Moderate Service Intensity.
Level 4: High Service Intensity.
Level 5: Maximal Service Intensity (Full Support).



Change in ECSII Scores (N=377)

Shows children with more than one assessment, change from first assessment of biennium to last of biennium (at least 2mo apart). This table shows that:

- Scores improved for 121 children (scores above the shaded diagonal),
- Scores remained the same for 214 children (scores in the shaded diagonal of cells), and
- Scores worsened for 42 children (scores below the shaded diagonal).

		Level of Care at Time 2					
Level of Care at Time 1		**5**	**4**	**3**	**2**	**1**	**0**
	5	6	6	5	1	0	0
	4	4	10	19	1	0	0
	3	0	11	113	56	6	0
	2	0	1	21	72	24	1
	1	0	0	1	1	13	2
	0	0	0	1	2	0	0

Total number of children measured: 377

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire, used in conjunction with the ECSII for children ages 3 through 5 years old. The SDQ ask about 25 attributes, some positive, and others negative. These 25 items are divided between 5 scales: (1) emotional symptoms, (2) conduct problems, (3) hyperactivity/inattention,

(4) peer relationship problems, and (5) prosocial behavior. Scales 1 through 4 are added together to generate a total difficulties score.

4. Conclusions and Evaluation.
Program evaluation data shows that the level-of-service-intensity need improved for 32 percent of children measured. For 11 percent of children, their needs intensified.

By far the greatest number of early childhood mental health referrals originated from Head Start programs, licensed child care, and early childhood special education. Unlicensed family, friend, and neighbor child care and general preschool each generated about 9 percent; and day treatment programs produced 8 percent. Local public health home-visiting nurses barely utilize community mental health resources.

During the 2012-2015 grant cycle, contracts required grantees to dedicate half of their budgets to services for uninsured and underinsured. As a result of federal and state health care reform during that period, fewer children lacked insurance than was projected at the beginning of the grant period. DHS found that most children covered by the grant were well-insured and, thus did not need grant coverage for direct services; this resulted in a high level of underspending in the *direct services* category; while the *infrastructure development* category was fully expended. To remedy this issue, the next round of grants (for SFY 2016-2020) removed the direct services requirement and re-focused funds on training a statewide network of providers. Clinical preparation does not end with the training event. Once trainees begin their new EBP practice, the expert trainers and the trainee cohort evaluate and critique trainees' work with ongoing case reviews.

For the 2016-2017 biennium, DHS switched to an individual outcomes measurement instrument that is more appropriate for this youngest population. The ***Child Behavior Check List,*** for children ages 1½ to 5 years of age, is the gold standard outcome measure used to develop evidenced based interventions. The CBCL has shown significant decline in symptoms and attention difficulties within 6 months of receiving treatment. These outcomes will be reported in detail in the next biennial report.

E. Cultural and Ethnic Minority Infrastructure Grants

1. Grant purpose and funded activities.
The function of these grants is to:

- Multiply culturally-diverse clinicians
- Spread effective treatment to all cultural-minority children

The Cultural and Ethnic Minority Infrastructure Grant program is designed to increase access to effective mental health services for children from cultural minority populations, by supporting members of cultural and ethnic minority communities to become qualified mental health professionals and practitioners, and by enhancing the capacity of providers to serve these populations.

With expanded insurance under state and federal healthcare reform, the grant program has begun to shift from covering direct services for uninsured families and, rather, to focus more on training and licensing culturally-diverse providers. With this shift comes more rapid progress toward a sustainable network of culturally-competent providers.

Infrastructure expansion. The Grant expands service infrastructure by covering costs of:

- Clinical supervision for racial or ethnic-minority, post-graduate clinical trainees, as they work to complete mental health professional licensure requirements; state law requires two years of supervised clinical experience after completing a master's or doctoral level clinical degree. (Since clinical supervision is not covered by public or private insurance, few providers have offered this critical infrastructure component on their own.
- Training clinical staff in culturally-appropriate evidence-based practices and interventions shown to be effective with a specific cultural population.
- Hardware or software investments to facilitate third-party billing or managed care contracting.

Clinical services. The Grant expands service capacity by covering direct services for children from cultural minority families who are uninsured or underinsured for mental health care services, such as mental health screening, diagnostic assessment, or treatment.

Amount of Funding:

A total of 10 Agencies were awarded Cultural and Ethnic Minority Infrastructure grants in SFY 2014 – 2015; however, two contracts were terminated due to grantees' inability to fulfil the requirements for the grant (leaving nine grantees in 2014 and eight in 2015). In both cases, the agencies were unable to recruit Somali clinicians, which left them unable to serve their target populations. Below is the summary of the awards.

Canvas Health: $160,000 award to provide mental health services to the Somali community in Faribault and supervision for one mental health practitioner. *(Contract terminated 2014)*

Change Inc.: $60,000 to provide clinical supervision and support to 36 mental health practitioners from cultural and ethnic minority backgrounds attain licensure in their fields and qualify as mental health professionals and clinical supervisors.

Comunidades Latinas Unidas En Servicio (CLUES): $100,000 to provide clinical supervision and support to 7 mental health practitioners from cultural and ethnic minority backgrounds to become licensed mental health professionals and one clinical supervisor, and provision of clinical services for 95 children and youth.

Minneapolis Urban League (MUL): $200,000 through a contract with Brakins Consulting and Psychological Services, LLC, to provide clinical supervision and support to eight African American mental health practitioners in attaining licensure and provide clinical services for 170 children and youth.

Progressive Individual Resource Inc. (PIR): $120,000 through a contract with Metro Social Services Inc. (MSSI) to provide clinical supervision and support to 17 mental health practitioners from cultural and ethnic minority backgrounds and two mental health professionals to qualify as clinical supervisors, and provision of clinical services for 46 children and youth.

Perspectives: $70,000 to provide clinical supervision and support to one mental health practitioner from cultural and ethnic minority background and provision of clinical services to 114 children and youth.

Volunteers of America (VOA): $100,000 to support 2 mental health practitioners from cultural and ethnic minority background to attain licensure as mental health professionals, and provision of clinical services to 50 children and youth. *(Contract Terminated 2015)*

Watercourse Counseling Center: $100,000 to provide clinical supervision and support to 11 practitioners from cultural and ethnic minority backgrounds to attain licensure; train five therapists in the Parenting through Change evidence-based practice; and to provide clinical and ancillary services to youth and families from cultural and ethnic communities. A total of 228 children, youth, and families received services in the course of this grant period.

Amherst H. Wilder Foundation: $179,994 to provide clinical supervision and clinical mental health training to 48 internal staff and external practitioners, all participants from cultural and ethnic minority backgrounds will provide clinical services to 200 children.

White Earth Mental Health Center: $70,000 to provide clinical supervision to two American Indian Mental Health Practitioners to complete Mental Health Professional licensure requirements and supervision to one provider working towards clinical supervisor status. Two Native American mental health staff completed training in the culturally-adjusted evidence-based practice models, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Incredible Years, and Parent-Child Interactive Therapy (PCIT); and provided culturally-appropriate services to twenty Native American children and families.

Location of services. Grant activities in the two-year period were located in the Metro counties and one non-urban tribal reservation, the White Earth Nation, which provided services to the American Indian communities at the Reservation and in the Bemidji and Duluth areas.

2. Financials.

	Appropriated	Expended	Unspent	% Unspent
State Fiscal Year 2014	300,000	242,972	57,028	19%
State Fiscal Year 2015	300,000	298,505	1,495	0%

History of funding. Appropriations for the Cultural and Ethnic Minority Infrastructure Grant has remained at $300,000 annually, since 2008.

3. Outcomes. Demographics; Locations; Treatment outcomes
The CEMIG grant had 9 grantees[75] during this cycle, 2014-2015.

Supervisees[76]

Gender of CEMIG Supervisees Reported

	Unique total	Percent of total
Female	54	70%
Male	22	29%
Missing	1	1%
Total:	77	100%

Race/Ethnicity of CEMIG Supervisees Reported[77]

	Unique total	Percent of total
Asian	24	30%
American Indian	2	3%
African American	25	31%
African Immigrant	14	18%
Native Hawaiian/Pacific Islander	1	1%
White	1	1%
Latino/Hispanic	9	11%
Missing	4	5%
Total:	80	100%

[75] Change, Clues, Perspectives, Progressive Individual Resource/Metro Social Services, Urban League, Volunteer of America, Watercourse, White Earth, Wilder.
[76] The numbers reported are likely less than the actual number of people receiving training as 4 grantees did not submit reports for 2014, 1 submitted half the year and only 4 submitted what was due. In 2015, 5 did not submit anything, 2 submitted only a quarter, 1 submitted half the year and only 1 submitted all the data requested.
[77] The numbers add to more than the total number of Supervisees because some identified as more than one racial/ethnic category.

Languages Spoken by CEMIG Supervisees Reported[78]

	Unique total	Percent of total
English	69	59%
Spanish	8	7%
Hmong	17	15%
Somali	4	3%
Other	14	12%
Missing	5	4%
Total:	117	100%

Self-identified community affiliation by CEMIG Supervisees[79]

	Unique total	Percent of total
African (unspecified)	3	4%
West African	2	3%
African American	17	22%
American Indian	1	1%
Asian (unspecified)	1	1%
Asian American	1	1%
Filipino	1	1%
Hispanic/Latino	8	10%
Hmong	13	17%
Japanese	1	1%
Korean	2	3%
Somali	3	4%
Minneapolis	1	1%
Missing	24	31%
Total:	78	100%

[78] The numbers add to more than the total because some Supervisees identified more than one language. Two Supervisees listed three languages.

[79] The numbers add to more than the total because some Supervisees identified more than one community.

Licensure Goals Reported by CEMIG Supervisees[80]

	Unique total	Percent of total
Clinical Supervisor	6	8%
Licensed Independent Clinical Social Worker[81]	16	21%
Licensed Marriage and Family Therapist	38	49%
Licensed Professional Clinical Counselor	5	6%
Licensed Psychologist	7	9%
National Certified Counselor	1	1%
N/A (reported)	4	5%
Total:	77	99%[82]

Outcomes

Sixteen new culturally-diverse mental health professionals are now available to serve Minnesota's children, as a result of clinical supervision paid by this grant. Post-graduate clinical trainees must complete two years (4,000 hours) of supervised clinical practice for licensure.

Of the 77 supervisees, 6 reported not completing any exams; 32 left that field blank; and 39 supervisees reported taking exams, including 2 supervisees who took two exams each—for a total of 41 exams taken toward licensure. Results are shown in the table that follows[83].

Licensure Exam Results Reported by CEMIG Supervisees

(for two years, 2014 and 2015)

	Passed Exam	Failed Exam	Don't know yet	Result Not Reported	Total Exams	Percent of Total
LAMFT	3	3	1	7	14	34%
LGSW	1	0	0	0	1	2%
LICSW	2	1	0	3	6	15%
LMFT (2nd test toward LMFT)	1	0	1	0	2	5%
LMFT Supervision Course	8	0	0	2	10	24%
LP test	0	3	1	3	7	17%
LPC	1	0	0	0	1	2%
Total Exams Taken:	16 (39%)	7 (17%)	3 (7%)	15 (37%)	41	99%[84]

[80] The numbers add to more than the total because some Supervisees identified more than one licensure goal.
[81] Three of the Supervisees also listed LGSW in addition to LICSW.
[82] Percentages do not add exactly to 100% due to rounding errors.
[83] Two of the Supervisees completed two tests. One completed the LAMFT twice, they failed the first time and passed on the second. The other completed two separate exams and passed them both on the first attempt.
[84] Percentages do not add exactly to 100% due to rounding errors.

Twenty-one percent of Supervisees reported successfully completing all the requirements for the relevant professional board.

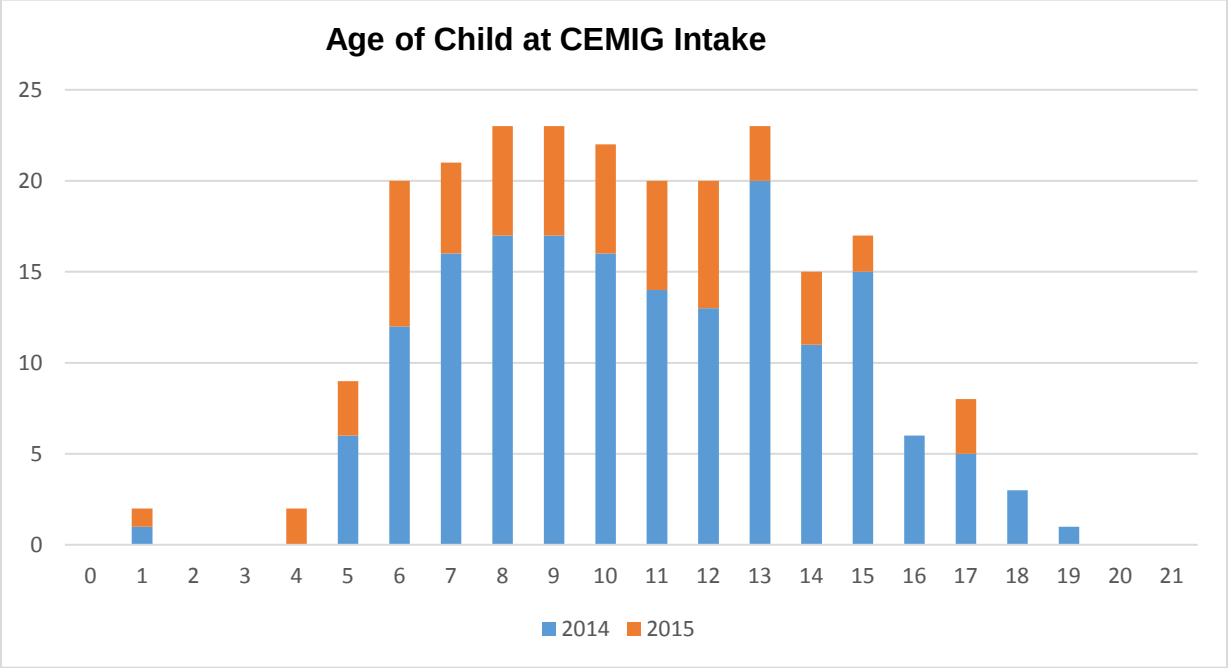
Supervisees Who Reported Completing All Board Requirements for Profession
(for two years, 2014 and 2015)

	Count	Percent of Total
LAMFT	6	8%
LGSW	2	3%
LICSW	4	5%
LMFT	2	3%
LP	1	1%
LPCC	1	1%
No	13	17%
N/A (from data)	1	1%
Missing/blank	47	61%
Total:	77	100%

Children receiving direct services from the CEMIG

The total number of children reported served by the Cultural and Ethnic Minorities Infrastructure grant is 337[85]. It is impossible to break the numbers down by year because grantees used different reporting periods and the data forms asked only for total number of children served since the beginning of the grant and demographic information about new students but does not include information about numbers served during the six month reporting period.

[85] The numbers reported are likely less than the actual number of students who received services. In the first half of 2014, 1 program did not provide their data. At the end of the second half, 3 grantees did not provide their data and 1 program only sent the data from 1 quarter, rather than the full six month period. Only 2 grantees provided their data for the first half of 2015, leaving 7 who did not follow through and none of the 9 grantees turned in data for the second half of 2015.



Gender of New Children Reported by CEMIG

	2014	2015	Total	Percent of total
Female	96	33	129	55%
Male	76	29	105	45%
Unknown	1	0	1	<.5%
Total:	173	62	235	100%

Race/Ethnicity of New Children Reported by CEMIG

	2014	2015	Total	Percent of total
Asian	2	5	7	3%
American Indian	3	5	8	3%
African American	147	32	179	76%
NHPI	0	0	0	0%
White	4	10	14	6%
Latino/Hispanic	17	10	27	11%
Total:	173	62	235	99%[86]

[86] Percentages do not add exactly to 100% due to rounding errors.

Primary Language of New Children Reported by CEMIG

	2014	2015	Total	Percent of total
English	70	39	109	46%
Spanish	16	3	19	8%
Hmong	2	0	2	1%
Somali	86	0	86	36%
Russian	0	2	2	1%
Ukrainian	0	2	2	1%
Missing	0	16	16	7%
Total:	174[87]	62	236	100%

Insurance Status of New Children Reported by CEMIG

	2014	2015	Total	Percent of total
MHCP	142	29	171	72%
Private insurance	12	7	19	8%
No insurance	9	27	36	15%
Missing	10	0	10	4%
Total:	173	63[88]	236	99%[89]

Client Outcomes data—the CASII and SDQ instruments)

(See page 18 for descriptions of these tools.)

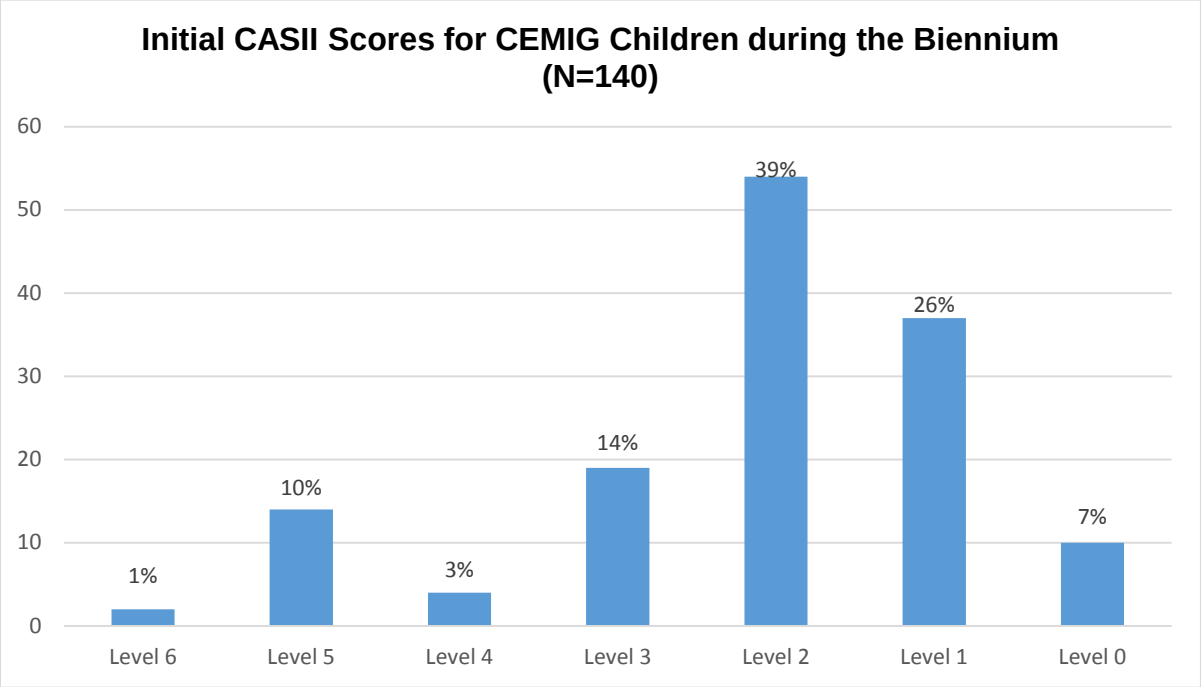
Key to CASII Levels of Care

Level 0: Basic Services.
Level 1: Recovery Maintenance and Health Management.
Level 2: Outpatient Services.
Level 3: Intensive Outpatient Services.
Level 4: Intensive Integrated Service without 24-Hour Medical Monitoring.
Level 5: Non-Secure, 24-Hour, Medically Monitored Services.
Level 6: Secure, 24-Hours, Medically Managed Services.

[87] This is the total number reported. It is possible that more than one primary language was reported for a child who is bilingual.

[88] This is the total number reported. It is possible that one child has both MHCP and Private insurance.

[89] Percentages do not add exactly to 100% due to rounding errors.



Change in CASII Scores (N=23)

Scores for children with more than one assessment were analyzed for change in level of service intensity need from the first assessment of the biennium to the last assessment of the biennium (at least 2 months apart). Lower scores indicate a lower level of service intensity needs.

		Level of Care at Time 2					
Level of Care at Time 1		**5**	**4**	**3**	**2**	**1**	**0**
	5	0	1	0	1	0	0
	4	1	0	0	0	0	0
	3	0	0	1	1	1	0
	2	1	0	1	6	2	0
	1	0	1	0	3	1	0
	0	0	0	0	0	1	1

[Score improved N=6, Score remained the same N=9, Score worsened N=8]

Strengths and Difficulties Questionnaire (SDQ) Scoring

	Original categories			New 4-band categories			
	Normal	Borderline	Abnormal	Close to Average	Slightly Raised (/lowered)	High (/low)	Very High (very low)
Parent completed SDQ							
Total difficulties	0-13	14-16	17-40	0-13	14-16	17-19	20-40
Emotional problems	0-3	4	5-10	0-3	4	5-6	7-10
Conduct problems	0-2	3	4-10	0-2	3	4-5	6-10
Hyperactivity	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems	0-2	3	4-10	0-2	3	4	5-10
Prosocial	6-10	5	0-4	8-10	7	6	0-5
Impact	0	1	2-10	0	1	2	3-10
Teacher completed SDQ							
Total difficulties	0-11	12-15	16-40	0-11	12-15	16-18	19-40
Emotional problems	0-4	5	6-10	0-3	4	5	6-10
Conduct problems	0-2	3	4-10	0-2	3	4	5-10
Hyperactivity	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems	0-3	4	5-10	0-2	3-4	5	6-10
Prosocial	6-10	5	0-4	6-10	5	4	0-3
Impact	0	1	2-6	0	1	2	3-6
Self-completed SDQ							
Total difficulties	0-15	16-19	20-40	0-14	15-17	18-19	20-40
Emotional problems	0-5	6	7-10	0-4	5	6	7-10
Conduct problems	0-3	4	5-10	0-3	4	5	6-10
Hyperactivity	0-5	6	7-10	0-5	6	7	8-10
Peer problems	0-3	4-5	6-10	0-2	3	4	5-10
Prosocial	6-10	5	0-4	7-10	6	5	0-4
Impact	0	1	2-10	0	1	2	3-10

Initial SDQ score for child during the biennium

(A child may be represented by all 3 category types although self-assessment is only for children older than 11)

	Parent (N=123)			Teacher (N=19)			Self (N=16)		
	Normal scores	Mean	SD	Normal scores	Mean	SD	Normal scores	Mean	SD
Emotional Symptoms	0-3	3.49	2.09	0-4	6.16	2.99	0-5	2.06	1.73
Conduct Problems	0-2	3.90	2.02	0-2	5.79	2.68	0-3	3.12	2.00
Hyperactivity-Inattention	0-5	5.46	2.27	0-5	7.42	2.09	0-5	4.19	2.37
Peer Problems	0-2	3.88	1.82	0-3	5.53	1.71	0-3	2.25	1.81
Total Difficulties[90]	0-13	16.73	5.26	0-11	24.89	7.25	0-15	11.63	4.98
Prosocial Behavior[91]	6-10	5.83	2.49	6-10	5.32	1.60	6-10	6.75	1.98
Impact Score[92]	0	2.31	2.65	0	3.79	2.20	0	1.64	1.82

Number of CEMIG Students in Each of the 4-band Categories

	Normal Range[93]	Slight Risk of Mental Health Concern	High Risk of Mental Health Concern	Very High Risk of Mental Health Concern
Parent completed SDQ (N=123)				
Total difficulties	38 (31%)	13 (11%)	33 (27%)	39 (32%)
Emotional problems	59 (48%)	22 (18%)	35 (28%)	7 (6%)
Conduct problems	30 (24%)	17 (14%)	53 (43%)	23 (19%)
Hyperactivity	71 (58%)	27 (22%)	8 (7%)	17 (14%)
Peer problems	26 (21%)	19 (15%)	30 (24%)	48 (39%)
Prosocial	32 (26%)	10 (8%)	19 (15%)	62 (50%)
Impact (N=103)	29 (28%)	23 (22%)	22 (21%)	29 (28%)
Teacher completed SDQ (N=19)				
Total difficulties	3 (16%)	1 (5%)	1 (5%)	14 (74%)
Emotional problems	4 (21%)	0 (0%)	3 (16%)	12 (63%)
Conduct problems	4 (21%)	2 (11%)	1 (5%)	12 (63%)
Hyperactivity	7 (37%)	5 (26%)	6 (32%)	1 (5%)
Peer problems	2 (11%)	10 (53%)	4 (21%)	3 (16%)
Prosocial	7 (37%)	11 (58%)	1 (5%)	0 (0%)
Impact (N=19)	5 (26%)	0 (0%)	0 (0%)	14 (74%)
Self-completed SDQ (N=16)				
Total difficulties	11 (69%)	3 (19%)	0 (0%)	2 (13%)
Emotional problems	15 (94%)	1 (6%)	0 (0%)	0 (0%)
Conduct problems	8 (50%)	3 (19%)	3 (19%)	2 (13%)
Hyperactivity	12 (75%)	2 (13%)	0 (0%)	2 (13%)
Peer problems	9 (56%)	3 (19%)	2 (13%)	2 (13%)
Prosocial	9 (56%)	2 (13%)	2 (13%)	3 (19%)
Impact (N=14)	6 (43%)	1 (7%)	3 (21%)	4 (29%)

[90] Total difficulties is the sum of Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention, and Peer Problems.

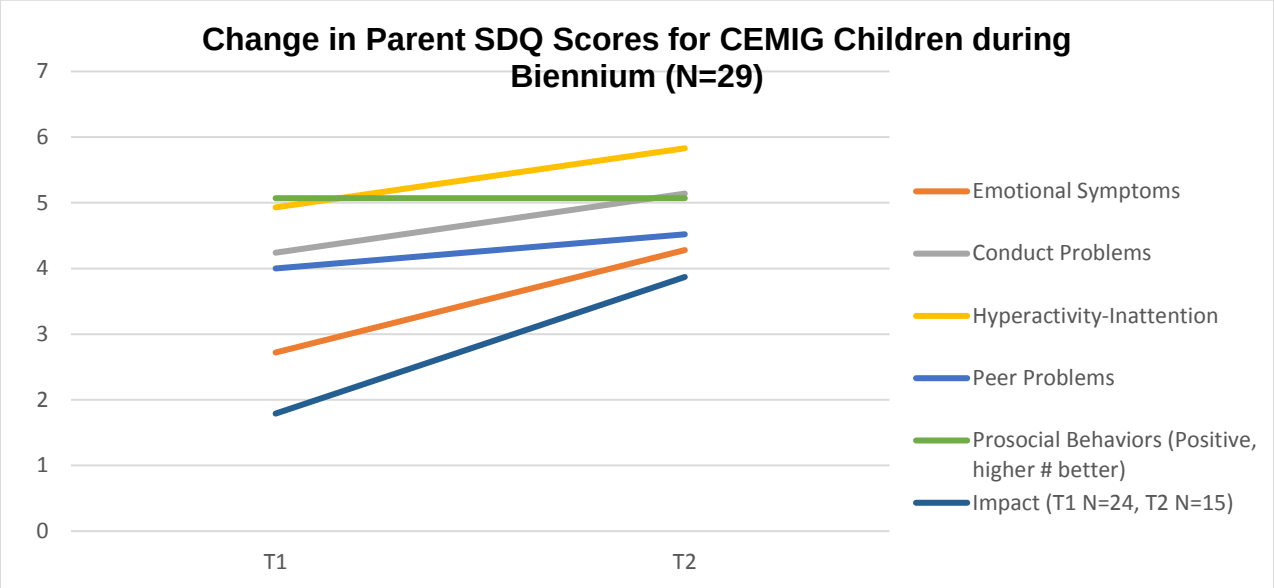
[91] This depicts a child's strengths and resources.

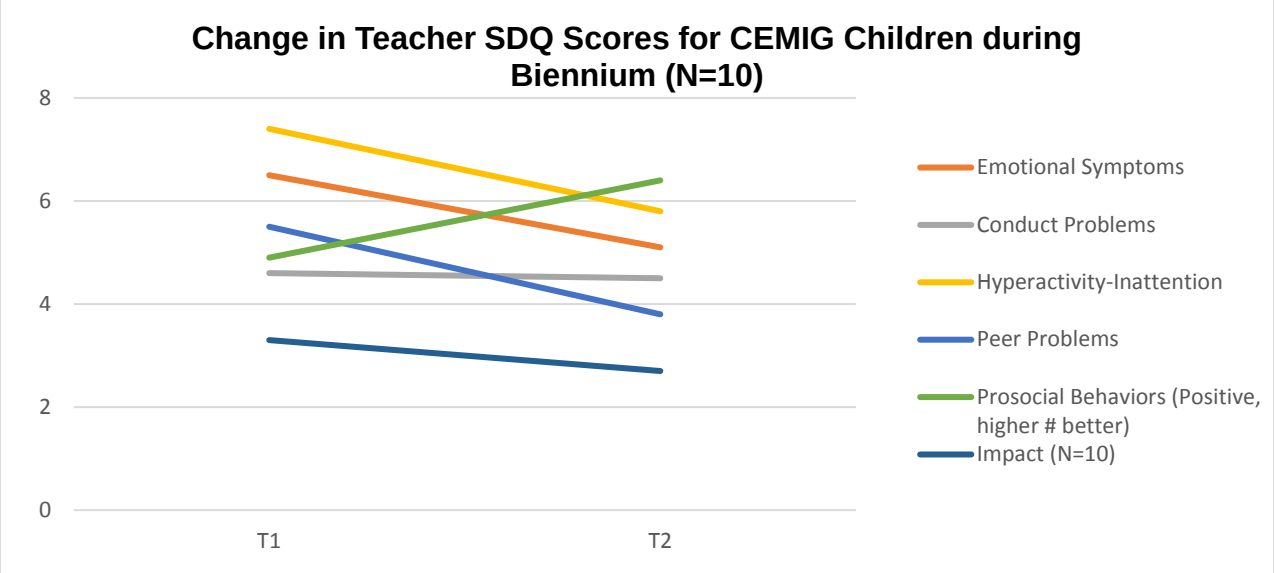
[92] Impact score is only available for those who completed the extended form. It addresses if the respondent thinks the child has a problem and, if so, how much of the child is impaired/burdened as a result.

[93] The categories are based on population norms. Close to Average (Normal) is 80% of the population, Slightly Raised/Lowered (Slight Risk) is 10% of population, High/Low (High Risk) is 5% and Very High/Very Low (Very High Risk) is 5%.

Change in SDQ scores for child during the biennium

For children with more than one assessment completed by the same role (parent/teacher/self), these graphs show change from first assessment of biennium to last of biennium (at least 5 months apart).





4. Conclusions and Evaluation.

Cultural and Ethnic Minority grants comprise the State's smallest children's mental health grant program. Sixteen new culturally-diverse mental health professionals began serving Minnesota's children in 2014 and 2015, as a result of clinical supervision paid by this grant. Post-graduate clinical trainees must complete two years (4,000 hours) of supervised clinical practice for licensure.

Of clinical supervisees receiving assistance toward completion of licensure requirements:

- 70 percent are female.
- 31% identified as African American; 30% as Asian; 18% as African immigrant; 11% as Latino/Hispanic; 3% as American Indian.
- 59% reported English as their primary language; 15% Hmong; 7% Spanish; 3% Somali; and 12% other.
- 22% affiliated with the African American community; 17% with the Hmong community; 10% with the Hispanic/Latino community; 4% Somali; 4% unspecified African; 3% Korean; 3% West African; 1% each affiliated with the American Indian, unspecified Asian, Asian American, Filipino, and Japanese communities.
- The largest portion (49%) are aiming for licensure as a Licensed Marriage and Family Therapist (LMFT); the next largest (21%) for licensure as a Licensed Independent Clinical Social Worker (LICSW). Nine-percent are aiming toward the doctoral-level Licensed Psychologist field. Eight-percent are completing Clinical Supervisor certification in their chosen discipline. Six percent are moving toward Licensed Professional Clinical Counselor (LPPC) discipline.

The Cultural and Ethnic Minority Infrastructure Grant covered direct mental health services for 337 children over the two years of this reporting period. Of those children:

- the greatest number clumped in the middle age range of 6 to 15 years.
- 55 percent were girls.
- 76% identified as African American; 11% as Latino/Hispanic; and 6% as White. Three percent each identified as Asian and American Indian.
- 46% spoke English as the primary language; 36% reported Somali as their primary language; 8% Spanish; and 1% each reported Hmong, Russian, and Ukrainian.
- Minnesota Health Care Programs (MA and MinnesotaCare) provided health coverage for 72 percent; 8 percent had private insurance; while an unexpected high of 15-percent were uninsured.

F. Children's Evidence-Based Practices Training Grants

1. Grant purpose and funded activities.

Managing & Adapting Practice (MAP)

MAP is an evidence-based model of treatment that has been proven effective on a wide diversity of treatment targets and ages. The MAP system provides access to a database with the most current scientific information, measurement tools, and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or, alternatively, can provide detailed recommendations about discrete components (practice elements) of evidence-based treatments relevant to a specific youth's characteristics. A clinical dashboard is provided to track outcomes and practices.

The MAP model is a nationally recognized evidence-based treatment system that can fill in gaps in the current state of clinical research, which offers few nationally-endorsed evidence-based practices for some widespread diagnoses and large demographic groups. That is, there simply are no proven treatments for some mental illness; and some recognized EBPs have not been validated on racial and ethnic minority populations. MAP can indicate treatments likely to work for a specific combination of diagnosis and demographic characteristics (gender/age/ethnicity).

The five days of classroom training are followed by 6 months of bi-weekly consultation calls. The MAP model provides for a "credentialing process" for trained professionals, which will help to ensure continued fidelity to the model and sustainability within mental health provider agencies.

Trauma-focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is an evidence-based treatment for children and adolescents ages 3-17 who are impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences. Over 80% of traumatized children show significant improvement in 12 to 16 weeks. Family functioning is improved because TF-CBT encourages the parent to be the primary agent of change for the traumatized child.

Research also documents that TF-CBT is effective for diverse, multiple and complex trauma experiences, for youth of different developmental levels, and across different cultures. The training include 5 days of classroom instruction and 12 months of bi-weekly phone consultation sessions. There is a national certification for TF-CBT for clinicians who complete the training requirements and pass and on-line assessment.

2. Financials.

	Appropriated	Expended	Unspent	% Unspent
State Fiscal Year 2014	750,000	645,876	104,124	14%
State Fiscal Year 2015	750,000	639,439	110,561	15%

History of funding. State appropriations have stayed constant at $750,000 annually since the program began in 2008.

Un-Spent Funds. In 2014, one agency receiving a grant award went out of business; a second lost the clinicians who were trainees under the grant. Because funds were awarded on a competitive basis, forfeited awards could not be redistributed to agencies that had not received awards.

In 2015, a higher-than-normal attrition rate among trainees accounted for the unused funds. While it is not unusual for a few clinicians who accept the training grants to leave their agencies in the course of training, the drop-out rate was unusually high this year.

In subsequent years, DHS obtained stronger commitments from agencies and individual clinicians. However, the State has no legal means to bind a trainee to complete the training or stay with her/his employer. It is likely that a small number will continue to drop out after grant contracts are executed, or they leave the agency sometime during the grant period. In either event, the agency cannot bill the grant for a person's unfulfilled commitment; but it is too late to re-distribute the funds to another agency because the training is in process.

3. Outcomes. Demographics; Locations; Treatment outcomes

80 clinicians from 16 agencies completed training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) during the period from mid-2014 to the end of 2015. A shortage of providers trained in the treatment approach existed across the central corridor prior to 2014. DHS issued a request-for-proposals specific to that area and trained three cohorts in West Central, Central, and the Metro regions. (See description of TF-CBT above.)

50 clinicians from 12 mental health provider agencies completed training in Managing & Adapting Practice (MAP) from late 2015 to mid-2016. School-based clinicians were the focus of these trainings. (See description of MAP above.)

4. Conclusions and Evaluation.

State-sponsored clinical training is critical if children in all parts of Minnesota are to receive the kind of treatment that is effective in overcoming severe mental illness. Mental health professionals complete their master's and doctoral-level education with little or no training and experience in the latest scientifically-proven treatment methodologies. Practicing therapists are forced to gain these practices while on the job. Until colleges and universities, in Minnesota and nationwide, build evidence-based practices into their professional training programs, the Children's Mental Health Division is assuming responsibility, with the Legislature's support.

This Grant supports the gradual dissemination of evidence-based practices to clinicians in all parts of Minnesota.

G. Child Welfare/Juvenile Justice Screening Grants

1. Grant purpose and funded activities.
In 2003, the Legislature required children in Child Welfare and Juvenile Justice to be screened for mental health symptoms. DHS integrates mental health screening into child welfare practices for children and youth (from 3 months to 18 years), specifically those receiving child protective services and those placed out of the home. The intent of this integration is to identify and respond sooner to children and youth with mental health problems, as well as to decrease the need for child welfare services.

The enacting legislation also amended the Minnesota Juvenile Code to require mental health screening for juvenile justice populations: those found to be delinquent; and those found to have committed a juvenile petty offense for the third or subsequent time. Seventy percent of youth involved with juvenile corrections have mental health disorders. DHS partners with other state and local agencies to improve outcomes for these youth, ages 10 to 18 years.

The Children's Mental Health Division distributes grant dollars based on the number of screens conducted by each county and then documented in the appropriate computer system. This money must be spent on screening costs and necessary follow-up assessments and treatment services for children who are uninsured and under-insured for mental health services. Screenings must be conducted with a DHS-approved screening instrument, in a manner that safeguards the privacy of children receiving the screening and complies with state and federal data protection laws. Parents may decline screenings for their children unless parental rights have been terminated or a juvenile court determines that the screening is in the child's best interest.

Counties are required to arrange for or provide children's mental health screenings, pursuant to subdivision 1, paragraphs (a)(12); (b); (c); and (d). Counties may use Screening Grants funds to pay screening costs and follow-up care.

2. Financials.

	Appropriated	Expended	Unspent	% Unspent
State Fiscal Year 2014	4,532,000	4,237,999	294,001	6%
State Fiscal Year 2015	4,412,000	4,390,911	21,089	0%

History of funding. Appropriations for this Grant dropped slightly more than $100,000 from SFY 2014 to 2015. For the current biennium, the based held steady at a little over $4.4 million.

3. Outcomes. Demographics; Locations; Treatment outcomes
*NOTE: **DHS is prohibited from collecting and reporting outcomes for this grant.** Pursuant to Minnesota Statutes, Section 245.4874, subdivision 1, paragraph (d), individual screening results cannot not be collected.*

Counties need only to report their screening budgets if the total grant award exceeded $25,000 in 2014 and $10,000 in 2015.

The total number of children screened in 2014 is 11,783 and the total screened in 2015 is 13,201.

Children receiving metal health screening, by program

	CY 2014	CY 2015
Juvenile Probation	4,164	3,892
Child Welfare	7,619	9,309
Total:	11,783	13,201

Mental Health Screening Funding Categories from Budgets Submitted

	CY 2014	Percent of 2014	CY 2015[94]	Percent of 2015
Administration/Operational Expenses	$ 2,218,800.73	53%	$ 731,282.75	18%
Data Collect/Reporting	0[95]	0	$ 193,869.20	5%
Clinical Services	$ 1,609,291.69	38%	$ 2,367,615.04	59%
Ancillary/Support Services	$ 367,859.96	9%	$ 691,094.31	17%
Training	0	0	$ 60,900.20	2%
Total:	$ 4,195,952.38	100%	$ 4,044,761.50	100%

4. Conclusions and Evaluation.

This grant program was designed to support the 2003 mandate to screen children and adolescents already deeply involved in the child welfare and juvenile justice systems. While screening for mental health conditions is mandatory, it is relatively inexpensive. As a result, the bulk of screening funds are intended to pay for the follow-up care, which is necessary after a positive screen (i.e., a result indicating a likely mental health condition). First, a child should be referred for a full diagnostic assessment; then, if a mental health condition is diagnosed, treatment should follow.

Beginning with calendar year 2015, DHS required counties receiving screening grant awards to report mental health follow-up services resulting from screenings. The data will be used to indicate the success or failure of the follow-up referral process.

However, DHS will have no way to measure the success of the treatment received by children identified through county screening. Until DHS is permitted to collect individual screening results, there is no way to determine whether the treatment has a positive impact on the child.

[94] Appear to be missing the 2015 budgets from Beltrami, Dakota, and White Earth.

[95] Data Collection & Training were not possible categories on the 2014 budget form