DEPARTMENT OF HUMAN SERVICES

Legislative Report

Mental Health Grants

Fiscal Years 2021-2022

Behavioral Health Division

November 2022

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $20,57 .

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Contents

I. Legislation

Minnesota Statutes 2015, Section 245.4661, subdivision 10:

PILOT PROJECTS; ADULT MENTAL HEALTH SERVICES

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 of law. The commissioner shall provide, at a minimum, the following information:

(1) The amount of funding to mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, 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.

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.

II. Introduction

The 2021-2022 Mental Health Grants report evaluates the programs that are funded under Minnesota Statutes, section 245.4661, subdivision 10 and Minnesota Statutes, section 245.4889, subdivision 3.
This report was requested on a biennial basis by the legislature for both adult mental health grants (MS
245.4661) and children's mental health grants (MS 245.4991). This report was developed by the Department of Human Services' Behavioral Health Division and includes both adult and children's mental health state grant funded services.

This report includes for each grant an explanation of the program, an overview of the activities that the grants funded between fiscal years 2021 and 2022 and outcomes data for the programs in either fiscal year or calendar year, depending upon how specific grant data are collected. The report starts with identified gaps in the adult mental health system and follows with a page for each of the grant funded programs.

The report notes instances where additional resources for a program that are working well would address service gaps in the continuum of mental health services in Minnesota. There are also several programs that are undergoing reforms or the Department is evaluating the most impactful way to use these state grant funds to better improve the mental health services in Minnesota. In these cases, future efforts have been outlined.

The Behavioral Health Division continues to review processes for collecting outcomes data on each of the grants to reduce missing or incomplete data.

III. Adult Mental Health Service Gaps

Minnesota's 19 Adult Mental Health Initiatives (AMHI), which provide alternatives to or enhance coordination of the delivery of mental health services, were asked to list the gaps and barriers to services in the application process for AMHI funds for CY2023/2024 funds. Applications were submitted in July 2022. The responses were analyzed and the top ranking responses are reported below.

Top Barrier to Receiving Services, 2022[1]	*Number of Regions*	*Percent of Regions*
Access to transportation	14	74%
Funding availability or Medicaid coverage of service	7	37%
Lack of housing	6	32%
Geographic location of providers/distance to services	6	32%
Cost of service (e.g., high copays)	5	26%
Long wait times	5	26%
Workforce shortage	5	26%
Lack of awareness of available services	5	26%

Top service needs by Adult Mental Health Initiatives, 2022[2]	*Number of Regions*	*Percent of Regions*
Housing services	13	68%
Workforce shortage	13	68%
Psychiatric beds	8	42%
Transportation services	8	42%
Crisis services	7	37%

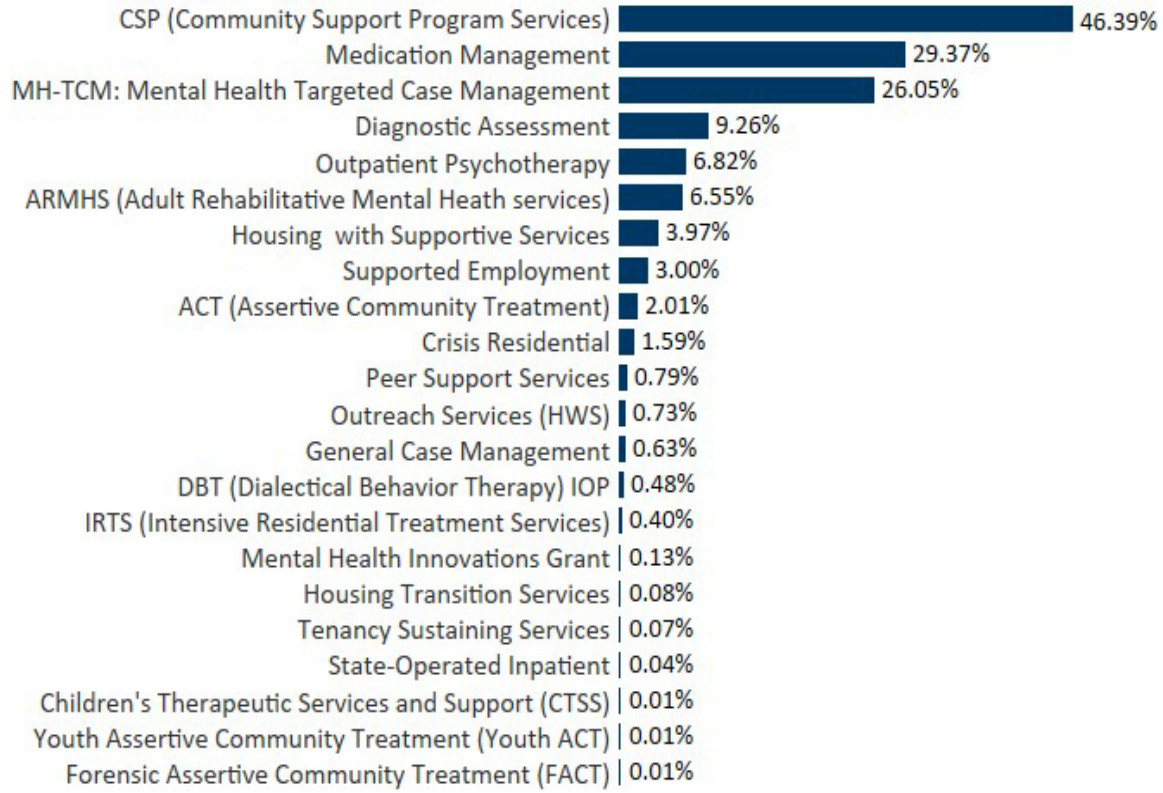
[1] Barriers listed by fewer than 25% of AMHIs include stigma, internet/phone access, cultural responsiveness of service providers, capacity to access services/navigate system, eligibility restrictions (e.g., qualifying criteria), ongoing impact of COVID-19 pandemic, fear, education, racial equity issues, lack of employment opportunities, lack of services for substance use disorders, lack of hospital beds, and lack of peer supports.

[2] Service needs listed by less than 25% of AMHIs include services for individuals with high behavioral needs, peer supports, coordination of services, long wait times, services for individuals with co-occurring disorders, psychiatric, detox and withdrawal management services, culturally specific providers or services, ACT teams, employment services, behavioral programming, access to providers, in-person mental health services, safety nets, transitional housing, hospital beds, ARMHS, AFC, changes in law enforcement response, requirements to receive services, psychiatrists who accept MA, treatment for eating disorders, ongoing impact of the COVID-19 pandemic, services within county, competency restoration, traditional teaching materials, lack of placement options, preventative supports, access to and support for technology use, insurance coverage for mental health services, and IRTS.

Adult Mental Health Initiative and Community Support Programs

State Funding Appropriated (FY21/FY22): $115,063,660; Funding Spent: $ 63,061,784
Federal Funding Appropriated (FY21/FY22): $1,380,000; Funding Spent: $1,191,640

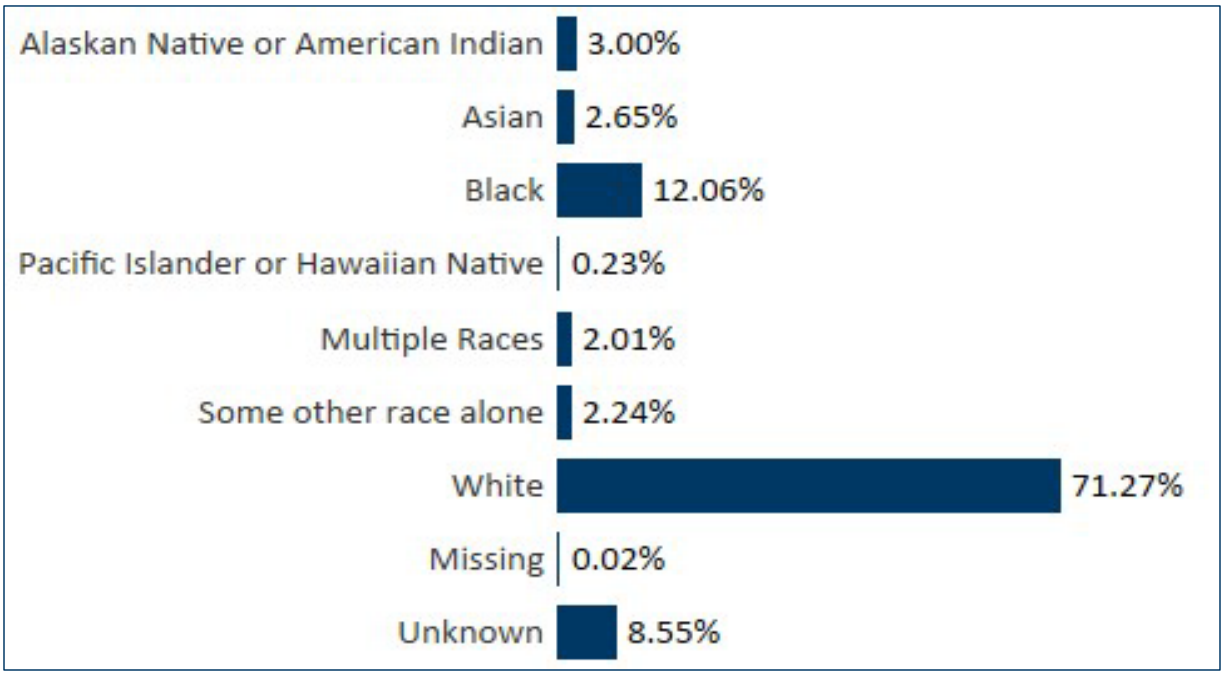
Adult mental health grant funding is designed to improve the lives of adults with serious and persistent mental illness. It promotes regional collaborations with counties and tribal nations to build community-based mental health services and encourage innovation of service delivery. The goal of this funding is to reduce the need for more intensive, costly, or restrictive placements and provides services that are supportive in nature.



In FY 2021-2022, 15,859 individuals received services funded by AMHI and CSP grant dollars. Nearly half (46%) of clients received CSP, 29% received Medication Management, and 26% received Mental Health Targeted Case Management (MH-TCM). Additionally, 9% of clients received Diagnostic Assessments, nearly 7% received Outpatient Psychotherapy, nearly 7% received ARMHS, and fewer than 5% received one or more of 16 other services.[3]

[3] Other services included Housing with Supportive Services, Supported Employment, Assertive Community Treatment (ACT), Crisis Residential, Peer Support Services, Outreach Services (HWS), General Case Management, Dialectic Behavioral Therapy (DBT), Intensive Residential Treatment Services (IRTS), Mental Health Innovations Grant, Housing Transitions Services, Tenancy Sustaining Services, State-Operated Inpatient, Children's Therapeutic Services and Supports (CTSS), Youth Assertive Community Treatment (Youth ACT), and Forensic Assertive Community Treatment (FACT).

Racial Distribution of Clients Served by AMHIs



The majority of clients receiving AMHI and CSP grant funded services were white (71%), 12% were black, 3% were Alaskan Native or American Indian, 3% were Asian, 2% were some other race alone, 0.23% were Pacific Islander or Hawaiian Native, 2% were multiple races, and nearly 9% were missing or unknown race. Adult Mental Health Initiative (AMHI) and CSP dollars support a multitude of services with wide-ranging outcomes. In 2020 and 2021, 91% of clients with outcomes data were housed, and 78% of clients resided in a private residence either independently or with housing supports. Employment outcomes varied greatly by program type. For example, 28% of all clients reported some form of employment in 2021, however, 66% of clients receiving Supported Employment services

Therapeutic Services and Supports (CTSS), Youth Assertive Community Treatment (Youth ACT), and Forensic

Assertive Community Treatment (FACT).

School-Linked Behavioral Health Grants

State Funding Appropriated (FY21/FY22): $27,008,000; Funding Spent: $26,592,091

Since 2007, Minnesota has pioneered efforts to bring mental health services to students through the school linked behavioral health (SLBH) program. Under Minnesota's model, community mental health agencies place mental health professionals and practitioners in partnering schools to provide mental health services to students. These mental health providers also consult with teachers, provide care coordination, and offer classroom presentations and school-wide trainings on mental health issues.

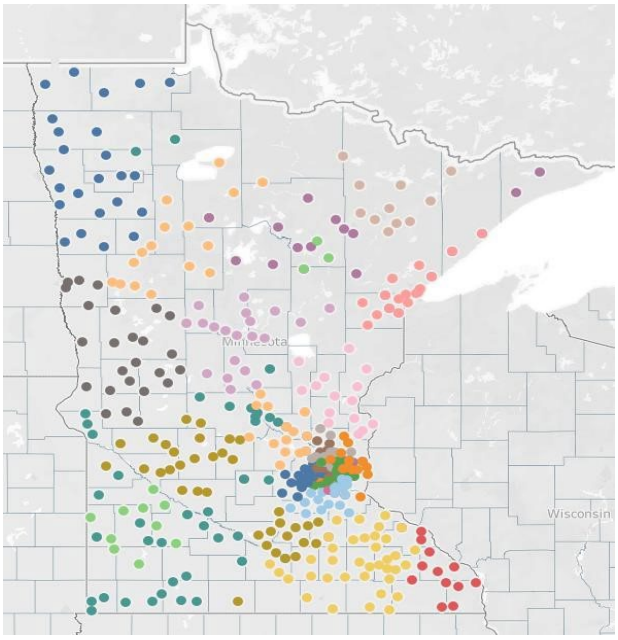
School-linked behavioral health services also eliminate common barriers for families such as taking time off from work, transportation, navigating complex systems, and longer wait times in the community clinic. The natural, non-stigmatizing location offers an early and effective environment for intervention. These services work to increase access to mental health services, improve clinical and functional outcomes for children and youth with a mental health disorder, and improve identification of mental health issues.8 Outcomes data show that when children receive services through school-linked behavioral health their mental health symptoms decrease and their overall mental health improves.

In FY 2021, grantees provided 41,148 students with school linked behavioral health services.

FY 2021 SLBH School District & School Site availability:

- SLBH at 268 of 325 Public Independent School Districts (82.5%)
- SLBH at 1,168 of 2,221 Public School Sites (52.5%)

School-linked behavioral health sites across Minnesota.



Mobile Crisis Service Grants

State Funding Appropriated (FY19/FY20): $40,484,340; Funding Spent: $27,643,205

Mobile crisis services teams consist of mental health professionals and practitioners who provide psychiatric services to individuals (adults and children) within their own homes and at other sites outside the traditional clinical setting. Mobile crisis services provide for a rapid response and work to assess the individual, resolve crisis situations, and link people to needed services. These services are available across the state 24 hours a day, 7 days a week.

Research has shown that mobile crisis services are:

- Effective at diverting people in crisis from psychiatric hospitalization;
- Effective at linking suicidal individuals discharged from the emergency department to services;
- Better than hospitalization at linking people in crisis

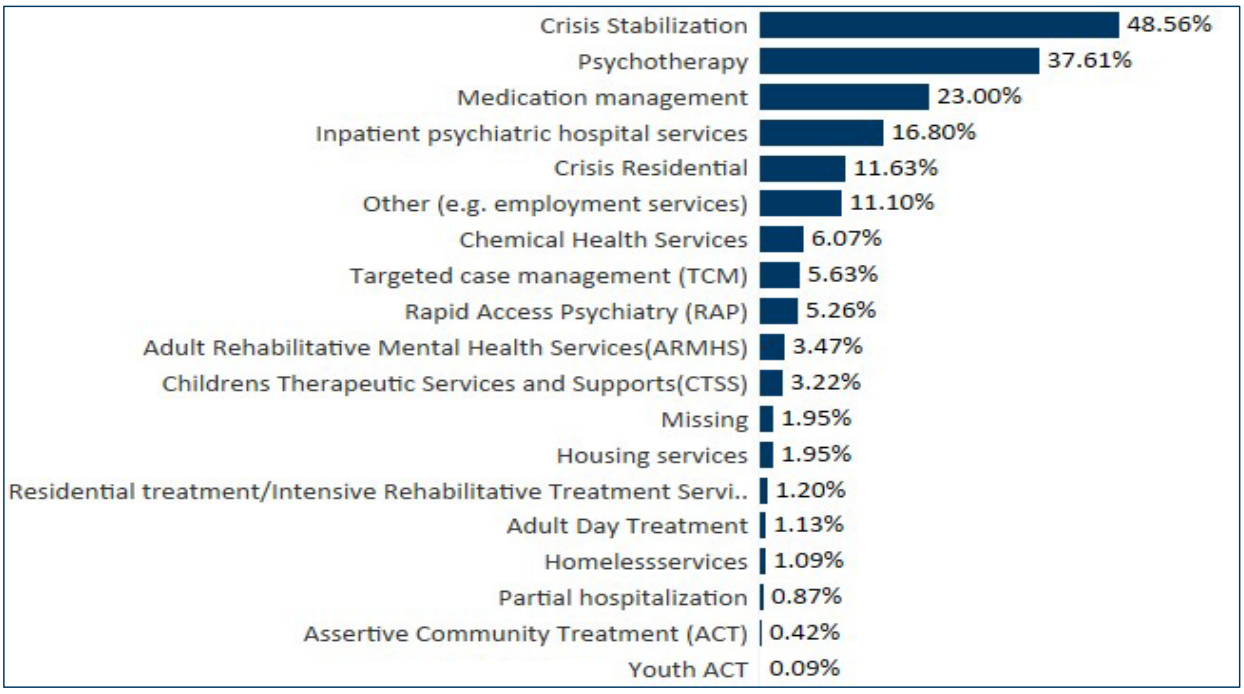
In fiscal year 2021-2022, there were 26,635 distinct episodes of mobile crisis services and 16,055 referrals. Mobile crisis teams responded to 83.5% of episodes in less than 2 hours.

Top 5 referral sources:

- Self, family, friend (46.93%)
- Hospital (22.38%)

Top 5 primary reason for intervention:

- Suicidal ideation (24.88%)
- Depression (18.69%)
- Anxiety/panic (16.05%)
- Other primary reason for intervention (12.61%)
- Dysregulated behavior (10.16%).



Crisis Text Message Grants

State Funding Appropriated (FY21/FY22): $2,250,000; Funding Spent: $2,103,895

Beginning in April 2018, the Department of Human Services contracted with "Crisis Text Line," a national nonprofit which provides free services to all 87 counties in Minnesota. People who text "741741" are connected 24 hours a day, 7 days a week with a trained counselor who helps defuse the crisis and connects the texter to local resources, including coordinating with mobile crisis teams. In fiscal years 2021 and 2022, Crisis Text Line staff responded to 3,665 and 4,394 text message conversations, respectively. Text conversations included 50 Active Rescues, in which Crisis Text Line staff collaborated with first responders in the texter's local area to ensure the texter's safety. The Crisis Text Line had an average monthly satisfaction rating of 82% during fiscal year 2021 and 80% during fiscal year 2022.

Regional Trainings on Text Services

Regional coordinators provide trainings to community members and providers, school staff, and social service providers. Grant funding went to three vendors, including a provider, a county, and a tribal nation. Vendors facilitated more than 500 programing activities in fiscal year 2022 alone, including outreach, presentations, tabling events, Question, Persuade and Refer (QRP) events, meetings, and collaboration with partners, and also SafeTALK. These activities help to increase awareness and knowledge of how to access the text messaging service.

Per program manager, demographic information of texters is not available. The contract ended at the end of FY22 and the data reporting portal used by contractors and the state had closed prior to the date of the legislative report data request.

1) There is a remaining encumbrance of $196,105

2) Crisis text messaging is not a Medicaid billable service.

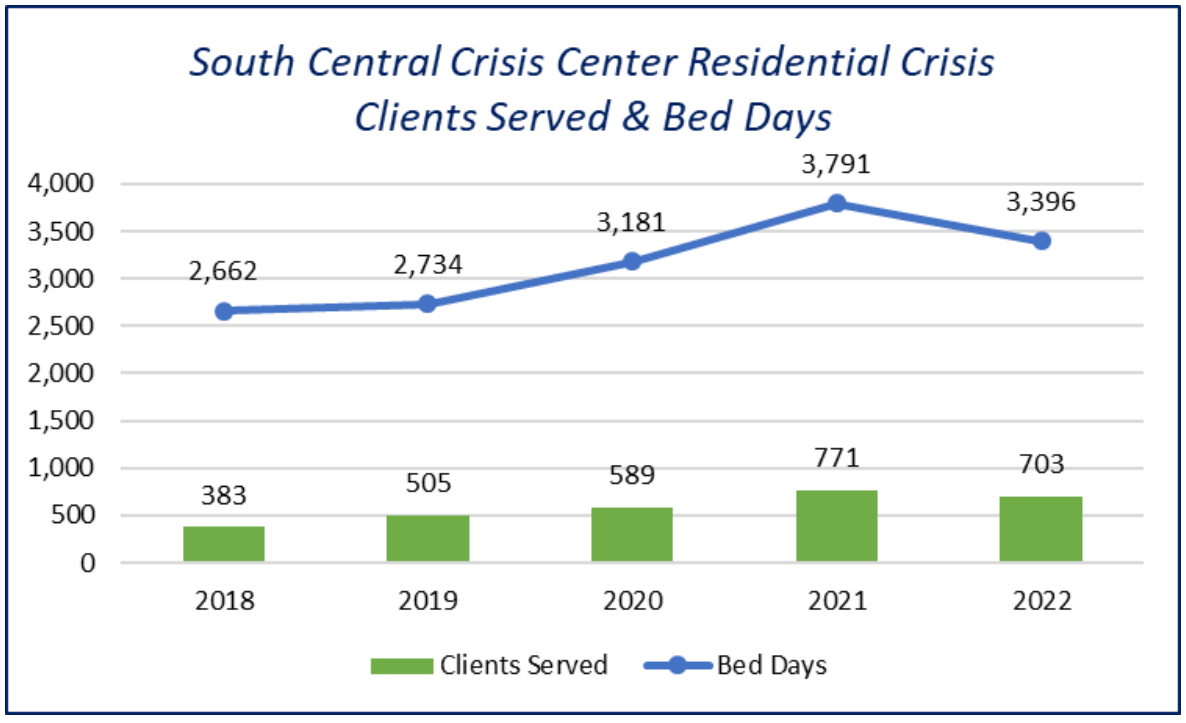
South Central Crisis Program

State Funding Appropriated (FY21/FY22): $1,200,000; Funding Spent: $1,140,384

This program provides rapid access psychiatry services to adults in the South Central region of the state. Starting in 2010, ongoing funds were appropriated directly to Blue Earth County and are used to pre-purchase psychiatry slots from providers in the area. If an individual is in crisis, they can use these slots to access psychiatry appointments quickly, even within the same day. The grant funded 407 rapid access psychiatry visits from CY 2021 to CY 2022.

The grant also funds the mobile crisis line for the region which individuals can call to request a mobile crisis assessment. In CY 2021, 3,709 calls were received and in CY 2022, after an integrated call line was implemented, 4,128 crisis calls were received for adults and adolescents.

Additionally, a portion of the funding covers the cost of uninsured and underinsured adults utilizing residential crisis stabilization beds and mental health urgent care in the region. All of these services are for individuals within the 10 county region (Blue Earth, Brown, Faribault, Freeborn, LeSueur, Martin, Nicollet, Rice, Sibley and Watonwan). The number of clients and bed days for residential crisis services are below.



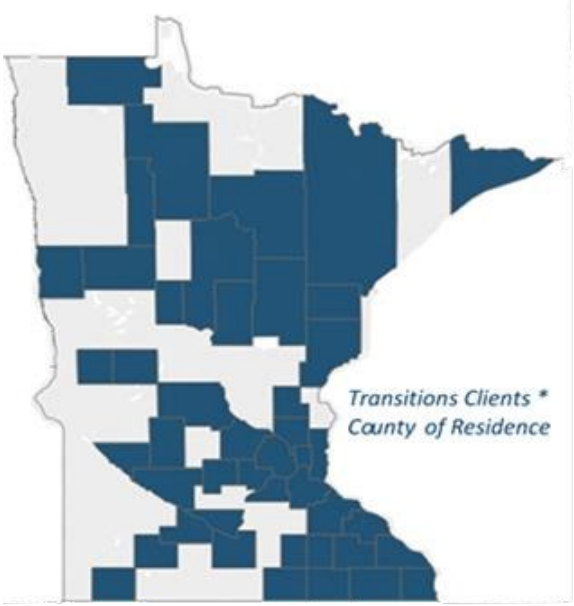
Transitions to Community Initiative

State Funding Appropriated (FY21/FY22): $7,122,000; Funding Spent: $3,098,290

The Transition to Community Initiative was established in 2013 to reduce the time that individuals remain within a residential treatment program beyond the point at which services are no longer clinically necessary. The initiative provides individuals transitioning from the Anoka Metro Regional Treatment Center (AMRTC), the Forensic Mental Health Program (FMHP (formerly known as the Minnesota Security Hospital) or a Forensic Nursing Home (FNH) access to a range of services, including home and community based waivers, flexible grant funding, intensive care coordination, and partnerships with providers and counties to address an individual's unique needs and challenges. The initiative has shown success in helping people overcome significant barriers to community living, thereby promoting recovery while also opening beds at AMRTC and FMHP for other individuals.

Race of Transitions Clients *

White	50.51%
Black	31.31%
Alaskan Native or American Indian	7.07%
Asian	5.56%
Some other race alone	4.55%
Unknown	3.03%
Multiple Races	0.51%



** Specifically clients aided by WIT funds.*

Transitions to Community Initiative dollars are distributed via three avenues: to county agencies in the form of transition grants; to grantee agencies to reimburse eligible services designated under the Whatever It Takes (WIT) program; and to Minnesota Housing for support of the Bridges Rental Assistance Program, which provides housing assistance to people who are discharging from AMRTC or FMHP while they are waiting for a Housing Choice Voucher or another rental subsidy.

Between July 1, 2020 and June 30, 2022, the client populations of AMRTC and Forensic Services (FMHP and FNH) were 827 and 574, respectively. Transition funding aided a portion those discharged (734 and 204, respectively), with WIT dollars benefitting 242 unique individuals. Note that these admission and discharge numbers are representative of a client base requiring a high level of care, which for some does involve cycling through different levels of care with multiple discharges and readmissions (i.e. the counts do not reflect unique individuals).

ACT Quality Improvement and Expansion Grants

State Funding Appropriated (FY21/FY22): $800,000; Funding Spent: $463,353

Assertive Community Treatment (ACT) teams help people treat and manage their mental illnesses and develop the skills they need for life in the community of their choice. Teams typically include a psychiatrist, mental health professionals, multiple nurses, substance abuse specialists, supported employment specialists, certified peer specialists, and other mental health professionals, practitioners, or rehabilitation workers. ACT teams strive to help individuals be successful with relationships, work, managing mental and physical health, and everyday living. ACT helps shorten the use of inpatient psychiatric care and helps prevent inappropriate inpatient care and homelessness.

This funding helps cover a portion of the start-up funding for new ACT teams while they build to reach capacity and sustainability. In addition, this funding is used to improve the quality of services of the ACT teams. Grant funds help support trainings offered to all ACT Teams on evidence based practices in Integrated Dual Diagnosis Treatment (IDDT), Supported Employment and Education (SEE), and a trauma informed Cognitive Behavioral Therapy (CBT) intervention, BREATHE.

Funds are also used to improve the quality of services by improved fidelity of teams through contracts with the Tool for Measurement of Assertive Community Treatment (TMACT) reviewers who visit teams and provide thorough and thoughtful guidance on how teams may improve. These teams moved from corrective action or low fidelity into the medium or high fidelity bracket. Because of restrictions on in-person visits during the COVID-19 pandemic, ACT teams were not scored during the FY 2021-2022 reviews as up to 83% of the TMACT fidelity items were negatively impacted by COVID. Instead, reviewers identified areas of strength and areas for development in service delivery.

Some areas of strength included:

- Utilizing a hybrid of in-person and virtual platforms for client meetings
- Providing transportation assistance to meet basic needs when community options were not available
- Utilizing different engagement strategies and demonstration of flexibility in treatment methods
- Working to engage clients despite limits imposed by the pandemic

Some areas for development included:

- Increasing the duration of client contacts and the amount of substance use treatment that teams are providing
- Infusing more of a clinical overlay into daily team meetings and dedicating consistent and fixed times for weekly treatment planning

- Reassessing the allocations of caseload duties
- Exploring alternative strategies for medication administration
- Building both intrinsic and extrinsic motivation for clients to engage in treatment
- Providing lifestyle interventions to support people in developing and maintaining physical wellness
- Beginning to actively recruit individuals in their geographic area who need ACT services

Number of ACT Clients Served by AMHI and CSP Grant Funding by FY

The number of ACT clients served through grant funding decreased during FY 2021 and FY 2022, largely due to restrictions and to staffing shortages related to the ongoing impact of the COVID-19 pandemic. The number of ACT clients served through grant funding increased from 287 to 330 from FY 2019 to FY 2020 but fell to 290 in FY 2021 and 228 in FY 2022.

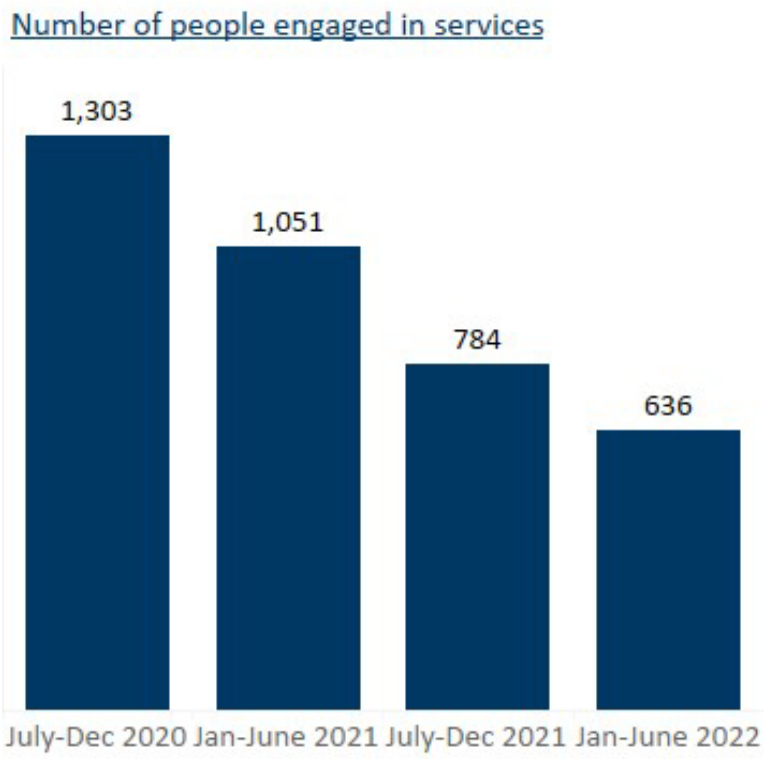
Finally, remaining grant funds were used to fund training on culturally responsive services for Black/African American and Asian clients for a variety mental health and substance use providers in Minnesota. In FY 2022, grant dollars were given to 6 organizations to conduct trainings.

Housing Support for Adults with Serious Mental Illness (HSASMI)

State Funding Appropriated (FY21/FY22): $9,100,000; Funding Spent: $5,383,208
Federal Funding Appropriated (FY21/FY22): $; Funding Spent: $

The housing with supports for adults with serious mental illness grant program (HSASMI), provides housing support services for individuals with serious mental illness (SMI) who are homeless, long term homeless, or exiting institutions who have complex needs and face high barriers to obtaining and retaining housing.23 The services provided assist individuals to transition to and sustain permanent supportive housing (PSH) which meets the PSH evidence-based practice fidelity standards.

The HSASMI grant program is focused on assuring that individuals have access to affordable, lease-based housing opportunities. The housing support services are recovery oriented, person-centered, and link tenants to best practice and evidence-based behavioral health services. In fiscal years 21-22, there were 1,955 people served by the HSASMI grant as reported in MHIS and 139 people transitioned from at-risk of homelessness/homeless to housed.



Crisis Housing Fund

State Funding Appropriated (FY21/FY22): $ 1,220,000; Funding Spent: $ 676,141

The Crisis Housing Fund (CHF) are grants given to nonprofits, government organizations, and tribal nations on behalf of individuals with serious mental illness. Individuals are identified by the applicant agency who assist with the Crisis Housing Fund application. CHF provides short-term housing assistance, including financial assistance to pay rent, mortgage, utility, and/or other housing related expenses. Funds are available for up to 90 days to individuals who are either using their income to pay for facility based behavioral health treatment or who are losing income due to their stay.

The Crisis Housing Fund prevents homelessness and supports access to treatment by helping individuals to retain their housing while seeking needed behavioral health treatment. In 2021 and 2022, 317 people were able to maintain their permanent housing through the Crisis Housing Fund.

The Crisis Housing Assistance Program did not have grantees administering services between July of 2021 and mid-May 2022. Hearth withdrew from contract negotiations to extend administration of the program and their contract ended June 30, 2021. DHS took several months to instate a contract with a new grantee, leading to significant underspending in 2022.

People Served and Months of Assistance	*FY 2021*	*FY 2022*
People Served	306	11
Months of Assistance	743	33

Summary of Expense Type	*FY 2021*	*FY 2022*
Rent & Mortgage Expenses	$619,884.00	$10,840.44
Utilities & Other Costs	$104,012.00	$874.54
Returns	($49,376.84)	-

Children's Respite Care Service Grants

State Funding Appropriated (FY21/FY22): $ 3,048,000; Funding Spent: $2,758,289

Respite services provide temporary care for children with serious mental health needs who live at home. Access to this program gives relief to families and caregivers while offering a safe environment for their children. Respite care can be provided in a family's home, foster home, or licensed facility in the community and gives families a chance to reenergize and refocus. Respite care includes planned routine care to support the continued residence of a child with emotional or behavioral disturbance with the child's family or long-term primary caretaker. This type of care can also be used on an emergency or crisis basis.

Minnesota is working towards a flexible and creative respite care system that is available statewide. The purpose of the grant is to support resilience and stability in families and grantees are encouraged to be innovative, using a variety of supports to reduce family stress and decrease the likelihood of out-of-home placements.

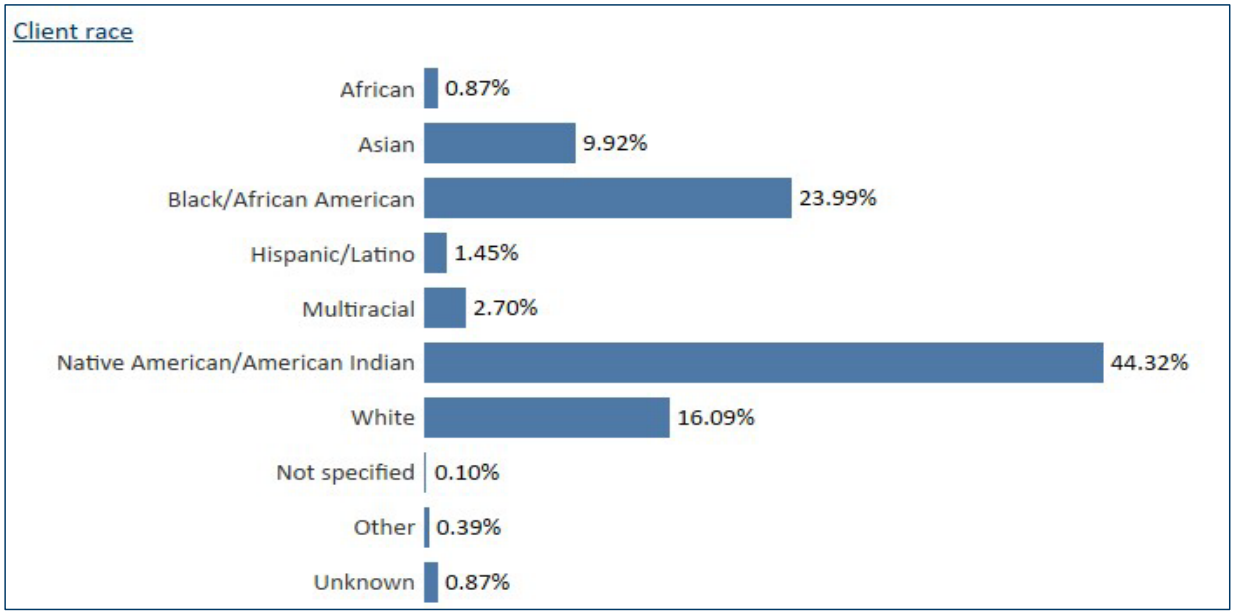
The goals of these grants include:

- Providing relief and support to caregivers
- Improving child functioning
- Decreasing out-of-home placements and hospitalizations
- Increasing safety and permanency
- Reducing family/parenting stress
- Providing access to activities and community that may not normally be present

Cultural and Ethnic Minority Infrastructure Grants

State Funding Appropriated (FY21/FY22): $600,000; Funding Spent: $589,250 Federal Funding Appropriated (FY21/FY22): $5,339,063; Funding Spent: $ 3,939,049

Cultural and Ethnic Minority Infrastructure Grants (CEMIG) supports mental health professionals and practitioners from cultural and ethnic minority backgrounds to obtain supervision hours, meet licensure requirements or certification to become qualified mental health practitioners, mental health professionals, and/or clinical supervisors.



Total clients served

Fiscal Year	
2019	607
2020	1,012
2021	712
2022	804

Communities served by supervisees funded by this grant: low income, African American, families, youth 12-17, students, adults 18+, youth 6-11, LGBTQIA+, Latino/a/x, 2nd generation immigrants, Mexican, homeless, Southeast Asian, Hmong, Somali, Central American, Karen, Youth under 5, immigrants, victims of trafficking, refugees.

Children's Evidence-Based Training Grants

State Funding Appropriated (FY21/FY22): $1,500,000.00; Funding Spent: $611,256
Federal Funding Appropriated (FY21/FY22): $1,516,000.00; Funding Spent: $598,044.64

Children's Evidence-Based Training Grants are awarded to mental health provider agencies serving children and youth to strengthen the clinical infrastructure by providing training and consultation to practicing mental health providers in the use of treatment strategies that have research to demonstrate their clinical efficacy and effectiveness.33 The practices supported by these grants are Managing and Adapting Practice (MAP), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), and Bounce Back. The number of clinicians trained in state fiscal year 2021 and state fiscal year 2022 is reflected in the table below.

	SFY 2021		SFY 2022	
EBP Trainings by Type	Number of Agencies	Number of Clinicians	Number of Agencies	Number of Clinicians
MAP	9	53	11	21
TF-CBT	15	51	10	36
CBITS	8	26	0	0
Bounce Back	6	18	0	0

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 as well as clinical dashboards to track outcomes and practices.

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.

CBITS is a school-based group and individual intervention program that is designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills. CBITS

uses cognitive-behavioral therapeutic techniques and is appropriate for students in grades 5 through 12 who have witnessed or experienced traumatic life events.

Bounce Back is an adaptation of CBITS designed to be administered to elementary students (ages 5-11) exposed to stressful and traumatic events, including natural disasters. Like CBITS, it is a school-based intervention program that includes group, individual, and parent sessions. While therapeutic elements are like CBITS, Bounce Back is designed with added elements and engagement activities, and more parent involvement so it is developmentally appropriate. Both MAP and TF-CBT training models include 5 days of intensive classroom instruction followed by 9-12 months of bi-weekly phone consultation sessions. Training groups are limited to 25-30 trainees and provide for a national certification that requires renewal every 3-5 years. CBITS and Bounce Back trainings are a day and a half (12 hours) and each program is typically offered every other year. There is no national certification, but CBITS and Bounce Back have the same phone consultations sessions as MAP and TF-CBT.

There was significant underspending due to 1) an influx of Covid-related funding, 2) staffing shortages in provider agencies, and 3) extended vacancy of the CMH EBP grant manager position.

Early Childhood Mental Health Capacity Grants

State Funding Appropriated (FY21/FY22): $2,048,000; Funding Spent: $ 1,024,000
Federal Funding Appropriated (FY21/FY22): $1,576,000; Funding Spent: $ 929,836

Since 2007, Minnesota has invested in building the capacity of and access to early childhood mental health services in Minnesota. To accomplish this, DHS awards competitive grants to mental health providers. In FY 2021 and FY 2022, DHS funded 33 mental health agencies that together cover every county in the state and two tribal nations. There are three core components of the Early Childhood Mental Health (ECMH) grant program. The purpose and accomplishments of each are as follows:

1) Provide appropriate clinical services to young children and their families who are uninsured or underinsured.

Total population served	Total children: FY21 - 4578 | FY22 – 4625 (not mutually exclusive). Underinsured: 99%. Gender: male – 61% | female – 38% | not reported – <1%. County: Residents from 100% of MN 87 counties.
Total individual services provided	295,090, of which 82% were clinical in nature and 18% were auxiliary. (Auxiliary services supplement or facilitate access to clinical services.)

2) Increase the clinical competence of clinicians across the state to serve children birth through five and their parents by training them in evidenced-based practices around assessment and treatment of young children.

Content of Evidence-Based Practices (EBPs) training sessions provided	Clinicians trained
Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5)	542
Attachment and Bio-behavioral Catch-up (ABC)	21
Child-Parent Psychotherapy (CPP) Booster	187
Parent-Child Interaction Therapy (PCIT) Booster	99
Early Childhood Service Intensity Instrument (ECSII)	383
Great Start	1198

3) Provide mental health consultation to childcare providers across the state to prevent expulsion and suspension of young children from childcare, to increase childcare staff morale and retention, and address the mental health issues of young children and their families accessing childcare

Total childcare sites where consultations provided:	107
Combined enrollments of sites that received consultations:	Over 6000 ongoing; 60% were preschoolers; infants and toddlers combined for 40%.

Child Welfare and Juvenile Justice Screening Grants

State Funding Appropriated (FY21/FY22): $8,864,000; Funding Spent: $ 7,043,262

The children's mental health screening initiative was a response to the Children's Mental Health Task Force of 2002. The Department of Human Services (DHS) partners with the Child Safety and Permanency Division of DHS and the Department of Corrections to provide means for county and tribal social services and juvenile justice programs to screen children within specific target populations and refer children, as needed, for further mental health assessment. The mandated target populations include children in the child welfare and juvenile justice systems. Children's mental health screening grants integrate mental health screening into current practice, promote the use of effective and efficient mental health screening instruments, facilitate referral of children for diagnostic assessments, and make funds available for screening and uncompensated mental health services. Mental health screening is a brief process to detect potential mental health problems. Children identified through the screening process should be referred to a mental health professional who can determine a mental health diagnoses and identify any necessary treatment or service.

Children who Received Mental Health Screenings	2020	2021
Child Welfare	6408	5826
Juvenile	1407	1299

Currently, statute restricts DHS from collecting individual screening results. Under this restriction, DHS has only been able to collect a minimal amount of basic summary data, such as the total number of screenings completed and the total numbers of children screened by race, age, and geographic area. This limitation hinders the ability of DHS to assess the effectiveness of the grant and determine whether grants meet statutory requirements.

Adverse Childhood Experience Grants

State Funding Appropriated (FY21/FY22): $726,000; Funding Spent: $ 676,836

This program provides training to Children's Mental Health and Family Services Collaborative on the impact of ACEs (Adverse Childhood Experiences), brain development, historical trauma, and resilience. Training outcomes include increased collective understanding among Collaborative about ACEs, resilience, and trauma, and increased protective factors for children, families, and communities.

This program has 4 phases of activities, as well as related conference and cohort activities:

Phase 1 – Training/Presenting to train community partners, parents and providers:

- Provided 38 ACE Interface Presentations (*Understanding Adverse Childhood Experiences: Building Self- Healing Communities*) reaching 959 people in Collaboratives' communities throughout Minnesota.

Phase 2 – Community & Regional Cohorts to train and create community presenters:

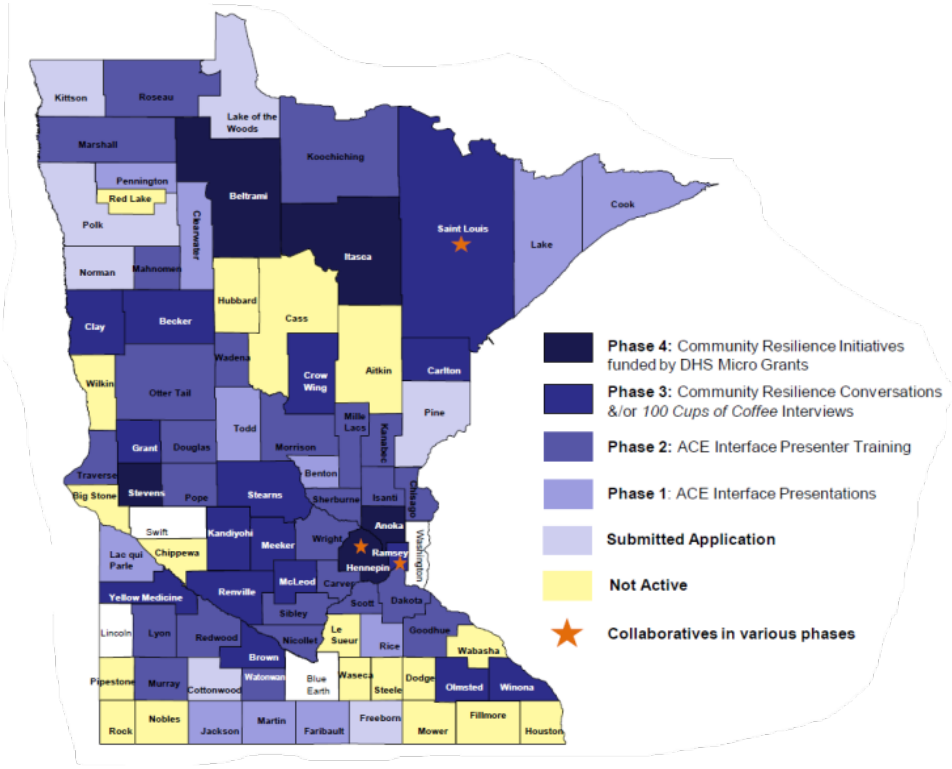
- Provided 5 ACE Interface Presenter Workshops training 138 community presenters.

Phase 3 – Community Resilience Conversations to discuss emerging community needs and inform Collaboratives' Community Resilience Plans, and *100 Cups of Coffee* Interviews:

- More Resilient Minnesota supported 7 Collaboratives to gather input from 347 people with Community Resilience Conversations and *100 Cups of Coffee* Interviews.

Phase 4 – Community Resilience Initiatives:

- DHS awarded 6 micro grants to support 6 Community Resilience Initiatives in 5 Collaboratives' communities.



Other Grant Activities:

Conference/Gathering to support and strengthen communities of practice among the Collaboratives. 572 people engaged in shared learning at the 2021 and 2022 annual *Collaboratives Addressing Adverse Childhood Experiences: Growing Resilient Communities* gatherings. Additionally, 16 Presenters/Trainers presented 33 presentations to 686 people in communities served by Collaboratives.

Client Admissions by Program	*Fiscal Year 2021*	*Fiscal Year 2022*
Hennepin Healthcare (HCMC), Minneapolis	52	63
M Health (University of MN Physicians), St. Louis Park	30	30
Human Development Center (HDC), Duluth	6	7

Services for First Episode Psychosis

State Funding Appropriated (FY21/FY22): $847,344.01; Funding Spent: $829,864.08 Federal Funding Appropriated (FY21/FY22): $2,981,000.00; Funding Spent: $2,225,787.06

First Episode Psychosis (FEP) programs are for all adolescents and young adults ages 15 to 40 experiencing a first episode psychosis, especially underserved and at-risk populations, including African Americans/Africans, American Indians, Asian Americans, Hispanics/Latinos, LGBTQ communities, people with disabilities, and transition age youth.

Psychosis can affect people from all walks of life, but often begins when a person is in their late teens to midtwenties. Reducing the time it takes for a person experiencing psychosis to get treatment is important because early treatment often means a successful recovery. Studies show that it is common for a person to have psychotic symptoms for more than a year before receiving treatment.

FEP uses the Coordinated Specialty Care (CSC) model to reduce psychosis symptoms, hospitalization, school dropout rates, unemployment, incarceration, homelessness, and application for disability, as well as improve quality of life. CSC is a recovery-oriented treatment program using a team who work with the individual and their family members to create a personal treatment plan. Depending on the individual's needs and preferences, services include psychotherapy, medication management, family education and support, case management, and employment or education support.

In Fiscal Year 2021/2022, funding continued to support three pilot sites[3]: Hennepin Healthcare**,** M Health, and Human Development Center. Grant dollars also funded the University of Minnesota's Department of Psychiatry and Behavioral Sciences to provide technical assistance, including training, consultation, reviewing fidelity and data collection for all FEP sites. Funding was also utilized for a 4th additional site to be developed with RADIAS health. The 4th site is still in the process of hiring staff, marketing the program, and finalizing procedure within their health record system for FEP services.

Funding has also been requested to start a First Episode Mood Disorder (FEMD) Program. The Behavioral Health Division received some legislatively approved funding this year to contract with the University of Minnesota, who are currently creating a proposed blueprint for the potential FEMD Program that they will deliver by the end of June 2023.

The following page contains a chart showing the client admissions for each of the FEP programs in fiscal year 2021 and fiscal year 2022. There is also some information detailing what was covered by grant funds for these programs.

Grant funds covered: [4]

[3] Site information can be found at: HCMC, http://hcmc.org/clinics/TheHOPEProgram/HCMC_D_047257; M Health, https://www.mhealth.org/care/conditions/psychosis-first-episode; HDC, https://www.humandevelopmentcenter.org/programs/adolescent/.

[4] FEP services are primarily funded by MHCP and consumer insurance, and grant dollars are used for non-covered services.

- Staff members (salary and fringe for staff meetings, training, consultation/supervision as well as no reimbursable staff, including Supported Employment and Education, Case Manager, Peer Support Specialist, and Family Peer Support Specialist)
- Program needs (rent, computer technology, phone/Wi-Fi, supplies, etc.)
- Client needs (bus pass, hygiene items, weather-appropriate clothing and footwear, clothing for interviews/work clothes, ID replacement, laundry supplies, food, etc.)
- Creation of 4th FEP program site
- Development of Psychosis Learning and Understanding Schizophrenia clinic and Substance Use and Innovation Treatment clinics provide further technical assistance, training opportunities and collaboration with treatment providers.