Children's Mental Health Integrated Fund Task Force

Report to the Minnesota Legislature

February 14, 1994

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I. Executive Summary

The 1991 Minnesota State Legislature created the Children's Mental Health Integrated Fund Task Force in response to the realization that children with emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and jobs and training. All too often this results in a stream of conflicting, duplicative, and ill coordinated services for these multi-system children.

The Children's Mental Health Integrated Fund Task Force was created with representation from: relevant state agencies; county government; children's service providers; parents; community corrections; public health; children's advocates; legislators; juvenile court; mental health advocates; state minority councils, and; third party payors. Over the past three years, the Task Force has studied the issues involved and recommended to the legislature and relevant state agencies an integrated service model designed to:

- allow local service decision makers to draw funding from a single local source so that funds follow clients, eliminating the need to match clients, funds, services, and provider eligibilities;
- create a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;
- improve the efficiency of use of existing resources;
- minimize or eliminate the incentives for cost and risk shifting; and
- increase the incentives for earlier identification and intervention

In 1993, the legislature directed the Task Force to "provide a report to the legislature with recommendations of the task force for promoting integrated funding and services for children's mental health. The report must include the following recommendations: (1) how to phase in all delivery systems, including the juvenile court and correctional systems; (2) how to expand the initial target population so that the state eventually has a statewide integrated children's mental health service system that integrates funding regardless of source for children with emotional and/or behavioral disturbance or those at risk of suffering such disturbances; (3) possible outcome measures of the local children's mental health collaboratives; and (4) any necessary legislative changes in the data practices act."

Recommendations for the Phase In of Delivery Systems

1. The Task Force recommends that the State Coordinating Council ensure that training and technical assistance on the Children's Mental Health Integrated Fund legislation be available to agencies implementing new local collaboratives and those agencies within their local system of care currently not included in the collaborative.

2. The Task Force recommends the newly formed local collaboratives work with their Local Coordinating Councils and Family Service Collaboratives (if any) to engage other child serving agencies within their local systems of care in order to discuss and plan for their eventual inclusion in the local collaborative. The Task Force also recommends the State Coordinating Council include in its annual report information on the collaboratives' progress in phasing in other members of their local system of care and identify any barriers encountered.

3. The Task Force recommends that representatives from local collaboratives meet with their governing boards at least twice a year to review their gains, setbacks, barriers and needs.

4. The Task Force recommends that representatives of the Task Force, family members, and the Departments of Human Services and Education be afforded an opportunity to provide input to the Minnesota Supreme Court Juvenile Court Rules Committee, to assist it to address the juvenile court's role in serving children with emotional and/or behavioral disturbances.

Recommendations for the Expansion of Initial Target Populations

1. The task force finds that it is too early in the implementation of the Children's Mental Health Integrated Fund legislation to identify barriers and make recommendations to promote the expansion of initial target populations. The Task Force recommends that the State Coordinating Council assess the progress of local collaboratives who begin with a limited initial target population and include in its annual report its findings and recommendations for overcoming any identified problems in expanding initial target populations.

Recommendations for Outcomes Measures

1. The Task Force recommends that a measure of child functioning serve as the primary outcome measure for local children's mental health collaboratives. The Task Force also recommends that the Department of Human Services work with local collaboratives to identify, or contract for the development of, an instrument for measuring child functioning appropriate for state-wide

use. This instrument should be made available for local collaboratives' use by July 30, 1994.

2. In addition, the Task Force recommends collection of the following data as partial indicators of child functioning:

   - School attendance
   - Number of school disciplinary referrals
   - Academic performance
   - Number of arrests
   - Number and type of court adjudications/dispositions
   - Number of Children in Need of Protection or Services (CHIPS)
   - Recidivism (eg.- new offense rates)

3. The Task Force recommends a longitudinal study using proven research techniques as the preferred methodology for evaluating the outcomes of an integrated children's mental health system.

4. The Task Force recommends that local collaboratives seek input from parents regarding effective ways of involving parents in their child's treatment and in developing a local method for evaluating their performance in encouraging parental involvement. Care should be taken to ensure that the measurement of this outcome does not produce coercive pressures on parents.

5. The Task Force recommends that at this time parental satisfaction should be measured only at the local level. The Task Force recommends that local collaboratives seek parental input while planning to evaluate their performance regarding parental satisfaction. Care should be taken to ensure that the measurement of this outcome does not produce coercive pressures on parents. The Task Force also recommends that the Departments of Human Services and Education convene a parent work group with the support of providers and experts in outcomes measurement to determine whether statewide measures of parent satisfaction and parent involvement are desirable. If deemed desirable, this work group could then recommend approaches for state wide measurement of parental satisfaction.

6. The Task Force recommends that local collaboratives make parent support services available in their communities. The Task Force recommends that the state and local collaboratives provide funding for these parent support groups.

7. While not strictly an outcome measure, the Task Force finds that service utilization data are important descriptors for evaluating the impact of a collaborative service system. The task force recommends that, to the extent existing data reporting systems permit, state agencies collect and report data to track the following for children served by collaboratives:

General
- Number of children served per unit of population
- Portion of target population served by the collaborative
- Child demographic information

Mental Health
- Hours of Out Patient Treatment
- Hours of Day Treatment
- Hours of Case Management
- Hours of Home-Based Services
- Days of Out-of-home placement (Rule 5, Hospital, Foster Care)
- Hours of Family Community Support Services
- Hours of Crisis Services
- Number of children receiving multi-agency plans of care

Juvenile Justice
- Number and type of Diversions

Education
- Level of Special Education Service

8. The Task Force finds that service utilization data is scattered across a large number of service reporting mechanisms in a variety of child serving systems. The Task Force recommends the State Coordinating Council lead its representative agencies to identify these various reporting streams and devise a way of coordinating them to allow tracking of service use by clients of local collaboratives.

9. The Task Force recommends that state agencies and local collaboratives take full advantage of national and local expertise in its development of outcome measures.

Recommendations for Data Practices

1. The Task Force finds that the Data Practices Act does not require changes to accommodate the functioning of local children's mental health collaboratives.

2. The Task Force recommends Minnesota's Comprehensive Mental Health Act be amended to provide those members of the local system of care subject to the Data Practices Act the explicit authority to collect and disseminate information necessary for the planning, coordination and delivery of mental health services.

3. The Task Force recommends the legislature appropriate funds to support an increase in the training and technical assistance available regarding data practices. Training and technical assistance regarding proper data practices are needed beyond the administration's current ability to provide it.

4. The juvenile court system operates outside the Data Practices Act and the Task Force recommends that the Minnesota Supreme Court Juvenile

Court Rules Committee examine its data practice regulations with an eye toward facilitating juvenile court's partnership in local collaboratives.

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II. Introduction

The Children's Mental Health Integrated Fund Task Force was created in response to the realization that children with emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and jobs and training. All too often this results in a stream of conflicting, duplicative, and ill coordinated services for these multi-system children.

The 1991 Minnesota State Legislature created the Children's Mental Health Integrated Fund Task Force to study the feasibility of a children's mental health integrated fund. The Task Force published a report in May of 1992 which outlined the existing service system; identified barriers to an effective efficient system; described a rationale for system integration; analyzed other innovative service models and funding strategies; and summarized conclusions on the feasibility of integrated funding based on this research and analysis. At the direction of the legislature the task force then followed up on this effort by producing recommendations for a functionally integrated local service system model in their February 1993 report.

Based on the recommendations of the February, 1993 report, the legislature enacted legislation providing guidelines and start-up funding for communities to begin development and implementation of local children's mental health collaboratives.

In order to better meet the needs of these multi-system children, the Children's Mental Health Integrated Fund legislation calls for an integrated children's mental health service system that:

"(1) allows local service decision makers to draw funding from a single local source so that funds follow clients and eliminates the need to match clients, funds, services, and provider eligibilities;
(2) creates a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;
(3) improves the efficiency of use of existing resources;
(4) minimizes or eliminates the incentives for cost and risk shifting; and
(5) increases the incentives for earlier identification and intervention." (MS § 245.491, Subd 2.)

II. Introduction

In July, 1993 the Department of Human Services released a request for proposals offering start-up grants for local children's mental health collaboratives. Fifty counties submitted proposals, and the State Coordinating Council awarded grants to 20 different collaboratives, encompassing 35 counties distributed throughout the state. 83 school districts have signed on as initial partners in these 20 collaboratives. Sixteen of the funded proposals include juvenile justice as partners. At the time this report was drafted, the Department of Human Services had approved the expenditure of an additional $200,000 of federal Community Mental Health Services Block Grant funds to be used by the State Coordinating Council to support collaboratives in their start-up efforts.

The legislature's current charge to the task force is:
"to provide a report to the legislature with recommendations of the task force for promoting integrated funding and services for children's mental health. The report must include the following recommendations: (1) how to phase in all delivery systems, including the juvenile court and correctional systems; (2) how to expand the initial target population so that the state eventually has a statewide integrated children's mental health service system that integrates funding regardless of source for children with emotional and/or behavioral disturbance or those at risk of suffering such disturbances; (3) possible outcome measures of the local children's mental health collaboratives; and (4) any necessary legislative changes in the data practices act."

The present report addresses these and other issues relevant to the development and implementation of the Children's Mental Health Integrated Fund.

III. Phase in of Delivery Systems

The legislature directed the Task Force to make recommendations regarding how to phase in all delivery systems, including the juvenile court and correctional systems.

Recommendations

1. The Task Force recommends that the State Coordinating Council ensure that training and technical assistance on the Children's Mental Health Integrated Fund legislation be available to agencies implementing new local collaboratives and those agencies within their local system of care currently not included in the collaborative.

2. The Task Force recommends the newly formed local collaboratives work with their Local Coordinating Councils and Family Service Collaboratives (if any) to engage other child serving agencies within their local systems of care in order to discuss and plan for their eventual inclusion in the local collaborative. The Task Force also recommends the State Coordinating Council include in its annual report information on the collaboratives' progress in phasing in other members of their local system of care and identify any barriers encountered.

3. The Task Force recommends that representatives from local collaboratives meet with their governing boards at least twice a year to review their gains, setbacks, barriers and needs.

4. The Task Force recommends that representatives of the Task Force, family members, and the Departments of Human Services and Education be afforded an opportunity to provide input to the Minnesota Supreme Court Juvenile Court Rules Committee, to assist it to address the juvenile court's role in serving children with emotional and/or behavioral disturbances.

Discussion

Because the Children's Mental Health Integrated Fund legislation mandates a locally integrated service system, the Task Force feels that the phase in of agencies within the local system of care will occur largely because of work done at the local level to make it happen. Each community is unique with different existing

relationships, geography, resources and personalities. Each community will have to figure out its own unique way to complete the membership of its local collaborative.

To this end, the members of the Task Force recommend that local planning for the eventual inclusion of the entire local system of care begin early. The newly funded collaboratives should, in partnership with their Local Coordinating Councils and Family Service Collaboratives (if any), approach other child serving agencies within their local system of care (especially juvenile justice and corrections) to discuss and plan for the eventual inclusion of these agencies into the collaborative. The resulting plan for each child serving agency should identify barriers and map out a path for the agency's inclusion in the collaborative.

Persons involved in the development of the local collaborative within a community should make a concerted effort to keep their governing boards (eg., county boards, school boards) apprised of and attentive to the progress made by the collaborative. Collaboratives should meet with their governing boards at least twice a year to review their gains, setbacks, barriers and needs.

The phase in of other service systems can only occur when local leaders within these service systems gain an understanding of the operation and advantages of the collaborative's approach to service provision and coordination. Many agencies in the newly funded collaboratives still struggle with the design concepts behind the Children's Mental Health Integrated Fund. Those agencies outside the initial collaborative are even less aware. There may be limited knowledge of children's mental health in many child serving agencies. This is true of juvenile court and probation officers as well as many social services staff and educators. Expansion of the collaboratives and phase in of other agencies is predicated on developing this awareness. With this in mind, the Task Force must repeat last year's recommendation that the State Coordinating Council act to coordinate the large amount of training and technical assistance which must accompany the implementation of the Children's Mental Health Integrated Fund.

Phase in of the juvenile justice system as a member of a local collaborative is frequently presented as potentially problematic. The juvenile justice and corrections systems are obligated to consider public safety concerns as well as treatment concerns of the individual child. This dual responsibility can make it harder to gain a unity of purpose and approach between these agencies and other child serving agencies. Juvenile court justices are perceived as enormously autonomous in their functioning. However, the concern that juvenile court judges will balk at working with service collaboratives in order preserve their judicial discretion may be unfounded. Judges may welcome having the added resources and expertise the collaborative can provide.

Several possible mutual roles for the juvenile justice system and local collaboratives are already defined in law. Minnesota Statues § 260.151 outlines the court's use of physical and mental examinations as a support to making findings and dispositions in juvenile cases.

Subd. 3 of this section provides county boards with the option of creating a multi-disciplinary team to conduct screening and make recommendations regarding placement. A collaborative, with juvenile justice participation, could fulfill this role.

Also, Minnesota Statutes § 260.185 Subd. 1 states, "...If the child is found delinquent due to the commission of an offense that would be a felony if committed by an adult, the court shall make a specific finding on the record regarding the juveniles mental health and chemical dependency treatment needs..." Members of the Task Force wonder if this was done as often as required. Involvement in a local collaborative would give the court ready access to the expertise necessary to meet this statutory requirement.

There was some discussion in the task force in support of extending this requirement to all children found delinquent rather than just those found delinquent of felony level offenses. Conversely, some Task Force members expressed concern that the confidentiality provisions for juvenile court case records could limit the utility of such findings. Since juvenile court records are sealed, the findings contained within them may be of little use to agencies involved in treating the juvenile following adjudication.

The Minnesota Supreme Court Juvenile Court Rules Committee convenes in the near future for the first time in 18 years. Rules established by this committee serve to direct juvenile court procedures and norms. This is a valuable opportunity to influence court procedures and the behavior of juvenile court judges and to build collaboration among systems. The Task Force recommends that representatives of the Task Force, family members, and the Departments of Human Services and Education be afforded an opportunity to provide input to the Minnesota Supreme Court Juvenile Court Rules Committee, to assist it to address the juvenile court's role in serving children with emotional and/or behavioral disturbances.

IV. Expanding the Initial Target Population

The legislature directed the Task Force to make recommendations regarding how to expand the initial target population so that the state eventually has a statewide integrated children's mental health service system that integrates funding and services regardless of source for children with emotional and or behavioral disturbances or those at risk of suffering such disturbances.

Recommendations

1. The task force finds that it is too early in the implementation of the Children's Mental Health Integrated Fund legislation to identify barriers and make recommendations to promote the expansion of initial target populations. The Task Force recommends that the State Coordinating Council assess the progress of local collaboratives who begin with a limited initial target population and include in its annual report its findings and recommendations for overcoming any identified problems in expanding initial target populations.

Discussion

M.S. § 245.492, Subd. 21 defines the target population for the Children's Mental Health Integrated Fund as follows: "Target population means children up to age 18 with an emotional or behavioral disturbance or who are at risk of suffering an emotional or behavioral disturbance as evidenced by a behavior or condition that affects the child's ability to function in a primary aspect of daily living including personal relations, living arrangements, work, school, and recreation, and a child who can benefit from: (1) multi-agency service coordination and wraparound services; or (2) informal coordination of traditional mental health services provided on a temporary basis.

Children between the ages of 18 and 21 who meet these criteria may be included in the target population at the option of the local children's mental health collaborative."

Local collaboratives are free to begin by concentrating on an "initial target population," defined as a subset of the ultimate "target population" described in the definition above. Once conceived and constructed to serve this "initial target population" collaboratives are expected to

grow in the scope of their efforts until they eventually serve the ultimate "target population".

Expansion of the initial target population is an important goal in that it facilitates the transition from a system based on intensive treatment to a system that emphasizes prevention.

Any discussion of how a local collaborative would expand its initial target population to eventually include the entire target population envisioned in legislation very quickly becomes mired in speculation. Local collaboratives, by law, are required to use any revenues earned by the collaborative to expand the initial target population or to develop or provide mental health services through the local integrated service system to children in the target population. This is all that is certain at this time. Since local collaboratives will start with a different initial target population and since each is likely to be unique in its existing relationships, geography, resources and personalities, it is too soon to predict the incentives and barriers that might affect a collaborative's expansion of its initial target population.

Because of this uncertainty, the Task Force recommends that the State Coordinating Council assess the progress of local collaboratives who begin with a limited initial target population and include in its annual report its findings and recommendations for overcoming any identified problems.

V. Outcome Measures for Local Collaboratives

The legislature directed the Task Force to consider and recommend outcome measures for local children's mental health collaboratives.

Recommendations

1. The Task Force recommends that a measure of child functioning serve as the primary outcome measure for local children's mental health collaboratives. The Task Force also recommends that the Department of Human Services work with local collaboratives to identify, or contract for the development of, an instrument for measuring child functioning appropriate for state-wide use. This instrument should be made available for local collaboratives' use by July 30, 1994.

2. In addition, the Task Force recommends collection of the following data as partial indicators of child functioning:

   - School attendance
   - Number of school disciplinary referrals
   - Academic performance
   - Number of arrests
   - Number and type of court adjudications/dispositions
   - Number of Children in Need of Protection or Services (CHIPS)
   - Recidivism (eg.- new offense rates)

3. The Task Force recommends a longitudinal study using proven research techniques as the preferred methodology for evaluating the outcomes of an integrated children's mental health system.

4. The Task Force recommends that local collaboratives seek input from parents regarding effective ways of involving parents in their child's treatment and in developing a local method for evaluating their performance in encouraging parental involvement. Care should be taken to ensure that the measurement of this outcome does not produce coercive pressures on parents.

5. The Task Force recommends that at this time parental satisfaction should be measured only at the local level. The Task Force recommends that local collaboratives seek parental input while planning to evaluate their performance regarding parental

satisfaction. Care should be taken to ensure that the measurement of this outcome does not produce coercive pressures on parents. The Task Force also recommends that the Departments of Human Services and Education convene a parent work group with the support of providers and experts in outcomes measurement to determine whether statewide measures of parent satisfaction and parent involvement are desirable. If deemed desirable, this work group could then recommend approaches for state wide measurement of parental satisfaction.

6. The Task Force recommends that local collaboratives make parent support services available in their communities. The Task Force recommends that the state and local collaboratives provide funding for these parent support groups.

7. While not strictly an outcome measure, the Task Force finds that service utilization data are important descriptors for evaluating the impact of a collaborative service system. The task force recommends that, to the extent existing data reporting systems permit, state agencies collect and report data to track the following for children served by collaboratives:

   General
   - Number of children served per unit of population
   - Portion of target population served by the collaborative
   - Child demographic information

   Mental Health
   - Hours of Out Patient Treatment
   - Hours of Day Treatment
   - Hours of Case Management
   - Hours of Home-Based Services
   - Days of Out-of-home placement (Rule 5, Hospital, Foster Care)
   - Hours of Family Community Support Services
   - Hours of Crisis Services
   - Number of children receiving multi-agency plans of care

   Juvenile Justice
   - Number and type of Diversions

   Education
   - Level of Special Education Service

8. The Task Force finds that service utilization data is scattered across a large number of service reporting mechanisms in a variety of child serving systems. The Task Force recommends the State Coordinating Council lead its representative agencies to identify these various reporting streams and devise a way of coordinating them to allow tracking of service use by clients of local collaboratives.

9. The Task Force recommends that state agencies and local collaboratives take full advantage of national and local expertise in its development of outcome measures.

Discussion

Task Force discussions about outcome measures brought members to revisit the vision behind the Children's Comprehensive Mental Health Act and Children's Mental Health Integrated Fund, and having done this, reconcile this vision with issues of outcome measurement and the cost and complexities of data reporting systems.

From the beginning, the Task Force resolved that an outcomes focus drive the implementation and ongoing function of local collaboratives in the Children's Mental Health Integrated Fund. Stating outcomes and choosing the way in which these outcomes are measured can have a profound affect on the progress and eventual performance of the Children's Mental Health Integrated Fund. Appendix B contains supplemental material on outcomes measurement that the Task Force found useful.

Improved child functioning is at the heart of why we provide mental health services for children and their families. The hope is that through these partnerships children and their families will be supported in leading as normal, productive and satisfying lives as possible. Stated this way, it is clear that these are long term outcomes - it's hoped that the services make lasting improvements in the way the child lives, works and relates to others, both now and throughout their adult lives. A true, empirical evaluation of these outcomes would require a longitudinal study using proven research techniques. The Task Force recognizes that it may be expensive and difficult to implement such a long term evaluation, but feels compelled to recommend it be done.

The Task Force recommends that measures of child functioning be the primary outcome indicators for children served by local collaboratives. The Task Force also recommends that the Department of Human Services and the local collaboratives be charged with the task of identifying, or if need be contracting for the development of, a child functional assessment tool. The instrument must be capable of measuring functioning across a broad cross section of children and be suitable for use in wide range of child serving systems.

In addition to this functional assessment tool, the Task Force recommends the following information be used as partial indicators of child functioning:

- School attendance;
- Number of school disciplinary referrals;
- Academic performance;
- Number of arrests;
- Number and type of court adjudications/dispositions;
- Number of referrals to CHIPS, and;
- Recidivism (eg.- new offense rates).

Family involvement in the planning and delivery of services is an important value in children's mental health services. The Task Force determined that it would be difficult to define or measure family involvement at the state level in a way that validly reflects the degree of family involvement. For example, an obvious approach to measuring this outcome would be to monitor the number of multi-agency

plans of care which parents had signed to indicate their input or approval. However, a signature says little about the actual level of involvement and, from the parent's perspective, this could create a coercive situation where parents feel they must fall in line or risk irritating the very people who'll work with their children. Rather than instituting a state level measure of family involvement, the Task Force recommends that family involvement should remain a standard feature of the treatment planning process as required in law and that each collaborative have a parents group to advise them at the executive level on how to achieve family involvement.

Parent satisfaction is also an important outcome for all services to children and families. The Task Force felt that outcome measures affecting parents should have parental input in their design and implementation. Therefore, the Task Force recommends that local collaboratives use parent task forces and/or parent focus groups to help develop local outcome measures of parent satisfaction. Based on the work of these focus groups, the Departments of Human Services and Education should convene a parent work group with the support of providers and experts in outcomes measurement to determine whether statewide measures of parent satisfaction and parent involvement are desirable.

The task force feels it is particularly important for collaboratives to involve local communities of color when soliciting input on measures of family involvement and parental satisfaction.

One item that came up repeatedly in conjunction with Task Force discussions on parental satisfaction was the statewide need for parent support services for parents of children with emotional disturbances. Parent support services follow a self help model and afford parents a resource for:

- information sharing;
- emotional support;
- problem solving;
- coping strategies, and;
- self-advocacy strategies.

The Task Force recommends that the state and local collaboratives respond to this identified need by funding and ensuring the provision of parent support services.

While not child outcomes in the strictest sense, measures of service utilization are important for evaluating the impact of collaborative service planning. The "depth" or intensity of services used by a given client in each of the child serving systems can provide a useful profile of descriptive information. Service utilization data allows us to answer questions such as:

- Are children served by local collaboratives more likely to access day treatment services than residential services;
- Are they more or less likely to require crisis services;
- Do children served through collaboratives spend more time in mainstream class room activity, and;
- Do local collaboratives make more efficient use of service resources for children they see?

Suggested service utilization data to be tracked in each system include:

General
- Number of children served per unit of population
- Portion of target population served by the collaborative
- Child demographic information

Mental Health
- Hours of Out Patient Treatment
- Hours of Day Treatment
- Hours of Case Management
- Hours of Home-Based Services
- Days of Out-of-home placement (Rule 5, Hospital, Foster Care)
- Hours of Family Community Support Services
- Hours of Crisis Services
- Number of children receiving multi-agency plans of care

Juvenile Justice
- Number and type of Diversions

Education
- Level of Special Education Service

Service utilization reporting mechanisms are already in place across the various child serving systems. It seems redundant to overlay another reporting infrastructure to serve the information needs of the Children's Mental Health Integrated Fund. To investigate and adapt the broad range of existing reporting infrastructures will take a diligent interagency effort of both state and local level agencies involved in the Children's Mental Health Integrated Fund. The Task Force recommends that the State Coordinating Council lead its representative agencies as it undertakes its charge to "develop methods to reduce duplication and promote coordination of services including uniform forms for reporting, billing and planning of services." (MS § 245.494, Subd. 1)

Finally, the Task Force recommends that state agencies and local collaboratives invite local and national applied research experts to assist in their development of outcomes measures. A carefully designed system can teach us which services models are working for children and their families.

VI. Data Practices

The legislature directed the Task Force to consider the information needs of local children's mental health collaboratives and, if necessary, to recommend changes in the Data Practices Act.

Recommendations

1. The Task Force finds that the Data Practices Act does not require changes to accommodate the functioning of local children's mental health collaboratives.

2. The Task Force recommends Minnesota's Comprehensive Mental Health Act be amended to provide those members of the local system of care subject to the Data Practices Act the explicit authority to collect and disseminate information necessary for the planning, coordination and delivery of mental health services.

3. The Task Force recommends the legislature appropriate funds to support an increase in the training and technical assistance available regarding data practices. Training and technical assistance regarding proper data practices are needed beyond the administration's current ability to provide it.

4. The juvenile court system operates outside the Data Practices Act and the Task Force recommends that the Minnesota Supreme Court Juvenile Court Rules Committee examine its data practice regulations with an eye toward facilitating juvenile court's partnership in local collaboratives.

Discussion

Implementation of the Children's Mental Health Integrated Fund requires no change in the Data Practices Act. The Data Practices Act as it relates to mental health data exists to protect the privacy rights of individuals and families. It requires that state and local governments and other members of the "welfare system" inform consumers of their services about the kinds of data to be collected and how this information will disseminated and used. The client then has an informed basis on which to decide whether or not they will supply the requested information. No deviation from this original plan for the collection, dissemination and use of private

information is permitted without first obtaining the client's informed consent.

Many of the potential participating agencies within a collaborative are not subject to the Data Practices Act. The data practices of chemical dependency service providers and education are subject to federal law. Private health service providers and the juvenile court system are also subject to their own unique laws and regulations. For the most part, these agencies can only share information outside their respective systems with the client's informed consent.

Since local collaboratives will contain a mix of agencies, some governed by the Data Practices Act, and other by other laws and regulations, the collaboratives must operate on a data practices standard that is common to all - the use of informed consent.

It would be untenable to consider creating a service delivery system that weakened or did not respect the privacy rights of those it serves. The use of informed consent does not impose a barrier to the collection and dissemination of data for the purposes of planning, coordination and delivering mental health services. In fact, most agencies likely to be involved in a collaborative already have experience in using informed consent. What will be new for the local collaboratives is to develop enough of an understanding regarding their use of data within the collaborative so that they can effectively and accurately inform the clients they will serve.

Much of the original perception that the Data Practices Act might present barriers to the formation and function of local collaboratives stems from the fact that the Data Practices Act itself is widely misunderstood. In any given community, implementation of data practices is largely governed by local interpretation of the Data Practices Act and other relevant laws and regulations. Misunderstanding and varied local interpretation make it exceedingly difficult for collaboratives to agree on data practice standards and procedures. The need for a unified and accurate interpretation of data practices requirements leads the Task Force to make several recommendations.

First, the Comprehensive Mental Health Act should be amended to provide explicit authority for organizations involved in the delivery of mental health services to collect and disseminate information necessary to the planning, coordination and delivery of mental health and supportive services. At present, this authority is implicit in the directive that these organizations provide services. An explicit statement of this authority would be less subject to varied local interpretation than we currently observe and would facilitate agreement between local service organizations on the kinds of data which may be collected, the situations where information can and should be shared, and the procedures necessary to assure client's privacy rights.

While an explicit statement of authority to collect and disseminate information necessary to the planning, coordination and delivery of mental health and supportive services will facilitate local collaboratives in the development of sound data practices, more is needed. The state departments involved with services to children should provide training and

technical assistance on data practices for collaboratives. This training and technical assistance should be available to the service agencies which are forming collaboratives, the members of the legal community which advise these organizations, and interested families.

The Task Force recommends that the legislature appropriate funds to support this data practices training and technical assistance. The Minnesota Department of Administration currently has staff with state-wide responsibility for technical assistance regarding compliance with the Data Practices Act. While impressively competent, this staff is not sufficient in size or scope of expertise to take on the additional demands for technical assistance created by the complex information sharing environment created by an increasingly integrated and interdependent children's service system. Given the ambitious implementation schedule planned for the local children's mental health collaboratives, and the limited technical assistance resources available to support it, the Task Force recommends that the legislature appropriate funds to support additional data practices training and technical assistance for communities forming local collaboratives.

The Task Force also recognizes that the juvenile court system may require special attention to sort out data practice issues and recommend procedures. Juvenile court services are excluded from the Data Practices Act and subject to their own laws and rules in this regard. In general, it is felt that justices operating within the juvenile court system will welcome the increased range of rehabilitative options a children's mental health collaborative will afford adjudicated and pre-adjudicated children and youths. The challenge appears to be in effective communications and data practice issues are central to building this communication. Fortunately, the rules and operating procedures for the state juvenile courts are about to be reviewed and updated for the first time in several years. As previously stated, the Task Force recommends that the Minnesota Supreme Court permit input from appropriate groups knowledgeable about the service needs of children with emotional disturbance and their families in this review process.

Finally, with regard to data practices, the Task Force wishes to draw attention to the potential risk a re-release of information originally used for service planning presents to children served by collaboratives. In their natural and proper functioning, collaboratives planning to meet the service needs of a child and his or her family will pool large amounts of information regarding that child and family. Some of the information may be stigmatizing if released inappropriately. In establishing data practices, the collaboratives need to ensure that the privacy rights of families are protected over time as well as during the time of direct service. Procedures that might help limit the re-release of private information include the adoption of time limits on the dissemination of data and a strict observation that the data not be disseminated for purposes other than which it was originally collected.

VII. Appendices

Appendix A - Proposed Legislation to Provide Explicit Authority to Collect and Disseminate Mental Health Data

The Task Force recommends the Comprehensive Mental Health Act be amended to add the following language to providing service providers the explicit authority to collect, store and disseminate mental health data.

COLLECTION AND DISSEMINATION OF MENTAL HEALTH DATA

Agencies and individuals engaged in the planning, coordination and delivery of services within M.S. § 245.461 to 245.496 are hereby authorized to collect, store and disseminate client data necessary for the planning, coordination and delivery of such services. For purposes of M.S. § 13.05, Subd. 3, this is an authorization to collect and disseminate data so long as the requirements of M.S. § 13.04, subd. 2 and 13.46, subd. 7 are met; and if the requirements of 42 CFR 431.300 to 431.307 are also met for client data relating to clients receiving services funded through the Medical Assistance Program.

Appendix B - Supplemental Materials on Outcome Measurement

The Task Force found the attached materials to be useful examples of approaches to outcome measurement for children's mental health services.

OUTCOME INDICATORS FOR COMMUNITY-BASED SYSTEMS OF CARE

Out-of-Home and Out-of-Community Placements

- Reduction of out-of-home placements
- Reduction of out-of-county placements
- Reduction of out-of-state placements

Utilization of Restrictive Service Options

- Reduction in utilization of inpatient services
- Reduction of length of stay in inpatient settings
- Reduction in utilization of residential treatment centers
- Reduction in length of stay in residential treatment centers

Functional Improvements

- Improved functioning on specific behavior or dimensions

Educational Status

- Improved school attendance
- Improved school performance

Law Enforcement Status

- Reduction in violations of the law
- Reduction in contacts with law enforcement
- Reduction in recidivism or incarceration for juvenile offenders

Family Involvement

- Increased family support
- Increased parent support

Satisfaction with Services

- Increased parent satisfaction with services

Cost Comparisons

- Comparisons of the costs of "traditional" or restrictive services with costs of community-based services for youngsters served
- Increased numbers of children served for similar costs
- Costs avoided or saved by implementing a more comprehensive community-based service array

Other

Source: CASSP Technical Assistance Center, Georgetown University - (202)338-1831

Name of Student:

(Tear Off and Destroy)

CSYF DEMONSTRATION PROJECT -- SCHOOL DATA

Date of Birth: __ __ / __ __ / __ __
M M D D Y Y

SSN: __ __ __ - __ __ - __ __ __ __

Youth ID #: _____ Project ID: _____

Name of Present School: _____

Name of School District: _____

Person Completing this Form: _____
(Name) (Phone)

SCHOOL YEAR 1992-1993

Number of School Days Absent (excluding suspensions): _____

Number of Days Suspended (in school): _____

Number of Days Suspended (out of school): _____

Expelled? _____Yes _____No

Dropped Out? _____Yes _____No

SCHOOL YEAR 1991-1992

Number of School Days Absent (excluding suspensions): _____

Number of Days Suspended (in school): _____

Number of Days Suspended (out of school): _____

Expelled? _____Yes _____No

Dropped Out? _____Yes _____No

SCHOOL YEAR 1990-1991

Number of School Days Absent (excluding suspensions): _____

Number of Days Suspended (in school): _____

Number of Days Suspended (out of school): _____

Expelled? _____Yes _____No

Dropped Out? _____Yes _____No

Name of Client: ______________________________

CSU ID: ______________________________

- -

(Tear Off and Destroy)

CSYF DEMONSTRATION PROJECT -- COURT SERVICE DATA

Date of Birth: __ __ / __ __ / __ __
M M D D Y Y

SSN: __ __ __ - __ __ - __ __ __ __

Youth ID #: ____________________ Project ID: ________

Name of Court Service Unit: ______________________________

Person Completing this Form: ______________________________
(Name) (Phone)

Please provide the following information, beginning January 1, 1990, through the present.

DATE OF INTAKE	NUMBER OF OFFENSES THIS INTAKE	NUMBER OF OFFENSES PETITIONED TO COURT	CHECK FOR MOST SERIOUS OFFENSE ONLY*
__ __/__ __/__ __ M M D D Y Y			___Felony ___Misdemeanor Status Offense
__ __/__ __/__ __ M M D D Y Y			___Felony ___Misdemeanor Status Offense
__ __/__ __/__ __ M M D D Y Y			___Felony ___Misdemeanor Status Offense
__ __/__ __/__ __ M M D D Y Y			___Felony ___Misdemeanor Status Offense
__ __/__ __/__ __ M M D D Y Y			___Felony ___Misdemeanor Status Offense
__ __/__ __/__ __ M M D D Y Y			___Felony ___Misdemeanor Status Offense

*Refers to "Offenses Petitioned to Court" (column 3), if any. If none, refers to all "Offenses this Intake" (column 2).

SITE CLIENT ID

4

Family Satisfaction Questionnaire
May 1993

Lynchburg

1. What is your relationship with the child (client)?
   - ☐ Natural mother
   - ☐ Natural father
   - ☐ Stepmother
   - ☐ Stepfather
   - ☐ Foster mother
   - ☐ Foster father
   - ☐ Other _____

2. How would you rate the quality of the services your family has received?
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

3. Has your family received the kinds of services that you wanted?
   ☐ No, definitely not ☐ No, not really ☐ Yes, generally ☐ Yes, definitely

4. To what extent have the services which you have received met your family's needs?
   - ☐ Almost all of our needs have been met
   - ☐ Most of our needs have been met
   - ☐ Only a few of our needs have been met
   - ☐ None of our needs have been met

5. If a friend were in need of similar help, would you recommend these services to him or her?
   ☐ No, definitely not ☐ No, I don't think so ☐ Yes, I think so ☐ Yes, definitely

6. How satisfied are you with the amount of help your family has received?
   - ☐ Quite dissatisfied
   - ☐ Indifferent or mildly satisfied
   - ☐ Mostly satisfied
   - ☐ Very satisfied

7. Have the services your family received helped you and your family to deal more effectively with your problems?
   - ☐ Yes, they have helped a great deal
   - ☐ Yes, they have helped somewhat
   - ☐ No, they really haven't helped
   - ☐ No, they seem to have made things worse

8. In an overall, general sense, how satisfied are you with the services your family has received?
   - ☐ Very satisfied
   - ☐ Mostly satisfied
   - ☐ Indifferent/Mildly satisfied
   - ☐ Quite dissatisfied

9. If your family were to seek help again, would you come back to the same program or services?
   ☐ No, definitely not ☐ No, I don't think so ☐ Yes, I think so ☐ Yes, definitely

10. Overall, how satisfied are you with your child's progress since services began?
    - ☐ Quite dissatisfied
    - ☐ Indifferent or mildly satisfied
    - ☐ Mostly satisfied
    - ☐ Very satisfied

11. Are there any services your family needs that you feel you have been unable to get? ☐ Yes ☐ No
    If yes, what other services are needed?

    _____

    _____

12. Have you had any problems getting the services your family needs? ☐ Yes ☐ No
    If yes, what problems have you had?

    _____

    _____

13. Of the services your family has received, which ones have been the most helpful?

    _____

    _____

Comprehensive, Community-Based Children's Mental Health Services Have Proven Extremely Effective

- California funded a demonstration project in Ventura County which provided comprehensive community-based mental health services for children similar to those envisioned in Minnesota's Children Mental Health Act. The results were so favorable that the approach is being expanded across the state. Some outcomes are highlighted on the back.

- By providing community-based mental health services, the Alaska Youth Initiative reduced the costs of services to severely emotionally disturbed children by 24% in its second year and by 36% in its third year.

Children Benefit Significantly From Day Treatment Programs

- 78% of children discharged from preschool day treatment programs in Hennepin County were in mainstream kindergarten or preschool at 6 month follow-up.

- 90% of those discharged from elementary day treatment programs were in a less restrictive setting at 6 month follow-up.

Home Based Family Treatment Has Enabled Children In Washington And Kandiyohi Counties To Avoid Residential Placement

- Intensive in-home services for children with severe emotional disturbances in Kandiyohi County enabled all but two children to be maintained in their home environment at a net savings to the county of $182,860.

- Over a four year period, 70-90% of children in Washington County who completed Human Services, Inc's home-based treatment program for children at high risk of placement were able to remain at home.

Family & Children's Service
OF THE MINNEAPOLIS METRO AREA

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Public Policy Director
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A Comprehensive Interagency System of Care for Seriously Emotionally Disturbed Children and Youth

SAN MATEO COUNTY, CALIFORNIA

As a result of implementation of a comprehensive, interagency system of mental health care for severely disturbed youth, **San Mateo County, California saved over $5 million, approximately $4 for every dollar spent on the program.** From July of 1989 through June of 1991:

- The numbers of youth placed and the cost for group home placements declined despite an increasing placement trend statewide.
- Due to reduced admissions and shorter lengths of stay, the number of group home placements decreased 16% over the previous 12 month period.
- State hospital utilization for children and youth decreased 69%, from 4,208 to 1,292 days between FY 1983/84 and FY 1991/92.

Fiscal and outcome data confirm the San Mateo Interagency Model has successfully provided the highest benefits for the lowest costs.

- The number of youth served increased 27.5% between FY 1986/87 and 1990/91 while the cost per child in constant dollars decreased 15.5% over the same period.

Recidivism declined among court wards:

- Youth in collaborative programs demonstrated 62% fewer arrests in the year following admission than in the year prior to admission.
- Probation placements decreased 28% from 1989/90 to 1990/91.

Educational performance improved.

Attendance exceeded the project objective of 75% for FY 1990/91.

- Attendance ranged from 80% to 93% of enrolled days, depending on the school. *Prior to attending these programs, most of the children had attendance patterns of 25% to 50% of enrolled days.*

Grade level equivalencies increased

- The gain in grade level equivalency is .82 of a grade level in reading comprehension and .6 of a grade level in math. *Most youth in these programs have serious academic deficiencies and are behind in school. Even slight increases in grade level equivalencies are significant.*

Ref: San Mateo County Mental Health Services Division, Second Annual Report, 1990-91

SURVEY OF YOUTH'S SATISFACTION WITH CASE MANAGEMENT SERVICE

Client: _____ Case Manager: _____

Date Completed: _____

By completing this survey you will help us determine if case management is working. After you complete the survey please mail it in the envelope which was given to you.

Please indicate the extent to which you agree or disagree with each of the following statements. Circle one number of each statement.

1. While receiving case management services I have learned useful information about my emotional problem.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

2. While receiving case management services I have learned some ways to keep my emotional problems from causing me big problems.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

3. I feel that my case manager really wants to help me.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

4. My case manager has helped me learn the skills I will need to as an adult to live on my own.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

5. Additional comments:

Ronnau, J., Rutter, J. and Donner, R. (July, 1988) Resource Training Manual for Family Advocacy Case Management with Adolescents with Emotional Disabilities. John Portner, Project Director. University of Kansas, School of Social Welfare).

YOUTH QUALITY OF LIFE ASSESSMENT SCALE

Please indicate how well you are doing for each of the following:

	Circle your answer					
	Very Well					Not Very Well
Your education at school	1	2	3	4	5	6
Having adequate transportation	1	2	3	4	5	6
Having adequate food and nutrition	1	2	3	4	5	6
Having adequate clothing	1	2	3	4	5	6
Managing the money you have	1	2	3	4	5	6
Having enough money to meet your needs	1	2	3	4	5	6
Getting adequate medical care	1	2	3	4	5	6
Getting adequate dental care	1	2	3	4	5	6
Feeling safe and secure	1	2	3	4	5	6
Feeling loved	1	2	3	4	5	6
Feeling good and secure about the future	1	2	3	4	5	6
Finding and keeping a job	1	2	3	4	5	6
Having strong, close relationships	1	2	3	4	5	6
Getting comfort and reassurance	1	2	3	4	5	6
Being able to express loving feelings	1	2	3	4	5	6
Getting along with family members	1	2	3	4	5	6
Needing other people	1	2	3	4	5	6
Having close friends	1	2	3	4	5	6
Attending social events	1	2	3	4	5	6
Having fun and recreation	1	2	3	4	5	6
Getting enough rest and relaxation	1	2	3	4	5	6
Enjoying a hobby	1	2	3	4	5	6
Feeling good about yourself	1	2	3	4	5	6
Recognizing your own strengths	1	2	3	4	5	6
Feeling good about home and family	1	2	3	4	5	6
Feeling needed and worthwhile	1	2	3	4	5	6

Ronnau, J., Rutter, J. and Donner, R. (July, 1988) Resource Training Manual for Family Advocacy Case Management with Adolescents with Emotional Disabilities. John Portner, Project Director. University of Kansas, School of Social Welfare).