



Children's Services



The Role of Collaboratives in the Children's Mental Health System



Report to the
2003 Minnesota
Legislature



January 2003



Minnesota Department of **Human Services**

The Role of Collaboratives in the Children's Mental Health System

Report to the Minnesota Legislature

Minnesota Department of Human Services
Children's Mental Health Division
January 15, 2003

For the Role of Collaboratives in the Children's Mental Health System Report for 2003

This report was prepared by the Minnesota Department of Human Services, Children's Mental Health Division and produced for the Legislature in response to a legislative directive in Minnesota Laws 2001, First Special Session, Chapter. 9, Article 9, Sec. 50. Copies of this report are available on the Children's Services Web site at www.dhs.mn.us/childint/publications/default.htm.

Total estimate cost:: \$36,498

This information is available in other forms to people with disabilities by contacting us as (651) 282-5329 or through the Minnesota Relay Service at 1-800-627-3529 (TDD), 771 or 1-877-627-3848 (speech-to-speech).

Table of Contents

Executive Summary	Page 4
Introduction	Page 6
The Role of Collaboratives in the Children’s Mental Health System	Page 8
Systems Results of Collaborative Interventions in Children’s Mental Health: Adding Capacity	Page 13
Results of Collaborative Interventions for Children Receiving Services Through Children’s Mental Health Collaboratives	Page 27
Conclusions and Recommendations	Page 32
Appendix A: Study Design	Page 35
Appendix B: Collaborative Study Work Group	Page 40
Appendix C: Background on the Children’s Mental Health System and the System of Care Approach	Page 42
Appendix D: Collaboratives Report on their Role in the Children’s Mental Health System	Page 47
List of Tables and Figures	Page 49
Endnotes	Page 50

Executive Summary

Children's mental health collaboratives were created to reduce fragmentation in the children's mental health system and enhance funding flexibility for agencies serving children with severe emotional disturbances. The findings of this report are that the three major contributions by collaboratives to the children's mental health system have been:

- Increased funding flexibility
- Increased family and community involvement
- Increased cross agency planning and service delivery, in particular between the county and schools.

Collaboratives have not had a major impact on the primary areas of need in the children's mental health system, such as funding or sufficient children's mental health providers. Children's mental health collaboratives are primarily involved in the development of community-based interventions and have played a role in increasing flexible funding for these interventions. Overall, human services funding for children's mental health services in the last decade has increased funding for community-based interventions. This has gone from 14 percent of the total human services funding for children's mental health in 1991 to 43 percent a decade later. Collaboratives have set up integrated funds where local, federal and state resources are pooled. These integrated funds are a non-categorical, flexible pool of funding for children's services, including mental health. So although collaboratives have had but a minor impact in overall funding for children's mental health services, they have increased the flexibility of the existing funding.

There was an expectation that the integrated funding strategy would be a means to broader system reform, but this has not occurred to the degree expected. Collaborative partners have not shifted major funding for children's mental health into the integrated fund. Local cash contributions to the integrated fund on average make up 7 percent of the total integrated fund. Through participation in the Local Collaborative Time Study (LCTS) collaboratives earn the greatest source of income directed to their collaborative integrated fund. The LCTS is a method for claiming federal medical assistance and Title IV-E dollars which provides assistance to support collaborative services directed at early intervention and prevention of out-of-home placement. Federal funding drawn down by this method make up over 50 percent of collaboratives' total integrated funding.

Federal reimbursement directed towards children's mental health services have been comparatively small. The percentage of earnings that collaboratives spend on children's mental health services is between 6 and 11 percent of the total Local Collaborative Time Study spending. The LCTS expenditures are primarily directed at prevention and the programs funded by this source are primarily provided through schools.

On the family and community involvement level, all collaboratives have expanded their boards beyond mandated partners to include parents and representatives from community organizations: health maintenance organizations, tribes, the business community and providers, among others. Parent and family participation in the governance and work of collaboratives is a significant and positive result of the collaboration model. Thirty-five collaboratives involve parents of children with a severe emotional disturbance as voting members of the collaborative governing boards. However,

important barriers to parent participation continue to exist, especially for parents from communities of color.

Collaboratives have enhanced the relationships between county agencies and the schools. This is especially important because these two public entities are the ones most involved in the lives of children with emotional disturbances and their families. Fifty-three county social services directors and 24 county commissioners represent the counties on collaborative boards. Schools, in turn, are represented by 51 superintendents and 23 school board members. High level decision makers from the mandated partners on the collaborative boards increases the likelihood that system-wide planning for children's mental health takes place. There are collaboratives, primarily in the metro area, that have program level staff representing the mandated public agency partners on the collaborative board.

Collaboratives have brought new programs and service delivery methods to communities across Minnesota. The wraparound process, which is the delivery of coordinated interdisciplinary services provided with the input of the child and family and tailored to the strengths and needs of the individual child and family, is used by collaboratives throughout Minnesota. Seventy-two percent of the children that received intensive services reported receiving wraparound. The number of wraparound coordinators and the use of common forms have both increased, indicating greater system coordination and commitment to collaborative work.

Overall, children's mental health collaboratives provided 7,000 children with individualized services in 2001. Of these, 4,500 children with a severe emotional disturbance received intensive services from a children's mental health collaborative. At six months after intake, 34 percent of children improved according to functional assessment scale scores.

The Minnesota Department of Human Services asked children's mental health collaboratives to survey satisfaction with collaborative services. In calendar year 2001, 890 parents responded and ninety percent indicated that they strongly agreed or agreed with the statement: "The services helped our child." Eighty-six percent indicated that they strongly agreed or agreed with the statement: "Our family's value and culture were respectfully included in our child's care plan." In calendar year 2001, 891 children responded. Eighty-one percent indicated that they strongly agreed or agreed with the statement: "The services helped me."

In light of the initial results of collaborative interventions, the recommendations from this report are that the state continue to support work with collaborative governance bodies to:

- facilitate system-wide, results-based planning
- involve key decision makers from the collaborative partners
- develop solid financial relationships that would enhance shifting of local resources to the collaborative integrated fund
- increase parent and family participation.

Additionally, the report recommends increasing the percentage of federal reimbursement allocated to children's mental health services, particularly for the implementation of evidence-based practices and demonstration of clinical and functional outcomes.

Introduction

The 2001 Legislature required the Commissioner of the Minnesota Department of Human Services to study the role of the children's mental health and family services collaboratives in the children's mental health system and report the findings to the 2003 legislature. The legislation provides:

Minnesota Laws 2001, First Special Session, Chapter. 9, Article 9, Sec. 50. [STUDY OF CHILDREN'S MENTAL HEALTH COLLABORATIVES.] *The commissioner of human services shall conduct a study of the role of the children's mental health and family services collaboratives in the children's mental health system. This study must be conducted in consultation with the commissioners of health, corrections, and children, families, and learning, providers of mental health services in schools, other providers of mental health services, parents of children receiving mental health services, local children's mental health collaboratives, counties, and other interested persons. The study must include an assessment and evaluation of the collaboratives. The commissioner shall report findings and recommendations to the legislature by January 15, 2003.*

The purpose of this report is to discuss the results of the study.

During the fall of 2001 and all of 2002, the Minnesota Department of Human Services designed and implemented the study to comply with the Legislation. Since the Department has oversight of the children's mental health collaboratives, which are key players in the children's mental health system, collaboratives are the primary focus of the evaluation. The Minnesota Department of Children, Families and Learning has oversight over the family services collaboratives. Family services collaboratives were examined with respect to the children's mental health services they deliver and with respect to their relationship to the children's mental health service system.

The following major activities took place to address the main areas of the study:

- formation and work of a Collaborative Study Work Group, composed of the entities mandated to provide the Department with consultation
- research by two teams from the University of Minnesota's Hubert H. Humphrey Institute of Public Affairs
- gathering of systems data through the Annual Collaborative Report
- gathering of individual data on children and families receiving mental health services from children's mental health collaboratives.

A description of each of these data streams is presented in Appendix A. The composition of the Collaborative Study Work Group is presented in Appendix B.

Mental health program consultants and evaluators from the Children's Mental Health Division were involved in the design of the report, the facilitation of the Collaborative Study Work Group meetings and writing the report. A consultant from the Hubert H. Humphrey Institute of Public Affairs, University of Minnesota, was hired for the development of the report. The research teams from the Humphrey Institute involved no cost to the Department.

The report addresses three main areas:

1. The role of collaboratives in the children's mental health system
2. The results of collaborative interventions to the children's mental health delivery system

3. The results of collaborative interventions for children and families served by the collaborative.

The Role of Collaboratives in the Children's Mental Health System

The original Children's Mental Health Integrated Fund Task Force saw children's mental health collaboratives as a response to the fragmentation in the system. "Our child-serving systems tear children into pieces, then treat the pieces," states the 1993 report to the legislature by the Integrated Fund Task Force.

"Before the Minnesota children who are suffering from emotional and behavioral disorders can receive the help they need, each child's community must secure three basic items: (1) Services to treat the children; (2) Systems to deliver those services; and (3) Funding sufficient to meet the needs identified."¹

The task force considered that the legislature had addressed services with the passage in 1989 of the Comprehensive Children's Mental Health Act.

For systems and funding, the task force recommended the creation of collaboratives:

"The implementation of the Integrated Children's Mental Health System, as proposed in this [Integrated Fund Task Force] report, proposes to create a flexible and coordinated system through which to deliver those services to children.

The integrated funding strategy proposed here can significantly enhance the efficiency of existing dollars and leverage significant new dollars through federal reimbursement. Whether sufficient funding will be generated by the Integrated Fund to bring these better services and better service delivery systems to every Minnesota child who needs them is yet unknown. However, reform— even when it generates resources— requires investment to begin."²

The focus of the collaborative legislation, therefore, was on system coordination and, ultimately, integration. Secondly it was on the creation of integrated funds that would provide flexible, non-categorical funding for services to children with severe emotional disturbances.

The Integrated Fund Task Force also identified the barriers to effective service delivery that children's mental health collaboratives were expected to address. These barriers included:

- **Child-serving systems approach children's needs in fragments.** Children's needs cross over the boundaries of distinct systems: one system serves psychiatric disorders, another addresses delinquent behavior, a third responds to failure in school while a fourth treats medical maladies. All ignore that a delinquent child usually has an emotional disorder, frequently is failing in school, and often suffers from some type of developmental or health disorder.
- **Schools are reluctant to identify emotional disorders** because federal law very often requires them to pay for treatment.
- **Seriously disturbed children use most of the resources,** leaving little or nothing for prevention and early intervention.

- **Child-serving systems tend not to identify disorders early.** As severity increases, treatment costs increase and eventual health is less assured.
- **Funding levels are inadequate to establish necessary community-based services without shifting resources away from residential treatment.** Yet a wholesale reallocation of resources would amount to abandoning many of the most severely disturbed children.
- **Funding structures consist in large part of categorical grants subject to eligibility criteria that make it difficult to match clients with dollars to pay for the type of services they need.** Created to overcome a funding shortage, categorical grants address some service needs, but tend to decrease the overall financial flexibility.
- **Cost shifting.** As a result of system fragmentation, private payers shift costs to public agencies, which shift costs to other public agencies.”³

The Children’s Mental Health Integrated Fund legislation (Minnesota Statutes 245.491 to 245.496) was passed in 1993 to offer communities a model of system integration and flexible funding to address the barriers presented above. The Integrated Fund legislation designed a system of interagency collaboration called “Children’s Mental Health Collaboratives.” Collaboratives would integrate and make funding flexible; involve the major child-serving agencies, primarily schools and counties; include a focus on early intervention and prevention; enhance community-based intervention and leverage additional funds for children’s mental health. In other words, the role envisioned for collaboratives by legislation was that of cross system coordination and integrated funding.

In 2001, children’s mental collaboratives provided intensive or long-term services to over 4,000 children with a severe emotional disturbance involved in more than one service system; 52 percent of these children received services through a new service delivery process, also multi-agency in nature: the “wraparound process.”⁴ Of a sample studied, over 38 percent of the children receiving collaborative services improved their functionality. Children’s mental health collaboratives reported providing short-term services and prevention interventions to over 11,000⁵ children in 2001 and this was done through county social services, but also in schools, at home and with the involvement of the family. Overall, the research carried out for this report by two teams from the University of Minnesota (see Appendix A) concluded that children’s mental health collaboratives have contributed “new programs, new methods of service delivery, information sharing and relationship building, funding and facilitating parent participation.”⁶

The Minnesota Models

Minnesota’s collaboratives are an ambitious effort. Major public child-serving agencies, like counties, schools and corrections entities, must modify their structure, finances, service delivery and evaluation systems to work together. These modifications imply not only changes in systems but changes in organizational cultures and philosophies.

Collaboratives in Minnesota are a local decision, not a mandate. Design and implementation of the collaboratives rests with the local child-serving agencies and the communities. Collaboratives vary from community to community.

There is more than one collaborative model in Minnesota with the potential of addressing children’s mental health needs. For this study, the two types of collaboratives in Minnesota are the family services collaboratives and the children’s mental health collaboratives. As the following tables show, some have integrated, and at least one of these types of collaboratives exists in 81 of Minnesota’s 87 counties.

*Table I
Overview of Collaboratives in Minnesota*

Total number of collaboratives	93
Family services collaboratives	50
Children’s mental health collaboratives	13
Integrated family services and children’s mental health collaboratives	30

Table I shows collaboratives by type: family services, children’s mental health and integrated family services and children’s mental health. The main statutory differences between the two types of collaboratives can be seen in Table II, below. The integrated collaborative has one collaborative board, a single governance agreement and fulfills the statutory mandates of both types of collaboratives.

*Table II
Children’s Mental Health vs. Family Services Collaboratives*

	Children’s Mental Health Collaborative	Family Services Collaborative
Minimum mandated partners	County, School, Mental Health Entity, Corrections Entity	County, School, Public Health Entity, Community Action Agency and/or Head Start Grantee
Target population	Children with an emotional disturbance or at risk of such a disturbance and those that can benefit from multi-agency coordination, birth to 18	All children, birth to 21.
Number of collaboratives per county	One	May be more than one.

The target populations and focus of the collaboratives vary. Family services collaboratives, which are designed to provide services to children from birth to age 21, are primarily established for prevention and early intervention and they deal heavily with school based programs aimed at prevention and at risk children. Their services can include anything from immunization to mental health interventions for severely emotionally disturbed children.

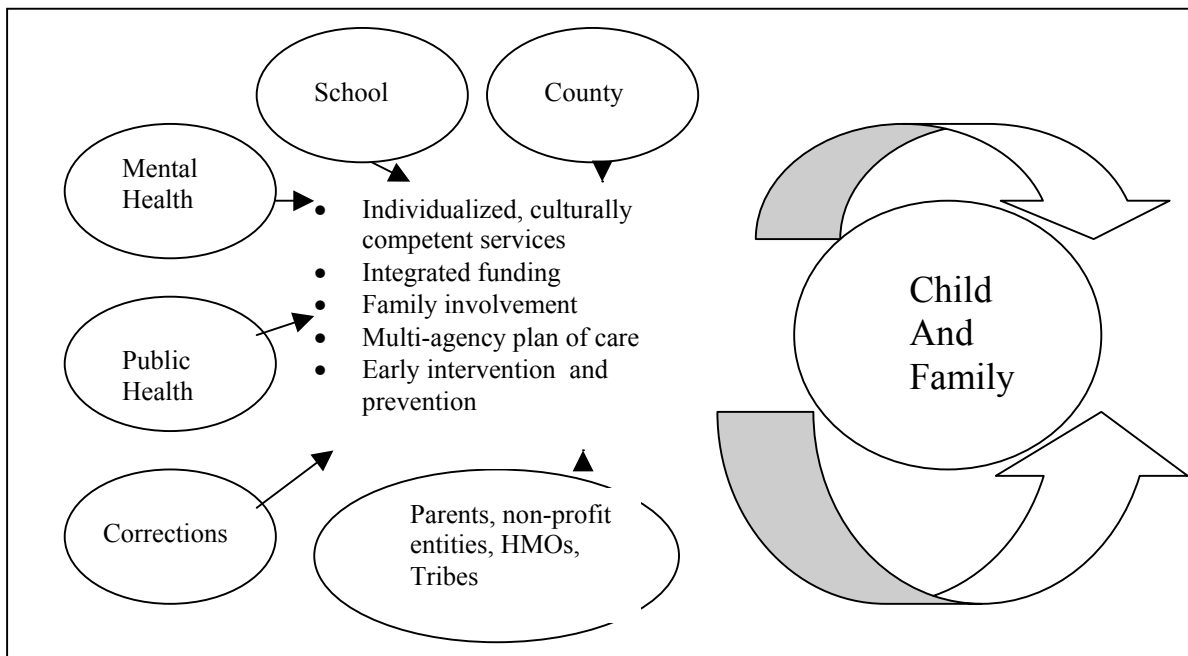
Children’s mental health collaboratives’ main focus is serving children with the most complex mental health problems who are involved in different service systems. They may also be involved in

prevention efforts. The Minnesota collaborative model develops an integrated service system with the following components:

- Collaboration across service sectors: county, school, mental health and corrections
- Improved outreach and early interventions
- Integrated funding
- Individualized services and supports
- Family centered, with significant family involvement at both the service delivery and service design levels
- A coordinated assessment process
- Use of a multi-agency plan of care.⁷

Figure 1 shows what the integrated service system model looks like.

*Figure 1
The Integrated Service System*



The Unmet Needs of the Children’s Mental Health System and Collaboratives

Children’s mental health collaboratives were designed to provide a more effective, less fragmented vehicle to meet the needs of children with severe emotional disturbances. Coordination among counties and schools, corrections and mental health centers around assessments, service plans, integrated funding, were all system changes aimed at reducing fragmentation, enhancing coordination of services and making funding more flexible. The issues of availability of services, adequacy of providers, evidence-based practices, sufficiency of funds for children’s mental health services overall remained to be addressed by the state supervised and county administered mental

health system, in coordination with the new partners the county had in children's mental health collaboratives.

An estimated 45 percent of the children with a severe emotional disturbance, or 33,646 children, is the responsibility of the public sector.⁸ The county administered mental health system overall reported serving 20,314 children with a severe emotional disturbance in 2001. This number includes those children who received services administered by children's mental health collaboratives that reported to the state.

Systems Results of Collaborative Interventions in Children's Mental Health: Adding Capacity

The system changes identified by the original Children's Mental Health Integrated Fund Task Force were:

- Reduction in system fragmentation
- Increased early identification and early interventions
- Enhanced funding for community-based services and increased flexible, non-categorical funding
- The involvement of other systems, in particular schools, in planning and interventions for children's mental health.

Also, legislation called for collaboratives to increase family involvement in the system and provide individualized, culturally competent services. (See the overall children's mental health collaborative history and the Child and Adolescent Service System Program (CASSP) principles involved in developing collaboratives in Appendix C of this report).

Collaboratives have added capacity to systems serving children with severe emotional disturbances through:

1. Increased flexible funding for the children's mental health system
2. Increased family and community involvement in the children's mental health system
3. Increased cross agency planning and service delivery, in particular between the county and schools. This has resulted in increased use of innovative service delivery models, such as wraparound and enhanced training, including cross-agency training, in new service delivery models.

These three categories of results fit closely with the results that the Integrated Fund Task Force envisioned. This section of the report looks at these results to show the progress and shortcomings within each category.

The research team from the University of Minnesota concluded:

In general, the research indicates that the collaborative picture is a bright one. The collaborative experience has resulted in new programs, new methods of service delivery, a previously unparalleled degree of information sharing and joint access to services among partner agencies and organizations. Collaborative partners report greater parent participation in systems organization and service delivery, an increased ability to deliver services seamlessly and effectively, and more flexibility in helping families' access and navigate through a complicated service network. (...) In sum, despite the challenges to effective collaboration and some differences of opinion among collaboratives, overall Minnesota's Children's Mental Health Collaboratives (CMHCs) represent a positive force in the lives of children with mental health needs and their families.⁹

More specifically, the Minnesota Department of Human Services convened experienced collaborative and county representatives, mental health providers, state agencies involved in the provision of children's services, and parents of children with a severe emotional disturbance as a consultation group for this report. (For more specifics on the group, see Appendix A). The stakeholder group convened by the Department to study the role of collaboratives in the children's mental health system identified the following as achievements made by collaboratives, based on their work experience with collaboratives. Collaboratives, they noted:¹⁰

- Add capacity to the system and integrate various service systems to increase services through efficiencies.
- Create a coordinated system ranging from prevention, early intervention, to intensive services for severely emotionally disturbed children, facilitate communication and planning between counties, schools and providers
- Reduce fragmentation
- Innovate.
- Refine the children's mental health system.
- Identify community needs and gaps in service.
- Increase awareness, not just to systems, but to the larger community by including the community, family, children, physicians, etc., within the system. Before collaboratives, children were referred to placement. Now, because of collaboratives, they receive home visiting, pre-school, mental health in the classroom, etc.
- Look at children and families, not at children in isolation
- Increase parental involvement in multi-agency planning
- Provide wraparound, individualized, family-driven, strength-based and culturally competent services
- Implement new programs

In the process of achieving these results, children's mental health collaboratives were mandated to comply with the integrated service system components defined in legislation:

- *Integrated funding*: a pool of both public and private local, state, and federal resources, consolidated at the local level, to accomplish locally agreed upon service goals for the target population.
- *Improved outreach, early identification and intervention* across systems.
- *Strong collaboration between parents and professionals* in identifying children in the target population facilitating access to the integrated system, and coordinating care and services for these children.
- *A coordinated assessment process* across systems that determines which children need multi-agency care coordination and wraparound services.
- *A multi-agency plan of care*: a written plan of intervention and integrated services developed by a multi-agency team in conjunction with the child and family based on their unique strengths and needs as determined by a multi-agency assessment.
- *Individualized rehabilitation services*: alternative, flexible, coordinated, and highly individualized services that are based on a multi-agency plan of care. These services are designed to build on the strengths and respond to the needs identified in the child's multi-agency assessment and to improve the child's ability to function in the home, school, and community.

The following table presents a summary of compliance with the integrated service system components. These components are required in statute by children’s mental health collaboratives, family services collaboratives and integrated collaboratives.

*Table III
Integrated Service System Components
Compliance by Collaborative Type*

Integrated service system component	Children’s Mental Health Collaboratives (CMHCs) Total=13	Integrated Family Services and Children’s Mental Health Collaboratives (Integrated) Total=29	Family Services Collaboratives (FSCs) Total=51
Integrated funding	All collaboratives have an integrated fund.	All collaboratives have an integrated fund.	All collaboratives have an integrated fund.
	The total integrated fund for CMHCs in CY 2001= \$14,741,155 (20% of total collaborative integrated funding)	The total integrated fund for integrated collaboratives in CY 2001=\$22,829,740 (31% of total collaborative integrated funding)	The total integrated fund for FSCs in CY 2001 = \$36,138,777 (49% of total collaborative integrated funding)
	The total LCTS* that CMHC reported in CY 2001= \$3,654,219.22 (9% of total LCTS*).	The total LCTS* that integrated collaboratives reported in CY 2001= \$13,291,014 (34% of total LCTS*).	The total LCTS* that FSCs reported in CY 2001 = \$22,687,336.78 (57% of LCTS*).
Individualized services and supports**	9 collaboratives offered IRS 10 collaboratives using wraparound (76%)	16 collaboratives offered IRS 26 collaboratives using wraparound (86%)	23 collaboratives offered IRS 21 collaboratives using wraparound (41%)
	826 wraparound service coordinators	353 wraparound service coordinators	251 wraparound service coordinators
Family centered, family involvement: strong collaboration between families and professionals, family participation	9 collaboratives with parents of children with a SED as voting members on boards (69% of CMHCs)	11 collaboratives with parents of children with a SED as voting members on boards (35% of Integrated)	16 collaboratives with parents of children with a SED as voting members on boards (31% of FSCs)
	10 collaboratives with parents involved in the system development (advocates, consultants, advisory committee members, etc.) (77% of CMHCs)	26 collaboratives with parents involved in the system development (advocates, consultants, advisory committee members, etc.) (87% of Integrated)	40 collaboratives with parents involved in the system development (advocates, consultants, advisory committee members, etc.) (78% of FSCs)
Coordinated assessment	Information not available	Information not available	Information not available
Multi-agency plans of care and/or unitary case management	13 collaboratives with a multi-agency plan of care (100%). ¹²	28 collaboratives with a multi-agency plan of care (93%). ¹⁴	39 collaboratives with a multi-agency plan of care (76 %). ¹⁶
Improved outreach, early identification and interventions	LCTS* funded interventions result in improved outreach, early identification and interventions aimed at preventing out- of- home placement.	LCTS* funded interventions result in improved outreach, early identification and interventions aimed at preventing out- of- home placement.	LCTS* funded interventions result in improved outreach, early identification and interventions aimed at preventing out- of -home placement.

* LCTS is the Local Collaborative Time Study, a federal revenue enhancement source of funding for collaboratives.

**CMH individualized rehabilitation services (IRS) or service delivery using the wraparound¹⁷ process.

Family services collaboratives are included in the table, because of similar integrated service system mandates. Their focus, however, is not children’s mental health, so it is understandable that they

would not have placed as much emphasis on certain children’s mental health integrated service system components.

Compliance with the components of the integrated service system shows a level of integration. Analyzing each of the three areas in which collaboratives have contributed towards service system integration will corroborate this.

1. Increased Flexible Funding for Children’s Mental Health

Two trends stand out in total human services funding (county, state and federal) for children’s mental health:

- An increase in state and federal funding and
- An increase in community-based interventions.

Human services funding of children’s mental health increased from about \$56 million in 1991 to almost \$154 million in 2001. In 1991, 46 percent of the total was county human services dollars. By 2001, county, state and federal shares were similar (see Figure II). Case management, community support services (including day treatment), professional home-based family treatment services, therapeutic support of foster care and housing subsidies made up 14 percent of the total human services funding for children’s mental health in 1991. By FY 2001 these categories made up 43 percent of the funding. The rise in community-based services is a response to legislation like the Children’s Mental Health Integrated Fund, which stressed interventions aimed at keeping a child with emotional disturbances at home and in the community.

Figure II
Funding for Children’s Mental Health by Source 1991/2001

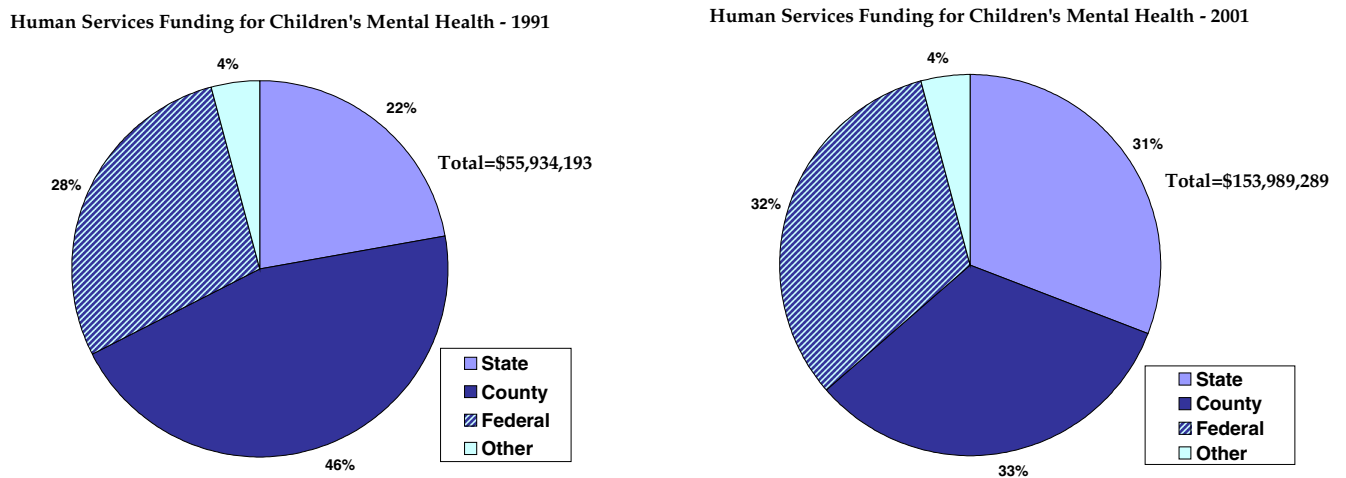


Figure II identifies the source of funding for children’s mental health, but does not identify whether the funding was categorical, nor how it was distributed (e.g., whether it was through a collaborative

or the county). One funding source that is specifically collaborative in nature is a method of claiming federal money known as the Local Collaborative Time Study (LCTS). Through participation in this method of claiming federal dollars, collaboratives agree to use dollars earned in ways that are consistent with the legislation governing collaboratives and the goals of prevention of out-of-home placements; enhancement of family support and children's physical and mental health services; development of a seamless system of services; and strengthening of local community-based collaborative efforts.

This report includes collaborative participation in the method of claiming federal MA/Title IV-E by collaboratives because in directing these dollars to the integrated fund:

- They become an important funding source for collaboratives
- They are flexible, non-categorical funds
- They are specifically directed at collaboratives (family services and children's mental health)
- They are to be used in early intervention and prevention of out-of-home placement
- They need to be directed to the collaboratives' integrated fund. There is joint administration of these funds by the different child-serving agencies partnering in a collaborative.

Of the total human services funding for children's mental health of \$153,989,289 for 2001 shown in Figure II, 32 percent was federal funding (\$49,571,907). Within these federal funds, an estimated 9 percent were dollars earned by collaboratives through participation in the LCTS.

Collaboratives have drawn some funding into human services for children's mental health. But these new dollars have not been substantial. They do, however, constitute flexible funding, as are the other dollars that are contributed by collaborative partners to the collaborative's integrated fund.

1.1. The collaborative integrated fund

A central component of the collaborative integrated service system is the integrated fund. Both family services and children's mental health collaboratives are mandated to establish an integrated fund. This is a pool of both public and private, local, state, and federal resources, consolidated at the local level to accomplish the agreed goals. Its objective is to provide the flexibility necessary to provide individualized, non-categorical services to children and their families.

The collaborative integrated fund was seen by some legislators as such a central component of the collaborative model, that the children's mental health collaborative legislation actually bears the name: *Children's Mental Health Integrated Fund*.

The Integrated Fund Task Force saw the collaborative integrated fund as a means to a broader system reform. It envisioned that public partners in collaboratives would shift significant resources available for the provision of mental health services into the collaborative's integrated fund, promoting systems change. The overarching purpose of creating a local integrated fund, with all of its inherent technical and political complexities, is to support the community's effort to create a better system for delivery of services to children. An integrated funding strategy is a means to a

broader system reform. The strategy proposed by the Task Force is twofold: first, to redirect current spending patterns and, second, to maximize federal entitlement reimbursement.¹⁸

The children’s mental health integrated fund legislation actually mandated that counties contribute the child welfare targeted case management dollars for the children served under collaborative administration into the integrated fund. Legislation also assumed there would be new federal and state resources designed to help the collaborative system change models. The state provided some dollars in grants, such as the Wraparound Grant or the Adolescent Services Grant. A main source of federal revenue was available in the LCTS.

The expectation that the integrated funding strategy would be a means to broader system reform has not occurred. The causes are interrelated. The strategy of redirecting spending patterns to an integrated fund by local partners has occurred only minimally. Therefore, the systems reform expected as an outcome of these financial changes hasn’t followed. The total integrated fund that collaboratives reported for calendar year 2001 was over \$73 million. Local cash contributions make up only 7 percent of the total and local in-kind contributions make up 13 percent. This has been constant through 1999 and 2000 (See Figure III).

Local cash contributions to the integrated fund vary greatly by collaborative. Overall, in 36 collaboratives local partners didn’t contribute any cash to the integrated fund. In 48 collaboratives where partners contribute cash to the integrated fund, the cash contribution is between 0 and 15 percent of their total integrated fund. Only in three collaboratives are local cash contributions to the integrated fund between 30 and 60 percent of the total.

Maximizing federal reimbursements has occurred to a greater degree than expected through the LCTS federal revenue enhancement program. This brought in significant new dollars to the collaborative integrated fund. This created the flexibility sought by the legislation, but it was primarily for new programs directed at prevention and early intervention, consequently it went to those collaboratives most involved in these activities: family services collaboratives.

Figure III

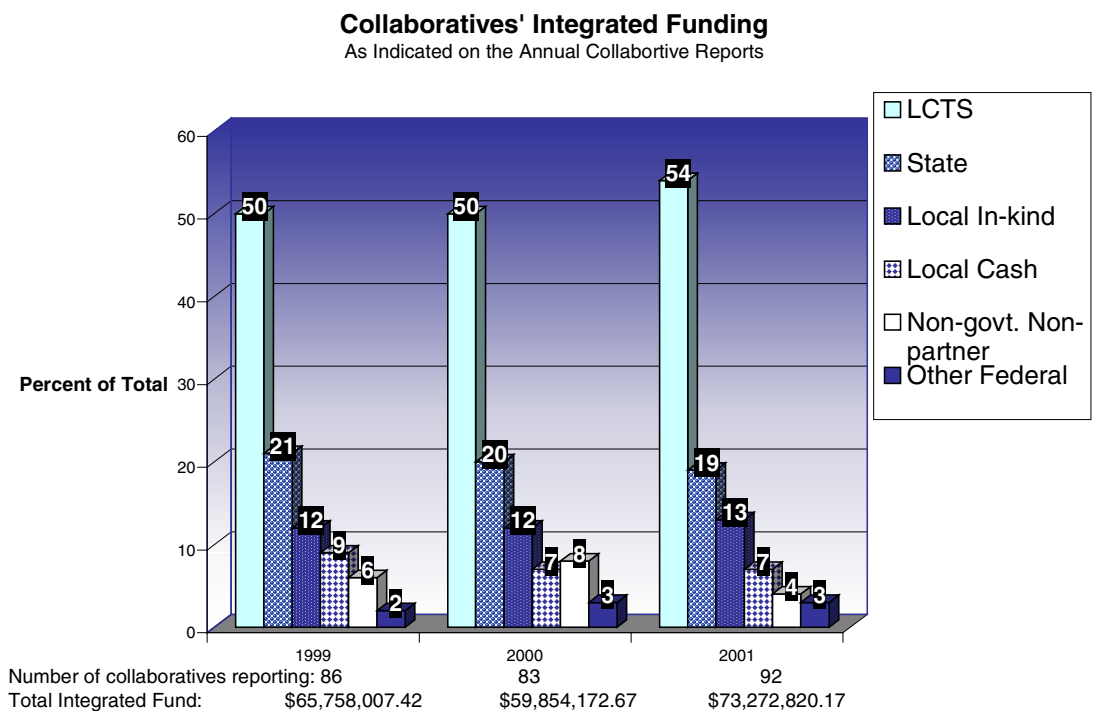


Figure III shows that a significant portion (over 50 percent) of the collaboratives' integrated fund are the Local Collaborative Time Study dollars.

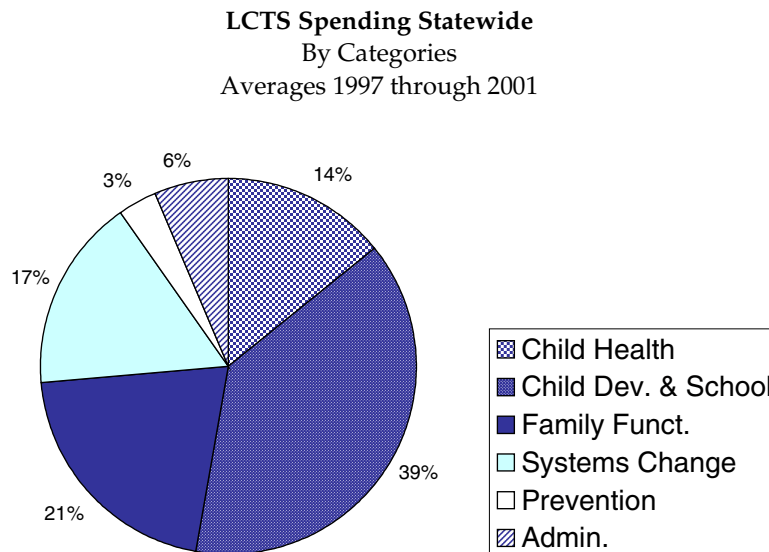
From 1997 through the end of calendar year 2001, Minnesota's collaboratives (family services, children's mental health and integrated) spent over \$117 million through the Local Collaborative Time Study, via Federal Title IV-E (funding for permanent homes and prevention of out-of-home placement) and Title XIX (Medicaid funding) reimbursement.

Collaboratives report to the department on LCTS dollars spent in five broad categories and administrative expenditures: indent these bullets

- Child Development and School Performance
- Family Functioning
- Child and/or Family Health
- Organization, Community and Systems Change
- Other Prevention and Early Intervention Services.¹⁹

Figure IV shows total spending on each of the five categories on average for all years.

Figure IV



On average, from 1997 to 2001, the Child Development and School Performance category is where most of the LCTS dollars have gone.²⁰ The LCTS spending report indicates that a significant portion of LCTS money is funding school-based programs. Additionally, from the 2001 Collaborative report we know that family services collaboratives, many of which are school based, reported over 60 percent of the total LCTS reported by collaboratives. Children's mental health collaboratives not integrated with a family services collaborative reported only 9 percent of the total LCTS reported.

The LCTS spending reports gives us a view of collaborative spending. Mental health services are a subcategory of Child and/or Family Health in the LCTS spending report categories. In CY 2001, over \$2 million was reported under this subcategory, which amounts to no more than 6 percent of the total LCTS spending for that year. However, there are subcategories in other LCTS spending categories that can capture children's mental health services as well, such as day treatment programs (health/mental health), case management and home-based services, which amount to 11 percent of the total spending for calendar year 2001. Although not all spending in these categories will be for mental health services, it does reveal that LCTS spending on children's mental health is more than just the 6 percent reported under mental health services. Some LCTS dollars are going to children's mental health education and prevention programs and early identification and screening programs based in schools as well. Additionally, some components of programs are directed at dealing with truancy, dropout prevention, justice programs that may also be children's mental health services.

Very little LCTS funding was spent on children's mental health interventions. However, much of the LCTS funding has been directed at early intervention and prevention of out-of-home placements. The Integrated Fund legislation focus has been met by the integrated collaboratives, which have provided a continuum of services from prevention, as well as early intervention, to intensive, long-term care services. LCTS dollars are also flexible and non-categorical, and under joint administration in an integrated fund, so they have contributed toward the expectations of the children's mental health integrated fund legislation.

With respect to the first system result of increased flexible funding for children's mental health:

- There have been substantial changes in the last 10 years in the services funded by local, state and federal human services, primarily in the direction of increased funding for community-based interventions, of which children's mental health collaboratives are an important piece.
- Collaboratives have developed integrated funds, but participation in a method to claim federal money for services to children has been a major source of revenue for collaboratives. Furthermore, the percentage of these federal dollars spent on children's mental health services is small.
- Flexible, non-categorical funding has increased in the children's mental health system because collaboratives have established integrated funds and some are shifting resources into their integrated funds.
- The expectation that the integrated funding strategy would be a means to broader system reform has not occurred to the degree expected.

2. Increased Family and Community Involvement in the Children's Mental Health System

Legislation mandated that the collaborative board include, at a minimum, county, school district, corrections, public health and mental health entities.²¹ Legislation also encouraged collaboratives to involve family and community representation on the boards. By 2001, all collaboratives established in Minnesota had more than just the minimum mandated partners and were involving parents, nonprofit organizations and many others at the decision-making table, as can be seen in the following table.

Table IV
Non-mandated Partners on Collaborative Boards

<i>Non-mandated partners</i>	<i># of collaboratives</i>
Parents	63
Parents of children with a Severe Emotional Disturbance	35
Nonprofit organizations	47
Advocacy organizations	31
Spiritual leaders	27
Academia	25
Business leaders	22
Health maintenance organizations	19
Tribal members	11
Foundations	10

Collaboratives have added the most notable capacity to the children’s mental health system through the involvement of parents and families. Family involvement at all levels is a core principle of the system of care model (see Appendix C), the Integrated Fund and Family Services collaborative legislation. Even though parents are not mandated partners in collaboratives, both the family services and children’s mental health collaborative legislation strongly encourage parent involvement at the system design and development level. Parent involvement at the child and family team level is, of course, mandated, since the collaborative individualized rehabilitation services process or “wraparound” is by definition family centered and family driven.

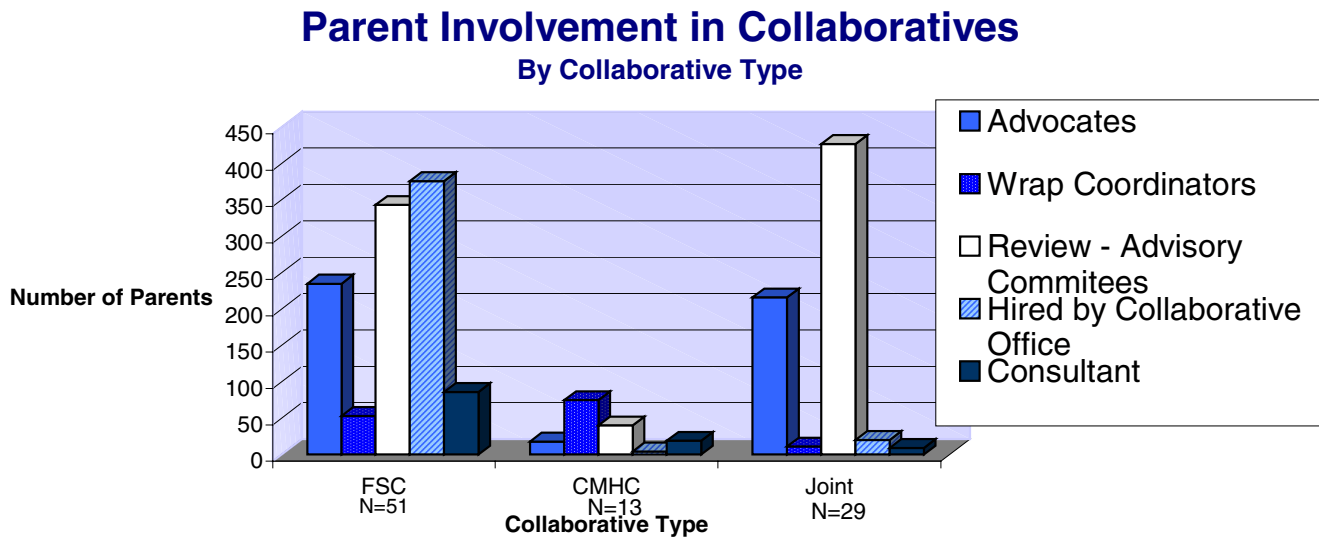
The University of Minnesota research team explained that in collaboratives where parents are actively involved coordinators reported that the insight gained through personal experience was invaluable. Most felt unequivocally that programming was better as a result of parent input. Coordinators also commented that parents have an important role to play in raising public awareness about children’s mental health issues. Because they are able to speak directly from personal experience, parents are better advocates than staff.²²

The 2001 Annual Collaborative Report provides a broad picture of the extent of parent involvement in collaboratives:

- Fifty-eight collaboratives reported having family/parents as voting members on the collaborative governance board
- Overall, 172 parents participate in collaboratives at the governing board level. Of these, 61 (35 percent) are parents of a child with an emotional disturbance or a severe emotional disturbance

It is not only at the collaborative governing board level that parents are involved. Seventy-two collaboratives said parents were involved in the collaborative’s organization, design and development. And 1,932 parents were reported as being involved in collaboratives as parent advocates, wraparound coordinators (facilitators of their children’s teams), parents participating on review or advisory committees, parents hired by the collaborative office as liaisons for parent involvement or as consultants to the collaborative. The following graph shows parent involvement in these different categories, by collaborative type.

Figure V



The following chart, from the 2000 collaborative report, shows the number of collaboratives that provided training and support for parent involvement:

Table V
Parent Involvement/Support Activities

Number of collaboratives that reported providing training for parents	43
Number of collaboratives that reported having support groups for parents	43
Number of collaboratives that reported providing stipends for parents participating in collaborative events	47
Number of collaboratives that produced or sent parent newsletters	31

The fact that collaboratives have begun to involve parents in the design and development of the collaborative system shows that participation is seen as a collaborative asset.

Nevertheless, there are barriers to parent involvement including:

- The commitment to parent involvement is uneven, with some partners being more open to the idea than others.
- The divide between “experts” and “non-experts” with parents experiencing an imbalance of power on collaborative boards.
- Logistical barriers: times when meetings take place, childcare, transportation and distance.
- Parents from communities of color are less involved, and there are cultural and linguistic barriers that need to be overcome in order to facilitate full participation. One county has committed to holding a seat on the committee for a parent of color.²³

With respect to the second system result of increased parent and community participation in children’s mental health:

- All collaboratives have expanded their boards beyond mandated partners to include parents and representatives from community organizations.
- Parent and family participation in the governance and work of collaboratives is a significant and positive result of the collaboration model.
- Important barriers to parent participation continue to exist, especially for parents from communities of color.

3.Increased Cross Agency Planning and Service Delivery and new Service Delivery Models

The partners involved in children’s mental health collaboratives interviewed by the University of Minnesota found that most partners believed that children’s mental health collaboratives help providers serve children better than before.

Part of this improvement resulted from stronger relationships between the county and the school. Legislation gave counties and school districts a lead role in collaboratives. Counties and schools also contribute a significant portion of the local cash dollars flowing to the integrated fund, as shown in Table VI. The county-school partnership is essential because these are the child-serving agencies most involved in the lives of children.

*Table VI
The County-School Partnership*

Counties in Minnesota with a collaborative	81
School districts involved in a collaborative	329
Collaboratives with county commissioners on the board	24
Collaboratives with county social services or human services directors representing the County on the collaborative board	53
Collaboratives with school board members on the board	23
Collaboratives with school superintendents on the board	51
Percent of local cash contribution to the integrated fund by counties (2001)	51%
Percent of local cash contribution to the integrated fund by schools (2001)	24%

Representation of the public mandated partners on the board varies. In most collaboratives, the county is represented by county commissioners or social/human services directors (77 collaboratives). There are collaboratives that have program-level staff representing the county. The same is true for schools. Some collaboratives involve school board members or superintendents (74 collaboratives), others have program staff representing the school partner. Some collaboratives have adequate representation by corrections and will have one of the three correctional systems represented on their board, but others will involve law enforcement instead (for example, the sheriff’s office or the police). Public health is in some cases represented by the county commissioner or social services director while others involve a public health nurse.

Who represents each partner on the collaborative will, of course, have an impact on the decision-making, as well as on the overall system change and planning. County-wide, coordinated planning for children's services is more likely to occur in collaboratives where commissioners or social services directors work with school board members or superintendents. Data from the annual collaborative reports indicate that collaboratives in counties where there are multiple, non-integrated collaboratives tend to have less participation from key decision-makers on the boards and more representation by program staff.

3.1. Individualized Services and the Wraparound Process

For children's mental health collaboratives, the integrated service system was designed to provide individualized rehabilitation services, as the children's mental health Integrated Fund legislation refers to them or services through the wraparound process, as they are locally known. The elements and characteristics of the individualized rehabilitation services and wraparound are basically the same:

- Flexible
- Coordinated
- Highly individualized
- Strengths-based
- Needs-based
- Services identified through a multi-agency assessment
- Services based on a multi-agency plan of care
- Services developed by a multi-agency team in conjunction with the child and family.

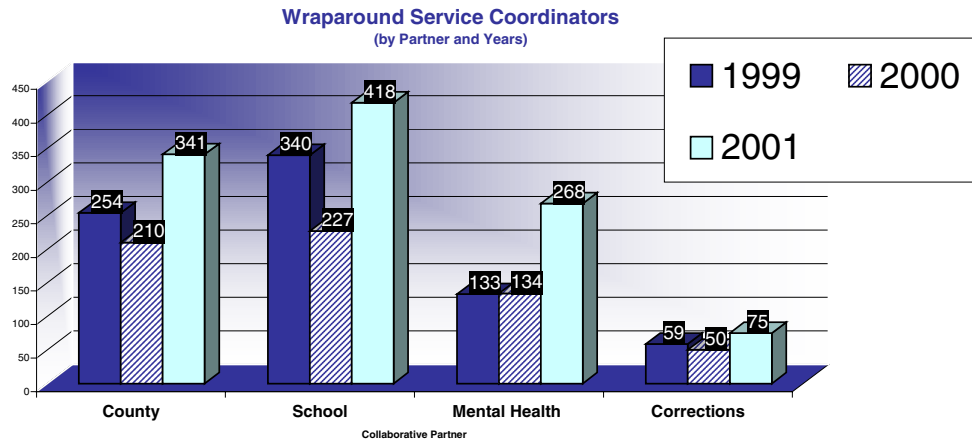
Service coordination within collaboratives takes place at two levels:

- At the child and family team level
- At the systems level.

At the child and family team level, front line staff are trained in the wraparound process to coordinate services among professionals, family and community members who will develop the child's multi-agency plan of care. These coordinators are known as "services coordinators" or "wraparound facilitators."

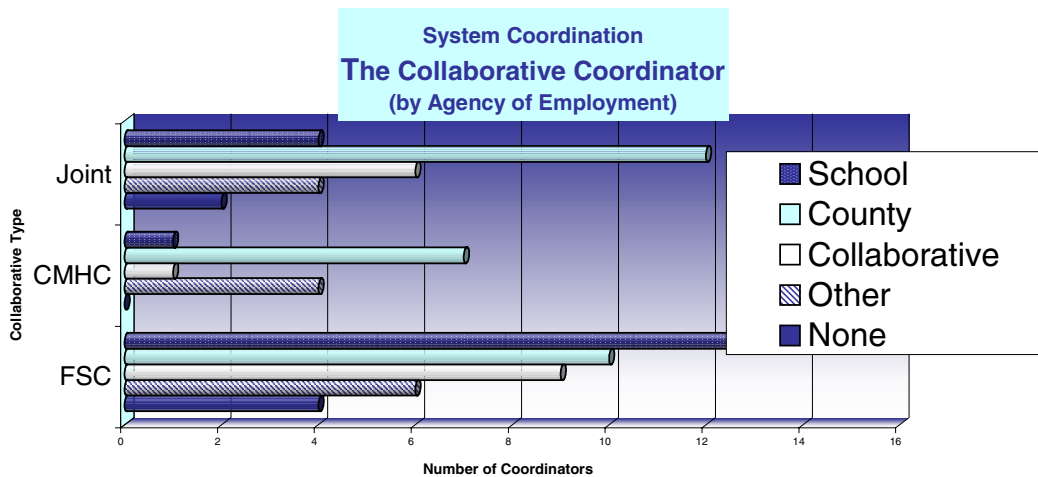
Figure VII shows the four main public partners in the children's mental health collaboratives and the number of service coordinators/wraparound facilitators they employ. Overall, the number of wraparound service coordinators has been on the rise in the past three years. In 2001, there were 1,430 service coordinators reported by collaboratives. The school partner employs the highest number of coordinators (418), followed closely by counties. Of the collaborative types, the integrated collaboratives employed 826 of the coordinators for the year 2001, followed by the stand-alone children's mental health collaboratives that, although there are only 13, employed 353 coordinators.

Figure VI



Collaboratives have two positions that facilitate the system level coordination: the collaborative board chair and the collaborative coordinator. In some cases they are the same. Board chairs and coordinators help bring the public agencies, family and community partners to the collaborative table for overall system planning. Only six of the collaboratives that reported in CY 2001 did not have a collaborative coordinator for the overall system coordination. Collaborative coordinators are mainly employed by the county partner, as Figure VIII shows.

Figure VII



Since the system of care approaches and processes, like wraparound, were originally designed around children’s mental health interventions (see CASSP principles in Appendix C), it is not surprising that the children’s mental health collaboratives show greater service coordination at the child and family team level than do family services collaboratives. Children’s mental health collaboratives (integrated or not) employ more service coordinators/wraparound facilitators than do family services collaboratives (826 vs. 221). Since children’s mental health collaboratives are using the wraparound process more intensively, this also leads to greater parent/family involvement at all levels, and a more frequent use of multi-agency or common plans of care.

3.2. Common Plans and Procedures

Using common plans and establishing common procedures are ways to make things easier for families. But it also is more efficient and adds capacity to the system. One of the common forms that legislation wanted to establish for children's mental health collaborative was the "Multi-Agency Plan of Care." By 2001, all but two of the 43 children's mental health collaboratives were using or in the process of implementing a multi-agency plan of care, be it developed locally or the state developed Collaborative Family Services Plan or the Individual Interagency Intervention Plan. Only 12 of the 51 family services collaboratives were not using one common plan. The multi-agency plan of care can replace with a single form up to eight different agency plans.

With respect to the third system result of increased cross agency planning and service delivery and new service delivery models:

- Collaboratives have enhanced the relationships between county agencies and the schools. This is especially important because these two public entities are the ones most involved in the lives of children with emotional disturbances and their families.
- Having high level decision-makers from the mandated partners on the collaborative boards is important because their participation increases the likelihood that system-wide planning for children's mental health takes place.
- The number of wraparound coordinators and the use of common forms have both increased, indicating greater system coordination and commitment to collaborative work.

\

Results of Collaborative Interventions for Children Receiving Services through Children's Mental Health Collaboratives

In CY2001, the Minnesota Department of Human Services received 16,000 children's mental health collaborative reports, often two reports a year per child. Of these records, 64 percent reported a valid child identifier and could be used in the analysis. More records of children receiving intensive services had valid child identifiers than did records of children receiving short-term or one-time services.

In order to find the total number of children receiving intensive or short-term or one-time services in CY2001 without counting them twice, the child identifier was used to distinctly identify children.

Children's mental health collaboratives also reported aggregate child, parent and family counts twice a year for those services provided that did not lend themselves to obtaining distinct identifier information from clients. These are reported as "service contacts" and are not unduplicated, i.e., a child, family or parent may be counted more than once in one or more services.

Who Received Services from a Children's Mental Health Collaborative?

In calendar year 2001, children's mental health collaboratives served 7,000 children with individualized services.

Additionally, children's mental health collaboratives reported aggregate counts of children, parents and families who received community education, prevention, information and referral, early identification and intervention and other services where collection of individual client information was not practical. With regard to these services, children's mental health collaboratives reported:

- 45,672 child service contacts
- 9,916 parent service contacts
- 154 family service contacts.²⁴

Most of the child services contacts involved community education/prevention (67 percent of child service contacts). Sixteen percent of child service contacts were for information and referral and 8 percent involved early identification and intervention.

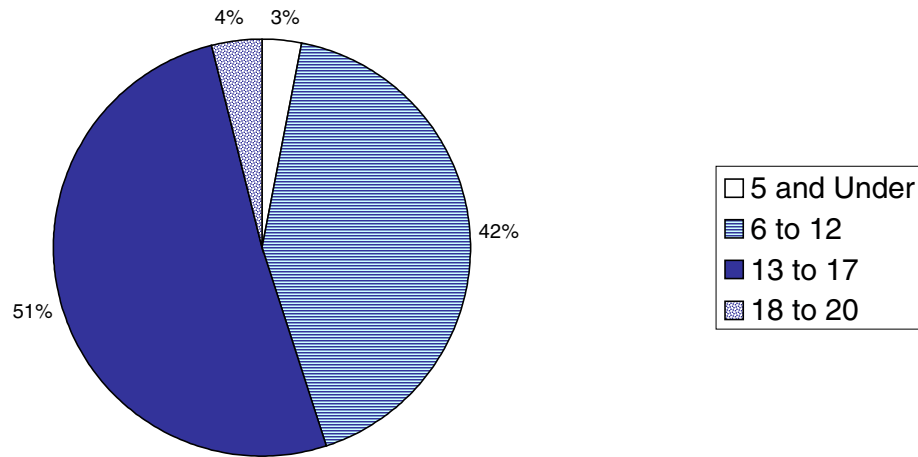
Children Receiving Intensive Services

The following data is about the 4,500 children who received intensive or long-term services from children's mental health collaboratives.

- 72 percent reported receiving wraparound services
- 66 percent were male
- 28 percent were American Indians, African Americans, Asians or Latinos.
- 78 percent lived at home with their parents.

Figure VIII

**Children Receiving Intensive Services
from a Children's Mental Health Collaborative
by Age**



Ages:

- 51 percent were adolescents 13 to 17.
- 42 percent were children 6 to 12.
- 3 percent were preschoolers 5 and under.
- 4 percent were 18 to 20.

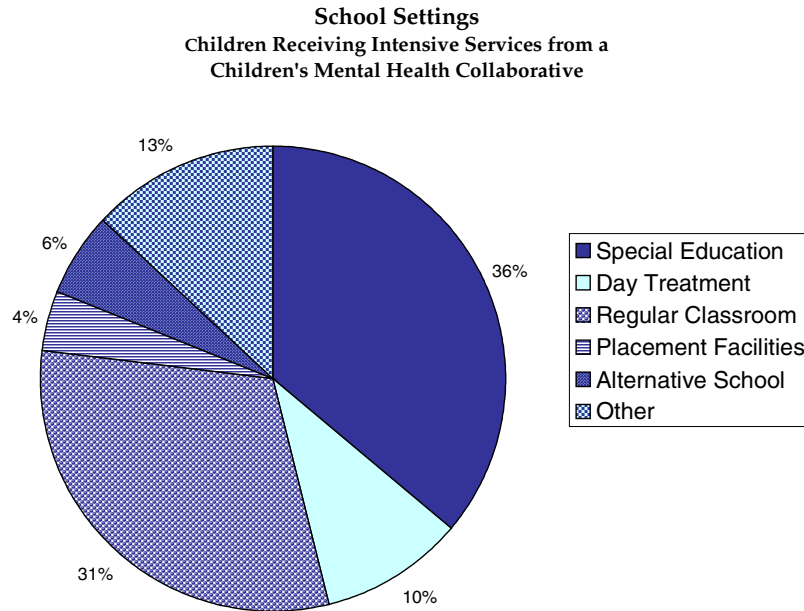
Primary DSM-IV Axis I Diagnosis²⁵:

- 34 percent reported Attention Deficit/Disruptive Behavior Disorder as the child's primary diagnosis.
- 15 percent listed depression or bipolar disorder as a primary diagnosis.
- 35 percent did not list a primary diagnosis.

School Settings:

- 35 percent were receiving some type of special education services.
- 10 percent were in day treatment settings.
- 6 percent were in alternative schools.

Figure IX

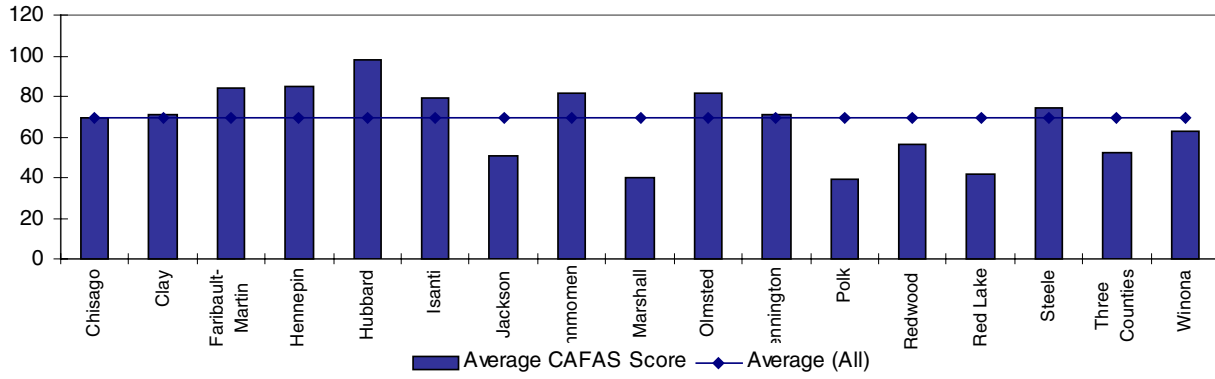


Functionality

Children's mental health collaboratives focused on different target populations to serve. Most children's mental health collaboratives collected functional assessment score information using the Child and Adolescent Functional Assessment Scale (CAFAS®) instrument.²⁶ The higher the CAFAS® score, the higher the level of impairment in functioning the child is experiencing.

The following chart (Figure XI) shows the average CAFAS® score for each of those collaboratives with an adequate sample size of functional assessment data. For all children in collaboratives in this sample, the average CAFAS® score was 69 indicating that, for the average child in this sample, outpatient treatment as well as additional supportive services beyond outpatient were appropriate. The CAFAS® total score is composed of eight sub-scale scores. When severe impairment scores occurred in one of these sub-scales, they were most often in the categories regarding functioning in the home or in school.

Figure X

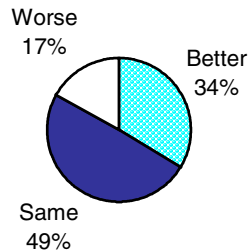


What Were the Outcomes for Children Receiving Intensive Services?

For 591 children, there were CAFAS® scores at intake and six months later. The children in this sample include Hennepin, Dakota and non-metro collaboratives. The following chart shows that, at six months, 49 percent of the children in this sample remained at the same level of impairment, and more children improved (34 percent) than did not improve (17 percent).

Figure XI

Level of Functioning at Six Months



A few counties also used the Child Behavior Checklist (CBLC) to measure changes in child behavior. This instrument categorizes children’s overall behavior into three categories: clinical, borderline or normal. Because there were not enough children with intake and sixth month review

CBCL scores to provide an adequate sample size, change in CBCL results cannot be reported. Hennepin, Ramsey, Scott and Washington children's mental health collaboratives collected CBCL data on children.

Satisfaction

The Minnesota Department of Human Services asked children's mental health collaboratives to include the following statements in any satisfaction survey they used and to report the results at year-end to the department.

For parents and families:

- "The services helped our child."
- "Our family's values and culture were respectfully included in our child's care plan."

For children:

"The services helped me."

Respondents were asked to report according to a four point scale: Strongly Agree, Agree, Neither Agree nor Disagree, Strongly Disagree.

In calendar year 2001, 890 parents responded:²⁷

- 90 percent indicated that they strongly agreed or agreed with the statement: "The services helped our child."
- 86 percent indicated that they strongly agreed or agreed with the statement: "Our family's value and culture were respectfully included in our child's care plan."

In calendar year 2001, 891 children responded:²⁸

- 81 percent indicated that they strongly agreed or agreed with the statement: "The services helped me."

Conclusions

- For those children receiving intensive services through children's mental health collaboratives:
- Most (78 percent) live at home;
- Most (66 percent) were boys;
- Most (51 percent) were adolescents; and
- Most (51 percent) were involved in special education, alternative schools or day treatment.
- At six months, about half of the children receiving intensive services remained at the same level of impairment while 34 percent of children improved according to CAFAS® need the registered trademark?functional assessment scores. Most often the areas of severe impairment were seen in the home and school.
- In addition to serving children with intensive services or one-time/short-term services, children's mental health collaboratives provide community education/prevention services, information and referral services, early identification and intervention services as well as other services.
- Parents and children from out-state collaboratives were generally satisfied with the services they received from children's mental health collaboratives.

Conclusions and Recommendations

The role of collaboratives in the children's mental health system is to reduce system fragmentation and increase funding flexibility. The stakeholders group convened for the purpose of this report, the research teams and family services and children's mental health collaboratives themselves concluded that cross-agency coordination is developing a system of care continuum for children's mental health. Collaboratives provide common ground for child-serving agencies, in particular counties and schools, to come together with the child's family and community to reduce fragmentation and increase funding flexibility for services to children and their families.

Children's mental health collaboratives have complied with the basic integrated service system components outlined in the original collaborative legislation. This includes an integrated fund, individualized services, a multi-agency plan of care and early intervention services. Both types of collaboratives have built relationships among the child serving agencies, communities and families. They have achieved at least one of the main goals: to bring county social services, schools, mental health entities, public health entities and corrections to the collaborative table. They have also included community agencies and parents.

In many communities in Minnesota, this has resulted in greater public agency coordination for children's services, the use of common plans of care, greater flexibility through non-categorical funding and the establishment of programs focused on early intervention and prevention. It has also meant the involvement of parents of children with severe emotional disturbances involved in various levels of system design and implementation. The research findings of the University of Minnesota teams state:

Overwhelmingly, interview participants identified innovative practices resulting from their collaborative experiences. Although many partners mentioned that some of these practices *could* have developed without the CMHC, most indicated that without the formal structure and impetus of the collaborative, it is unlikely that they *would* have. Partners' identified innovations fell into five primary themes: new programs, new methods of service delivery, information sharing, relationship building, funding and facilitating parent participation.²⁹

Reduce System Fragmentation

An important percentage of children who received intensive mental health services through the children's mental health collaboratives show improvement as measured in functionality scores. Additionally, 81percent of the children surveyed, who received services through children's mental health collaboratives, strongly agreed or agreed that the services had helped them. Ninety percent of the families surveyed strongly agreed or agreed that collaborative services had helped their child.

These outcomes were supported by the cross-agency work of collaboratives. Collaboratives have enhanced the relationships between county agencies and the schools. This is especially important because these two public entities are the most involved in the lives of children with emotional disturbances and their families. The participation of high level decision-makers from the mandated partners increases the likelihood that system-wide planning for children's mental health takes place.

Increase funding flexibility

Adequate funding for the children's mental health service system has been a concern since the Children's Mental Health Act was passed in 1989. Collaboratives have not had a significant impact on this situation. Collaboratives have been able to leverage some additional resources, mainly through the new funds earned through the Local Collaborative Time Study. But this is primarily used for prevention efforts in school-based interventions. Only a small percentage is directed towards children's mental health services overall. Still, prevention and school-based interventions are an important part of the continuum of services for children.

Flexible, non-categorical funding has increased in the children's mental health system because some collaboratives shifted resources into their integrated funds. However, the expectation that the integrated funding strategy would be a means to broader system reform has not occurred to the degree expected.

Increased family and community involvement

Unlike many child-serving agencies on their own, collaboratives have brought parents into the design and development of the systems and services that serve their children. Parents, through collaboratives, participate in child and family teams, participate in parent support groups, participate in training, provide consultation to collaborative boards and as voting members of many of the collaborative boards they are decision-makers.

The same can be said for communities. Collaboratives involve non-profit organizations, health maintenance organizations, tribes, business and spiritual leaders on the collaborative boards.

All collaboratives have expanded their boards beyond mandated partners to include parents and representatives from community organizations. Parent and family participation in the governance and work of collaboratives is a significant and positive result of the collaboration model. However, important barriers to parent participation continue to exist, especially for parents from communities of color.

There is still important state interagency work that needs to take place. The State of Minnesota Children's Mental Health Task Force in 2002 recommended that state leadership provide unified vocabulary, tools and services for children's mental health. The Task Force also recommended that the Minnesota Department of Human Services spearhead a multi-agency approach to disseminating an evidence-based approach, which involves families and diverse communities in all aspects of this effort.

The recommendations from this report build on the Children's Mental Health Task Force.³⁰ In a multi-agency approach:

- Work with collaborative coordinators and their governance bodies to: check amount of indent on bullets
- Help them develop solid financial relationships that would enhance shifting of local resources to the collaborative integrated fund.
- Increase the percentage of Local Collaborative Time Study dollars allocated to children's mental health services, particularly for the implementation of evidence-based practices and demonstration of clinical and functional outcomes.

Work with collaborative coordinators, their governance bodies, and parents/family members to:

- Continue to increase parent and family participation.
- Remove specific barriers to such participation.
- Focus efforts on increasing participation by parents and family members from communities of color.

Work with collaborative coordinators and their governance bodies to:

- Facilitate system-wide, results-based planning.
- Reinforce participation of key decision makers from the mandated partners on collaborative boards.

And, as the Children's Mental Health Task Force also recommended, provide the Minnesota Department of Human Services, in conjunction with other state agencies serving children and adolescents, the capacity to develop and monitor best practices in compliance with mandates for access to children's mental health services. This includes ensuring the quality of children's mental health services provided by or facilitated through the children's mental health collaboratives and the family services collaboratives.

Appendix A

Study Design

During the fall of 2001 and all of 2002, the Minnesota Department of Human Services (DHS) designed and implemented a study, involving three major evaluation and study areas, to comply with the 2001 Collaborative Study Legislation. The Department oversees the children's mental health collaboratives and these collaboratives are key in the children's mental health system, therefore they were the primary focus of the evaluation. The Minnesota Department of Children, Families and Learning (CFL) has oversight over the family services collaboratives. Family services collaboratives were examined with respect to the children's mental health services they deliver and their relationship to the children's mental health service system.

The following major activities took place to address the main areas of the study:

- formation and work of a Collaborative Study Work Group;
- research by the University of Minnesota's Hubert H. Humphrey Institute of Public Affairs,
- gathering information through the Annual Collaborative Reports,
- gathering individual data on children and families receiving mental health services from children's mental health collaboratives.

1) The Collaborative Study Work Group. In order to meet the legislative mandate to develop the collaborative study in consultation with key stakeholders, DHS convened a Collaborative Study Work Group to provide input and advice to DHS regarding the activities for the study, processes, outcomes and recommendations to the Legislature. The Collaborative Study Work Group met threetimes and its members included staff from the state departments, counties, local children's mental health collaboratives and family services collaboratives, providers of children's mental health services and parents of children receiving mental health services.

2) Research. Two research teams of graduate students from the University of Minnesota's Hubert H. Humphrey Institute of Public Affairs "Managing Collaboration" class under the direction of Dr. Melissa Stone, examined the system collaboration and structure, and the parent involvement and participation. The teams spent more than 500 hours during the spring semester (January-May 2002) conducting research, analyzing data, writing the reports and presenting findings.

In order to gain the most in-depth and historical information, the Humphrey teams focused their analysis on the original 16 children's mental health collaboratives formed in 1995. Due to time and resource constraints, the system collaboration team selected a stratified sample of nine of the original 16 collaboratives, using geographic location and integration/non-integration with a family services collaborative as the primary sampling selection criteria. Table I presents a brief profile of the sample collaboratives.

Table I
Sample Profile of Collaboratives

<i>Collaborative</i>	<i>Integrated</i>	<i>Location</i>
Beltrami	Yes	Rural
Clay	Yes	Suburban/small
Hennepin	No	Urban
North Shore	Yes	Rural
Olmsted	No	Suburban/small
PACT 4	Yes	Rural
Ramsey	No	Urban
Scott	Yes	Suburban/small
Washington	No	Suburban/small

The team gathered information from each collaborative’s mandated partners. These included: representatives from the county, public health, mental health, corrections, two school districts and the collaborative coordinator for each collaborative. All participants signed a consent form and confidentiality was guaranteed. Participation was voluntary, and some interviewees chose not to participate. Two primary data collection tools were used: phone interviews and written surveys. The average phone interview lasted 35-45 minutes. Of the 60 partners contacted, 51 interviews were completed and 32 written surveys returned, for a response rate of 85 percent and 53 percent, respectively. In addition to the written survey questions, survey respondents were also asked to draw two “visual maps” indicating the partner agencies with whom their organization works on children’s mental health issues. One map would demonstrate the relationships prior to the collaborative. The other map would demonstrate the relationships since the collaborative. The written survey responses are woven into the overall systems team findings when appropriate. Survey participants were asked to indicate their responses on a seven-point scale. The scale’s lower range indicates a negative response, while higher numbers reflect positive agreement.

The team that analyzed parent involvement gathered data from all 16 original collaboratives. The study team created a three-step process for data collection by means of telephone interviews and review of existing collaborative parent satisfaction surveys. One challenge in conducting primary research with parents was determining how to get a clean sample of parents involved in the collaboratives. Almost every option confronted the team with the problem of bias because the advocacy and support groups were not exclusively composed of parents receiving collaborative services. The team also encountered data privacy issues. To effectively reach these parents for future research, satisfaction surveys, needs assessments, point-of-service surveys and focus groups are recommended.

The first step consisted of telephone interviews with the collaborative coordinators. Four interviewers each contacted four coordinators. The coordinators were asked a series of six questions. Interviewers recorded the responses in writing and the entire research team reviewed the responses to each question. The research team then used a card sort methodology (individual responses were written on index cards and then sorted into common subject areas) to synthesize the responses into themes.

For the second step, the research team reviewed the parent satisfaction surveys received from eight of the original collaboratives. Collaboratives had collected these data between 1997 and 2001. The team synthesized it into eight content areas and compared this information to the phone interviews.

In the third step the research team developed a series of questions to establish whether themes from the coordinator interviews were similar to those from the parent representatives. Telephone interviews were conducted with parent representatives of 12 of the 16 original collaboratives. Four collaboratives could not identify parent representatives and due to concerns regarding confidentiality of the parents, these four were not included in the analysis of parent representatives.¹ Four interviewers contacted the parent representatives who were recommended by the coordinators of the collaboratives. The parents were asked a series of eight questions and their responses were recorded in writing by the interviewers. The research team reviewed the responses and used a card sort methodology to synthesize the responses into themes. Those themes from the parent representatives were then compared and contrasted with the themes from the coordinators.

A final integrated report was compiled from the two research teams' work with Melissa Stone, Ph.D. as principal investigator. They presented their report to the Collaborative Study Work Group's June, 2002 meeting for review and discussion. A summarized version is incorporated into the present report as part of the results section.

3) The Annual Collaborative Report Information. Since 1999 Minnesota's children's mental health and family services collaboratives have been required to complete an Annual Collaborative Report prepared by the Minnesota Department of Human Services (Children's Mental Health Division and Revenue Enhancement Unit) and the Minnesota Department of Children, Families and Learning (Safe Communities Division)³¹. The purpose of these annual reports is to monitor integrated service system development, and hear from the field about successes, best practices and collaborative issues. The 2001 Annual Collaborative report, from which information was extracted for this report was completed by 91 of the existing 93 collaboratives. To receive direct input from all collaboratives on the legislative study, the following question was added to the 2001 Annual Collaborative Report: "What is the role of your collaborative in the children's mental health system?" DHS staff analyzed the answers to this question and others and presented both the summary of the Annual Collaborative Report and its findings³² to the Collaborative Study Work Group at their June 2002 meeting for review and comment.

Following the system and child results of collaborative interventions, this report will present a summary of what the family services and children's mental health collaboratives themselves said of their role in the children's mental health system.

4) Individual Service Data. The Minnesota Department of Human Services collects individual service data on children and families who receive mental health services from children's mental health collaboratives. Data elements include number of children served, their age, race, gender and services provided by collaborative and in aggregate form. An analysis of this data and what it means regarding the role of the children's mental health collaborative is in the Collaborative Study. Preliminary data was presented to the Collaborative Study Work Group at their June 2002 meeting.

4.1. Background on children's mental health collaborative outcome reporting

In 1995, the Minnesota Departments of Human Services and Children, Families and Learning worked with the collaboratives to develop outcome indicators, engaging a consultant from the University of Minnesota. Because of their prevention and intervention focus, family services collaboratives settled on broad societal indicators such as rate of underage pregnancy and statistics from the Minnesota Student Survey to gauge their effectiveness in the community³³.

Because of their focus on children with mental health needs requiring multi-agency coordination, in May 1997 children's mental health collaboratives selected 17 child specific outcomes. Children's mental health collaboratives planned for the information to be collected on state databases on specific children served by the children's mental health collaboratives. Attempts to collect this information across state databases in 1998 proved difficult because of two system issues:

In response to this, two things happened:

- 1.1 The Community Mental Health Reporting System (CMHRS), which collects service utilization information for publicly funded services, underwent an information needs study and determined to change the file format to include a "collaborative" field, "multi-agency plan" field as well as to require the use of the Social Security number as the client identifier.
- 1.2 DHS and children's mental health collaboratives worked together to develop data collection forms.

Since July 1999, children's mental health collaboratives have collected child specific data on children receiving intensive services, long-term services and one-time or short-term services. For services that did not lend themselves to collection of individual child data, children's mental health collaboratives collected aggregate counts of persons with summary descriptions of the services provided. Many of these aggregately reported services were community prevention/intervention services, information and referral services and other such services.

For children receiving intensive services, long-term services, collaboratives were required to submit functional or behavioral assessment score information—usually the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Child Behavioral Checklist (CBCL or "Achenbach" form).

As of January 1, 2000, collaboratives were also required to report all mental health services to CMHRS (the Community Mental Health Reporting System). However, compliance with this reporting requirement is still a concern.

The development of the children's mental health collaborative individual child outcome reporting mechanism was a stop-gap measure to ensure that the Minnesota Department of Human Services had descriptive information on children served in children's mental health collaboratives as well as some usable outcome information for those children. The underlying plan was to phase out this collection system and incorporate reporting within the existing state databases of CMHRS and SSIS as much as possible and as soon as those systems could accommodate the reporting needs for collaboratives.

By 2001, 43 children's mental health collaboratives (either integrated or stand-alone) were in existence. That same year, the Minnesota Legislature required a study of the role of the children's

mental health collaboratives in the children's mental health system by January 2003. The information is part of this study.

Appendix B

Collaborative Study Work Group

**Collaborative Study Lead Staff,
Work Group Facilitator**

Amalia Mendoza, Program Consultant

Children's Mental Health Division

Minnesota Department of Human Services

Holly Biggins

Parent

Patty Butler

Parent

Toni Branness

Coordinator

PACT 4 Families Collaborative

Kandiyohi, Meekeer, Renville, Yellow

Medicine Counties

Judith Brumfield

Minnesota Association of County Social Services

Administrators MACSSA

Scott County Human Services Director

Glenace Edwall

Director

Children's Mental Health Division

Minnesota Department of Human Services

Linda Harris

Supervisor

Safe and Healthy Communities Division

Minnesota Department of Children, Families and Learning

Mary Heiserman

Mental Health Provider

Wilder Foundation

Ramsey County Children's Mental Health Collaborative

Board Member

John Hurley

Supervisor

Minnesota Children with Special Health Needs

Minnesota Department of Health

Mark Kuppe

Mental Health Provider

Director, Human Services Inc.

Washington County Children's Mental

Health Collaborative

Gary Mager

Supervisor

Mental Health Information Systems

Minnesota Department of Human Services

Joanne Mooney

Safe and Healthy Communities Division

Family Services Collaborative Liaison

Minnesota Department of Children, Families and

Learning

Amelia Ortega

Parent Liaison

Children's Mental Health Division

Minnesota Department of Human Services

John Pugleasa
Coordinator
Beltrami County Integrated Collaborative

Rob Sawyer
Director
Olmsted County Community Services
Olmsted Children's Mental Health Collaborative

Veronica Schulz
Coordinator
Hennepin County Children's Mental
Health Collaborative

Melissa Stone
Professor
Hubert H. Humphrey Institute of Public Affairs
University of Minnesota

Tim Walsh
Supervisor
Juvenile Services Unit
Minnesota Department of Corrections

Tonja Rolfson
Evaluator
Children's Mental Health Division
Department of Human Services

Deborah Saxhaug
Director
Minnesota Association for Children's Mental Health

Jerry Soma
Minnesota Association of County Social Services
Administrators (MACSSA)
Anoka County Human Services Division Manager

Mary Jo Verschay
Collaborative Grant Manager
Children's Mental Health Division
Minnesota Department of Human Services

Appendix C

Background on the Children’s Mental Health System and the System of Care Approach

National Scope and Background

In 1984, the National Institute of Mental Health implemented a planning initiative called the Child and Adolescent Service System Program (CASSP). This program “supports the development of comprehensive, coordinated, community-based, and culturally competent systems of care for children and adolescents with serious emotional disturbance and their families.”³⁴

In 1988, the Robert Wood Johnson Foundation launched a \$20.4 million initiative in eight states designed to integrate service systems for children with serious mental, emotional, and behavioral disturbances.

In 1992, the U.S. Legislature passed Public Law 102-321, based on system of care principles, creating the Comprehensive Community Mental Health Services for Children and their Families Program.

Today, many states and communities are lauding the success of a CASSP model of care. The U.S. Department of Health and Human Services continues to promote CASSP as their service delivery model of choice through the following:

- funding system of care grants to states and Indian tribal organizations
- research and publications about CASSP and its implementation
- national biannual training on the system of care.

In a CASSP system of care, mental health, education, child welfare, juvenile justice and other agencies work together. They work together to ensure that children with mental, emotional and behavioral problems and their families have access to the services and supports they need to succeed. These may include diagnostic and evaluation services, outpatient treatment, emergency services (24 hours a day, 7 days a week), case management, intensive home-based services, day treatment, respite care, therapeutic foster care, and services that will help young people make the transition to adult systems of care.

A true system of care is a partnership. This partnership must be made up of service providers, families, teachers and others who care for a child. Together, the team develops an individualized service plan that builds on the unique strengths of each child and each family. This customized plan is always implemented in a way that is consistent with the family’s culture and language.³⁵

CASSP Values and Principles

Core Values:

- Child-centered, family focused, and family driven
- Community-based
- Culturally competent and responsive.

Principles:

- Service coordination or case management
- Prevention and early identification and intervention
- Smooth transitions among agencies, providers, and to the adult service system
- Human rights protection and advocacy
- Nondiscrimination in access to services
- A comprehensive array of services
- Individualized service planning
- Services in the least restrictive environment
- Family participation in all aspects of planning, service delivery, and evaluation; and
- Integrated services with coordinated planning across the child-serving systems.³⁶

Minnesota Background

In 1989, Minnesota adopted the Child and Adolescent Service System Program with the passage of its Children's Mental Health Act (Minnesota Statute 245.487 – 245.4888). This Act outlined a CASSP system of care for children with emotional disturbances.

Counties, as the local mental health authorities, were responsible for implementing:

- Education and prevention services
- Early identification and intervention
- Emergency services
- Outpatient services
- Family community support services
- Day treatment
- Residential treatment
- Acute care hospital inpatient treatment
- Screening
- Case management
- Therapeutic support of foster care
- Professional home-based family treatment.

The system of care included service coordination at the individual case level and the local agency level. Individual service coordination was to be overseen by county staff or a contracted case manager. The newly created Local Coordinating Councils (LCCs) planned and implemented coordinated service delivery across organizations and agencies. LCC representatives were from mental health, social services, education, health, corrections and vocational services.

In 1991, the Legislature established the Children's Integrated Fund Task Force to study the feasibility of a children's mental health integrated fund. State policy regarding children's mental health had moved toward a community-based, non-residential system that coordinated services across agencies as described in the Children's Mental Health Act. But more work needed to be done in the areas of funding mental health services and integrating services among major systems of care.

In 1992, the Children's Integrated Fund Task Force published "A Preliminary Report." This report found that a design was needed to promote interagency service coordination, and resources were needed to pay for services. The report stated the Task Force should focus on two broad goals:

- 1.1 improve the effectiveness of treatment and the treatment system
- 1.2 improve the cost efficiency of the system.

These goals are compatible. Strategies combining coordinated service delivery with flexible, integrated funding seem to produce healthier clients at lower cost.

In 1993, the Children's Mental Health Integrated Fund Task Force presented its findings to the Legislature in the report, "An Integrated Children's Mental Health System: Coordinating The Needs Of Children With Multiple Problems." The Task Force found that establishing an Integrated Fund was "both feasible and desirable in Minnesota." The Task Force also found "that an integrated service delivery system, supported by an integrated fund, would greatly resolve the problems" identified in their Preliminary Report.

The Task Force recommended that funding be integrated locally because:

- Local governments and school districts own and control the greatest share of dollars going into children's mental health services
- Most services are controlled at the local level
- Flexibility can be enhanced when a local community can tailor its integrated system initiative whenever it is ready
- The model encourages local-state partnership that ensures commitment to reform at both levels.

To implement an integrated service delivery, the Task Force proposed that the state support multi-agency local collaboratives with:

1. legislation that grants local communities certain powers in exchange for commitments and accountability;
2. technical assistance;
3. coordination of state medical programs;
4. coordination of state departments by way of the State Coordinating Council.

The Task Force further stated that local collaboratives should include a minimum of the county, school district or special education cooperative and a mental health agency.

Additional products of the Task Force included the following: a legislative proposal, a service system design, an integrated funding model, methodology for Medicaid revenue enhancement, inclusion of mental health managed care provisions into state managed health care recommendations, coordination of model development with related state level initiatives, and working with insurers and HMOs.

The detailed work of the Task Force set the stage for action by the legislature and support from state agencies, counties, advocacy groups and parents. The Task Force worked with legislators to draft a bill for statewide implementation of integrated children's mental health systems at both the local and state levels. The Children's Mental Health Integrated Fund Act (Minnesota Statutes 245.491 – 245.496) was signed into law in May 1993.

At the same time that the Children's Mental Health Integrated Fund Proposal was being drafted, a few members of the Task Force envisioned a broader use of the Task Force legislative recommendations. These members established their own work group to apply the integrated fund and collaborative concepts to address the needs of children at risk. They developed a legislative proposal to establish family services collaboratives. Their proposal also became law in 1993 and is known as the Family Services and Community-Based Collaboratives (Minnesota Statute 124D.23). Both laws included appropriations for grants to communities and for technical assistance and state level coordination.

State and Local Collaboration

State level coordination for support to local level integration was a key component of the system envisioned by the Task Force. In fact, the Integrated Fund legislation relied significantly on the state level coordination in the form of the Children's Cabinet, a 10 agency, commissioner-level group with statutory oversight and approval of collaboratives.

The duties of the Children's Cabinet in legislation include:

- Assist local children's mental health collaboratives in meeting the requirements of the Integrated Fund Legislation, by seeking consultation and technical assistance from national experts and coordinating presentations and assistance from these experts to local children's mental health collaboratives.
- Develop methods to reduce duplication and promote coordinated services including uniform forms for reporting, billing and planning of services.
- Assist in the implementation and operation of local children's mental health collaboratives by facilitating the integration of funds, coordination of services and measurement of results, and by providing other assistance as needed.
- Develop procedures and provide technical assistance to allow local children's mental health collaboratives to integrate resources to maximize federal participation and improve efficiency of funding.
- Identify barriers to integrated service systems that arise from data practices and make recommendations including legislative changes needed in the Data Practices Act to address these barriers.

Both the family services and children's mental health collaboratives were created to develop a seamless system of care for children and their families, connecting fragmented systems and empowering participants.

Collaboratives were envisioned as a means to:

- Address the needs of children faced with complex problems with multiple interrelated causes and effects.
- Maximize impact and resources by enhancing coordination among systems and reducing duplication.

- Involve citizens, especially families, in the system redesign and implementation, so that their needs were effectively met.

Children's mental health collaboratives, in particular, were created to provide interagency services for children with severe emotional disturbances. The Integrated Fund legislation stipulated that children's mental health collaboratives:

- Allow 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.
- Create a local pool of state, local and private funds to procure a greater medical assistance federal financial participation. Improve the efficiency of using existing resources.
- Minimize or eliminate the incentives for cost and risk shifting.
- Increase the incentives for early identification and intervention.

Appendix D

Collaboratives Report on their Role in the Children's Mental Health System

As part of the study on the role of collaboratives, the Minnesota Department of Human Services and the Minnesota Department of Children, Families and Learning included the following question in its Annual Collaborative Report for calendar year 2001:

“What is the role of your collaborative in the children’s mental health system?”

Of the 93 collaboratives in Minnesota in 2001, 84 collaboratives responded to this report question. Responders included 43 of the 51 family services collaboratives (FSC), 13 of the 13 children’s mental health collaboratives (CMHC), and 28 of the 29 integrated family services/children’s mental health collaboratives (Joint).

Responses to the question fell into the categories of planning and coordination, and service provision.

Planning and Coordination

Thirty-seven collaboratives reported that their role was that of system planning and coordination for children’s mental health for the geographic area and target population that they served (11 – FSC, 13 – CMHC, 13 – Joint). Identification of service gaps, filling those gaps, promotion of best practices, and evaluation of the system of care were also roles noted by several of these collaboratives.

Fourteen collaboratives noted that client service planning was their role in the children’s mental health system (4 – FSC, 4 – CMHC, 6 – Joint).

Service Provision

Collaboratives reported the service provisions listed in Table I. Services were provided through contracts with other agencies and individuals, and/or by collaborative staff. Table I does not reflect all services provided by collaboratives. Rather, it is the list of service provisions that the collaboratives identified as their role in the children’s mental health system.

Table I
Children's Mental Health Service Provision
By Collaborative Type

Service	FSC	CMHC	Integrated	Total
Early intervention	23	3	7	33
Prevention	14	1	10	25
Outreach	8	7	6	21
Education	10	3	6	19
Information and referral	14	1	2	17
Early identification	2	2	7	14
Parent support and education	5	2	4	11

Additionally, collaboratives described the provision of mental health treatment services as part of their role. These mental health treatment services were provided through contracts with other agencies or individuals, and/or by collaborative staff. Mental health treatment services included, but were not limited to the following: mental health screening and assessments, diagnosis, outpatient, day treatment, case management, crisis, psychological and psychiatric services, in-home family therapy, family community support services, mentoring, respite care, multi-systemic therapy, and wraparound facilitation. Thirty-eight Collaboratives affirmed that they provided mental health treatment services in school settings (10 – FSC, 3 – CMHC, 15 – Joint). Thirty-nine collaboratives acknowledged that they provided mental health treatment services in community (non-school) settings (10 – FSC, 11 – CMHC, 18 – Joint).

In conclusion, collaboratives see their role in the children's mental health system as one of system and client coordination, as well as service and mental health treatment provision. All of the children's mental health collaboratives, and many of the family services and integrated collaboratives noted an ownership and responsibility for the mental health system of care for children with mental health needs.

List of Tables and Figures

<i>Table I : Overview of Collaboratives in Minnesota</i>	<i>Page 10</i>
<i>Table II : Children’s Mental Health vs. Family Services Collaboratives</i>	<i>Page 10</i>
<i>Table III: Integrated Service System Components</i>	<i>Page 15</i>
<i>Table IV: Non-mandated Partners on Collaborative Boards</i>	<i>Page 21</i>
<i>Table V: Parent Involvement / Support Activities</i>	<i>Page 22</i>
<i>Table VI: The County-School Partnership</i>	<i>Page 23</i>
<i>Figure I: The Integrated Service System</i>	<i>Page 11</i>
<i>Figure II Funding for Children’s Mental Health by Source 1991/2001</i>	<i>Page 16</i>
<i>Figure III: Collaboratives’ Integrated Funding</i>	<i>Page 18</i>
<i>Figure IV: LCTS Spending Statewide by Categories 1997-2001</i>	<i>Page 19</i>
<i>Figure V: Parent Involvement in Collaboratives</i>	<i>Page 22</i>
<i>Figure VI: Wraparound Service Coordinators</i>	<i>Page 25</i>
<i>Figure VII: System Coordination – The Collaborative Coordinator</i>	<i>Page 25</i>
<i>Figure VIII: Children Receiving Intensive Services by Age</i>	<i>Page 28</i>
<i>Figure IX: School Settings</i>	<i>Page 29</i>
<i>Figure X: Functionality Scores</i>	<i>Page 30</i>
<i>Figure XI: : Levels of Functioning at 6 Months</i>	<i>Page 30</i>

Endnotes

¹ Children’s Integrated Fund Task Force, *An Integrated Children’s Mental Health System: Coordinating the Needs of Children with Multiple Problems*, Report to the Minnesota Legislature, February 1993.

² Children’s Integrated Fund Task Force, *Ibid.*

³ Children’s Integrated Fund Task Force, *Ibid.*

⁴ Wraparound has been defined as: “The delivery of coordinated interdisciplinary services provided with the input of the child and family and tailored to the strengths and needs of the individual child and family.” [Hodges, S., Nesman, T., & Hernandez, M. *Promising practices: Building collaboration in systems of care. Systems of Care: Promising Practices in Children’s Mental Health*, Volume VI. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research, 1998].

As John VanDenBerg adds: Another term used interchangeably with wraparound is “individualized.” Wraparound is a simple process of people helping people. It means that a community starts with the child and the family around them, and the friends and kin around the family, and asks a crucial question – “What do this child and family, and sometimes the people around them, need to have a better life?” When we ask that question we really mean it— if the child and family need something our services do not offer, we create a way to meet the identified needs with something new, individualized to the strengths, culture, preferences and “ways” of the child and family. [VanDenBerg, J., & Grealish, E.M. *The Wraparound Process. Training Manual*, 1998].

⁵ As reported to the Minnesota Department of Human Services in the 2001 Annual Collaborative Report.

⁶ Stone, M., Nicol, B., Classen, J. *Understanding the Role of Collaboratives in Minnesota’s Children’s Mental Health System*, University of Minnesota Hubert H. Humphrey Institute of Public Affairs. Final integrated report compiled by: Julia Classen and Barb Nicol. Individual team reports prepared by: Ben Anderson, Julia Classen, Matthew Eastwood, Lisa Gardner-Springer, Kerri Gordon, Fang Jiang, Barb Nicol, Thilaphong Oudomsine, Marie Strom, Clara Tako, Joan Willshire. Mellisa Stone, Ph.D. principal investigator.

⁷ The good news is the children’s mental health collaborative model in Minnesota has a head start in the policy direction identified by the federal mental health agency. What is more, the National Association of State Mental Health program directors convened a meeting in January 2002 to review the findings from state commission reports on the status of mental health and needed improvements, for the purpose of identifying their primary policy implications.⁷ In response to the serious dissatisfaction most states reported with the adequacy of efforts to address the mental health needs of children and adolescents, and their families, the Commission reports consistently called for:

- **“A focus on the values and principles of systems** of care, including collaboration across service sectors, the support of a strong role for families, and the provision of individualized, comprehensive, and culturally competent services. There was a clear recognition that progress would be limited unless the mental health agency had effective partnerships with other child-serving sectors.
- **An increased emphasis on prevention**, based on models of risk and protective factors, and a better balance between prevention/early intervention, and services for children with serious emotional disorders and their families.
- **A re-examination of funding policies**, with an intent to create more flexibility in funding, to reduce categorical funding, and to expand the coverage offered under Medicaid. These calls for examining funding policies were frequently accompanied by calls for increased funding overall; in addition;

-
- **Greater attention to planning, accountability, and responsibility.** There was a pervasive concern that while multiple public and private entities had important roles to play in meeting the mental health needs of children and families, there was an absence of overall comprehensive planning, accountability was as fragmented as the rest of the system, and as a consequence there was a sense that nobody was responsible at the system level;
 - **A review of governmental structures, with an intent of creating a strong coordinated voice** for the needs of children and families specifically, for mental health overall, or for specific emphases, such as prevention.
 - **The creation of closer partnerships between schools and mental health** was a very strong emphasis in reports, and four states specifically identified a need for a greater focus on services for adolescents making a transition into adulthood;
 - **The improvement of quality of services through increased attention to professional training** (in partnership with universities), to overall issues of recruitment and retention of professional staff, to greater use of evidence-based practices, and to the establishment of professional standards for organizations and individuals;
 - **Greater public education efforts** both to reduce stigma and to increase support for child and adolescent mental health services.

[Friedman, R.M. *Child and Adolescent Mental Health: Recommendations for Improvement by State Mental Health Commissions*. University of South Florida, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, January 2002].

⁸ The public responsibility percent is based on a Duke University study of health insurance in North Carolina which estimated the percentages of children on Medicaid and those without insurance who have a SED. Applying these percentages to the people eligible for Medicaid and Minnesota Care who are ages 5-17, the (33,646) figure was estimated.

⁹ Stone et. al., *Ibid.*

¹⁰ Notes from the Collaborative Study Work Group's June 19, 2002 meeting on the Role of Collaboratives in the Children's Mental Health System.

¹¹ Six children's mental health collaboratives using the CFSP, five using the IIIP and two using their own multi-agency plan of care.

¹² Six children's mental health collaboratives using the CFSP, five using the IIIP and two using their own multi-agency plan of care.

¹³ Nineteen of the Integrated collaboratives are using the IIIP; six are using the CFSP and two are using their own.

¹⁴ Nineteen of the Integrated collaboratives are using the IIIP; six are using the CFSP and two are using their own.

¹⁵ Twenty-six of the Family Services Collaboratives are using the IIIP; seven are using the CFSP; six have developed their own multi-agency plan of care.

¹⁶ Twenty-six of the Family Services Collaboratives are using the IIIP; seven are using the CFSP; six have developed their own multi-agency plan of care.

¹⁷ See definition of wraparound in footnote 5.

¹⁸ Children's Integrated Fund Task Force, *Ibid.*

¹⁹ The five categories were decided by the local collaboratives themselves through Focus Group meetings between local collaboratives and the state. The categories responded to the direction the evaluation efforts were taking. Collaboratives felt they would best capture what they needed to report.

²⁰ In calendar year 2001, collaboratives reported LCTS spending \$38,939,259. The percentages of LCTS expenditures by categories was:

2001 LCTS Spending Statewide

Child development and school performance	34.9%
Family functioning	20.8%
Organization, community and system change	20.6%
Child and/or family health	14.7%
Administrative expenditures	5.2%
Other prevention and early intervention services	3.8%

²¹ Minimum mandated partners for children’s mental health collaboratives are the county, at least one school district, a mental health and a corrections entity. Minimum mandated partners for family services collaboratives are the county, school districts and a public health entity.

²² Stone et. al., *Ibid.*

²³ Stone et. al., *Ibid.* Written survey applied to collaborative partners. See appendix A.

²⁴ Note that a child, family or parent may be counted more than once in one or more services.

²⁵ DSM-IV is the Diagnostic and Statistical Manual of Mental Disorders – IV.

²⁶ In the CAFAS® Scoring System the total score is composed of sub-scale scores regarding levels of impairment of functioning and recommendations for service provision levels is as follows:

0 -10 = No noteworthy impairment.

20 -40 = Youth likely can be treated on an outpatient basis, provided that risk behaviors are not present.

50 - 90 = Youth may need additional services beyond outpatient.

100 - 130 = Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care

140 + = Youth likely needs intensive treatment.

²⁷ The responses came disproportionately from parents and families from out-state collaboratives.

²⁸ The responses came disproportionately from children from out-state collaboratives.

²⁹ Stone et. al., *Ibid.*

³⁰ State of Minnesota Children’s Mental Health Task Force. *Blueprint for a Children’s Mental Health System of Care.* St. Paul, December , 2002.

³¹ Prior to 1999, collaboratives completed a self-evaluation instrument known as the “Progress Report,” also sent in to the Minnesota Departments of Human Services and Children, Families and Learning.

³² Mendoza, A. *Report on Family Services and Children’s Mental Health Collaboratives: Summary Data from the 2001 Collaborative Report,* Children’s Mental Health Division, Minnesota Department of Human Services, June 2002.

³³ Sepanen, P., Ingram, D. *Minnesota’s Family Services and Children’s Mental Health Collaboratives. A Summary of Two Years Outcome Reports and Outcome Evaluation Plans.* Center for Applied Research and Evaluation Improvement. University of Minnesota. Minneapolis, 1996.

³⁴ National Mental Health Information Center, *Systems of Care: A Promising Solution for Children with Serious Emotional Disturbance and Their Families,* Washington, 2001.

³⁵ National Mental Health Information Center, *Ibid.*

³⁶ National Mental Health Information Center, *The Family Guide to Systems of Care for Children with Mental Health Needs*, Washington, 2001.



Minnesota Department of **Human Services**

Children's Services

444 Lafayette Road North
St. Paul, MN 55155-3839
www.dhs.state.mn.us

MS-1943e-ENG / GF (12/02)