



Minnesota Department of **Human Services**

Minnesota Family Investment Program and Children's Mental Health Pilot Evaluation

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Summary and Recommendations

The Minnesota State Legislature, through Minnesota Laws 2007, Chapter 147, Article 8 appropriated funds to implement children's mental health screening programs for children in families served by the Minnesota Family Investment Program (MFIP) at two pilot sites. The aim of this appropriation was to identify and address the mental health needs of children in MFIP families and modify MFIP Employment Plans to include children's mental health activities. Screening children and referring the children to services if indicated was hypothesized to improve the parent's getting or keeping a job.

The legislation posed two research questions: (a) What is "the effect of children's identified mental health needs, including social and emotional needs, on Minnesota Family Investment Program (MFIP) participants' ability to obtain and retain employment,"; and (b) What is "the effect on work activity of MFIP participants' needs to address their children's mental health needs."

The pilots operated for 18 months in Becker County with Becker County Children's Initiative (BCCI) as the grantee and for 15 months in Ramsey County at the Employment Services (ES) Provider Lifetrack Resources in St. Paul.

Children served by this program had a broad range of mental health and social-emotional conditions. The pilots identified these conditions in children who had not previously been identified through other service delivery systems and referred these children for a broad range of services. Not all these services were received. A lack of capacity in the children's mental health system was one reason children did not receive services. Lack of follow-through by parents and other caregivers was another. On the other hand, many services were still ongoing at the end of the study period.

Parents and relative caregivers reported a high level of satisfaction with the screening program; however, there is no evidence that the pilots had a positive impact on the employment of MFIP caregivers. The timeframe of the study may have been too short, and other family challenges too many and serious for employment outcomes to be improved. There were no obvious or available comparison groups as the offer was widely broadcast. Positive results may be long-term with many other intervening events. For all these reasons, it is not possible to give a definitive answer to the research questions.

Benefits of the program, according to the sites, included the education received by job counselor staff on the benefits of serving the mental health needs of families and the way the program encouraged a holistic systems approach to serving the needs of families rather than focusing narrowly on employment for the caregivers. Both sites have made changes to their service delivery models in part due to learnings from these pilot projects.

We recommend not continuing funding for these two pilot projects and that their models not be implemented statewide due to the high cost per screening and the lack of evidence that it improves MFIP outcomes.

The idea of creating a more formal link between MFIP Employment Services and children's mental health, however, has value because there is evidence that low-income children are at higher than average risk of developing mental health issues and less likely to receive services. Integrating MFIP and children's mental health services could be pursued in the following ways:

1. Educate job counselors working with MFIP families receiving Family Stabilization Services (FSS) on how to connect families with mental health resources for their children as these families could be under high levels of stress due to the employment barriers experienced by the family. Lifetrack Resources found referrals to home-based Children's Therapeutic Services and Supports (CTSS) to be particularly helpful to families facing multiple challenges.
2. Use the Employability Measure (EM) with MFIP participants to get a comprehensive picture of the family strengths and challenges. This will ensure that job counselors inquire about the children in MFIP families. This will be an opportunity for job counselors to discuss social-emotional development and refer families for children's mental health screening, if indicated.
3. Provide training on children's mental health at the annual MFIP conference. Training could be modeled after the training regarding children's mental health required for foster care families.

An additional general recommendation resulting from this pilot is to bring together a range of stakeholders, including legislators, the Department of Human Services (DHS), counties and advocates, prior to development of legislation to give guidance and ensure alignment of the hypothesis, program components and evaluation so that research questions can be addressed meaningfully.

Background

Research from the National Center for Children in Poverty (NCCP) supports screening children in low-income families for mental health and social-emotional development issues. A 2006 fact sheet from the NCCP reports that diagnosable mental health disorders affect one in five children and the rate is even higher in children in households with low income. Also, as many as 80 percent of children needing mental health services do not get them.¹

¹ National Center for Children in Poverty 'Children's Mental Health: Facts for Policymakers' November 2006. www.nccp.org

Often, mental health issues present during adolescence and can lead to problems at school and home, as well as involvement with the child welfare and juvenile justice systems.² Even very young children are affected by mental health issues. Infants and toddlers in low-income households and neighborhoods and those whose parents have a mental illness are more likely to develop behavior problems and very few of these children are identified.³ It is appropriate to target screenings to MFIP participants because they are necessarily low-income families and the MFIP Longitudinal Study found 40 percent of the ongoing recipients group received a serious mental health diagnosis over the course of nine years.⁴

Research conducted by DHS finds that families receiving public assistance often face multiple and severe barriers.⁵ Yet, traditionally, services to public assistance participants have been narrowly focused on getting the caregiver into the labor market. DHS has a number of initiatives to broaden the scope of services to MFIP participants. These initiatives include the Integrated Services Project, a pilot program seeking to provide comprehensive services to long-term MFIP families; Family Stabilization Services⁶, a statewide service track designed to help MFIP families facing certain barriers to employment through a case management model; Family Connections, a pilot connecting child welfare and MFIP, aiming to prevent child maltreatment in MFIP families; and the Employability Measure, developed by DHS to assess status in 11 areas, including child behavior, that affect employment.

The literature suggests that many children in need of mental health services are not being identified and served and these children are concentrated in low-income families. This supports screening children in MFIP families for mental health conditions. The legislation goes a step further to suggest that screening children in these families, referring them for appropriate mental health services, and modifying the parents' Employment Plans will lead to better employment outcomes for the parents of these children. That linkage was the focus of these pilots.

² National Center for Children in Poverty 'Adolescent Mental Health in the United States' June 2009. www.nccp.org

³ National Center for Children in Poverty 'Social and Emotional Development in Early Childhood' August 2009. www.nccp.org

⁴ Minnesota Family Investment Program Longitudinal Study: Five Years from Baseline and Beyond. (2008, October). Retrieved October 14, 2009 from: <http://edocs.dhs.state.mn.us/lfsrver/Legacy/DHS-4450K-ENG>

⁵ Minnesota Family Investment Program and the Diversionary Work Program: Characteristics of December 2008 Cases and Eligible Adults. (2009, September) Retrieved October 14, 2009 from:

<http://edocs.dhs.state.mn.us/lfsrver/Legacy/DHS-4219K-ENG>

Danziger, S., Corcoran, M., Danziger, S. Heflin, C., Kalil, A., Levine, J., Rosen, D., Seefeldt, K., Siefert, K., Tolman, R. (1999, June). *Barriers to the Employment of Welfare Recipients*. Retrieved October 14, 2009 from: <http://www.irp.wisc.edu/publications/dps/pdfs/dp119399.pdf>

⁶ DHS Bulletin 'Implementing DWP/MFIP Family Stabilization Services (FSS) #07-11-07

Program Description

The legislation (see Appendix A) provided broad mandates for the MFIP and Children's Mental Health Pilot projects. The law required DHS to fund a pilot to "measure the effect of children's identified mental health needs, including social and emotional needs, on MFIP participants' ability to obtain and retain employment" and also to "measure the effect on work activity of MFIP participants' needs to address their children's identified mental health needs." The pilots were to be funded for 18 months, January 2008 to June 2009, although the second project lasted only 15 months due to the necessity to issue a second Request For Proposals (RFP).

The legislation required interested providers to submit proposals detailing how they proposed to:

1. "identify participants whose children have mental health needs that hinder the employment process;
2. connect families with appropriate developmental, social and emotional screenings and services; and
3. incorporate those services into the participant's MFIP Employment Plans."

Providers were to develop a protocol to inform participants of the availability and purpose of screening and how the results of the screening would be used to identify and address barriers to employment, including by modifications to the MFIP Employment Plan.

Funding covered state fiscal years 2008 and 2009 (i.e., July 2007 to June 2009). Funding for the projects was federal TANF dollars and therefore could only be used to cover allowable costs for families who were receiving MFIP assistance. To avoid duplicating services, funding could not be used to provide cash payments, vouchers, vendor payments, or other forms of benefits designed to meet a family's basic needs. Also, funding could not be used to cover the cost of medical services including chemical or mental health assessment and treatment or diagnostic testing and evaluation. The cost of mental health screening was an allowable expense.

Required Activities

The RFP required the pilot projects to:

- Describe the child social-emotional and mental health criteria to be used for selection into the target population to be offered screening.
- Develop a protocol to inform MFIP participants with children at risk for mental health issues:
 - about the availability of social-emotional and mental health screening for children;
 - about the purpose and benefits of the screening;
 - how the information will be used to help the family identify and address social-emotional or mental health problems their child may be experiencing,

- that their MFIP Employment Plan may be modified based on screening results.
- Obtain written informed consent of participants for participation in the project, including consent for social-emotional development and mental health screening. A sample of the proposed consent form had to be submitted with the proposal.
- Connect families with social-emotional development and mental health screenings and then with referrals to mental health services, if appropriate.
- Coordinate with MFIP employment service providers, county social service agencies and health plans to assist participants with arranging necessary services.
- Revise the MFIP Employment Plan to incorporate participation in screenings, assessments, and identified services and record project participation using the appropriate codes and identifiers on the Workforce One system.

All MFIP families were eligible to be offered screening for their children and a caregiver's participation was completely voluntary. Children were eligible to be screened if they were not currently under the care of a mental health professional and had not received a diagnostic assessment or mental health screening in the past 180 days.

Screening Instruments

The screening tools mandated by DHS for use by the pilots were the Pediatric Symptoms Checklist (PSC) and the Ages and Stages Questionnaire, Social-Emotional (ASQ:SE). These instruments were chosen because they are straightforward and have proven to be valid and reliable. Use of the same instruments provided uniformity across the sites for the evaluation. DHS wanted to select measures that could be used by a variety of practitioners with varying levels of skill so that, if successful, projects could be more easily replicated. Both screeners were administered by the program staff who interviewed the parent or other caregiver.

The PSC⁷ is a screening tool for children ages 6 to 18 years. The measure is designed to identify possible cognitive, emotional or behavior problems. The questions are answered by the child's parent or caregiver.

The ASQ:SE⁸ is marketed as an easy to use screening tool which focuses on a child's social and emotional development. This tool is valid for children ages 3 to 60 months and questions are also answered by the parent or caregiver of the child.

⁷ http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf

⁸ <http://www.brookespublishing.com/store/books/squires-asqse/index.htm>

Referrals for services were made for most children with an elevated score on the appropriate screening tool, and also when in the program staff's judgment the child could benefit from further assessment. While allowing referrals based on the program staff's judgment damaged the integrity of the program model, nearly half of the children identified in this way received services.

At the Becker site, the case manager often also used the Strengths and Difficulties Questionnaire (SDQ), a behavioral screening tool for 3 to 16 year olds.⁹ The case manager found four children likely to benefit from further assessment using the SDQ who were not shown to need further intervention after scoring the PSC. Because this site believed the quality of information obtained using the SDQ was superior, they used both the PSC and SDQ when screening children for this pilot.

Program Theory

Research shows that children in low-income families are at higher risk for developing mental health conditions and that these children are often under-identified and under-served. Screening children in MFIP families and referring children identified as needing mental health services to providers would help meet the mental health needs of an under-served group of children. Additionally, the opportunity for the MFIP caregiver to have a modified Employment Plan that could replace work and activities leading to finding a job with activities related to the child's services would produce better long-term employment and economic outcomes for the family. There are a number of faults with this program theory. These issues can be summarized as short duration, narrow focus, and the lack of a clear intervention.

The short-term nature of the projects was a barrier. Eighteen months of operation is a short time, especially considering that a diagnostic assessment of a child often takes place over multiple appointments and many months. The time it takes a child to successfully complete a service plan and the parent then to obtain employment could be quite long.

Another flaw was the narrow focus. It is widely known from other research at DHS, that families receiving MFIP face multiple barriers to employment¹⁰ but this pilot sought only to uncover the mental health needs of the children in these families. Lifetrack Resources wrote in their narrative report for the quarter ending September 30, 2008, "One deterrent is the fact that many of the families we serve are in crisis. While they are interested in providing additional services to their children, they also need to address basic needs such as shelter and food before agreeing to play therapy or home visits."

There was considerable overlap between this pilot program and Family Stabilization Services (FSS) and Adult Rehabilitation Mental Health Services (ARMHS). In their final report on the program, Lifetrack Resources indicated the most effective program model

⁹ <http://www.sdqinfo.com/>

¹⁰ Minnesota Family Investment Program Longitudinal Study Reports Series. (1999, August – 2008, October). Retrieved October 14, 2009 from: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectio nMethod=LatestReleased&dDocName=id_004113

was a collaborative partnership between the participant, job counselor, and ARMHS practitioner. The families served by this program were experiencing multiple and often severe barriers to employment.

Also, screening children is not an intervention. There is a large logic gap between screening children, and perhaps modifying the Employment Plan and caregivers obtaining employment. The theory assumes that children who receive positive scores on the screening instruments will then follow up with mental health services and successfully complete treatment soon enough to affect their caregiver's employment. The broad range of identified needs and services children were referred to makes discerning a program effect difficult.

Furthermore, the underlying program theory assumes a child's mental health issues must be addressed before a caregiver can become employed. Lifetrack Resources provided a story in a narrative report where the opposite was true. The advocate first helped a father secure appropriate child care so he could maintain a job he had recently started and waited until his job was stable to proceed with screening for his child.

Evaluation Method

The purpose of this study was to conduct an evaluation of the MFIP and Children's Mental Health Pilot projects to help determine the impact of screening for a child's mental health needs, including social-emotional needs, on the parent's ability to work and participate in Employment Services and, ultimately, obtain and retain employment. There was no random assignment experimental design and therefore a determination of the impact of the pilots is not possible from the data.

At the direction of the DHS Institutional Review Board (IRB), diagnoses and treatments of children were to be referred to generally as needs and services.

Research Questions

The Legislature required the evaluation to address the following questions:

- How many MFIP participants and their children were served by the projects?
- How many children screened needed referral or follow-up services?
- What services were received and from what agencies?
- How many Employment Plans were modified to include activities recommended in the screenings?
- Was there a change in the following measures?
 - Work Participation Rate,
 - Sanction rate,
 - Unemployment Insurance reported earnings
- What did the participants report about the projects' effectiveness?

Data

To investigate these questions, DHS analyzed data from six sources;

1. quarterly narrative reports prepared by the sites,
2. observations made during site visits by DHS staff,
3. program data collected by the sites,
4. administrative data¹¹ from
 - DHS's MAXIS system which determines eligibility for MFIP and other public assistance programs and collects demographic and program data
 - The Department of Employment and Economic Development's (DEED) Workforce One system which is a case management system for work programs including MFIP Employment Services,
5. data from a telephone survey conducted with program participants, and
6. information collected from the two sites during phone calls, videoconferences, and email communication.

The information from meeting minutes, the quarterly narrative reports, site visits and other contacts is used primarily to provide program descriptions and investigate program implementation. DHS held meetings with each site to discuss the required program activities, explain the evaluation and finalize the contracts. The meeting with BCCI and its partners in Becker County was held via videoconference and the meetings with Lifetrack Resources were held at the site. Each site was required to submit a written narrative at the end of each calendar quarter.

The BCCI site was visited once during August 2008. During the visit, the evaluator and contract manager met with BCCI and staff at Becker County and attended an ES Overview during which the case manager presented the program to new MFIP participants. Because of its proximity to DHS, Lifetrack Resources was visited more frequently. The evaluator visited the site quarterly to collect data and discuss program operation.

Two conference calls were held with DHS and both sites. This allowed DHS to learn more about how the pilots were being implemented and allowed the sites to discuss effective strategies for engaging and serving participants with each other.

To report on the number of families served and the services their children received, each site was given a database on which to record data from their site. MAXIS identifiers and names were collected for each adult MFIP participant offered child mental health screening through the pilot and for their children. Other data points collected included whether the family accepted screening, declined, or was excluded; scores on screening instruments; names of agencies children were referred to for ongoing services; and data on the type, duration, intensity and result of those services. The program staff member hired for the grant at each site had the responsibility for accurate and complete data collection. In addition to the database, each site was given a menu and explanation of the data to be collected to ensure consistency of the data across the two sites and technical assistance in using the database.

¹¹ Administrative data extracted from the DHS data warehouse which contains data from state administrative systems including MAXIS and Workforce One.

Administrative data from the DHS data warehouse on MFIP use, earnings, employment status, sanction status and Employment Plans were used to determine changes in the Work Participation Rate (WPR), MFIP exit rate, sanction rate and earnings. Demographic information described the group participating.

A random sample of participants whose children received mental health screening and referrals for additional services through the project was selected each quarter and invited to participate in a telephone survey. Participants responded to a short survey about their opinions of program effectiveness.

Possible Confounders

Three other DHS projects were concurrent with this one and families may have been affected by more than one project.

1. FSS, a new employment service track for MFIP participants who are not making significant progress in MFIP or DWP Employment Services due to a variety of barriers to employment, was implemented statewide in February 2008. Job counselors are allowed greater flexibility in providing services and FSS participants are served through a case management model.¹² These cases are state-funded and not included in the WPR. Essentially everyone in FSS is allowed to have their Employment Plan modified. At Lifetrack Resources, 35 percent of the children screened during calendar year 2008 had a caregiver participating in FSS. In Becker County, 49 percent of the children screened had a caregiver participating in FSS. The most common FSS categories over the course of the pilot for MFIP participants who were offered the program at Lifetrack Resources were family violence waiver, mentally ill and IQ less than 80. In Becker County the most common FSS category over time was ill or incapacitated followed by special medical criteria, and care of an ill or incapacitated family member.
2. Family Connections, a pilot project connecting child welfare services and MFIP families and focused on the prevention of child abuse, was operating at one of the sites selected for this pilot, Lifetrack Resources, during the same time period. Nine families were offered services from both programs.
3. The Integrated Services Project was a pilot project operating at 8 sites around the state, including Lifetrack Resources. The project's aim was to develop models of service delivery, to coordinate services for long-term MFIP families, and to improve both economic and social outcomes. One participant from the Becker County site and three from Lifetrack Resources received services from an ISP at some time between 2005 and 2009.

¹² More information on Family Stabilization Services is available in DHS Bulletin #07-11-07.

Site Selection

A RFP was initially posted August 27, 2007. Only one agency, Becker County Children's Initiative (BCCI) submitted a proposal in response. BCCI, located in Detroit Lakes, is a family service collaborative. Its members include local school districts, Becker County Community Health, Becker County and the White Earth Reservation. A review panel made up of DHS staff from Transitions to Economic Stability (TES), Children's Mental Health, and Program Assessment and Integrity Division (PAID) and Ramsey County Mental Health, Chisago County MFIP and a Children's Mental Health Advocate evaluated the proposed project and requested changes to the budget that BCCI made before the review panel approved the proposal.

With approximately half of the allocation remaining, a second RFP was issued on December 10, 2007 and an effort was made to advertise the second posting more widely to elicit more responses. Seven proposals were received in response to the second RFP. The proposals were from both urban and rural parts of the state and both public and non-profit institutions. The same review panel was convened to select the second site and Lifetrack Resources, a community based non-profit, was the successful respondent. At the time they were selected as a pilot site, Lifetrack Resources¹³ held a contract to provide MFIP Employment Services to participants in Ramsey County.

The second pool of proposals contained a few promising models for delivering children's mental health screenings to MFIP families but due to the amount of funding remaining only one additional site could be funded.

The contract for BCCI in Becker County was effective from January 1, 2008 to June 30, 2009. The contract for Lifetrack Resources in Ramsey County was in effect from April 1, 2008 to June 30, 2009.

Lifetrack Resources

Target Population

Lifetrack Resources serves MFIP participants in Ramsey County and the office in which the pilot operated is located in an urban neighborhood in St. Paul. In addition to serving the broader MFIP population, Lifetrack's caseload included all 18 and 19 year-old caregivers who chose the MFIP employment option. For this reason, their population tended to be younger mothers with younger children. Also, Lifetrack Resources serves MFIP participants who are immigrants to the U.S.

Table 1 displays demographic information of the caregivers offered screening through the pilot at Lifetrack Resources.

¹³ Lifetrack Resources lost its MFIP contract with Ramsey County in March 2009.

Table 1. Lifetrack Resources – Caregiver demographics

Lifetrack Resources MFIP Caregivers		N = 116	
Mean age (in years)			26
Mean benefit months (months)			33
Race	Count	Percent	
African American	62	53%	
White	32	28%	
Hispanic	9	8%	
Hmong	5	4%	
American Indian	3	3%	
Multiple	3	3%	
Somali	2	2%	
Diagnoses of caregiver	Count	Percent	
Serious Mental Health	49	42%	
Chemical Dependency	32	28%	
Co-occurring	21	18%	

The mean age of caregivers was 26 years and the average number of months the caregiver had been on MFIP was 33. Half of the caregivers were African American¹⁴, about one-quarter were white and the remainder were Hispanic, Hmong, American Indian, Somali or identified themselves with multiple races. Forty-two percent had a serious mental health diagnosis¹⁵ and 28 percent had a chemical dependency diagnosis (for drugs or alcohol, but not tobacco) in claims submitted to a public health insurance program¹⁶ within the previous three years.

Table 2 displays demographic characteristics of the children offered screening by Lifetrack Resources. Nearly three-quarters of the children offered screening at this site were under age six. Fifty percent of the children had an African American caregiver, 27 percent had a white caregiver, 7 percent had a Hispanic caregiver, the remainder of the children had caregivers who were Asian, American Indian or of multiple races.

¹⁴ African Americans are defined as blacks born in the U.S.

¹⁵ Diagnosis of serious mental health condition, including psychosis, depression, personality disorder, post-traumatic stress syndrome, or anxiety state.

¹⁶ Data on mental health and chemical dependency diagnoses are from claims data submitted to a Minnesota Health Care Program between June 2006 and June 2009.

Table 2. Lifetrack Resources – Child demographics

Lifetrack Resources Children		N = 210	
Age Group	Count	Percent	
0-5 years	153	73%	
6-12 years	40	19%	
13-18 years	17	8%	
Race of the caregiver	Count	Percent	
African American	105	50%	
White	56	27%	
Hispanic	15	7%	
Hmong	9	4%	
Multiple	9	4%	
Somali	9	4%	
American Indian	7	3%	

Program Staff

Lifetrack Resources hired a full-time MFIP Child Advocate to assume the direct work of the pilot. The advocate provided education on children’s mental health issues and screenings to MFIP job counselors, offered screening to families, completed mental health screenings of children in MFIP families, and referred children for further assessment and services when appropriate. The advocate also followed up on referrals to collect data for the evaluation. The job description for the MFIP Child Advocate was matched to the activities of the contract.

“A single mother who had been in sanction for 5 months was referred to the pilot program due to concerns about her child’s development. The mother admitted to using drugs and said she wasn’t sure how to be a good mom. The family is now having regular home visits from a therapist and is making progress.”

Lifetrack Resources Structure

The structure developed by this site lent itself well to this screening pilot. The advocate was an employee of the non-profit and located with the MFIP job counselor staff in the agency and supervised by the MFIP manager. Because children’s mental health services were offered on-site through the Beginnings program, the advocate had access to mental health practitioners when necessary. This structure allowed the advocate to be known to agency staff and MFIP participants. Her office was located near the front of the employment service area so job counselors and MFIP participants were often passing by.

“A family dealing with loss, drug addiction and culture shock was referred to the program. After screening the children were referred for separate therapy based on their unique needs.”

There was a large decrease in referrals when the agency lost its MFIP contract in March 2009 and the advocate began working with other employment service providers in Ramsey County for referrals. In the narrative report for the quarter, Lifetrack wrote, “While HIRED and EAC proved to be willing collaborators, the benefits of having an on-site advocate cannot be argued.”

Another beneficial aspect of the structure at this site was that families requiring further assessment and services were most often referred to in-house programs or to providers with which Lifetrack Resources had a close relationship. The proximity of the in-house programs and the strong relationships with external providers aided follow up on referrals. Family Innovations, an external provider which provides in-home CTSS services to families was a particularly good match for the target population.

Program Process

To inform MFIP caregivers about the screening program, the advocate presented program information and brochures at three to four MFIP overview meetings per week, and at job club each morning. Initially the advocate attempted to recruit new MFIP participants into the program, but she learned early in the first quarter of operation that MFIP participants who had already had time to build a rapport with their job counselor and the agency were more likely to take advantage of the screening program.

The site reported that MFIP participants can be difficult to engage in new programs. When a referral was received, the advocate would make several phone calls, send a letter and attempt a home visit before determining that a participant was not interested in participating in the program.

“A young mother of three wasn’t working and didn’t have permanent housing. All children had elevated screening scores and are now receiving in-home therapy. The visits have prompted the mother to also seek mental health services through the ARMHS program.”

Referrals to the screening program came from the job counselors on staff. Early in the program, when referrals were low, the advocate held contests for job counselors rewarding those with the highest number of referrals to the program. During this time the advocate spent a lot of her time educating job counselors on the benefits of screening and treating mental health in children. This investment in education paid off when job counselors became adept at sending appropriate referrals and convincing their participants of the benefits of screening, by the second quarter of operation. When the agency lost its contract with the county, the advocate developed relationships with two other agencies, Employment Action Center (EAC) and HIRED, ES providers in Ramsey County, for referrals into the program.

The advocate met with caregivers to provide information about social-emotional development and offer screenings. Each of the pilot sites recognized the stigma often associated with mental health problems and Lifetrack Resources replaced the term “mental health” in their discussions with clients with “social-emotional skills.” If the caregiver agreed to screening, the advocate would conduct the screening and score the instrument. A discussion with the caregiver regarding the result would determine the most appropriate referral, if warranted.

During the second quarter of the program, the advocate began partnering with Adult Rehabilitative Mental Health Services (ARMHS) practitioners, often doing outreach on home visits. Working as a team to comprehensively address mental health concerns of

“A single father of a two-year-old boy was referred due to the child’s anger and low level of social skills and speech. The dad had just started a new job and didn’t have child care. The advocate first helped arrange child care to start the very next day and then helped set up in-home therapy once the family had settled into dad’s new work schedule.”

all family members proved to be the most effective service model, according to Lifetrack Resources’ report from the second quarter of the program. This connection to ARMHS services likely targeted families with children at risk of needing mental health services.

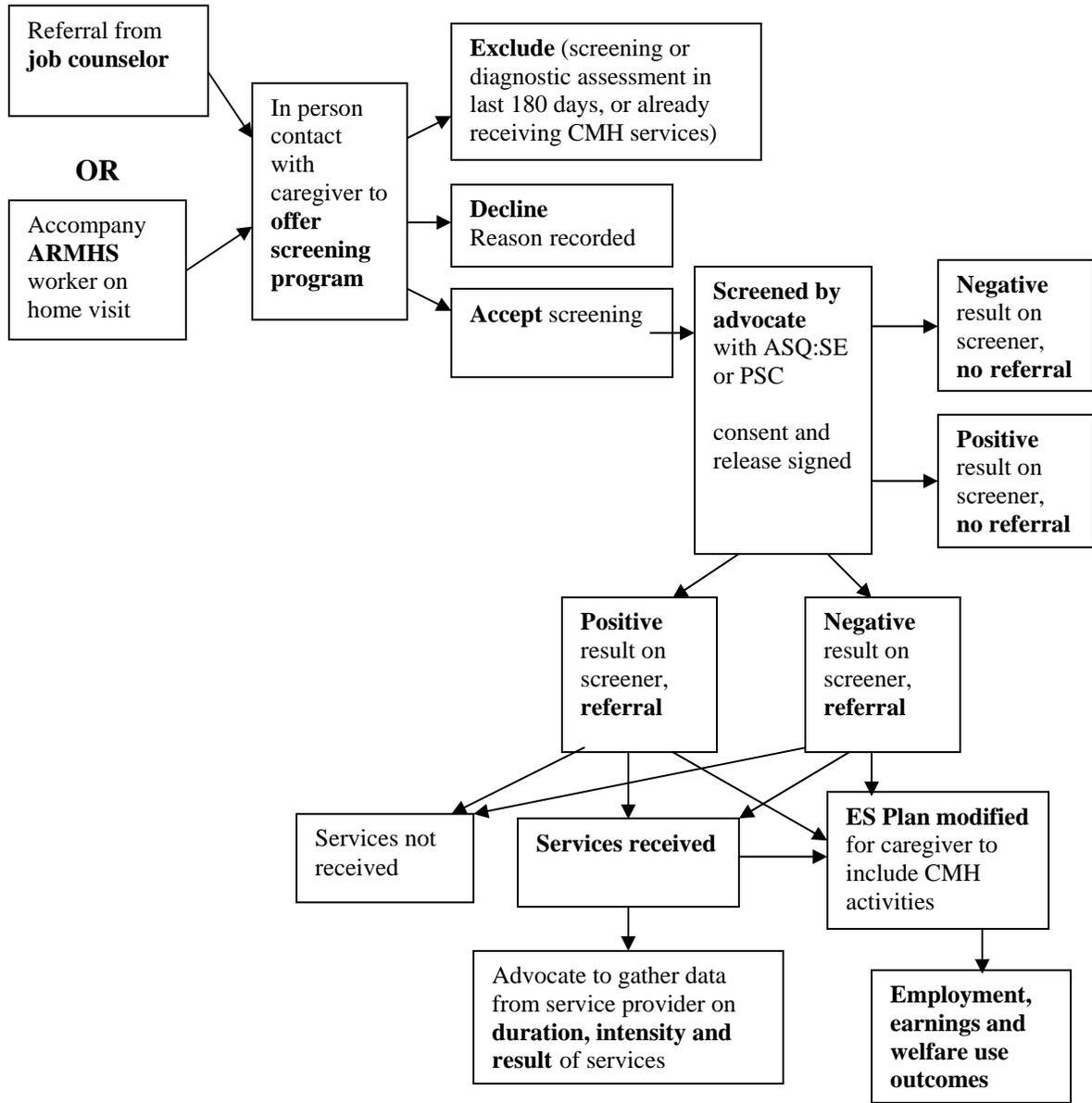
Families were most often referred for home visiting, therapy services, or to supported learning environments. Home visiting referrals included Beginnings In-Home Therapy and Family Innovations and supported learning environments included Families Together Therapeutic Preschool, Head Start and Early Head Start.¹⁷

By the end of the third quarter of operation, job counselors were including screenings and follow-up services in Employment Plans for MFIP participants. Incorporating these program activities into the Employment Plan helped increase the rate of follow through by participants, according to the site.

The advocate was also responsible for following up on referrals made for further assessment or services to collect data on any services received by the child. Figure 1, developed by DHS, is a visual representation of the Lifetrack Resources program, verified by the site.

¹⁷ A January 2006 report by the National Center for Children in Poverty supports Early Head Start and home visiting programs as interventions that successfully address social and emotional development and target vulnerable infants and toddlers. ‘Helping the Most Vulnerable Infants and Toddlers’ January 2006. www.nccp.org

Figure 1. Lifetrack Resources Process Model



Implementation

The number of families taking advantage of the screening program was fewer than expected. Additionally, those who made appointments with the advocate often did not follow through. The advocate did make considerable efforts to reschedule participants and even attempted home visits, however many families who initially agreed to screening for their children never followed through with screening.

For families who did follow through with screening, capacity issues limited their ability to get services for their children. Even by the second quarter of operation, preferred referral sites were reaching their limits. The advocate made connections with additional service providers, even providers outside Ramsey County, in an attempt to ensure participants could get needed services. In interviews with participants, a few expressed frustration with being on waiting lists for services. In December 2008, the Beginnings In-Home Therapy program lost funding which further limited the availability of services to which participants could be referred.

The following quarter Lifetrack Resources lost its MFIP contract with Ramsey County and the agency ceased to provide MFIP Employment Services in March 2009. This change resulted in the loss of the sole referral source to the program. To keep the screening program active, Lifetrack Resources reached out to the two ES providers in Ramsey County mentioned above, EAC and HIRED. With one quarter of program operation time left, the advocate made presentations and met

with clients off-site at the other agencies, but this was less effective and resulted in only 5 screenings during the final quarter of the program.

“When a young mother of three didn’t show for her scheduled appointment, the advocate made a home visit. She found the children didn’t have designated sleeping areas and spent the majority of their time in the small apartment watching TV. The screening revealed elevated scores for two of the children and all were referred to Head Start. Having the children engaged in a structured half day activity allowed the mother to seek services for her own mental health concerns.”

Site Comments

“We have found this program to provide an invaluable service for our clients. Introducing early childhood mental health screenings into the MFIP program has helped us to think of case management in a more holistic and family oriented way, which we hope will positively affect the services provided, and our participants’ level of reception towards them.”

Becker County Children’s Initiative

Target Population

Becker County, which spans nearly 1,500 square miles, is located in west central Minnesota and has a largely rural population. Detroit Lakes, the county seat, has a population of approximately 8,000.¹⁸ Rural Minnesota CEP provides Employment Services to all MFIP participants living in Becker County except those living on White Earth Reservation which is partially located in Becker County. Becker County’s average MFIP caseload is approximately 250 cases. Rural Minnesota CEP was a partner in this pilot whereas the White Earth Reservation was not. For this reason, only American Indian families that were not served by White Earth Employment Services were offered services through the pilot.

Table 3 displays demographic information of the caregivers offered screening through the pilot project, which they titled Collaborative and Comprehensive Assessment & Access Project (CCAAP). The mean age of caregivers was 31 years and caregivers at this site had been on MFIP an average of 34 months. Over three-quarters of the caregivers were white and the rest were American Indian. Based on data from the public health insurance program, nearly half had a diagnosis of a serious mental health condition in the past three years and one-quarter had a chemical dependency diagnosis over the same time period.¹⁹ The rates of serious mental health diagnoses and chemical dependency were similar at the two sites and higher than in the general population.

Table 3 . BCCI – Caregiver demographics

BCCI MFIP Caregivers		N = 27	
Mean age (in years)		31	
Mean benefit months (months)		34	
Race		Count	Percent
White		21	78%
American Indian		6	22%
Diagnoses of caregiver		Count	Percent
Serious Mental Health		13	48%
Chemical Dependency		7	26%
Co-occurring		6	22%

Table 4 displays demographic information for the 72 children offered screening at this site. Eighty-one percent had a white caregiver and 19 percent had an American Indian caregiver. The children served at this site were older, on average, than those served by Lifetrack Resources.

¹⁸ <http://www.city-data.com/city/Detroit-Lakes-Minnesota.html>

¹⁹ Data on mental health and chemical dependency diagnoses are from claims data submitted to a Minnesota Health Care Program between June 2006 and June 2009.

Table 4. BCCI – Child demographics

BCCI Children		N = 72	
Age Group	Count	Percent	
0-5 years	27	38%	
6-12 years	31	43%	
13-18 years	14	19%	
Race of the caregiver	Count	Percent	
White	58	81%	
American Indian	14	19%	

Program Staff

Becker County Human Services hired a full-time case manager to assume the direct work of the pilot. The case manager had experience providing children’s mental health case management in Becker County. According to the job description of the case manager, 55 percent of the case manager’s time was devoted to providing children’s mental health case management. Case management activities included making necessary services available to children with ED/SED/CD, helping families obtain comprehensive assessments, developing and maintaining an Individual Support Plan, coordinating services and reassessing services for appropriateness over time. Ten percent of the case manager’s time was dedicated to the intake activities of providing initial evaluation and assessment,

“A single mom-had her children screened. One child was already receiving case management and now the mental health needs of the other two children are being met through in-home and school-based services. Now mom is able to focus on finding a job to help support her family.”

“A single mom was referred by her job counselor. Four of her children were having sibling problems. Mom had to constantly be home to defuse situations between them. This made it difficult for her to hold a job. The children received case management, in-home services and individual counseling. They have been working on understanding the importance of family and working together. Their case management services have now ended due to their amount of progress.”

identifying appropriate services and making referrals.

The time allocation in the job description did not match the expectations of the contract. DHS and BCCI lacked a common understanding of the purpose of this pilot. The contract with BCCI states the program’s focus would be on engaging MFIP families to participate in the program, screening children and assisting families with arranging for further services when appropriate. The contract does not include case management services as part of the project. This mismatch resulted in the low numbers of participation and screenings at this site. More site visits might have made the site’s misunderstanding obvious sooner.

BCCI Structure

BCCI, a family services collaborative, held the contract with the State of Minnesota for this pilot project; however, it had a small financial stake in the pilot. In the initial proposal, BCCI envisioned a larger role in data collection and evaluation. The proposal that was approved by DHS decreased BCCI’s allocation in the budget by 63 percent of

their initial request which in turn reduced BCCI's role to grant reporting, program coordination and meeting facilitation.

The case manager hired to provide program services was an employee of Becker County Human Services and was supervised by the Director of Mental Health at Becker County. The largest portion of the grant allocation went to Becker County for the case manager's salary and to provide supervision.

MFIP Employment Services in Becker County are provided by Rural Minnesota CEP and the case manager spent two days each week for the first eight months of the program at the CEP office. It was expected that job counselors at CEP would be a main source of referrals to the program. Rural Minnesota CEP did not receive any additional funding through this pilot.

"A husband and wife were referred by their job counselor regarding concerns that their oldest child may have Autism. The parents were having a difficult time getting a referral for appropriate testing. Through the pilot project they received the appropriate referrals for testing and now the child is receiving counseling and meeting with a neurologist."

Another partner in this project was the Minnesota Consortium for Advanced Rural Psychology Training (MCARPT) program whose role was to consult on utilization and interpretation of the screening tools and provide diagnostic assessments to children identified through screening. MCARPT received a portion of the funding equal to what was received by BCCI. The MCARPT psychologist held a brownbag lunch session together with the case manager to inform MFIP participants and staff at CEP about mental health issues and also attended some ES overviews.

Program Process

According to the project model in the contract, the case manager was expected to present the pilot project to MFIP participants, administer the ASQ:SE or PSC, consult with MCARPT psychologists as needed, discuss recommendations with the participant, and make referrals to mental health professionals. As part of the employment and training team, she would help to incorporate the screening process and any follow-up services into the MFIP participants' Employment Plans.

In practice, the case manager provided case management services to children identified for services. According to the site, insufficient capacity in the children's mental health system resulted in the case manager having to provide a greater degree of service to families. BCCI pointed out that the older children at this site tended to have more complex mental health needs and needed a case management approach.

To engage new MFIP families, the case manager gave presentations and offered brochures on the screening program to MFIP participants during semi-monthly Employment Services overviews at Rural Minnesota CEP. The MCARPT psychologist often accompanied the case manager and assisted during these presentations. Over the

course of the project, 134 MFIP participants attended these presentations.²⁰ This group presentation was an attempt to inform participants in a non-threatening way about the services available. During the presentation observed by DHS staff on August 19, 2008, the case manager described it as “a program to help kids on MFIP.” She explained to the MFIP participants present that most MFIP services are directed toward parents, but kids also experience stress and sometimes they need help too. She stressed that the program was voluntary and that “parents are in the driver’s seat.” The screening was described as a guide and a way of knowing if your children’s development was appropriate for their age.

The case manager discovered early in the program that she was more successful engaging families that had been receiving MFIP for awhile rather than families that were new to MFIP.

Existing MFIP families were also eligible to participate in the program and financial workers and job counselors were asked to inform MFIP participants about the program during one-on-one meetings.

At the pilot’s inception in Becker County, it was thought that referrals to the screening program would come mainly from financial worker staff at the county and from job counselors at Rural Minnesota CEP. When referral numbers were low, the case manager reached out to public health, child protection and mental health to increase the number of families coming into the program. Eight months into the pilot, the case manager began to office solely at Becker County Human Services due to the lack of referrals coming from CEP. Referrals were coming from financial workers and social services that were located at the Becker County office.

“A family who had recently relocated to Becker County was referred due to problems the teens were having at school. The teens had very little reading ability and this was causing anxiety. They were often calling from school saying they didn’t feel well. Mom would have to leave work to pick them up and she wasn’t meeting the MFIP work requirements. The case manager worked with the school to create an IEP and the teens received help with learning disabilities. Now mom started a new job and she doesn’t have to leave work to pick up the kids from school.”

According to the contract, families in need of additional screening and assessment were to be referred to MCARPT for diagnostic assessments and then on to mental health service providers in the area. To provide information on the result of services, children receiving services were to have a CASII and SDQ²¹ every six months to gauge their progress. It is not known if this was done; no follow-up data were submitted.

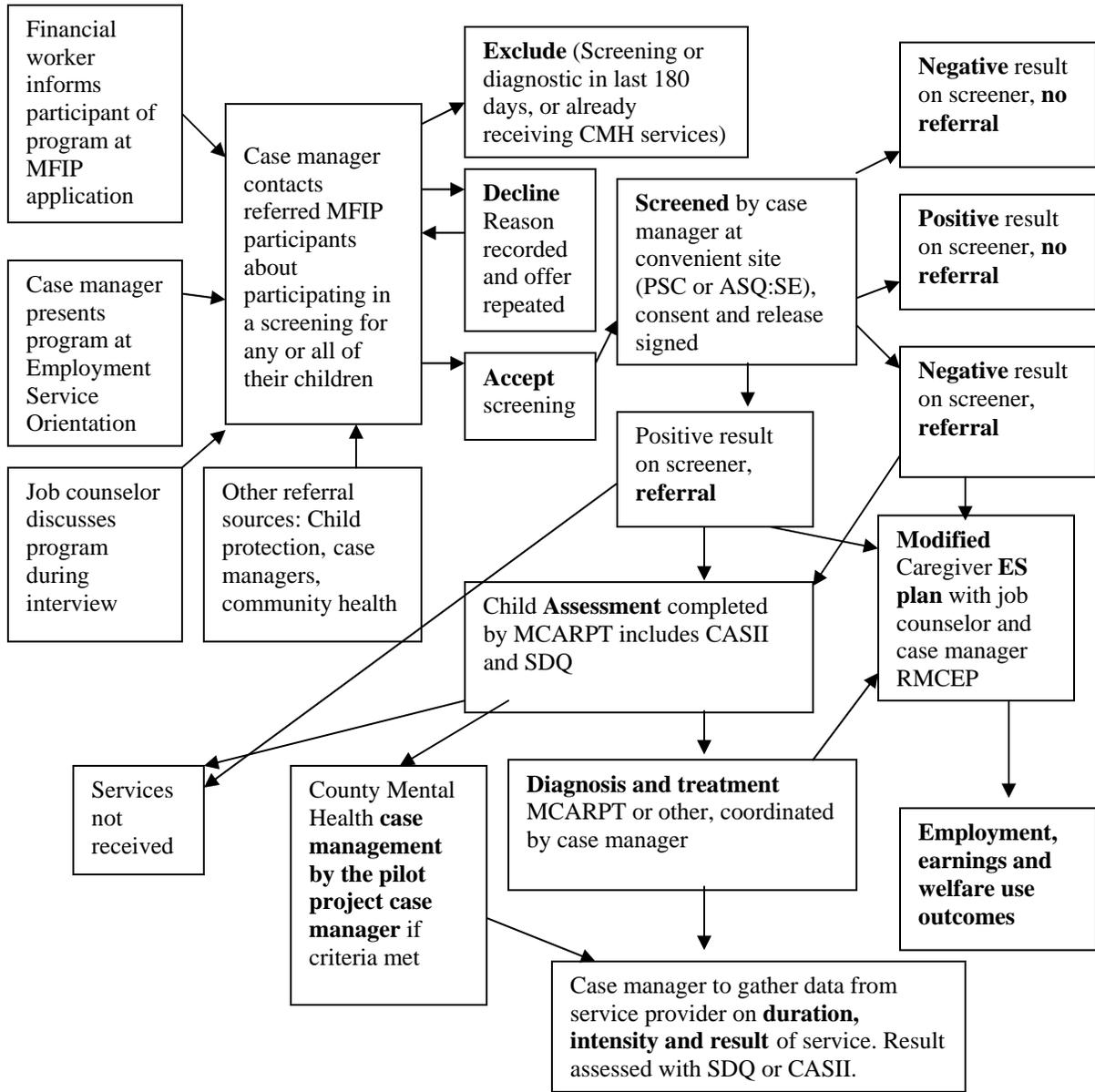
²⁰ MFIP participants from both Becker and Otter Tail counties attended overview presentations at this office. Otter Tail county MFIP participants were not eligible to receive screenings through this program. If an Otter Tail participant expressed interest having their child(ren) screened, they were referred to Otter Tail County Human Services.

²¹ SDQ – Strengths and Difficulties Questionnaire <http://www.sdqinfo.com/b1.html>. CASII – Child and Adolescent Service Intensity Instrument http://www.aacap.org/cs/root/member_information/practice_information/casii

While Becker reported frequent communication between the case manager and CEP staff, CEP staff remained unclear about which Employment Plans should be modified to include children's mental health activities.

Figure 2, developed by DHS, gives a visual description of the BCCI program, verified by the site.

Figure 2. BCCI Process Model



BCCI reported that the pilot project led to new connections between mental health and MFIP in Becker County. Adult mental health services through MCARPT are now available to MFIP participants at Rural Minnesota CEP. Job counselors now have the ability to make referrals for both adults and children. Because MCARPT funding is not tied to health insurance plans, participants are able to receive services whether or not they have health insurance. This has been a positive unintended result of the pilot, according to the site.

Implementation

There were a number of challenges experienced at this site. The structure of the program appears to be the main contributing factor.

BCCI was the grant holder but the case manager was an employee of Becker County and supervised directly by Becker County. BCCI was outside of the day-to-day operation of the pilot. This was evident in the quarterly reports submitted by BCCI, in which parts were copied from earlier quarterly reports, such as family stories.

At the outset, the case manager was using a screening tool that was not prescribed in the contract to screen children. The children who had received screening had to be re-screened with the correct measure and a new consent form had to be signed. The RFP and contract were clear about what screening instruments were to be used for the pilots, yet since it was BCCI that produced the proposal and held the contract it is unclear what level of oversight was provided and what level of detail was shared with the county, which was responsible for program operation.

Another major issue at this site was the low number of referrals to the program, particularly in the last two quarters. When DHS tried to reach BCCI and Becker County via phone and email in April 2009 regarding concerns about the low number of program offers and screenings after the data were submitted for the first quarter of 2009, no response was ever received. BCCI did not submit a quarterly report for the first quarter of 2009.

The site reported challenges in delivering services in a rural community. According to BCCI, an inadequate number of referral sources and the large geographic area served made focusing solely on screening and referrals impossible. The level of care needed by the families in the program required intensive interaction between the family and case manager.

In the last two quarters of the program there were no new program offers to MFIP participants. The site reported difficulty getting referrals because workers were reluctant to refer participants to a program that would be ending soon. During this time the case manager was providing case management to nine children identified for services through the pilot. The case manager worked not only with the identified child but the family as a whole.

In the quarterly narratives, BCCI noted families were often difficult to engage for two reasons. First, BCCI recognized that MFIP participants had a distrust of the “system.” They were also overwhelmed by other challenges and therefore unable to acknowledge their children’s possible mental health needs. The site reported serving multiple families struggling with stable housing and homelessness.

In a narrative, BCCI reported they had found it was important to be immediate with follow-up services to families. They wrote, “Tracking down families for follow-up can be difficult.” The site reported some families did not have access to a telephone and many lacked transportation in their rural community.

Site Comments

“The impact [of the grant] will be felt well into the future. First and foremost, a strong connection between Becker County Human Services and the MCARPT program was made with Rural Minnesota CEP. In the future, when CEP workers encounter clients who are struggling, they will have more tools with which to determine whether or not a referral to mental health services is appropriate. Additionally, financial workers are routinely addressing the mental health needs of their participants and making appropriate referrals. This is a significant change in services in Becker County.”

Program Data

The RFP asked for estimates of the number of families and children that would be reached through this screening program. Both sites gave estimates far above those achieved during the 18 months of program operation. BCCI proposed to offer the program to 100 percent of MFIP families in Becker County (excluding those served by White Earth) over 18 months and screen children in 290 families. Lifetrack Resources was serving 1,800 MFIP families through their MFIP Employment Services when they submitted their proposal. They estimated all would have access to information about the screening, 800 would be referred for screening and 400 would follow through to be screened.

Program Participation

Table 5 reports data from each of the sites on the numbers of participants reached by the pilot. The case manager in Becker County made contact with 27 families and completed screenings with 43 children. Twenty-one children screened at this site had positive scores on the appropriate instrument and 22 children received referrals for mental health services. Half of the children who received referrals also received services, according to the data provided by the site.

The advocate at Lifetrack Resources completed screenings for 89 children. Sixty-eight of the children screened at this site were between 3 and 60 months of age. It was expected that Lifetrack Resources would serve younger children because of the MFIP population served by the agency. Forty-seven percent of the children whose caregiver had accepted the screening (70 children) were not screened because the family did not follow through.

Eighty children were referred for further services and 33 children received those services, according to data submitted by the site.

Twenty-two children screened at Lifetrack Resources and 6 in Becker County had negative scores on the PSC or ASQ:SE but received a referral for services. Thirteen of the children who received referrals this way received a diagnosis and services.

Nineteen of the 27 caregivers who were offered the program in Becker County (70 percent) accepted screening for at least one child. At Lifetrack Resources, 85 percent of caregivers accepted screening for at least one child (99 of 116). These high rates could indicate that MFIP caregivers have concerns about their children’s mental health and social-emotional development, the referrals that were received were appropriate for the program, MFIP caregivers were encouraged by the prospect of having their Employment Plan include services for their children, or the advocate and case manager were skilled at engaging MFIP participants.

Table 5. Program data submitted by each site

Pilot site data	BCCI	Lifetrack
Case (family) data		
Number of cases with personal offers for screening	27	116
Number of cases that accepted screening offer	19	99
Number of cases with child(ren) screened	18	63
Number of cases with child(ren) screened and referred	14	60
Number of cases with CMH activities in EP	6	40
<i>Expected number of cases with child(ren) to be screened per proposal</i>	290	400
Child data		
Number of children offered screening	72	210
Number of children whose caregiver accepted screening offer	46	158
ASQ:SE	7	68
PSC:35	36	21
Number not completing screening	3	69
Number of children excluded	6	0
Number of children declined	20	52
Screening results and referrals		
Number of children with positive scores	21	60
Number of children with positive scores not referred	5	2
Number of children with negative scores referred	6	22
Number of children referred for services	22	80
Mental health services		
Number of children who received services	11	33
Percent of referrals	50%	47%
Type of services		
Medication Management	1	0
Therapy	10	14
Family Therapy	0	2
Play Therapy	0	15
No data	0	2

At Lifetrack Resources, 56 percent of children whose caregiver agreed to participate (89 of 159) actually received screening. In Becker County, the figure was 93 percent (43 of 46). Both sites acknowledged difficulty in getting MFIP participants to follow through with various aspects of the program. While the advocate at Lifetrack Resources made efforts to be available ‘on demand’ for screenings, this was not always possible and participants had to schedule appointments for screening. The site reported a high rate of no shows for these appointments. The rate at which screenings were completed in Becker County was significantly higher; that could be due to the smaller number of families the case manager was engaged with.

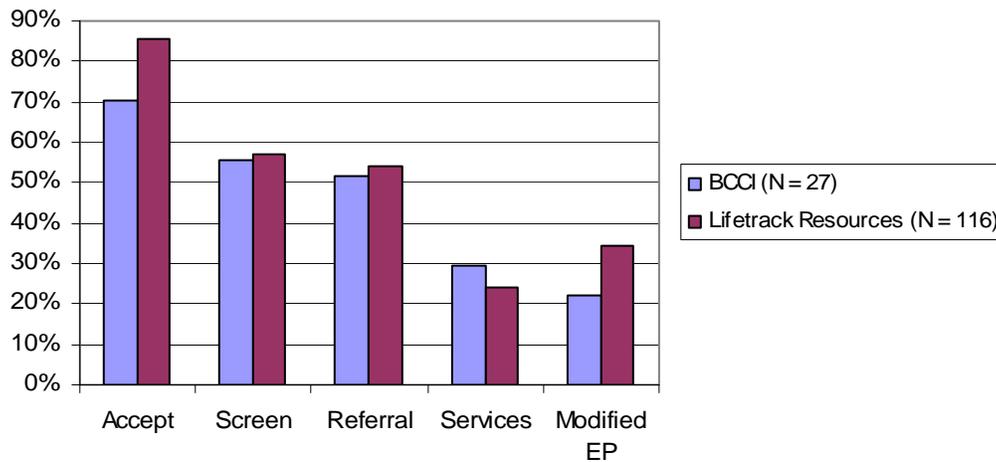
In Becker County, referrals were received by Lakeland Mental Health, MCARPT, Merit Care, Becker County, Lutheran Social Services and Solutions for CTSS. Lakeland, MCAPRT and Merit Care all received multiple referrals. Children identified for services by Lifetrack Resources were referred to Family Innovations, the Lifetrack Resources Beginnings program, Head Start, Hoistad and Associates, the Associated Clinic of Psychology, Ramsey County Case Management, Early Head Start, other Lifetrack Resources programs, Families Together, Kris Muyskens, Lutheran Social Services, Ramsey County Public Health and the local school district. Most referrals were made to Family Innovations, Beginnings and Head Start.

The types of services received by children included therapy, family therapy, play therapy and medication management. Head Start and Early Head Start were recorded in the data as play therapy.

Twenty-two percent of the MFIP caregivers who were offered the child mental health screening in Becker County and 34 percent at Lifetrack Resources had activities related to the children’s mental health pilot included in their Employment Plans. Because there is a lot of variation in Employment Plan activities it was not possible to determine if the children’s mental health service activities included in the plans were a result of the screening, as requested in the legislation. Employment Plans were considered to be modified for children’s mental health when the plan included any activities related to screening or the pilot project.

Figure 3 demonstrates the declining participation in the program from a caregiver accepting screening to following through with services. At Lifetrack Resources, one-quarter of caregivers who agreed to screening for at least one child received services. At BCCI, 30 percent of caregivers who agreed to screening also received services.

Figure 3. Program participation by site



Based on the total allocation to each site and the number of screenings completed, BCCI spent \$2,790 for each child screened and Lifetrack Resources, \$1,395 per child. The needs of the children screened and services provided by the sites varied.

Result of Services

On the study database provided to sites, staff were required to record data on the type, duration, intensity, and result of services. Lifetrack Resources collected follow-up data on 28 children who received referrals for services through their program. Twenty-four of the children followed a treatment plan. The types of services the children received included individual, family and/or play therapy. None of the children had completed a treatment plan when the pilot ended June 30, 2009. Frequency of services ranged from once to twice per week. Eighteen of the children were successfully following their treatment plans and 15 children were making progress, according to the service provider. Generally, it was too soon to expect results for children from treatment still in process.

No data on the result of services were submitted by Becker County on the eleven children who received services through the pilot.

Outcome Measures

The legislation asked about the effect of children's identified mental health needs on MFIP participants' obtaining and retaining employment and on work activity. The measures requested included changes in the Work Participation Rate, sanction rate and earned income. This report adds percent of participants working 120 or more hours per month and the MFIP exit rate.

Due to the low number of participants from BCCI, only Lifetrack Resources' program is discussed in this section of the report. Table 7 displays measures for the 57 participants who had at least one child that received a screening and a referral for services through Lifetrack Resources from April 2008 to March 2009, with at least six months follow up.

Table 7. MFIP Measures for Lifetrack Resources participants with a child screened and referred for services

Outcome Measures	Offer Month	Month 6	Change
N = 57 adults			
Work Participation Rate	18%	14%	-4%
Working 120 or more hours	5%	4%	-1%
MFIP exit rate		14%	
Sanction rate	9%	2%	-7%
Count with UI earnings	16	17	1
Average UI earnings	\$896	\$518	-\$378

The WPR²² is a measure of involvement in work and certain work activities for TANF-funded MFIP participants. The official rate is calculated annually by the federal government. DHS estimates the WPR monthly, based on work and activities reported for MFIP participants by financial workers and Employment Services providers. The estimated WPR (percentage meeting the participation requirements) for the subsets of the 57 cases receiving federally funded MFIP in the offer month (28 cases) and six months later (14 cases) is displayed in the table. The WPR decreased by 4 percentage points over this period. Because this measure only applies to a subset of the study population, it is not a good measure of success for this pilot program.

The percent of participants working 120 or more hours per month was determined by calculating the number of cases where the applicant worked 120 or more hours divided by the number of cases on MFIP for that month. These data are only available for participants on MFIP as once a case is no longer active participants do not report hours and wages. The percent of participants working 120 or more hours decreased slightly from the offer month to month six. The denominators were 55 and 48 in the offer month and six months later.

To be considered an exit, a case did not receive an MFIP grant in the fifth and sixth months after the offer month. Fourteen percent of cases had exited six months from the offer month. The number of cases exiting increases with the passage of time and cannot be considered a result of the pilot program.

The sanction rate was calculated by dividing the number of cases in sanction during the month by the number of cases on MFIP during the month. Sanctioning policy was not consistent for the entire MFIP caseload. Cases receiving FSS are unlikely to be sanctioned. The percent of cases in sanction decreased from 9 percent in the offer month to 2 percent six months later. The decrease in the percent of participants sanctioned could be considered positive, however it cannot be attributed to the pilot program.

DEED provides quarterly data on wages paid and reported by employers in the Unemployment Insurance (UI) program. Average UI quarterly wages for the entire

²² The numerator contains TANF participants who are Work Eligible Individuals (WEI) as defined by federal law and funded by federal dollars successfully participating in work or work activities divided by the number of cases with TANF WEIs.

group decreased by \$378 by six months from the offer month. This decrease in average quarterly wages could be affected by the large economic recession that began in 2008.

The Self-support Index is another outcome measure for MFIP. This measure could not be used for this pilot because it requires three-year follow-up data.

The pilot program cannot be shown to have had a positive impact on the MFIP measures discussed six months from the offer month.

Participant Experience

“She’s not inflicting pain upon herself anymore.”

“He used to have a very short temper. Now that he has someone to talk to about his problems he thinks about what he does or says before he acts.”

“He likes school a lot better. He doesn’t blow up as much as he used to. He’s interacting much better.”

A telephone survey was conducted with a sample of MFIP caregivers who had at least one child who received a referral for mental health services through the pilot. There were a total of 77 caregivers eligible to be sampled, 14 from BCCI and 60 from Lifetrack Resources. Interviewers attempted to contact 46 participants for their reactions to the program and completed surveys with 24 caregivers (4 from BCCI and 20 from Lifetrack Resources), a response rate of 52 percent.

Gauging participants’ reaction to the screening program was difficult due to the short amount of time pilot program staff spent with participants. At Lifetrack Resources especially, the advocate met with participants briefly to screen the children, but all follow-up services were received from other providers. In Becker County the case manager provided case management services to many of the children who received screening through the pilot, but diagnostic assessments and mental health services were provided by other agencies.

All 24 participants surveyed reported they were treated with respect by the pilot program staff during the screening process and all but one participant reported their questions were answered about the screening. Half of the participants received services for their child and this was the first time that this type of service had been received for the majority of the children. Therefore, this program did identify

children in need of services who had not been identified or served through other systems.

For the 11 participants who did not receive the services they had been referred for, three reported other life events were preventing them from following through, two families had moved, one family was starting services through a different program, one reported they were never contacted to schedule an appointment, another said there were no openings at the program they were referred to and one was unsure why.

Of the participants who received services for their child, all but one reported they felt more confident assisting their child as a result of the services and more than half reported

their child's behavior was improving. Approximately one-third of respondents indicated that they had an easier time working with their child's school or child care provider and one-third reported their ability to find and keep a job had improved as a result of the services.

Overall, participants had positive reactions to the program. When asked to rate the program on a scale of 1 being not helpful and 5 being very helpful, the BCCI participants averaged a 4.0 and Lifetrack Resources participants, 4.3.

One participant from Lifetrack Resources remarked, *"I've been having a really hard time with my daughter and I don't know what I would have done without it."* Another Lifetrack Resources participant observed, *"I'm learning how to communicate better with my son."*

A participant from BCCI commented, *"They offered me a lot of support and put my son in contact with a positive male role model."* Another whose child had received a referral for services through the program stated, *"We need something like this in our county. I'm so glad we have [the case manager]."*

Lessons Learned

While it was not possible to establish a connection between screening children in MFIP families for mental health issues and the ability of participants to engage in work and employment service activities, important lessons were learned as a result of this pilot.

Provider Lessons

For 11 of the 13 MFIP participants surveyed who received services for their child, this was the first time their child had received mental health services. The projects were identifying mental health needs that were not being identified through other avenues such as school, child welfare, or health care providers.

Capacity issues within the children's mental health system limited the effectiveness of referrals. Some children identified for services were unable to get the help they needed because of the lack of service providers at both the urban and rural sites.

While the screening tools selected for use by the pilots were chosen for their usability, they were often not effective in identifying children who were in need of additional assessment and services, according to the sites. At least thirteen children were appropriately referred for and received services despite negative scores on the screening tool. If MFIP is to incorporate children's mental health screening into its service delivery, which screening tools to use should be re-evaluated.

Introducing job counselors to children's mental health concepts encouraged a holistic view of MFIP participants and challenges they face to employment.

MFIP families who had time to build a rapport with their job counselor were more likely to take advantage of the program. BCCI reported many families ‘distrust’ the system and were hesitant to get involved with another worker and another program.

Both pilot sites found commonalities in trying to engage and serve MFIP families. Each site reported MFIP families were often difficult to engage in screening and follow-up services because they were overwhelmed by trying to meet basic needs. The sites stressed that without an advocate or case manager to help families get to the next step and access services for their children, most families will not follow through with referrals.

Employment Service (ES) agencies need to develop effective protocols for making referrals for children. The effectiveness of these referrals will be limited by inadequate capacity in the system for services and the lack of MFIP participant’s ability to follow through with services for their children as was found by both pilot sites.

Lifetrack Resources has incorporated an informal child screening into their process with participants of all programs who have children ages birth to five by including a questionnaire that addresses child health and development. If the participant raises concerns and is interested in a referral for the child, the staff person is equipped with a list of agencies that address particular health and development areas to which to refer the family. This addition to Lifetrack Resources’ process was developed, in part, due to learnings from the pilot.

The Becker site reported that county financial workers now routinely look at the mental health needs of MFIP participants and make appropriate referrals when necessary. This was not happening prior to the pilot and is a change that will continue as a result of the project. Additionally, new connections were made between Rural Minnesota CEP and MCARPT.

DHS Lessons

Convening a range of stakeholders to give input into the hypothesis, program components, and evaluation of a pilot project could result in more effective program change and evaluation. The lack of alignment between the projects and the research questions posed in the legislation made answering those questions impossible.

Timing was a challenge for this pilot. The pilots could have been improved with more time to recruit grantees, more time to train the grantees regarding the expectations set in the contracts, more time for treatment plans to be followed, more time for implementation, and more time for the projects to produce results. BCCI reflected, “real, tangible results and changes within the short time span of the grant, compounded by the complex and high level of needs with families, was not a realistic expectation.” To fully analyze the impact of an intervention on the employment outcomes of MFIP participants, the project needs to be longer in duration, and include a comparison group.

This project was required to report to and gain the approval of the IRB. Bringing the project before the IRB helped to focus the project and the feedback received improved the telephone survey portion of the evaluation.

Better, more comprehensive data collection is needed. Job counselors need to be given clear direction about what to include in Employment Plans when involved in pilot projects to enable researchers to track results. The sites need more training on using the database to record services and document their part in the project.

Communications are important. There was a large gap between what the first grantee and the DHS thought the project required, that was not correctable with one site visit, a teleconference, several telephone calls and emails. Face-to-face meetings on the details of the project, as were possible with the second grantee, are invaluable. In addition, the pilot highlighted the complexity of communicating with multiple providers serving these children.

The MFIP caseload is not static. Many families receive MFIP one month but not the next for various reasons. This makes following specific families over time in administrative data difficult and administrative MFIP measures such as the WPR and sanction rate include decreasing subgroups of the MFIP population over time. Supplementing administrative data with surveys and interviews is critical.

Appendix A Legislation

Minnesota Laws 2007, Chapter 147, Article 8

Sec. 36. MINNESOTA FAMILY INVESTMENT PROGRAM AND CHILDREN'S MENTAL HEALTH PILOT PROJECT.

Subdivision 1. **Pilot project authorized.** The commissioner of human services shall fund a three-year²³ pilot project to measure the effect of children's identified mental health needs, including social and emotional needs, on Minnesota family investment program (MFIP) participants' ability to obtain and retain employment. The project shall also measure the effect on work activity of MFIP participants' needs to address their children's identified mental health needs.

Subd. 2. **Provider and agency proposals.** (a) Interested MFIP providers and agencies shall:

- (1) submit proposals defining how they will identify participants whose children have mental health needs that hinder the employment process;
- (2) connect families with appropriate developmental, social, and emotional screenings and services; and
- (3) incorporate those services into the participant's employment plan.

Each proposal under this paragraph must include an evaluation component.

(b) Interested MFIP providers and agencies shall develop a protocol to inform MFIP participants of the following:

- (1) the availability of developmental, social, and emotional screening tools for children and youth;
- (2) the purpose of the screenings;
- (3) how the information will be used to assist the participants in identifying and addressing potential barriers to employment; and
- (4) that their employment plan may be modified based on the screening results.

Subd. 3. **Program components.** (a) MFIP providers shall obtain the participant's written consent for participation in the pilot project, including consent for developmental, social, and emotional screening.

(b) MFIP providers shall coordinate with county social service agencies and health plans to assist recipients in arranging referrals indicated by the screening results.

(c) Tools used for developmental, social, and emotional screenings shall be approved by the commissioner of human services.

Subd. 4. **Program evaluation.** The commissioner of human services shall conduct an evaluation of the pilot project to determine:

- (1) the number of participants who took part in the screening;
- (2) the number of children who were screened and what screening tools were used;
- (3) the number of children who were identified in the screening who needed referral or follow-up services;
- (4) the number of children who received services, what agency provided the services, and what type of services were provided;

²³ While the legislation called for the project to be funded for three years, the legislature only appropriated funds for two.

(5) the number of employment plans that were adjusted to include the activities recommended in the screenings;

(6) the changes in work participation rates;

(7) the changes in earned income;

(8) the changes in sanction rates; and

(9) the participants' report of program effectiveness.

Subd. 5. **Work activity.** Participant involvement in screenings and subsequent referral and follow-up services shall count as work activity under Minnesota Statutes, section 256J.49, subdivision 13.

Subd. 6. Evaluation. Of the amounts appropriated, the commissioner may use up to \$100,000 for evaluation of this pilot.

Minnesota Laws 2007, Chapter 147, Article 19, Sec.3, subd 4(g)

MFIP and Children's Mental Health

Pilot Project. Of the TANF appropriation, \$100,000 in fiscal year 2008 and \$200,000 in fiscal year 2009 are to fund the MFIP and children's mental health pilot project. Of these amounts, up to \$100,000 may be expended on evaluation of this pilot.

Appendix B BCCI Program Brochure

guardians and mental health professionals. They will work together to decide what best suits the child's mental health needs.

If the team reviews the case and additional mental health services are needed the child will be referred on to the appropriate services.

The referrals could be made to:

- Mental health professionals
- Social service agencies
- Community resources

Contact: Amber Bunkowske
Becker County Children's Mental
Health Case Manager
(218) 847-5628 Ext:5210

Primary agencies

Involved with the CCAAP Program:

Becker County

Children's Initiative

Becker County Human
Services

Rural Minnesota CEP

And

MCARPT

Bridging the Gap!



Helping Families
achieve Success!

What is the CCAAP Project??

Collaborative & Comprehensive Assessment & Access Project (CCAAP) is a new program in Becker County MN. This program works with family's who are enrolled in the Minnesota Family Investment Program (MFIP), helping to bridge the gap between employment and the mental health needs of their children.

The primary focus of the program will be to reach MFIP applicants at their entry point into the MFIP system. This will be the easiest and fastest way to get services out to those children in need.

What is the Process?

1. Meet with Mental Health worker.

The family will first meet with a children's mental health worker

to discuss the screening. At this time the worker can answer any questions that the family may have about their child and the screening process.

What are the benefits of a mental health screening??

A mental health screening can help you and those working with your family make the best choice for your child and their mental health needs.

Mental health screening is available to help identify possible concerns you may have about your child's emotional and developmental behavior. Screening helps to catch and prevent problems early, and to improve children's health, happiness and success in and out of school.

What is mental health screening??

A mental health screening is a brief set of questions for parents, guardians or youth. Your responses may identify possible mental health issues that may arise with your child. This is strictly a screening. It is only meant to inform parents, guardians and those working with the family of issues that may need further evaluation.

2. Participate in the screening

Those families that choose to participate will have their child screened by a mental health worker. This screening is voluntary and you have the right to discontinue service at any time.

3. Review of Screening

The results of the screening will then be viewed by a team that is made up of the parents/

Appendix C Lifetrack Resources Program Brochure

How I can help you

- Talk to your job counselor, call me or stop by my office.
- Fill out a questionnaire that takes about 15 minutes.
- After you complete the questionnaire, I will score it and go through your options with you.
- We can find something that best suits your family and your child's needs.

Lifetrack Resources

MFIP Child Advocate

Do you have any concerns about your child's social-emotional health?

Do you have any questions about your child's development?

Do you or others have concerns about your child's behavior?

Lifetrack Resources
Chandra Larson - MFIP Child Advocate
709 University Ave West
Saint Paul, Minnesota 55104
Phone: 651.265.2426
E-mail:
ChandraL@lifetrackresources.org

Social-Emotional Health

Early Intervention is a natural advantage to your child's success because their brain is still developing.

Social-emotional includes how your child:

- interacts with others
- builds secure trusting relationships
- expresses emotions
- Regulates his/her own behavior.

Social-emotional health is equally as important as physical health.

If a young child cannot regulate his/her behavior it can affect his/her:

- relationships
- social development
- functioning at home, school and the community.

Without treatment, your child could have a greater risk of:

- school failure
- contact with the criminal justice system
- dependence on social services.

The first 3 years are the most critical years for your child's brain development

A few questions to ask yourself:

- Does your baby cry, scream or have tantrums for longer than 15 minutes?
- Does your baby stiffen or arch her back when picked up?
- Does your child have trouble falling asleep?
- Does your child have any eating problems such as gagging or vomiting?
- Has anyone else ever expressed concerns about your child's behavior?
- Does your child destroy or damage things on purpose?
- Has your child been exposed to any abuse or violence?
- Has your child been exposed to any toxins such as lead, alcohol or drugs?

If you answered yes to any of these questions, there are many free resources that can help you.

There are many resources within the community that specialize in these areas:

- **Aggression and violence**
- **Anxiety**
- **Attachment**
- **ADHD**
- **Depression**
- **Family issues and Parenting**
- **Grief**
- **Sexual abuse**
- **Posttraumatic stress**
- **Sleep disturbances**

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