



# Family Housing Fund Visible Child Initiative: Children's Mental Health Pilot Project

*Providing access to early childhood  
mental health services in supportive  
housing sites*

D E C E M B E R 2 0 1 5

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## Executive Summary

As a housing intermediary, with the mission to help the affordable housing network meet the needs of families in complex and changing conditions, the Family Housing Fund is tasked with testing system level interventions to end family homelessness. According to Wilder Research's 2012 One-Night Survey of Homelessness, children and their parents now make up approximately one-third of the state's population experiencing homelessness and over half are experiencing long-term homelessness. The National Center on Family Homelessness reports that children experiencing homelessness exhibit four times the developmental delays and three times the rate of behavioral and emotional problems as their housed peers. These avoidable consequences set children up for life-long challenges, including homelessness as adults.

The Family Housing Fund's Visible Child Initiative created the Children's Mental Health Project pilot to address trauma, teach positive parenting skills, and enhance the social emotional wellbeing of homeless children through services paid for by Minnesota Medical Assistance programs. The pilot meets families where they are, by providing access to early childhood intervention and mental health services in supportive housing sites across the Twin Cities. The pilot sought to produce positive changes for young children, parents, supportive housing site staff, and lay the ground work to embed children's mental health services within affordable housing across the region and state.

At the start of the pilot half of the children participating were identified as needing additional support for their healthy development based on the Ages and Stages Questionnaire: Social Emotional (ASQ:SE). After a year of children's mental health services, the follow up screening indicated that only 30 percent of children needed additional support. Even when children still needed additional support, the ASQ:SE indicated that they had made progress achieving social emotional benchmarks for their age. Supportive housing staff reported that the change in parent behavior, as a result of the children's mental health services, had the largest effect on improving children's behavior. Through this pilot, staff and clinicians reported that parent's gained confidence in parenting, improved their understanding of early childhood development, developed increased empathy for their children, increased their recognition of how their behavior affected their children, felt reduced stigma for mental health services, and expanded their family's engagement in the community.

By evaluating the pilot's effect on children and families and assessing the strengths and challenges of the pilot, Wilder Research identified several recommendations for next steps that will maintain the positive effect of this pilot. The recommendations include building a strong pool of early childhood mental health clinicians of color and increasing medical reimbursement rates for early childhood mental health services.

## Background

### *Visible Child Initiative*

In 2005, the Family Housing Fund partnered with clinical psychologist and University of Minnesota researcher Dr. Abigail Gewirtz on a needs assessment of 450 children living in Twin Cities supportive housing facilities. The assessment revealed that risk factors for social, emotional, and developmental problems among these children significantly escalated with age. The assessment also identified a surprising lack of data on the needs of young children – newborn to 4 years old – who have experienced homelessness.

In pursuit of its mission to help the affordable housing network meet the needs of families, the Family Housing Fund launched the Visible Child Initiative in an effort to join research with strategic practice, public policy, and community support to elevate the needs of children who have experienced the trauma of homelessness.

For the past 10 years, the multi-faceted Visible Child Initiative has worked to end homelessness by elevating an understanding of the needs and status of children who have known homelessness in order to invest in their healthy development and academic success. The Visible Child Initiative achieves this by working with supportive housing providers to leverage community resources to lessen the traumatic effects of homelessness and invest in children's healthy development, thereby seeking to end the generational cycle of homelessness.

The Visible Child Initiative ensures that frontline staff in shelter and supportive housing has the best evidence-based research knowledge and tools available to support the social and emotional needs of children and influence positive parenting practices by offering regular training; recommending policy, process, and practice; and testing promising solutions and sharing the results. Through its family-centered approach, the Visible Child Initiative mitigates the potential for generational homelessness that happens when homeless children grow up to head our community's future families.

### *Children's Mental Health Project*

The Family Housing Fund's Visible Child Initiative created the Children's Mental Health Project pilot to address trauma, teach positive parenting skills, and enhance the social emotional wellbeing of homeless children through services paid for by Minnesota Medical Assistance programs. The pilot meets families where they are, by providing access to early childhood intervention and mental health services in supportive housing sites across the Twin Cities. The pilot sought to produce positive changes for young

children, parents, supportive housing site staff, and lay the ground work to embed children's mental health services within affordable housing across the region and state.

The Children's Mental Health pilot is built on a partnership between the Family Housing Fund, which facilitated the partnership and provided funding to build the capacity of the partners; the African American Child Wellness Institute, which provided early childhood mental health services and provided training to supportive housing staff; and supportive housing sites, which provided referrals and support for the early childhood mental health services. The pilot enabled families in four supportive housing sites<sup>1</sup>, in the Twin Cities metro area to access early childhood mental health services area over the course of one year.

The Visible Child Initiative seeks to elevate the need of our community's youngest children; therefore the pilot served families living in supportive housing that had at least one child under age six who displayed signs of behavioral, attachment, social emotional, or other mental health issues as identified by the Ages and Stages Questionnaire: Social Emotional (ASQ:SE).<sup>2</sup> Thirty-nine percent of children living in supportive housing are under age six, so the results of this pilot can affect future services for a significant number of children.

Staff at the supportive housing sites referred families to the pilot and they were then matched with a clinician who specializes in early childhood mental health. In order to provide culturally relevant support, staff worked to match clients with clinicians from similar cultural backgrounds whenever possible.

Once a clinician was matched with a family, the clinician would meet with the family at the supportive housing site. The sessions usually involved working with both the parent and the child together to teach the parents how to engage with the child in a positive, supportive, developmentally-appropriate way. If needed, the clinician would also have sessions with just the parent or just the child to address family-specific issues. In some cases, the clinician would work with the parent and more than one child in the target age group of the pilot.

In addition to the direct services provided, the Family Housing Fund's Visible Child Initiative hosted three in-person trainings and three phone case consultations for supportive housing site staff to build their knowledge, skills, and network around early childhood mental health.

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<sup>1</sup> The four supportive housing sites participating in the pilot were: Emma Norton Services-Emma's Place, Model Cities, PPL-Collaborative Village, and St. Paul YWCA.

<sup>2</sup> The Ages and Stages Questionnaire: Social Emotional is an evidence-based screening tool to assess the social-emotional development of young children.

The Children's Mental Health Project pilot sought to produce positive changes at each of the following levels:

- **Parents:** Increase parents' knowledge of early childhood social-emotional development and ability to provide responsive, consistent parenting for their young children.
- **Children:** Increase children's social emotional skills and well-being in the areas of self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and interaction with people.
- **Supportive housing site staff:** Increase staff skills and use of strategies to support the health and wellbeing of young children who have experienced trauma.
- **Mental health systems:** Increase access to and serve as a model for effective culturally appropriate early childhood mental health services. Improve systems to support infant and early childhood mental health for high-risk young children.

## Methodology

The Family Housing Fund contracted with Wilder Research to evaluate the Children's Mental Health Project pilot through a combination of parent surveys, site staff interviews, a clinician focus group, and a questionnaire focusing on social emotional outcomes of children. The evaluation involved gathering information directly from clinicians, supportive housing site staff, and parents, and indirectly from children.

- **Parents:** Twelve parents completed written surveys about their experience with the pilot and changes they have identified within their children and themselves. In some cases, site staff assisted parents with reading the tool, but parents were asked to mark their own responses and submit the surveys in a sealed envelope to increase confidentiality.
- **Children:** Eleven eligible children were screened using the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) at the start of the pilot. This screening tool indicates whether children are developmentally at risk in the social emotional areas of: self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and interaction with people. Ten were rescreened with this tool at the end of the pilot to allow for comparisons between baseline and follow-up assessments.
- **Supportive housing site staff:** Eight staff from the four sites participated in key informant interviews to discuss their experience with the initiative and their observations of changes in participating children and parents. Each supportive

housing site received a small grant, based on the number of families participating. Supportive housing sites could choose how to spend the grant; some used it to support the additional staff time needed to participate in the pilot and evaluation and others put it back into family programming related to the pilot.

- **Clinicians:** Three of five clinicians participated in a focus group to provide their perspective on the project's strengths, challenges, opportunities, and outcomes. The pilot provided a \$15,000 contract to the practice supplying the clinicians to cover associated costs that were not reimbursed by Medical Assistance.

# Program Outcomes

## Child behaviors

Early childhood mental health services often rely on engaging parents and changing their interactions with their children to better support sustainable positive mental health in the children. Therefore, many of the outcomes associated with early childhood mental health services are directly seen in parents and indirectly seen in children.

Children participating in the pilot were screened using the ASQ:SE. Because this is a screening tool and there are different versions for different ages between 6 months and 60 months, the results are dichotomous as either “above the cutoff,” which means they need more screening or support or “below the cutoff,” which means they do not need more screening or support.

Half of the children who completed both a baseline and follow-up screening were identified as needing additional screening or support at baseline. At follow-up, this dropped to 30 percent. All three of the children “above the cutoff” at follow-up had a drop in their score between baseline and follow-up, meaning that their social emotional development had improved, even though they remained in the “above the cutoff” group.

Confirming the results of the ASQ:SE, the majority of parents surveyed (58%) reported that they saw positive changes in their children’s behavior since participating in the project. In addition, supportive housing site staff also identified positive changes in children’s behaviors. After receiving the early childhood mental health services, staff shared that children tended to be calmer, more respectful, and better behaved. In most cases, staff directly connected the changes in children to the changes in their parents, both of which tended to happen concurrently.

Specific changes in children’s behaviors that staff identified included:

*I used to hear the parents chasing and yelling at their kids daily. Their son was a little cyclone coming through the office and taking stuff off the walls. Mom was frazzled, yelling, and embarrassed, and didn’t want to take him anywhere she didn’t have to. It was very disruptive to mom and others. It hasn’t been an issue since the pilot. He comes down, is respectful, he knocks on the door, he doesn’t run around or take stuff off the walls. Mom doesn’t yell at him or chase after him anymore. There has been a change in her language and their demeanor is completely different.—Staff*

*Their children, once they entered daycare or school, would have had a lot of behavior issues, and parents would have really struggled, and staff would have had to intervene more, and be more reactive instead of proactive. We were able to be more proactive with the pilot because it was before they entered school. – Staff*

*For the participating families, we saw a huge difference in children’s behavior and the parents’ behavior. As the children calmed down, the parents calmed down. –Staff*

## Parent knowledge and skills

Parents responding to the survey tended to report positive changes since beginning their work with clinicians. Most parents reported that they compliment their children’s good behaviors (83%) and learned ways to talk to their children more often (75%). Two-thirds of parent respondents (67%) also shared that they are now more confident and better able to comfort their children when they are upset. Over half of parents (58%) said that they have a better understanding of their children’s behavioral and emotional needs (Figure 1).

In addition, most parents (83%) reported that they will be able to continue to use what they learned from this pilot even after it is over.

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### 1. Parent self-reported changes (N=12)

Since starting this program...	Strongly agree/ Agree	Strongly disagree/ Disagree
I am more likely to tell my child when he or she does a good job	83%	17%
I learned ways to talk to my child more often	75%	25%
I am a more confident parent	67%	33%
I am better able to comfort my child when he or she is upset	67%	33%
I understand my child’s behavioral and emotional needs more	58%	42%

Many of the changes site staff and clinicians identified echoed the changes parents reported as well. Site staff and clinicians identified changes in parents as the greatest benefit of the Children’s Mental Health Project. The changes they observed are listed below.

### *Greater confidence in parenting*

Both site staff and clinicians felt that the parents served by the project became more confident in their parenting. Staff and clinicians specifically shared:

*She was so excited knowing that someone was coming to give their time to help her get confident in her parenting again. –Staff*

*It's great to see a parent who had a lack of confidence evolve—to see how they learn how to play with their kids and notice them, and then kids and parents communicate better. –Staff*

*We are building confidence and helping mothers feel like they are good parents, and they may just need a little extra support. –Clinician*

### ***Improved understanding of early childhood development***

Staff described increases in parents' understanding of early childhood development and realistic developmental expectations of their children. Clinicians agreed, stating:

*The program educated parents on expected development of the child to make sure parents have reasonable expectations of their children. We've given them accurate information about what to expect and how to deal with their children, including developmentally appropriate discipline. –Clinician*

### ***Increased empathy for children***

Staff also identified increases in parents' empathy for their children and interactions with their children around emotions. Some staff observed parents interacting with their children in more patient, less angry ways, while maintaining better boundaries and structure. Staff and clinicians shared some specific examples of these changes, including:

*One parent always used to yell and correct her daughter and tell her “no.” Now, she respects her daughter's feelings, asks about her feelings, and tries to talk things out with her and understand her emotions. –Staff*

*She didn't know how to manage her son, especially around bedtime. They worked quite a bit to get a routine around bedtime. Mom is more comfortable reinforcing what she's saying and getting into a routine that works for the both of them. –Staff*

*She had a lot of parenting questions and behavioral problems with her daughter. She had a really strong attitude and tended to be negative toward people. Over time, she worked on her anger management and figuring out a way to parent where she's not angry all the time or taking her frustrations out on her daughter. She stopped seeing [clinician] and still kept improving. –Staff*

*These parents are in high-stress parenting conditions and often the best skill sets are dropped for more rudimentary, reverting-back, survival skills. We are working with [parents] to establish new skill sets and new practices that are more beneficial and appropriate. We are helping them identify what made behaviors happen before they spiral out. –Clinician*

## ***Increased recognition of connection between parent and child behaviors***

Clinicians also saw shifts in parental understanding of how their own behaviors affect their children's behaviors.

*They are observing that changes in their behavior are associated with changes in their children's behavior, which is an eye opener. —Clinician*

*Clients really benefitted. They now understand what is connected to their child's symptoms, and how a mother's behavior is connected to her child's behaviors. Families are receptive toward wanting to better their lives and their children's lives. —Clinician*

## ***Reduced stigma around mental health services***

Clinicians noticed an increased awareness of and openness to mental health services. For example:

*Families often didn't know that families or young children could receive services. Our time together built awareness that these services are available without the stigma of the mental health field. One client was reflecting on the progress made, and said she was so scared at first because she thought the services were because she had been identified as a "bad mom" and she thought the clinician was documenting things and going to take away her child. This helped me understand how to better frame her opening conversation to explicitly state that [the clinician] is not there to take away her child. It is a fear of many families – so it's important to be mindful about those fears. —Staff*

## ***Enhanced engagement***

Clinicians also observed some notable changes in parents' comfort engaging with their children and their community. This included going out and doing activities with their children and seeking employment and childcare. Clinicians described this change as:

*Some families showed a lot of progress getting out and doing things with their children. One mom had really bad anxiety. We worked on strategies to decrease her anxiety and recognize how her anxiety is related to her child's issues and what that means for her child. She now goes out and does different activities with her child, she is able to leave the apartment, and even had a job for a little while. —Clinician*

*Mothers have gotten jobs, which also builds their confidence. Children are in daycare and they had never been in any kind of daycare or school before, so they are getting more social interaction. When they started, they wouldn't have been in a place where they could progress to that point. They have fun together and their children are happier. —Clinician*

*We do activities with the families [using] supplies they can get low cost or free, so they can replicate them on their own to build the parent-child connection and spend time together. Parents had no idea or were too depressed to do activities with their child before the pilot. —Clinician*

## Site outcomes

Supportive housing site staff reported personally learning from the pilot. They reported having a better understanding of early childhood mental health needs, trauma, and resources for families. Some staff also described that they have been able to use the skills they learned to better help other families in their sites.

Staff specifically shared the following reactions:

*It's given me more resources and a better glimpse into what I need to be focusing on, especially in terms of parenting skills and bringing in parenting classes.—Staff*

*We are now looking at [the youngest] population of children and what other programming we can implement within our program that will help that age group.—Staff*

*[The clinician] has shared information with staff, so they have been able to apply things they're learning when working with other families.—Staff*

*I'm really grateful to be part of [this pilot]. It's been helpful to understand that children under five have mental health needs too. We have looked more at the impact of trauma on them. It's caused a greater awareness of the impact of trauma and appropriate services for addressing it.—Staff*

Staff felt that the pilot provided them with a resource they cannot usually access. There are no other similar early childhood mental health services available to their families, particularly with a direct connection or the easy access that this pilot provided. Staff felt that their families looked forward to the interactions with clinicians. Now that staff has seen how the children's mental health services can benefit families, it is a need they would like to be able to fill.

Finally, staff from one site discussed how helpful it was to have supplemental funds from the pilot to help support the families being served in “nontraditional ways.” This site used the supplemental funds to help support positive experiences with the children and parents being served, such as excursions or childcare for siblings to allow for one-on-one time with parent and child. The staff reported that these funds helped them “support families wanting to be together to spend time together and maximize their strengths more than they normally could.”

# Participant Satisfaction

Overall, most of the parents responding to the survey were highly satisfied with the pilot. In particular, nearly all respondents (92%) felt that the clinicians respected their culture and worked with them in an understandable way. The culturally-matched clinicians may have driven the parent satisfaction with the children’s mental health services.

In addition, most responding parents felt that the clinician gave them useful advice (83%), respected them as a parent (83%), and helped them see what they do well as a parent (75%). The majority of parents said that they had enough visits with their clinician (83%) and worked with their clinician to set goals (75%). Finally, three-quarters of respondents (75%) would recommend the program to others (Figure 2).

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## 2. Parent satisfaction (N=12)

	Strongly agree/ Agree	Strongly disagree/ Disagree
The clinician my child and I work with talks with me in a way that I understand	92%	8%
The clinician my child and I work with respects my culture	92%	8%
The clinician my child and I work with gives me useful advice	83%	17%
My child and I get enough visits with our clinician	83%	17%
The clinician my child and I work with respects me as a parent	83%	17%
The clinician my child and I work with helped me see what I do well as a parent	75%	25%
The clinician and I work together to set goals for me and my child	75%	25%
I would recommend this program to others	75%	25%

Parents responding to the survey were also asked to identify the most positive aspect of the program. Several parents commented that they enjoyed the activities and the time with their child. A couple of parents also said they appreciated having the clinician witness their children’s behavior so they could get more targeted feedback.

Parent comments on the positive aspects of the pilot, including the following:

*I was able to apply the suggestions and understand everything suggested to me by the clinician. I saw the progress in my child and I know that the clinician helped with that progress.—Parent*

*The goals [the clinician] set and how many times she applauded me for my improvement as a parent.—Parent*

*My better understanding of his behavioral and emotional actions and needs. – Parent*

Parents were also asked for suggestions on how to make the project more helpful. Three respondents said that the program was helpful as it was or they wouldn't change it. One parent suggested that the program include co-parenting classes. Most of the suggestions made by other parents focused on wanting more of the program, such as longer visits or more appointments. One respondent mentioned that scheduling appointments could be easier if there was more clinician availability, while another would like better communication.

*I wish the clinician and I would have kept meeting. I was just starting to open up and be able to relax around her. –Parent*

Finally, parents were offered an opportunity to provide any additional feedback about the program beyond the questions already asked. A couple of respondents shared additional critiques rooted in their relationship with a specific clinician, including:

*Just things need to be worked on and clinician should not judge my family before she gets to know us. –Parent*

*[The clinician was] very rude. Made it clear I was a white family and she didn't like it. –Parent*

However, most of the additional comments expressed appreciation for the program and clinicians, such as:

*It was very helpful and I recommend this program to anyone. –Parent*

*[The clinician] is awesome! –Parent*

*I wish I didn't stop seeing [the clinician] when I got too busy. –Parent*

*It was nice to talk to someone about my son.—Parent*

*[The clinician] was very nice and had a lot of good things to say about me and my daughter that made me feel good and lucky to have what I have. –Parent*

*Thank you for this research. I was nervous about meeting with a therapist through a housing program, then actually sticking with the program changed my life. Thank you. –Parent*

*Thanks for all your help. –Parent*

# Program Characteristics

## Program strengths

Supportive housing site staff, clinicians, and parents identified several strengths of the pilot model. These strengths align with the key elements of the model as it was conceptualized, and they would need to be in place in order for the model to be successful at a larger scale.

### *Clinicians*

One of the most important strengths of the program staff from all supportive housing sites identified was the clinicians. One challenge working with families who have experienced the trauma of homelessness is building trust. Staff appreciated that the clinicians spent one-on-one time with the families, and put effort into building a trusting relationship with them. Several staff respondents shared that the rapport clinicians built with parents allowed parents to trust their judgement and openly receive information. Because families trusted their clinician, they were also more receptive to other referrals made by the clinician, especially when the clinician could directly link the family to a specific service provider, as opposed to an agency in general. One staff member shared:

*The client loved her--the feedback she gave them, and the play therapy she did with the kids. [The clinician] was willing to work with different dynamics, including something similar to couples therapy to figure out arrangements for [the client's] daughter. She worked with them as a family unit.—Staff*

### *Culturally-specific support*

Clinicians strongly emphasized the importance of having culturally-specific mental health services. They discussed the stigma that is often attached to mental health services, particularly in African American families. The clinicians saw an important aspect of their work as making mental health services more approachable and less “scary.”

Clinicians also described the need to help parents identify that intergenerational, culturally-rooted advice about childrearing is not always the most developmentally appropriate advice. They needed to draw on their cultural connections to change these perceptions without undermining the importance of tradition. This includes teaching families a completely new skill set that is more emotionally sensitive and centered on reasonable expectations of child development.

Finally, clinicians shared that having culturally-matched clinicians can provide an important role model to families. Culturally-matched clinicians can provide “cultural affirmation” for the child and the parent. It can contribute to healthy cultural development and break stereotypes of who can be a helper. Clinicians specifically stated culturally-matched clinicians can:

*Help clients to have a culturally congruent core image of themselves and their world. Black and nice can go together and can have a congruent coming together and sense of self. –Clinician*

*Show clients that they can come from the same circumstances and be able to have a more satisfying life. It can express that there are different roads clients can take. –Clinician*

Site staff also mentioned the importance of having culturally-matched clinicians working with families. Staff felt that having clinicians who look like their families helped to more quickly facilitate trust and dispel concerns that their parenting or their children were going to be judged. One staff respondent stated:

*The families really needed services, especially with culturally-specific clinicians who looked like them and understood their culture.—Staff*

### ***Communication between clinicians and site staff***

Clinicians emphasized the importance and benefits of communication with supportive housing site staff. They felt it was very important to have a key contact at the site to make sure clients would be attending appointments. Some clinicians reported regular communication with the site staff, and they found that this communication helped to make sure everyone was on the same page to provide the best support possible to families. Clinicians felt that the burden for this communication was usually placed on them, and they would have liked it to be more reciprocal.

Similarly, some site staff shared that they appreciated when the clinicians communicated with them to share what was happening with families. Staff reported that one clinician in particular talked to them consistently, and frequently asked if there was information the clinician should know about the family to inform her work. The staff felt that the partnership was beneficial for the families.

While communication between supportive housing staff and clinicians was a strength of the pilot when it was working well, there were also communication challenges, which are addressed in the Program Challenges section of this report.

## *Staff Training and Case Consultation*

Staff from all sites felt that the in-person trainings they received were valuable. They appreciated that the information was useful and interesting, they enjoyed the opportunity to network with other staff, and they liked having a chance to connect with the clinicians in-person. Several staff commented that the kick-off training at the beginning of the project was particularly informative, as it provided useful information about the project background and processes. Some staff would have preferred that trainings were held earlier in the project, as the information would have helped them look for signs for referrals or identify the “window of opportunity” when a family is most ready for and engaged in services. Other respondents would have liked the opportunity to have more of their staff participate in the training at their site, including training about early childhood mental health services.

Clinicians felt that the trainings and case consultations helped to foster good communication and establish allies within the sites. They would like to see the trainings and case consultations as mandatory, for both clinicians and site staff, in order to make sure everyone is on the same page. Clinicians believe that these opportunities should not have been optional; then, some who had been resistant would have the opportunity to participate and communicate about their resistance.

Staff had mixed perceptions of the usefulness of the phone case consultation calls. Some respondents felt that the calls were helpful because they allowed for more targeted networking and hearing about what was happening at other sites. However, some staff respondents felt that the calls were less personal, it was difficult to tell who else was on the call, and it was hard to hear each other.

## *Focus on early childhood*

Clinicians discussed the value of focusing on the younger children living in supportive housing. They specified that early childhood is a “prime time of personality development” and, therefore, a critical time to receive needed mental health services.

Site staff also appreciated that the initiative specifically focused on early childhood. They felt that the youngest children are often overlooked for services, and it is important to reach children early in order to prevent longer-term issues. A staff member described this by saying:

*I appreciate the attention to the smallest children. If we can get them on steady feet, it can make a difference down the road. –Staff*

## *Onsite support*

Staff from all four supportive housing sites said that having the clinicians come to their site was a strength of the pilot. Clinicians also agreed that this is a particular strength of the project. Both groups felt that the onsite support removed a crucial barrier to formerly homeless families seeking and maintaining support. One site staff member and one clinician described this in more depth:

*Families don't have to go anywhere [to participate in the pilot]. They don't even need to get dressed. They don't need to worry about transportation. It's a huge benefit because a lot of families live such chaotic lifestyles, so it's very hard to get up, get dressed, be ready, and arrive at appointments. –Staff*

*The services were offered onsite. Parents are reluctant to go out, but they could just go downstairs, so it removed excuses and barriers. That was a good incentive for parents to go through with services. –Clinician*

## Program challenges

Clinicians, site staff, and parents identified several challenges with the pilot. If the pilot were to be expanded or replicated, addressing these challenges would improve the recruitment, retention, and outcomes for families.

### *Clinician capacity*

The limited number of culturally-matched clinicians who were qualified in children's mental health was the greatest challenge described by both clinicians and site staff. Clinicians shared that they received more referrals, more rapidly than expected and they were unable to keep up with the demand. Clinicians identified that it is very difficult to find qualified culturally-specific clinicians who are also trained in early childhood mental health services.

There tends to be a lack of training in early childhood concepts and care for clinicians and social workers, in part because children's mental health is a relatively new field of study. The clinicians recognized that ongoing training is essential to maintaining a pool of qualified staff they can mobilize as referrals are made. The practice tried to train interns to serve families, but the interns were reluctant to continue to serve families because they did not feel prepared to address early childhood mental health in high-need families. Interns may have had a lot of skills in helping parents with mental health issues, but they were not necessarily prepared to identify and address the specific early childhood mental health disorders.

The lack of clinician capacity was exacerbated when clinicians and parents were not a good fit. As one clinician stated:

*If the parent doesn't like the clinician, we would need a deep bench to reassign a new clinician.—Clinician*

Several supportive housing site staff also identified that there were too few culturally-specific clinicians to serve all of the families that needed help in their sites. Consistent with clinician reports, some sites said they were assigned interns, who did not appear to be comfortable serving high-need families. Other sites were assigned clinicians who were not a good fit for families, but in both situations there were no other clinicians available to provide services.

Site staff reported that the lack of clinician capacity led to fewer families being served during the pilot than initially planned. Two sites in particular were disappointed that only a fraction of the families they referred were able to be served. They felt that the services were beneficial to those who received them, but they would have liked for more families in need to have access to the same helpful support. One staff person specifically said:

*The families served really loved the program, so we wanted other families to have that experience.—Staff*

Similarly, staff from three of the four supportive housing sites specifically discussed challenges with clinician responsiveness to referrals. This may be related to limited capacity, or it may be a separate procedural issue. Staff respondents commented that the lag time between a referral and an intake, which was over one week, often resulted in families losing momentum or getting discouraged. Staff would have liked more communication during this period to help clinicians troubleshoot arranging services and some staff felt that clinicians gave up on trying to contact families too easily. One staff respondent shared:

*It takes so long to talk to a participant and get them bought into the [pilot]. To get them to understand we're not saying that they're a bad parent and their children aren't bad, especially with this population because they're reluctant about mental health services to begin with. After all of that hard work, if they don't get the services, it's down the drain.—Staff*

The clinicians also identified that working with formerly homeless families requires a particular personality type, in addition to other qualifications. Successful clinicians need to be able to take initiative and be proactive without much “micro supervision.” The work is “very unstructured,” so they need to individually create a structure for when they go to sites and follow-up with clients. For example, it is essential to call families the day of

the appointment to remind them, and it requires a lot of follow-up to make sure things are going smoothly. A successful clinician needs to build that time into their schedule.

### *Clinician punctuality*

A couple of site staff also commented that clinicians struggled with punctuality and communication when they were going to be late. Staff specified that this was a consistent issue, and sometimes the clinicians were up to an hour late or just would not show up. These respondents felt that the chronic lateness was disrespectful to the families and to staff who needed to be available to provide access to the therapy space.

### *Communication between clinicians and site staff*

In addition to when communication was identified as a strength, several supportive housing site staff commented that communication with clinicians was a significant challenge. Staff would have liked much more communication, including regular check-ins and notification when difficulties arose with families. Some staff specifically shared that communication worked well with one clinician, but was a challenge with others.

Staff would have liked communication every week or every other week. They would like the opportunity to exchange information about what was happening with families with clinicians. They recognized that confidential information could not be shared, but a discussion about key concerns or status changes would have been helpful. Staff respondents said:

*The more we work together, the better it would be for the parent.—Staff*

*We could have had more communication as a team to help the client out. —Staff*

In some cases, the clinicians would communicate directly with the families to schedule, reschedule, or cancel appointments. That created difficulties for staff who needed to be available to allow for access to the therapy space and/or needed information about what was happening with the services their families were receiving. One respondent suggested a shared calendar or scheduling system that both the clinicians and the site staff can access.

While clinicians did not report as many issues with communication as the supportive housing site staff, clinicians would have liked improved communication at key points in their work. First, clinicians would have liked more up-front communications with site staff to establish shared expectations about their individual roles. This up-front meeting would have been instrumental in getting everyone “comfortable enough to be open and free to speak without any ramifications.” They would also like a mid-point check-in

about the project, how things are going, and how they could be improved. Clinicians did not necessarily want to wait until something had gone wrong or the project was over to hear about what could have worked better. Finally, when a client moves out of the housing site, for any reason, clinicians were not consistently notified. They would like to be able to terminate the relationship with the client in a more strategic way to “help provide information and coping strategies, and to advocate to get them what they need to do well.”

### *Supportive housing sites*

Clinicians felt that the supportive housing sites were not necessarily set up in ways that helped to reinforce or support the goals of the pilot. They felt that some of the sites were not child-friendly and that some sites did not provide enough services to help families be successful, such as a lack of accessible child care or a reluctance to make referrals to the pilot. The clinicians recognized that this was likely due to limited resources and competing priorities. Clinicians argued that the supportive housing sites need more funding to enhance their child and family services, such as a child-friendly environment, childcare, parenting classes, and tutoring.

One goal that developed organically during the pilot was to build a sense of community among parents and children within the supportive housing sites. Clinicians would have liked to see more events or activities to build community in support of this goal. They felt that the open houses hosted by the pilot were very successful, and similar opportunities would be equally successful. If these events had a topic, they could function as an educational tool while also building relationships and creating additional supports. If events on-site are not feasible, the clinicians also suggested providing a list of free events or activities families can attend. Unstructured time for children and families can be challenging, so developing tools that families can use to fill their time in constructive, positive ways would greatly enhance the skills the pilot aimed to build.

Finally, both site staff and clinicians voiced challenges about the space available for therapy. Clinicians shared that the space available to them worked well in most sites, but it was sometimes inconsistent or spread out over multiple locations, which was challenging. Conversely, two sites mentioned that they were asked to provide specific space and supplies at the beginning of the pilot, but then the expectations changed when clinicians opted to meet with families in their homes, rather than the therapy space, without informing staff. Staff saw the investment of time and money as a waste.

## *System supports*

Similar to the need for increased resources to help make supportive housing sites more child-friendly, clinicians also identified additional financial or systemic challenges they encountered during this pilot.

Most importantly, clinicians identified several challenges with billing for mental health services. Early childhood mental health work is highly specialized and time intensive, and the current billing rates are inadequate. Although the clinicians can bill more for some interactive complexity codes, such as play therapy or translation, this supplemental rate is still not sufficient. In addition, clinicians are unable to bill for both an individual session with a child and a family session in the same day. Therefore, they are unable to perform those services within the same visit to the site, which necessitates more trips to the site or less intensive services with a family. Clinicians are also unable to bill for collateral contact, such as coordinating with daycares or supportive housing sites, and for follow-up with families. If they are unable to get paid for these services, then practices need to identify an additional funding stream to support them or clinicians need to do the ancillary services outside of their paid time.

The funds for the pilot allowed families to receive support even if they are uninsured or underinsured, which is important for families living in supportive housing. Many families have had difficulty accessing Medical Assistance funds for themselves and their children. Medical Assistance requires constant monitoring and paperwork, and it is often one of the last things to get addressed during periods of transition or crisis. Now that the pilot has ended, the supportive housing sites and clinicians need to find ways to support children served who are uninsured or underinsured.

An additional challenge to providing onsite services is that clinicians are not able to bill for mileage or transportation to get to the supportive housing sites. The onsite support for families is a key strength of this initiative. If it is not feasible to provide onsite services because of the inability to bill insurance companies or Medical Assistance for mileage, then the community needs to better support reliable transportation for formerly homeless families. Some of the supportive housing sites are not close to consistent or straightforward public transportation and while there are medical cab rides available for therapeutic services, they tend to be unreliable.

Clinicians also connected the reimbursement challenges with the lack of clinician capacity. The current billing rates are not enough to draw qualified clinicians to the specialized field of early childhood mental health. Clinicians believe that it takes passion to commit to this particular area of expertise. Currently, most graduate programs do not include an emphasis on early childhood mental health, so clinicians need to be motivated



to seek out training and experience. Clinicians identified that this is a need among all mental health providers, but it is more critical in ethnic minority groups.

# Recommendations

Overall, the evaluation highlighted many clear benefits of the early childhood mental health pilot. Based on feedback from parents, clinicians, and supportive housing site staff, Wilder Research identified the following opportunities for improving any expansion or replication of this pilot.

## ***Build a strong pool of qualified clinicians***

The feedback from parents, site staff, and clinicians all illustrate the necessity of having a strong pool of qualified clinicians to provide early childhood mental health services. Most of the project successes and challenges revolve around the availability of qualified clinicians. When clinicians are available and a good fit with families, there are many important benefits to parents, children, and supportive housing site staff. On the contrary, when there are not enough clinicians, clinicians are unavailable, or there is not a good fit, then the program cannot be as successful. Therefore, the strongest recommendation is to identify, recruit, train, and retain a strong group of qualified clinicians. Ideally, these clinicians would have the ability to stagger their schedules to offer more coverage and availability to families.

## ***Increase structural supports for the project***

In order to build a group of available clinicians, there need to be important structural changes in the field of early childhood mental health. First, there would need to be a stronger emphasis on building clinicians' skills in working with young children and their families. This is not currently offered as a focus or specialty in most educational programs, so clinicians are not equipped with these skills when they finish their initial training. Second, early childhood mental health services and services with formerly homeless families are not sufficiently reimbursed through medical billing. In order to recruit and retain more clinicians to serve these populations, there needs to be adequate compensation to accommodate the additional training and skills required.

## ***Maintain core project components***

This evaluation has highlighted four core components of an effective early childhood mental health program in supportive housing sites. When these four components were implemented with families, it resulted in positive outcomes for parents and children, and high levels of parent and supportive housing site staff satisfaction. These core components include:

- ***On-site mental health services*** to reduce barriers for families in accessing support.
- A sufficient number of ***available clinicians with experience in early childhood mental health services***, because it is a specialized area requiring unique understanding of early childhood development and approaches for engaging families in services.
- ***Culturally-specific support*** to increase family comfort with and reduce stigma around mental health services.
- Infrastructure to support clear, consistent ***communication between supporting housing site staff and clinicians***.

## Next Steps

The Family Housing Fund will use the information from this evaluation to establish next steps for the Visible Child Initiative and share the report with others to inform decision making.

- The Family Housing Fund's Visible Child Initiative identified funds to support clinicians continuing to work with pilot families for a few months or limited number of visits as the Family Housing Fund pursues the structural recommendations outlined in this report.
- Medical Assistance is a feasible and reliable system for child mental health services. The Family Housing Fund's Visible Child Initiative Director will advocate to increase the reimbursement amount that Medical Assistance provides to fully cover the cost of children's mental health services that are offered at on-site facilities.
- Minnesota has a shortage of culturally sensitive and diverse clinicians. The Family Housing Fund's Visible Child Initiative Director will advocate for Minnesota governmental agencies to address this shortage. One option would be to make public resources available to encourage more students of color to pursue degrees that prepare them to offer children's mental health services.

## Thank You

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