Getting to Yes: What Works in Supporting Children with Complex Mental and Behavioral Health Needs

CENTER FOR ADVANCED STUDIES IN CHILD WELFARE

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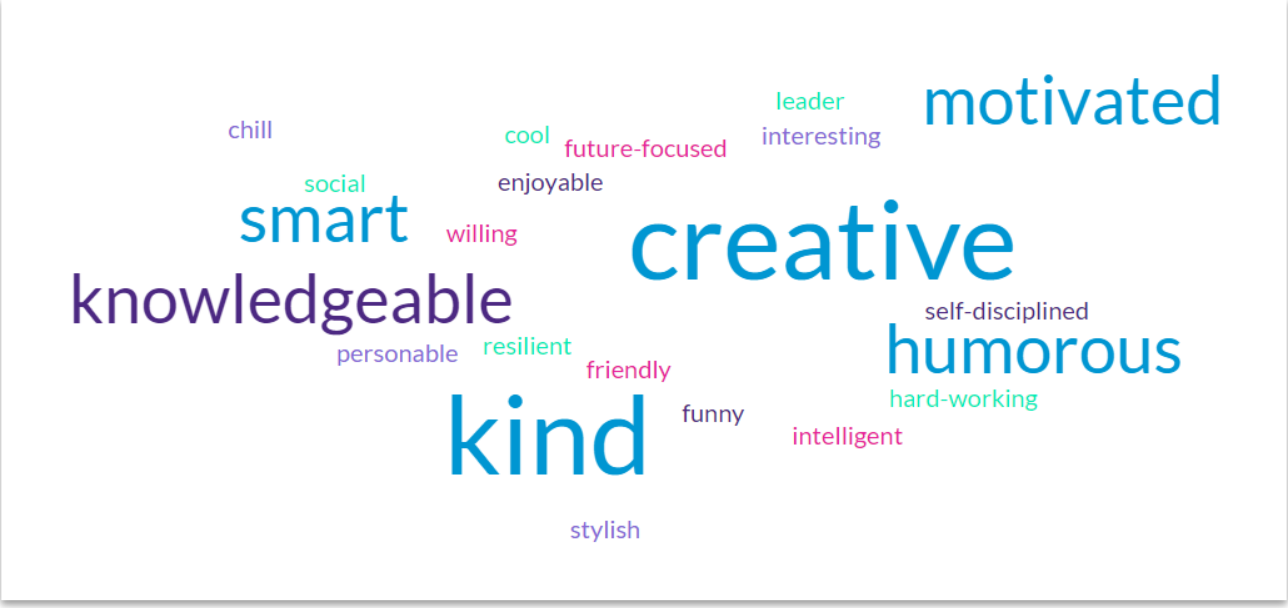
Appreciation for the Children and Youth Included in this Study

This study includes information around twelve children (aged 11 to 17 at the time of their case record) with complex mental/behavioral health needs and their care journeys. Select cases are included in more depth in this report as examples of children's care journeys in the state. These children are important and valued members of their families, friend groups, schools, and broader communities, and were described in their case records and in interviews with case managers and parents/guardians as interesting, creative, enjoyable, good students, and good at making friends.

Figure 1. Descriptions of the children and youth included in this study



The children in this study self-identified several strengths and interests, including physical activities like going for walks, hiking, playing at the park, swimming, dance, bowling, fishing, and skateboarding; engaging in team sports like basketball, football, baseball, and soccer; playing games and working on puzzles; being with animals, including dogs; drawing and painting; listening to music; reading books; cooking and baking; playing guitar; photography; spending time with friends and family, and participating in school. The children in this study were described by staff as motivated to complete their treatment goals, and identified their own goals to complete after discharge, including getting a job and an apartment, increasing their support systems, working in healthcare, becoming a musician, and learning how to dance.

The children and youth in this study are more than case numbers and have lives, hopes, and dreams beyond their care journeys. They are loved by their families, friends, teachers, and the staff that work with them. They are kind, motivated, knowledgeable, creative, humorous, and smart. ***They deserve better access to the care they need so they can thrive as part of our communities.***

Terms and Acronyms Used in this Report

Boarding – This study uses the term "boarding" to describe when a child is staying in a place that can keep them safe but is not able to provide the appropriate level of care the child needs.

CASCW – Center for Advanced Studies in Child Welfare

CADI Waiver – Community Access for Disability Inclusion Waiver

Continuum of Care – Term describing the various levels of mental/behavioral health services available in Minnesota. (Figure presented in the Appendix of this report)

DHS – Minnesota Department of Human Services

ED – Emergency Department

ER – Emergency Room

JDC – Juvenile Detention Center (also "Corrections")

Level 5 – Level of care; in this report, typically a residential treatment center or facility.

Level 6 – Level of care; in this report, a locked mental/behavioral health care facility.

MDH – Minnesota Department of Health

Milieu – The social environment of the mental/behavioral health service organization.

Outpatient Services – Mental health services that take place in a clinical or office setting (including telehealth) but do not require overnight stay (e.g., individual or family therapy, day treatment).

PHP – Partial Hospitalization Program

PRTF – Psychiatric Residential Treatment Facility

RTC – Residential Treatment Center or Facility

Step up/step down – Used to describe when a child moves up into a higher level of care or down into a lower level of care.

Executive Summary

Background

The Minnesota Department of Human Services (DHS), AspireMN, the Mental Health Collaboration Hub and the Center for Advanced Studies in Child Welfare (CASCW) at the University of Minnesota (UMN) partnered to better understand useful supports for children with complex mental/behavioral health needs and their families on their care journey, despite the ongoing challenges of accessing appropriate care.

Methods

We considered information from de-identified case records (n=12) of pediatric patients with complex mental/behavioral health needs, and interviews with five parents/guardians (n=5) and case managers (n=5) of these pediatric patients and local professionals (n=15) with system-level expertise regarding the care of children with complex mental/behavioral health needs in Minnesota. The case record reviews and interviews were summarized into themes and recommendations.

Case-Specific Perspectives

Positive Experiences with Programming

Many participants highlighted the benefits youth experienced during their treatment, including benefits associated with their formal treatment plan and those associated with other, more informal opportunities including physical activity, outings, music and art therapy.

Family Involvement

Several of the children involved in this study had deeply engaged families. Their engagement was highlighted as a key component for ensuring the child was able to access services and saw positive results during their programming.

Formal and Informal Support Network

Participants emphasized the critical role that the mental/behavioral health care staff and other providers in their broader communities of care played in creating positive experiences for the children and in accessing appropriate levels of care.

Communication and Partnership

In addition, there were clear, positive impacts related to communication and partnership between the provider staff and the child's family. Communication was important during times of uncertainty and through transitions to new providers.

Service Availability

It is easier to maintain continuity of care and treatment success when services are available near the family home. However, families in smaller communities find it difficult to access the services they need. While telehealth options are useful when in-person options are unavailable, many participants reported a preference for in-person service options.

System-Level Perspectives

Collaboration Across Organizations

There are many useful partnerships and ongoing collaboration between agencies in mental/behavioral health care in Minnesota. Participants highlighted the benefits of the Mental Health Collaboration Hub.

Dedicated Workforce

The pediatric mental/behavioral health system in Minnesota has many dedicated and experienced workers with the skills and expertise to provide quality support and treatment. These workers need to be celebrated and rewarded for their commitment to their work.

Intensive In-Home Interventions

Experts highlighted current processes and practices in Minnesota that are supportive of children experiencing mental/behavioral health challenges. They note that flexible funding that allow for creative service allocation allows agencies to better meet youth needs.

Local Advocacy Efforts

Many positive changes that have occurred Minnesota were associated with advocacy efforts of local agencies. Agency advocacy is integral to initiate large scale change to support needed service access across the state.

Data Collection

New, innovative data collection strategies throughout the state support positive change by highlighting the different experiences of children served by the system.

Recommendations

Based on the case records reviewed and the interviews with families, agency representatives, and system-level leaders, this study recommends:

Options for Workforce Recruitment and Retention

1. Allocate funding to recruit and retain an effective, committed workforce and to fairly compensate individuals to acknowledge the difficulty of the work.
2. Initiate partnerships that help to recruit and train individuals for pediatric mental/behavioral health careers directly from college and/or university programs.

Access to Community Options and Prevention Services

3. Invest in intensive, community-based services to expand the state's continuum of care and to create additional options to support youth in their homes with their families.

Enhanced Capacity for Collaboration

4. Continue to expand the options for collaboration between pediatric mental/behavioral health professionals with formal options like the Mental Health Collaboration Hub.
5. Identify ways to create consistency in practice by standardizing intake processes and streamlining options to access mental/behavioral health across the state.
6. Create processes that standardize decision-making to prioritize child treatment needs regardless of the agency's financial constraints.

Family-System Perspectives in Treatment

7. Focus on the entire family-system in treatment.
8. Identify parent navigators or other individualized supports for caregivers.

Conclusion

The caregivers we spoke with recalled the power of human relationships for their children. The compassion and creativity of the workforce helped these families to experience moments of hope. While families undoubtedly experienced many significant challenges in their care journeys, Minnesota's current pediatric mental/behavioral health care system also provided them with meaningful supports. By supporting these existing beneficial interventions, we can do better for Minnesota's children. And even more so, it is clear that better is well within reach.

Introduction

In line with the rest of the nation, Minnesota has been experiencing a crisis in pediatric mental health for years. In recent years, escalating numbers of pediatric patients have sought care for mental health, emotional, and behavioral crises[9], including outbursts of aggression and violence[24]. Children with complex mental/behavioral health needs often end up in inappropriate settings, such as hospital emergency departments (EDs), juvenile correctional facilities, and other boarding situations with counties, when they have nowhere else to go and/or have exhausted all other available options. These settings, which can also include county administrative facilities and higher levels of inpatient care than appropriate for the child's needs, may be able to keep children safe but struggle to provide the appropriate level of care the children need and leave children who are experiencing increased and/or new behavioral/mental health systems in environments with no active treatment.

The State of Pediatric Mental/Behavioral Health Care in Minnesota

Minnesota is facing a dire shortage of mental health providers, including a lack of community-based outpatient facilities that are better equipped to care for children experiencing emotional and behavioral crises[6]. In a provider survey conducted by AspireMN in 2022, 100% of day treatment providers surveyed cited closure of programs or significantly decreased capacity to serve children[2]. Concurrently, Minnesota hospitals have reported increases as high as 30% in pediatric patients presenting in EDs seeking care[15;25]. A recent report from the Minnesota Department of Health found that the major reasons for ED discharge delays for youth that have extended youth boarding in EDs include delays in identifying foster care placement (29%), other social service or government agency delays (24%), and a lack of available beds at provider agencies in the state (24%)[17]. In addition, youth in the study (33%) often faced delays due to history of behavioral issues and/or dysregulation[17].

In response to this crisis, the Mental Health Collaboration Hub was created to bring together hospital and community-based providers to foster a community of care that better facilitates the transfer of pediatric patients to more appropriate community-based settings[1]. Since its inception, the Mental Health Collaboration Hub has been a resource to support planning for children who need options outside of boarding, regardless of where boarding has occurred.

While the pandemic exacerbated the boarding crisis in Minnesota, the challenges the state faces due to the lack of available services for children with complex mental/behavioral health needs are not new. Even in 2003, Hennepin County reported that dozens of children in need of residential treatment facilities were placed out of state due to an overall lack of options in Minnesota[11]. The report noted that "many of these children do not need to be far away, but for reasons of safety or treatment, need to be in facilities that match their needs," yet spaces that met their needs were not available in Minnesota (p. 5)[11]. In 2008, the Minnesota Legislature directed a convening of stakeholders to develop recommendations for reducing the length of time pediatric patients were staying in acute care facilities[20]. The resulting report highlighted issues associated with the continuity of care in the system, the number of children needing services, workforce shortages, and data limitations as key factors influencing child and family experiences in the system[20].

In the last decade, various groups have presented reports regarding the state of Minnesota's pediatric mental/behavioral health care system[6;10;21]. Recently, the Legislative Working Group on Youth Interventions identified various barriers to adequate pediatric mental/behavioral health care, including availability of services, funding, siloing of system services, a lack of service availability, and persistent staffing shortages[30]. Many of the challenges noted in their report were also identified 25 years earlier in the 1999 Juvenile Out-of-Home Placement Program Evaluation Report published by the Office of the Legislative Auditor for the State of Minnesota[30] and remain as challenges highlighted in the findings of this report.

The Minnesota pediatric mental/behavioral health system is complex; while more data is needed to inform policies and practices going forward, we have known for decades that our systems of care are failing Minnesota's children. Considering these known persistent challenges, this study presents current strengths of the existing system that can be built upon by the state to be sure all Minnesota children have access to the care that they need today, tomorrow, and into the future.

Study Background

Much of the prior research that examined the crisis of pediatric mental health boarding describes the frequency and duration of pediatric mental health boarding in a single-center[14]. Some studies explored the experiences of families with children boarding in EDs and the staff who care for these children seeking to improve the experiences of pediatric patients, families, and staff while boarding[3]. In all, these studies highlight challenges in addressing basic needs or providing access to a balanced diet or fresh air[8;28], feelings of frustration, confusion, and helplessness among patients, families, and staff[8;13], and moral distress experienced by staff who felt helpless to provide the needed care to pediatric patients boarding in EDs[8;13].

In addition to these challenges, camaraderie and interdisciplinary collaboration between providers and families, streamlined processes for transfer to other services, and the variety of options for supportive services have been noted as system strengths[3;23;29]. One study found that a centralized database that contains relevant patient information to connect patients to community care, similar to the Mental Health Collaboration Hub, helped to help ease the distress experienced by pediatric patients, their families, and ED staff [29]. However, these studies broadly examined experiences of patients and families to identify ways to improve their experiences rather than examining the supportive factors that were meaningful to children and families over the course of their care journeys that could be built upon to create a more supportive and accessible care system.

Further, the literature stresses the need for increased community health resources and coordinated systems of care to support children and families in crisis[8;9;29]. Large-scale systemic solutions, like investing in community health resources and efforts to bolster the workforce, are essential to remedy this crisis. A recent study by the Minnesota Department of Human Services recommends one such solution, suggesting that new rate methodologies should be used to build rates that are more reflective of provider needs based on their current costs and workforce realities[19].

While Minnesota has commissioned studies and convenings of stakeholders to better understand gaps in the state's mental health system and make recommendations to the state's governing

bodies[21], this is the first study to move beyond identifying systemic care gaps to specifically examining the factors that support pediatric patients' experience accessing appropriate care. Policymakers and providers in Minnesota can leverage "what works" to enhance current resources and to improve children's experiences and outcomes. Minnesota has long been a leader in pediatric mental health advocacy and care[16]; this study helps to highlight the supportive factors in the system to inform innovative solutions for Minnesota and other states across the country.

Study Purpose

Given the increase of pediatric mental health crisis in the state, the Minnesota Department of Human Services (DHS), AspireMN, the Mental Health Collaboration Hub and the Center for Advanced Studies in Child Welfare (CASCW) at the University of Minnesota (UMN) partnered to better understand what meaningful interventions or experiences were identified (by the child or caregiver) as effectively supporting children with complex mental/behavioral health needs during their care journeys, despite the ongoing challenges of accessing appropriate care.

While we know a lot about the challenges in the mental/behavioral health system, we know less about the meaningful interventions that are present in the system. This study sought to better understand those positive factors, asking: ***What existing system resources supported Minnesota children with complex mental/behavioral health needs and their families during their journeys to access appropriate care?*** By exploring the supportive factors that children and families have experienced, policymakers in Minnesota will be more equipped to ensure children with complex mental/behavioral health needs have access to necessary and appropriate care.

Methods

Data collection

Case records. Case records included in this study were identified by participating organizations and included children who met the following criteria: **(1)** the child experienced boarding for 21 days or longer and was boarding due to a behavioral health related need, **(2)** something worked for the child to help them shift from boarding to appropriate care in a community-based setting, and/or **(3)** the case represented a family who demonstrate unique resilience in being able to care for a complex child. Case vignettes of four cases are included in *Appendix B* to provide an in-depth picture of the information collected for each case and to highlight the characteristics associated with the sample for this study.

Interviews. Twenty-five individuals were interviewed for this study, including five parents/guardians, two county legal guardians (both were also the child's case manager), three case managers/supervisors associated with the selected cases, and fifteen local professionals with system-level expertise regarding pediatric mental/behavioral health care in Minnesota. Each interview lasted between 30 and 60 minutes and were conducted via Zoom.

Data analysis

Researchers used the qualitative analysis software, NVivo (Version 14), to identify themes within and across the case records and interview transcripts. Case records were distilled into case record summaries in an Excel spreadsheet for additional analysis across case records. Interview transcripts were analyzed in NVivo using the a priori codes created during the case record review process, in addition to inductive thematic analysis as necessary. Codes were created for case-specific and, separately, system-level interviews to reflect the different questions being asked in interviews. Recommendations were coded into themes and subthemes across case-specific and system-level interviews

Child Characteristics

The children associated with the twelve case records included in the case record review range from 11 years old to 17 years old. As reported in the case records, five (42%) of the children identified as male, four (33%) as female, two (17%) as transgender male, and one (8%) as gender fluid. The majority of children identified as White (n=7, 58%), two children (17%) as Black or African American, two children (17%) as multiracial, and one child (8%) identified as Hispanic/Latino. Six children (50%) have histories of law enforcement involvement, including assault, trespassing, substance use, and/or due to a behavioral crisis or for safe transport to crisis services. Eight children (67%) have history of IEP or 504 plans to support special education needs at some point in their educational history. Nine children (75%) have histories of child welfare involvement and/or adoption (including international adoption). These demographic characteristics are comparatively similar to the population of children who are found to be boarding in Minnesota, representing a disproportionate number of children of color, those who are in early to late adolescence, and children with history of child welfare placement in boarding situations[5].

Case records for ten children (83%) included CASII scores, used to determine the necessary level of behavioral/mental health care. Of these ten children, six (60%) received scores of 28 or higher (Level 6), three (30%) scored between 23-27 (Level 5), and one (10%) scored 18 (Level 3) services. Cases spanned an average of 114 days (Median = 30) at the partner organization.

Case-Specific Findings

Case-specific findings provide insights from case-specific interviews (N=8) that represent parents/guardians (n=3, 38%) and county legal guardians (n=2, 25%) of the children whose cases were included, and interviews with case managers (n=3, 38%) who oversaw the associated cases.

Positive Experiences with Programming

Participants across all six cases noted that the child had benefitted in some way from being a part of the programming offered at the partner organization that provided the child's case record as part of the study. Some participants mentioned the benefits of other organizations along Minnesota's continuum of care that cared for the child at some point in their care journey. This participant noted that the child's experience in programming overall was helpful:

> *"[Child] has taken some big steps. I think the residential program really was a benefit. [Child] has come back to the house and is able to work through different difficulties because of that, so his experience turned out to be a positive experience."* ***– Parent/Guardian***

Others identified specific aspects of the programming that were helpful or enjoyable for the child, including physical activity, outings, and therapeutic options like music and art therapy:

> *"Then he brought home stuff that he had created, I think like drawings, paintings, things like that. And he actually is, if he applied himself, he could probably be quite a good artist. He does have an artistic flare. It seemed like they had stuff for him to do."* ***– Parent/Guardian***

Family Involvement

Participants for these cases noted the importance of family involvement in being able to provide support and care for the children whose cases were shared as part of this study. Several of the children had families who were deeply engaged, and participants highlighted this as a key aspect of the child's ability to access services and progress positively through programming:

> *"For her, having family members that were willing to kind of stick it out with her through a lot of her movements to different places, she was pretty lucky there. We had a lot of kids that don't necessarily have that."* ***– County Legal Guardian***

Some of these children also benefitted from having families who had knowledge of resources and/or accessed resources early in the child's care journey:

> *"Right from day one, before I even had the boys here with me, I had already lined up some therapeutic services, and so I was getting connected. Some people might not have been able to have that familiarity."* ***– Parent/Guardian***

Formal and Informal Support Network

Participants emphasized the critical role that staff at mental/behavioral health care providers played in creating positive experiences for the children and in accessing appropriate levels of care. Some participants highlighted the professionalism and skill of staff members, including for children with specialized care needs:

> *"There was a certain staff that really excelled at what they were doing. They went above and beyond, and so it made it much more pleasurable. [Child] was able to bond with one particular staff person that was a unit-based staff person. And she really was able to focus in on his developmental disabilities as it related to treatment."* ***– Parent/Guardian***

Others noted how staff members were committed to providing excellent care and support to the child and family:

> *"They didn't give up on her, so she presented some of the same big and scary behaviors that she had at previous programs. And it did include trips to the emergency room at times. But they took her back and they kept working with her. Eventually I think she felt safe enough to do some work with them."* ***– County Legal Guardian***

Some participants also mentioned the critical role of care providers in the families' broader communities of care, including teachers, county workers, and outpatient therapists who had been a part of the child's community care system for a long time:

> *"One thing that was really huge was that the special education teacher in [city] was amazing. I mean, she just truly has been amazing throughout and continues to be. I don't know what I would have done without her, and she's just maintained. So, I would say her, and the case manager at the county."* ***– Parent/Guardian***

In addition, some participants were able to identify supportive groups in their communities that had been helpful as they navigated the complexity of their child's care journey.

> *"We were pretty involved with church, and this town we live in is very small. We have been very, very much supported. I don't know where I would have been without all the support."* – ***Parent/Guardian***

Communication and Partnership

Participants noted the positive impact of communication and partnership between the provider staff and the families of the children included in the study. Especially in times of uncertainty, such as provider transitions, communication and a commitment to partnering with the family were key:

> *"Communication is always super important when it comes to these kinds of things, because you ultimately can't make those referrals and get him on to the next step if you don't have the family "okay". So, communication with family was super important with this. And in responses, the parents were really involved. They were kind of "game on" to have an email string just to keep things moving when there's so many moving parts with a lot of referrals."* ***– Case Manager***

Some participants highlighted the importance of offering additional family support, including parenting education, recommending individual therapy for parents, and meeting regularly with parents to prepare them for their child's discharge into their care or another location:

> *"The program did good family work and just communication in general, and helped us come up with a good transition plan. The grandparents were pretty lucky because I think the team that was working with her was pretty good about educating them as to a lot of what they needed to know to help make the transition successful."* ***– County Legal Guardian***

Service Availability

Participants also highlighted how important it was to have services available near the homes of the families. This helped maintain continuity of care after discharge when children discharged from a provider organization to home:

> *"It was very helpful that it was a close distance to me so that I could really participate fully with his programming. That was huge, and it was very accommodating given since I have other kids that also require quite a bit of attention."* – ***Parent/Guardian***

The location of service options is also supportive of a positive transition and makes it easier to ensure continuity of care post-discharge:

> *"In transitioning out, we were set up with a therapist right away. There was no lapse in time of therapy, and that really did help. Recommendations came [from partner organization], and we were able to kind of slide right into that. Which I think made his transition a lot easier than it otherwise would if we had to kind of start all over again."* – ***Parent/Guardian***

However, finding resources close to home was a challenge for some families:

> *"I've had a lot of people tell me that they just don't have CTSS [Children's Therapeutic Services and Supports] in their areas. Or, you know, they're very rural and they don't have services at all, which makes it a little bit of a challenge."* – ***Case Manager***

Some participants noted that telehealth options had become a resource for them when they could not find in person options, and that this flexibility was helpful for some families. However, in person services, including at provider organizations, were still preferred by some participants:

> *"It's one of those things where you do it because it's, it's nice that we have that virtual therapy option. Otherwise we wouldn't have it at all, you know? So it's nice, but in a perfect world, in person would be what we'd prefer."* – ***Parent/Guardian***

System-Level Perspectives

System-level findings represent insights from interviews with system-level experts (N=15) that represent Minnesota state and county agencies (6), hospital systems (3), and other collaborating agencies (6) who participated in interviews. Each of the 15 of the individuals we spoke with are engaged professionals in the pediatric mental/behavioral health space. As engaged members of the community, they have a deep understanding of the areas of strength and the areas of opportunity to better support children and families.

Collaboration Across Organizations

The most consistently identified strength in expert interviews was the significant benefit of ongoing collaboration across organizations, which was mentioned by 13 experts. Agencies are more successful when they can work together to collaborate for youth treatment needs.

> *"What I've seen in the last few years is providers starting to come together and partner in ways that I haven't previously seen. Which has been really, really good because it allows for connection and support in different ways"* – ***Direct-Service Expert***

Beyond general collaboration between partner agencies for case-specific needs, the Mental Health Collaboration Hub has been a great resource to support collaboration, both for specific cases and to foster more inter-agency collaboration in general.

> *"It's people coming to the table and listening to each other and being willing to attempt to problem solve, you know what I mean? Or attempt to reconsider, attempt to think again. So I think that's a really big strength."* – ***Direct-Service Expert***

Some experts also mentioned that ongoing collaboration through the Mental Health Collaboration Hub sessions give participants more insight into the challenges faced at other agencies and helps

to clarify common issues or misunderstandings, noting that agencies often want to help, they just have barriers in place that limit how much they can do.

> *"I think some of the strengths [with the Mental Health Collaboration Hub sessions] is for emergency departments to gain an understanding that counties aren't trying to say "no, not my problem." It really brings people together saying, can we meet this child's needs? Let's take a look at that. It feels like we're being more supportive, too, because there's this understanding of the fact that we are trying, but we've got a lot of hoops to jump through for a placement."* – ***County Expert***

Dedicated Workforce

Most experts (12) also highlighted the dedication and experience of the current workforce as a strength. They have the skills and training to successfully support youth with mental and behavioral health needs. Expert participants emphasized the need to celebrate these quality, motivated workers and to identify retention strategies for the rest of the workforce.

> *"People are passionate about this work. People are willing to look at different creative ways to meet children and families where they're at and get them the support they need. That's probably our biggest strength."* – ***Direct-Service Expert***

Higher pay was an option to support recruitment and retention of a stable workforce that regularly came up in interviews. The workforce deserves higher pay to recognize their expertise and the overall difficulty of the job we ask them to do.

> *"There's some really, really skilled people out there, but they're not willing to get hit, kicked, and punched for minimum wage."* – ***Hospital Expert***

Intensive In-Home Interventions

In addition, 12 experts identified the benefits of existing or improved practices in Minnesota. For the most part, experts highlighted opportunities for providers to use funding in creative ways to support intensive in-home interventions that keep youth out of institutions.

> *"I think that a lot more families would be willing to take kids home [with more intensive in-home services] because they would feel like they have some extra support or someone there to help if the kid gets aggressive to help deescalate them or help distract them so mom can keep the other kids in the home safe."* – ***Hospital Expert***

In addition, a notable takeaway from experts was that a one-size-fits-all service approach does not work, rather, agencies need to identify supports to tackle the specific challenges faced by the child and family. Beyond wraparound services, experts mentioned other beneficial services, such as respite care, mobile care teams, multi-systemic therapy, and collaborative intensive bridging.

> *"Respite care, when that can be accessed, is a huge supportive factor. Mobile transition teams have some really positive outcomes…kids and families are getting the support that they need. I've heard that those things are effective and working to address some of the needs"* – ***County Expert***

Local Advocacy Efforts

A handful of experts (5) also suggested that there have been positive changes in policy and practice associated with agency advocacy efforts. They identified efforts their state legislators, agencies, colleagues, and current/former clients have taken to advocate for system change.

> *"I think there is an interest and a momentum in getting kids out of hospital emergency rooms, which has been on the forefront more lately. I do think that's a positive and a strength. …hospitals have access and means to do outreach and get media attention to get people to understand what's happening. I think there has been a push with that, and I do truly believe that is why the state has responded to the hospital crisis."* – ***Direct-Service Expert***

While these experts agreed that local advocacy is useful to support change for the children and families they work with, they also identified the need for larger scale change to support needed service access across the state.

Data Collection

Some experts also highlighted the benefit of new and innovative data collection processes to support change. More data collection regarding boarding and the types of children experiencing boarding is bringing the issue more to the forefront. Policymakers respond to data, and consistently highlighting the problem with data may lead to more motivation for change.

> *"That's one of the things that we love about the Mental Health Collaboration Hub, is we're tracking data that has never been tracked before. It's hard evidence looking right at you."* – ***Direct-Service Expert***

Recommendations

The families, direct-service professionals, and system-level experts that participated in this study each had important insight into the strengths and opportunities for change in Minnesota's pediatric mental/behavioral health system. In addition, they provided important recommendations for Minnesota to expand the state's service capacity to better meet the needs of children and families involved with mental/behavioral health systems. Their recommendations and other opportunities for change identified through case-record review fall within four key categories. Each category is described in more detail below and include: **(1)** options for workforce recruitment and retention, **(2)** access to community options and prevention services, **(3)** enhanced capacity for collaboration, and **(4)** family-systems perspectives in treatment.

Options for Workforce Recruitment and Retention

The most consistently identified recommendations highlight the need for increased funding to build and maintain a committed pediatric mental/behavioral health workforce in the state.

1. **Allocate funding for the pediatric mental/behavioral health system to recruit and retain an effective, committed workforce, to fairly compensate individuals**

at a level that acknowledges the difficulty of the work, and to recognize the dedication and experience of professionals who remain in the system.

Many participants suggested that Minnesota needs to fund the workforce in a more competitive way in order to recruit and retain an appropriate number of workers to meet the staffing needs of currently overburdened residential facilities. Two participants highlighted the influence of pay on the stability of the workforce:

> *"I think that we really, our state really needs to prioritize paying for these people that are doing this really important work. Otherwise, we're paying for it in different ways – more at the opposite end rather than preventatively."* – ***Direct-Service Expert***

Even if a facility has a bed available, without enough trained staff to provide care, the facility is unable to open the bed for placement. A county legal guardian reflected on a common response they hear from providers:

> *"We have programs that tell us, "well, we do have more beds, but we can't open them up right now because we just don't have the staff to complement the need" and other ones will be honest and say "look, we've got the staff at the moment, but our turnover rate is so high, we're trying to train these new staff and we're just not there yet" as far as being able to work with some of the tougher kids."* – ***County Legal Guardian***

Current rates of vacancy and the consistency of turnover in the mental/behavioral health workforce affects the quality and continuity care those engaged in the system receive. When one worker leaves, another needs to take over the work left behind and re-establish a relationship with the child. One parent we talked to recounted how that affected their son:

> *"They quit all the time, all the freaking time. My son who is now 20, in the last year, he's had seven case managers. And this is the guy who, he won't even talk to the case manager now because they're going to quit on him anyway. Right? So why bother?"* – ***Parent/Guardian***

2. Initiate partnerships that help to recruit and train individuals for pediatric mental/behavioral health careers directly from college and/or university programs.

Other systems, such as public child welfare[27] and rural healthcare[12], have seen promising results in recruiting, training, and retaining their workforce through strong partnerships between state agencies and university degree programs. While these partnerships have not fully solved workforce issues, they have been useful in identifying students who are interested in the work, training them to be effective and quality practitioners, and reducing the overall workforce shortages experienced by both systems. As one participant noted during their interview,

> *"We need to get a pipeline for people wanting to go into these fields. If you look at social work, any of those specialty areas, there's less and less people going into that, so it's kind of drying up. What are we going to do?"* ***– Direct-Service Expert***

While initiation of university partnerships would require upfront state investment, similar recruitment strategies have shown promise for ongoing retention. Retaining a committed workforce leads to cost savings that reduce the money and effort required to fill ongoing vacancies. One estimate suggests that each incident of turnover costs the agency more than $50,000 due to the time and effort required to hire and train new staff[22].

Access to Community Options and Prevention Services

In addition to workforce related concerns, this study highlights the need for investments in Minnesota's continuum of care to increase availability of community support options and to renew the focus on preventative services for youth with mental/behavioral health needs.

3. **Invest in agencies that provide intensive, community-based services in order to expand the state's continuum of care and to create additional options that support youth with mental/behavioral health needs to stay in their homes with their families.**

> *"We're focusing on the wrong problem or the wrong solution to the problem; there's a reason that they got to the emergency department in the first place. We've got to focus further upstream."* – ***Hospital Expert***

Families and professionals who participated in this study overwhelmingly highlighted the need for services to support youth in their own community, through intensive in-home or other community-based options.

> *"The first step has to be investment earlier in a robust continuum of care. I've seen it work – we spent a decade where we might have had a handful of kids spend more than three to four months in residential treatment because we could meet the needs of the families in the community. That's the real solution."* – ***County Expert***

In addition, many participants indicated that some emergency department boarding and other higher-level placements occur because lower-level options are full or otherwise unavailable. Unnecessary boarding or higher-level placements lead to even more issues for youth and their families, and cost the state more resources to support.

> *"We're left with kids who need the most help that are not getting it, and they end up in boarding in hospitals or too frequently crossing over into some criminal stuff and ending up in detention centers or more correctional type placements. I think if there were more mental health resources a little earlier in their journey, some of those things probably could have been avoided"* – ***County Legal Guardian***

Instead, investing in intensive, community-based services will help prevent emergency department boarding and other unnecessary higher-level placements. While it will require an initial investment of funding at the state level, preventative services can lead to cost savings in the future by limiting unnecessary placements and focusing higher-level services to those in most need of treatment.

Enhanced Capacity for Collaboration

While the ongoing collaboration within the pediatric mental/behavioral health system was identified as a major strength in Minnesota, participants also highlighted the need for continued collaboration in various ways. Overall, their recommendations for enhanced collaboration seek to identify options to streamline care options, ensure consistency for youth in placement, and clarify processes to prioritize child treatment needs.

4. **Continue to expand the options for collaboration between pediatric mental/behavioral health professionals with formal options like the Mental Health Collaboration Hub.**

   The Mental Health Collaboration Hub was highlighted as a major strength in the current system, and interview participants agreed that expansion of the Mental Health Collaboration Hub to include participants from a wider variety of organizations or creation of additional options for collaboration would help professionals work together to support youth with high needs. One county expert suggested that collaboration allows us to build on what has worked in the past, rather than continually re-thinking treatment options. They say,

   > *"We can all learn from one another. We don't need to keep reinventing the treatment plan for these children. We need to build upon the treatment plan."* – ***County Expert***

   In particular, interview participants suggested that more buy-in from both hospital and county partners for the Mental Health Collaboration Hub would allow for more robust collaboration. Even when they do not have a particular situation to discuss, their input is helpful for expanding the creative thinking and strategies available to craft a sustainable treatment plan.

5. **Create consistency in practice by standardizing intake processes and streamlining options to access mental/behavioral health across the state.**

   Intake processes and standards vary widely across the state, making it difficult to track availability and manage referrals. While providers take various details into consideration when determining appropriateness for treatment, larger consistency in intake processes would support more streamlined access to treatment. One participant suggested,

   > *"I think it would be awesome to have centralized intake of some sort where there's someone who knows all the openings at all the places. Even just universal intake paperwork – every place has their own set of intake requirements, having that more universal."* – ***County Legal Guardian***

   Identifying options to streamline access to treatment may also be useful for supporting equitable access to resources across the state. Pediatric mental/behavioral health practitioners have a hard time keeping track of availability and provider strengths with consistent changes at treatment agencies. A hospital expert recommended that breaking down silos to standardize access may be a useful strategy saying,

   > *"We have a siloed system where the responsibility seemingly falls to the counties to build a mental health system and there probably haven't been resources to the extent*

they need to make that happen. Having 87 different solutions to children's mental health is not going to get us anywhere closer to building a sustainable mental health system" – ***Hospital Expert***

6. **Create processes that standardize decision-making to prioritize child treatment needs regardless of the agency's financial constraints.**

A few participants described issues between treatment provider recommendations and county payer approval processes that limit the treatment options available for youth. While any treatment does require payment and the county payer needs authority over their finances, current processes seem to prioritize money over comprehensive treatment.

> *"There's been quite a few [counties] where we'll make a recommendation and the county's like, "nope, they don't need that." And it's like, well, the hospital is saying that they need that, like board approved psychiatrists and therapists are saying that they need that."* – ***Case Manager***

Standardizing decision-making processes regarding treatment needs will ensure that children across Minnesota receive access to the same service regardless of their county's financial means. This could include state-level processes that determine appropriateness of treatment recommendations or allocating state funds to meet treatment needs of youth when local budgets cannot cover the cost of care.

Family-System Perspectives in Treatment

Participants also emphasized the need to re-focus the Minnesota pediatric mental/behavioral health system on the family system, rather than just the child. In its current state, the system provides necessary treatment for the child, but largely ignores the needs of the child's parents or siblings.

7. **Focus on the entire family-system in treatment.**

When one family member is in treatment, all family members feel the burden associated with that treatment. One parent summarized this perspective well:

> *"Hospitals, as you expect, talk about the one person, the one patient, and not the family as a whole. How I like to say it is, when my husband had cancer, the whole family had cancer, it wasn't just him."* ***– Parent/Guardian***

Attending to the needs of the family is an important step in ensuring the child is successful after discharging back to their home. Parents automatically become the child's primary caregiver and need to understand the complexities of their child's needs to be successful. One case manager we spoke to suggested:;

> *"I think even having services like outpatient for the parents who aren't in placement. I think kids and families need to have services that help parents engage in conversations about [expectations at home, behaviors, and mood changes] with the child…the one*

piece that is missing is how does that translate to home? How do we actually do that at home?" ***– Case Manager***

Ensuring that parents are informed and that the family-system has capacity to provide the necessary care is critical to a child's post-discharge stability at home. The family's capacity to provide care can include outside supports (both formal (e.g., intensive in-home services) and informal (e.g., relatives, neighbors, etc.)), but needs to be assessed prior to discharge. Parents or other primary caregivers need to be involved in comprehensive discharge planning that considers the home environment and supports the family's capacity to translate treatment recommendations to the home to ensure post-discharge success.

8. **Identify patient navigators or other individualized supports that can help parents be informed caregivers for their children in treatment.**

We also need to remember that the systems that families are required to navigate to access treatment for their children are bureaucratic and complicated, particularly for those who have never experienced them. In addition, practitioners are often overburdened and have limited capacity to explain the complexities of processes within the system. As such, many parents do not know what is normal, the questions to ask, or the timeline or protocol to expect. One parent who has experience in mental health noted:

"This is a system that you don't know how to do until you have a kid in there. You need to be able to figure out how to do it; I mean, even my background is in mental health and I had no idea how complicated it was" ***– Parent/Guardian***

Parents should have access to a patient navigator that has the time and energy to explain the complexities of the system, prompt parents of the important questions to ask, and outline what they should expect from the process. One parent recommended:

"Somebody who supports the parent and helps us understand what it is they they're either asking of us or diagnosing our kid, or what kind of questions we can ask, would make a huge difference." ***– Parent/Guardian***

In the current system, parents often use up their energy trying to make sense of the stressful environment their family is currently experiencing. However, if parents have an assigned, accessible support, they will have more capacity to focus their energy and attention on their child's needs.

Data Considerations and Future Research

While this study highlights many crucial findings, it is also important to note that this study centers the expertise of study partners, including AspireMN and the Mental Health Collaboration Hub, as well as that of the parents/caregivers and system professionals involved in the study. Thus, findings do not encompass the experiences of all people or contexts within Minnesota's mental/behavioral health care system. Future studies should work to stratify sampling to further examine barriers to

care that were identified in this study, including history of aggression, family income level and insurance plans, and child welfare or juvenile justice system involvement.

Conclusions

Much like various other jurisdictions throughout the United States, Minnesota has been experiencing a crisis in pediatric mental/behavioral health care for many years. The system crisis, which was exacerbated by the COVID-19 pandemic, has led to limited availability of treatment options for children and youth with complex mental/behavioral health needs and an associated increase in youth boarding in inappropriate settings, such as hospital emergency departments and juvenile correctional facilities**. Minnesota needs to reinforce the mental/behavioral health continuum of care to consistently meet the needs of youth with complex needs.**

This study focuses on the positive aspects of our pediatric mental/behavioral health system. We highlight the formal and informal factors that support the needs of children with complex mental/behavioral health needs and ultimately helps them to succeed. While some of the findings discussed are like those we have known from other studies and reports[20;30], they differ in one important way. **These findings represent perspectives that include families who have been and/or currently are directly impacted and involved in the system we studied**. We raise their voices to highlight the direct impacts of both the challenges and beneficial factors of the system.

While some of the recommendations that result from this study will require targeted state investments to enhance service options and support recruitment and retention of the workforce, it is important to note that some of the most powerful solutions that are highlighted are informal aspects of the system that can be enhanced. **Often, the informal services and relationships children experienced in treatment create the most memorable moments of hope and are the easiest to translate to the community or home.** One parent describes the role that drawing played in helping their child to learn emotional regulation. Another parent highlights the supportive role that a special education teacher played for their child even outside of school. The impact of the activities and people in and around the pediatric mental/behavioral health space is undeniably powerful and help children with these complex needs to find success in treatment.

Even with the challenges and other areas of opportunity in the pediatric mental/behavioral health care system in Minnesota, it is important to highlight what works to identify how to move forward. The benefits of treatment and positive experiences highlighted in this report provide Minnesota practitioners and policymakers with a unique opportunity to begin to address challenges by building on identified strengths. In doing so, Minnesota can work to ensure all children, youth, and families involved in pediatric mental/behavioral health care in the state have positive experiences during treatment and find success in their communities. **We know we can do better, and even more so, we know that better is within reach.**

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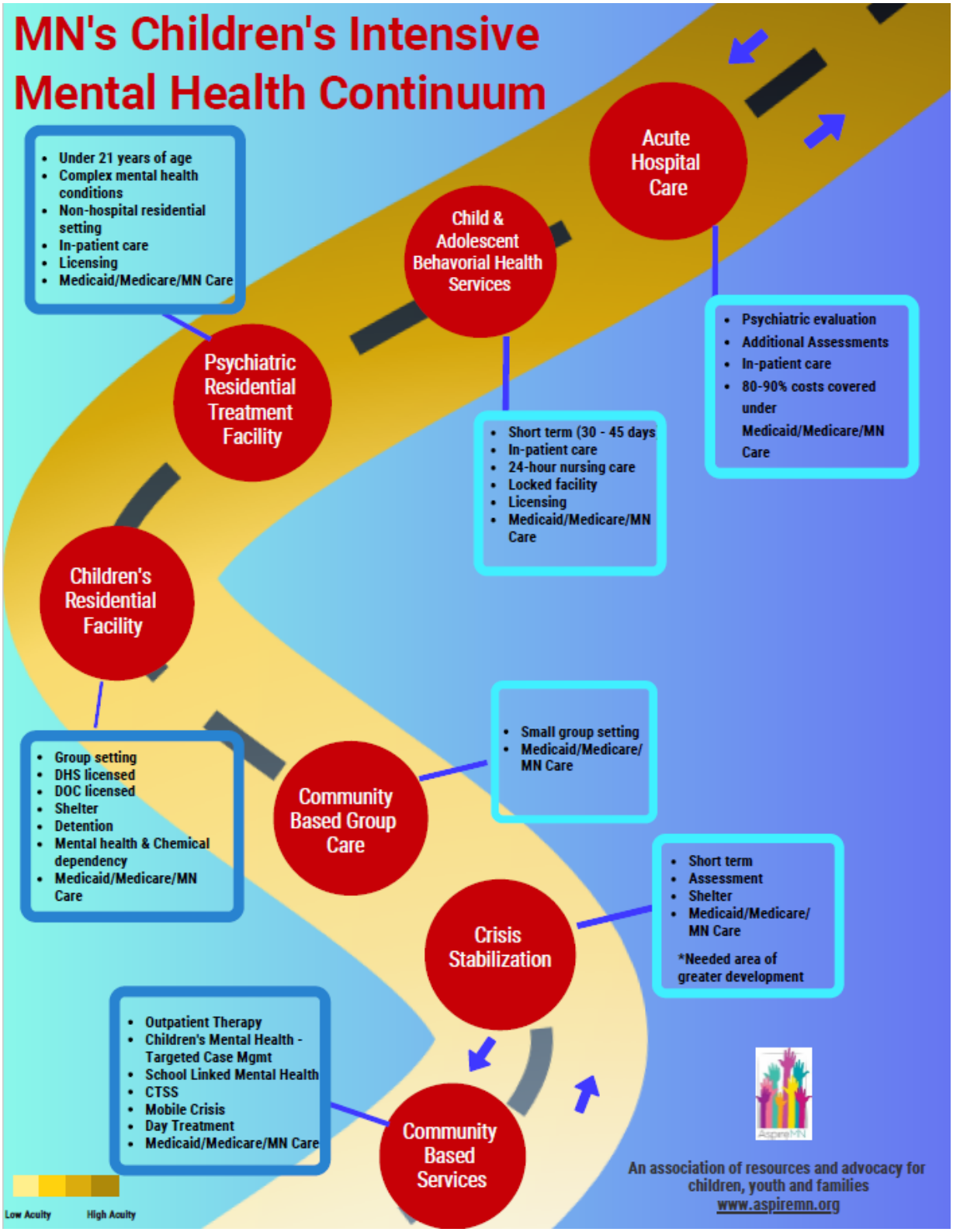
Appendices

Appendix A: Minnesota Continuum of Care Diagram[2]



Appendix B: Case Vignettes

We have included four case vignettes that we feel were strong representations of the study aims. These cases included detailed case record information and had parents/guardians and/or case managers who agreed to participate in interviews as part of this study. The vignettes have been created from data provided in the de-identified case records (4), interviews with parents/guardians (2), county legal guardians (2), and case managers (2; one participant provided insight into two cases).

For two of the children who both experienced the highest level of care available in Minnesota (Vignette 1 and Vignette 2), we were able to interview the county workers/case managers who served as the children's legal guardians at the time of the case records included in the study. Case managers from the partner organization for these two cases were not available for interview or follow-up around case specifics. For the other two children (Vignette 3 and Vignette 4), we were able to interview case managers as well as the parents of the children, allowing for added depth and nuanced understanding around the experiences of these specific children and their families.

Vignette 1: Case Record Review, Case Manager/County Guardian Interview

At the time of the case record provided for the study, this youth was a sixteen-year-old White female, who presented to the partner organization via the hospital due to homicidal ideation, self-harm, and making threats to staff and peers. The youth had extensive trauma history which led to intense and frequent symptoms such as hallucinations, self-harm, and intrusive thoughts. The youth endorsed a history of substance use, including alcohol, marijuana, and pills. The youth had the highest CASII (Child and Adolescent Service Intensity Instrument) score of the case records included in this study, which recommended treatment Level 6 (a locked facility). The youth had an IEP at their school, had a history of law enforcement involvement, including one recorded instance of assault. The youth had child welfare involvement, including foster care, and was under county guardianship at the time of the case record.

The youth was described in the case records as open and engaged in her therapy sessions at the partner organization, as well as honest and willing to answer questions and progress with her treatment plan. This youth was described as resilient, smart, hard-working, and friendly, and enjoyed reading, playing video games, and drawing.

This youth's case manager/county guardian relayed some of the struggles of the youth's care journey, including that even when the youth got into a residential treatment center (RTC) that was willing to take her on, she was sent to the hospital due to some behaviors and the RTC refused to take her back. This happened a second time with a different RTC, where the youth was sent to the hospital and the RTC again said they could not take her back. The case manager noted that the youth had experienced boarding in hospital settings for weeks at a time, and that due to her history of aggression and running from placements, she required a higher level of care. Eventually, the youth was able to access care at this partner organization, which was a locked facility. The case manager said this about these experiences:

> *"Even though she failed out of different RTCs, I think she still got some good experience at a couple of them, good interaction with people who cared about her. Ultimately, they were in a tough spot because she showed a high level of aggression and they didn't really have the capacity. So, it was a tough road bouncing back and forth, but eventually getting to [partner organization] where they did not give up on her when she presented some of the bigger, scarier behaviors."*

According to the case manager/county guardian, one of the main supportive factors for this youth on their care journey was the fact that the partner organization didn't give up on the youth. This helped the youth feel more stable, safe, and secure, which in turn helped the youth engage in treatment more willingly and effectively.

> *"[Partner organization] didn't give up on her. So, she presented some of the same big and scary behaviors that she had in previous programs. And it did include trips to the emergency room at times. But they took her back and they kept working with her. So, eventually I think she kind of felt safe enough to do some work with them. They were committed to work with her even though she was difficult at times."*

The case manager/county guardian also noted that the partner organization being a locked facility helped deter some of the challenging behaviors, particularly the youth's history of running. As far as the youth's transition to their family for community-based care, the case manager/county guardian mentioned that the partner organization "did good family work" including "educating them as to a lot of what they needed to know to help make [the transition] successful." He noted that the partner organization also communicated well with the care team, including himself, which helped them come up with a good transition plan.

The case manager/county guardian additionally highlighted that the youth's family lived outside of the Twin Cities metropolitan area, "so we could actually find a day treatment program that had an opening." Other outpatient services, like individual and family therapy, were also close to the family's home and in their community, which was considered helpful. The youth's school was also mentioned as being supportive and working well with the youth and her family.

With the support and commitment of the partner organization, the youth was able to engage in her treatment, including trauma-focused cognitive behavioral therapy, which the case manager/county guardian mentioned was particularly helpful. The case manager/county guardian also noted that the partner organization did a good job of preparing the youth's family for the transition home, including "giving them some skills so she could continue to work on the skills that she was learning in the program… they were able to use some of the same language and some of the same skills for her." In this way, the partner organization demonstrated a strong ability to foster consistency for the youth, both in the programming and as part of the transition home. This consistency can be vital to the wellbeing of children with complex mental/behavioral health needs.

Vignette 2: Case Record Review, Case Manager/County Guardian Interview

This child was 11 years old at the time of the case record provided for this study, and identified as biological female and gender fluid, using the pronouns he/they. They identified as biracial (African American and White). They had a history of inpatient, residential, and partial hospitalization

treatment for thoughts of self-harm and suicidal ideation. The child had a CASII score the recommended the highest level of treatment, Level 6 (locked facility). The child was denied an IEP plan at the time of the case record, but was in the process of being assessed again for one. The child was in foster care before the start of the case, and was under county guardianship during the case.

The child was described in their case record and by their county guardian as creative and interesting, and actively engaged and receptive to their treatment plan. The child endorsed enjoying dance and various types of art, including painting.

The child's county guardian noted that there were challenges getting the child into an RTC placement because the child had some sexualized behaviors that resulted in placements saying "no" to her referral. Prior to the start of the case record at the partner organization, the child had been placed with a foster family who were "really involved" and when challenging behaviors showed up, "the foster parents knew how to access [partial hospitalization services], how to get them emergency care, and so those outpatient services got set up right away. It's just that things escalated." The child ended up at a primary care hospital until they were able to get them into an RTC. The county guardian noted that the county had to pay for this placement, as it was not a program that would be covered with Minnesota Medical Assistance. Instead, "the county ended up having to make an exception and pay for a program like that, which we normally don't do, because we needed to get them out of the hospital." However, the child was "running quite a bit," so they were moved to the partner organization (which provided their case record for the study), which was a locked facility.

> *"The other piece about it for them was, they were 11 and they looked 16. So, they're in with all of these older kids, and I think that got in the way of them getting good services just because people forgot they were little, they were 11."*

The county guardian mentioned that the care the child received at the RTC, prior to moving into the care of the partner organization, was still positive:

> *"I think they tried really hard, but it was a small facility. I do think they had some good connections with staff there. A barrier was that I think they had a couple therapists there – people were changing, jobs changed a lot – but I know that she did make connections to staff there."*

Upon transition home, the partner organization and the county worked to have the needed outpatient mental health services "set up right away," including in-home therapy support for the family. Additionally, the county guardian noted that the county team for this child was a strong and consistent source of support for the child and their family:

> *"Their team here is solid and has been around a long time and has been with them since the beginning. I think those people did a really decent job making that transition… the stability and workers in this unit, we've all been around a long time and aren't going anywhere, so kids have us through the long haul."*

The county guardian noted that the size of the county was a strength that allowed for a balance between adequate resources and speed to get the child into a placement that was more appropriate.

> *"I think [our county] is the right size where we have resources but it's not so big that you don't know who makes what decision… I think we're still a small enough county that [the paperwork] goes pretty quickly. The bottom line is, if we're paying for it, then we just do the paperwork to get it rolling."*

The county guardian also highlighted the importance of collaboration between the county and mental/behavioral health organizations, as well as the strength of the county in being willing to be flexible and fund a placement in order to get the child out of the hospital.

> *"Our administration understood the need to get them out of a hospital setting and that no kids should just sit in a hospital for months. So, we tried all the normal places that we go that take Medical Assistance, and when that fell apart, the county understood we needed to move them into something else. The supervisor, the managers above us also really understand the problem that we have a lot of kids with really high needs and we don't have a lot of spots for them, so they understand we have to be creative and we're going to probably also spend a lot of money sometimes to do the right thing for a kid."*

As with Vignette 1, collaboration between the county and the partner organization, the support of staff at various placements, the engagement of family, and the consistency of the child's care team were all helpful supports to the child that allowed them to transition home.

Vignette 3: Case Record Review, Parent Interview, Case Manager Interview

At the time of the case record provided for this study, this child was 16 years old. This child identified as male and Black, and the case records provided went back to 2016, although the child's parent noted that the child had experienced a need for higher levels of care from a young age. The child had an extensive history of treatment, including inpatient hospitalization, residential treatment, partial hospitalization programs, intensive outpatient services, group homes, and various forms of therapy. In various episodes at the partner organization, the child presented for admission via hospital emergency departments due to acute safety concerns for the child and others. The child was adopted as an infant, and the case record identified the child as having fetal alcohol spectrum disorder. The child had IEP accommodations for learning disability and emotional behavior.

The child was described in case records as a leader who did well in school. His hobbies included listening to music, reading books, cooking, and playing various sports. He was described as making friends easily, being future oriented, and well-connected to his family and outpatient caregivers.

In describing the child's care journey, the child's parent noted:

> *"We've been in almost every psychiatric children's unit in Minnesota. We've also been to North Dakota. We've been to Wisconsin… ER visits probably number close to 100. And most of the time, it's assessed and he's sent home, even if it's assessed as 'endangering others,' he's sent home… The first time he went to [partner organization] he was around five. So, when they have a place available for him, they know him extremely well and it makes a huge difference. The continuity of care is huge. For him it's a big deal because he's very aware of where he's going, what's expected of him, what the routine is. It isn't as anxiety-producing as if he had to go someplace else."*

In relation to the child's most recent experience the partner organization, the child's case manager highlighted that the child had experienced boarding in their facility:

> *"This youth has been to residential treatment twice. Both times, there was a bit of a stay that led to us feeling like he was boarding here in our hospital. He probably was here a month longer than he needed to be. He was more or less locked in our hospital on a psychiatric unit. He was getting so frustrated, and would feel really, really hopeless. It was really hard for him and for everyone involved that we couldn't get him the care that he needed simply because our state didn't have it."*

The child's parent noted that having continuity of care in this more recent stay at the partner organization was crucial. Over time, the parent had developed relationships with the staff at the partner organization, and was able to call up his former case manager to let them know the child was going to be referred to the partner organization and to ask that their familiar psychiatrist be assigned to the case. Not only did was the child's former case manager able to be sure that the familiar psychiatrist was assigned to the child's case again, the former case manager came back to manage the case personally, even though she had been promoted to a supervisor position at the partner organization:

> *"She not only grabbed [the psychiatrist] for us, but she came back to be his case manager, and thank God. Those two, to be able to have continuity of care is everything, and [psychiatrist] adores [child], he has worked with [child] since he was seven. One of the reasons I really like [psychiatrist] is he actually will talk to me. We have had so many hospitalizations where the psychiatrist refuses to talk to parents, they say it's not their job. He actually calls, he listens, he is a team player."*

The case manager also described the child's continuity of care beyond the staff at the partner organization. The case manager noted that the child's outpatient therapist had been a consistent resource for years, including keeping the same time for therapy sessions, and that that had been extremely helpful for the child. The case manager additionally highlighted that the child's group home staff was incredibly engaged with him when he left his group home temporarily to be in the partner organization's inpatient hospital:

> *"A lot of times we see that group homes don't feel like they have the supports to have a child return to their care, but that was literally never the case with this group home. They were so consistent with him. They joined the family therapy sessions at the hospital. We invited them with the parents and we all did it together. They'd come pick him up with the parents at discharge. They called him every day. I've never really seen a group home provider do that before. It was just really a team, but family, effort for him. And he could feel that."*

Most importantly, the case manager highlighted the crucial and consistent involvement of the child's family:

> *"My first thing I always say about this case is these parents are highly involved. They are absolutely incredible advocates. They really approach him from a strengths-based lens. There's a lot of love. They're consistent even when they're burnt out, and they'll name that to professionals."*

Other aspects of care provided at the partner organization were particularly helpful for the child, including music therapy and art therapy, and the partner organization's commitment to healthy

eating and physical movement. In addition to the availability of gym facilities, the parent noted that even the facility's security guard helped get the child engaged in physical activity: "He needed activities and the security guard said, 'I bet you can't beat me in running,' and they literally ran the halls. He just noticed that the child needed movement, and I'm like 'I love that security guard.'" The case manager also noted that the child was spiritual and valued being able to engage with the partner organization's spiritual care chaplains during his stays.

The child's history of aggressive behavior was one of the challenges in moving the child to a residential treatment center that resulted in the child boarding at the partner organization while awaiting placement. The social worker notes from the child's case records showed that the child was referred to eight residential treatment centers or facilities. Several facilities told the case manager they were not able to locate the referrals that were sent, and the referrals had to be resent. Facilities expressed concerns around the child's low IQ, fetal alcohol syndrome, and level of functioning in addition to his history of aggression, and others declined to take the child due to their current milieu and/or due to lack of staffing. The case manager engaged over email with admissions staff at several facilities to address concerns and provide clarity around the child's needs, and eventually a spot at an in-state facility opened up and was willing to take the child.

Both the child's parent and the case manager highlighted that the efforts of individual workers, communication and collaboration across the various organizations with which the child had engaged over time, and continuity of care was impactful for the child. The case manager additionally noted that the family's access to commercial health insurance – while imperfect and not always willing to cover the care that was needed, which could mean discharging before the patient had completed the treatment plan – was at times an asset to the child receiving appropriate levels of care compared to children on medical assistance insurance plans. The case manager noted that this child's case, despite several challenges and a need for intensive mental/behavioral health care over the course of his life thus far, "was everything you could dream of for someone who has some really serious psychiatric and development disabilities. I think he has the best team that our system can set up for him as a youth."

Vignette 4: Case Record Review, Parent Interview, Case Manager Interview, Case Supervisor Interview

At the time of the case record provided for this study, this child was 16 years old. He identified as a White, non-Hispanic/Latino male. The child presented due to impulsive self-harm behaviors and property destruction. The patient had a history of substance use (including marijuana, nicotine, and alcohol), heated arguments with his parents, lack of self-control, and impulsivity. At the time of the first episode included in the case record, the patient had had no previous psychiatric hospitalization or residential treatment, but had been in therapy for several years. The child was adopted at birth.

The child was described in case records as future-oriented, motivated for treatment, and a "chill, cool kid." His hobbies included playing the guitar and listening to music. His parent described him as very artistic.

The case record presented two recent episodes where the child was admitted to the partner organization for inpatient hospitalization. The case manager and the case supervisor described the second episode as moving into the realm of boarding: the child stayed at the partner organization longer than was necessary because there was no availability in the residential treatment centers close enough to home for the parents to feasibly visit.

Although the child ended up boarding at the partner organization, the child's parent noted that his stay at the partner organization was probably the most positive experience they had had with a facility: "We felt like he was in a place where he was safe and that he was provided with enough to do. The programming there helped him look at what had happened, what he had done. It seemed they had the support system there: therapists, social workers, and psychiatrists. I felt assured he was safe there."

The case supervisor emphasized that one of the strengths of the child's case was that the parents were very engaged. The parent noted that the staff at the partner organization were very communicative: "They let us know what was going on. We had regular contact. They let us know when we could come, when we could visit, how all those things would go. They recognized that we needed to be part of the team as far as getting help for him." The case manager added that different staff members were willing to take the time, "whether it's nurses or doctors or myself, to talk to [the family], to talk about the concerns… I think it helps quite a bit in figuring out a place for the kid to go."

In the process of moving the child from the partner organization to a residential treatment center, the case manager noted that she advocated for the child when the center originally declined to admit him based on his history of substance use: "I was able to advocate on his behalf and say, 'Look, his substance use really isn't that bad. He's addressed it. He hasn't used in this long. Are you able to reassess to see if you'd be a good fit?'" The case manager went on to mention that the residential's willingness to look at the case again was not the norm. Additionally, the residential worked hard to get him a spot within a week because the case was classified as an emergency because the child was in the inpatient hospital setting and didn't need to be.

The case supervisor added that the residential facilities they reached out to were prompt with their responses and that the county case manager was also very responsive. As the child transitioned, the case supervisor noted that the residential facility and the partner organization worked to provide information to the child and to the family to help understand what the transition and new situation would look like. Additionally, the partner organization set up medical transportation for the child which took that responsibility off of the parents' plate and they could meet him at the new facility for admission. The case manager highlighted how important it was that the child was able to get into a facility that was closer to home: "They did live kind of further up north and there's not a whole lot in that area. So, being able to get him in a place that's a little closer to home so that the family could visit was really beneficial for them."

Both the case supervisor and the case manager mentioned the important role of the county in being able to move the child quickly into the residential program. Because the child was not covered under commercial insurance, the county typically would go through a variety of funding meetings and assessments before making the determination to move the child to residential. However, in this case, the county was able to waive those meetings until after the child had been placed:

> *"We don't always see this with counties, so this was really great. Oftentimes the hospital treatment team would be of the opinion that a youth, and specifically this youth, is in need of a swift crisis transition. So, we wanted to bypass some of the screening and the assessments needed at the county level. Those should still occur obviously per state statute, and occur once at residential instead of that holding up the process. So, with this county specifically, the county supervisor approved our request to start his treatment journey sooner because the [residential treatment center] had an opening."*

Even though the case manager and case supervisor described the ability of the county to move the process along in partnership with the partner organization and the residential treatment center as a strength, it is important to note that the parent described this transition process as frustrating and stressful:

> *"The transition process was pretty challenging because there just wasn't space available in places. From our standpoint, we understood t because we get that if there's not a place available, there isn't one. But I think [child] didn't quite understand that very much, and it was very frustrating for him. He felt like he had different things being told to him. The place that took him had originally said he couldn't come, and all of a sudden he could. That was just confusing."*

In addition, the child's parent noted that the funding process was "a nightmare," and that the county was "horrible to work with" because the child was on medical assistance and the county requested incredibly detailed information about their finances in order to clear the child's transfer to residential, which "would've taken us weeks to compile all the financial information." The parent relayed that they got medical assistance involved who stepped in and said "No, all you have to do is give them a copy of your taxes." The parent stressed that the process was "very chaotic and we're just going, 'What just hit us?' Because not only are we trying to get our kid the help that he needs, but we're trying to figure out how to even go about it. He could have been in a place, and we're still trying to figure out all this financial stuff they wanted from us."

Despite the challenging and stressful transition, the child's parent highlighted that the care the child received at the partner organization was a positive experience. The parent mentioned that the partner organization prioritized opportunities for the child to engage in physical movement and to create art. The parent highlighted that the child said that "people in the lunchroom and things like that were kind, they were nice to him. And so all around, it seemed for the most part that the people were there with an understanding of why they worked there." Additionally, the child's parent noted that the child's local outpatient therapist has been "amazing. There are definite positives. There are people that have stepped in and have been supportive."