

Children's Intensive Mental Health Services Study

Executive Summary

Author: Melanie Ferris

MARCH 2019





Future residential treatment services and steps for building a more robust continuum of care

Youth with mental illnesses and their families need access to the right level of mental health treatment at the right time including, when appropriate, residential treatment services. In 2018, the federal Centers for Medicare and Medicaid (CMS) reclassified many of the state's children's residential treatment facilities in a way that leaves them ineligible for federal Medicaid reimbursement for mental health treatment services. While this decision necessitates an urgent response, it also creates an opportunity to reassess the role of residential treatment, identify service gaps and unmet needs, and clarify the steps needed for the state to have a more robust continuum of services in place for youth and families.

The Children's Intensive Mental Health Services Study was commissioned by the Minnesota Department of Human Services (DHS) at the request of the 2017 Minnesota State Legislature. The purpose of the study was to conduct an analysis of Minnesota's current continuum of mental health services and identify potential service models and funding mechanisms to address gaps in the state's continuum of mental health services.

Using results from the study, the project team developed a series of recommendations that will build on the services currently in place across the state and establish a more robust continuum of high-quality services for youth with mental illnesses and their families. The recommendations are designed to achieve five key goals:

- Increase the adoption of effective residential treatment practices
- Expand the capacity of the state's intensive in-home and community-based mental health treatment options
- Expand Psychiatric Residential Treatment Facilities (PRTFs) in the state using a flexible approach that will allow this level of care to reach youth with a broader range of mental health needs
- Continue efforts to increase the mental health workforce
- Develop the data framework necessary to understand the needs of youth with mental illness and the effectiveness of services

The full report, including a more comprehensive narrative of study findings and final recommendations are available on the Wilder Research website: www.wilderresearch.org.

Background

Minnesota has a fragmented and complicated children’s mental health system. As a result, youth with mental illnesses have varying access to mental health services depending on where they live in the state, the type of insurance they have, and whether they are involved in other child-serving systems. While the state has made immense gains, particularly over the past two decades, in establishing a strong community-based array of services, there are still notable gaps statewide. It is in this context that funding for many of the state’s children’s residential treatment centers is in jeopardy, increasing the urgency for clear next steps.

About the study

In 2018, the Centers for Medicare and Medicaid (CMS) made a final decision to define many of Minnesota’s current residential facilities as Institutes of Mental Diseases (IMDs) and therefore ineligible to receive Medicaid reimbursement for treatment services. Prior to this decision, the state had actively opposed these facilities being classified as IMDs. The final CMS decision currently impacts 371 treatment beds in Minnesota and, unless other funding mechanisms are put into place, will place financial responsibility for mental health treatment services provided to youth enrolled in public insurance health care plans on counties. Based on the state’s fiscal note, this is an estimated \$2.4 million gap in annual funding.¹

This study was conducted to:

- Assess the purpose, need, and appropriate role for children’s mental health residential treatment in Minnesota’s publically financed continuum of care
- Describe the effectiveness of Minnesota current residential services and other intensive mental health service models
- Establish criteria or characteristics of effective treatment models and identify effective treatment models that could be adopted in Minnesota
- Analyze changes in service delivery capacity, financial implications, and potential impacts on youth and families resulting from the federal CMS decision
- Recommend one or more children’s mental health treatment models with potential funding options

This Children’s Intensive Mental Health Services Study was conducted by Wilder Research, AspireMN, NAMI Minnesota, the Minnesota Association for Children’s Mental Health (MACMH), and independent consultants Glenn Andis, Chris Bray, and Glenace Edwall. The study used a mixed method approach that included a literature review, interviews with caregivers of youth who had received residential treatment services, county referral and financial data, key informant interviews with national experts and state administrators who have led service reform efforts, and analysis of Student Data Reporting System (SDRS) data and other information submitted by residential treatment providers in the state.

¹ The fiscal note estimates this gap to be \$2.34 million in FY20 and increasing to \$2.64 million by FY23.

Children’s residential treatment centers

An estimated 20 percent of children, approximately 84,000 school-age children in Minnesota, experience some type of mental health issue each year. For many of these children and youth, standard outpatient or community-based services, including Minnesota’s school-linked mental health services, are the right level of mental health treatment. A relatively small number of youth with mental illnesses have symptoms or behaviors serious enough to impact daily functioning at a level where intensive mental health treatment, including treatment provided in residential settings, is needed.

In Minnesota, residential treatment services are intended to: stabilize crises; help the child develop the skills necessary to return to the community, including improved family and social functioning; and avoid placements that are more intensive, costly, or restrictive than necessary to meet the child’s needs. Children’s residential treatment centers (RTCs) are licensed in Minnesota as Children’s Residential Facilities (CRFs). They are less restrictive and provide less intensive treatment services than inpatient hospitalization and Psychiatric Residential Treatment Facilities (PRTFs). Minnesota has 18 licensed facilities in the state and has certified 6 facilities in other states (Arizona, Missouri, South Dakota, and Wisconsin) as meeting CRF requirements. Nine of the 18 facilities, operated by five different agencies, were designated as IMDs (Figure 1). Combined, these facilities have the capacity to serve 371 youth at any time.

1. Children’s residential treatment facilities designated as IMDs

Facility name (agency)	City	County	Capacity
Avanti Center for Girls (VOA)	Blaine	Anoka	28
Children’s Residential Treatment Center (VOA)	Minneapolis	Hennepin	24
Gerard Academy (Nexus)	Austin	Mower	93
Leo A. Hoffman Center, Inc.	St. Peter	Nicollet	32
Mille Lacs Academy (Nexus)	Onamia	Mille Lacs	96
North Homes Cottage	Grand Rapids	Itasca	20
Northwood Children’s Services	Duluth	St. Louis	44
Northwood Children’s Services – Assessment and Diagnostic Center	Duluth	St. Louis	8
Omegon, Inc. (VOA)	Minnetonka	Hennepin	26

Notes: The following residential treatment facilities are not designated as IMDs: Bar None Residential Treatment Services (VOA); Minnesota Girls Academy; Nexus Glen Lake; Woodland Hills (The Hills Youth and Family Services; and Pathfinder Child’s Treatment Center (Sanford). In addition, the Anna Westin House (The Emily Program) and Park Nicollet Melrose Center are also licensed as CRFs, but provide specialized treatment for adolescents with eating disorders. Paragon, a licensed CRF, cannot currently accept public insurance.

Without action, the full cost of mental health and rehabilitation services provided at facilities designated as IMDs will fall to the counties. This places additional financial pressure on counties already concerned about the large and growing amount of funding allocated for residential services and out-of-home placements of all types. While the financial impacts will vary by county, this would likely disproportionately impact counties with a smaller tax base, a larger number of youth living in the county in need of residential services, or limited options for other intensive in-home and community-based services. In addition, with the passage of the federal Families First Prevention Services Act, there is potential that use of Title IV-E funds will no longer be available to a portion of room and board costs, increasing financial burden to counties when the act is fully implemented. The increased financial pressure could create disincentives for youth to be able to access the right level of care at the right time. The situation also introduces concerns about the long-term stability of funding among agencies that provide residential services. While it is not clear how these changes may ultimately impact the availability of mental health services in the state, these challenges present an immediate need to determine the future of residential treatment services and a longer-term vision for how these services will be part of a robust continuum of effective and high-quality mental health services across the state.

Description of youth served and unmet needs

Neither counts of, nor the data necessary to calculate, the total number of youth who receive mental health residential treatment services annually were provided by DHS. To estimate the number of youth who receive, or who may be in need of intensive mental health services, data were compiled from multiple sources. Our estimate, using data submitted by a majority of residential treatment providers and counties, is that approximately 1,500 youth receive residential treatment services annually, with another 150 or more receiving services from facilities located outside of Minnesota. It is critical that the state has the data infrastructure needed to regularly track and monitor this in the future as services are expanded and enhanced.

Descriptive information about presenting behaviors and mental health treatment needs is also limited. Data submitted by a subgroup of providers into the Student Data Reporting System, managed by AspireMN, show that the most common presenting behaviors or concerns for 280 youth who began to receive residential treatment services in 2017 are disobedience and oppositional behaviors, impulsivity, depression, and difficult relationships with peers and caregivers. Over half of the youth exhibited suicidal thoughts or self-injurious behaviors, or were verbally or physically aggressive. Trauma was present for many youth; over half of the youth had experienced some type of abuse or neglect and over one-third were experiencing loss or grief.

Across multiple stakeholder groups who work directly with youth who have intensive mental health needs, including county social service administrators, providers, intermediate school districts, and juvenile corrections stakeholders, there was shared concern that youth who demonstrate highly aggressive behaviors, who have lower cognitive functioning, and who are at high risk of self-harm are not well-served by the continuum of services available in the state. These youth are among those most likely to be referred out of state to residential programs better designed to meet these needs. The study also identified a number of populations underserved by the current children's mental health system. This includes youth involved in the juvenile corrections system, experiencing homelessness or living in shelters, living with fetal alcohol syndrome disorders, or who have

The most difficult times were when she got older and taller and bigger. As a large African American young woman, no one in the five state region would accept her as a client. Even though she was court-ordered for treatment she was in juvenile detention because no one would take her.

- Caregiver

been sexually exploited. Local stakeholders also brought attention to the importance of considering the unique needs of youth who are wards of the state, in foster care placements or recently adopted, as well as youth who are both chemically dependent and diagnosed with mental illnesses. In addition, because many of these youth have experienced trauma, due to either experience or separation from family, local stakeholders underlined the importance of making trauma-informed services available for all youth.

To address these complex needs, the state needs a skilled workforce trained in effective treatment practices and an array of coordinated services, including services with the intensity needed to support youth and their families.

Effective residential treatment practices

Current best practices in children's mental health residential treatment services reflect new and growing knowledge about children's mental health and effective treatment models, including the impact of trauma on brain development. Whereas past models of care emphasized the importance of a highly structured group setting (i.e., a group milieu), systems that rewarded good or compliant behavior, and other behavioral models, the modest gains made in these settings were difficult to maintain after discharge without effective community-based services in place.² The current literature emphasizes the following as key components of effective residential treatment services: high levels of family involvement in treatment, planning, and decision-making; adoption of organizational trauma-informed care practices; use of appropriate and effective treatment models and evidence-based practices, including trauma-informed services; and continuity of care from residential to community-based and in-home services.

Residential treatment allowed everyone to be safe and allowed our daughter the opportunity to learn the skills necessary to live at home. There were times when her dysregulation made it impossible for our family to feel safe and for her to feel healthy.

- Caregiver

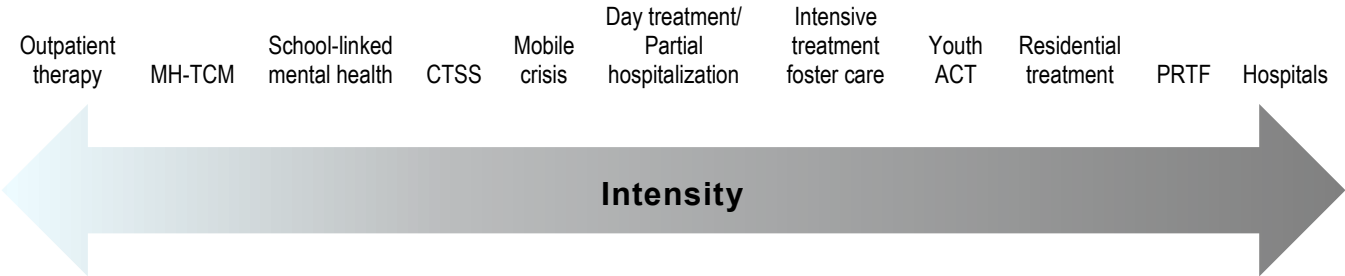
Overall, based on information shared by providers, the experiences of caregivers, and the perceptions of local stakeholder groups, residential treatment providers in the state are integrating a number of these components into their program models. For example, nearly all treatment providers have staff trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or other effective treatment models. In addition, a number of providers described ways that they are working to involve families in all phases of treatment, including through family therapy, improved communication, and deeper engagement with families in planning and decision-making. Further, multiple agencies are providing community-based services or working in partnership with community-based providers to strengthen continuity of treatment services as youth transition to community-based and in-home services. There is more that can and should be done in order for providers to fully adopt and implement these best practice. Improvements can be made to integrate a wider range of effective treatment models into residential settings to individualize treatment, adopt trauma-informed organization principles, increase family involvement in treatment and decision-making, and place greater emphasis on increasing time at home and with the family to help ensure gains made in treatment are maintained. Another key improvement to address is the continuity of care across service levels to ensure youth with mental illnesses and their families get timely access to the right type of service. Success in this area requires shared responsibility of families, residential and community-based providers, counties, state agencies, and schools.

² Hair, H.J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies*, 14(4): 551-575.

Residential treatment services as part of the continuum of care

Residential services are a critical component of Minnesota’s continuum of children’s mental health services, and are most effective when intensive community-based and in-home services are in place to support youth and families. Minnesota’s vision for a continuum of children’s mental health services was conceptualized by the Minnesota Mental Health Action Group (MMHAG) in 2004. This has been the state’s road map to improve access, quality, and accountability in the children’s mental health system. Since then, Minnesota has developed a robust Medicaid benefit set that provides a structure to build and expand the community-based and in-home services necessary to ensure that youth and families can access the right level of service at the right time (Figure 2).

2. Minnesota’s current continuum of children’s mental health services



Notes. Adopted from the Department of Human Services, 2018.

Child psychiatry and respite services are also part of the state’s array of services and may be appropriate for youth at multiple points across the continuum. Because this study focuses largely on intensive mental health services, the early childhood mental health services available in the state are not included in this figure.

MH-TCM: Mental Health Targeted Case Management

CTSS: Children’s Therapeutic Support Services

Youth ACT: Assertive Community Treatment

PRTF: Psychiatric Residential Treatment Facility

Over the last few years, there has been significant expansion in Children’s Therapeutic Services and Supports (CTSS) and school-linked mental health (SLMH) services across the state. While there is still more to be done to ensure youth across the state have access to this level of service, it is important to note that for many youth who may need or who are leaving residential settings, these services may lack the intensity needed to effectively address complex symptoms and behaviors. Anecdotally, some current residential providers noted that a lack of intensive community-based and in-home services was a factor in youth continuing residential treatment services rather than transitioning to a lower level of service, although the degree to which this occurs could not be quantified in this study.

Potential treatment models to address service gaps

Reviews of best practices in the literature, interviews with local stakeholders, feedback from caregivers, and interviews with state administrators in other states all reinforced the need for services that can both increase the effectiveness of and, in some cases, reduce the need for residential treatment services. While services across the continuum of care can be enhanced, critical gaps in the system needed to support effective residential treatment interventions are: intensive in-home and community-based services; care coordination services; and mobile crisis response and stabilization services. The study explored opportunities to expand eligibility for services in Psychiatric Residential Treatment Facilities (PRTFs) as a way to better address the needs of youth with mental illnesses, including youth who are currently served in RTCs and most likely to be referred to providers out of state. It also identifies strategies to mitigate barriers for providers to transition to a PRTF level of service, which has stable funding mechanism in place. While specific services are being identified in the study, the transitions between services and ensuring continuity of care across varied levels of treatment intensity are also critical aspects of effective treatment to improve youth and family outcomes.

Psychiatric Residential Treatment Facilities (PRTFs) can be implemented with greater flexibility than initially envisioned. PRTFs are new to Minnesota, with the first facility opening in June 2018. Similar to services provided in children’s residential treatment facilities, PRTFs provide a safe setting where youth can receive intensive mental health treatment services if community-based options cannot meet the child’s needs. Minnesota had initially envisioned PRTFs broadening the continuum of residential treatment services available and providing a higher level of care than available at existing RTCs. Although outcome data are not yet available from Northwood Children’s Services, the first agency to implement a PRTF, the director stated that the lower staffing ratio allowed them to serve youth with a higher acuity than at their RTC. This suggests that, with this service level in place, the state will have greater capacity to address some of the complex and challenging needs that currently result in youth being served out of state.

In addition, through discussions with other states with experience implementing PRTFs, the project team identified a number of ways that Minnesota can change certification requirements and eligibility rules to reduce barriers to implementation and broaden eligibility criteria. Tiered models, for example, can be used to meet the needs of youth with more varied mental health needs or to create models for specialized treatment services. Changes in interpretation of staffing requirements, such as having 24/7 access to nursing instead of 24/7 on-site nursing services, can reduce barriers to establishing new facilities in areas of the state with a limited workforce. Additional planning is needed to create new standards and to then identify the specialty programs and step-down services, including reconsidering the current role of RTCs, to complement the PRTF level of care being available in the state.

The first residential treatment center was too far away and we could only go every other week. We couldn't incorporate him back into daily life. He felt like we were just getting rid of him.

- Caregiver

Expanding the services in Minnesota’s current Medicaid benefit set could increase the availability of more intensive community-based services.

Two services, Youth Assertive Community Treatment (Youth ACT) and Intensive Treatment Foster Care (ITFC), are intensive team-based mental health services and support with a care coordination element. If expanded, both could help address the state’s current gap of intensive in-home and community-based individual and family therapy options. **Youth ACT** is currently a service offered by four agencies and available in 12 counties to adolescents and young adults (age 16-20), including youth with co-occurring disorders. It uses a team-based approach to provide a flexible array of services, including psychotherapy, skills training, crisis assistance, care coordination, clinical consultation, and medication management. Multiple stakeholder groups have suggested expanding the benefit to include children as young as 6, with age-appropriate adaptations to the treatment model. **ITFC** is a new therapeutic service that provides individual and family therapy three times a week with the youth and foster family and, when appropriate, the biological family. It is currently provided by four agencies. Currently, ITFC is only available for youth in foster care; when youth return to their biological or adoptive family, they are no longer eligible for this service. Changes to this benefit to ensure eligibility is informed by level of mental health need and available to youth in multiple types of settings is another option for increasing the availability of effective community based services in the state.

If residential care is not an option but the intensity of the daily treatment is necessary, then there needs to be more alternatives. To go from residential treatment with daily lessons and group/ individual therapy to one hour of service a week while living in a group home is not an acceptable alternative.

- Caregiver

Additional service models that support continuity of care and provide intensive in-home services should also be explored and piloted. Through the state’s System of Care expansion grant, 17 counties are piloting the Collaborative Intensive Bridging Services (**CIBS**) model, where a community-based therapist works intensively with a child before, during, and following a residential placement. The effectiveness of this promising model, which is being used in Dakota, Hennepin, and Olmsted counties, will be evaluated through the grant to help DHS determine the degree to which this type of service can or should be expanded.

DHS and providers should explore other models that integrate best practices in treatment and ensure continuity of care to community-based and in-home settings. Given the varied workforce capacity in different areas of the state and the degree to which families can participate in family therapy during a child’s residential stay, other approaches or step-down residential models of care may provide intensive family therapy and ensure continuity in mental health treatment. Examples of over residential options include smaller residential treatment centers or therapeutic group home settings. DHS, in considering rates and certification standards, can support innovation among current residential and community-based providers to establish new approaches that build on effective treatment practices. Health plans, which have supported innovation through past demonstration projects, could also play a key role, particularly as a number of community-based and in-home services currently available to youth enrolled in public insurance plans (e.g., Youth ACT, CTSS) are not covered by private, commercial plans.

Strong care coordination services are needed for youth who have complex mental health needs. Wraparound is an intensive, individualized case planning and management process for youth with mental illness and their families. It is more robust than case management services and, when optimally implemented, helps to ensure youth and families have the services and support they need across transitions in care. Several studies have demonstrated that the use of fidelity Wraparound services reduces the need for residential treatment and improves outcomes for youth when coupled with evidence-based interventions. Wraparound is also being piloted in 16 counties through the state's System of Care expansion grant, providing DHS with an opportunity to not only evaluate the effectiveness of the service, but to fully understand what is necessary for statewide adoption and implementation.

Mobile crisis response and stabilization have been identified by the Substance Abuse and Mental Health Services Administration as a critical service in a system of care. These services are intended to ensure youth and families can rapidly access support in crisis situations and connect to appropriate intervention and stabilization services. In a number of states, strong mobile crisis services have reduced inpatient hospitalization use and created an easy access point to children's mental health services. In Minnesota, crisis services are organized by county, with each county having its own crisis number. While recent investment in this service has increased the availability of crisis response services across the state, there are only three crisis teams in the state that focus exclusively on children. DHS does provide trainings for all crisis response providers, including training for working with adolescents in crisis and other specific topics related to youth and families. However, continuing to increase the knowledge and skills of crisis teams across the state to work effectively with children and families will help make this an increasingly effective service.

Lessons learned from other states

Any state or region that has undergone a significant change to its array of intensive mental health services has needed to make multiple changes simultaneously. A clear vision and thoughtful planning needs to be accompanied by ongoing, real-time monitoring to ensure implementation of changes does not result in new gaps in services or unintended consequences. For example, reducing lengths of residential treatment stays to save system costs without having the necessary community-based and in-home services available can lead to increased emergency department and hospitalization use. The experiences of other states described in the full report illustrate additional types of services that may be useful in Minnesota and provide insights into potential strategies to encourage the adoption of best practices, foster creativity to address unmet needs, and create flexible funding mechanisms. The experiences of other states also illustrate the immense challenge of creating and maintaining a robust array of services and finding the necessary balance of residential and community-based services to ensure youth have access to the right level of service in the least restrictive setting possible.

Recommendations

Overall, the study recommendations offer a number of ways that PRTFs can be designed to address a broader range of mental health needs than initially envisioned and reduce barriers to implementation. However, time is needed to update clear standards that can be implemented by providers and to determine the need for any other types of residential services while also expanding the availability of intensive community-based and in-home services. Therefore, the recommendations include stop-gap funding over the next two years to ensure youth with mental illnesses and their families do not lose access to needed services while changes are implemented to create a more robust continuum of children's intensive mental health services across the state.

The following recommendations, informed by the literature about effective mental health treatment approaches and models and further described in the full report, are changes that should be adopted concurrently:

A. Increase the adoption of effective residential treatment practices

- Set expectations for clinicians and therapists to be trained in the state's Managing and Adapting Practice (MAP) model to increase their capacity to implement evidence-based and individualized mental health treatment models
- Consider finance mechanisms to encourage the adoption of effective treatment components in flexible and innovative ways
- Involve families, counties, tribes, schools, and other supports in determining how to establish consistent lines of communication with mental health providers and improve continuity of care
- Engage tribes directly in ongoing discussions about the services and supports necessary to meet the needs of Native youth
- Continue to explore ways to better understand the needs of, and services appropriate for, youth with mental illness who are involved in the juvenile justice system

B. Expand intensive in-home and community-based mental health treatment options statewide

- Identify and establish funding mechanisms to expand ITFC to additional settings and to broaden age eligibility for Youth ACT
- Use results from the System of Care expansion grant evaluations of Wraparound and CIBS to consider how those services may be integrated into the state's continuum of care
- Continue to strengthen the state's mobile crisis response and stabilization services
- Enforce mental health parity to ensure all youth have access to intensive in-home and community-based treatment services
- Eliminate barriers and disincentives to care coordination

- Adopt recommendations from past reports including: increase funding for respite care; create and fund crisis homes or stabilization units in residential settings; increase funding for school-linked mental health grants; ensure service regulations have the flexibility needed for service providers to integrate effective culturally responsive practices into treatment
- C. Expand PRTFs in the state using a flexible approach that will allow this level of care to reach youth with a broader range of mental health needs
- Appropriate stop-gap funding through June 2021 for residential treatment services that will no longer be eligible for Medicaid reimbursement during this transition period
 - Amend PRTF licensing rules and statutes to: a) expand eligibility and b) mitigate barriers to opening new facilities
 - Continue to explore the need for additional types of residential models for step-down services from PRTFs or to best meet lower levels of mental health needs
- D. Continue efforts to increase the mental health workforce
- E. Develop the data framework needed to understand the needs of youth with mental illnesses and the effectiveness of services
- Establish the data framework needed to monitor PRTF implementation, system capacity, and key outcomes
 - Consider adding a requirement for Fetal Alcohol Spectrum Disorder (FASD) and brain injury screening, as appropriate, referrals for diagnostic assessments, when PRTF referrals are made
 - Revisit mental health screening processes and requirements used by child-serving systems to help ensure that youth and their families receive the mental health services they need as early as possible

Acknowledgements

The project team would like to extend their appreciation to the many individuals, caregivers, organizations, and associations who provided their insights about Minnesota's current continuum of children's mental health services, including its gaps, and unmet youth mental health needs, including: American Indian Advisory Committee; Association of Black Psychologists; Child Psychologists; the Children's Mental Health Subcommittee; Indian Child Welfare Act Advisory Council; Juvenile Justice Advisory Committee; Minnesota Association of County Social Service Administrators; Minnesota Coalition of Licensed Social Workers; Minnesota Council of Health Plans; Minnesota Hospital Association; Minnesota Juvenile Detention Association; Psychiatry Leaders; Safe Harbor and homeless youth providers; school special education directors; behavioral directors and providers from Leech Lake and Red Lake tribes; and mental health providers.

The study team would also like to recognize providers affiliated with the National Organization for State Associations for Children and the National Association for Children's Behavioral Health, as well as the following providers and state administrators: Cathy Connolly; Robert Lieberman; Bruce Kamradt; Elizabeth Manley; Tim Marshall; Sheamekah Williams; Sheila Pires; and Jeff Vanderploeg.

Wilder Research staff who contributed to this report include: Cheryl Holm-Hanson, Nora Johnson, Bunchung Ly, Azra Thakur, and Kerry Walsh.

Wilder Research, a division of Amherst H. Wilder Foundation, is a nationally respected nonprofit research and evaluation group. For more than 100 years, Wilder Research has gathered and interpreted facts and trends to help families and communities thrive, get at the core of community concerns, and uncover issues that are overlooked or poorly understood.

451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700 | www.wilderresearch.org

Wilder Research®

Information. Insight. Impact.

The following organizations were partners in this study: AspireMN, NAMI Minnesota, and the Minnesota Association for Children's Mental Health (MACMH). Independent consultants, Glenn Andis, Chris Bray, and Glenace Edwall, also contributed to this report.

