State Advisory Council on Mental Health & Subcommittee on Children's Mental Health:

2026 Report to the Governor and Legislature (Final)

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Land Acknowledgement and Commitment to Equity and Service

As members of the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health, we begin by acknowledging that the land on which we live and serve is the ancestral and contemporary homeland of Indigenous peoples. We also acknowledge that the wealth and institutions of this country were shaped through stolen land and the enslaved, exploited and underpaid labor of African American, Indigenous, immigrant and other marginalized communities. These histories continue to influence the systems, opportunities and inequities we encounter today.

We recognize that mental health does not exist apart from the conditions in which people live. Racism, poverty, housing instability, violence, discrimination, immigration-related fear, barriers to health care and other forms of systemic inequity can profoundly affect individual, family and community well-being.

Recent events in Minnesota have reinforced the importance of this responsibility. Federal immigration enforcement activities, including Operation Metro Surge and the deaths of Renée Good and Alex Pretti in Minneapolis in January 2026, created fear, grief, trauma and uncertainty for many Minnesota communities. We acknowledge both those immediate experiences and the lasting effects that fear, violence, instability and loss of trust can have on mental health and people's willingness to seek help.

We also recognize that efforts to ensure accountability and prevent fraud, waste and abuse can have unintended consequences when policies or practices fail to account for the communities they affect. Small, rural, culturally specific, community-based and other organizations often reach people historically underserved by larger systems. Accountability and stewardship must be pursued alongside equity, access and an understanding of community impact.

As a Council and Subcommittee, we have a responsibility to examine not only our intentions, but the impact of our decisions, policies, practices and recommendations. This includes

examining our own implicit biases and recognizing the ways systemic and structural racism and other inequities can create barriers to safety, belonging, treatment, recovery and well-being.

We, therefore, commit to listening openly to the experiences of Minnesota's diverse communities; centering the voices of people with lived experience; examining policies and practices that disproportionately harm vulnerable and underserved populations; and supporting equitable access to mental health services, resources and opportunities.

Executive Summary

The State Advisory Council on Mental Health was established in 1987 under Minnesota Statute 245.697(1) and the Subcommittee on Children's Mental Health was established in 1989. Members for both the Council and Subcommittee include individuals with lived experience of mental illness, parents and family members of those with mental illness, county commissioners, social service directors, advocacy organizations, educators, psychiatrists, psychologists, social workers, community corrections, legislators and representatives of state agencies. The Governor appoints members to the State Advisory Council on Mental Health. Members of the Subcommittee on Children's Mental Health are appointed by the chair of the State Advisory Council on Mental Health.

Per statute, the Council and Subcommittee are charged with:

- Advising the Governor and heads of state departments and agencies about policy, programs and services affecting people with mental illness
- Advising the Commissioner of Human Services on all phases of the development of mental health aspects of the biennial budget
- Advising the Governor about the development of innovative mechanisms for providing and financing services to people with mental illness
- Encouraging state departments and other agencies to conduct needed research in the field of mental health
- Educating the public about mental illness and the needs and potential of people with mental illness
- Reviewing and commenting on all grants dealing with mental health and on the development and implementation of state and local mental health plans
- Coordinating the work of local children's and adult mental health advisory councils and subcommittees

The 2026 Report to the Governor and Legislature provides recommendations from the members of the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health. The Council and Subcommittee are dedicated to improving mental health services for all Minnesotans. Members considered current social, cultural, whole family and person-centered needs when developing these important recommendations.

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health's 2026 recommendations to the Governor and the Legislature include the prioritization of the following areas related to mental health in the state of Minnesota:

Recommendations from Workgroups

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health have organized their recommendations in the following Workgroups:

- Integrated Care and Access
- Mental Health and Schools
- Mental Health and Juvenile Justice
- Mental Health Wellbeing and Supports Workgroup
- Outreach to Diverse Communities
- Local Advisory Councils

Integrated Care and Access Workgroup

Statewide behavioral health data integration: Epidemiological needs assessment and services inventory for Minnesota

Problem Statement: Within the State of Minnesota are many governmental programs operating to address the behavioral health needs of Minnesotans. Additionally, there are local, private, public, non-profit, tribal etc. entities and institutions also serving components of Minnesotans' mental and behavioral health needs. Despite a multitude of programs and services, the consensus is that the current supply and infrastructure are inadequate to meet the needs of all state residents. Furthermore, the individual programs and entities operate with little, if any, coordination or communication with each other. Without a comprehensive understanding of what and where the behavioral health needs for the population of Minnesota are, it is difficult to understand the inadequacies in behavioral health: what to provide, where and how much, as there is no comprehensive bird's eye view of what the epidemiological landscape of behavioral health concerns are and no comprehensive data bank of all resources available.

Background Information: As of December 2025, only 24.9% of Minnesota's mental health care needs are met.[1] Minnesota's behavioral health system shows measurable gaps, reflected in a homelessness rate of 16.0 per 10,000 residents.[2] In Minnesota, recently jailed individuals report substantially higher rates of mental illness than the general population, with 31% experiencing depression, 37% experiencing anxiety and 9% having attempted or considered suicide, compared to 17%, 23%, and 2% statewide, respectively.[3]

Recommendation Part 1: Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) in collaboration will create Minnesota's Behavioral Health Epidemiological Data Bank to provide a comprehensive understanding of Minnesota's behavioral health landscape.

This data bank should provide all users with an understanding of what the population of Minnesota comprises in terms of behavioral health diagnoses and level of care need. The data should be gathered county by county and tabulated numerically in a manner that removes the ability to identify individual patients in the data bank. For very large metro counties, DHS may decide to divide the county into smaller regional areas, by zip code perhaps, to more accurately pinpoint population demographics. For example: County XYZ has a total population of 100,000, number of people with schizophrenia is 435, with a bipolar diagnosis is 565, etc. DHS, with input from MDH, the governor and legislature and mental health advocacy groups, will determine which diagnoses to track and monitor, and how to manage dual diagnosis data. Additional data

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[1] KFF. (2026). *Mental health care health professional shortage areas (HPSAs)*. https://www.kff.org/other-health/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

[2] World Population Review. (2026). *Homeless population by state 2026*. https://worldpopulationreview.com/state-rankings/homeless-population-by-state

[3] Widra, E. (2025, December 18). *Large Minnesota study underscores disproportionate rates of health problems among recently incarcerated and unhoused people*. Prison Policy Initiative. https://www.prisonpolicy.org/blog/2025/12/18/minnesota-health-study/

gathered should include what percentage of the population is in treatment, what level of treatment is being provided (inpatient, residential, outpatient psychotherapy, psychiatric management, etc.) and what percentage is taking medication. Data input will need to include health plans, MA and Medicaid data, hospital and facility census, pharmacy refill data, etc. All data supplied to DHS is numerical, and no individual patient identifying information may be collected.

To help assess unmet need, such as people who do not have a diagnosis yet or who are untreated, the data bank may analyze numeric data from mental health emergency room visits, hospitals, jails, homelessness and social service organizations and Local Mental Health Advisory Councils (LAC). It may be helpful to pilot data-gathering methods in diverse areas of Minnesota to determine the most effective collection strategy.

Unexpected discrepancies should prompt DHS to request a deeper dive at the county/subcounty level to evaluate the accuracy of the data. For example, a county with a much lower rate of schizophrenia than expected for their population size may be undercounting, and an analysis of their tabulations can be undertaken.

Recommendation Part 2: Creation of a comprehensive behavioral health service and structure inventory of all available behavioral health structures and programming in Minnesota.

This information should include both total capacity and real-time availability. To accomplish this, parameters for access will need to be developed and agreed upon; for example: How long of wait times are acceptable for the patient's level of severity? What is an acceptable distance of travel the patient undertakes to get to care? Or alternatively, what is an acceptable wait time for remote/video access to care given the acuity of need? Once parameters are established, the service survey will need to track and monitor access and availability. LACs can be helpful in developing these guidelines, as well as providing information on service availability.

This inventory could function as a website like FastTrackerMN.org and would allow users to rapidly understand what services exist, where they are located and whether there is availability to use the service now. This resource could provide information to the consumer, to DHS, MDH, to mental health advocacy organizations and to the legislature to assess the adequacy and type of treatment available to state residents and help with direct funding decisions for future projects.

Expected outcomes & who will benefit if this recommendation is implemented: With a comprehensive data bank of behavioral health epidemiology, paired with an up-to-date inventory of behavioral health services, proactive actions/legislation can be taken to develop programming and infrastructure in the locations that will best reach the needs of our population.

Furthermore, as data is analyzed over time, and severity of illness is tracked by monitoring what levels of care are utilized, information will be available to assess how well the continuum of care meets the needs of the population. The addition of geo-mapping data would allow analysis of mental stability across the counties, across the lifetime and when paired with a service availability inventory, would identify gaps in care. Needs can be targeted, and programming effectiveness could be extrapolated. Geo-mapping is a highly useful tool to best plan where to place infrastructure and programming to best target the populations at need.

What is the impact on diversity of this recommendation? A comprehensive epidemiological data bank will provide DHS and MDH with information on which segments of the population are at risk, which are inadequately served; a service inventory will highlight where targeted programs need to be developed. Racial and ethnicity data as well as poverty and social status data may be included to ensure that solutions to care gaps are distributed equitably.

Reimbursement rate adjustment to support mental health services

Problem Statement: The current rates of mental health services reimbursed are below standards given the reimbursement rates for other medical services. Low reimbursement rates are having a negative ripple effect in areas of employment retention, equitable access to care and the ability of agencies to remain open.

Background Information: Mental health services have been underfunded for years despite the ongoing need for services in the community being on the rise. For example, since 2018, Children's Minnesota experienced almost a 100% increase in emergency room visits related to mental health needs.[4] The number of available residential treatment beds for children in Minnesota decreased from 2,474 to 1,586 between 2005 and 2023.[5] The pandemic did not help an already difficult situation and resulted in increased requests for mental health services, while the field of mental health experienced (along with other sectors) a workforce crisis. Nationally, salaries for mental health providers have risen, but the reimbursement rates for the mental health services (a portion of which is passed onto providers) remains stagnant. Mental health providers and organizations are having more difficulty keeping their doors open with inadequate funding to support operating costs. In July 2023, Options Family and Behavior services, an organization operating for 27 years and serving adolescents with severe mental health issues and substance use disorders closed their doors.[6] North Memorial closed their mental health outpatient services in 2024. This is during a time when requests for mental health support services are rising versus declining. The growing numbers of Minnesota residents whose care is paid by Medical Assistance (MA) have trouble accessing care.[7] Current rates are unsustainable for providers and agencies. Advocates during the 2022-23 legislative session pushed for increases in the 30% range. The legislature provided a 3% increase. In 2024, the MN legislature failed to correct the sunsetting of a critical care access law supporting a variety of mental health services. Medicaid has paid approximately 54% of commercial insurance and 83% of Medicare rates. Furthermore, the impact of funding losses related to HR1 (One Big Beautiful Bill Act; OBBBA) has put significant strain upon our already underfunded mental health systems within

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[4] AspireMN. (2024). *Mental health rates factsheet*. https://assets.senate.mn/committees/2023-2024/3123_Committee_on_Health_and_Human_Services/Mental-Health-Rates-Factsheet.pdf

[5] AspireMN. (2023, July). *Lost capacity for children's mental health: Decades of decline in services contribute to today's crisis*. https://www.house.mn.gov/comm/docs/kiqk6xEr2U6b3ClryAKodQ.pdf

[6] Swanson, K., & Campbell, R. (2023, November 15). *Dead phone lines and empty offices: Mental health providers are closing and Minnesota doesn't know*. KSTP. https://kstp.com/kstp-news/top-news/dead-phone-lines-and-empty-offices-mental-health-providers-are-closing-and-minnesota-doesnt-know/

[7] NAMI Minnesota. (2024, April 16). *MHLN members across the state urge legislators: Raise Medicaid rates to end children's mental health crisis*. https://namimn.org/mhln-members-across-the-state-urge-legislators-raise-medicaid-rates-to-end-childrens-mental-health-crisis/

our state. The 2025-26 legislative session did not have a bill in circulation addressing some of the disparities for certain mental health services. It is paramount to keep this topic in the minds of our state leadership teams to prevent the collapse of both our rural and urban mental health systems within our state.

Recommendation: The Minnesota Legislature instructed DHS to produce a rate analysis to assess this area and to provide recommendations. DHS has completed this task and published a comprehensive rate analysis in January 2024.[8] The recommendation is for our legislature to continue to use this resource as a tool to establish reimbursement rates across mental health services in addition to any movements available to them to prevent further cuts to monies allocated for mental health resources.

Expected outcomes & who will benefit if this recommendation is implemented*:* The expected outcome is growth and support for Minnesotans in need of mental health/substance use services. Addressing this topic is critical in resolving the current mental health crisis being experienced by our communities. This adjustment should be seen as building a base of stability for our mental health system. The benefits will create a ripple effect that is restorative. Those involved in the business of mental health will be able to pay competitive wages to their employees. Young people will see the mental health field as a viable occupational choice for themselves to seek education. Our workforce will be increased. Families will be able to obtain the services needed. Restored mental health in turn can benefit other larger societal areas where there are known influencing intersections with mental health such as: abuse, violence, school functioning, homelessness, substance use, crime, incarceration, etc.

What is the impact on diversity of this recommendation? As described above, marginalized populations have been inordinately impacted by a lack of resources. Addressing the topic of rate reimbursement directly impacts those who are most in need.

Address delays in neuroleptic treatment for civilly committed patients in Minnesota by reforming the Jarvis Order Process and investing in the infrastructure needed to make timely review meaningful.

Problem Statement: Minnesota's Mental Health Commitment Law creates conditions in which patients involuntarily hospitalized for serious mental illness may wait up to 14 days, and in some counties more than 21 days, before receiving a court-authorized neuroleptic medication order (Jarvis Order) as part of the final commitment hearing. During this period, clinicians are generally limited to administering neuroleptics (neuroleptics, also known as antipsychotic medications, are used for the treatment and management of symptoms associated with various psychiatric disorders) only in response to acute behavioral emergencies, not as part of a proactive, clinically guided treatment plan.

[8] Minnesota Department of Human Services. (2024, January 22). *Minnesota Health Care Programs fee-for-service outpatient services rate study: Second report*. https://mn.gov/dhs/assets/Final%20Rate%20Study%20Report_tcm1053-610638.pdf

This gap between hospitalization and the initiation of definitive psychiatric treatment causes prolonged inpatient stays, reduced bed availability for other patients in crisis, increased uncompensated care costs to hospitals and counties and potential worsening of psychiatric outcomes for patients who go weeks without stabilizing medication.

Background: Minnesota permits involuntary commitment for both mental health conditions and substance use disorders under Chapter 253B. The Jarvis order, which authorizes administration of neuroleptic medications over a patient's objection, is governed by a separate procedural track under 253B.092, though it often runs concurrently with the commitment proceeding. When a patient refuses medication and a written request for a hearing is filed, the court must schedule that hearing within 14 days. In practice, county-level resource constraints, including judicial availability and public defender capacity, can extend the time before a hearing occurs beyond that statutory window, sometimes to 21 days or more, though this reflects implementation pressure rather than a change in the statute itself.

Minnesota was rated the highest-performing state in the nation by the Treatment Advocacy Center's 2020 Grading the States analysis, receiving 97 out of 100 points.[9] That ranking reflects the statutory quality of Minnesota's commitment framework, through its criteria, its AOT provisions, and its procedural clarity, though the TAC analysis is explicitly based on law as written rather than implementation in practice. Any reform should be designed to improve that strong foundation without dismantling the due process protections that contributed to it.

That said, this does not mean Minnesota's 14-day window is optimal. For example, the current process creates the following documented harm:

- Patients who lack decisional capacity and have a clear clinical need for neuroleptics may spend one to three weeks (if not more) hospitalized without receiving the medication most likely to stabilize them, with treatment limited to behavioral emergencies only.
- Extended inpatient stays tied to the Jarvis timeline contribute to a geometric mean length of stay (GMLOS) that exceeds national averages, creating reimbursement risk for Minnesota hospitals whose payers use national benchmarks.
- Delayed bed turnover reduces capacity for other patients in acute psychiatric crises.
- County-level resource failures, like inadequate public defender staffing, judicial unavailability and lack of virtual hearing infrastructure, sometimes extend the statutory window in practice, compounding the statutory delay with an operational one.
- Rural counties face disproportionate burdens due to limited access to appointed counsel, examiners and court capacity.

Recommendation: The Legislature and relevant stakeholders should pursue a multi-pronged approach that addresses both the timeline problem and the infrastructure failures driving it. The

[9]Treatment Advocacy Center. (2020). *Grading the states: An analysis of involuntary psychiatric treatment laws 2020*. https://www.tac.org/reports_publications/grading-the-states-an-analysis-of-involuntary-psychiatric-treatment-laws-2020/

following options should be explored and evaluated together rather than treated as competing alternatives.

Option 1: Shorten the statutory window with robust procedural safeguards intact. A window of seven to 10 days from petition to hearing is the range most likely to balance clinical urgency with due process. But a shorter timeline without the infrastructure to support it just creates a new way to fail patients. Any shortening must include timely appointment of counsel, an independent psychiatric evaluation before the hearing and an explicit ban on the "under advisement" practice that currently allows indefinite delay after a hearing has already been held.

Option 2: Allow a preliminary medication order earlier in the process. Rather than collapsing the entire timeline, Minnesota could authorize a time-limited preliminary neuroleptic order at the probable cause hearing (which already occurs within 72 hours of emergency hold), conditioned on a finding of both incapacity and clinical need, with a mandatory final review at the existing 14-day hearing. This mirrors the structure already used for other preliminary orders in civil commitment and preserves full judicial review while allowing earlier clinical intervention in clear cases.

Option 3: Expand the behavioral emergency standard to include documented clinical deterioration. The current requirement that neuroleptics be limited to behavioral emergencies prior to the Jarvis order is narrower than what clinical evidence supports. Minnesota could expand this to permit clinically guided neuroleptic administration when a licensed psychiatrist documents that a patient lacks decisional capacity, has a clear clinical indication and is experiencing measurable psychiatric deterioration with mandatory reporting and oversight rather than unlimited clinical discretion.

Option 4: Expand the pre-order standard beyond acute behavioral emergencies. Under current law, clinicians can continue medication before the final Jarvis order, but only by documenting every day that an active emergency exists. That framing forces clinicians to justify real treatment as if it were crisis response, creating legal risk and discouraging actual care planning. The legislature should either clarify the bridge provision so ongoing treatment doesn't require daily emergency re-documentation, or expand the pre-order standard to allow clinically guided medication when a psychiatrist documents incapacity, clinical need and measurable deterioration, with oversight and mandatory reporting built in.

Option 5: Mandate and fund the infrastructure needed to make the current timeline work as written. Many of the documented harms attributed to the 14-day window are harms caused by county failures to meet it. The Legislature should require counties to meet the statutory deadline, mandate virtual or telephonic hearing options for rural counties, fund adequate public defender and appointed counsel capacity for commitment proceedings, remove the “under advisement” option and establish statewide reporting on Jarvis petition timelines by county. Transparency about which counties are failing to meet current standards may be a more efficient first intervention than changing the standards themselves.

Option 6: Create an expedited pathway for clear cases while protecting contested ones. Not all Jarvis petitions are equally contested. When a patient has a documented treatment history, a prior Jarvis order and both the treating psychiatrist and an independent examiner agree on the clinical need and incapacity, a streamlined review pathway, including combined hearings and abbreviated timelines, may be appropriate. For first-time petitions, contested cases or patients without a prior commitment history, the full 14-day window with robust counsel should be preserved.

Option 7: Collect the data needed to know what is and isn't working. Minnesota lacks robust published data connecting the Jarvis timeline to patient outcomes, hospital stays or costs. The legislature should require hospitals and counties to report, at minimum, time from petition to Jarvis hearing, time from commitment to authorized treatment, length of stay by county, price and discharge destination. Without this, future reform efforts will face the same evidentiary gaps this one does.

All of these options should be evaluated with the following requirements: mandatory judicial review before a Jarvis order is finalized, retention of independent legal counsel for the patient, elimination of the "under advisement" loophole and collection of outcome data, including length of stay, medication side effects and rates of subsequent voluntary treatment engagement, to assess whether any change actually improves patient outcomes rather than only system throughput.

The goal of timely, patient-centered care for people in psychiatric crises is the goal. Achieving it requires engagement with both the clinical problem and the civil rights framework that exists to protect some of the most vulnerable people in the state.

Mental Health and Schools Workgroup

Align student support personnel in each licensure area with national staffing standards.

Problem Statement: The State of Minnesota provides inadequate funding for specialized instructional support personnel such as licensed school social workers, school psychologists, school counselors and school nurses. Minnesota currently has a workforce shortage of professionals in these roles, making it a challenge to find, hire and maintain staff in these roles.

Background Information: Schools are often the first line of defense in addressing the mental health and well-being of students. The lack of workforce and funding prevents schools from providing these crucial needs. With Minnesota's recent community experiences and stressors plus world events, there is a tremendous need for additional specialized instructional support personnel to support students with mental health concerns.

In the 2025 Minnesota Student Survey, students reported improved mental health since 2022.[10] However, starting in 8th grade, girls scored worse on many indicators of physical health and emotional well-being, suggesting we need to support girls more effectively beginning in middle school. The survey shows a decline in eighth grade students feeling safe at school when compared to 2016. Students reported one or more adverse childhood experiences (ACEs) at the following rates: grade 11 at 43%, grade 9 at 39% and grade 8 at 37%. The survey reported symptoms of depression and anxiety to be greater among girls than boys and, although lower than 2022, still above 56% for depression and 68% for anxiety for grades 9 and 11 girls. The survey showed that rates of suicide attempts in 2025 were the same for boys and a slightly decrease for girls when compared to 2022 results.

Recommendation:

1. Increase and fund student support personnel in each licensure area to be aligned with national staffing standards.
2. Identify and develop a plan to implement solutions to the workforce challenges in filling these crucial positions.

Expected outcomes & who will benefit if this recommendation is implemented: All Minnesota students would have adequate access to specialized instructional support personnel to support their mental health. Minnesota workforce challenges would be identified and addressed so that positions can be filled.

What is the impact on equity and diversity of this recommendation? Data gathered across Minnesota and the nation indicates an overall rise in the mental health crisis of our state's young people, with a disproportionate effect on marginalized youth. By providing all schools with specialized support personnel there will be a positive impact on all youth, especially those reporting greater mental health impacts.

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[10] Minnesota Student Survey Interagency Team. (2025). *2025 Minnesota Student Survey*. Minnesota Department of Health. https://www.health.state.mn.us/data/mchs/surveys/mss/index.html

Fund the 10 regional school crisis response teams

Problem Statement: There is a state mandate to have regional crisis response teams, however, this is an unfunded mandate and cannot be sustained.

Background Information: It is essential that all public and charter schools have access to a crisis response team in the event of a school crisis. School crises can include, but are not limited to, death of a student or staff member, suicide attempt or completion, substance abuse, building intruder, automobile accident, natural disaster and medical emergency. The purpose of these teams is to support schools to mitigate the impacts of trauma for school staff, students and communities. Crisis response teams help to restore the learning environment in the aftermath of a crisis.

To ensure timely responses to school crises, Minnesota Statues, section 119A.035 mandates that each region in Minnesota has a crisis response team. This is an unfunded mandate. When there is a school tragedy, staff may be profoundly impacted by the event and unable to provide the necessary support to themselves and their students. Regional School Crisis Response Teams (RSCRT) deploy volunteer members trained to respond, unattached to your district and without strong emotional ties to the students or staff. This allows RSCRT to make decisions more objectively and counsel groups and support individuals to assist in restoring the emotional well-being of the school.

Crisis response team members may include school administrators, guidance counselors, psychologists, social workers, teachers, nurses, security experts, law enforcement, medical professionals and other related areas. Services may include:

- Facilitate meetings/conversations with staff
- Prepare internal and external announcements
- Establish and staff comfort rooms
- Assist with security needs
- Arrange parent/community meetings
- Support students and staff
- Individual or group counseling/debriefing sessions
- Triage (identify individuals who may require additional services)
- Psychological first aid
- Compassion/team fatigue: supporting adults/staff/admin/teams
- Consultation regarding rituals/remembrances, etc.
- Provide resources
- Educational opportunities for students, staff, and community
- Longitudinal planning for ongoing support

Recommendation: Provide funding for 10 regional crisis response teams.

Expected outcomes & who will benefit if this recommendation is implemented:

The expected outcomes of this recommendation will be on-going and sustained funding to support the 10 regional crisis response teams. The entire school and community will benefit from this recommendation if funded.

What is the impact on diversity of this recommendation?

The impact on diversity of this recommendation will include equitable access to culturally responsive school crisis response team services.

Comprehensive school mental health systems (CSMHS)

Problem Statement: Comprehensive school mental health systems (CSMHS) are not currently cited in Minnesota statute. It is necessary to define a comprehensive school mental health system to align with related legislation and state statutes (e.g., Positive Behavioral Interventions and Supports (PBIS), Social and Emotional Learning (SEL), school-linked mental health grants, etc.) Defining comprehensive school mental health will ensure consistency in state and local school district implementation.

Background Information: CSMHS are defined as school district community partnerships that provide a continuum of mental health services to support students, families and the school community. CSMHS provides a full array of supports and services that promote positive school climate, social and emotional learning and mental health and well-being, while reducing the prevalence and severity of mental illness. Core features of a CSMHS include: 1) well-trained educators and specialized instructional support personnel, 2) family-school-community collaboration and teaming, 3) access to school linked mental health services, 4) comprehensive suicide prevention strategy, 5) needs assessment and resource mapping, 6) multi-tiered system of support, 7) mental health screening, 8) culturally responsive, evidence-based practices and emerging best practices, 9) data and data driven decision-making and 10) funding and sustainability. It is important to note that consultation with Tribal Governments needs to occur when developing a CSMHS to ensure Tribal Schools and Native Immersion Programs have access to mental health services and support while recognizing their sovereignty.

Recommendation:

1. The Minnesota Department of Education in cooperation with the Minnesota Department of Human Services and the Minnesota Department of Health define comprehensive school mental health systems (CSMHS) in statute and provide implementation guidelines for all schools in Minnesota.
2. Provide a 25% funding carve-out requiring school districts with school-linked mental health services to contract with culturally specific mental health organizations/providers to render culturally congruent services to children, youth and families. Include a definition of culturally specific mental health organizations/providers for eligibility to receive funding.

Expected outcomes & who will benefit if this recommendation is implemented:

Defining comprehensive school mental health will ensure consistency in state and local school district implementation.

What is the impact on diversity of this recommendation?

Students of marginalized cultures experience mental health distress at higher rates relative to their peers. Students who identify a LBGTQ+ are nearly twice as likely to report mental health

concerns as students who do not identify as LGBTQ+. The comprehensive school mental health approach will positively impact all youth, especially those reporting greater mental health impacts by fostering a more inclusive and supportive educational environment where students can reach their full potential.

Ensure integration of Social Emotional Learning in the Health Instructional Standards.

Problem Statement: Social Emotional Learning is not currently in the Health Instructional Standards and therefore not taught uniformly by districts and the state.

Background Information: Social emotional training helps students develop essential skills like self-awareness, empathy and responsible decision-making, which improve their academic performance and mental well-being. It fosters a positive school climate and enhances students' ability to build healthy relationships and cope with challenges.

The Suspensions and Expulsions Report show Indigenous students were 10 times more likely to be suspended or expelled than white students.[11] Black students were eight times more likely to be suspended or expelled than white students. Students with disabilities were two times more likely to be suspended or expelled than students without disabilities.

The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines five core competencies of Social Emotional Learning:

1. Self-awareness: Self-awareness is the ability to recognize your emotions and how they influence your behavior. When you're self-aware, you can identify your strengths and weaknesses and take control of how you respond to different situations.

2. Self-management: Self-management refers to the ability to control your emotions, thoughts and behaviors in different situations. This competency helps individuals cope with stress, stay focused on tasks and act with integrity.

3. Social awareness: Social awareness involves understanding and empathizing with the emotions and perspectives of others. It's the ability to recognize social cues, such as body language, and to understand the broader social environment.

4. Relationship skills: Relationship skills are the abilities required to build and maintain healthy, meaningful relationships with others. This includes effective communication, cooperation, conflict resolution and teamwork.

5. Responsible decision-making: Responsible decision making involves the ability to make choices based on ethical standards, safety concerns and social norms. It helps individuals weigh the potential consequences of their actions before making decisions.

Recommendation:

- Ensure integration of Social-Emotional Learning in the Health Instructional Standards.

[11] Minnesota Department of Human Rights. (2022, June 1). *Suspensions and expulsions report: Lessons learned and next steps*. Minnesota.gov. https://mn.gov/mdhr/assets/Suspensions%20and%20Expulsions%20Report_tcm1061-529594.pdf

- Track outcome data related to Social-Emotional Learning standards.

Expected outcomes & who will benefit if this recommendation is implemented:

- Students will have greater skills to manage stress related to current events in Minnesota
- Improved mental health and wellbeing for students
- Students will have an increased capacity to self-regulate their emotions.
- Educators and students will have common language and skills around emotion regulation and de-escalation.
- Increased positive student-teacher relationships

What is the impact on diversity of this recommendation? The Suspensions and Expulsions Report shows that BIPOC students have disproportional impact on disciplinary actions. Increasing social-emotional skills for all students will decrease this disproportionately.

Mental Health and Juvenile Justice Workgroup

Mental health services desperately needed in correctional facilities for youth with mental health issues

Problem statement: Correctional facilities are currently being used to house kids with mental health issues due to the loss of residential treatment beds over the last five years, loss of community mental health services and the current workforce shortage in mental health. Community health service loss and workforce shortage contribute to increased youth incarceration.

Background Information: Data reviewed by AspireMN of data provided by the Minnesota Department of Human Services Licensing Division to analyze capacity found a loss of residential treatment beds from 2005 to 2023.[12] In 2005 there were 2,474 licensed children's residential beds in Minnesota. In 2023 there were only 1,586 licensed beds in Minnesota. This represents an overall loss of 888 beds, a reduction in capacity of 36%. Due to the impact of COVID, between 2020 and 2023 601 beds closed, meaning 30% of total capacity has been lost in the last three years.

There has been an increase in the prevalence of diagnosable mental health conditions for our youth during and after COVID.

- The Journal of Pediatrics reports "behavioral and mental health conditions are the most prevalent and costly impacting children today. One in six has a diagnosable mental health condition. One in thirteen high school students attempted suicide in the past year. Fifty to seventy percent of kids with serious mental health issues do not receive treatment."
- American College of Emergency Physicians, observes worsening trends through the pandemic, including a 51% increase in suicide attempts by teenage girls from 2019 to 2020.

With the current lack of mental health beds and community services, youth with mental health issues are being boarded at correctional facilities while waiting for mental health placements, sometimes for months. These youth with mental health issues often have related high-risk behavioral needs that cannot be safely managed by families and outpatient services.

There are insufficient onsite services to meet youth's mental health needs in correctional facilities. Decriminalizing mental illnesses not only saves resources in the long term, but it saves lives and promotes safety and justice for all Minnesotans.

***Recommendation*:**

[12] AspireMN. (2023, July). *Lost capacity for children's mental health: Decades of decline in services contribute to today's crisis*. https://www.house.mn.gov/comm/docs/kiqk6xEr2U6b3ClryAKodQ.pdf

- Maintain and develop the critical capacity of mental health services in residential treatment beds and community-based service including:
    - Increasing respite care
    - Sustaining existing residential treatment capacity including making investments in residential treatment staffing
    - Fixing the Medicaid outpatient community-based rate structure so early intervention and transition care is available to children and families
- Increase resources to meet the mental health needs of the youth in Minnesota Juvenile Detention Association Facilities (MNJDA)
- Allocate $3-4 million per year for MNJDA facilities to contract for services or hire staff
- Minnesota Department of Corrections will request the funding and oversee the use of funding
- MNJDA facilities will approve a funding formula based off the size of the facility
- Funding can be used for direct mental health treatment services, safety stabilization staff to support children in being safe and staying out of their rooms or transition services to and from facilities to maintain continuity in treatment plans
    - $4 million provides approximately:
        - Two to five contracted or facility positions for each 11 MNJDA members based on number of youths served
    - $3 million provides approximately:
        - One to four contracted or facility positions for each 11 MNJDA members based on number of youths served.

Expected outcomes & who will benefit if this recommendation is implemented: Youth that are in correctional facilities will receive needed mental health services that will support their recovery, prevent their mental health from worsening and potentially reduce the time needed in residential treatment once a placement is secured. In preparation for the January changes in room-time in correctional facilities, these services would reduce the use of room time, improve mental health outcomes for youth and increase staffing with skills to meet the needs of youth before room time is necessary.

What is the impact on diversity of this recommendation? Youth benefit holistically from culturally relevant strategies that are based in rehabilitation and restorative practices. Providing needed mental health services in a timely manner will enable BIPOC youth to progress and be released sooner rather than later and significantly disrupt and end the school to prison pipeline and intergenerational incarceration for the BIPOC population.

Increase crisis stabilization and placement options for younger youth

Problem statement: There are not enough placements for youth of all ages, and particularly for youth ages 10-12. Beginning August 1, 2026, the age of delinquency in Minnesota will change from 10 to 13. This will create an influx of younger children who previously were served in the criminal justice system that will now need to be served by child protection and human services.

Background information: In 2022, the legislature authorized the creation of crisis stabilization beds for children. Any mental health professional, physician or member of a mobile crisis team can make the referral if they have assessed the child and found that they are experiencing a mental health crisis and need this service. The child can stay up to 30 days. If the child needs to continue in care after 30 days, they will need to go through the typical process for accessing residential treatment. These beds can be provided in a residential facility or youth shelter. The program must develop a crisis treatment plan within 24 hours. Services included are crisis stabilization, mental health services, health services, medication administration and referrals to community services. Room and board are funded under the behavioral health fund, and treatment is provided under public and private health insurance.

While the service is authorized there is still a need for providers to provide it. Additionally, the Department of Human Services is in the process of developing a Medicaid benefit for crisis stabilization.

Recommendation:

- Increase access to children's crisis stabilization services by investing in grants and other more sustainable funding mechanisms.
- Complete development of a Medicaid benefit for children's crisis stabilization.
- Invest in flexible placements for youth aged 10-12.

Expected outcomes & who will benefit if this recommendation is implemented: Funding children's crisis stabilization beds would ease a pressured system for counties and people with mental illnesses. Minnesota spends county dollars sending children to different states for treatment that cannot be found at home. In the worst cases when there is no place to stabilize, children end up boarding in emergency rooms, juvenile justice settings and in hotels. We expect children and families to be positively impacted by increased access to crisis services. Specifically, crisis services can intervene before a situation escalates to law enforcement or emergency room visits. This will divert children away from the criminal legal system.

What is the impact on diversity of this recommendation? Black children and children of color are overrepresented in the Minnesota juvenile justice system. By providing diversion away from the legal system, we minimize involvement for families who may be at risk of involvement in the juvenile justice system.

Expand access to Treatment Courts in Minnesota

Problem statement: People with mental illnesses and substance use disorders are overrepresented in the United States criminal legal system. When people cannot get the help they need in the community, they may become involved with law enforcement because of untreated symptoms. Oftentimes, the criminal legal system only offers punishment for harm and not support and resources for people who have unmet needs.

Background information: About 44% of people in jail have a history of mental illness; twice the average of the public.[13] Courts and incarceration have traditionally been the way to address harm in communities, despite the lacking results. We know that people with mental illnesses and substance use disorders are being criminalized for untreated symptoms.

Treatment courts offer an alternative to incarceration. Instead of incarceration, participants are given case management services and put on probation. With the added resources they participate in accountability through weekly court visits. The intention is to create stability for the person who has been charged with a crime. Treatment courts can serve people with serious charges too.

Treatment courts in Minnesota are currently serving adults. Treatment courts may also have a valuable benefit for youth. According to the 2025 Minnesota Student Survey, students reported symptoms of depression and anxiety above 56% for depression and 68% for anxiety for 9th and 11th grade girls.[14] Students also reported an overall decrease in substance use, however 10% of 11th graders report alcohol use and 8% report vaping and marijuana use. When these untreated needs bring youth into contact with the juvenile justice system, a focus on treatment, support and resources over punishment may lead to better outcomes for youth and their families. Youth treatment courts would need tailored support distinct from adult systems due to their developmental differences, needing developmental lenses that include the need for more information about the role of the prefrontal cortex and development of the brain. Supports such as diversion and/or restorative justice for youth would be part of the service.

Recommendation:

- Invest in expanding treatment courts in Minnesota.
- Research, develop and invest in youth treatment courts in Minnesota.
- Create policies to track the efficacy of treatment courts in Minnesota.

Expected outcomes & who will benefit if this recommendation is implemented: Incarceration can be a traumatic experience for many people. People with mental illnesses and substance use disorders will benefit by having alternatives to incarceration. This could also mean a reduction in repeat crimes and charges.

What is the impact on diversity of this recommendation? People with mental illnesses are overrepresented in the United States justice system. Moreover, Black and brown people also live at the intersection of disparity in the legal system. Treatment courts may be a way to reduce the harm of a disparate system.

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[13] National Alliance on Mental Illness. *Mental health treatment while incarcerated*. NAMI. https://www.nami.org/advocacy-at-nami/policy-positions/improving-health/mental-health-treatment-while-incarcerated/

[14] Minnesota Student Survey Interagency Team. (2025). *2025 Minnesota Student Survey: Statewide tables (regular public schools, by grade and gender)*. Minnesota Departments of Corrections, Education, Health, Human Services, and Public Safety. https://www.health.state.mn.us/data/mchs/surveys/mss/docs/statewidetables/statewidegradexgender.pdf

Centralized data collection system for juvenile justice system

Problem statement: Meaningful system change must be led by measurable, reliable and current data. Minnesota has no statewide juvenile justice data system that gathers data consistently, using the same definitions, data points and measures.

Background information: The juvenile justice system needs significant reforms and the legislature must address the impacts of incarceration on children and families. Recently released data from The Sentencing Project shows that youth are detained or committed to a juvenile facility at a rate 4.7 times higher than their white peers according to the nationwide data collected in 2021.[15] (This same data shows Minnesota in 2021 to have a 7.4% disparity). Minnesota needs to implement strategies aimed at reducing the number of youths of color in 17 correctional facilities as disparity reduction efforts and reforms happening statewide are not sufficient.

More support for youth in our communities is needed. Recent research from the University of Minnesota showed that over half of all adults incarcerated in Minnesota jails and prisons are caretakers of minor children.[16] Further research has shown that children with incarcerated parents are more likely to be involved in the juvenile justice system and face negative outcomes in health, education and social life down the road. Children and families need resources to connect with their loved ones and prevent generational cycles of incarceration. Currently youth with mental health diagnosis contributing to at risk behaviors are being boarded in correctional facilities due to the lack of mental health residential treatment placements. There is no tracking of the time they spend waiting for placement or what mental health services are being provided during the time in the correctional facilities.

Without proper data collection and analysis across jurisdictions we cannot understand the scope of disparities in the juvenile justice system or find adequate solutions. The National Alliance on Mental Illness (NAMI) supports the creation of a statewide data hub that requires stakeholders to report regularly and for accurate real time tracking of the number and demographics of youth in the system so that meaningful changes and improvements can be made.

Recommendation: Create a centralized database for the juvenile justice system to include reports to allow real-time tracking of numbers and demographics of youth in detention facilities and correctional out-of-home placements. Support data transparency by mandating

[15] Rovner, J. (2023). *Black disparities in youth incarceration*. The Sentencing Project. https://www.sentencingproject.org/app/uploads/2023/12/Black-Disparities-in-Youth-Incarceration.pdf

[16] Shlafer, R., & Saunders, J. B. (2017). *Parents in Minnesota jails and their minor children*. University of Minnesota. https://robinainstitute.umn.edu/publications/parents-minnesota-jails-and-their-minor-children; Shlafer, R., Duwe, G., & Hindt, L. (2019). Parents in prison and their minor children: Comparisons between state and national estimates. *The Prison Journal, 99*(3), 310–328. https://doi.org/10.1177/0032885519836996

stakeholders to report data on a regular basis and by having the data available and easily accessible for providers, researchers and the public.

Expected outcomes & who will benefit if this recommendation is implemented: Acknowledge and address the racial disparities of youth in the juvenile justice system by updating the juvenile justice process to be more person-centered including more opportunities for diversion, mental health services and engagement in voluntary treatment. Expected outcomes would include more support and assistance for at-risk and BIPOC youth by having more referrals sent into the community for mental health evaluations and services. Increase assistance to families unaware of alternative services to address delinquent and criminal behavior. Protect youth while promoting the justice system to be more just, fair and balanced.

What is the impact on diversity of this recommendation? Youth benefit holistically from culturally relevant strategies that are based in rehabilitation and restorative practices. These approaches support and strengthen the BIPOC populations where services can be provided in the community of the justice involved youth. This community engagement provides more support and opportunity to the youth and family allowing for a more just and equitable way of life that can significantly disrupt and end the school to prison pipeline, and intergenerational incarceration for the BIPOC population.

Mental Health Wellbeing and Supports Workgroup

Reinvigorate Peers in the mental health and substance use disorder recovery continuum of care

Problem Statement: There has been a significant decrease in utilization of certified peer specialists (Peers) over the past five years according to Department of Human Services peer support staff. This trend is quite concerning for trained Peers who cannot find employment and for consumers who may benefit from peer support and are unable to access that service. Peers who are trained are unable to find employment per peer support graduates. Potential employers report that they cannot find Peers to hire per DHS Managed Care Organization (MCO) lead. There is a huge gap in the support of Peers once they have their certification as many individuals may not have worked in some time. There is no ongoing support system for Peers in Minnesota once they enter the workforce other than their immediate employer.

Background Information: Certified peer specialists (Peers) are individuals who have had personal experience of mental health conditions and are trained to be direct service mental health staff. Minnesota Statute 256b.0615 was approved in 2007 and the first training was in 2009. During those years over individuals were trained as Peers. Since that time Certified Peer Recovery Specialists and Family Peer Specialists were trained outside of the state approved mental health certification. There is no record of the number of Peers that have been trained. State funded programs are mandated to hire and utilize Peers and are not currently being held accountable when they do not. Not holding State funded programs accountable to this mandate has added to the decrease in utilization of Peers.

Recommendation: Create and fund an organization that will certify, provide employment guidance, soft skill support and potentially contract with interested employers to assist with successful employment of trained Peers.

Expected outcomes & who will benefit if this recommendation is implemented:

- Peers will gain employment
- Trained Peers will gain increased professionalism and recognition
- Mental health and substance use services will gain employees in areas where there is a lack of employees
- Participants in mental health and substance use services will have access to peer support services
- All participants will experience improved mental health and wellbeing

What is the impact on equity and diversity of this recommendation? All peer training courses have a goal to encourage individuals from BIPOC communities to become certified Peers to be able to work with people from their own ethnicity.

Build community-initiated care to support young people and families

Problem Statement: The current Minnesota system of supports does not adequately promote mental well-being across the population and cannot meet the depth of need and current interest in promoting well-being. Children and families need a range of opportunities to build skills, mental health awareness and social supports. Minnesota does not have adequate community-based infrastructure for mental health promotion and prevention to offer evidence-based programs that can augment the current system of care.

Minnesota community experiences and stressors, world events, mental health reimbursement rates and the subsequent workforce shortage have all highlighted and exacerbated poor mental health well-being throughout the community, especially among those who experience the greatest social inequities including those with disabilities, of lower socioeconomic status, and from diverse communities.

Background Information: Community initiated care is a model that provides community support by nonspecialized health care workers or 'lay' community members and can include community services that are not clinical.[17] This model has been successfully used internationally to offer support through trained non-specialized health care providers and lay community members. This could include a support or skills group, programs to develop mental well-being awareness and skills among community members (e.g. barbers, hairdressers, baristas) and culturally specific healing practices offered in community.

There are current Minnesota examples. For example, Wellshare International used resources during COVID to train community health workers from the Somali, Latinx and Oromo communities in Living Life to the Full, an evidence-based program that has been broadly implemented in Scotland, Wales, Ireland, Australia and Canada.[18] Kente Circle co-launched a community mental health clinic in Minneapolis, and launched a program to equip barbers with knowledge and awareness of mental health and well-being so they can offer general support and accurate information to customers.[19] Many different organizations have offered culturally specific healing circles throughout recent events in our communities and state.

Recommendation:

- Grant funds to community-based organizations to train community members in evidence-based and culturally informed programs
- Conduct an evaluation of the impact of community-initiated care on mental well-being
- Establish a network or community of practice to build sustainability and quality improvement
- Develop an advisory council to outline best practices and build the infrastructure needed to sustain this work. Infrastructure includes things such as an inventory of current informal support models, a utilization assessment, established guidelines for

[17] Shields, A. (2021, September 11). *Community initiated care: Building skills to improve mental health*. Well Being Trust. https://wellbeingtrust.org/news/community-initiated-care-building-skills-to-improve-mental-health/
[18] Living Life to the Full. (n.d.). *Evidence*. https://llltf.com/evidence/
[19] Hallman, C. (2022, August 3). *New mental health project enhances barbers' listening skills*. Minnesota Spokesman-Recorder. https://spokesman-recorder.com/2022/08/03/new-mental-health-project-enhances-barbers-listening-skills/

implementation (e.g., how to connect to higher levels of care), formal linkages to existing programs (e.g., Family Home Visiting and an assessment of sustainable funding sources (e.g., MA billing)

Expected outcomes & who will benefit if this recommendation is implemented:

- Improved mental well-being among participants
- Improved mental well-being among families of participants
- Reduced social isolation among participating families
- Improved awareness and understanding about mental health and well-being
- Reduced barriers to higher clinical levels of care for those who need it through early informal intervention/prevention
- Potentially reduce the service demand on current providers for higher clinical levels of Mental Health Service.

What is the impact on equity and diversity of this recommendation?

Building the infrastructure and expanding access to community-initiated care will allow BIPOC communities greater opportunity to get mental well-being support directly from BIPOC people. It can help center culturally specific practices, and it can facilitate access to clinical care when needed among populations with historical distrust of health care systems. Community care can help BIPOC individuals address collective trauma and continuous trauma from ongoing social and health inequities in the community.

Provide additional funding for Vocational Rehabilitation Services

Problem Statement: State funding for Vocational Rehabilitation Services has been frozen for several years, with only a slight increase last session. New participant applications continue to be received, resulting in an order of selection being implemented and creating a waiting list.

Background Information: Vocational Rehabilitation Services help individuals with disabilities prepare for, find and keep competitive integrative employment and live as independently as possible. According to Minnesota's Vocational Rehabilitation Services 2025 Outcomes Report, Vocational Rehabilitation Services has had between 4,000 and 7,000 applications per year since 2017, with participants closely reflecting the census-defined racial and ethnic demographics of Minnesotans with disabilities.[20] The largest percentage is 68% white and 30% BIPOC individuals. Historically flat program funding with increased applications and costs has put Minnesota in an order of selection and creation of a waiting list for services.

Recommendation: Increase the funding provided to Vocational Rehabilitation Services, including an annual cost-of-living increase, to fully serve those with mental health and other disabilities in the State of Minnesota.

Expected outcomes & who will benefit if this recommendation is implemented:

[20] Minnesota State Rehabilitation Council. (2025). *State Rehabilitation Council annual report: Program year 2024 (July 1, 2024–June 30, 2025)*. Minnesota Department of Employment and Economic Development, Vocational Rehabilitation Services. https://mn.gov/deed/assets/2025-src-annual-report-acc_tcm1045-717831.pdf

- Employment for those Minnesotans with mental health conditions and other disabilities and our BIPOC individuals
- Improve Mental Health and Wellbeing for Minnesotans with Mental Health and other disabilities
- Increase community participation for Minnesotans with Mental Health and other disabilities

What is the impact on equity and diversity of this recommendation?

There are inequities in this space for BIPOC individuals, as participants do not reflect the state's demographics.

Exploration of state transit systems mental wellness support

Problem Statement: There is often a lack of support and resource guidance for mental illness and substance use disorder among the unhoused using buses, trains and stations for shelter and solace in metro transit systems across the state.

Background Information: The model for this recommendation for action would be similar to that which exists between Mental Health Minnesota and the Metro Transit Homeless Action Team, a project which received a grant in Winter of 2024 to address mental illness and addiction among the un-housed using buses, trains and stations to connect them to treatment and resources. The following data is from Mental Health Minnesota's work with Metro Transit on the Green Line as part of the Transit Service Intervention Project (TSIP), which was a pilot project that ran from January 2024 through February 2025. This project led to a contract between Mental Health Minnesota and Metro Transit to work as part of the Homeless Action Team. The contract/program involves in-depth work with individuals to gain access to housing vouchers which help get people into permanent housing. The program works directly with counties to help connect individuals with social services, health care, treatment if needed, employment services, case management, etc.; all that they may need long-term supports for.

The following data is from the 14 months that the Transit Service Intervention Project operated:

1. 2,703 contacts/connections made with individuals riding the Green Line or spending time on platforms who were experiencing mental health and/or substance use concerns and/or had frequent interactions with Metro Transit officers
2. 1,240 referrals to services made, including the following:
    - 296 referrals to substance use treatment and resources
    - 238 referrals to mental health treatment and resources
    - 117 referrals to shelters/drop-in centers/warming centers
    - 189 referrals to temporary/short-term/permanent housing
    - 208 referrals for basic needs (ex. food, clothing)
    - 123 referrals to social services (ex. Medicaid, housing, case management, etc.)
    - 69 referrals for employment services
3. Perhaps the most impressive statistic: During those 14 months, 64 individuals were successfully connected with treatment for mental illness and/or substance use disorder. A successful connection meant working to find an available treatment facility/bed and helping the person get right to the door of the facility.

Recommendation: Explore partnerships, supports and funding for outreach, peer support and service coordination to expand mental health outreach to statewide transit systems, perhaps through similar state supported grants.

Expected outcomes & who will benefit if this recommendation is implemented: Smaller cities like St. Cloud, Rochester, Duluth, etc. could benefit from similar programming and connect many more unhoused to available treatment resources using a peer support model.

As stated, this is currently a project of Metro Transit's existing homeless outreach team. The goal would be to learn from their successes, engage transit organizations in other areas of the state and determine the path that best fits those needs. The needs and existing resources of, for instance, Duluth transit may be wholly different from that of Rochester. Therefore, the first step of this plan would be exploratory in nature.

What is the impact on diversity of this recommendation?

Individuals from marginalized groups are disproportionately represented in experiencing hardships associated with housing and homelessness. Supporting this recommendation will serve to uplift underserved communities.

Housing and supports to reduce homelessness

Problem Statement: Minnesota community experiences, stressors and world events have increased housing instabilities for many Minnesotans. With the pause of the Housing Stabilization Services and Support there is now a bigger gap in critical support services to help individuals and families maintain stable housing.

Background Information: According to the Minnesota Coalition for the Homeless, for more than 20 years Minnesota has built a strong housing and homeless response system that helps thousands of people stay stably housed.[21] A list of programs include: the Family Homelessness Prevention and Assistance Program (FHPAP), which provides flexible financial assistance and supportive services to families, youth and single adults who are unhoused or at imminent risk of becoming unhoused, to lead towards housing stability; Local Homeless Prevention Aid (LHPA), which provides flexible, locally controlled funding to address community-specific needs and keep people housed; and other supportive housing and unhoused response systems that provide long-term housing with services for people with disabilities, families, and individuals with histories of homelessness so they can remain stably housed.

The most recent Minnesota Homeless Study was conducted in 2023, through face-to-face interviews with unhoused Minnesotans and a statewide count.[22] What we know from the statewide 2023 study of being unhoused in Minnesota is that 10,522 people were experiencing homelessness in Minnesota on a single night in 2023. The study has consistently demonstrated that people with mental illness are overrepresented in the homeless population.

[21] Minnesota Coalition for the Homeless. (n.d.). *Home*. https://www.mnhomelesscoalition.org/
[22] Wilder Research. (2024, March). *2023 Minnesota Homeless Study counts fact sheet: Single night count of people experiencing homelessness*. Amherst H. Wilder Foundation. https://mnhomeless.org/

In 2024-2025, fraud by a few providers was discovered in the Housing Stabilization Services, and the program ended in 2025. Prior to the service ending there were several providers of Housing Stabilization Services with integrity and showed it to be a successful and needed service in reducing homelessness.

Recommendation:

1. **Expand and strengthen the BRIDGES Rental Assistance Program:** Minnesota should increase base funding and expand eligibility for the BRIDGES Rental Assistance Program, which provides temporary rental subsidies and housing-related supports for low-income individuals with mental illness.
2. **Expand and strengthen services that support housing stability for people with mental health disabilities, BIPOC and formerly incarcerated individuals:** Expanding BRIDGES, including prioritizing access for BIPOC and formerly incarcerated individuals, would provide an evidence-based, immediate pathway to housing stability while individuals wait for longer-term subsidies such as Housing Choice Vouchers.
3. **Restart the Housing Stabilization Services:** Reimplement the Housing Stabilization Services to assure people with disabilities have access to needed housing support to exit homelessness and obtain and keep stable housing including revising the program to ensure funding and billing integrity.

Expected outcomes & who will benefit if this recommendation is implemented:

1. Minnesotans will maintain stable housing which will improve their lives and wellbeing.
2. There will be less homelessness in Minnesota.

What is the impact on diversity of this recommendation?

According to the 2023 Unhoused Study, a disproportionate number of BIPOC individuals were homeless. These services would help decrease the disparity.

Outreach to Diverse Communities Workgroup

Establish A small business mentorship and support program for mental health and substance use disorder providers

Problem statement: Many mental health and substance use disorder providers, particularly small, independent and culturally specific providers, face significant barriers to starting, sustaining and growing their practices due to a lack of business infrastructure, mentorship and administrative support.

Background information: Mental health and substance use disorder providers are not only clinicians, but often small business owners responsible for navigating complex systems, including billing, licensing, compliance, workforce management and contracting with insurers and government programs. Many providers, especially those from BIPOC, rural or historically underserved communities, lack access to mentorship, technical assistance and organizational infrastructure needed to successfully operate within these systems.

Existing supports are often fragmented, difficult to navigate or not tailored to the realities of behavioral health providers. As a result, many providers experience burnout, financial instability or are unable to expand services despite high community need.

Models such as the IRS Taxpayer Advocate Service demonstrate the effectiveness of providing independent, accessible support to help individuals navigate complex systems and resolve systemic barriers.[23] A similar model could be adapted to support mental health and substance use disorder providers in navigating Minnesota's regulatory, funding and service delivery systems.

Without intentional investment in small provider infrastructure, Minnesota is already seeing the loss of existing providers, limitations related to the growth of culturally specific organizations and workforce shortages and access disparities.

Recommendations:

- Establish a statewide Small Business Advocacy and Mentorship Program within DHS (or in partnership with a community-based entity) to support mental health and substance use disorder providers.
- Provide one-on-one mentorship, coaching and technical assistance for providers related to business operations, billing, compliance, licensure and contracting.
- Create a "Provider Advocate" role or office, like a taxpayer advocate model, to help providers navigate administrative barriers, resolve system issues and access available resources.

[23] Taxpayer Advocate Service. (n.d.). *Home*. Internal Revenue Service. https://www.taxpayeradvocate.irs.gov/

- Develop culturally responsive and community-based mentorship pathways that prioritize support for BIPOC, rural and small-scale providers.
- Offer training, toolkits and peer learning communities (Communities of Practice) focused on sustainable business practices for behavioral health providers.
- Provide startup and stabilization grants for small and emerging providers to build infrastructure, including administrative support, technology and workforce development.

Expected outcomes & who will benefit if this recommendation is implemented:

- Increased sustainability and retention of small and independent mental health and substance use disorder providers
- Growth of culturally specific and community-based provider organizations
- Improved access to mental health and substance use disorder services, particularly in underserved and rural communities, leading to better outcomes for clients/consumers
- Reduced administrative burden and burnout among providers
- Strengthened behavioral health workforce capacity and system navigation

What is the impact on equity and diversity of this recommendation?
This recommendation directly supports historically underserved providers, particularly BIPOC and community-based organizations, by addressing systemic barriers to entry and sustainability. By investing in mentorship, infrastructure and advocacy support, Minnesota can foster a more diverse, culturally responsive and equitable behavioral health system that better reflects and serves its communities.

Increase funding for the Cultural and Ethnic Minority Infrastructure Grant (CEMIG)

Problem statement: Minnesota has a need for increased funding to expand the nationally recognized CEMIG program. There is a need to increase the mental health workforce within cultural and ethnic minority communities. In the Gearing Up for Action report from January 2015, the current workforce is aging out and does not reflect the emerging diversity of the communities being served. Because of these factors, there is a great deal of pressure to quickly develop a responsive group of qualified mental health professionals. The shortage of mental health professionals in general, while significant, pales in the face of the even greater shortage of mental health providers from diverse cultural backgrounds. Nonetheless, funding for initiatives to support this growing problem has been inconsistent and anemic.

Background information: In 2007, Minnesota introduced a grant program to address the dearth of underrepresented ethnic minority mental health professionals. The CEMIG Program works to increase access to mental health services provided by racially and ethnically diverse mental health professionals who are proficient in providing culturally responsive and specific services to children, youth and families from diverse communities. This grant program builds capacity by supporting professionals in obtaining clinical supervision and licensure support. It also increases access to mental health and substance use disorder services for individuals from cultural and ethnic minority communities.

During the 2023 Legislative session, $3.4 million was appropriated for CEMIG. The program is currently supplemented with federal funds due to the increased need and demand for culturally specific mental health providers. CEMIG needs additional state funds that can support the cultural needs of the communities served as opposed to the Federal funds CEMIG has been allocated which come with many funding restrictions. There is a continued need for sustainable and increased funding that is equitably distributed.

The program eligibility for the CEMIG grant began to target culturally specific organizations by requiring participating organizations to attest that 75% of the population they serve came from culturally underserved groups. Instead of upholding the policy to ensure that culturally underserved organizations would be the primary recipients of the funds, the legislature reduced the required percentage of vulnerable populations served from 75% to only 25%. That legislative action enabled well-resourced and larger, non-culturally specific organizations to monopolize the funds that were needed for training and service delivery among the much smaller, culturally specific organizations.

Finally, and most importantly, legislation unintentionally marginalized the access for culturally specific trainees to learn the indigenous and culturally congruent practices necessary to serve their communities and, in turn, created additional barriers for children and families looking for culturally and linguistically specific and culturally responsive services.

Recommendations:

- Expand the availability of the CEMIG Program by increasing state funding for this grant program to an amount of $10M and $15M each biennium.
- Grant awards should focus on increasing access to mental health services among agencies that are culturally specific and responsive with at least 75% of the adults, children, youth and families receiving services coming from underserved cultural and ethnic communities.

Expected outcomes & who will benefit if this recommendation is implemented:

- Improved mental health access and well-being outcomes for diverse communities
- Reduced workforce shortages among participating providers
- Increased connection to their school and community (E.g., an increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them)

What is the impact on equity and diversity of this recommendation? Communities will have access to more positive, cost-effective mental health services.

Increase financial support for peer recovery support specialists and the providers who employ them.

Problem statement: There is a lack of cultural competency in the healthcare workforce. Minnesota can and should do more to address the unmet need for culturally, racially and ethnically appropriate care for individuals dealing with substance use disorders, brain differences and mental health issues. Adequately supporting peer recovery support specialists and the providers who support them is an essential component in meeting this need.

Background information: Research shows that the use of certified peer recovery specialists is effective in supporting recovery and reducing recidivism among those whose lives are impacted by substance use disorders, mental health disorders, brain differences and incarceration.[24] Among that group, there is an overrepresentation of members of the BIPOC population, although there is an underrepresentation of BIPOC specialists who are trained. Additionally, the rate of pay for peer recovery specialists' services is too low for providers to support specialists at a living wage.[25]

According to the Substance Abuse & Mental Health Services Administration (SAMHSA), among individuals who need treatment for illicit substance use disorders, whites receive treatment 23.5% of the time, while Black and Hispanic individuals receive treatment 18.6% and 17.6% of the time, respectively.[26] SAMHSA further reports that adults who identify as two or more races have the highest estimated need for mental health services, followed by white adults and American Indian or Alaskan native adults; however, people from racial and ethnic minority groups are less likely to receive mental health care than the overall population.[27]

Recommendation:

- Increase the current rate of reimbursement that providers receive for peer recovery specialist services.

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[24] Tuttle, C. R., Berger, A. T., Barton, S. L., Nguyen, B., & Merrick, W. (2024). Evaluation of peer recovery services for substance use disorder in Minnesota: Impact of peer recovery initiation on SUD treatment and recovery. *Drug and Alcohol Dependence Reports*, *11*, Article 100224. https://doi.org/10.1016/j.dadr.2024.100224

[25] Tuttle, C. R., Berger, A. T., Barton, S. L., Nguyen, B., & Merrick, W. (2022, July 19). *Evaluation of peer recovery services for substance use disorder in Minnesota: Impact of peer recovery on SUD treatment and recovery*. Minnesota Management and Budget, Impact Evaluation Unit. https://mn.gov/mmb/assets/MMB_PRS_report_final_20220718_tcm1059-534084.pdf

[26] Center for Behavioral Health Statistics and Quality. (2021). *Racial/ethnic differences in substance use, substance use disorders, and substance use treatment utilization among people aged 12 or older (2015–2019)* (Publication No. PEP21-07-01-001). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

[27] SAMHSA (2015). *Racial/ethnic differences in mental health service use among adults* (HHS Publication No. SMA-15-4906). Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf

- Provide funding for the recruitment and training, specifically for BIPOC peer recovery specialists.

Expected outcomes & who will benefit if this recommendation is implemented:

- Increased availability of providers in rural and urban settings
- An increase in BIPOC providers to address the disproportionate level of need
- A reduction in the recidivism rate of incarceration and successful treatment outcomes for substance use, brain differences and mental health issues
- Improved mental health and well-being outcomes
- Reduced social isolation for participants receiving services

What is the impact on equity and diversity of this recommendation?

- Minnesota will have access to more peer support specialists
- Minnesota will be taking steps to meet the current National Drug Control Strategy to address the unmet need for culturally, racially and ethnically appropriate care for individuals seeking substance use treatment
- Participants will have opportunities to connect with peer support specialists who have similar backgrounds and experiences

Address the workforce shortage of licensed mental health professionals from diverse backgrounds

Problem statement: There is a severe workforce shortage of licensed mental health professionals from diverse backgrounds serving the state of Minnesota.

Background Information: The pandemic highlighted the importance of investing in our health care workforce. Investing in this high-need career area is vital for the future health of our state. Building and maintaining an adequate mental health workforce requires the successful recruitment and retention of licensed mental health providers.

First, there is a need to address the racial disparities as seen in graduate program recruitment and admission in the healthcare workforce.

Plus, there is a tremendous need to invest more in scholarships, loan forgiveness and paid internships to promote a more diverse and representative workforce, particularly in underserved areas. This should include a wide range of relief for individuals experiencing barriers to licensure, including paid supervision costs, childcare, transportation, cost of living, examination preparation fees, examination application fee, etc. And this can help address the fact that about 50% of people who complete a master's degree in one of the mental health professions don't become licensed.

We know underserved groups like BIPOC, non-English speakers and LGBTQ+ communities often struggle to find appropriate services. The demographics of the mental health workforce

often do not reflect those of the people they serve, limiting the ability of people to get culturally and linguistically appropriate care.

The workforce shortage has been particularly problematic in rural areas, where people may wait months to access therapy. Untreated mental health conditions can have devastating consequences, such as loss of employment, chronic health issues, substance use disorders and suicide.

Minnesota has a shortage of mental health professionals, with one in four jobs in the field vacant as of April 2024.[28] This is the highest vacancy rate compared to other health care professions, and the situation has been especially problematic since the pandemic.

We continue to have a shortage of culturally specific providers. The Minnesota Department of Health (MDH) found that 73.4% of psychiatrists, 88.3% of mental health clinicians and 86% of LADCs were white. Data also shows that providers of color serve a higher percentage of people from culturally diverse communities, including people who are low-income and people who need interpreters. The pandemic resulted in increased numbers of children and adults struggling with their mental health, and the workforce shortages are causing our already fragile mental health system to continue to collapse.

According to NAMI's Mental Health Crisis document, dated Feb. 22, 2022, NAMI Minnesota created a survey in December 2021 to learn more from people who are current mental health professionals and from people who were or are on the path to becoming one.[29] Barriers to licensure included finding someone to provide supervision (34%), paying for supervision (52%), and low or no pay to complete the number of hours required for supervision (69%). In the comments, people included barriers such as: cost of the exam and license; inadequate or ineffective supervision; trouble finding someone in the same field to supervise me; paperwork; number of hours to complete supervision; delays by the boards in completing applications; not allowing online applications; knowing all the requirements to become and stay licensed; test was difficult because English is not my first language; cost of test preparations; transportation; time commitment; time provided to complete required hours; supervision is too tight; trouble finding culturally informed and diverse supervisors; lack of paid internships; low pay while completing number of required hours; continuing education units (CEU) costs and difficulty accepting licenses from other states.

Recommendations:

- Implement culturally responsive strategies for recruiting, admitting, training and retaining licensed mental health professionals with diverse backgrounds and identities that reflect the populations they serve.

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[28] Bryant, M. (2024, April 29). *Licensing, scope bill targets shortage of mental health workers*. Minnesota House of Representatives, Session Daily. https://www.house.mn.gov/sessiondaily/Story/18343

[29] NAMI Minnesota. (2022, February 22). *Mental health workforce crisis*. Minnesota House of Representatives. https://www.house.mn.gov/comm/docs/iifYmJzb10uPOF4OungF3w.pdf

- Provide funding for the development of a licensed mental health workforce pipeline to address the barriers to obtaining licensure, including but not limited to, cost of attendance, unpaid internships, cost of supervision, exam fees and licensure fees.
- Support BIPOC organizations through funding to provide culturally specific training and supervision for BIPOC students working to obtain licensure as mental health professionals.

Expected outcomes & who will benefit if this recommendation is implemented:

- Increased number of licensed mental health professionals in Minnesota serving diverse communities
- Improved mental health access and well-being outcomes for underserved communities
- Increased number of culturally competent licensed mental health professionals

What is the impact on equity and diversity of this recommendation? These recommendations will result in recruitment, training and retention of licensed mental health professionals with diverse backgrounds and identities that reflect the populations they serve.

Collect and provide community access to data to support accountability

Problem statement: Many Minnesota entities fail to capture or allow for community accessibility demographic data that could lead to system changes.

Background information: BIPOC community mental health students, trainees, providers and agencies frequently complain that disaggregated, easy-to-find data is not required by notable entities. This lack of accessible data serves to perpetuate inaction and a lack of accountability among systems. For example, data on the Minnesota Student Survey requires hours of data mining to gather comparative information across racial and ethnic groups.[30] Licensing boards do not readily provide or publish information that identifies the demographics related to those who have failed or passed their licensing exams. Additional problems occur in other systems, such as juvenile justice, where the existence of data on mental health screenings is muddy, and the outcomes based on those screenings are not shared; it is unclear if youth who are detected as having mental health concerns are ever referred to treatment.

Recommendations:

- Entities receiving state or federal dollars should be required to report data on services rendered by formulating comparative, disaggregated results based on ethnic/racial demographics, as well as other key identifiers (i.e., urban or rural).
- Professional and government-based entities should not receive state or federal funds until they have reported key disaggregated data identifiers.

[30] Minnesota Student Survey Interagency Team. (n.d.). *Minnesota Student Survey data*. Minnesota Department of Health. https://www.health.state.mn.us/data/mchs/surveys/mss/index.html

- State agencies should provide disaggregated and comparative data across all systems where disparities are noted (especially areas such as criminal justice, schools, out-of-home placement and child protection)
- Providers and agencies that are required to report disaggregated data should be provided with appropriate compensation and support to account for the time and cost needed to collect and supply the data

Expected outcomes & who will benefit if this recommendation is implemented:

- Improvement in tracking evidence-based and practice-based outcomes, especially regarding mental health access and well-being outcomes for diverse people
- Increased awareness of where funds are needed for future statewide interventions and/or investments
- Measurable success of these recommendations based on how the data is currently handled (i.e., whether it is reported or not)

What is the impact on equity and diversity of this recommendation? Communities will have access to more positive, cost-effective mental health services and targeted knowledge of where corrections are needed.

Provide affordable and supportive housing, especially for BIPOC populations and formerly incarcerated populations

Problem statement: BIPOC and formerly incarcerated Minnesotans with mental health and substance use conditions face disproportionate and systemic barriers to accessing safe, stable and affordable housing, resulting in significantly higher rates of housing instability and homelessness.

Background information: Safe and stable housing is a core dimension of mental health recovery.[31] Yet many Minnesotans with mental illness, particularly those who are BIPOC or formerly incarcerated, face significant barriers to accessing affordable and supportive housing. Mental health symptoms, job instability, hospitalization and involvement in the criminal legal system often compound housing insecurity, making recovery more difficult without a stable living environment.

State data shows both progress and persistent inequities. Targeted housing programs have increased access for Indigenous, Black and households of color, with participation rates as high as 80 to 89% in some programs. However, BIPOC households still make up only 24% of the overall mortgage market and the affordable housing supply remains limited, with only 237 homes financed in one key program in 2024 despite high demand.[32]

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[31] Substance Abuse and Mental Health Services Administration. (2024, November 25). *About recovery*. U.S. Department of Health and Human Services. https://www.samhsa.gov/substance-use/recovery/about

[32] Minnesota Housing. (2025, November 18). *2024 housing disparities report*. https://www.lrl.mn.gov/docs/2025/mandated/251811.pdf

Housing instability is closely tied to homelessness and incarceration. Wilder Research estimates that more than 10,000 Minnesotans are experiencing homelessness on any given night, with many unsheltered and 64% reporting a diagnosed mental illness.[33] BIPOC individuals and LGBTQ+ youth are disproportionately represented. Additionally, formerly incarcerated individuals face major housing barriers, with Black and Indigenous people comprising about 50% of those released and experiencing homelessness.[34]

Some housing programs, especially for youth, create excessive barriers that require them to unenroll from school to have access to housing supports, which sets them up for failure. Those who are struggling with their mental health and/or their housing, should have access to as many programs as possible to find stability to build a self-directed life.

Together, this data highlights the urgent need for expanded, culturally responsive and supportive housing to address systemic inequities and improve mental health and reentry outcomes.

Recommendations:

- **Expand community-based housing supports for BIPOC and formerly incarcerated individuals with mental health or substance use disorders:** Minnesota should increase funding for culturally responsive housing navigation, peer support, tenancy support and reentry-focused housing services. Evidence from Minnesota programs shows that housing paired with supportive services improves stability and prevents homelessness, particularly for individuals with serious mental illness transitioning from institutions or unstable housing situations.
- **Increase the supply of affordable and supportive housing for BIPOC and formerly incarcerated individuals:** Minnesota should expand funding for affordable housing, permanent supportive housing, recovery residences and reentry housing, with prioritization for culturally specific providers.
- **Reduce structural and procedural barriers to accessing housing:** Minnesota should address systemic barriers such as landlord denials, criminal background screening practices and administrative hurdles by requiring individualized assessments, limiting blanket exclusions and improving transparency in tenant screening.

Expected outcomes & who will benefit if this recommendation is implemented:

[33]Wilder Research. (2024, March). *Single night count of people experiencing homelessness: 2023 Minnesota Homeless Study counts fact sheet*. Amherst H. Wilder Foundation. https://www.wilder.org/wilder_research/single-night-count-of-people-experiencing-homelessness-2023-minnesota-homeless-study-counts-fact-sheet/

[34] Minnesota Department of Corrections. (2023). *2022 homelessness report*. https://mn.gov/doc/assets/2022%20Homelessness%20Report_tcm1089-582969.pdf

- More resilient and formalized alliances promoted among diverse groups of mental health professionals who are working to support BIPOC communities and formerly incarcerated individuals
- Increased access to affordable, safe housing for marginalized populations and previously incarcerated individuals; having safe and secure housing will support health, wellness and decrease stress; having secure housing will allow formerly incarcerated individuals an opportunity to work towards successful community reintegration and, ideally, decreased rates of recidivism

What is the impact on diversity of this recommendation? Alliances between culturally diverse providers and specialized housing programs will reduce barriers for those in need and will create innovative culturally congruent strategies of healing, support and overall wellness within their communities. Given that diverse communities are often overrepresented in homeless populations, specifically supporting these populations will serve to address inequities.

Continue to support Communities of Practice and community-based wellness resources

Problem Statement: Mental Health providers often practice in silos and their systems are not equipped to financially support consortia or alliances.

Background Information: According to research, the idea of Communities of Practice (CoPs) has been around for 25 years. It "refers to groups of people who genuinely care about the same real-life problems or hot topics, and who on that basis interact regularly to learn together and from each other."[35]

Many BIPOC, culturally specific organizations do not have the infrastructure or means to access funding that will support their growth, development and participation in the mental health marketplace. Thus, there is very little support in meeting new guidelines to be licensed or certified as service providing agencies for designations/programs such as Certified Community Behavioral Health Clinics (CCBHC), substance use disorder, Adult Rehabilitative Mental Health Services (ARMHS), mental health centers, Children's Therapeutic Services and Supports (CTSS), etc. While these groups may be actively engaged in their communities, there are very few mentors or organizational road maps to follow. Consequently, they often work in silos. Additional funds for supporting community of practice alliances will not only promote the sharing of technical assistance, but such coalitions will also increase access to financial support and increase the presence, viability and sustainability of a more diverse workforce and mental health marketplace.

Most BIPOC communities hold communal value systems that require collaboration (vs. competition) as cultural strengths. Traditional ways of sharing knowledge and resources create

[35] Pyrko, I., Dörfler, V., & Eden, C. (2017). Thinking together: What makes Communities of Practice work? *Human Relations*, *70*(4), 389–409. https://doi.org/10.1177/0018726716661040

systemic problems that detract from optimal success among multiple organizations. These practices lead to fractured community alliances, communication problems and the limited sharing of resources.

Recommendations: We recommend the creation of innovative paths that facilitate alliances that empower culturally diverse providers to name and legitimize cultural ways of engaging within their groups and with allied organizations.

Expected outcomes & who will benefit if this recommendation is implemented:

- Increased availability of culturally consistent support of traditional healing practices and ongoing research and establishment of shared knowledge and better practice-based evidence models
- More resilient and formalized alliances among diverse groups of mental health professionals

What is the impact on equity and diversity of this recommendation? Culturally diverse providers will create innovative strategies for healing and supporting their communities.

Local Advisory Council Workgroup

Dedicated DHS staff member to support, train, organize information and confirm the compliance of Local Mental Health Advisory Councils.

Problem Statement: While every Minnesota county or group of counties is statutorily mandated to establish Local Mental Health Advisory Councils (LACs) for adults and children, there is currently no dedicated infrastructure to ensure these councils are compliant with state law or that their findings effectively inform state policy. This has created several issues:

- Lack of Oversight and Accountability: There is no centralized mechanism to confirm if county LACs are fulfilling their statutory requirements under Minnesota Statute 245.466 Subd. 5 and Minnesota Statute 245.4875 Subd. 5, such as meeting at least quarterly and providing annual reports on unmet local mental health needs.
- Information and Contact Gaps: Although the Department of Human Services (DHS) technically requires contact information for LAC chairs, there is no updated statewide directory. This lack of accessible contact information prevents effective networking between LACs and hinders the state's ability to disseminate important policy updates or requests for proposals.
- Unsustainable Reliance on Volunteers: Current efforts to support, train and organize data for LACs across the state rely on voluntary community participation and the leadership of typically a single individual, the Chair of the LAC Workgroup through the State Advisory Council on Mental Health. This model is unsustainable, creates a high risk for advocate burnout and fails to provide an adequate level of support for the LACs.

- Barriers to State-Level Impact: While LACs are a vital part of gathering community-driven information, there is no formal, sustainable avenue for their local insights to reach the state level beyond voluntary efforts. Without a dedicated DHS staff member to bridge this gap, the wisdom of those who have been impacted by mental health concerns firsthand often fails to inform statewide policy and funding decisions, as intended by the Comprehensive Mental Health Acts.

Background Information: The LACs are a vital part of gathering community-driven information to identify the gaps and needs of Minnesota's local mental health systems. These councils consist of community members who give their time and energy to provide feedback, recommendations, and insight into how Minnesota's local mental health systems are serving individuals with mental health conditions.

Recommendation:

1. **Update MN Stat. § 245.696 (Additional Duties of Commissioner):** Add a new subdivision mandating the Commissioner to employ a full-time staff person whose primary duties include:
    a. Maintaining a current, public statewide directory of relevant LAC contact information
    b. Providing standardized training and onboarding materials for LAC chairs and members to ensure they understand their statutory roles, such as reviewing local mental health delivery systems and identifying unmet needs
    c. Monitoring and confirming statutory compliance, ensuring every county establishes an LAC that meets at least quarterly and provides required annual reports to their respective county boards
    d. Support coordination between LACs and AMHI. Support coordination between LACs and the Minnesota State Advisory Council on Mental Health
2. **Update MN Stat. § 245.466 Subd. 5 (Local Adult LACs):** Add a clause stating the local adult mental health advisory council shall receive technical assistance and coordination support from the Department of Human Services staff member appointed under section 245.696 to facilitate the sharing of local recommendations with state-level policy makers.
3. **Update MN Stat. § 245.4875 Subd. 5 (Local Children's LACs):** Add language to ensure equity between adult and children's councils by requiring the dedicated DHS staff member to provide the same level of training, data organization and compliance monitoring for children's LACs. This includes supporting children's LACs in their duty to seek input from parents and former consumers about local service needs.

Expected Outcomes & who will benefit if this recommendation is implemented:

- **Improved Compliance:** A dedicated staff member will ensure all Minnesota counties are meeting their legal obligations to host and listen to LACs.
- **Enhanced Diversity and Equity:** Professionalized support will help LACs cast a wider net for membership, ensuring diverse perspectives and marginalized communities are better represented in local mental health discussions.
- **Sustainable Advocacy:** Shifting administrative burdens from volunteers to a full-time state employee ensures the long-term viability of these mandated and extraordinarily useful councils.

Expanding required community participation in Local Mental Health Advisory Councils by mandating diverse stakeholder and Adult Mental Health Initiative (AMHI) input

Problem Statement: Minnesota Statute 245.466 Subd. 5(1) should be updated to better reflect the status of the LACs by updating the language to expand the required participation. This allows all interested parties to have a voice when discussing the gaps and needs in local mental health systems.

Background Information: The LACs are a vital part of gathering community-driven information to identify the gaps and needs of Minnesota's local mental health systems. These councils consist of community members who give their time and energy to provide feedback, recommendations and insight into how Minnesota's local mental health systems are serving individuals with mental illnesses.

Recommendation: Update Minnesota Statute 245.466 Subd. 5(1) to mandate LACs arrange mental health input from a wider variety of interested individuals, including local representatives from the Adult Mental Health Initiative, as they should be helping to assess the gaps and needs in the mental health systems, they are funding.

Suggested updated language: (1) arrange for input from community members, representatives from the Adult Mental Health Initiative and providers of mental health and substance use disorder services for adults in the county or counties.

Expected outcomes & who will benefit if this recommendation is implemented: The updated language will instruct the LACs to cast a wider net when looking for important feedback related to local mental health systems. Ideally, this should allow for more diverse perspectives and experiences to be heard.

What is the impact on equity and diversity of this recommendation? This recommendation advances equity by requiring LACs to intentionally seek input from a broader range of stakeholders, including community members, AMHI representatives and local providers. By structurally expanding participation, the statute reduces reliance on informal networks and increases the likelihood that individuals with lived experience, historically underserved communities and those impacted by service gaps have a voice in identifying local mental health needs. Including AMHI representation also promotes better alignment between funding decisions and community-identified priorities. Overall, this update strengthens inclusive decision-making and helps ensure that local mental health systems reflect the diverse needs of the communities they serve.

Adopting inclusive person-first terms in the Adult Local Advisory Council statute

Problem Statement: The Adult LAC statute, Minnesota Statute 245.466 Subd. 5, refers to people with a lived experience of mental health conditions as "consumers." Some mental health advocates are uncomfortable with the word "consumer" because it can feel transactional and reduce people to service users rather than whole individuals with lived experience, dignity and

agency. The term can also overlook those who have experienced mental health challenges but are not currently "consuming" services. It is best practice to use person-first language when referring to a group of individuals living with mental health conditions.[36]

Background Information: The Minnesota Comprehensive Adult Mental Health Act was enacted in 1987. While the term "consumer" was originally introduced as a non-stigmatizing alternative to "patient" or "client," language preferences have since evolved. Other areas of Minnesota law have been updated to reflect person-centered language, yet the statute governing Local Advisory Councils (LACs) remains outdated. (*See* Minnesota Statute 245.462 Subd. 20).

Recommendation: Update the language of Minnesota Statute 245.466 Subd. 5. (Local advisory council) from "consumer" to the inclusive person-first equivalent of "individual with a lived experience of a mental illness."

Expected outcomes & who will benefit if this recommendation is implemented: This change will formally align state law with the wisdom of those who are impacted by mental health concerns firsthand. It demonstrates that the State of Minnesota values the humanity and agency of its residents over their clinical status. Individuals with lived experience will benefit from a statutory framework that recognizes them as active participants and leaders in policy discussions rather than passive users of a system.

What is the impact on equity and diversity of this recommendation? The implementation of person-first language promotes a "culture of inclusiveness" and reinforces the understanding that individuals are people first, regardless of their mental health condition. Adopting inclusive language is a key step in combating the persistent stigma surrounding mental illness, particularly in marginalized and underrepresented cultural communities where clinical labels may serve as a barrier to engagement and advocacy.

Equity between Adult and Children's Local Mental Health Advisory Councils statutes regarding the coordination between LACs and the Minnesota State Advisory Council on Mental Health

Problem Statement: There are differences between the statutory requirements for adult and children's LACs. The adult LAC statute includes language that requires coordination between the adult LACs and the State Advisory Council on Mental Health; the children's LAC statute does not.

Background Information: The LACs gather community-driven information to identify the gaps and needs of Minnesota's local mental health systems. These councils consist of community members who give their time and energy to provide feedback, recommendations and insight as to how Minnesota's local mental health systems are serving individuals with mental illnesses.

[36] American Psychological Association. (2021). *Inclusive language guidelines*. https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines

Recommendation: Add language to Minnesota Statute 245.4875 Subd. 5. (local children's advisory council) to parallel the language of the adult LAC statute (245.466 Subd. 5) to promote coordination and support from the State Advisory Council on Mental Health to children's LACs.

Suggested language: Minnesota Statute 245.4875 Subd. 5(4): coordinate its review, evaluation and recommendations regarding the local mental health system with the state advisory council on mental health.

Expected outcomes & who will benefit if this recommendation is implemented: Children's LACs and their individual counties will have additional support and a partner to move local issues to a state platform.

What is the impact on diversity of this recommendation? By requiring support from the State Advisory Council on Mental Health, children's LACs will have the opportunity to bring forward their county-based needs and concerns to advocate at the state level, which may allow a more diverse set of problems and solutions to be heard.

Establish compensation and operational funding standards for Local Mental Health Advisory Councils

Problem Statement: Minnesota Statute 15.059 provides compensation guidelines for state advisory councils and committees, however, there is no consistent statutory requirement ensuring compensation or operating budgets for county and regional Local Advisory Councils (LACs).

As a result, compensation for LAC members varies significantly by county and in many counties members receive no compensation as the LACs are currently an unfunded mandate. Additionally, many LACs lack dedicated operating budgets to support recruitment, marketing, training, accessibility needs and administrative functions. This inconsistency creates barriers to participation, limits recruitment and retention and undermines the effectiveness and representativeness of LACs.

Background Information:

As of 2026, Minnesota Statutes §15.059, Subdivision 3 provides that:

- Members of advisory councils and committees may be compensated at $55 per day spent on council or committee activities when authorized.
- Members may also receive reimbursement for expenses, including travel and childcare.
- State or political subdivision employees may not receive compensation during paid working hours unless they use vacation or compensatory time.
- Councils must adopt internal standards defining what constitutes a "day" of service.

Currently, this compensation framework applies to state-level advisory bodies such as the State Advisory Council on Mental Health (SACMH).

County-level Local Advisory Councils, however, do not have a uniform statutory requirement for compensation or for a designated county budget. This results in inequitable access to participation and structural inconsistency across counties.

Recommendation:

1. **Align LAC compensation with SACMH standards:** LAC compensation should reflect the compensation amount outlined for appointed members who are not otherwise compensated.
    - Compensation
    - Reimbursement for expenses, including mileage and childcare
    - Internal standards defining a “day” of service
2. **Minnesota should allocate each county a reasonable annual LAC budget for County Boards to oversee**, including but not limited to:
    - Administrative support
    - Member compensation, reimbursements and per diem
    - Membership recruitment
    - LAC marketing and outreach
    - Operating expenses (technology, accessibility, meeting space, interpretation)
    - Educational and training opportunities for members
    - Accessibility accommodations beyond basic compliance

Expected outcomes & who will benefit if this recommendation is implemented: If implemented, this recommendation is expected to increase recruitment and retention of LAC members by reducing financial barriers to participation and demonstrating that members’ time and lived expertise are valued. Establishing consistent compensation and budget requirements across counties would promote greater uniformity in how LACs operate, while expanding participation from individuals with lived experience of mental health conditions. In turn, this would strengthen the quality of advisory input and lead to more informed, practical and community-centered recommendations to county boards. Formalized funding structures would also enhance accountability and transparency in LAC operations.

Those who benefit include individuals with lived experience of mental health conditions; family members and caregivers; BIPOC communities and other historically underserved populations; individuals with lower incomes and rural residents who may otherwise face financial or logistical barriers to participation. Counties and policymakers would benefit from receiving stronger, more representative guidance, and the broader mental health system would benefit from improved policy recommendations grounded in diverse community perspectives.

What is the impact on equity and diversity of this recommendation? This recommendation directly advances equity and diversity by addressing the financial barriers that limit who can participate in Local Advisory Councils. Without compensation, LAC participation is largely restricted to individuals who can afford to volunteer their time, often retirees, individuals with financial stability or those with flexible employment. This structure unintentionally excludes low-income individuals, working parents, people who require childcare, individuals with disabilities, people from marginalized racial and ethnic communities and those balancing multiple jobs or caregiving responsibilities. Providing compensation and reimbursement reduces financial

barriers to civic engagement, makes participation more accessible to diverse communities, and sends a clear message that lived experience expertise is valued.

The Minnesota State Advisory Council on Mental Health and Subcommittee on Children's Mental Health 2026

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