DEPARTMENT OF HUMAN SERVICES

DRAFT Minnesota FFY 2026-2027 Combined Block Grant Application for Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG)

Environmental Factors and Plan

August 21, 2025

D. Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers; Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a. Adults with serious mental illness (SMI):
b. Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)
c. Pregnant women with substance use disorders
d. Women with substance use disorders who have dependent children
e. Persons who inject drugs
f. Persons with substance use disorders who have, or are at risk for, HIV or TB
g. Persons with substance use disorders in the justice system
h. Persons using substances who are at risk for overdose or suicide
i. Other adults with substance use disorders
j. Children and youth with serious emotional disturbances (SED) or substance use disorders
k. Children and youth with SED and a co-occurring I/DD
l. Individuals with co-occurring mental and substance use disorders

The MN DHS Behavioral Health Administration (BHA) develops and implements policies and procedures that expand the functionality of adults and children throughout the state of Minnesota. Focusing on and providing early detection and diagnosis and interventions to increase autonomy and reduce over utilization of Medicaid services through undiagnosed and treated SMI/SED/IDD/co-occurring disorders. The BHA coordinates with counties and tribes to ensure that people across the state receive timely access to necessary services. Minnesota coordinates several different publicly funded payment systems to ensure that people have a method to pay for mental health and substance use services including a Behavioral Health Fund for those that do not qualify for Medicaid and do not have other insurance.

Adults with serious mental illness (SMI): The Statewide Adult Mental Health initiatives (19 Initiatives and one Tribe) have seen an increase of funding assigned to outreach and engagement activities. This includes outreach to homeless encampments, shelters and other congregate gathering sites. There has also been an increase in public education to reduce stigma and provide information on Minnesota's continuum of care for services such as AMH-Targeted Case Management, Assertive Community Treatment and community based residential stabilization services. Information is shared with hospital, clinic, housing and the SUD community providers. Within the Minnesota Department of Human Services, there is also strong collaboration between the Behavioral Health Administration and the Health Care Administration to build strong connections between primary care and obstetrics programs for pregnant and parenting adults with mental illness to ensure we have seamless care coordination, mental health treatment that is evidence based and accessibility to care. Minnesota has implemented the wrap around services model of care allowing an increase in access to Assertive Community Treatment (ACT), Adult rehabilitative Mental Health Services (ARMHS), and peer support services through Certified Community Behavioral Health Clinics (CCBHCs) for community members seeking various, less intensive levels of care, and a desire/need to stay in the community.

Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD): Minnesota has licensed an Intensive Residential Treatment and Residential Crisis Stabilization Services program that specializes in serving adults with co-occurring SMI intellectual or developmental disabilities. This is being monitored for potential expansion as census demonstrates the need for this service. Diagnostic assessment for all mental health services must include an assessment of developmental incidents for

the client and appropriate referrals would need to be made if a person had a co-occurring intellectual or developmental disorder. Mobile crisis teams all have access to expert consultation for clients that have an SED and co-occurring Intellectual or Developmental Disabilities (IDD), Traumatic Brain Injury (TBI), Autism Spectrum Disorder (ASD), or Dementia-related condition. School Linked Behavioral health services were recently expanded in Minnesota with the use of grant funding to ensure SUD screenings and treatment was provided to children in schools which had many positive outcomes. The state is now introducing a new set of Medicaid reimbursable mental health services through an IEP/IFSP to enhance and expand these services in schools. DHS also coordinates trainings for providers in evidence-based practices for treating co-occurring mental health and Fetal Alcohol Spectrum Disorders (FASD). Home and Community Based Service providers which specialize in providing services to those with intellectual or developmental disorders coordinate care with mental health providers when needed. Workforce development investments have increased the cross relational work with MH and neurodiverse populations by supporting training and consultations and collaborating with DOH, ADSA and other state systems serving SMI and IDD.

Pregnant women with substance use disorders and women with substance use disorders who have dependent children: There are several residential and outpatient treatment programs that are licensed to specialize in providing SUD treatment for pregnant women and women with children. The state provides an enhanced rate for these services. Additionally, the state supports specialized recovery support services for this population which assists, prioritizes, and increases admissions to residential and outpatient programs for this population. Several of these programs also address the mental health of the participants. Workforce development efforts have been supported to train practitioners in models that address the needs of children born to mothers with substance use disorders as well as pregnant women with substance use disorders. Minnesota understands the importance of keeping families together during treatment and recovery. The state offers specialized inpatient and outpatient programs that allow women with substance use disorders to bring their dependent children with them to treatment. These programs provide services for the parent, but also safe housing where mothers and their children can live together while the parent receives care.

Persons who inject drugs:

Minnesota has aligned its opioid treatment program (OTP) requirements with SAMHSA's revised standards to increase access and retention in OTPs. Minnesota also supports Office Based Opioid Treatment. These programs are located throughout the state and both types of treatment are covered by Medicaid and by the state paid Behavioral Health Fund for those that do not have Medicaid or other insurance coverage. Minnesota has implemented the process of Direct Access in all Substance Use Disorder Treatment programs to move community members from assessment and into treatment on the same day, connecting them with resources, treatment, and linking of services quickly. Assessment requirements were revised to allow providers to update a previously completed assessment to streamline treatment intake. Treatment provider licensing standards require priority placements for those that inject drugs.

Persons with substance use disorders who have or are at risk for TB:

All substance use disorder treatment programs provide an orientation to clients about TB symptoms, resources and treatment. Providers are required to report known cases to the Minnesota Department of Health which coordinates the treatment of any person with TB.

Persons with substance use disorders in the justice system: The Minnesota Department of Corrections provides behavioral health care to people in state correctional facilities including mental health and substance use disorder assessments and treatment. Services include support services, self-help groups, evaluations, short-term treatment, and intensive treatment for more serious mental health issues. Minnesota has made access to comprehensive substance use disorder assessments available to those

with involvement in the justice system through telehealth before discharge from jail or prison. These community members can receive referrals to programs they can enroll directly into at discharge. Minnesota also utilizes substance use treatment courts to assist in the recidivism and relapse prevention for those involved in the justice system instead of criminalization. DHS, working in close partnership with DOC, has submitted a Section 1115(a) Reentry Demonstration Waiver application that seeks to improve health outcomes, reduce deaths, decrease recidivism rates, and address related disparities for people who have been incarcerated. If approved, Minnesota will achieve this by providing a set of Medicaid covered services in certain jails and prisons to eligible participants who are within 90-days of release. Initially, the program will be limited to three prisons and five jails. All people in these settings will be screened for SUD, mental health, and medical conditions to determine whether they need additional assessment. Having an assessed need is one of the criteria to receive services covered by the waiver.

Reentry services are covered fee-for-service. In some jails and prisons, carceral staff will provide the service and the setting will be the Medicaid enrolled provider. In jails and prisons, all or some waiver services may be furnished by community providers. The flexibility of this design is necessary due to the unique nature of the settings and variation in provider capacity throughout the state. All providers serving participants must meet all state licensing and credentialing requirements and enroll as a Minnesota Medicaid provider. Following release, participants have access to the full Medicaid benefit set and may receive services from any qualified provider based on their coverage.

Persons using substances who are at risk for overdose or suicide: The Minnesota Department of Human Services in partnership with the Minnesota Department of Health, providers, community services, and many other organizations has made Naloxone available throughout the state free of charge. Community organizations funded through DHS provide outreach to those at risk of overdose or suicide to assist them in getting necessary services.

Other adults with substance use disorders: Minnesota operates a person-centered Direct Access model that allows individuals to go directly to a chosen provider for a comprehensive assessment and immediate access to substance use disorder treatment. Services include all levels of substance use disorder treatment, withdrawal management, and peer recovery support services and utilize the American Society of Addiction Medicine (ASAM) model of care.

Children and youth with serious emotional disturbances (SED) or substance use disorders: Due to an increase in utilization of Intensive Residential Mental Health Services (IRMHS), Children's Intensive Behavioral Health Services, and other programs that utilize Evidence-Based practices to improve outcomes, a mental health collaboration HUB has been developed to determine how to get youth with SED into appropriate placements after boarding in an emergency department. School Linked behavioral health grant utilization has increased to serve children with SED to provide needed psychotherapy and skills work in schools. This includes training teachers and staff how to best interact with children with SED in the classroom.

Children and youth with SED and a co-occurring I/DD: School Linked Behavioral health services were recently expanded in Minnesota with the use of grant funding to ensure SUD screenings and treatment was provided to children in schools which had many positive outcomes. The state is now introducing a new set of Medicaid reimbursable mental health services through an IEP/IFSP to enhance and expand these services in schools. Mobile crisis teams all have access to expert consultation for clients that have an SED and co-occurring Intellectual or Developmental Disabilities (IDD), Traumatic Brain Injury (TBI), Autism Spectrum Disorder (ASD), or Dementia-related condition.

Individuals with co-occurring mental and substance use disorders: Minnesota requires that all professionals who perform substance use disorder assessments to screen clients for co-occurring mental health disorders and for all staff who perform mental health diagnostic assessments to screen for co-

occurring substance use disorders. They must use screening tools approved by DHS. If a client screens positive for a co-occurring mental health or substance use disorder, the professional must take steps to ensure that further assessment and treatment occur for the co-occurring disorder. Many substance use disorder and mental health treatment programs in Minnesota specialize in treating co-occurring mental health and substance use disorders at the same time including CCBHCs, co-occurring outpatient treatment programs, co-occurring residential treatment programs, children's residential co-occurring treatment programs, and Intensive Residential Treatment Services programs. Other non-occurring treatment programs are required to refer clients and coordinate treatment with another provider. Minnesota has adopted the best practice model of wrap around services that enhances the care of both mental health and substance use disorder treatments.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

Minnesota's mental health and substance use disorder parity laws are built upon federal requirements while adding state-specific protections and enforcement mechanisms. All health plans must meet federal requirements including the Mental Health Parity Act of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, with cost-sharing requirements and benefit limitations for mental health and substance use services that must not place a greater financial burden on enrollees or be more restrictive than those for outpatient medical services. The law prohibits higher copays, deductibles, and coinsurance for behavioral health care compared to physical health care, as well as stricter visit limits or more restrictive prior authorization requirements. Additionally, mental health therapy visits and medication maintenance visits are considered primary care visits for cost-sharing purposes, regardless of the provider's professional license.

To ensure compliance and enforcement, Minnesota established the Mental Health Parity and Substance Abuse Accountability Office within the Department of Commerce to create and execute strategies to implement federal and Minnesota parity requirements, oversee compliance reviews, conduct stakeholder engagement, review consumer and provider complaints, and serve as a resource to ensure health plan compliance. The Department of Commerce takes various enforcement actions including reviewing complaints, educating consumers and providers, monitoring insurance companies, and imposing fines as a last resort, while commissioners may require detailed information from health plan companies including comparisons of prior authorization requirements, drug formulary design, claim denials, and rehabilitation services between mental health and medical treatments. Three state agencies provide oversight and consumer assistance: the Department of Human Services for public program enrollees, the Department of Commerce for individual and small group insurance policies, and the Department of Health for HMO policies.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Minnesota supports the provision of integrated services for individuals with co-occurring mental and substance use disorders through a comprehensive framework that includes mandatory screening, evidence-based treatment models, and coordinated care systems. The state requires individuals who perform substance use disorder assessments to screen clients for co-occurring mental health disorders,

and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders, with approved screening tools and documented action plans for positive results.

The state's service delivery approach centers on multiple integrated care models, including Behavioral Health Home (BHH) services, Certified Community Behavioral Health Clinics (CCBHCs), outpatient and residential substance use disorder treatment programs licensed to treat co-occurring mental illness, and children's residential facilities that provide co-occurring mental health and substance use disorder treatment. BHH services utilize multidisciplinary teams to deliver person-centered care that coordinates medical, social, and behavioral health conditions, providing comprehensive care management and care coordination with the team acting as the central point of contact for implementing and monitoring individualized health action plans. CCBHCs serve as "one-stop-shops" that offer integrated mental health and substance use disorder services to increase access to community-based services, advance integration of behavioral health with physical health care, and improve utilization of evidence-based practices, serving individuals regardless of ability to pay or place of residence. CCBHCs must offer care that is person-centered, family-centered, trauma-informed, and recovery-oriented, integrating mental health and substance use disorder services in coordination with physical health care and social services to serve the "whole person," with staff working in an integrated way. The integrated assessment process identifies the interaction between substance use and mental health symptoms and disorders and how this relates to treatment during periods of both stability and crisis, ensuring that individuals with co-occurring disorders receive evidence-based practices that are nationally recognized and research-supported.

a. Please describe how this system differs for youth and adults.

The Minnesota DHS Behavioral Health Administration utilizes a developmental lens when designing and delivering mental health and substance use disorder services across the lifespan. This approach recognizes the distinct needs of youth and adults, ensuring that services are developmentally appropriate and tailored to the individual's stage of life. The state employs integrated treatment models that address co-occurring mental health and substance use disorders through evidence-based practices, mandatory screening requirements, and coordinated care delivery systems.

For youth, services are embedded within a broader system of supports that includes families, caregivers, and educational institutions. The State has prioritized collaboration with school systems to integrate mental health and substance use services directly into educational settings, particularly for children and adolescents experiencing Serious Emotional Disturbance (SED). Youth-specific services include Children's Therapeutic Services and Supports (CTSS), which provides flexible mental health and rehabilitation services for children with emotional disturbance or co-occurring substance use disorders, delivered in natural environments such as home, school, and community settings. BHA is also working with partners in the juvenile justice systems to ensure that youth with mental health and substance use issues who are being released from justice system are able to access appropriate integrated care in the community that is both developmentally appropriate and family supportive. Similarly, the State has been actively training and intends to continue to train the mental health workforce in providing evidence-based family interventions for youth and children with co-occurring disorders. This integration allows for early identification, access to care in familiar environments, and coordinated supports that engage both the youth and their caregivers. The youth mental health system emphasizes prevention, early intervention, and strong partnerships to ensure continuity of care, especially during transitions into adulthood through specialized transition services for ages 14 to 25.

In contrast, adult mental health and substance use disorder services are designed with a generational lens, recognizing the complex and often long-term needs of individuals living with Severe and Persistent Mental Illness (SPMI) and co-occurring substance use disorders. Services are on a continuum from community-based to intensive residential, including Integrated Treatment for Co-Occurring Disorders (IT-COD), Behavioral Health Homes (BHH), and Certified Community Behavioral Health Clinics (CCBHCs) that serve as "one-stop-shops" for integrated mental health and substance use services. They are regionally coordinated which serves as mechanisms for local collaboration and innovation. CCBHCs provide comprehensive, coordinated care that integrates mental health and substance use disorder services with physical health care and social services, serving individuals regardless of their ability to pay while using evidence-based practices and harm reduction approaches. Supported by grant funding, these initiatives and programs enable the development of flexible, person-centered programs across all 87 counties in Minnesota, with the goal of improving the quality of life for adults with SMI and co-occurring disorders.

Throughout both youth and adult systems, Minnesota maintains a strong commitment to a comprehensive continuum of care that is clinically responsive and addresses co-occurring mental health and substance use disorders through mandatory screening requirements and integrated assessment processes. The Behavioral Health Administration works across departments, divisions, and community partners to ensure integrated service delivery and coordinated care that treats the "whole person" rather than addressing conditions separately. This systemic approach supports individuals at every stage of their mental health and substance use recovery journey and promotes seamless transitions between youth and adult services as well as into aging services. Minnesota's behavioral health system is unified in its mission to meet the mental health and substance use disorder needs of residents across the lifespan through collaborative, developmentally informed, and community-rooted care models that emphasize integration, evidence-based practices, and coordinated treatment for co-occurring conditions.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

The state's service delivery approach centers on multiple integrated care models for treating co-occurring disorders , including Behavioral Health Home (BHH) services, Certified Community Behavioral Health Clinics (CCBHCs), outpatient and residential substance use disorder treatment programs licensed to treat co-occurring mental illness, and children's residential facilities that provide co-occurring mental health and substance use disorder treatment. BHH services utilize multidisciplinary teams to deliver person-centered care that coordinates medical, social, and behavioral health conditions, providing comprehensive care management and care coordination with the team acting as the central point of contact for implementing and monitoring individualized health action plans. CCBHCs serve as "one-stop-shops" that offer integrated mental health and substance use disorder services to increase access to community-based services, advance integration of behavioral health with physical health care, and improve utilization of evidence-based practices, serving individuals regardless of ability to pay or place of residence. CCBHCs must offer care that is person-centered, family-centered, trauma-informed, and recovery-oriented, integrating mental health and substance use disorder services in coordination with physical health care and social services to serve the "whole person," with staff working in an integrated way. The integrated assessment process identifies the interaction between substance use and mental health symptoms and disorders and how this relates to treatment during periods of both stability and crisis, ensuring that individuals with co-occurring disorders receive evidence-based practices that are nationally recognized and research-supported.

c. How many IT-COD teams do you have? Please explain.

Not applicable

d. Do you monitor fidelity for IT-COD? Please explain.

Not applicable

e. Do you have a statewide COD coordinator? ☐ Yes ☒ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a. Access to behavioral health care facilitated through primary care providers

b. Efforts to improve behavioral health care provided by primary care providers

c. Efforts to integrate primary care into behavioral health settings

d. How the state provides integrated treatment for individuals with co-occurring disorders

The DHS Behavioral Health Administration works closely with the DHS Health Care Administration to ensure continuity of care between medical services and behavioral health service providers. In particular, the Behavioral Health Administration is partnering with the Health Care Administration's Transforming Maternal Health Model to ensure the mental health and substance use workforce is prepared to serve newly pregnant and parenting adults who are struggling with mental health and substance use disorders. Block grant funds will be used to train the mental health and substance use workforce in serving pregnant and parenting adults with severe mental illness. All licensed behavioral health programs are required to coordinate care with physical health care providers and Minnesota provides an enhanced payment rate for substance use disorder treatment programs that provide additional medical services.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a. Adults with serious mental illness (SMI)

b. Adults with substance use disorders

c. Adults with SMI and I/DD (Intellectual and/or Developmental Disability)

d. Children and youth with SED or substance use disorders

e. Children and youth with SED and I/DD

The Minnesota Department of Human Services (DHS), Behavioral Health Administration (BHA), works with partners and providers to ensure that child and adult mental health and substance use disorder programs and services are available throughout Minnesota, including care coordination. Partners include counties, providers, and tribes delivering services so that children and adults with SED, SMI, substance use disorders, and I/DD can develop and function as fully as possible in all areas of their lives. DHS is committed to a continuum of services that are informed by research and that will lead to a measurable reduction in symptoms and increases in strengths and functional abilities. Minnesota's publicly provided mental health system is supervised by DHS and administered by counties. Counties are the local mental health authority for providing care coordination of children's and adult mental health services. County responsibilities also include application processing, eligibility determination Medicaid and other financial resources for services, case management, and either direct service delivery or contracting with providers.

The mental health system provides a comprehensive continuum from early childhood mental health consultation through psychiatric hospitalization, including community-based services, residential treatment, crisis intervention, and care coordination through county staff and providers. Services are delivered by diverse providers including for-profit and not-for-profit organizations, hospitals, tribal governments, counties, and state-operated facilities. Depending on the severity of seriousness and complexity of individual behavioral health needs, county staff ensure more intensive community based and residential services are made available to person.

The DHS BHA, creates and ensures a unified, accountable, comprehensive children's mental health service system that including preventative services, identifying children who are eligible for mental health services, and assures access to a continuum of services. County workers provide care coordination to ensure a range of social and human services are provided to children and their families by community providers, residential programs, and the Departments of Education, Human Services, Health, and Corrections. This addresses the treatment of the mental health, substance use disorder, and I/DD needs of children are met in the least restrictive setting appropriate to their needs and to prevent further deterioration. They also ensure a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age.

The DHS BHA works with partners and providers to ensure that adult mental health programs and services are available throughout Minnesota. People may need assistance in a variety of areas, such as employment, housing, social connections, family relations and other co-occurring conditions. While DHS sets policy and standards for care, and provides funding for services of mental health treatment, our partners and providers are the key to delivering mental health services within Minnesota.

County workers provide care coordination to ensure a range of services are provided to adults with SMI and their families by community providers, residential programs. This addresses the treatment of the mental health, substance use disorder, and I/DD needs of the adult are met in the least restrictive setting appropriate to their needs and to prevent further deterioration. Depending on the severity of seriousness and complexity of individual behavioral health needs, county staff ensure more intensive community based and residential services are made available to person.

Through the Adult Mental Health Initiative (AMHI) funding, the Minnesota Department of Human Services Behavioral Health Administration, provides funding to all 87 Minnesota Counties and 1 Tribe. Funds are used to develop a continuum of care that meets the individual needs of adults with SMI in each county or Tribe. Services are determined through a needs assessment, gaps and barriers. A broad range of Evidence Based Practices are used to create a system approach to mental health services, which includes; but is not limited to, outreach and engagement, employment assistance, and voluntary engagement activities to divert higher levels of care and case management.

For both children with SED and adults with SMI, Targeted Case Management for Mental Health is available to assist recipients in gaining access to needed educational, health, legal, medical, social, vocational and other services and supports. The four core components are assessment, planning, referral/linkage and monitoring/coordination. Case managers ensure service coordination by regularly reviewing programs and services.

For substance use disorder treatment, Minnesota operates a person-centered Direct Access model allowing individuals to go directly to chosen providers for comprehensive assessment, immediate care access, and care coordination. Services range from primary prevention, outreach, brief intervention and treatment referral, assessments, outpatient and residential substance use disorder treatment, peer recovery services, and withdrawal management. The services utilize the American Society of Addiction Medicine (ASAM) model of care for all publicly funded providers. All service providers are required to provide care coordination as part of their integrated services. The state operates under the 1115 SUD Treatment Reform Demonstration, a Medicaid waiver expanding access to evidence-based substance use disorder treatment services with improved care coordination and provider capacity enhancement. Minnesota counties determine eligibility for Medicaid, the state's Behavioral Health Fund, and other financial resources for services.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Minnesota requires that all professionals who perform substance use disorder assessments to screen clients for co-occurring mental health disorders and for all staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. They must use screening tools approved by DHS. If a client screens positive for a co-occurring mental health or substance use disorder, the professional must take steps to ensure that further assessment and treatment occur for the co-occurring disorder. Many substance use disorder and mental health treatment programs in Minnesota specialize in treating co-occurring mental health and substance use disorders at the same time including CCBHCs, co-occurring outpatient treatment programs, co-occurring residential treatment programs, children's residential co-occurring treatment programs, and Intensive Residential Treatment Services programs. Other non-occurring treatment programs are required to refer clients and coordinate treatment with another provider. Minnesota has adopted the best practice model of wrap around services that enhances the care of both mental health and substance use disorder treatments. Minnesota supports the provision of these services through training, integrated care model rates, and an enhanced payment rate for co-occurring substance use disorder treatment.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD),** including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Minnesota has licensed an Intensive Residential Treatment and Residential Crisis Stabilization Services program that specializes in serving adults with co-occurring SMI and intellectual or developmental disabilities. This is being monitored for potential expansion as census demonstrates the need for this service. Diagnostic assessment for all mental health services must include an assessment of developmental incidents for the client and appropriate referrals would need to be made if a person had a co-occurring intellectual or developmental disorder. Mobile crisis teams all have access to expert consultation for clients that have an SED and co-occurring Intellectual or Developmental Disabilities (IDD), Traumatic Brain Injury (TBI), Autism Spectrum Disorder (ASD), or Dementia-related condition. School Linked Behavioral health services were recently expanded in Minnesota with the use of grant funding to ensure SUD screenings and treatment was provided to children in schools which had many positive outcomes. The state is now introducing a new set of Medicaid reimbursable mental health services through an IEP/IFSP to enhance and expand these services in schools. DHS also coordinates trainings for providers in evidence-based practices for treating co-occurring mental health and Fetal Alcohol Spectrum Disorders (FASD). Home and Community Based Service providers which specialize in providing services to those with intellectual or developmental disorders coordinate care with mental health providers when needed. Workforce development investments have increased the cross relational work with MH and neurodiverse populations by supporting training and consultations and collaborating with DOH, ADSA and other state systems serving SMI and IDD.

8. Please indicate areas of **technical assistance needs** related to this section.

Not applicable.

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Navigate	10

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27(only include MHBG funds).

FY2026	FY2027
$1,700,000.00	$1,700,000.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

All agencies providing FEP services in Minnesota can bill Medicaid when delivering services to uninsured or under-insured individuals. Any services provided as part of FEP response which fall outside of standard insurance coverage can be supported with MHBG or state grant funds.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

Ten teams based out of six Minesota agencies provide FEP services in the state. Four of these agencies are located in the greater Minneapolis metro area, one agency is located in Duluth in the upper north-east corner of the state and another located in St. Cloud. All providers are using the evidence-based NAVIGATE model for Coordinated Specialty Care (CSC) and provide services to persons 15-40 years old.

5. Does the state monitor fidelity of the chosen EBP(s)? ☒ Yes ☐ No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☒ Yes ☐ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

> Minnesota FEP teams utilize software for data collection and review in order to provide measurement-based care. They also meet regularly with the training provider for consultation needs and required trainings.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

> Minnesota will be looking to develop additional FEP teams or expand capacity of current teams. Reaching rural areas in Minnesota will be a priority. Additional activities will be related to creating a state policy for FEP to be a covered service under the state's Medicaid plan.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

> The Navigate model is designed to provide treatment to individuals who are experiencing a first episode of psychosis with a schizophrenia spectrum disorder.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

> While there is not data specific to Minnesota, approximately 3 out of 100 individuals experience a first episode of psychosis each year.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

> The agencies that currently provide FEP services, engage on a consistent basis with other community agencies, resource providers, law enforcement, crisis teams, schools, emergency departments, county and tribal agencies, religious organizations, and others to provide outreach and education regarding first episode psychosis, often to build awareness of FEP so these symptoms do not go unnoticed. The FEP in MN are also able to provide FEP services, and coordinate with other providers the client may have during treatment.

12. Please indicate area of technical assistance needs related to this section.

> None at this time.

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers, and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from https://acl.gov/news-and-events/announcements/person-centered-practices-resources.

1. Does your state have policies related to person centered planning? ☒ Yes ☐ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages people with SMI and their caregivers in making health care decisions and enhances communication.

Person-centered practice is a philosophy and an approach to how we do business. Person-centered support planning is critical to this effort. Minnesota uses person-centered practices in all areas of service delivery, and DHS requires lead agencies to use the "Person-Centered, Informed Choice and Transition Protocol" to implement person-centered practices in support planning. The protocol addresses the federal and state statutes, rules and court requirements related to person-centered practices and principles. DHS reviews the protocol on an annual basis and makes revisions as necessary.

For mental health services, DHS provides technical assistance in the implementation of the protocol. Person-centeredness is an important part of recovery and resiliency for children, families and adults who receive mental health services. DHS encourages mental health targeted service providers to use person-centered philosophies in all aspects of their work. To do this, providers are asked to use the protocol as a guide.

In addition, before providing any mental health treatment, a personalized treatment plan must be completed for a child, youth, or adult. For a child client, providers should use a child-centered, family-driven, and individualized planning process that allows the child's parents and guardians to observe and participate in the child's individual and family treatment services, assessments, and treatment planning. For an adult client, providers should use a person-centered, individualized planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning. This individualized approach ensures that treatment planning is tailored to each person's unique circumstances, values, and preferences while maintaining meaningful involvement from their support systems throughout the care process. The treatment plan includes:

- Treatment goals and objectives based on the most recent diagnostic assessment
- Specific strategies and methods for treating needs identified by the diagnostic assessment
- Schedule for accomplishing the goals and objectives
- Responsibility for providing each treatment component
- Mental health status and progress, including changes in functioning

The treatment plan must be based on the client's diagnosis and established standards of practice for mental health treatment corresponding to that diagnosis. For children, the plan should incorporate developmentally appropriate interventions that consider the child's age, cognitive abilities, and family dynamics. For adults, the plan should reflect evidence-based practices suitable for adult populations while considering individual life circumstances and goals. The objectives must represent achievable, measurable steps toward improved mental health and overall functioning. The ultimate goal is to reduce the duration and intensity of symptoms and service needs to the least intrusive level possible that effectively maintains the individual's mental health stability and supports their ability to function in their preferred environment and roles.

4. Describe the person-centered planning process in your state.

DHS created the Person-Centered, Informed Choice and Transition Protocol as a guide lead agencies (counties, tribal organizations and managed care organizations) must use to implement person-centered practices. The protocol helps support planners use good practices and shows them how to develop and use person-centered plans. DHS ensures that all assessments and treatment plans include a client driven planning process to ensure the unique needs of each individual are met. This includes mobile crisis response, early childhood consultation, as well as other MHBG funded programs. In addition, DHS offers professional development for providers in several evidence-based practices to support workforce development to engage families in treatment decisions for children and youth.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as A Practical Guide to Psychiatric Advance Directives)?

Minnesota's Health Care Directive law, Minnesota Statutes Chapter 145C, allows individuals to create legally binding documents that may include instructions about psychiatric medications (like neuroleptics) and appoints someone to make treatment decisions during a crisis when an individual can't make those decisions themself.

According to statute, the suggested form may include a declaration regarding intrusive mental health treatment. This includes preferences about:

- Specific medications they do or don't want to receive
- Types of treatment facilities they prefer or want to avoid
- Individuals they want involved (or not involved) in their care decisions
- Other treatment preferences and instructions

The law requires that these directives be followed by healthcare providers when the person is unable to make decisions about their mental health treatment, as long as the directive is valid and the specific situation is covered by the document.

Minnesota's approach recognizes that people experiencing psychiatric crises may have periods where their decision-making capacity is impaired, but during stable periods they can make informed choices about their future care. This helps ensure their autonomy and preferences are respected even during acute episodes.

Free Minnesota Health Care Directive forms and resources are widely available, including online from the Minnesota Attorney General, using a Minnesota Health Care Directive Planning Toolkit offered by the University of Minnesota, from Light the Legacy, and from most health care provider organizations.

6. Please indicate areas of technical assistance needs related to this section.

N/A

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds.

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in 42 U.S.C. §300x–5 and 42 U.S.C. §300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. §300x–55(g), there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of Block Grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒ Yes ☐ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ☒ Yes ☐ No
3. Does the state have any activities related to this section that you would like to highlight?

The State of Minnesota's Department of Human Services, through its Behavioral Health Administration (BHA) utilizes a comprehensive three-tiered oversight structure for state and federal-funded grant management:

State Level (Department of Administration). The Office of Grants Management establishes standardized grant-making practices through comprehensive policies. Key policies cover: Grants Conflict of Interest, Public Comments Concerning Fraud and Waste, Pre-Award Risk Assessment, Grant Payments, Grant Monitoring, and Evaluating Grantee Performance

Agency/Department Level (DHS Central Grants Office). The Central Grants Office also oversees the Contracts Integration System (CIS) for DHS. They provide oversight and continuous improvement of DHS grant-making processes by offering standardized tools, forms, guidance, and training. This includes checklists and tools for completing Pre-Award Risk Assessments and financial reconciliations. They provide grant oversight by increasing efficiency and standardizing management processes (ex. Development of DHS grant management policies and procedures that align with state and federal requirements) and agency-wide coordination and implementation of grant oversight legislative requirements.

Division Level (Behavioral Health Administration). Administers and manages approximately 1,000 grant contracts in alignment with state and federal requirements, Office of Grants Management policies, and Central Grants Office standards. Partners with Central Grants Office to implement extensive training (25+ modules). Hosts weekly "Lunch and Learn" sessions on grant processes. Training includes grant monitoring, site visits, fraud prevention, contract evaluation, and conflict of interest.

Grant Managers: Grant managers oversee a grant program(s) and selection of grant-funded organizations and serves as a relationship manager with grantees, providing consultation and technical assistance as needed. They direct and coordinate all phases of the grant lifecycle, from pre-award activities through award, post-award administration, monitoring, and final close-out. Their responsibilities include comprehensive grant monitoring through conducting site visits, reconciling financial records, overseeing and approving invoices, reviewing program and financial reports submitted by grantees, and performing final close-out evaluations.

Contract Specialists: Contract specialists work closely with grant managers and serve as the primary liaison with the DHS Contracts and Legal Compliance Unit (CLC) while providing direction, management, and coordination throughout all phases of the contracting process (pre-award and award phases) in accordance with state and federal laws, regulations, and mandates. The contract specialist coordinates and manages request for proposal (RFP) processes, drafts and executes contracts and amendments, and delivers technical assistance, training, monitoring, and general consultation regarding contract processes.

Federal Grants Team Manager: Oversees the entire lifecycle of federal SAMHSA Community Mental Health Services Block Grant (MHBG), Substance Use Prevention, Treatment, and Recovery Services Block Grant

(SUPTRS BG or SUBG), and discretionary federal grants from application and award to monitoring, reporting, and closeout. Ensure compliance with federal regulations, guidelines, and reporting requirements for each grant program. Develops and implement strategies to maximize grant utilization and achieve programmatic objectives.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. **Information dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals' families and communities.
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities.
3. **Alternative programs** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral**, that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco, and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? ☒ Yes ☐ No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):
   a. ☐ Data on consequences of substance-using behaviors
   b. ☒ Substance-using behaviors
   c. ☒ Intervening variables (including risk and protective factors)
   d. ☐ Other (please list)

   Not applicable
3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply):
   a. ☐ Children (under age 12)
   b. ☒ Youth (ages 12-17)
   c. ☒ Young adults/college age (ages 18-26)
   d. ☐Adults (ages 27-54)
   e. ☐Older adults (age 55 and above)
   f. ☒ Rural communities
   g. ☐ Other (please list)

   Not applicable
4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply):
   a. ☒ Archival indicators (Please list)

   - Crash Facts and Impaired Driving
   - DANES: Substance Use Treatment Data for Minnesota

   b. ☐ National Survey on Drug Use and Health (NSDUH)
   c. ☐ Behavioral Risk Factor Surveillance System (BRFSS)
   d. ☐ Youth Risk Behavior Surveillance System (YRBS)
   e. ☐ Monitoring the Future
   f. ☐ Communities that Care
   g. ☒State-developed survey instrument
   h. ☐ Other (please list)

   Not applicable

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ☒ Yes ☐ No

a. If yes, (please explain in the box below)

In 2025, the Behavioral Health Administration completed comprehensive surveys of providers and community members this year to identify unmet needs in behavioral health services. This survey provides critical data that informs our funding allocation decisions by:

- Identifying geographic areas with the highest unmet prevention needs
- Determining priority populations that require targeted prevention interventions
- Assessing gaps in current prevention service delivery
- Understanding community-specific challenges and barriers to accessing prevention services
- Evaluating provider capacity and resource needs across different regions

b. If no, please explain how SUPTRS BG funds are allocated:

Not applicable

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

   a. ☒ Yes (if yes, please describe) ☐ No

Minnesota Certification Board (MCB) https://www.mcboard.org/. The Minnesota Certification Board (MCB) is a non-profit agency dedicated to protecting the citizens of Minnesota by ensuring that certified professionals working in a wide range of professions are providing safe and competent services to the public. The MCB is a member board of the International Certification and Reciprocity Consortium (IC&RC). They offer certifications for professionals in the areas of alcohol and drug counseling, co-occurring disorders, prevention, clinical supervision, peer recovery, and criminal justice.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?

   a. ☒ Yes (if yes, please describe mechanism used) ☐No

Training and Technical Assistance for Substance Use Primary Prevention Workforce

The Behavioral Health Administration (BHA) has established a comprehensive formal mechanism to provide training and technical assistance to the substance use primary prevention workforce through multiple coordinated programs and initiatives.

Regional Prevention Coordinators (RPCs): BHA funds seven Regional Prevention Coordinators, one in each region of Minnesota, providing comprehensive training and technical assistance since 2006. These coordinators:

- Support over 110 community coalitions across Minnesota focused on substance misuse reduction

- Hold National Substance Misuse Prevention Certification
- Provide direct technical assistance, training, and support to anyone in Minnesota wanting to engage in substance misuse primary prevention work

Formal Training Programs: RPCs deliver standardized training curricula including:

- Prevention Ethics (1-day class)
- SPF Application for Prevention Success Training (SAPST) (4-day course)
- Prevention Core Competencies - Introduction to prevention skills

All services are guided by SAMHSA principles within the Strategic Prevention Framework to build and maintain effective prevention programming.

Minnesota Prevention Resource Center (MPRC): The MPRC provides ongoing workforce development through:

- Annual statewide prevention conference
- Ongoing training opportunities covering prevention basics, skills, and ethics
- Easy-to-search online collection of prevention resources
- Essential news and information communication
- Creation of prevention-based resources

Data and Decision-Making Tools The SUMN.org tool provides access to data on substance use patterns, consequences, and contributing factors, helping the workforce make informed, data-driven prevention decisions.

Positive Community Norms (PCN) Training Through partnership with The Montana Institute, the state provides:

- Two in-state 2-day trainings annually on using Positive Community Norms to reduce substance misuse
- Individual technical assistance to nine PCN grantees, RPCs, and state staff
- Quarterly webinars for PCN grantees
- Training and technical assistance for media consultants

Evaluation Technical Assistance The Improve Group provides monthly technical assistance to individual grantees, ensuring the workforce understands evaluation importance and methodology for sustainable programming.

Bright Bound Program Building on the success of the LifeSkills Training Project, the Behavioral Health Administration developed the Bright Bound Program as the next step in youth substance use prevention. Aligned with 2024 Minnesota Statutes §120B.215, which requires school districts or charter schools to implement a comprehensive education program on cannabis use and substance use, this program uses curriculum developed by Emily's Hope Inc. to equip students with practical life skills for healthy, substance-free choices.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

   a. ☐ Yes (if yes, please describe mechanism used) ☒ No

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years?

   ☐ Yes (If yes, please attach the plan in WebBGAS)

   ☒ No

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

   ☐Yes

   ☐No

   ☒ Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

   a. ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
   b. ☐ Timelines
   c. ☐ Roles and responsibilities
   d. ☐ Process indicators
   e. ☐ Outcome indicators
   f. ☒ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ☒ Yes ☐ No

   a) Does the composition of the Advisory Council represent the demographics of the State? ☒ Yes ☐ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ☐ Yes ☒ No

   a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a. ☒ SSA staff directly implements primary prevention programs and strategies.

   b. ☐ The SSA has statewide contracts (e.g., statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c. ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d. ☒ The SSA funds regional entities that provide training and technical assistance.

   e. ☐ SSA funds regional entities to provide prevention services.

   f. ☒ SSA funds county, city, or tribal governments to provide prevention services.

g. ☒ SSA funds community coalitions to provide prevention services.

h. ☐ The SSA funds individual programs that are not part of a larger community effort.

i. ☐ The SSA directly funds other state agency prevention programs.

j. ☐ Other (please describe)

Not applicable

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a. Information Dissemination:

Minnesota Prevention Resource Center (MPRC) Website

- Comprehensive website containing primary prevention information available to anyone
- Easy-to-search online collection of prevention resources
- Ready-to-use data factsheets, reports, and tip sheets available for download

Monthly Newsletter Distribution

- MPRC maintains a listserv distributing monthly newsletters with essential prevention news and information
- Regional Prevention Coordinators (RPCs) each maintain listservs sending monthly newsletters to their regions
- Communication of prevention work stories and updates across Minnesota communities

SUMN.org Data Tool

- Provides access to data on substance use patterns, consequences, and contributing factors in Minnesota
- Allows users to view data by topic, location, or demographic categories
- Enables creation of custom charts, maps, and data tables

b. Education:

Evidence-Based Curriculum Implementation

- Each Positive Community Norms (PCN) Initiative grantee implements either Social Emotional Learning curriculum or evidence-based substance misuse curriculum
- Curriculum delivered to students in grades 6, 7, and 8, plus two years in high school
- Bright Bound Program curriculum developed by Emily's Hope Inc. aligned with Minnesota Statutes §120B.215

Formal Training Programs

- Prevention Ethics (1-day class) delivered by certified RPCs
- SPF Application for Prevention Success Training (SAPST) - 4-day course
- Prevention Core Competencies training - introduction to prevention skills
- Two in-state 2-day trainings annually on Positive Community Norms

Annual Prevention Conference

- MPRC hosts Minnesota's annual Primary Prevention Conference, Program Sharing
- Ongoing training opportunities covering prevention basics, skills, and ethics

c. Alternatives:

Youth Group Alternative Activities

- Each PCN Initiative grantee forms middle school and high school youth groups
- Youth groups plan and implement substance-free alternative activities for middle school and high school students in their schools
- Activities provide positive engagement opportunities as alternatives to substance use

d. Problem Identification and Referral:

PhotoVoice Projects

- Each PCN Initiative grantee's middle school and high school youth groups conduct PhotoVoice projects
- Projects identify community factors that prevent youth substance use and factors that encourage or facilitate use
- Projects displayed at various community venues to raise awareness
- Annual selection of one issue that encourages youth substance use for targeted intervention

Community Needs Assessment

- Each PCN Initiative coalition conducts comprehensive community needs assessments
- Assessments identify local substance use issues, risk factors, and service gaps
- Data used to inform strategic prevention planning and resource allocation

e. Community-Based Processes:

Community Coalition Development

- Each PCN Initiative grant is led by a community coalition with representatives from 14 community sectors
- Coalitions develop Strategic Prevention Plans with different sectors overseeing different components
- Annual review process examines data and makes decisions about continuing, changing, or adding prevention strategies

Regional Prevention Coordinator Support

- Each RPC works with multiple community coalitions annually to improve community-based primary prevention efforts
- Over 110 community coalitions across Minnesota supported with reduction of substance misuse as primary or secondary goal

- Technical assistance and support provided to strengthen local prevention capacity

Culturally Specific Community Partnerships

- Culturally specific grants partner with spirituality-based organizations to bridge gaps in substance use services for BIPOC women
- Workshop series on substance use, mental health, and parenting tailored to community needs

f. Environmental:

Social Host Ordinance Implementation

- PCN Initiative coalitions work to establish Social Host Ordinances at city and county levels in communities that don't yet have them
- Ordinances create legal consequences for adults who provide alcohol to minors

Environmental Change Projects

- Youth groups annually select one community factor that encourages substance use
- Groups work to implement environmental changes to address the identified issue
- Projects focus on modifying community conditions that influence substance use behaviors

Responsible Beverage Server Training and Compliance

- Responsible Beverage Server Training provided to reduce access to alcohol
- Alcohol compliance checks conducted to ensure merchants follow age verification laws

Positive Community Norms Media Campaigns

- Media campaigns implemented to correct adult and youth misperceptions that "most" youth use substances
- Campaigns promote accurate norms showing that most youth do NOT use substances
- Environmental messaging strategy to shift community perceptions and social norms

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means?
   a. ☒ Yes (if so, please describe) b. ☐ No

In primary prevention RFPs, applicants are to include in their application for funding, all primary prevention funds they have received for the past ten years and how they used the funds.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years?
   ☐ Yes (If yes, please attach the plan in WebBGAS) ☒ No
2. Does your state's prevention evaluation plan include the following components? (check all that apply)
   a) ☒ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
   b) ☐ Includes evaluation information from sub-recipients
   c) ☐ Includes National Outcome Measurement (NOMs) requirements
   d) ☐ Establishes a process for providing timely evaluation information to stakeholders
   e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making

f) ☐ Other (please describe)

g) ☒ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:
   a) ☒ Numbers served
   b) ☒ Implementation fidelity
   c) ☒ Participant satisfaction
   d) ☒ Number of evidence-based programs/practices/policies implemented
   e) ☒ Attendance
   f) ☒ Demographic information
   g) ☐ Other (please describe)

   Not applicable

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

   a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc.
   b) ☐ Heavy alcohol use
   c) ☐ Binge alcohol use
   d) ☒ Perception of harm
   e) ☒ Disapproval of use
   f) ☐ Consequences of substance use (e.g., alcohol-related motor vehicle crashes, drug-related mortality)
   g) ☐ Other (please describe)

   Not applicable

6. Statutory Criterion for MHBG – Required for MHBG

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Narrative Question

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

1. **Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.**

The Minnesota Department of Human Services (DHS), through the Behavioral Health Administration (BHA), works with partners and providers to ensure that children, adolescent, and adult mental health programs and services are available throughout Minnesota. People may need assistance in a variety of areas, such as employment, housing, social connections, family relations and other co-occurring conditions. While DHS sets policy and standards for care, and provides funding for services of mental health treatment, our county and tribal partners and community providers are the key to delivering mental health services within Minnesota.

Minnesota Statute Chapter 245 – Department of Human Services, provides the legal framework for Minnesota's comprehensive community-based mental health service system.

The Minnesota Comprehensive Adult Mental Health Act (Minnesota Statutes 245.461 to 245.486) aims to create a unified, accountable, and comprehensive mental health service system for adults in the state. The act's core goals include eliminating abuse of adults with mental illness, increasing their level of functioning, stabilizing their condition, preventing the worsening of mental illness, and promoting higher levels of emotional well-being. It emphasizes the right of adults with mental illness to control their lives and promotes their independence and safety.

The act outlines the responsibilities of the Minnesota Department of Human Services (DHS) and counties in providing mental health services. Counties act as the local mental health authority and are responsible for developing and coordinating a system of affordable and locally available adult mental health services. This includes developing a biennial mental health plan with the involvement of local advisory councils and ensuring access to services for adults with serious and persistent mental illness.

Key components of the act include:

- Mental Health Services - The act mandates the provision of various mental health services, including outpatient services, community support services, crisis services, and residential treatment.
- Targeted Case Management - The act provides for targeted case management services, particularly for adults with serious and persistent mental illness, to help them access and coordinate necessary services.
- Funding - The act emphasizes the importance of securing federal and other non-state funding to support mental health services.
- Local Planning - Counties are required to develop local mental health plans, involving consumers, families, providers, and other stakeholders, and designate a managing entity to oversee the implementation of these plans.
- Individual Treatment Plans - The act emphasizes the importance of individualized treatment plans, developed in collaboration with the client, and reviewed regularly.
- Partnerships - The act encourages partnerships between counties, DHS, providers, and other stakeholders to build capacity and improve the effectiveness and accessibility of mental health services.
- Consumer Rights - The act recognizes the right of adults with mental illness to control their own lives and make choices about their treatment.

In essence, the Minnesota Comprehensive Adult Mental Health Act provides a framework for a comprehensive and locally driven mental health system in Minnesota, with a focus on improving the lives of adults with mental illness through accessible, effective, and person-centered services.

The Minnesota Children's Mental Health Act (Minnesota Statutes 245.487 to 245.4887) establishes standards for mental health services for children and assigns counties as local mental health authorities. It aims to identify children in need, provide preventive services, ensure access to a range of services, and address the unique challenges of funding these services. The Act emphasizes providing services in the child's community, promoting least restrictive settings, and supporting transitions to adult services.

Key Aspects of the Act include:

- County Responsibility - Counties are designated as local mental health authorities and are tasked with identifying children eligible for services, making preventive services available, and ensuring access to a continuum of care.
- Service Delivery - The Act mandates that services be provided in the least restrictive setting appropriate for the child's needs, with a focus on community-based care and avoiding unnecessary residential or inpatient treatment.
- Transition Planning - Residential treatment facilities and regional treatment centers are required to develop discharge plans to help children transition back to community-based services, ensuring access to necessary supports.

- Early Intervention and Prevention - The Act emphasizes the importance of early identification and intervention for mental health issues, including screening and referral to appropriate services.
- Access to Services - The Act aims to ensure access to a range of mental health services, including prevention, early intervention, and treatment, recognizing the unique needs of children and their families.
- Addressing Funding Challenges - The Act acknowledges the specific challenges in funding mental health services for children and works to address those issues. In essence, the Minnesota Comprehensive Children's Mental Health Act is a comprehensive framework for ensuring that children in Minnesota receive the mental health services they need, when they need them, in the most appropriate settings.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a. Physical Health ☒ Yes ☐ No
b. Mental Health ☒ Yes ☐ No
c. Rehabilitation services ☒ Yes ☐ No
d. Employment services ☒ Yes ☐ No
e. Housing services ☒ Yes ☐ No
f. Educational services ☒ Yes ☐ No
g. Substance use prevention and SUD treatment services ☒ Yes ☐ No
h. Medical and dental services ☒ Yes ☐ No
i. Recovery Support services ☒ Yes ☐ No
j. Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) ☒ Yes ☐ No
k. Services for persons with co-occurring M/SUDs ☒ Yes ☐ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Adult Mental Health Grants - These support a broad range of vital community service needs. The grants provide funding for infrastructure, community services, supports, and coordination activities not covered by Medical Assistance, and/or for persons who are uninsured or under-insured by public or private health plans. These grants are distributed in a number of ways. Some are allocated to counties and tribes in the form of block grants that can be used to fund a number of services. Other grants are awarded competitively to counties, tribes, mental health providers, and other organizations for specific services, projects, and programs. Services include, but are not limited to the following:

Housing with Supports - These grants fund the development of permanent supportive housing for

persons with serious mental illness, by providing options that assist individuals who need housing linked with supportive to help maintain an individual's mental health and housing stability while living in the community.

Project for Assistance in Transition from Homelessness (PATH) - PATH is a federal program supplemented with state matching funds to provide outreach, service coordination, and related services designed to find and engage persons with serious mental illness who are homeless or at imminent risk of becoming homeless and provide them with services to meet basic needs, resources, and housing.

Crisis Housing - This program provides direct payments for rent, mortgage, and utility costs, to assist persons in retaining their housing while getting needed facility-based treatment. The program prevents homelessness while the individual uses their income to pay for treatment or loses income while getting needed treatment.

Crisis Response Services - Provides an array of services from mobile crisis response teams to crisis stabilization beds and aftercare services. Mobile crisis teams respond to an individual experiencing a severe mental health problem that requires immediate assistance in their home, place of employment, or in a hospital emergency department. Many components of crisis services are not reimbursable under Medicaid, such as telephone contacts with a person in crisis, linkage and coordination, benefits assistance, and post-hospital transition services. Ancillary services that are not able to be billed to MA are being provided through grant funding.

Mental Health Innovations - These grant funds are dedicated to finding innovative approaches for improving access to and the quality of community-based, outpatient mental health services. Programs are focused on helping people with mental illness receive effective and individualized services in their community.

3. Describe your state's case management services.

Mental Health Targeted Case Management (MH-TCM) assists clients in gaining access to educational, health, legal, medical, social, vocational, and other services and supports. There are four core components of MH-TCM. These four core components must be present in evaluation and planning documents for clients who receive MH-TCM. The four core components of MH-TCM are: assessment, planning, referral/linkage, and monitoring/coordination.

Adult Mental Health Targeted Case Management services (AMH-TCM) are person-centered and individually responsive services designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services for the client's mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the client to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Children's Mental Health Targeted Case Management services (CMH-TCM) means activities that are child-centered, family-focused, individually responsive, and community-based to assist families and to help children who have been diagnosed as seriously emotionally disturbed and to gain access to needed medical and mental health, social, educational, vocational, and other necessary services as

they relate to the child's mental health needs. Case management services include developing a functional assessment and individual family community support plan, referring and assisting the child to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Minnesota Department of Human Services (DHS) formed the Acute Care Transitions Advisory Council in October 2023 to create supports for children and adults who face barriers when moving from hospitals and other settings into their home and community.

The council published a report in October 2024 that made recommendations to:

- Improve the ways in which regions support people with complex transition challenges.
- Reduce multiple roles and services that make it hard to find support.
- Design a way to assess and measure the challenges that occur during Transitions.
- Change policies and procedures.
- Consider ways the state can invest in new programs to help people in transition.
- Address geographic, racial and ethnic disparities that children and adults in transition experience.

Complex Transitions Team – The Minnesota Department of Human Services' complex transitions team supports people who might benefit from DHS technical assistance to move from hospital and institutional settings back into the community. The team connects with subject matter experts across departments and divisions within the state to be a single point of contact for people who need to navigate the supports available through DHS. The complex transitions team technical assistance is not a substitute or waiver of requirements, nor a substitute for regular communication channels and processes. The hospital must continue to collaborate with the lead agency and the support team working with the person. If you have an exceptional circumstance that may require DHS consultation, please contact us through the referral form under the How to get help tab below.

Transitions to Community Initiative - This initiative is designed to reduce the time that individuals remain at the Anoka Metro Regional Treatment Center (AMRTC) or the Forensic Mental Health Program (FMHP) located in St. Peter (formerly known as the Minnesota Security Hospital MSH) once they no longer need hospital level of care. This program funds transitional services, referred to as the Whatever It Takes (WIT) program, which is designed to work with the individual and their treatment teams in addressing unique discharge barriers faced by some individuals. The initiative promotes recovery and allows individuals to move to integrated settings of their choice as outlined in the Minnesota Olmstead Plan, which then opens beds at AMRTC and MSH for other individuals who need them.

Adult Mental Health initiative (AMHI)- Minnesota has added the ability to provide needed and eligible funding through the AMHI 2025 legislatively approved direct payment to counties/regions and tribes to include pre-commitment support to divert individuals from hospitalization or jail. Direct payment was proposed and approved to minimize administrative, contract, reporting and financial reporting not applicable when providing state funding to county partners. Government to government

allocations will reduce the administrative burden and allowing for more technical assistance and innovation in services to the residents of Minnesota.

5. Please indicate areas of technical assistance needed related to this section.

Not applicable

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus. Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system. MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Priority Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	3%	2.86%
2. Children with SED	5%	2.44%

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Calculation methodology: The statewide prevalence percent is calculated by the number of people in the state with either SMI or SED at the time divided by the state population. The statewide incidence percent is calculated by the number of new cases in the state during the period divided by the state population.

The sources are as follows:

- The number of people with the condition at the time: Uniform Reporting Services (URS) BCI, CLD data
- Total state population at the time: Census Bureau Website
- Number of new cases during the time: Calculated from MMIS (claims data warehouse)
- Population at risk during the time period: Calculated from Census website and URS data

DHS does not use prevalence and incidence rates as the primary means of planning purposes for mental health services. Planning for services are primarily determined by needs identified by several sources including community feedback and reports, provider surveys and community surveys.

2. Please indicate areas of technical assistance needs related to this section.

Teradata and access to census websites

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

1. Does your state integrate the following services into a comprehensive system of care [1]

a. Social Services	☒ Yes ☐ No
b. Educational services, including services provided under IDEA	☒ Yes ☐ No
c. Juvenile justice services	☒ Yes ☐ No
d. Substance use prevention and SUD treatment services	☒ Yes ☐ No
e. Health and mental health services	☒ Yes ☐ No
f. Establishes defined geographic area for the provision of the services of such systems	☒ Yes ☐ No

2. Please indicate areas of technical assistance needs related to this section.

Not applicable

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

a. Describe your state's tailored services to rural population with SMI/SED. See the federal Rural Behavioral Health page for program resources.

Adult Mental Health Initiative (AMHI) Services - Adult Mental Health Initiatives (AMHI) are grant programs administered by the DHS Behavioral Health Administration to fund regional collaborations charged with overseeing adult mental health services and funding to counties and tribal governments in their area. Each county board, county boards acting jointly, or tribal government must provide or contract for sufficient infrastructure for the delivery of mental health services under the Minnesota Comprehensive Adult Mental Health Act. Over time, this has resulted in 18 regional county initiatives and the White Earth Nation tribe who have identified as AMHIs. Each region ranges in size from single, large county entities in the metro area to regions encompassing up to 18 counties in greater Minnesota.

[1] A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

These AMHI's are responsible for designing, planning, improving, and maintaining a mental health service delivery system for adults with serious and persistent mental illness that:

- Provides an expanded array of services from which clients can choose services appropriate to their needs,
- Is based on purchasing strategies that improve access and coordinate services without cost shifting,
- Prioritizes evidence-based services and implement services that are promising practices or theory-based practices so that the service can be evaluated,
- Incorporates existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors, and
- Utilizes existing categorical funding streams and reimbursement sources in combined and creative ways.

The following three distinct grant programs and services are funded through the AMHI:

- Mental Health Crisis Services
- Housing with supports for adults with serious mental illness
- Projects for assistance in transitioning from homelessness (PATH program)

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal Homeless Programs and Resources for program resources[2]

Project for Assistance in Transition from Homelessness (PATH) - PATH is a federal program supplemented with state matching funds to provide outreach, service coordination, and related services designed to find and engage persons with serious mental illness who are homeless or at imminent risk of becoming homeless and provide them with services to meet basic needs, resources, and housing. Crisis Housing – This program provides direct payments for rent, mortgage, and utility costs, to assist persons in retaining their housing while getting needed facility-based treatment. The program prevents homelessness while the individual uses their income to pay for treatment or loses income while getting needed treatment.

Housing with Supports - These grants fund the development of permanent supportive housing for persons with serious mental illness, by providing options that assist individuals who need housing linked with supportive to help maintain an individual's mental health and housing stability while living in the community.

c. Describe your state's tailored services to the older adult population with SMI. See the federal Resources for Older Adults webpage for resources[3]

Minnesota's Medicaid waiver programs for older adults include the Elderly Waiver (EW), a federal Medicaid waiver program that funds home and community-based services for people 65 years old and older who are eligible for Medical Assistance, require the level of care provided in a nursing home, but choose to live in the community, and the Alternative Care (AC) program, a state-funded program that supports limited home and community-based services for people 65 years old and

[2] https://www.samhsa.gov/homelessness-programs-resources
[3] https://www.samhsa.gov/resources-serving-older-adults

older who are not financially eligible for Medical Assistance but meet AC financial and service eligibility requirements and require nursing home level of care. These waiver programs help people pay for things like additional medical supplies and equipment, help with daily living activities, case management, counseling and other services not covered through regular Medical Assistance, with services coordinated through Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO) managed care organizations. Both programs also offer Consumer Directed Community Supports (CDCS), which empowers individuals to direct their own care services, and are designed to help older adults remain in their homes and communities rather than requiring institutional nursing home care.

d. Please indicate any other areas of technical assistance needs related to this section.

Not applicable

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

1. Describe your state's management systems.

Minnesota's mental health service delivery system operates through a comprehensive management framework where the Department of Human Services (DHS) serves as the primary coordinating entity for community-based care. The state utilizes a decentralized service delivery model in which the majority of mental health services under the plan are provided by community mental health providers throughout Minnesota. DHS functions as both the financial steward and capacity-building facilitator, directing block grant resources to qualified providers while coordinating essential training and technical assistance for service delivery organizations. The department's leadership and grant management teams collaborate to identify service gaps, develop new programs, and issue competitive Requests for Proposals to community mental health organizations for evidence-based interventions targeting individuals with serious mental illness (SMI) and serious emotional disturbance (SED). To enhance crisis response capabilities, DHS has established an interagency partnership with the Minnesota Department of Public Safety to provide specialized training for law enforcement officers statewide in emergency mental health interventions. Grant managers provide ongoing technical assistance to funded programs, supporting policy development and ensuring compliance with service standards. Minnesota's strategic priorities for block grant funding focus on five key areas: workforce development initiatives to address provider shortages, enhancement of crisis intervention services, expansion of early serious mental illness (ESMI) programs, implementation of evidence-based practice training for providers, and ensuring equitable access to services for individuals with SMI and SED across all geographic regions of the state.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities.

Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Minnesota Health Care Programs (MHCP) members (Medicaid recipients) eligible for mental health services can receive mental health services delivered through telehealth. Telehealth includes: secure video conferencing, store-and-forward technology, and audio-only communication between the health care provider and the patient (until July 1, 2027).

According to a 2024 Minnesota Department of Health Study of Telehealth Expansion and Payment Parity that was presented in a final report to the legislature:

- Prior to the onset of the COVID-19 pandemic, most telehealth visits for Minnesotans with commercial health insurance were through digital health platforms such as Virtuwell®, Teladoc®, or Doctor on Demand®. Today, telehealth is commonly available from the same providers Minnesotans see for in-person care. As of July 2023, about 60% of Minnesota physicians, physician assistants, and drug/alcohol counselors, and about 75% of behavioral health providers, report using telehealth for at least some of their visit.
- Behavioral health care has become the most common type of telehealth visit. Prior to 2020, the most common reasons for telehealth visits among commercial enrollees in Minnesota were for non-emergency acute care (e.g., sinusitis, urinary tract infections). In 2021, the most common reasons for telehealth visits were for behavioral health care (e.g., depression and anxiety). Over 50% of mental and behavioral health visits were conducted via telehealth in 2022.
- Audio-only telehealth is an important tool for accessing care, including behavioral health care, particularly among those who experience challenges accessing in-person care or audio-visual telehealth care.

During a 2025 special session of the Minnesota legislature, the sunset of audio only telehealth was extended from July 1, 2025 to July 1, 2027. Audio only will be covered if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication or if a scheduled appointment was not possible due to an

emergency or crisis services initiated by an enrollee for substance use disorder treatment services and mental health care services delivered through audio- only telehealth.

3. Please indicate areas of technical assistance needs related to this section.

Not applicable

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. Does your state provide:
   a. A full continuum of services (with medications for addiction treatment included in v-x):
      i. Screening ☒ Yes ☐ No
      ii. Education ☒Yes ☐ No
      iii. Brief intervention ☒ Yes ☐ No
      iv. Assessment ☒ Yes ☐ No
      v. Withdrawal Management (inpatient/residential) ☒Yes ☐ No
      vi. Outpatient ☒ Yes ☐ No
      vii. Intensive outpatient ☒Yes ☐ No
      viii. Inpatient/residential ☒ Yes ☐ No
      ix. Aftercare/Continuing Care ☒ Yes ☐ No
      x. Recovery support ☒ Yes ☐ No
   b. Services for special populations:
      i. Prioritized services for veterans? ☐ Yes ☒No
      ii. Adolescents? ☒ Yes ☐ No
      iii. Older adults? ☐ Yes ☒ No

Criterion 2: Improving Access and Addressing Primary Prevention – see Section 8

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? ☒ Yes ☐ No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ☒ Yes ☐ No
3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☒ Yes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? ☒ Yes ☐ No
5. Has your state **identified a need** for any of the following?
   a) Open assessment and intake scheduling? ☒Yes ☐ No
   b) Establishment of an electronic system to identify available treatment slots? ☒ Yes ☐ No

c) Expanded community network for supportive services and healthcare? ☒ Yes ☐ No

d) Inclusion of recovery support services? ☒ Yes ☐ No

e) Health navigators to assist clients with community linkages? ☒ Yes ☐ No

f) Expanded capability for family services, relationship restoration, and custody issues? ☒ Yes ☐ No

g) Providing employment assistance? ☒ Yes ☐ No

h) Providing transportation to and from services? ☒ Yes ☐ No

i) Educational assistance? ☒ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Minnesota DHS Behavioral Health Administration employs comprehensive monitoring strategies to ensure program compliance related to activities and services for Pregnant Women and Women with Dependent Children (PWWDC). Our multi-layered approach includes the following specific strategies:

Regular Reporting Requirements

All grant-funded, women-specific programs are required to submit:

- **Mid-year program progress reports** - Comprehensive assessments of program implementation and participant outcomes
- **Year-end program progress reports** - Final evaluations of annual goals, objectives, and service delivery
- **Quarterly fiscal reports** - Financial accountability documentation to ensure proper use of funds

Ongoing Communication and Support

The Behavioral Health Administration conducts **monthly meetings with all women's programs** to:

- Identify any concerns programs are experiencing in real-time
- Provide technical assistance and support
- Address emerging issues before they become compliance problems
- Facilitate peer learning and best practice sharing among programs

Compliance Assessment Methods

Desk Audits

- The Behavioral Health Administration project manager performs desk audits on every sub-grantee to determine program compliance
- Reviews include analysis of program reports, fiscal documentation, and adherence to grant requirements
- Systematic examination of data quality, service delivery metrics, and outcome achievements

Site Visits

- Conducted as required based on risk assessment and program performance
- On-site verification of program operations, service delivery, and compliance with federal and state requirements
- Direct observation of program implementation and participant services

External Evaluation

- An external evaluation entity is utilized to provide independent assessment of sub-grantee performance
- Determines whether sub-grantees successfully meet their established goals and outcomes
- Provides objective analysis of program effectiveness and compliance

Corrective Action Process

When compliance issues are identified through any of the monitoring strategies, the Behavioral Health Administration implements appropriate corrective actions including:

- Development of corrective action plans with specific timelines
- Enhanced technical assistance and training
- Increased monitoring frequency
- Resource reallocation or program modifications as needed

This comprehensive monitoring framework ensures continuous oversight, early identification of potential issues, and prompt resolution of compliance concerns to maintain high-quality services for pregnant women and women with dependent children.

Criteria 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), and Hypodermic Needle Prohibition

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
   a. 90 percent capacity reporting requirement? ☒ Yes ☐ No
   b. 14-120 day performance requirement with provision of interim services? ☐ Yes ☒ No
   c. Outreach activities? ☒ Yes ☐ No
   d. Monitoring requirements as outlined in the authorizing statute and implementing regulation? ☒ Yes ☐ No

2. Has your state identified a need for any of the following:
   a. Electronic system with alert when 90 percent capacity is reached? ☒ Yes ☐ No
   b. Automatic reminder system associated with 14–120-day performance requirement? ☐ Yes ☒ No
   c. Use of peer recovery supports to maintain contact and support? ☒ Yes ☐ No
   d. Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? ☐ Yes ☒ No

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Minnesota Department of Human Services' Behavioral Health Administration employs comprehensive monitoring strategies to ensure program compliance for People Who Inject Drugs (PWID). According to the Minnesota Department of Human Services definition, "programs serving people who inject drugs" may be referred to as opioid treatment programs, as defined in SAMHSA 42 CFR § 8.12 (a).

Regulatory Requirements. The Behavioral Health Administration has built specific requirements for this population into key areas:

Assessment, Referral, and Placement

- Clients must be referred to an opioid treatment program per Minnesota Administrative Rule 9530.6622 Placement Criteria, Subpart 5. Dimension 5: relapse, continued use, and continued problem potential (https://www.revisor.mn.gov/rules/9530.6622)
- Assessment and placing authorities must provide treatment option information to clients via standardized materials (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6745-ENG)

Program Standards

- Specific standards are incorporated into licensing requirements for Opioid Treatment Programs under Minnesota Statute 245G.22 (https://www.revisor.mn.gov/statutes/cite/245G.22)

Compliance Monitoring Strategies

County and Tribal Compliance Officers

- Screening, assessment, funding, and referral activities are monitored by County Compliance Officers and Tribal Compliance Officers housed within the Behavioral Health Administration
- Officers conduct regular oversight of placement decisions, referral processes, and assessment compliance

Licensing Division Oversight

- Substance use treatment provider compliance is monitored and enforced by the DHS Office of Inspector General's Licensing Division
- Regular licensing reviews ensure adherence to Minnesota Statute 245G.22 requirements

Monitoring Activities

- Review assessment documentation for proper evaluation of injection drug use history
- Verify appropriate referrals to opioid treatment programs according to placement criteria
- Ensure clients receive required treatment option information
- Conduct regular OTP compliance assessments with state standards

Corrective Actions. When compliance issues are identified, the Behavioral Health Administration implements:

- Technical assistance and training for non-compliant programs
- Enhanced monitoring frequency for programs with deficiencies
- Formal corrective action plans with specific timelines and measurable objectives
- Licensing Division enforcement actions including potential sanctions or license modifications
- Direct intervention by County or Tribal Compliance Officers

This monitoring framework ensures continuous oversight, early identification of compliance issues, and prompt corrective measures to maintain high-quality services for people who inject drugs.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
    a. Business agreement/MOU with primary healthcare providers? ☐ Yes ☒ No
    b. Cooperative agreement/MOU with public health entity for testing and treatment? ☐ Yes ☒ No
    c. Established co-located SUD professionals within FQHCs? ☐ Yes ☒ No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Minnesota laws require licensed SUD treatment providers to provide client education and information on tuberculosis (TB) and tuberculosis screening and to report a known tuberculosis infection to the Minnesota Department of Health. Compliance is monitored by the Minnesota Department of Human Services Office of Inspector General's Licensing Division during licensing reviews.

For this purpose, DHS recommends the use of TB information materials produced by the Minnesota Department of Health (MDH). When checking the use of TB information during licensing reviews, it has been found that most licensed SUD treatment providers distribute the TB information recommended by DHS to fulfil these obligations.

Licensed SUD treatment providers must also agree to comply with the block grant requirements for ensuring clients have access to TB services through an assurance statement for receipt of block grant funds.

MDH closely monitors TB cases and publishes quarterly and annual reports to track trends and inform prevention and control efforts. Additional resources regarding TB and TB screening are available to all providers from MDH.

Early Intervention Services for HIV (For "Designated States" Only)

Not Required for Minnesota - Minnesota is not a designated state.

Follow WebBGAS instructions for states not required to complete this section.

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances (42 U.S.C.§ 300x-31(a)(1)(F))? ☒ Yes ☐ No

Criteria 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available,

identified gaps in service, and outlines the state's approach for improvement? ☐ Yes ☒ No

2. Has your state **identified a need** for any of the following:
   a. Workforce development efforts to expand service access? ☒ Yes ☐ No
   b. Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? ☐ Yes ☒ No
   c. Establish a peer recovery support network to assist in filling the gaps? ☐ Yes ☒ No
   d. Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? ☒ Yes ☐ No
   e. Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? ☐ Yes ☒ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered care? ☒ Yes ☐ No
2. Has your state **identified a need** for any of the following:
   a. Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services. ☒ Yes ☐ No
   b. Establish a program to provide trauma-informed care. ☒ Yes ☐ No
   c. Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. ☐ Yes ☒ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§300x-65, 42 CFR Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? ☒ Yes ☐ No
2. Does your state provide any of the following:
   a. Notice to Program Beneficiaries? ☐ Yes ☒ No
   b. An organized referral system to identify alternative providers? ☐ Yes ☒ No
   c. A system to maintain a list of referrals made by religious organizations? ☐ Yes ☒ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? ☐ Yes ☒ No
2. Has your state identified a need for any of the following:
   a. Review and update of screening and assessment instruments? ☒ Yes ☐ No
   b. Review of current levels of care to determine changes or additions? ☒ Yes ☐ No

c. Identify workforce needs to expand service capabilities? ☒ Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? ☒Yes ☐ No
2. Has your state identified a need for any of the following:
   a. Training staff and community partners on confidentiality requirements? ☐ Yes ☒ No
   b. Training on responding to requests asking for acknowledgement of the presence of clients? ☐ Yes ☒ No
   c. Updating written procedures which regulate and control access to records? ☐ Yes ☒ No
   d. Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure? ☐ Yes ☒ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☒ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§300x-52(a)) and 45 §CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.
   a. Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved

FFY 26/27
20

3. Has your state identified a need for any of the following?
   a. Development of a quality improvement plan? ☐ Yes ☒ No
   b. Establishment of policies and procedures related to independent peer review? ☒ Yes ☐ No
   c. Development of long-term planning for service revision and expansion to meet the needs of specific populations? ☒ Yes ☐ No
4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ☐ Yes ☒ No
   a. **If Yes,** please identify the accreditation organization(s)
      i. ☐ Commission on the Accreditation of Rehabilitation Facilities
      ii. ☐ The Joint Commission
      iii. ☐ Other (please specify) _____

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ☐ Yes ☒ No
2. Has your state identified a need for any of the following:
   a. Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ☐ Yes ☒ No
   b. Implementing MOUs to facilitate communication between Block Grant service providers and group homes to assist in placing clients in need of housing? ☐ Yes ☒ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have **an opportunity to receive** training on an ongoing basis, concerning:
   a. Recent trends in substance use disorders in the state? ☒ Yes ☐ No
   b. Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ☒ Yes ☐ No
   c. Performance-based accountability? ☐ Yes ☒ No
   d. Data collection and reporting requirements? ☒ Yes ☐ No

   If the answer is No to any of the above, please explain the reason.

   Minnesota does not currently have a performance-based accountability system but is exploring the possibility of one in the future.

2. Has your state identified a need for any of the following:
   a. A comprehensive review of the current training schedule and identification of additional training needs? ☐ Yes ☒ No
   b. Addition of training sessions designed to increase employee understanding of recovery support services? ☐ Yes ☒ No
   c. Collaborative training sessions for employees & community agencies' staff to coordinate and increase integrated services? ☐ Yes ☒ No
   d. State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ☒ Yes ☐ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

    a. Prevention TTC? ☒ Yes ☐ No

    b. SMI Adviser (*Formerly known as "Mental Health TTC")* ☒ Yes ☐ No

    c. Addiction TTC? ☒ Yes ☐ No

    d. State Opioid Response Network? ☒ Yes ☐ No

    e. Strategic Prevention Technical Assistance Center (SPTAC) ☒ Yes ☐ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 42 U.S.C. §300x-22(b), 300x-23, 300x-24 and 300x-28 (42 U.S.C. §300x-32(e)).

1. Is your state considering requesting a waiver of any requirements related to:

    a. Allocations Regarding Women (300x-22(b)) ☐ Yes ☒ No

2. Is your state considering requesting a waiver of any requirements related to:

    a. Intravenous substance use (300x-23) ☐ Yes ☒ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

    a. Tuberculosis ☐ Yes ☒ No

    b. Early Intervention Services Regarding HIV ☐ Yes ☒ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (42 U.S.C. §300x-28)

    a. Improvement of Process for Appropriate Referrals for Treatment ☐ Yes ☒ No

    b. Professional Development ☐ Yes ☒ No

    c. Coordination of Various Activities and Services ☐ Yes ☒ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.revisor.mn.gov/statutes/?id=245A
https://www.revisor.mn.gov/statutes/cite/245F
https://www.revisor.mn.gov/statutes/cite/245G
https://www.revisor.mn.gov/statutes/cite/245I
https://www.revisor.mn.gov/statutes/?id=254A
https://www.revisor.mn.gov/statutes/?id=254B
https://www.revisor.mn.gov/rules/?id=9530

[1] https://www.samhsa.gov/technology-transfer-centers-ttc-program

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Guidelines and resources for specific questions below (Narrative Question)

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> …….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.
>
> CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:
>
> - Crisis call centers
> - 24/7 mobile crisis services
> - Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.
>
> STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include Crisis Services: Meeting Needs, Saving Lives, which consists of the National Guidelines for Behavioral Health Coordinated System of Crisis Care as well as an Advisory: Peer Support Services in Crisis Care. There is also the National Guidelines for Child and Youth Behavioral Health Crisis Care which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with

serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment

should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (P.L. 116-172) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. **Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.**

Minnesota's crisis response system is comprised of multiple service lines and supports, designed to address the mental health needs of individuals across the state. A total of 37 mobile crisis teams serve both adults and children in all 87 counties, as well as 4 of the 11 tribal reservations. These mobile crisis services provide assessment, intervention, and stabilization in community-based settings, including individuals' homes, offering care outside of traditional clinical environments. Services are available statewide, 24 hours a day, 7 days a week.

As an extension of mobile crisis services, crisis stabilization is also offered in community settings to support individuals after the initial crisis intervention. Crisis stabilization seeks to return the individual to their pre-crisis level of functioning and facilitate their connection to ongoing care. This process usually spans from 30 to 45 days, based on medical requirements. When necessary, individuals may be referred to safer, more structured environments, such as emergency departments or residential crisis stabilization programs.

Minnesota currently has 32 licensed adult residential crisis stabilization programs, located across 12 counties and providing a total of 196 beds. These programs are partially supported through grant funding, which ensures access for uninsured and underinsured individuals, covers critical infrastructure costs, and supports additional services not reimbursable through Medical Assistance (MA).

In alignment with national efforts, Minnesota transitioned to using the 988 Suicide & Crisis Lifeline as of July 16, 2022. The 988 Lifeline Centers in Minnesota are specifically established to handle inquiries that come from area codes within Minnesota. Regional coordinators for suicide prevention are currently concentrating on raising awareness and encouraging use of the 988 system, which encompasses the crisis text line, as a vital resource for suicide prevention and mental health. They provide education and outreach to communities, emphasizing how to access immediate support and connect to local services.

Established local and tribal crisis hotlines continue to operate alongside the statewide 988 line, providing contact details for both adult and children's mobile crisis teams. These receive support from the Minnesota Department of Health (MDH) and the Behavioral Health Administration of the Department of Human Services, which work together to manage several initiatives that constitute the state's comprehensive and integrated crisis response system.

2. **In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.**
   - The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
   - The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on published guidance. This includes coordination, training and community outreach and education activities.
   - **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.

- **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.
- **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early implementation Less than 25% of counties	Partial Implementation - About 50% of counties	Majority Implementation- At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☒
Someone to respond	☐	☐	☐	☐	☐	☒
Safe place to be	☐	☐	☒	☐	☐	☐

3. Briefly explain your stages of implementation selections here.

Someone to Talk To: The 988 system has been fully implemented across Minnesota, and is funded through a telecommunication fee, similar to the 911 fee, to ensure long-term sustainability. The Minnesota Department of Health oversees four local 988 centers, three of which can also respond via chat or text messaging. This flexibility may contribute to the system's high in-state answer rate.

Someone to respond: Minnesota's mobile crisis response system assists individuals residing in the state's metropolitan and urban areas, encompassing a broad array of cultural backgrounds and geographic features. Mobile crisis teams provide both adults and children with critical, community-based mental health support in all 87 counties and 11 Tribal Nations. Local counties and Tribal Nations work in partnership with emergency responders and community stakeholders to ensure timely, effective response to individuals experiencing a mental health crisis. In some areas—especially those that are geographically isolated or have limited resources—response may involve collaboration with law enforcement or access to more restrictive settings to ensure safety and stabilization. Services are sustained through a combination of insurance billing, state grant funding, and the federal MHBG, with many communities and counties contributing local funding as well.

Place to go: Rural areas in Minnesota face distinct challenges in providing crisis stabilization services in walk-in settings. In many cases, individuals and families experiencing a mental health crisis must travel long distances to receive care, sometimes in restrictive environments far removed from their homes, communities, and support systems. Mobile crisis teams collaborate closely with Certified Community Behavioral Health Clinics (CCBHCs), the Minnesota Department of Health's Suicide Prevention Unit, and other key partners to connect individuals to the appropriate levels of care. Minnesota has a robust short-term residential stabilization network for adults and is exploring wider use of the short-term 23-hour mental health urgent care model. Some CCBHCs and other local community mental health providers have developed walk-in models, though availability of these

programs is not statewide. Minnesota is also in the research stage of developing residential stabilization service specifically for children.

4. **Based on the National Guidelines for Behavioral Health Crisis Care and the National Guidelines for Child and Youth Behavioral Health Crisis Care, explain how the state will develop the crisis system.**

Minnesota is currently most focused on the development of the "somewhere to go" phase of the crisis system. The state is engaged in research and development for a residential crisis stabilization service aimed at children. Additionally, a pilot program for adolescent mental health urgent care has recently been completed, with an ongoing evaluation process. Although certain regions in Minnesota offer reasonable access to mental health walk-in services, the overall system and network are not yet fully established throughout the state, particularly for children.

5. **Other program implementation data that characterizes crisis services system development.**

Someone to contact: Crisis Contact Capacity

a. **Number** of locally based crisis call Centers in state
    i. In the 988 Suicide and Crisis Lifeline network: 4
    ii. Not in the suicide lifeline network: NA
b. **Number** of Crisis Call Centers with follow up protocols in place
    i. In the 988 Suicide and Crisis Lifeline network: 4
    ii. Not in the suicide lifeline network: NA
c. Estimated **percent** of 911 calls that are coded out as BH related:

9% of referrals to crisis services come from law enforcement.

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

- **Independent of public safety first responder structures (police, paramedic, fire**): All 87 Counties out of 87 Counties and 4 tribes out of 11 tribes.
- **Integrated with public safety first responder structures (police, paramedic, fire)**: Many are but exact number is not tracked by DHS and changes over time.
- **Number that utilizes peer recovery services as a core component of the model:** Variable - all are able to include Peer Services as a mobile crisis component, but availability of certified peers makes this number very fluid.

Safe place to be

- **Number of Emergency Departments**: 123 (Source: MN Hospital Association)
- **Number of Emergency Departments that operate a specialized behavioral health component**: 3 EmPATH Units in MN, other BH component models not tracked by Minnesota Department of Human Services
- **Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis):** Not currently tracked by Minnesota Department of Human Services

6. **Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.**

The DHS Behavioral Health Administration is planning to use the 5% crisis set aside to address a variety of crisis service needs in Minnesota. Certified Community Behavioral Health Centers (CCBHCs) are a primary provider of mobile crisis services in Minnesota. CCBHCs often serve their whole county and frequently cover services in the surrounding area as well. Additionally, CCBHC's have the most well-developed walk-in crisis services available in the state. In order to further develop this system, Minnesota DHS and MDH have partnered to offer relationship-building site visits bringing together 988 centers, mobile crisis teams, and CCBHCs. We anticipate these relationship building efforts to continue throughout the next few years.

Proposed Activities:

- Funding to support one Full-Time Equivalent (FTE) staff position responsible for coordinating the implementation of action steps outlined in this application. This position will lead the research and development of a proposal to address stabilization separation within the current billing model and identify next steps for legislative and systems-level changes. Additionally, the position will explore the feasibility of the 23-hour walk-in model for crisis services in Minnesota and develop a proposal for consideration.

- Contract with a qualified consultant to support the continued development of an equitable funding formula for the Department of Human Services (DHS) to ensure equitable grant distribution across mobile crisis programs statewide.
- Contract with a qualified consultant to update and enhance DHS's online training materials and web-based modules related to mobile crisis services. In collaboration with DHS staff, this work will include content updates, platform functionality improvements, and efforts to increase user accessibility and ease of use.
- Competitive grant funding for crisis service providers to supplement, expand, and enhance existing crisis services, or to support the development of innovative crisis response models aimed at improving access and service delivery for Minnesota residents.
- Strategic planning consultant—Contract with a qualified consultant to support the mobile crisis policy team in developing a comprehensive strategic plan. This plan will outline the future direction of mobile crisis services and define their role within Minnesota's broader crisis response continuum.

7. Please indicate areas of technical assistance needs related to this section.

N/A

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of *health* (access to quality physical health and M/SUD treatment); *home* (housing with needed supports), *purpose* (education, employment, and other pursuits); and *community* (peer, family, and other social supports). The principles of a recovery-guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/orsubstance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope
- Recovery is person-driven
- Recovery occurs via many pathways
- Recovery is holistic
- Recovery is supported by peers and allies
- Recovery is supported through relationship and social networks
- Recovery is culturally based and influenced
- Recovery is supported by addressing trauma
- Recovery involves individuals, families, community strengths, and responsibility
- Recovery is based on respect.

Please see Working Definition of Recovery. States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care.

Technical assistance and trainingon a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the Recovery Support Services Table.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. **Does the state support recovery through any of the following:**
   a. Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
      ☒ Yes ☐ No
   b. Required peer accreditation or certification? ☒ Yes ☐ No
   c. Use Block Grant funds for recovery support services? ☒ Yes ☐ No
   d. Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system?
      ☒ Yes ☐ No

2. **Does the state measure the impact of your consumer and recovery community outreach activity?** ☐ Yes ☒ No

3. **Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.**

The Minnesota Department of Human Services utilizes state funding, Medicaid, and discretionary and block grant funding from SAMHSA to provide comprehensive, evidence-based recovery services. For those with SMI or SED this has included:

- Certified Family Peer Services
- Certified Peer Specialist Services
- Clubhouse services
- Peer-Led Support Groups
- Peer operated warmlines
- Housing support services
- Permanent Supportive Housing
- Homeless outreach programs

- Person-Centered Planning, and
- Culturally based recovery practices

4. **Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.**

The Behavioral Health Administration provides comprehensive recovery and recovery support services through the following approaches. These are provided through RCOs or licensed treatment providers.

Service Expansion and Access

- Increase the capacity of the Behavioral Health Administration to provide comprehensive, personalized services to pregnant and parenting women with Substance Use Disorder (SUD) or Opioid Use Disorder (OUD) and co-occurring mental health conditions
- Expand capacity to provide these services to all populations of need
- Inform individuals with SUD or OUD and co-occurring mental health conditions about direct access to qualified behavioral health care services providers

Recovery Support Services

- Provide recovery support services including housing, transportation, job training, employment assistance, and food security
- Offer peer recovery services in all stages of treatment and recovery from SUD or OUD and co-occurring mental health conditions
- Support linkage to personalized community resources for individuals with SUD or OUD and co-occurring mental health conditions

Community-centered and Training

- Provide population specific and linguistically adequate substance use treatment and recovery services
- Train peers who belong to the same population of need as the individuals receiving behavioral health care services

5. **Does the state have any activities that it would like to highlight?**

In 2023, the Behavioral Health Administration held a SUD Summit to support the SUD community and identify best steps to support recovery in our community. This summit was widely attended by providers, families, people who experience substance use, tribal partners, county partners, and managed care organizations. Following the summit, we established a community of practice that has been ongoing since the event to continue ensuring the voice of the community is heard in our recovery efforts.

Additionally, the Behavioral Health Administration implemented ASAM (American Society of Addiction Medicine) standards in our state law to ensure access to the most appropriate level of care.

Moving forward, the Behavioral Health Administration plans to invest resources in an

integrated training program that supports certification of individuals who may have lived experience with substance use disorder or a mental health condition. This integrated training will provide peers with greater knowledge about working with populations with Substance Use Disorder (SUD) and co-occurring mental health conditions.

6. **Please indicate areas of technical assistance needs related to this section.**

Not applicable.

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD

[1] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children — United States, 2005-2011. MMWR 62(2).
[2] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593–602.
[3] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.
[4] The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

Please respond to the following:

1. Does the state utilize a system of care approach to support:

a. The recovery of children and youth with SED? ☒ Yes ☐ No

b. The resilience of children and youth with SED? ☒ Yes ☐ No

c. The recovery of children and youth with SUD? ☒ Yes ☐ No

d. The resilience of children and youth with SUD? ☒ Yes ☐ No

[5] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM

2. **Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs**

   a. Child welfare? ☒ Yes ☐ No

   b. Health care? ☒ Yes ☐ No

   c. Juvenile justice? ☒ Yes ☐ No

   d. Education? ☒ Yes ☐ No

3. **Does the state monitor its progress and effectiveness, around:**

   a. Service utilization? ☒ Yes ☐ No

   b. Costs? ☒ Yes ☐ No

   c. Outcomes for children and youth services? ☒ Yes ☐ No

4. **Does the state provide training in evidence-based:**

   a. Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No

   b. Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No

5. **Does the state have plans for transitioning children and youth receiving services:**

   a. to the adult M/SUD system? ☒ Yes ☐ No

   b. for youth in foster care? ☒ Yes ☐No

   c. Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ☒ Yes ☐ No

   d. Is the state providing trauma informed care? ☒ Yes ☐ No

6. **Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)**

Minnesota has developed a comprehensive System of Care approach that coordinates services across multiple systems to serve children and youth with complex mental health needs and their families. The vision for the Minnesota System of Care for Children's Mental Health is to create a coordinated network of effective, community-based supports and services designed to meet the needs of children, youth, and young adults with serious mental health challenges, and their parents and caregivers. This initiative focuses on services that are culturally responsive, family driven and youth guided, representing a fundamental shift toward collaborative, integrated service delivery.

Wraparound Services and Intensive Coordination form the cornerstone of Minnesota's integrated approach. Wraparound is a type of intensive, individualized care coordination involving a team process that wraps services, supports and resources around a child or youth with a severe emotional or behavioral disorder to meet goals set by the team. Wraparound focuses on collaboratively serving those children and youth with complicated issues who are involved with multiple service systems and often at risk of out-of-home placement. Additionally, Collaborative Intensive Bridging Services (CIBS) is an intensive treatment program designed to serve children ages 6 to 17 and their families in circumstances where community-based services have not been sufficient to meet the child's safety and mental health.

Educational and School-Based Integration represents a critical component of the coordinated system. School-linked behavioral health services connect or co-locate effective behavioral health services with schools and students at the local level. This project has proven particularly effective in reaching children who have never accessed behavioral health services. The SBHC model is an evidence-based approach for delivering health education, care and support to children and adolescents through coordinated and youth-centric environments. The Minnesota State Interagency Coordination (MnSIC) system planning initiative helps local school and county boards establish a coordinated service system to support these efforts.

Child Welfare and Juvenile Justice Integration ensures coordinated responses across legal and protective systems. The Children's Justice Initiative is the collaboration between the Minnesota Judicial Branch and the Minnesota Department of Human Services. The purpose of the initiative is to improve the processing of child protection cases and the outcomes for abused and neglected children. The local social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability.

Substance Use Disorder and Mental Health Integration addresses co-occurring conditions through coordinated treatment approaches. Minnesota provides integrated dual disorders treatment for situations when mental illness and substance use disorders occur together, using specific approaches to address both conditions simultaneously. Youth ACT or Intensive Rehabilitative Mental Health Services (IRMHS) serve youth ages 16 through 20 with serious mental illness or both mental illness and substance abuse disorders through multidisciplinary teams.

Structural Coordination and Future Development continues to evolve through new organizational approaches. The Department of Children, Youth, and Families is working to better coordinate and resource systems serving children and youth, with programs transferring from multiple departments (Human Services, Education, Health, and Public Safety) between July 2024 and July 2025. This integrated approach emphasizes family-driven, youth-guided, culturally responsive services delivered in community-based settings, recognizing that children with complex needs require coordinated rather than fragmented services across multiple systems.

Local Children's Mental Health Collaboratives were established by the 1993 Minnesota Legislature in recognition that children with or at risk for severe emotional disturbances often require services from multiple systems. Since no single agency can assume sole responsibility for providing services that are effective, non-duplicative and less fragmented in every circumstance, a network of child-serving agencies in which the family was a full partner was needed. There are currently 89 Children's Mental Health & Family Services Collaboratives, including:

- 8 Children's Mental Health Collaboratives,
- 42 Family Services Collaboratives, and
- 39 Integrated Children's Mental Health and Family Services Collaboratives.

7. Does the state have any activities related to this section that you would like to highlight?

Early Childhood Mental Health Capacity Grants- Identifying difficulties early, before age 6, and providing families with the proper assessments and interventions can make a difference in a child's earliest years and for many years thereafter. DHS awards competitive grants to mental health providers to provide early childhood mental health services in Minnesota. There are two core components of the Early Childhood Mental Health (ECMH) grant program: 1) providing appropriate clinical services to young children and their families who are uninsured or underinsured, 2) increasing the clinical competence of clinicians across the state to serve children birth through five and their parents by training them in evidenced-based practices around assessment and treatment of young children. The State has reissued the request for proposals in this area and now has 31 grantees and subgrantees that cover all 87 counties within the State.

Early Childhood Mental Health Consultation- The State is supporting the professional development of mental health professionals providing mental health consultation to early childhood professionals (childcare, school, child welfare, public health etc.) who are serving young children. The mental health consultation prevents the suspension and expulsion of young children from care and increases staff morale for those allied professionals serving those young children.

Fetal Alcohol Assessment and Treatment – The State has identified the need to increase provider capacity to competently assess and treat children ages birth to 21 who have symptoms of Fetal Alcohol spectrum disorder (FASD). As the symptoms often mirror those of other neurodiversity diagnoses but do not respond well to the same treatments for other neurodiverse diagnoses, the State will be providing more targeted training for providers to grow the number of FASD clinics and also train clinicians in an evidence-based intervention to ameliorate the impact of the disorder on the child's functioning.

School-linked mental health services - These grants provide funding to community mental health agencies that place mental health professionals and practitioners in partnering schools to provide mental health services to students. These mental health providers also consult with teachers, provide care coordination, and offer classroom presentations and school-wide trainings. Under this program, 60 behavioral health provider agencies partner with 1,290 school sites across 323 districts to support students, teachers, and families. This includes 43 of the 46 independent school districts located in the seven-county metro area and 234 of the 279 independent school districts located in Greater Minnesota.

Children's Evidence-Based Practices Grants – These grants are awarded to mental health provider agencies serving children and youth for strengthening the clinical infrastructure. The grants are used to provide training and consultation to practicing mental health providers in the use of treatment strategies.

Minnesota Student Survey - The Minnesota Department of Education, the Minnesota Department of Health, the Minnesota Department of Human Services, and the Minnesota Department of Public Safety conduct the Minnesota Student Survey to inform policy and to develop and implement effective, evidence-based prevention and intervention strategies. The Minnesota Student Survey is administered every three years in public elementary and secondary schools, public charter schools, Tribal schools, and juvenile detention centers.

Adverse Childhood Experience grants - This program provides training to Children's Mental Health and Family Services Collaboratives on the impact of ACEs (Adverse Childhood Experiences), brain development,

historical trauma, and resilience.

Collaborative Psychiatric Consultation Service - The Psychiatric Consultation Service offers a phone line for health care professionals to help determine the most appropriate medication for children and youth struggling with mental illness.

Mental Health—Targeted Case Management Mental Health – Targeted Case Management assists recipients in gaining access to needed educational, health, legal, medical, social, vocational and other services and supports. The four core components are assessment, planning, referral/linkage and monitoring/coordination.

Screening in child welfare and juvenile justice systems - Grants to child welfare and juvenile justice agencies help them provide mental health screenings to children receiving child protective services or those in out-of-home placement; children for whom parental rights have been terminated; children found to be delinquent; children in juvenile detention; and certain children in trouble with the law.

Children's mental health screening grants - Children's mental health screening grants integrate mental health screening into current practice, promote the use of effective and efficient mental health screening instruments, facilitate referral of children for diagnostic assessments, and make funds available for screening and uncompensated mental health services.

Positive Community Norms – DHS, through the Behavioral Health Division, funds Positive Community Norms grants to strengthen the collaboration between community entities to reduce substance use and opioid use among youth. Every responder to the RFP is expected to strengthen and expand an existing or newly formed Alcohol, Tobacco and Other Drug (ATOD) community prevention coalition by increasing the number of members of the coalition. Responders to the RFP must have a clear vision and mission statement, bylaws, and their own strategic plan for reducing substance use and opioid use among youth in their local communities. For this purpose, a coalition is defined as a formal arrangement for the purpose of cooperation and collaboration between groups or sectors of a community in which each group retains its identity, but all agree to work together toward a common goal of building a safe, healthy, and drug-free community.

Bright Bound: Building on the success of the LifeSkills Training Project (LST), DHS developed the Bright Bound Program as the next step in youth substance use prevention. Aligned with the 2024 Minnesota Statutes §120B.215, Bright Bound will use a curriculum developed by Emily's Hope Inc. Once implemented, it will equip students with practical life skills to make healthy, substance-free choices—furthering Minnesota's commitment to prevention and student well-being.

8. Please indicate areas of technical assistance needs related to this section.

No needs at this time.

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. **Have you updated your state's suicide prevention plan since the FY2024 – 2025 Plan was submitted?**

   ☒ Yes ☐ No

2. **Describe activities intended to reduce incidents of suicide in your state.**

The 2023-2027 Minnesota State Suicide Prevention Plan, which is developed, implemented, and evaluated by the Minnesota Suicide Prevention Taskforce with support and coordination from the Minnesota Department of Health (MDH), calls for a comprehensive approach to suicide prevention. This includes improving infrastructure, increasing collaboration, and building capacity for local communities to work in upstream prevention, early intervention, crisis intervention, and postvention (support after a death by suicide). The State Plan outlines two main goals: 1) Improve, expand, and coordinate the suicide prevention infrastructure in Minnesota, and 2) Prevent Minnesotans from having suicidal experiences and improve the lives of all those who are struggling, so they know they are not alone, help is available, and healing is possible.

In support of these two main goals, the State Suicide Prevention Plan includes 6 goals with specific objectives and strategies to be implemented by the Minnesota Department of Health- Suicide Prevention Unit, Minnesota state agencies, Minnesota Suicide Prevention Taskforce, Community Grantees funded by MDH-Suicide Prevention Unit, and local communities. They include:

- Increase individuals, organizations, and communities' capacity to develop and implement a comprehensive public health approach to prevent suicide.
- Promote factors that offer protection from suicidal experiences across the individual, relationship, community, and societal levels.
- Identify and support individuals who are experiencing mental health challenges or who are having suicidal experiences.
- Strengthen access and delivery of care for mental health and suicide.
- Connect, heal, and restore hope to those impacted by suicide.
- Improve the timeliness and usefulness of data.

Annual action plans assist with the implementation of these goals, objectives, and strategies. The action plans provide the state agencies, MDH-Suicide Prevention Unit and Minnesota Suicide Prevention Taskforce a detailed plan to move the strategies laid out within this plan. The actions taken because of this plan are evaluated utilizing both qualitative and quantitative data, allowing the opportunity to provide any mid-course corrections along the way.

3. **Have you incorporated any strategies supportive of the Zero Suicide Initiative?** ☒ Yes ☐ No

4. **Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments?** ☐ Yes ☒ No
   If yes, please describe how barriers are eliminated.

5. **Have you begun any prioritized or statewide initiatives since the FFY 2024 – 2025 Plan was submitted?** ☒ Yes ☐ No

   If so, please describe the population of focus:

The Minnesota Department of Health, grantees, and partners have worked to build the skills and confidence of Minnesotans to recognize signs of suicide risk and mental health struggles, and to compassionately intervene with their loved ones and people in their community. Significant efforts have been made in the past two years to educate the public and raise awareness about 988 and normalize discussions about mental health. Through the establishment of the Suicide Prevention Training Network, Minnesota is expanding the training capacity across the state. Suicide Prevention Regional Coordinators and comprehensive suicide prevention grantees are building and equipping local networks to increase suicide prevention community coordination, while efforts such as the Zero Suicide and Pathway to Care cohorts encourage the adoption of organizational best practices for suicide prevention in hospital and behavioral health systems, schools, and communities. MDH staff and 988 Minnesota Lifeline Centers are working to implement a multi-agency system of care and support.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information

regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.

- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?

   ☒ Yes ☐ No

2. Has your state identified the need to develop new partnerships that you did not have in place?

   ☒ Yes ☐ No

If yes, with whom?

The Minnesota Department of Human Services (DHS) has identified the need to partner with the Minnesota Department of Education (MDE) and local schools to address young people's mental health and substance use disorder and prevention and treatment needs in the schools. Recent federal legislation, guidance, and State Plan Amendment approval from the Centers for Medicare and Medicaid Services have expanded opportunities to use Medicaid funding for behavioral health supports in educational settings, building upon existing programs available in many, though not all, school environments. DHS and MDE have established a collaborative team to support and guide schools in maximizing new and emerging Medicaid opportunities. This

partnership helps schools utilize funding strategically to expand services while maintaining compliance with Medicaid requirements and ensuring program integrity.

DHS, working in close partnership with the Department of Corrections (DOC), has submitted a Section 1115(a) Reentry Demonstration Waiver application that seeks to improve health outcomes, reduce deaths, decrease recidivism rates, and address related disparities for people who have been incarcerated. If approved, Minnesota will achieve this by providing a set of Medicaid covered services in certain jails and prisons to eligible participants who are within 90-days of release. Initially, the program will be limited to three prisons and five jails. All people in these settings will be screened for SUD, mental health, and medical conditions to determine whether they need additional assessment. Having an assessed need is one of the criteria to receive services covered by the waiver. Reentry services are covered fee-for-service. In some jails and prisons, carceral staff will provide the service and the setting will be the Medicaid enrolled provider. In jails and prisons, all or some waiver services may be furnished by community providers. The flexibility of this design is necessary due to the unique nature of the settings and variation in provider capacity throughout the state. All providers serving participants must meet all state licensing and credentialing requirements and enroll as a Minnesota Medicaid provider. Following release, participants have access to the full Medicaid benefit set and may receive services from any qualified provider based on their coverage.

The State is building stronger partnerships with local juvenile detention centers to ensure continuity of care and appropriate discharge planning for youth who qualify as seriously and emotionally disturbed. This partnership effort will mirror the efforts in the Model Jails program for adults Supporting Children of Incarcerated Parents - MN Dept. of Health.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Minnesota uses the ASAM level of care system to ensure that SUD treatment is provided at the right level of care for the right amount of time. The Minnesota Department of Human Services (DHS) trains and monitors SUD providers to ensure they are correctly providing the right level of care. Peer support services and recovery housing are supported by DHS to ensure the people have additional supports outside of a treatment setting.

The Minnesota Department of Human Services (DHS) supports local county social services with their responsible for conducting and coordinating case management for adults with SMI and children with SED to ensure mental health services are provided efficiently, effectively and within a person's community in non-residential settings whenever possible based on each person's level of care needs. DHS supports a broad statewide system of Certified Community Behavioral Health Centers, Community Mental Health Centers, and other outpatient services and clinics. Assertive Community Treatment for adults with SMI) and Youth Assertive Community Treatment/Intensive

Rehabilitative Mental Health Services for children with SED provide 24/7 intensive multidisciplinary team services to ensure that children and adults can continue to live in their homes and outside of institutional settings. DHS also supports a robust system of Mobile Crisis Services to prevent hospitalization of persons experiencing a mental health crisis.

New efforts with juvenile detention will ensure that youth with an SED diagnosis who are being discharged from the juvenile justice system have the continuum of mental health services they need to thrive in the community and to prevent recidivism. This process will include consultation by the State or a State-selected entity with detention center staff when youth are in the process of being released to ensure mental health needs are planned for when they are back in the community. Like Model Jails, this work will include juvenile detention staff gathering at least quarterly to share statewide resources, identify gaps in the children's mental health continuum of care, and plan system improvements that are needed to serve youth who qualify as SED and are justice involved.

Through the development and implementation of Minnesota's 1115 Reentry Demonstration waiver, the Department of Human Services (DHS) has established unprecedented cross-sector partnerships that strengthen the state's reentry into the community after incarceration infrastructure. This will ensure people will receive the necessary mental health and substance use disorder treatment to prevent the need for residential treatment or hospitalization.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.