MINNESOTA
OLMSTEAD
IMPLEMENTATION OFFICE

Redacted Survey Responses: Crisis Services

These survey responses have been redacted to exclude personally identifying information.

Responses about all crisis services goals

- The crisis services goals appropriately focus on helping people remain in their communities after a crisis. However, maintaining stability before a crisis occurs is equally important. Family Residential Services homes are among Minnesota's most integrated and individualized residential options for people who require daily support. When these homes become unstable due to funding changes that do not reflect actual support needs, individuals are more likely to experience placement disruption that can lead to crisis-level transitions. Strengthening community stability through funding structures that align with assessed needs would better support the intent of the Olmstead Plan and reduce reliance on emergency and institutional services.
- The current Crisis Services goals are directionally positive, but they are structurally too weak to produce measurable change. They rely heavily on training, coordination, and post-event data collection, which are reactive mechanisms. That approach will not prevent institutional placement or crisis escalation in a meaningful way. The core issue is that the framework is not prevention-driven enough, and it lacks enforceable standards. “Cross-training” and “collaboration” are not substitutes for operational requirements, service timelines, or accountability when systems fail. Without enforceable expectations, these goals risk becoming administrative activity rather than performance improvement. A stronger model would prioritize prevention-first design: defined service access timelines, mandatory early intervention triggers, and clear requirements that crisis supports must be delivered in the least restrictive, fully accessible setting at the first point of contact. If the system cannot meet that standard, the failure should trigger immediate corrective action-not retrospective reporting. There is also a significant gap in disability-specific system design. Crisis services are currently framed as universal, but “universal” in practice often means generic. For Deaf and DeafBlind individuals in particular, generic crisis response is not functionally equivalent access. Prevention must include pre-established, disability-specific pathways that are ready at the point of need, not improvised during crisis. Minnesota State Academies represent an underutilized structural asset in this space. A prevention-focused system should formally integrate specialized educational and communication expertise into early intervention pathways, rather than

defaulting to generalized crisis systems that may lack communication competence. The current framework does not clearly leverage that kind of specialized capacity in a systematic way. Finally, neutrality in communication access is not neutral in outcome. When systems do not explicitly prioritize effective language access-particularly American Sign Language for Deaf individuals-the result is predictable inequity in safety, education, and crisis outcomes. This is not a matter of preference; it is a question of functional access and risk prevention. In summary: the goals need to shift from coordination and reporting to enforceable prevention, from generalization to disability-specific system design, and from reactive crisis management to upstream structural prevention with measurable accountability.

- The crisis services goals recognize the importance of helping people remain in their communities after a crisis, but they do not address how funding stability helps prevent crises from happening in the first place. Family Residential Services homes provide individualized, integrated placements that often reduce the need for emergency interventions. When providers must make placement decisions based on financial viability rather than person-centered planning, the risk of disruption increases. Maintaining funding structures that reflect assessed support needs helps preserve stable community placements and supports the intent of Minnesota's Olmstead Plan.
- These goals rely on a broken system and siloed services to address the problem. I am certain that individual families want crisis services to be available. However, I am also certain they would prefer supports and services that meet their on-going needs PRIOR to the mental health crisis.
- Focusing on training professionals helps the professionals do their job with more compassion. However, in absence of supports in place to meet the ongoing 24/7 needs that families have in caring for children with complex needs little will change.
- Everytime I went it was a self improvement go ahead. But they were not ready for the animal that was on his way that knew more in every sense from life experience and also schooling!
- The goals for this Olmstead Plan are simply following the natural trajectory of improvement and are not aspirational. The mission of the Olmstead Plan is supposed to provide actual growth and improvement in the lives of PWD and this plan misses the mark completely.
- No
- I am not sure what will be included in the definition of institutional placements for the purpose of this goal and the associated data tracking. For example, will it only include settings like PRTFs, or will it include shelters, group homes, residential treatment, boarding in hospitals, juvenile detention centers, hotel crisis respite. We would advocate for the definition to include everything previously listed, essentially anything that is not in a typical home setting. Feedback submitted by (redacted), Office of the Foster Youth Ombudsperson (OOFY)
- Throwing money at a situation will not get you where you want to be.
- Throwing money at a situation will not get you where you want to be.
- see above.

- I have no idea if this goes under crisis services or health and services (probably both) but DHS needs to end the ban on receiving ACT services and waivered services at the same time. The idea that ACT services are inherently duplicative of waivered services (or vice versa) is absurd, particularly because a) most waivered service providers who provide 24-hour emergency assistance or other crisis services do not take clients with psychiatric issues and b) ACT services will not help with things like homemaking/PCA services. The criteria of what needs are so extensive that you can get waivered services on top of ACT are so vague as to be useless, and telling people to "consult their case manager" is useless when your case manager is brand new and doesn't know anything. I guess if you have significant physical disabilities on top of SMI, there's a clearer line, but my experience with parsing "neurodevelopmental disability" from "SMI" needs is that the evaluator will just lump all my needs in whatever category makes me ineligible for the services they're evaluating for.
- These goals rely heavily on the "knowledge deficit fallacy"-the assumption that children and adults are institutionalized because caseworkers lack training, compassion, or best-practice guides. This is a fundamental misdiagnosis of the problem. Disabled Minnesotans are institutionalized due to a severe structural vacuum in community capacity, restrictive funding architectures, and high administrative friction for early intervention supports. Furthermore, using a "data-gathering phase" as a reason to delay setting targets for mobile crisis outcomes is an unacceptable administrative stall. Overall, these goals are designed to generate compliance paperwork and administrative churn rather than shifting power, resources, and actual infrastructure into the community. Until the Olmstead Plan mandates hard capacity-building and measures the system's failures rather than just individual acuity, it is planning for the status quo.
- Educate, support, each county shoukd have same rules and funding not "at their discretion"
- Crisis has not been common, but better services and evaluation would be helpful.
- Data needs to be collected for clients who use different modes of communication, different needs of communication. In terms of deciding Crisis Services, they need an interpreter there. There's something about removing the bias of things and they just nod along. Have what they understand written down so you know what they understand. CDI's Certified Deaf Interpreters for court proceedings. Diversion Procedure. There was a time when it was important to bring a certified deaf interpreter. Considering children who may be forced to learn oralism rather than learning or being paired with other children who are deaf. In terms of leaving the county, if they are staying within a certain area, they could maybe be moved to another county that could support their situation if there are more resources available. Having additional resources to move people around as needed would be helpful.
- Disability Systems Change Council (p11 under Measurable goals and strategies) -- there is NOTHING on the home and community based services that make the rest even possible. Under "tracking progress" (p14) they talk about percentages of increase or decrease. Singe digits? Then the claim: "This target reflects changes that DCYF can realistically make." "Discipline" (p18) means suspension longer than 10 days, or expulsion...but not reducing or eliminating

restraint. Later on in the document (p22), they refer to “restrictive procedures” -- but do not specifically address restraint. After reading this far, WTF is the Disability Systems Change Council for exactly? Looks like the OIO already decided on everything. Another charade like the WRAC committee, true to (redacted) past behavior. Abuse & Neglect research and goals pertain ONLY to facilities, not home environments and not group homes. NO mention of fortifying Adult Protection to become useful at all and NO mention of the catch-22 in Child Protection when families are not given sufficient funding for the HCBS supports. MDH will “Continue to train health care and other service providers about identifying and reporting abuse and neglect” -- which is absolutely stupid when NOTHING USEFUL ACTUALLY COMES OF IT. The trainers and trainees get more money, but the people get nothing. Housing Universal Design standards (p32) says nothing about those with Chemical Sensitivities who are homeless bc of construction toxins, shared ductwork and previous tenancies destroying the air quality with their substances. Also loans for “improvements” if you already own, but no loan opportunities for NEW home owners. They want us to rent and be under the thumb of landlords. Transportation (start p 34) NO Rideshare access. More unnecessary research for “potential approaches.” That money could be spent on ACTUAL RIDES. A whole bunch of “MnDOT is working to confirm targets and baseline data.” Why is MNDOT doing it themselves and not surveying the people to see what's needed? And then cost of transportation will go up under this plan with “updated rates would also more closely match the actual cost of providing services.” Sounds like the state will not be subsidizing, which means a greater disability tax gap for us to foot. Anoka Metro Regional Treatment Center (AMRTC) p 40 -- NO mention of home and community based supports being a solution. A mention of “Increase access to peer support across all service areas”...are they going to pay people with disabilities or are they expecting us to do more volunteer work? Crisis service (p48): “DHS recommends that in the future, this goal counts voluntary residential treatment as “staying in community.” They are trying to pawn off an idea that is not, in fact, “in the community.” Community Employment (p50) - “If someone makes $600 or more per month, they are counted as having CIE. If someone makes $599 or less per month, they are counted as having non-competitive employment.” It says NOTHING about the hourly wage or how many hours. This is a stupid way to assess competitve employment. Competitive employment is GETTING A JOB AGAINST AN ABLED PERSON -- COMPETEING WITH AN ABLED PERSON FOR THE SAME JOB. They are passing off a definition that is not correct. They are also talking about allowing “subminium wages” after all the advocacy and new laws. “DHS is working on getting data that will show the number of people who have CIE” (p51) means that we're spending more money on a researcher instead of actually holding these job brokers/coordinators accountable for the already high rates they get. Councils and Advisory Boards (p61): “Minnesota is in the process of redesigning advisory councils to come into compliance with federal regulation (Access Rule). It is reforming the Medicaid Advisory Council and establishing an Interested Party Advisory Council. -- all these councils to pretend like they are engaging stakeholders. It's a ruse. Mechanical Restraints (p62) -- NOT physical restraint, NOT chemical restraint. ONLY “mechanical.” Restraint should be addressed without an

adjective/qualifier. Segregated settings to integrated settings (p65) -- again no mention of home settings or group home settings as being “segregated.” If a person can't leave their home or group home in a self-directed fashion, it's segregated. Lots of consultants are being paid! (p66) to do more nothing useful. This money could be used to fund proper levels of care in HCBS settings instead of consultants. Community Engagement -- Telling us what we want to hear, but likely not to deliver bc of history of leadership. “Community engagement is accountable when there is full transparency with participants (p68) , “During engagement, facilitation must fit the needs of the community...We prioritize leading with a spirit of co-creation and honoring the community's feedback.” (p69) -- We are being fed a line of BS right now. I personally won't believe it until (redacted) no longer serves in or for a state agency and until the program designs actually support the people. “Community engagement is core to OIO's work” (p70) and yet, their procedures are exclusive, the agency representatives don't follow through meaningfully with solutions. they say “surveys will focus on quality of life for people in segregated settings...and that doesn't include everyone who is segregated. Agency Connect (p71) “OIO will track state agencies' timeliness and responsiveness” -- but not the quality of the responses. Remove (redacted). Her role on the OIO is a HUGE CONFLICT OF INTEREST to oversee this plan having been the former director of DHS Aging & Disability Services. She threw us under the bus many times during her time at DHS, namely with the Waiver Reimagine's MnChoices Assessment and Budget Methodologies. More: - No mention of Waiver Reimagine even though HSRI's own data projects people facing average $34,644 budget cuts and many will face 50-80% reductions concentrated in home and family living settings. - An independent legal analysis already in the Minnesota Senate record (O'Meara Wagner, P.A., SF 4512, April 12, 2026) written by the same attorney whose prior litigation CREATED Minnesota's Olmstead Plan identifies Waiver Reimagine as illegal under the ADA, Olmstead, and federal Medicaid law. The 2026 plan does not mention it. - Minnesota is misclassifying 5-6 person congregate settings that meet the DOJ's definition of mini-institutions as participants' “own home.” Every community integration statistic the state reports is built on miscoded data and a definition that is wrong. - No budget adequacy standard and nothing requiring that waiver budgets actually be sufficient to sustain community living. - No home care staffing or nursing goals even though nursing and DSP vacancies represent 10-15% of ALL job openings in the state. You cannot access employment, housing, or community life if there is no one to help you perform ADLs in the morning. MN leads the nation in nursing homecare shortages. Goals without access consideration are unattainable. -The public comment process itself routes feedback through a filtered anonymous Formstack survey with text boxes and checkboxes. Also, the Olmstead Plan needs to clearly define what “supports” means. We demanding tangible supports: direct and indirect, formal and informal. Supports should be meaningful to the individual and their family if they choose. Undefined terms create enforcement gaps and leave too much room for narrow interpretation and cost-shifting onto families.

- Qualitative Interviews in addition to tracking numbers of people so can understand where there are gaps

- The DSCC should focus on rebuilding a disability support system based on actual access to services rather than paper authorizations and administrative metrics. Minnesota's disability system is increasingly dependent on unpaid caregiver labor, fragmented services, and crisis-driven responses while families struggle to access staffing, nursing, behavioral supports, transportation, and continuity of care. The council should prioritize: - measurable access standards, - workforce stabilization, - continuity-of-care protections, - transparent reporting of unmet service needs, - and alignment with the actual integration requirements of Olmstead rather than administrative definitions of compliance. True transformational change requires addressing the operational failures that are destabilizing disabled Minnesotans and their families across nearly every service system.
- We need go professionals to provide services. It's hard work.

Crisis Services Goal 1

- Crisis intervention supports for dual diagnosis (substance use and mental health disorders) that do not have to rely on corrections involvement to enforce or compel treatment and supports. Including options for families that are unsafe maintaining their children in their homes.
- A more effective approach is to replace broad training and coordination language with enforceable service standards, clear accountability, and measurable outcomes. The current strategy risks becoming another layer of process without changing real-world placement decisions. First, prevention must be defined as a time-bound requirement, not a goal. When a child is identified as at risk, there should be mandatory response timelines for in-home and community-based services. If services cannot be delivered within those timelines, the system must escalate immediately to ensure capacity is created or redirected-no open-ended waiting lists. Second, shift from “cross-training” to enforceable competency standards for providers and caseworkers. Training alone has limited impact unless it is tied to demonstrated ability to deliver appropriate interventions, including disability- and communication-access-informed practice. Accountability should be built into contracts and licensing expectations. Third, require real-time tracking of placement prevention outcomes, including why institutional placements occur when they do. If placements are due to service gaps, those gaps should trigger corrective action plans with deadlines, not just reviews. Fourth, streamline interagency coordination to eliminate duplication and administrative delay. The focus should be fewer handoffs, clearer decision authority at the case level, and faster authorization of services. Efficiency should be measured by speed of support delivery, not number of programs involved. Fifth, government-to-government coordination with Tribal Nations should respect sovereignty and remain collaborative, with opt-in technical assistance and shared outcomes reporting when requested. The system should avoid duplicative mandates while ensuring equitable access to resources when Tribes choose to engage. Overall, the plan should prioritize speed of service delivery, enforceable accountability, and measurable prevention outcomes. If a strategy cannot

demonstrate reduced time to support and reduced institutional placements, it should be redesigned or removed.

- Given that the focus of this goal is addressing the high rates of institutional placement for children and youth in foster care, I am confused why there is a focus on a “juvenile justice” mental health continuum of care. Also some youth in foster care are involved with juvenile justice, we need a broader coordinated support system to try to prevent mental health crises for youth involved in child protection and foster care, and to support them when crises happen. In order to truly impact the rates of institutional placements for this specific population of youth in this goal - children and teens in foster care - we need strategic, targeted efforts to increase the availability of non-institutional placements for these children. This might include targeted expansion of the MITH program, or other efforts to increase the options of family settings that are prepared to meet the needs of foster youth.
- This goal lacks the pro-active component! Having worked in child protection, I can say that almost all families involved consist of 1 or more individuals with unmet needs in regard to a diagnosis or disability. If services and supports were more accessible to ALL Minnesotans, we could be preventing mental health crises.
- Almost every single action step here relies on “training,” “educating,” “cross-training,” or “creating best practice guides.” This is a systemic flaw, assuming the primary driver of youth institutionalization is a knowledge deficit among caseworkers and youth providers. It isn't. It is a resource vacuum. You can train staff on early intervention and “compassion” all day long, but if the local community supports have a two-year waitlist or if provider reimbursement rates are too low to sustain a workforce, that child is still going to an institution. Replacing structural capacity with staff training does not fulfill the Olmstead mandate. DYCF's strategy #1 is to help juvenile justice facilities and staff “respond to mental health crisis” via a continuum of care and trauma-informed training. Making a juvenile justice facility slightly more tolerable for a disabled youth is not Olmstead compliance. The Olmstead mandate is integration and prevention. If a youth is in a juvenile justice facility receiving this “better” crisis response, the system has already failed. This strategy needs to focus on systemic diversion AWAY from the juvenile justice system entirely. Where are the action steps for non-law-enforcement mobile crisis teams? Where is the infrastructure to ensure disability-related behavioral crises aren't criminalized in the first place? DYCF's strategy #2 states that the trainings will “emphasize early intervention and compassion.” Compassion is a feeling, not a funded mandate. Families don't need caseworker compassion; they need frictionless access to services. The strategy should focus on reducing the administrative friction required to secure in-home supports. The state admits families say they “could not get the right supports early enough.” The barrier usually isn't that they didn't know about them-it's that the bureaucratic hurdles to access them are impossibly high, especially when parents are already burning out. WHAT'S MISSING: The Economics of Placements There is zero mention of funding mechanics, waiver capacity, or provider infrastructure. Why do counties often default to institutional placements? Often because it is the path of least administrative resistance, or because the financial architecture

incentivizes it. Cobbling together highly customized, 24/7 wrap-around community care requires a robust workforce that currently doesn't exist because of how the state structures its funding. There needs to be a strategy to expand waiver capacity, streamline the financial approval process for early intervention, and ensure the economic incentives for counties reward community wrap-around care rather than institutional placement. SUGGESTIONS FOR WHAT TO DO INSTEAD FOR STRATEGIES: 1) Fund Capacity, Not Just Training: Mandate the expansion of available community-based crisis beds and mobile crisis response units that are completely untethered from law enforcement. 2) Administrative Friction Reduction: Create a fast-track funding mechanism for early intervention supports so families aren't placed on wait lists while the child's situation escalates into an institutional crisis. 3) Juvenile Justice Diversion Mandates: Replace “training juvenile justice staff” with creating structural diversion pipelines that intercept disabled youth before they are placed in juvenile justice facilities. If those new strategies are not added and implemented, the Crisis Services Goal 1 as written will NOT improve the lives of Minnesotans with disabilities, particularly the disabled youth involved with the juvenile system.

- This goal is only adding a solution to an outcome that needs reducing in itself. The high level of institutional placement is due to a failure to appropriately support families with disabilities. Families with disabilities are more likely to interface with CPS due to systemic ableism and lack of appropriate long term services and supports to prevent frequent crisis intervention. if we are only focusing on what happens to the child after they are in the system we are failing the family and the child by not focusing on preventing family interuptions that could be avoided with better disability systems.
- Usage of trauma-informed practices that are community tested is important. For instance, CBT, which is used to challenge cognitive distortions, may approach an issue related to feeling like you are being watched by the government is inaccurate. But systemic racism implemented by an institution can have a similar result. Thus, CBT acts as a gaslighter. I'd recommend methods like DBT. Also on community treatments- Autism behavioral therapy is accepted at institutions, but is not accepted by the Autism community. So it's less for me about where they are placed and more on is the treatment humane and supportive of dignity
- How are you defining 'institutions'? If it is hospitals, I think this is good goal. However, if you are considering group homes as institutions, I do not think this is realistic.
- I am really truly just still trying to contact you guys and any agencies that will follow through with HELP for a 100% disabled guy that has been trying to well.... just say my story is far to dambing for others who not just broke but shattered the Federal and State laws that are supposed to protect me! I am a NAVY VET that was in School at the NAVAL ACADEMY at 17 and when left there went into working with agencies and also going to school for Federal Shield at same time. It was found out from some dirty, yet nasty officials in town that run things and others that wanted me gone due to I was stopping their illegal payday and also shined a light on every aspect of how ,why,when they all and all inside (redacted) helpers are repaid. I was then almost killed a few times by law enforcement officers in duty clothes. Also manage to buy and

pay off a house in Duluth, MN so that I had a start to my Retirement Savings .And also Many more things after that I still can't get a lawyer for even trying to pay for one!!! We live in one of or as working with a few of ,then the best team out of all teams in agencies. That Central MN is the Hub of all Criminal Activities in THE UNITED STATES ðŸ‡ºðŸ‡¸!! I TOLD THEM THAT BECAUSE I KNEW FROM A FEW CLOSE FRIENDS THAT ARE LIKE BLOOD AND 1 IS! I THEN SHOWED THEM HOW TO FIX. THEN THEY STARTED BUT TO LATE! WE HAVE LOST OUR ONLY JUDGE THAT WAS CLEAN, I LOST A FULLY PAID OFF HOUSE JUST BECAUSE NOBODY WANTED TO EXPLAIN OR EVEN TALK TO MY REALTOR THAT WAS IN CHARGE OF MY UP NORTH ASSETS AT THE TIME I was in school full-time and doing GODS WORK While also due to Family pride staying off books to never have a link back to me and making sure that I was like I was given thumbs up as a new recruit fresh out of the FARM or something like ðŸ‘□! Then found after only a few months that every single UC officer and Deputy in town lives on same lake and all have over 8 lawn sales each summer of all new items. Then one of my old girlfriends came asking for help to find her stuff that got stolen out of a bus that got searched by drug task force and they said basically they took half of the bags that didn't have tags! I noticed earlier behaving like big wannabes! I started cleaning up when all of downtown stopped taking cards and only took cash!! That is how the US TASK F CLEANED ANY MONEY!! I THEN was told by a very close friend from NAVY AND MY TIME THAT I worked in California for years doing major UC WORK.HE TOLD ME THAT SOMEONE INSIDE OF OFFICE SOLD ME OUT TO ENTIRE LISTS OF FELONS AND EVEN USED INTERNET TO DROP MY PERSONAL INFORMATION ALL OVER THE PLACE!! AFTER FAMILY FRIENDS RETIREMENT dinner (redacted) , he told dad and I that I was the only reason That his wife and hime were able to go up north and retire, yet modestly and not like even Rookies he laughed on my squads, he was just wondering how I was still able to receive anything from anyone. I said I didn't get anything from anyone. Then now! I made more money at 13 as a professional Fishing Guide each day I made more in 6 hours then I make now from SSA ALL month due to How they are breaking civil and some had broken a few judicial and civil laws along with me getting all drs asking almost daily why all paperwork says I am positive at 100% disabled at date 5-5-07 and on top of that I have SEVERE EYE ðŸ‘□PROBLEMS LIKE LESS SIGHT THEN 10/200 AND I have NONE YES NO PERIPHERAL VISION AND WHEN I sweat or get heated in talking ar working out, can't anymore because drs say insurance is terrible due to my place on SSA BOOKS FOR SOO LONG! I HAVE APPEALED MANY TIMES YET NOTHING! I ALSO HAVE HAD MY IDENTITY STOLEN ALMOST EVERY MONTH NOW IT SEEMS AND ALMOST EVERY 3 MONTHS IS ANOTHER MAJOR DATA BREACH THAT I am on yet the settlements have my name on them and I even had people say " well like weird paid you over $25,000 on the first breach alone! I had others track it down and it found its way to same (redacted) that stole my information to buy NEW TRUCK AND PONTOON ALMOST A DECADE AGO OR MORE? THEN I THINK THEY GOT ARRESTED AND THE COMPANIES GOT REIMBURSED! YET I NOW THAT NOT ONLY I LOST HOUSE AND EVERY FRIEND , FAMILY, CLOTHES, WELL- LETS JUST SAY MY SHEINK THAT I USED TO HAVE AND I did math way before he retired. And he ran the STATE HOSPITAL for over 25 yrs. He said if was his favorite and also 1 of the most interesting and intelligent people he had ever met that

he wasn't allowed to go home without consent to bring a story of my past for his wife. I ,well, yeah ... anyways. We figured just before moving back into home with patients with starting new business that required new schooling that they robbed me and I had to call law enforcement and they wanted me to go to court but they wouldn't go and at time ai didn't have money to get even the paperwork, let alone lawyer or even time away from drs!! Yet now.. he'll, I still can't get anyone to call me!!they stole all my business EIN CREDIT OVER $3,000,000 AS FAR AS I know along with many other things I am nothing mentioning on here but I had to file and never will see. Lost over another $2.5M on what else was Taken in Duluth! My Mortgage remember is paid off and There are laws and statutes that are very clear that many people along with companies have to legally comp me back and I also have many more things and items I need help with! I had my inheritance taken or part of due to a very major head case in my AUNT from CA! I STILL CANT GET HELP COLLECTING OVER A HANDFUL OF OFFICAL ITEMS THAT WERE IN MY NAME OR STILL ARE!

- This goal is confusing. What is an institutional setting? How/why is this under crisis services? From the strategies, it seems to indicate that the reason some are institutionalized is due to contact with law enforcement. It seems like more information needs to be known up front ast to who these children are and why they are institutionalized?
- We should include remote crisis services in your own home. Where people would be more comfortable setting
- You seem to be lacking parents / family and caregivers as members of the team. You seem to be focused more about the numbers and less about the quality.
- Tiering of rates for FRS child and adult will increase institutionalization of all youth, there will be no family waiver providers in 5 years or less. Youth with disabilities needing out of home placement will be housed in shift staff settings with cookie cutter goals. Nonfamily settings feature an ever-changing set to staff with varying capacity and passion for the work. Youth in foster care become members of families, and communities through care. Bio family members develop unpaid support systems through their loved one's providers that help scaffold and support successful reunification. Integration in families allows for cultural connection and development of waiver funded services in family settings. We should be recruiting family providers and supporting them through the waiver and mhcp licensing and enrollment.
- This is a status quo statement, not an aspirational goal.
- Former Foster Youth peer counselors working with in home therapists and families
- Fostering high needs children is exhausting work. Pay families good compensation.
- Competent staff to be hired with livable wages.

Crisis Services Data Goal 1

- The current framing of “mobile crisis services” is too vague and system-centered. It assumes a generalist response model that does not work for Deaf, DeafBlind, hard of hearing, blind, or visually impaired individuals. This approach is reactive and risks repeating the same failures that

lead to avoidable hospitalization or institutional placement. This goal should be rewritten to establish disability-specific, prevention-first crisis pathways that are defined at the point of system entry, not adapted after crisis occurs. For Deaf, DeafBlind, hard of hearing, blind, and visually impaired individuals, crisis response must be delivered through disability-competent systems with built-in communication access and sensory-aware protocols from the outset. Generic mobile crisis deployment should not be the default model for these populations. Minnesota should formally leverage existing specialized infrastructure, including the Minnesota State Academies, as part of a proactive prevention and stabilization framework. This should include early intervention capacity, consultation support, and defined referral pathways before escalation occurs. The current system underutilizes this expertise and instead relies on generalized crisis response that is not consistently accessible. The goal should be reframed as follows: reduce crisis escalation by ensuring immediate, disability-appropriate intervention pathways that prevent hospitalization, incarceration, or institutional placement through pre-structured, accessible response systems. Accountability must be tied to outcomes for disability populations specifically, not aggregate community retention data. If Deaf, DeafBlind, blind, or visually impaired individuals are disproportionately routed into restrictive settings, that indicates system design failure-not individual crisis complexity-and must trigger structural redesign.

- how are we focusing on preventing dependency on crisis services?
- Tracking without the necessary supports to maintain safety in the community will not do anything to improve outcomes.
- This is a goal that reduces carceral logics in our crisis centers. Many people who are experiencing a crisis have supports, like a plushie or an environment like their bed/room that is safe for them and reduces crisis symptoms. These supports are removed in institutions. When the emphasis is on person centered planning, the goal should be to support the individual's agency in figuring out their best option for navigating the crises. If they want to go to an institution- that should be respected. If they want to be in the community, that should be done as long as safety can be maintained.
- I have been asked a few times now as a friend to do a blacked out interview on FOX N FRIENDS MORNINGS DUE TO WHAT 1 BUDDY KNOWS AND HE FIGURED THIS PART OF HIM GETTING MY WORDS OF ABUSE AND A PERFECT LOOKING GUY , GIVEN LIFE TO USA, then all around him other then the ones not expected treat him like a 3 legged shot goat! And I already know of 2 people that are nervous I might talk so they tried to retire but not enough but soo scared I heard they took their scenes to a different state! I would get around $4,000 more each month plus actually get helping benefits like dentist office after yrs of opiods! And no paying for vitamins or copay!
- mobile crisis services are key - important area to focus on
- No feedback
- Define what you are tracking better - are you tracking by mental health diagnosis, physical disabilities, intensity of medical needs, etc.

- Again, look to strengthen not kill waiver funded family foster care.
- People entering “voluntary” residential treatment (I question how “voluntary” these programs are when there is a either a MH crisis worker or a cop, both of whom have the power to commit you, sitting right there) should not be counted as “staying in the community.” One, residential treatment (particularly in a hospital/IMD) is definitionally not “in the community,” it is institutional. Facilities like IRTS houses I suppose are not institutional in the same way an IMD is, but if you are stuck in a locked facility, unable to leave, with staff there who WILL threaten to commit you if you try to leave voluntarily, how is that not an institution? Because it's a house on a street rather than a hospital?
- Data will tell...
- Collecting data is good - but you have to USE DATA to improve the lives of people with disabilitities
- While establishing a data baseline is necessary, using a “data-gathering phase” as a reason to delay setting a measurable goal is an unacceptable administrative stall. Furthermore, the proposed data collection parameters are deeply flawed and must be restructured around systemic accountability rather than individual pathologizing. My feedback on how this goal must be rewritten is as follows: 1. Stop the “Baseline” Administrative Stall. Waiting for a baseline cannot pause actionable funding and infrastructure mandates. In 2026, the lack of this data points to systemic negligence, and data collection cannot be used as a shield to freeze systemic investment. While the baseline is being established, there must be concurrent, immediate mandates to fund the expansion of mobile crisis units (especially rural/out-state and after-hours capacity) and peer-led response models. 2. Track the structural bottleneck, not just the individual's “acuity.” When mobile crisis intervention *does* result in a hospital or jail placement, the state must change how it tracks the “why.” Historically, state data frames institutionalization as a result of the individual's “high acuity” or “severe behaviors.” This pathologizes the disabled person and absolves the state. The data collection must be forced to capture the *system's* lack of capacity. If someone goes to the hospital or jail, the data must specify the structural failure: Was there a lack of accessible crisis beds? Was there a waiver or funding denial? Were in-home support staff unavailable due to workforce shortages? The data must measure the system's failure, not the individual's crisis level. 3. Track unmet demand and law enforcement intercepts to avoid “survivor bias.” Tracking outcomes only for people who actually received mobile crisis services ignores the current infrastructure vacuum. The data must capture what happens when the system fails to show up. We need to track how many requests for mobile crisis resulted in police response, arrest, or ER transport simply because the mobile crisis team lacked capacity, was understaffed, or only operates during business hours. Otherwise, the state will claim a 90% “success rate” for the small fraction of people they actually reached, while hiding the majority who were criminalized because the system wasn't funded to respond. 4. Define “community” as stable, supported integration, not systemic abandonment. Defining success merely as “avoiding more segregated settings like hospitals or jails” creates a dangerous loophole. From a disability justice lens, if a mobile crisis team

prevents a hospitalization but leaves a disabled person in an unstable environment, experiencing homelessness, or bouncing between precarious couches, that is systemic abandonment masquerading as community integration. The data must track *where* in the community the person is staying post-crisis, and explicitly track whether wrap-around funding and ongoing services were actually authorized and deployed to stabilize them.

- Connect people that use crisis services with peer support or other professional service
- Yes, the data needs to be tracked. Mobile crisis services are needed.
- Great goal

Missing crisis services goals

- One important issue missing from the crisis services goals is the role that stable Family Residential Services homes play in preventing crisis placements for adults with disabilities who require ongoing daily support. Recent implementation of the flat-rate funding structure for Family Residential Services is already creating instability across smaller residential homes. As a designated coordinator working with multiple providers, I am seeing staffing reductions and restructuring of placements in order to remain financially viable. These changes increase the likelihood that individuals will experience service disruption and emergency transitions. Preventing crisis placements requires maintaining stable community-based residential options that match assessed needs. Funding structures that destabilize these homes increase risk of movement into higher-cost and more restrictive settings and should be addressed as part of crisis prevention planning under the Olmstead Plan.
- The current Crisis Services goals omit a foundational prevention issue: language deprivation and communication neglect as drivers of crisis system involvement for Deaf, DeafBlind, and hard of hearing individuals, as well as other populations dependent on accessible communication. This gap should be addressed directly in policy. Language deprivation must be explicitly recognized as a preventable form of harm that contributes to crisis escalation, institutional placement, and justice or child welfare involvement. Crisis systems cannot function effectively if individuals are systematically deprived of accessible language during critical developmental periods or ongoing care, with no accountability when that deprivation occurs. The Olmstead Plan should be revised to require the following: First, communication access must be treated as a core safety and neglect consideration within child welfare and vulnerable adult systems. Failure to provide timely, appropriate, and consistent access to a primary language (including qualified ASL access or other necessary communication modalities) should be evaluated as a potential form of neglect when it results in developmental harm, preventable crisis, or increased risk of institutionalization. Second, crisis prevention metrics must include upstream indicators of communication deprivation. Data collection should not only track crisis outcomes, but also identify whether lack of communication access was a contributing factor in system involvement. Third, accountability mechanisms must be established when communication access failures are identified as causal or contributing factors. This includes corrective action

requirements for agencies responsible for service delivery gaps that lead to avoidable crisis escalation. Finally, legislative alignment should be pursued to ensure statutory definitions of neglect for minors and vulnerable adults explicitly include failure to provide necessary communication access when such failure results in foreseeable harm or functional deprivation. In short, crisis services reform must extend beyond response systems and address upstream structural neglect. Without explicit recognition of language deprivation as a preventable harm with enforceable accountability, crisis services will continue to address downstream consequences rather than preventable causes.

- One issue missing from the crisis services goals is the importance of maintaining stable small Family Residential Services homes that prevent placement disruption before a crisis occurs. I became a Family Residential Services provider after leaving a career of more than 30 years in order to support a stable one-person placement. After implementation of the flat-rate funding structure, I was required to accept an additional resident in order to remain financially viable. This type of change was not based on assessed support needs and affects placement stability. Funding structures that require providers to restructure homes for financial reasons increase the likelihood of service disruption and emergency transitions for individuals receiving supports.
- Access to MH services (on-going) prior to crisis. Accessibility of those services.
- We NEED more crisis services - statewide. We need shorter waits and affordability of assessments and treatment. It took over a year to get my challenging kiddo assessed so we could find treatment.
- The goals do not adequately address the root causes driving disability-related crises in Minnesota, particularly the collapse of staffing, continuity of care, accessible behavioral supports, and medically appropriate community services. Many crises are preventable and occur because families cannot access the staffing, nursing, respite, stabilization services, or long-term supports already authorized on paper. Disabled individuals are frequently pushed into crisis because the system fails long before emergency intervention occurs. The plan should specifically address: - workforce shortages, - continuity-of-care protections, - emergency backup staffing systems, - medically complex crisis response, - autism and neurodivergent-specific crisis supports, - and the lack of community-based stabilization options that can safely prevent hospitalization or institutional placement. Minnesota should also recognize that families are functioning as the unpaid crisis prevention infrastructure for the disability system. Without caregiver support and sustainable in-home services, crisis prevention efforts will continue to fail.
- adolescent mental health and substance use disorder are severely lacking. Additionally, the protection afforded to minors around substance use makes it incredibly difficult for families to be able to support those they are legally responsible for.
- Current insurance models support non-community supported care, such as ABA. In a crisis, modalities and supports being used, regardless of by who, should be both evidence based and community supported

- how and who will be completing these services?
- Should be able to help people like me first!!! I have been waiting and literally selling off all my personal items to survive!! Then even just now (redacted) just had a DHS worker give me and my money and dad (redacted) for having a saving account and mom said she felt like crying. I also know that i never had more then over $1,500 all together in the bank at once!! They say $2K but I use a $500 buffer!! So Don't forget who actually if wanted to has push. I have shaken 3 presidents hands! I shook the Dhali Lhama's hand then his comment was that I was one of the oldest souls that he had ever met!! So think about that??!!! I was interviewed by (redacted) at age (redacted) as the only person to get accepted to the USNA without a letter of Recommendation!! Think on that? Another reason I haven't received help in MN i was told, is that you only need 3rd grade education to work in the jobs you guys have listed on your site. I swear I only met 1 guy and it has been like in 20 yrs at SSA. IT WAS LAST YR, HE SAID I WOULD GET SSDI NO PROBLEM. THEN IT CAME BACK AS I SHOULDN'T HAVE GOTTEN SSI EVEN BECAUSE NOBODY WANTED TO EVEN READ IT SEEMS ANY PAPERS!! MY EYE DR ASKED ME IF SHE COULD HELP ME BY LOSING A DAY OF WORK AND DRIVE 2 HRS THERE AND BACK TO TELL SSA that they are using an eye dr that's is terrible and didn't listen to me anyway! I have major experience coaching anyone in an interview yet that's what he does there! I even tried it when I could see and he checked it up he wants his part of the dirty money!! Stuff like that helps nobody!! One day soon I will severely knock over a person worse then I have in the past due to when my eyes lose their sides and I look through tubes!!
- Outings at programs
- One goal is not enough. You need to add long term support following a crisis - what is working and what is not.
- Develop, recruit and maintain community based unit services so that people can remain in family and informal living settings. Consider addressing the staffing challenges with statewide access to affordable health care and retirement benefits to retain talented staff.
- What will DCYF/DHS/etc do to actually make these goals a reality? My experience with mobile crisis services, over and over again, is that unless you are actively asking to go to a hospital, they don't do anything. They show up, look at you, tell you that you're clearly not in that great a need because of some aspect, and then promise to follow up but never do. My county's crisis team has promised to refer me to ACT services (did not happen), to contact a different county agency on my behalf (never happened), and to help me get long-term stabilization services (did not happen). Is there an actual plan to help people stay in the community and get the services they need, or is this just another case of “as long as the person doesn't end up committed, we can mark them down as successfully treated, regardless of whether they got help or not”?
- The Economics of Placements & Infrastructure Investment: There are no action steps addressing the financial mechanisms that drive institutionalization. The goals completely ignore the need for immediate funding mandates to expand community-based crisis beds, provider capacity, and out-state/after-hours mobile crisis units. - Systemic Diversion vs. Harm Reduction: The juvenile justice strategies focus on making facilities “trauma-informed” rather than creating

robust, non-law-enforcement diversion pipelines to intercept youth before they enter the justice system. - Data on Systemic Failure: The data tracking plans fail to measure unmet demand (e.g., when a mobile crisis team is requested but unavailable, resulting in police override) and the structural bottlenecks that lead to institutionalization (e.g., lack of accessible beds, waiver denials, workforce shortages).

- There are not enough resources or enough education on the countless diagnosis and deeds of our children
- The last time my son had a crisis, he spent 5 days in the ER at Abbot. All they did was change meds. No therapeutic services.
- Crisis Services Data Goal 1: Asking a question of "do you feel safe at home?" After a situation is determined, are they being communicated with properly? Crisis Services Goal 1: For social workers, those conversations need to have a deaf perspective and a disability perspective. May find it difficult to communicate needs and wants. Disability advocate to be present in the space.
- see below
- Ongoing Follow up services after crisis service provided
- Avoid taking people to emergency departments that don't need medical care. Have mobile crisis teams go to group homes etc. Case Managers should be on call in counties.
- MCIL is a national leader on the 7 life sustaining dimensions for stabilizing families, children and individuals with disabilities. The plan falls short in elevating the human need and human suffering that is currently the reality for all communities with disabilities. The plan needs to reorder the focus on the state institutions but on how are people with disabilities faring? What are the gaps in services that destabilize families, children and individuals with disabilities? This plan came about due to the co-equal federal judicial branch as a result of responding to human need. The direct care crisis is real and there is no elevation of this crisis in the plan, and it needs to be written better in the plan and in the summary.
- No
- Legislation to fund staffing for service providers for competent staff..you can dump a lot in for services, but do families think it's helpful?

End of document