MINNESOTA
OLMSTEAD
IMPLEMENTATION OFFICE

Spring 2026 Public Comment Summary: Crisis Services

Contents

Introduction

This report shares findings from the spring 2026 public comment period on the draft Olmstead Plan. The public comment period sought feedback about proposed Olmstead Plan goals.

Draft Olmstead Plan background

The first Minnesota Olmstead Plan was adopted in 2015. In 2023, the Olmstead Subcabinet decided it was time for a more comprehensive update. For the plan update, OIO worked with a contractor called Dendros Group. Dendros Group brought on people with lived experience of disability as Inclusion Consultants. Inclusion Consultants worked with state agency staff to write goals and strategies for the draft plan.

The draft plan included both measurable goals and data collection goals. Measurable goals are specific, measurable, achievable, relevant, and time-bound (SMART). Measurable goals are the foundation of an effective Olmstead Plan. Data collection goals represent issues that agencies want to write goals about, but don't have the data to create a measurable goal yet. The draft plan grouped goals into seven topics:

- Crisis services
- Education
- Employment
- Health and safety
- Housing
- Transportation
- Transition

For more information about Olmstead, the 2026 plan drafting process, and to read the draft plan, please visit the OIO website: MN.gov/olmstead

Public comment period background

The Olmstead Implementation Office (OIO) held the public comment period in partnership with the Dendros Group, Inclusion Consultants, and state staff. The public comment period took place in April and May 2026. It included:

- An online survey
- Virtual meetings and individual interviews
- Email comments and submissions from organizations

Online survey

The online survey was available in English, Spanish, Hmong, Somali, and American Sign Language (ASL).

Survey participants could choose which goal topics to share feedback about. They could also choose to give general feedback about topic areas overall, specific feedback about individual goals, or both. The survey was anonymous, and all questions were optional.

Survey questions

The survey asked the following questions about each topic area:

- Do you think reaching these goals will improve the lives of Minnesotans with disabilities? (multiple choice question)
- Are there any topics or issues you feel are missing from these goals? (comment box question)
- Do you have any general feedback about these goals? (comment box question)

The survey asked the following questions about each individual measurable goal:

- Do you think this is an important question for the lead state agency to address? (multiple choice question)
- This measurable goal is… (multiple choice question)
- Do you have any ideas of other strategies and action steps to reach this goal? (comment box question)
- Do you think reaching this goal will improve the lives of Minnesotans with disabilities? (multiple choice question)

For data collection goals, the survey asked, “Do you have any feedback about this goal?” with a comment box.

The survey also included optional demographic questions.

Virtual meetings and individual interviews

Dendros Group planned and implemented virtual meetings as part of the public comment period. Inclusion Consultants facilitated the meetings. Dendros held seven meetings, one for each topic in the plan. The meetings were intended to be an accessible alternative to the online survey. Registration was open to the public, and the meetings took place on Zoom.

Facilitators asked the following questions during virtual meetings:

- What would make these goals more effective to improve the lives of Minnesotans with disabilities?

- What would make these goals more effective to better integrate Minnesotans with disabilities in community life?
- What's missing from these goals?

Dendros Group also offered individual interviews. The interviews were intended to be an accessible alternative to the survey and virtual meetings. Inclusion Consultants conducted the interviews.

Email comments and submissions from organizations

OIO also received public comments through email. These comments came from individuals and organizations.

Goals included in this report

- Crisis Services Goal 1: Fewer children and teens in foster care will experience institutional placements.
- Crisis Services Data Goal 1: More people will stay in the community after a crisis.

Total number of community input submissions and comments

This table shows the number of submissions and comments about transportation.

Source	Number of submissions	Number of comments
Survey	29	79
Virtual meeting	13	Not available
Emails and letters	3	7

Notes:

- Submissions from organizations are counted as one respondent.
- The number of comments from virtual meetings is not available.
- Interviews are included in the survey totals.
- The number of survey submissions counts people who answered open-ended questions. Some participants may have only answered multiple-choice questions. For that reason, the number of survey submissions may not match with the number of responses to multiple-choice questions.

General feedback

This section summarizes feedback about the topic overall. Feedback about specific goals is included later in this document.

Survey question: Do you think reaching these goals will improve the lives of Minnesotans with disabilities?

Response	Count	Percentage
Yes, good improvement	9	24.3%
Yes, some improvement	13	35.1%
No improvement	5	13.5%
Unsure	10	27%
Total	37	100%

Themes from all input

The Olmstead Plan should address crisis prevention.

Many public comments shared that while crisis services are important, the state needs to also prioritize prevention of crisis before services are needed.

Quotes:

- "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 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."

- “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.”

The staffing shortage affects crisis prevention and services.

Public commenters shared that having enough well-trained staff was critical for not only helping during crisis but also preventing crisis.

Quotes:

- “We need professionals to provide services. It's hard work.”
- “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.”
- “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.”
- “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.”

Missing topics from Crisis Goals

People shared which topics they thought were missing from the crisis goals.

Quotes:

- “Intersectionality: Community members said the state must address disparities based on other identities held by people with disabilities. These identities can include race, ethnicity, gender, sexuality, socioeconomic status, language, and more.”
- From the HACER Public Comment Meeting: “Provide more bilingual and bicultural staff in mental health institutions and recovery services. In addition, families need more resources in their preferred language inside mental health institutions and throughout recovery. It is still too common for bilingual staff or providers from the same cultural background to be limited or unavailable. Recovery can be more difficult when youth and families do not feel culturally understood, cannot communicate effectively, or do not see themselves reflected in those supporting them. Increasing bilingual, bicultural, and culturally responsive staff would help build trust, improve engagement, and strengthen outcomes."
- “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."

- "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."
- "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."
- "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.
- "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)."
- From the HACER Public Comment Meeting: "Mental health crisis response should also rely more on trained mental health professionals instead of law enforcement whenever possible. For many families, especially immigrant communities or those with trauma related to police or legal systems, police presence during a mental health crisis can feel intimidating and escalate

fear. Expanding mobile crisis teams with de-escalation training, cultural humility, and language capacity could help families feel safer and receive the right care earlier."

- From the Somali Parents Autism Network (SPAN) Public Comment Meeting: "Crisis services remain inaccessible and ineffective for many individuals with developmental disabilities, particularly those with autism and co-occurring mental health conditions. Law enforcement is still too often the default response, which can escalate situations rather than resolve them."

Feedback about individual goals

Crisis Services Goal 1: Fewer children and teens in foster care will experience institutional placements.

Lead agency: Department of Children, Youth, and Families (DCYF)

Survey questions about Crisis Services Goal 1

The following tables show results of multiple-choice survey questions.

Do you think this is an important issue for DCYF to address?

Response	Count	Percentage
Very important	14	73.7%
Important	3	15.8%
Not important	0	0%
Not at all	1	5.3%
Unsure	1	5.3%
Total	19	100%

This measurable goal is...

Response	Count	Percentage
Too high	0	0%
Just right	3	15.8%
Too low	9	47.4%
Not sure	7	36.8%
Total	19	100%

Do you think reaching Crisis Services Goal 1 will improve the lives of Minnesotans with disabilities?

Response	Count	Percentage
Yes, good improvement	5	25%
Yes, some improvement	4	20%
No improvement	5	25%
Not sure	6	30%
Total	20	100%

General feedback about Goal 1

There were no consistent themes in feedback about this specific goal. Individual comments included:

- This goal has the potential to create barriers to medically necessary care for children. OMHDD supports the intent of serving children in out-of-home placements in non-institutional, community-based, and most integrated settings. However, we do caution about a goal that has the potential to create barriers to children receiving medically necessary care.
    - For years, OMHDD has raised concerns about access to children's residential treatment under Chapter 260D wherein children are voluntarily placed for treatment. We also want to acknowledge the shrinking capacity of children's residential and psychiatric residential treatment facility capacity due to a multitude of reasons, including workforce shortage. Aspire MN reported a reduction in bed capacity in children's residential facilities during the pandemic, from 2020-2023 of 601 beds, or 30% of all licensed capacity in those settings. With sustained reductions in capacity, fewer children will enter care in institutional settings regardless.
    - Importantly, this goal is about all children in out-of-home placement, not specific to children with disabilities who make up only 71% according to the baseline information provided.
    - As a strategy, DCYF proposes partnering with DHS to "create cross-training for child welfare, children's mental health, and children's waiver case workers and residential services providers…" How are these training and proposed resources to be developed different than that already offered by DHS or DCYF?
- "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."
- "This goal is confusing. What is an institutional setting? How/why is this under crisis services?"
- "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."

- "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."
- "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 interruptions that could be avoided with better disability systems."
- "Replacing structural capacity with staff training does not fulfill the Olmstead mandate."
- "I agree with this goal, but the strategies for achieving it need to be more clearly defined. The current language is too broad and does not explain how the goal will be put into practice. Explicitly include parents and caregivers of African American/Black children and American Indian/Alaska Native children, who are often underserved by existing programs."
- From the HACER Public Comment Meeting: "While there are training opportunities for children and teens and funding available at the county and city levels, these resources are not consistently reaching the communities that need them most." The plan must "outline specific steps to ensure equitable access, such as targeted outreach, partnerships with trusted community organizations, and accountability measures to track who is being served."
- "Ensure 24/7 access to mobile crisis services that are culturally competent, multilingual, and trained to support families in-home to prevent unnecessary hospitalization or institutionalization."

Strategy ideas for Crisis Goal 1

Respondents shared many strategy ideas to consider for Crisis Goal 1. These suggestions have not been vetted for scope or funding and are submitted as written.

Quotes:

- "Former Foster Youth peer counselors working with in home therapists and families."
- "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."

- “DYCF's (Department of Children Youth and Family) 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.”
- “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 of what to do instead for strategies:
        - 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.
        - 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.
        - 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.”
- “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."

- From the Somali Parent Action Network Public Comment Meeting: "Recruit more minority foster parents, specifically from Somali and East African communities. In Minnesota, there are fewer Somali and East African foster parents. Most Somali parents don't want their children to be placed under non-Somali Christian families due to religious stigma and Islamic dietary restrictions."

Crisis Data Collection Goal 1

There were no consistent themes in feedback about this specific goal. Individual comments included:

- "Yes, the data needs to be tracked. Mobile crisis services are needed."
- "Define what you are tracking better - are you tracking by mental health diagnosis, physical disabilities, intensity of medical needs, etc."
- "People entering 'voluntary' residential treatment (I question how 'voluntary' these programs are when there is a either a mental health 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?"

- "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."

Strategy ideas for Data Goal 1

Respondents shared many strategy ideas to consider for Crisis Data Goal 1. These suggestions have not been vetted for scope or funding and are submitted as written.

Quotes:

- "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:
    - 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.
    - 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.
    - 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.
    - 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."
- "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."