POLICY ANALYSIS

The Youth and Families Mental Health Ecosystem

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Youth mental health develops within a system of relationships among schools, families, health services, public spaces, transportation, employment, and government, and the Youth and Families Mental Health Ecosystem represents it as an institutional model: thirty-seven elements and forty-seven connections identify where authority sits, how services are reached, which conditions shape exposure to risk or protection, and where coordination fails. Developed through the author's doctoral research at Claremont Graduate University, the model draws on the Minneapolis Community Assessment, official student surveys, public administrative sources, and peer-reviewed studies. Its scientific proposition is measurable: if the connections represented in the model function as intended, young people should encounter fewer barriers to support, complete more referrals, experience stronger protective conditions, and show improved outcomes over time. The model therefore links institutional design to observable measures without treating the existence of a program as evidence of access or effect.

The Problem

The scale and distribution of youth mental-health need in Minnesota are documented in the 2025 Minnesota Student Survey, a triennial census-style study conducted in partnership by the Minnesota Departments of Health, Education, Corrections, Human Services, and Public Safety: in its statewide tables, 28 percent of eleventh graders reported a long-term mental, behavioral, or emotional problem. Fifteen percent reported feeling depressed or hopeless more than half the days or nearly every day during the preceding two weeks, 26 percent reported nervousness or anxiety at that frequency, 8 percent had seriously considered suicide during the preceding year, and 2 percent reported an attempt. Analyzing the Centers for Disease Control and Prevention's nationally representative 2023 Youth Risk Behavior Survey, Verlenden et al. (2024) reported 39.7 percent of U.S. high school students experiencing persistent sadness or hopelessness, 28.5 percent reporting poor mental health, 20.4 percent seriously considering suicide, and 9.5 percent attempting suicide during the survey's specified periods. Differences in questionnaire wording, reference periods, grade coverage, and geographic scope prevent direct comparison of these percentages, while their respective distributions establish substantial need at state and national levels.

These surveillance estimates sit within the disruption produced by the COVID-19 pandemic, and the scale of that disruption has a specific published measure: Racine et al. (2021) pooled 29 studies involving 80,879 participants age 18 or younger and estimated clinically elevated depression symptoms at 25.2 percent and anxiety symptoms at 20.5 percent during the first pandemic year, approximately twice the prepandemic estimates used in the meta-analysis. The pooled estimates describe symptom burden across heterogeneous studies; they do not identify which Minneapolis institutions account for local outcomes. Their relevance to the Ecosystem lies in the range of conditions through which distress may be prevented, detected, referred, and treated.

The Minnesota survey also measures conditions that sit outside a clinical diagnosis yet affect whether support can be reached: among eleventh graders, 40 percent reported being not at all comfortable speaking with a school counselor or social worker when upset or stressed, 58 percent used technology between midnight and 5 a.m. on at least one school night during an average week, and 6 percent reported experiencing people using guns to threaten or hurt others in person. These measures represent different mechanisms: willingness to seek help, a digital and sleep-related exposure, and

interpersonal safety. Their presence within the same student population explains why a mental-health strategy confined to treatment capacity leaves consequential parts of the system unmeasured. The published statewide tables report separate item percentages and do not provide respondent-level relationships among these variables, so they support a multidomain measurement framework without establishing correlations between individual responses.

The Ecosystem Model

The Ecosystem organizes the local system into eight connected layers converging on one shared outcome, youth safety and mental health: lived experience, where youth and families set priorities; backbone coordination and accountability; policy and funding authority; early access through schools and mental-health supports; protective factors in safe places and with trusted adults; the crisis-response pathway; stabilizing conditions covering basic needs and mobility; and shared navigation, data, and learning infrastructure. The City of Minneapolis, Hennepin County, Minneapolis Public Schools, the Minneapolis Park and Recreation Board, Hennepin County Libraries, community providers, street and school-based outreach workers, faith and cultural organizations, and the elected officials and funders who hold budget authority occupy different positions within these layers because their authority, service settings, and funding sources differ. The Minneapolis Youth Congress carries youth priorities through a tracked pathway from recommendation to the Youth Coordinating Board to policymakers, and six operating networks, covering backbone alignment, safe third spaces, crisis-to-support referral, data and navigation, youth voice and policy, and funding and basic-needs support, carry the day-to-day relationships the map represents. The interactive map traces pathways across those institutions, and the Gaps and Actions analysis identifies twelve points where a pathway can stop. This structure treats coordination as an observable sequence from need identification to referral, service entry, service completion, and outcome measurement.

The 2024 Minneapolis Community Assessment supplies local descriptive evidence about the conditions surrounding those pathways. Across 44 youth items scored from zero to ten, Children's Participation produced the lowest goal-area mean at 5.85, while Equitable Social Services produced the highest at 7.54. Across 50 parent items, the same contrast appeared: Children's Participation averaged 5.14 and Equitable Social

Services averaged 8.34. At the item level, youth rated meaningful opportunities to voice ideas and concerns about city decisions at 5.38; parents rated involvement in community planning or decision-making at 2.85 and opportunities to influence budgets for children's programs and services at 1.39. The repeated difference between ratings of service availability and ratings of participation identifies an institutional asymmetry: respondents perceived stronger service conditions than opportunities to shape the decisions governing those conditions. These are domain and item averages, not respondent-level correlations, and their analytical value lies in locating participation as a weak connection within the local system.

Transportation scores identify another connection between an available service and practical access to it: youth rated safe and well-lit local transportation waiting areas at 5.85, while parents rated safety on buses or other public vehicles at 5.35 and safe, well-lit, clean waiting areas at 5.32. A program may be funded and geographically present while remaining difficult to reach after school or in the evening; mobility therefore enters the model as a mechanism linking service supply to service use. The Community Assessment records perceived conditions and does not measure completed clinical visits. Referral records, travel-time measures, and service-entry data are required to test whether lower transportation ratings are associated with lower uptake.

School connectedness carries its own measured relationship to outcomes: in a systematic review of 34 studies of school connectedness and suicide among high-school youth, Welty et al. (2024) found that 73.3 percent of the studies examining suicidal ideation reported a protective association, as did 50 percent of the studies examining suicide attempts. Variation in definitions, omitted variables, and study design limited causal inference across the literature, yet the recurring inverse association gives empirical grounds for placing peer relationships, trusted adults, school belonging, and access to school-based support within the mental-health model. The Ecosystem consequently represents school connectedness as a condition linked to outcomes and as a pathway through which prevention and referral can operate.

The Policy Framework

Minneapolis distributes authority for these pathways across governments: Hennepin County holds statutory responsibilities under Minnesota's Comprehensive Children's

Mental Health Act; Minneapolis Public Schools provides daily contact with students and school-based support; the City operates public-health and neighborhood-safety functions; and the Park Board governs many out-of-school settings. Minnesota created the Youth Coordinating Board through a 1985 special law to coordinate these public bodies around children and youth. Federal policy adds clinical and crisis pathways through Medicaid's Early and Periodic Screening, Diagnostic and Treatment benefit and the 988 Suicide & Crisis Lifeline. The Youth Master Plan and the Child Friendly Cities Local Action Plan translate these authorities into local priorities.

What coordination means at the service level is specified in McHugh et al. (2024), a systematic review of 15 studies of community-based integrated mental-health care for young people ages 12 to 25: multidisciplinary teams appeared in 13 studies, workforce training in 14, shared treatment plans in 11, shared electronic records in 10, and care coordinators in 7. Every one of the seven studies reporting access or engagement found higher rates in the integrated-care group. Six studies with 970 participants contributed to the meta-analysis of depressive symptoms at four to six months, producing a standardized mean difference of −0.260 relative to usual care (95 percent confidence interval −0.39 to −0.13; $p = .001$). The pooled effect was small, and the evidence base concentrated on urban settings, primary-care integration, and depression; six included studies excluded participants with recent suicidal ideation or common comorbidities. Within those boundaries, the findings connect multidisciplinary staffing, shared planning, information exchange, and follow-through to measured improvements in access and depressive symptoms.

The policy problem arises because direct services and connective functions follow different administrative logics. Clinical programs can have defined eligibility, reimbursement, and administering agencies, while a shared directory, common indicators, referral follow-through, and cross-jurisdiction accountability depend on staff capacity and agreements that fall between agency budgets. The Ecosystem locates this gap at the connection between policy resources and operational delivery. Funding a service without funding its referral and measurement infrastructure can increase nominal capacity without demonstrating that young people entered or benefited from care.

Implementation

The twelve identified gaps describe four interacting components of implementation: navigation infrastructure covers the cross-jurisdiction directory, shared indicators, and an accountability record; institutional capacity covers sustained backbone funding and the youth-work workforce; service reach covers supervised places after hours, completed referrals, family supports, youth employment, and program quality; and legitimacy covers culturally and linguistically responsive care and institutional responses to the digital environment. Their relationships can be tested as a sequence: whether stronger navigation and capacity predict service entry, whether entry predicts completion, and whether completion is associated with changes in symptoms, safety, connectedness, and functioning.

Youth employment illustrates the distinction between an ecosystem pathway and a measured outcome: in a randomized trial, Heller (2014) assigned 1,634 Chicago high-school students to a summer jobs program or a control group, and assignment to the eight-week program reduced violent-crime arrests by 43 percent over 16 months, equivalent to 3.95 fewer arrests per 100 participants. Random assignment supports a causal interpretation for that arrest outcome in the evaluated population; the trial did not estimate a mental-health treatment effect. Within the Ecosystem, the result supports structured employment as a tested safety pathway while requiring Minneapolis to measure its own participation, completion, safety, and mental-health outcomes.

Evaluation of the Minneapolis model requires measures matched to each stage of the proposed relationship. Repeated Community Assessment scores can track perceived participation, transportation, trust, and service conditions when respondent counts, weighting, confidence intervals, and missing-data rates accompany the estimates. Minnesota Student Survey data can track standardized population outcomes when district estimates and disclosure rules permit local reporting. Administrative records can measure referral initiation, successful contact, service entry, completion, wait time, and return to care. Linked respondent-level data can test associations among connectedness, safety, participation, access, and mental-health outcomes; repeated longitudinal observations can establish temporal ordering; and experimental or quasi-experimental designs are required when the objective is to estimate causal effects.

The Ecosystem is therefore an empirical governance model, not a claim that institutional coordination improves mental health by definition. Its value depends on whether the represented connections generate measurable changes in access, continuity, protective

conditions, and outcomes. Assigning an owner, data source, baseline, and review date to every connection converts the institutional map into a scientific framework through which Minneapolis can determine where support reaches young people, where pathways break, and which interventions produce change.

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