MINNESOTA

Legislative Report

Community Competency Restoration Task Force

Interim Legislative Report

Behavioral Health Division and
Direct Care and Treatment

February 2020

For more information contact:

Minnesota Department of Human Services
Direct Care and Treatment
P.O. Box 64979
St Paul, MN 55164-0979

651-431-3206

For accessible formats of this information or assistance with additional equal access to human services, write to dhsdirectcareandtreatment@state.mn.us, call 651-431-3206, or use your preferred relay service. ADA1 (2-18)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $1,600.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

Contents

I. Executive summary

People who have been charged with crimes have a constitutional and statutory right not to be tried if a judge determines they are, due to mental illness or cognitive impairment, incapable of understanding the proceedings or participating in their defense. Being incompetent to stand trial means that the prosecution of the criminal charges must wait until the person becomes competent or the charges are dismissed. Over the last five years the number of individuals who have been found incompetent has steadily risen. Under court rules of criminal procedure, if a person is found incompetent to stand trial, they must be referred for possible civil commitment. Only about one-third of those found incompetent to stand trial are actually civilly committed. In 2013, changes were made to the Civil Commitment Act (MS 253B.10, Subd. 1b), which require the commissioner of human services to prioritize, over all others, the admission of civilly committed individuals from county jails into a state-operated treatment facility – if the individual had been found incompetent to stand trial.

Since 2013, the number of people in Department of Human Services (DHS) facilities who are incompetent to stand trial has more than doubled, but treatment capacity has remained the same. In December 2018, to address this pressure on admissions, DHS announced a change in its discharge policy: DHS would provisionally discharge people when they are psychiatrically stable even if they are incompetent to stand trial, which is the same standard required of all individuals who are civilly committed. While people are provisionally discharged with a treatment plan, there are currently few to no competency restoration programs in community settings. In response to this policy change and the desire to develop a continuum of options to support the increased number of people deemed incompetent, the Legislature enacted the Community Competency Restoration Task Force. To meet the requirements set forth by the Legislature, the Community Competency Restoration Task Force was appointed in the summer of 2019 and has held seven monthly meetings since its first meeting on July 31, 2019.

The task force identified and defined the complex and multidisciplinary process a person moves through before and after they are found incompetent. Throughout this process, the task force identified various gaps that may contribute to the increase in the number of people found incompetent to stand trial. Increased prevalence rates of mental illnesses and co-occurring substance use disorders coupled with inadequate access to the correct level of mental health care make individuals more susceptible to crisis and subsequent justice involvement. For those who do become involved in the criminal justice system, the system is often unequipped to adequately treat people living with mental illnesses throughout their stay in custody and court proceedings, leading to a high risk that they will decompensate and be found incompetent when they get to trial.

This issue is compounded by what are known as “gap” cases. When a person is found incompetent to stand trial civil commitment proceedings are triggered. However, if a person does not meet the commitment standard they cannot be required to participate in treatment. If the charges are for misdemeanors, the charges will be dismissed and many of these individuals will not receive help and may reoffend. If the charges are for gross misdemeanors or felonies, the charges will be suspended; however if a person does not meet the standard for commitment, prosecutors can only file a notice and wait for a defendant to be restored to competency, again with no mechanism to ensure that a person receives treatment or restoration.

The task force reviewed the resources necessary to restore a person to competency. These resources consist of two parts: 1) mental health treatment and stabilization; and, 2) competency education concerning court proceedings and working with an attorney.

The task force identified several general categories of people who are found incompetent to stand trial defined by the length of time and necessary resources likely needed to restore them to competency:

- Short term: These individuals may quickly be restored through treatment of an acute mental health crisis and/or competency restoration education.
- Intermediate: These individuals may require a longer term of treatment and/or more intensive competency restoration education.
- Long Term: These individuals require the longest term and intensity of treatment and/or competency education.
- Unrestorable: Some individuals will likely never attain competency due to the nature of their cognitive impairment.

These categories indicate that the resources necessary to restore a person to competency vary greatly and must be responsive to individual needs. The task force identified and defined the complex and multidisciplinary process a person moves through before and after they are found incompetent.

Competency restoration provided in community or jail environments is necessary to ease the pressures on both the mental health and criminal justice systems. Though some barriers exist, the task force identified two Minnesota counties that have piloted outpatient competency restoration in the community: Olmsted County and Crow Wing County. The task force also identified several diversion programs operating in the state that serve to connect people in a mental health or substance use disorder crisis to services and divert them from the criminal justice system.

The task force reviewed available Minnesota data concerning the number of individuals who were ordered to be examined for competency and the number of individuals who were admitted to a state-operated facility after a finding of incompetency by county. Preliminary analysis of this data revealed that metropolitan and urban areas have the highest volume of people who were examined and people who were admitted. For the counties that experience high numbers per capita the task force identified consistencies in those counties and the gaps in available resources. These gaps were further highlighted by examining case studies and testimony submitted to the task force. The DHS Forensic Evaluation Department reviewed current literature about the settings and effectiveness of competency restoration programs around the nation and surveyed states through the National Association of State Mental Health Program Directors ListServ. Analysis from around the nation show that Minnesota is not unique in experiencing increased numbers of people found incompetent nor the issues it faces in restoring people to competency. The task force will conduct further research to ascertain the most effective programs that can be implemented in Minnesota.

Final recommendations of the Community Competency Restoration Task Force will be presented in the Final Legislative Report due to the Legislature on February 1, 2021.

Topics for further exploration and preliminary recommendations from the Community Competency Restoration Task Force include:

- Increase prevention and diversion efforts.

- Clarify the roles and responsibilities of state and county entities relating to competency restoration
- Identify process improvements for reducing the amount of time individuals remain in the criminal justice system
- Ascertain funding needs for community-based competency restoration services across continuums of care and secure resources
- Establish key measures to track outcomes and expected timelines for implementation to assess whether progress is being made.

II. Legislation

In 2019, the Legislature established the Community Competency Restoration Task Force. *See* Minnesota Laws 2019, 1st Special Session, Chapter 9, Article 6, Section 77, as follows:

Sec. 77. COMMUNITY COMPETENCY RESTORATION TASK FORCE.

Subdivision 1. Establishment; purpose. The Community Competency Restoration Task Force is established to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.

Subd. 2. Membership.

(a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:
   (1) a representative appointed by the governor's office;
   (2) the commissioner of human services or designee;
   (3) the commissioner of corrections or designee;
   (4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;
   (5) a representative appointed by the designated State Protection and Advocacy system;
   (6) the ombudsman for mental health and developmental disabilities;
   (7) a representative appointed by the Minnesota Hospital Association;
   (8) a representative appointed by the Association of Minnesota Counties;
   (9) two representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan area;
   (10) a representative appointed by the Minnesota Board of Public Defense;
   (11) a representative appointed by the Minnesota County Attorneys Association;
   (12) a representative appointed by the Minnesota Chiefs of Police Association;
   (13) a representative appointed by the Minnesota Psychiatric Society;
   (14) a representative appointed by the Minnesota Psychological Association;
   (15) a representative appointed by the State Court Administrator;
   (16) a representative appointed by the Minnesota Association of Community Mental Health Programs;
   (17) a representative appointed by the Minnesota Sheriffs' Association;
   (18) a representative appointed by the Minnesota Sentencing Guidelines Commission;
   (19) a jail administrator appointed by the commissioner of corrections;
   (20) a representative from an organization providing reentry services appointed by the commissioner of corrections;
   (21) a representative from a mental health advocacy organization appointed by the commissioner of human services;
   (22) a person with direct experience with competency restoration appointed by the commissioner of human services;
   (23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections; and
   (24) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. Duties. The task force must:

(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;
(2) analyze current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;
(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;
(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and
(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

Subd. 4. Officers; meetings.

(a) The commissioner of human services shall convene the first meeting of the task force no later than August 1, 2019.
(b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.
(c) The task force is subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. Staff.

(a) The commissioner of human services must provide staff assistance to support the task force's work.
(b) The task force may utilize the expertise of the Council of State Governments Justice Center.

Subd. 6. Report required.

(a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.
(b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

Subd. 7. Expiration. The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.

EFFECTIVE DATE. This section is effective the day following final enactment.

III. Introduction

Rule 20 of the Minnesota Rules of Criminal Procedure prescribes court procedures for defendants who, because of mental illnesses or cognitive impairments, may lack competency to be prosecuted or the mental state necessary to be held criminally responsible for their actions. The order to examine an individual to determine their competency to stand trial is commonly referred to as a "Rule 20.01" order by court officials and is common language throughout this report. This order is distinct from a "20.02" order which requires evaluation of criminal responsibility i.e. whether a defendant knew the nature of the offense and that it was wrong at the time of the offense. A "Rule 20.04" order is ordered so that an examiner may evaluate both the competency of a defendant and their eligibility for civil commitment at the same time. The primary concern of this report deals with individuals who are found incompetent to stand trial under a Rule 20.01 order; however, Rule 20.02 and 20.04 orders often intersect with competency evaluations and have been defined here for clarity.

People who have been charged with crimes have a constitutional and statutory right not to be tried if a judge determines they are, due to mental illness or cognitive impairment, incapable of understanding the proceedings or participating in their defense. Being incompetent to stand trial means that the prosecution of the criminal charges must wait until the person becomes competent or the charges are dismissed.

Competency restoration services are intended to restore an incompetent defendant's functioning to a level where they can understand the proceedings and participate in their own defense. Generally, these services consist of two key components: mental health treatment and competency education. The goal of treatment is stabilizing a person's mental health condition. The goal of competency education is to help the person understand the charges and penalties they face, work with attorneys to aid in their own defense and behave appropriately in court. Mental health treatment is provided by psychiatrists, psychologists and other highly trained clinicians. Competency education requires no specific expertise and can be provided in most any setting. Incompetency is not a mental illness and competency education is not mental health treatment.

Minnesota law is silent regarding the provision of competency restoration services. No state law requires any state agency or local unit of government to provide competency restoration services. Additionally, no state statute requires individuals to undergo competency restoration. Instead, a court rule of criminal procedure requires that people found incompetent to stand trial be referred for civil commitment if they have been charged with a gross misdemeanor or a felony. Only about one out of every three people referred for civil commitment after being found incompetent to stand trial is ultimately civilly committed because the legal standards for civil commitment and for competency to stand trial are not the same.

Competency restoration services are currently provided almost exclusively at two Department of Human Services (DHS) state-operated facilities and only to those who are civilly committed to the Commissioner of the Department of Human Services.

In 2013, changes were made to the Civil Commitment Act (MS 253B.10, Subd. 1b), which require the commissioner of human services to prioritize the admission of the following individuals from county jail into a state-operated treatment facility:

(1) ordered confined in a state hospital for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state hospital or other facility pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

As the legislature has instructed, the Department of Human Services (DHS) has prioritized admissions of such individuals to Anoka Metro Regional Treatment Center (AMRTC) and the Forensic Mental Health Program (formerly known as the Minnesota Security Hospital). When a medically appropriate bed is available, the admission occurs within 48 hours of receiving the order for commitment unless there is a delay in transportation. While many people believe that under the statute the admission is required within 48 hours once the person has been committed, it's important to note that often people have already been waiting in jail two to three months before commitment occurs. In the event that a medically appropriate bed is not immediately available, regardless of their location prior to admission, individuals are placed on a waiting list. People from county jails who meet the criteria above are prioritized over people from other locations, such as community-based hospitals and emergency departments.

The number of transfers from county jails under the priority admission law continues to increase every year. In addition, the directive to prioritize the admission of these people over others requires DHS to keep several beds available in anticipation of court orders for recent or pending hearings. Of all DHS-operated direct care facilities, AMRTC accepts the vast majority of people under priority admission law because it serves those with the highest acuity.

Since 2013, the number of people in DHS facilities who are incompetent to stand trial has more than doubled, but treatment capacity has remained the same. In December 2018, to address this pressure on admissions, DHS announced a change in its discharge policy: DHS would provisionally discharge people who were still incompetent to stand trial, but are psychiatrically stable, which is the same standard required of all individuals who are civilly committed. Once a person is provisionally discharged from DHS facilities, either to the community or to jail, DHS' competency education services cease. While people are discharged with a treatment plan, there are currently few to no competency restoration programs in community settings.

In response to this policy change and the desire to develop a continuum of options to support the increased number of people deemed incompetent and thus need competency restoration services in order to participate in their defense, the Legislature enacted the Community Competency Restoration Task Force. *See* Minnesota Laws 2019, 1st Special Session, Chapter 9, Article 6, Section 77.

Specific mandates of the Community Competency Restoration Task Force, include:

(1) Identifying current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;
(2) Analyzing current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;
(3) Analyzing selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;
(4) Researching how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and
(5) Developing recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

Under the legislation creating it, by February 1, 2020, the Community Competency Restoration Task Force is required to submit a report on its progress and findings. A final written report is due by February 1, 2021 and must include recommendations to address the growing number of individuals deemed incompetent to stand trial.

To meet the requirements set forth by the Legislature, the Community Competency Restoration Task Force was appointed in the summer of 2019 and has held seven monthly meetings since its first meeting July 31, 2019.

Since July, the Community Competency Restoration Task Force:

- Appointed Sue Abderholden as chair of the task force and William Ward as vice-chair.
- Defined the applicable laws and processes in Minnesota for a person found incompetent, from arrest to provisional discharge from a DHS facility
- Analyzed available data concerning the number of individuals by county with a court order for a competency evaluation and the number of individuals by county admitted to a DHS facility under a civil commitment after being found incompetent
- Reviewed available information on the current diversion efforts in Minnesota
- Reviewed current Minnesota Rules concerning the screening and treatment of people with mental illnesses in jail
- Developed a chart to document task force member perspectives on the reasons for the rise in the number of people found incompetent since 2015, as well as necessary data needed to support these hypotheses, and possible solutions
- Examined case studies and heard testimony from people with lived experience with competency restoration
- Analyzed available resources presented by two private correctional health care providers in Minnesota concerning mental health and substance use disorder treatment and medication management in jails
- Reviewed the draft report and recommendations of the Judicial Branch Psychological Services Workgroup presented by the Minnesota Judicial Branch

- Reviewed research concerning competency restoration issues and practices throughout the United States presented by the DHS Forensic Evaluation Department and NAMI Minnesota
- Reviewed information about the impact of treatment courts in Minnesota presented by the Minnesota Judicial Branch
- Reviewed current pilot outpatient competency restoration programs presented by Olmsted County Community Services and Crow Wing County Community Services

IV. Progress assessment

Overview

Mandated activities of the Community Competency Restoration Task Force include:

(1) Identifying current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;
(2) Analyzing current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;
(3) Analyzing selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;
(4) Researching how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and
(5) Developing recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

A. Review of current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial.

Rule 20 of the Minnesota Rules of Criminal Procedure state:

> ‘‘A defendant is incompetent and must not plead, be tried, or be sentenced if the defendant due to mental illness or cognitive impairment lacks ability to:
>
> (a) rationally consult with counsel; or
>
> (b) understand the proceedings or participate in the defense.”

The resources necessary to restore a person to competency consist of two parts:

1. Mental health treatment and stabilization and
2. Competency education concerning court proceedings and working with an attorney.

The task force identified several general categories of people who are found incompetent to stand trial defined by the length of time and necessary resources likely needed to restore them to competency:

- **Short term**: These individuals may quickly be restored through treatment of an acute mental health crisis and/or competency restoration education.
- **Intermediate**: These individuals may require a longer term of treatment and/or more intensive competency restoration education.

- **Long Term**: These individuals require the longest term and intensity of treatment and/or competency education.
- **Unrestorable**: Some individuals will likely never attain competency due to the nature of their cognitive impairment.

These categories indicate that the resources necessary to restore a person to competency vary greatly and must be responsive to individual needs. The task force identified and defined the complex and multidisciplinary process a person moves through before and after they are found incompetent.

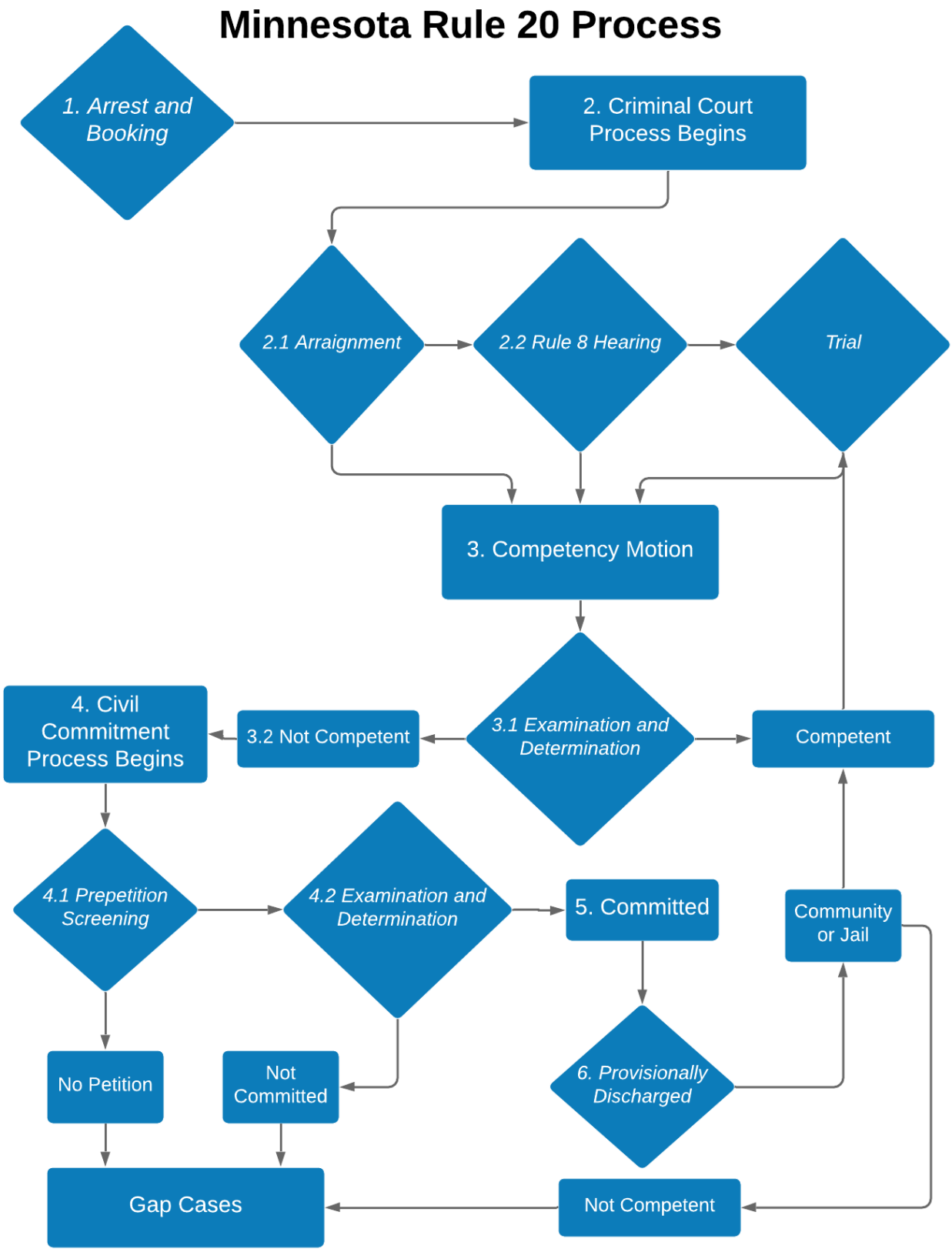

Minnesota Rule 20 Process
1. Arrest and Booking
2. Criminal Court Process Begins
2.1 Arraignment
2.2 Rule 8 Hearing
Trial
3. Competency Motion
3.1 Examination and Determination
3.2 Not Competent
Competent
4. Civil Commitment Process Begins
4.1 Prepetition Screening
4.2 Examination and Determination
5. Committed
Community or Jail
No Petition
Not Committed
6. Provisionally Discharged
Gap Cases
Not Competent

Image Description: Flowchart describing the Rule 20 Process in Minnesota. 1. Arrest and Booking 2. Court Process: 2.1 Arraignment: 2.2 Rule 8 Hearing 2.3 Trial (at any time during the court process a court official may raise the issue of the defendant's competency) 3. Competency Motion: 3.1 Examination and Determination: 3.2 Finding of Incompetence (if found competent the court procedures will resume, if found incompetent, civil commitment proceedings are triggered) 4. Civil Commitment Proceedings 4.1 Prepetition Screening (if the civil attorney decides not to file for commitment, this case falls in the gap) 4.2 Examination and Determination (if a person does not meet the standard for commitment, the case falls into the gap) 5. Commitment 6. Provisional Discharge (if a person is provisionally discharged without being restored to competency this case falls into another gap).

There are several significant points in this process when analyzing resources available to people who are found incompetent:

The Mental Health System: The resources available in the mental health system reveal several barriers to adequately prevent mental health and substance use crises and reduce the risk for criminal justice involvement. The members of the task force represent diverse disciplines that interact with the criminal justice and mental health systems at varying points. The following key elements in no particular order represent the different perspectives, not a consensus, concerning what might be contributing to the rise in people found incompetent to stand trial:

- Increase in prevalence rate of mental illnesses especially among youth and more people seeking care.
- Increased potency and use of substances of abuse as co-occurring disorders with mental illnesses.
- Individuals who lack insight to voluntarily seek treatment.
- Inadequate timely access to the correct level of mental health care.
- Discharge from inpatient hospitalization without adequate community supports and limited access to acute care.
- Difficulty accessing and becoming eligible for Medical Assistance Home and Community-Based Waivers in a timely manner.
- Discrimination under Medical Assistance, Medicare, and private insurance which leads to less coverage for needed mental health and substance use disorder treatment.
- Workforce shortages of rural providers and culturally competent providers for culturally diverse communities.
- Lack of long-term housing with intensive supports and lack of affordable housing.
- Incomplete crises response systems, raising the risk for criminal justice responses to mental health needs.

Law Enforcement: Given the increased prevalence rates and the remaining gaps in the mental health system, law enforcement agencies are routinely encountering people with mental illnesses and co-occurring substance use disorders. Figure 1 shows data shared with the task force by the State Court Administrators Office.

Figure 1

Prevalence of gap cases, by degree

	Number of mandatory criminal cases with a finding of incompetency between 2016-2018	Number of those cases where the defendant appears on a civil commitment filing within 30 days of the incompetency finding	Number of those cases where the civil commitment filed within 30 days leads to a commitment order	Number of those cases where the civil commitment filed within 30 days leads to a continue for dismissal order	Percent of cases with an incompetency finding where defendant was ultimately committed
Felony	1,471	865	672	19	46%
Gross Misdemeanor	487	264	184	9	38%
Misdemeanor	1,256	700	449	32	36%

MINNESOTA JUDICIAL BRANCH

14
1/17/2020

This document is written and published by the Minnesota State Court Administrator's Office.

From 2016-2018 of all the mandatory criminal cases with a defendant found incompetent, 1,471 were for felony charges, 487 were for gross misdemeanors, and 1,256 were for misdemeanors. The Minnesota Rules of Criminal Procedure require that misdemeanor charges be dismissed for defendants who are found incompetent to stand trial. This means from 2016-2018, 1,256 individuals moved through the Minnesota court system, many generating costly jail stays and court examinations, ultimately to have their charges dismissed.

Diversion and Prevention: This has led to a growing interest in interdisciplinary programs to divert people from the criminal justice system. Diversion from the justice system may occur at three points in a law enforcement encounter: pre-arrest, pre-booking, or pre-trial. Pre-arrest diversion intervenes with connection to services before any charges are brought against a person and is generally at the discretion of the law enforcement officer involved in the encounter, often with the input of a co-responding mental health worker. Pre-booking diversion can occur when a person is detained temporarily and a diversion plan and connection to services are worked out before charges are brought against a person. Pre-trial diversion occurs when a diversion plan is created after a person is taken into custody and often includes the county attorney's agreement as well as law enforcement and social services. The goal of diversion projects is to connect people to services and avoid justice involvement, however charges may still be brought against a person who is diverted. In these cases, diversion still serves the purpose of working to treat the underlying cause of criminal behavior and reduce recidivism.

The task force identified several diversion programs with preventative elements operating in Minnesota:

Community Action Team – Stearns County, St. Cloud: The Community Action Team (CAT) is next generation prevention work, further upstream from the RAP program and other previous work in the jail. CAT is made up of county social workers & corrections agents, CentraCare healthcare providers, county and municipal law enforcement officers, and the Central Minnesota Mental Health Center providers. The team meets weekly to discuss and determine how to best reach and engage individuals who are repeatedly in detox, the ER, or in law enforcement interactions. Stearns and Benton County Jails contract with CentraCare health to provide medical and mental health care to jail residents. Utilizing a community-based provider gives jail residents a higher level of care and can offer a seamless continuum of care after incarceration to decrease recidivism. Since implementation, the system savings has averaged $35,000/per person served by the team. Stearns County has seen a reduction in law enforcement encounters, jail, detox, and ER stays.

Dakota County Adult Detention Alternatives Initiative: In 2016, Dakota County joined the National Stepping Up and White House Data Driven Justice Initiatives and entered partnerships with the GovLab and City University of New York to collect a comprehensive picture of the prevalence of mental illnesses in their jail population. Dakota County has worked to develop a high level of cross-department communication so that county social workers are notified when their clients have been booked into local custody. This allows social workers to connect with clients and offer a better continuum of care. The county jail also hired a Licensed Professional Clinical Counselor as the Mental Health Coordinator to better serve incarcerated people.

Duluth Police Department Mental Health Unit: In 2016, the Duluth Police Department piloted a program embedding a social worker to respond with officers to service calls and connect individuals to services and divert them from arrest. After several years of continued success, the program became official in 2018 and includes a Lieutenant, a Sergeant, two dedicated mental health officers, and two embedded social workers (LICSW and LSW). Since its inception in 2018, The department has seen a 31% drop in calls for service among those with the most frequent contact with police. The unit has worked collaboratively in the community with the assistance of a comprehensive Release of Information to expedite connection to services and reduce recidivism.

Hennepin County Criminal Justice Mental Health Initiative (CJBHI): The CJBHI, launched in 2014, has made Hennepin County a national innovator in targeting specific touchpoints to bring tailored services to people with Serious Mental Illnesses or Co-occurring Disorders and divert them from justice responses where possible. The county has been awarded several competitive federal and state grants to advance this work and inform the national dialogue that is shaping policy and practice. Through this initiative, Hennepin County has trained law enforcement in Crisis intervention Training, created shared data bases across justice and human service agencies, began using the Brief Jail Mental Health Screening for everyone booked into jail, embedded mental health professionals jail, the courts, and local law enforcement agencies including the establishment of a co-responder model, developed a behavioral health center that serves as a low barrier alternative to jail and hospitalization and specialty intensive residential treatment programs that address criminogenic risk and need, and began a forensic assertive community treatment team.

Olmsted County Law Enforcement Liaison and Jail Diversion Program: At the beginning of 2018, Olmsted County Health, Housing, and Human Services partnered with the Olmsted County Sheriff's Department and the Rochester Police Department to hire their first Law Enforcement Liaison Social Worker. The liaison works directly in the field with law enforcement to provide a social service lens to the calls they receive. They act as a resource and referral agent, but also assists in deescalating crises in

effort to decrease unnecessary trips to the emergency department. The jail diversion program diverts individuals with serious mental illness and often co-occurring substance use disorders away from jail and provides linkages to community-based treatment and support services. The individual thus avoids arrest or spends a significantly reduced time period in jail and/or lockups on the current charge or on violations of probation resulting from previous charges.

Region 5+ Comprehensive Re-Entry Project - Aitkin, Cass, Crow Wing, Morrison, Todd and Wadena County: The Comprehensive Re-Entry Project places a social worker in each County Jail in the Central Minnesota region. The goals and focus of the program have been based on *Stepping Up Initiative* which is committed to reducing the number of people with mental illnesses booked into the jail, reducing the length of time spent in jails, increasing connections to treatment, and reducing recidivism. Social workers screen individuals for mental health or chemical dependency issues upon booking and provide prompt response and early intervention to the incarcerated individuals in need of assistance. It is designed to help and get the correct services in place at the right time, for the individual to be successful in the community. The project has continued to grow and collaborations with the jail, law enforcement, and attorney's office continue to improve.

St. Paul Police Department Community Outreach and Stabilization Unit: The Mental Health Resource Team, under the Community Outreach and Stabilization Unit, is a collaborative response between the Saint Paul Police Department and community-based resource partners. Comprised of partners from Ramsey County Crisis and People Incorporated, an embedded Licensed Clinical Social Worker works with specially trained Mental Health officers to respond to in-progress crisis related calls for service in the Co-Responder Program and conducts follow up and outreach efforts in the Case Management Program.

West and South St. Paul Mental Health Coordinated Response: The West St. Paul and South St. Paul Police departments have collaborated with Dakota County Social Services to create the law enforcement-mental health Coordinated Response pilot. Through the pilot, a dedicated Dakota County Mental Health Coordinator, who is a licensed mental health professional, works directly with a Community Engagement Officer from each city to provide follow-up to individuals in the community when a crisis has passed. They have found greater success connecting people to services in these follow up meetings than in referring them in the initial crisis call.

The Yellow Line Project – Blue Earth County: The Yellow Line Project began by embedding a social worker at the front door of the jail to connect eligible people to services and divert them from the justice system. All people are voluntarily screened for mental illness and substance use disorders before booking by a county social worker. The project has since grown to staff 2 social workers and now partners with a Mobile Crisis Team through Horizon Homes Adult Mental Health to provide 24/7 mobile screening to allow for the earliest possible intervention. Project growth also includes continual screening and pretrial referrals for people incarcerated 1-3 days who may have opted out of or been unable to complete pre-booking screening. In-jail crisis services (assessment, intervention and stabilization) is also offered through Horizon Homes. Care Coordination through the Yellow Line Project is offered up to 60 days.

The *Stepping Up Initiative* was established in 2015 through a partnership between the American Psychiatric Association Foundation, the National Association of Counties, and the Council of State Governments Justice Center. The initiative "provides key resources intended to assist counties with developing and implementing a systems-level, data-driven plan that can lead to measurable reductions in the number of people with mental

illnesses in local jails."[1] Nineteen counties in Minnesota have passed a *Stepping Up* resolution through their county boards, though they are at varying levels of participation in the initiative's stated goals:

- Aitkin
- Beltrami
- Blue Earth
- Carlton
- Carver
- Cass
- Crow Wing
- Dakota
- Hennepin
- Olmsted
- Otter Tail
- Ramsey
- Roseau
- Scott
- Stearns
- Traverse
- Wadena
- Washington
- Winona

County Jails: For those individuals who are charged and held in custody, access to adequate mental health and substance use disorder treatment during incarceration is essential for reducing the number of people found incompetent to stand trial. Many people who are found incompetent when they get to trial were decompensating long before their first appearance before a judge. For others, a defendant in custody may appear for multiple hearings and decompensate over the time of their incarceration due to the environment and lack of resources in some jails to adequately treat mental illnesses. There are several options and methods for providing mental health care in jail settings. Many jails contract with private correctional care providers or community healthcare systems for their mental health care. Some jails have formed community-based partnerships with healthcare providers or mental health centers. Some jails have separate, more therapeutic units dedicated for people experiencing mental illnesses, and some jails in rural areas have made use of telemedicine to increase access to care. All of these options face some significant obstacles in providing timely and adequate mental health care in a jail setting. Adequate treatment in a jail setting involves several elements:

> **Screening:** The Minnesota Administrative Rules 2911.5800 AVAILABILITY OF MEDICAL AND DENTAL RECORDS also requires medical screening and inquiry into "use of alcohol and other drugs that include types of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of problems that may have occurred after ceasing use, for example, convulsions" and "past and present treatment or hospitalization for mental illness or attempted suicide". However, this language never specifies procedures pertaining to mental health referrals or treatment. Minnesota Statute 641.15 Subd. 3a was amended in to 2006 to require use of "a mental health screening tool approved by the commissioner of corrections in consultation with the commissioner of human services and local corrections staff to identify persons who may have mental illness." The Minnesota Department of Corrections utilizes the Brief Jail Mental Health Screen (BJMHS) which is validated by the Substance Abuse and Mental Health Services Administration.
>
> Several issues still arise from the screening process. Any information gathered from a screen is given voluntarily and many people being booked into a jail are reluctant to honestly disclose their drug use

[1] https://stepuptogether.org/toolkit

history or mental health symptoms. Another barrier to gathering accurate screening results can be the cultural competency of the person administering the screen. Negative attitudes about mental illnesses and past negative experiences in corrections systems may also make a person reluctant to disclose diagnoses or past treatments. These issues can be further complicated when an individual has a lack of insight into a mental illness does not believe they are exhibiting symptoms. Several of the diversion programs in Minnesota utilize a customized screening tool in addition to the BJMHS to gather more comprehensive information.

Treatment Availability and Medication Issues: When a person does screen positive for mental health issues, available resources and procedures to connect a person to treatment also vary greatly. Each jail is unique in its medication formulary, and this may or may not include the most effective medication for a person living with a mental illness. Several medications are not allowed in many jails due to concerns of diversion or misuse and some jails have no formularies at all. If a person has their prescribed medication with them when they are booked into a jail, it will usually be confiscated. For these reasons, individuals may have to discontinue the most effective medication while incarcerated or transition to a less effective medication. For a person who may be recovering from an opioid addiction not all jails provide Medication Assisted Treatment.

Discharge: Discharge planning varies as well, depending on the mental health service provider in the jail. Due to safety policies in jails there are some restrictions on the amount of medication a person may have at one time. These restrictions also limit providers' ability to discharge people with more than a few day's supply of medication. Often with privately contracted correctional health care providers a person will not be discharged with a new prescription and it may take months to find a new prescriber in the community. If the mental health provider in the jail is county or community based there is a greater opportunity for continuity of care; however, for many people in jail, Medical Assistance is suspended or terminated creating barriers to maintaining medication and treatment. In some cases, a person may access treatment after discharge, before being re-enrolled in Medicaid. Medicaid pays retro-actively to cover these expenses, but this does not apply to pharmacies and financial thus, logistical barriers remain for people accessing medication.

Such interruptions in treatment and medication increase the risk of relapse, crisis, and justice involvement. It is not uncommon for a jail to release a person only for them to be booked again within days and in some cases hours, with new charges. These individuals are sometimes called "high utilizers" for their frequent encounters with law enforcement and apparent chronic conditions. Several of the diversion projects in Minnesota have successfully reduced encounters with "high utilizers" through collaboration and a focus on continuity of care. Furthermore, many of the counties with diversion programs or the Stepping Up Initiative have social workers in jails to assist in re-enrolling in insurance, and to improve discharge planning and continuity of care.

The task force conducted an informal survey of twenty jail administrators three from the Metro area and seventeen from rural communities. The survey results revealed that the availability of mental health services in jails varies greatly throughout the state[2]. Only about half of the jails offered individual therapy or had open formularies. About half of the surveyed jails had community-based contracts or partnerships, but the availability of mental health professionals varied from a full-time psychiatric nurse to a mental health professional who

[2] Appendix B

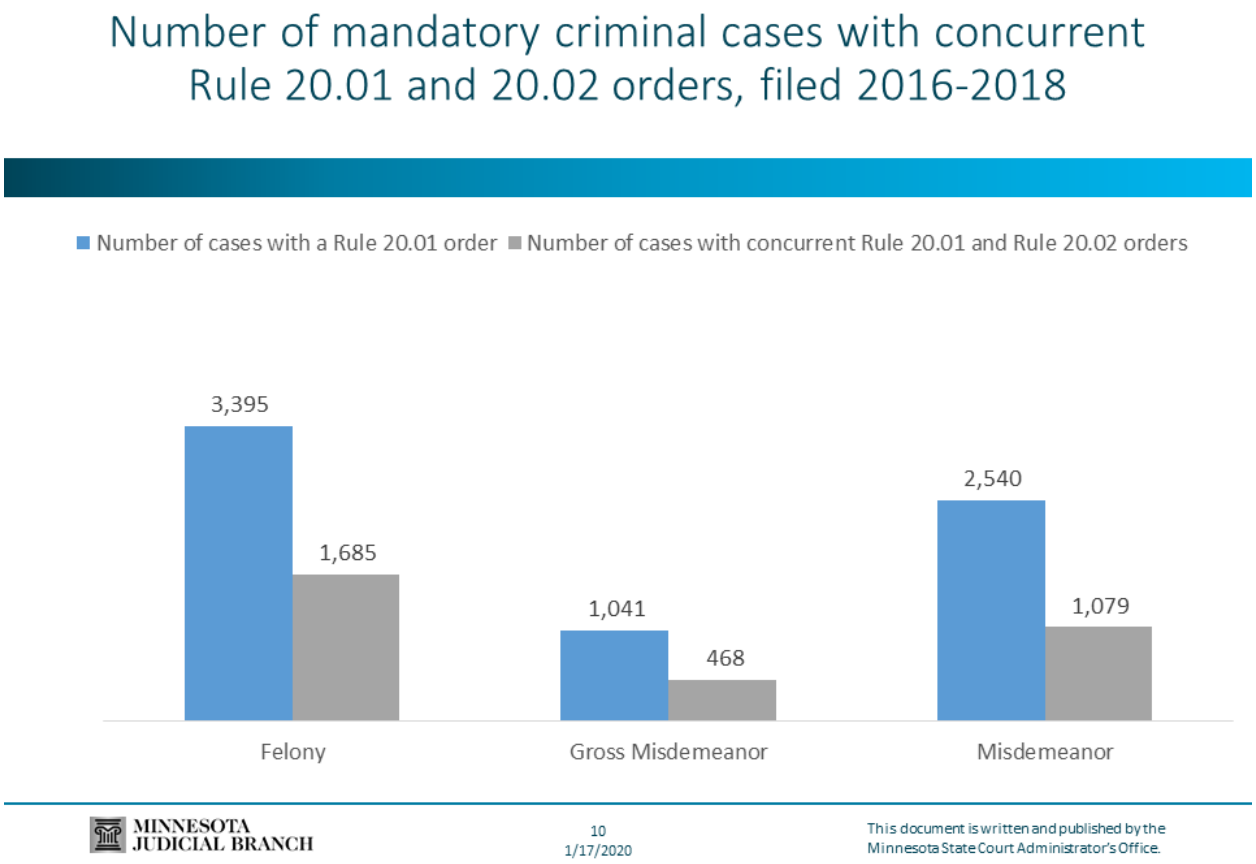
worked two to four hours a week. Only six of the twenty jails had social workers or community mental health center workers to aid with discharge planning. While this survey is only a small sample of the over eighty jails in the state of Minnesota, it offers a picture of the variance in care that person may receive and the available continuities of care around the state.

Court System: The task force identified several points of interest in analyzing the available resources in the court system to a person whose competency is in question.

Training and Awareness of Court Officials: Many court officials credit the rise in the number of people found incompetent to an increased awareness of and training on mental illnesses and competency. Though this awareness seems to be growing throughout the state, continued education of public defenders, county attorneys, and judges to recognize and understand mental illnesses and substance use disorders is an important factor in relieving pressure and saving resources in the court system. Continued education concerning the laws around defendants with mental illnesses is another necessary factor to reduce costs.

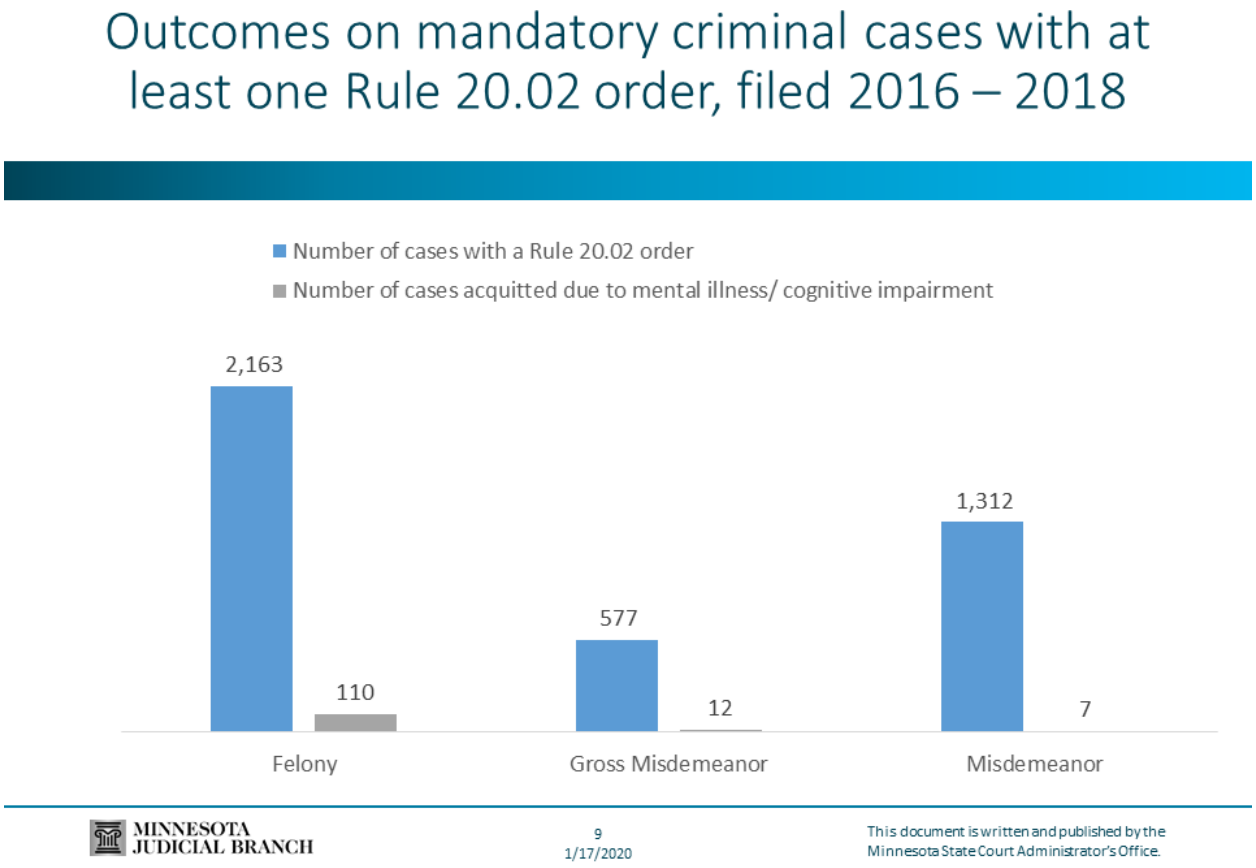
For example, data in Figure 2 from the State Court Administrator's Office showed that from 2016-2018 around 50% of all Rule 20.01 orders (competency examinations) were being ordered concurrently with a Rule 20.02 (defense of mental illness or cognitive impairment).

Figure 2



According to the rule, a 20.02 examination should only take place if the defense asserts its intention to use a "mental illness or cognitive impairment defense.[3]" However, if a defendant's competency is in question, they should not be deciding their defense until the question of competency has been resolved. Furthermore, Figure 3 shows that in the same period from 2016-2018 an average of 3% of all "mental illness or cognitive impairment" defenses resulted in acquittal.

Figure 3



This means that from 2016-2018 the court spent many resources ordering over 3,000 Rule 20.02 examinations that ultimately affected very few outcomes.

Availability, Quality, and Timeliness of Competency Examinations: Rule 20 of the Minnesota Rules of Criminal Procedure requires the examiner's opinion on competency to be returned to the court no more than 60 days after the order for the examination. Even in some areas with the greatest concentration of resources, examiners struggle to conduct and return examinations in a timely manner, and may result in some defendants being in jail for weeks.

[3] Rule 20.02, Minnesota Rules of Criminal Procedure subd. 1

Minnesota's 4th and 6th Judicial Districts have piloted projects to reduce this time and streamline the process of examinations. In the 4th Judicial District, Psychological Services implemented a successful pilot which has since become a permanent program (now the Targeted Misdemeanor Rule 20 program). The program successfully reduced time to resolution, examiner hours and cost to the court. The program involved having an examiner on call who interviewed misdemeanor defendants either on the same day as the Rule 20 order if the defendant was residing in the community, or within two days if detained. The 4th District is exploring avenues to broaden the scope of the program in ways that do not result in an increase in contested hearings, as that would detract from the positive results experienced. This must be approached carefully due to the highly adversarial setting of criminal court.

Minnesota's 6th Judicial District piloted a project in 2018 to prescreen all individuals for whom competency is questioned. The pre-screening process is fast and less costly than a full Rule 20.01 evaluation. As a result, the 6th District saw a 25% decrease in the number of Rule 20.01 orders from 2017 to 2018. They also saw an increase in the percent of people found incompetent, meaning that the pre-screening process was saving time and resources by filtering out people who might have previously been inappropriately examined. Trusted relationships are essential in the success of such an initiative because attorneys and judges must be assured that the screener is not biased against court officials.

The task force also learned that in some cases, even if the examination is conducted and returned in a timely manner, a judge may not issue a finding for several weeks. This is another important point of education for court officials to reduce the time that people wait in jail and are at risk to decompensate.

Treatment Courts: Minnesota currently has 68 treatment courts including Adult Drug Court, DWI Courts, Veterans Treatment Courts, Mental Health Courts, Family Dependency Treatment Courts, Juvenile Drug Court, Tribal Healing to Wellness Courts, and Hybrid Treatment Courts. While a defendant cannot participate in a treatment court until their competency is restored, the task force has identified treatment courts as a useful resource for connecting people to treatment and reducing cycles of recidivism.

Gap Cases: One of the most significant issues in analyzing data on people in jail who are found incompetent to stand trial is the difference between the standards for determining incompetence and civil commitment. The standard of competency is a legal one that requires a defendant be able to understand their court proceedings and participate in their defense. The standard of civil commitment is based on whether that person poses a significant threat of harming themselves or others. When a person is found incompetent, the civil commitment proceedings are immediately triggered. However, if a person does not meet the commitment standard they cannot be required to participate in treatment, and in Minnesota, two inpatient DHS state-operated facilities are generally the only source of competency restoration education.

If the charges are for misdemeanors, the charges will be dismissed and many of these individuals will not receive help and may reoffend. If the charges are for gross misdemeanors or felonies, the charges will be suspended; however if a person does not meet the standard for commitment, prosecutors can only file a notice and wait for a defendant to be restored to competency, again with no mechanism to ensure that a person receives treatment or restoration. Charges must be dismissed within 30 days for gross misdemeanors unless a notice is filed. If a notice of intent to prosecute is filed for a gross misdemeanor the charges must be dismissed after one year if the defendant would be entitled to custody or confinement credit if convicted. Felony charges, except for murder, must dismissed after three years unless a notice is filed, which is the practice for most cases.

The Robina Institute at the University of Minnesota showed in their 2016 report "*Closing the "Gap" Between Competency and Commitment in Minnesota* that "of 1,545 case files spanning 2010-2014 in which competency

of the defendant was raised, no civil commitment petition was filed in 45% of the cases. In 21% of cases, the petition did not succeed. This means that only 34% of the defendants declared incompetent to stand trial were actually civilly committed for treatment[4]." Data from Figure 1 shows that from 2016-2018 in 64% of misdemeanor cases the person did not go on to be civilly committed after being found incompetent. In the same period, 62% of gross misdemeanors and 54% of felony cases were "gap" cases.

With the change in DHS policy in December 2018, another type of gap is introduced. Even if a person found incompetent is civilly committed, they may now be discharged from treatment without being restored to competency. When DHS deems a person ready for provisional discharge, they engage in discharge planning with the responsible county. For those at AMRTC, once a person is deemed ready for provisional discharge the county of financial responsibility takes on 100% of the cost of hospitalization in the state operated facility while the person is transitioning, approximately $1,400 a day. Upon discharge people are either returned to jail or to the community where the county of financial responsibility often faces difficulty in finding an appropriate setting with the correct level of care, and a provider willing to take an individual with pending charges. Though counties work hard to find these placements, even then these people will not receive competency restoration education and are again in the gap.

Competency restoration provided in community or jail environments is necessary to ease these pressures. However, competency restoration consists of mental health stabilization and education, and the education piece is strictly a legal requirement and not billable as a medical service. Though these barriers exist, two Minnesota counties have piloted outpatient competency restoration in the community.

Crow Wing County: In 2015, Crow Wing County trained one case manager and a supervisor in the Competency Restoration curriculum provided by the Minnesota Department of Human Services. They had their first case in January of 2018 and have had six cases total since the pilot began. Two of those cases required inpatient treatment at a state operated facility after the process had begun in the community. One case started in AMRTC and transferred out to finish the Competency Restoration Process. The other three were done solely in the community. One has completed the process and was found competent at a later court hearing. Her charges were reduced, and that person continues to be in the community. Two are still pending upon the date of this writing but have recently had their second competency evaluations and are indicating that they will be competent.

Though the county receives no additional funding, case managers provide competency restoration education out of necessity to save costs. Providing this education allows people to be discharged from a state operated facility and returned to the community where the hours spent by case managers are significantly less expensive than the cost the county bears for people who do not meet criteria for inpatient level of care stay at a state operated facility. Rough estimates of cost savings show potential savings of over $150,000.00 to provide the same service in the community (when appropriate) rather than AMRTC. Crow Wing County case managers can also provide this service for defendants deemed incompetent but not fit for civil commitment (gap cases) and eligibility is decided based on the case managers, supervisors and attorney's discretion. If someone can be served in the community with their own providers, this route has been favorable.

[4] https://robinainstitute.umn.edu/file/2321/download?token=SRTfUWFG

Olmsted: In 2014, Olmsted County was the recipient of the *Whatever It Takes* grant to provide services to people transitioning out of state operated facility in the 10-county Adult Mental Health Initiative CREST Region in Southeast Minnesota. The *Whatever It Takes* grant fully funds two social workers assigned to the Minnesota Security Hospital who began a pilot community-based competency restoration program in 2018. Because Olmsted uses the *Whatever It Takes* grant to fund competency restoration education, individuals in need of competency restoration must also meet criteria for the WIT program: those that have been civilly committed and have received treatment at AMRTC or MSH. Other eligibility requirements include that people:

- be from the CREST Region
- have participated in discharge planning with the *Whatever It Takes* Social Workers
- be psychiatrically stable
- be willing to take medications as prescribed
- be willing to participate in the program
- be determined to be appropriate for program by the team.

Another social worker assigned to AMRTC is funded on a fee-for-service basis charged to the CREST region and to streamline discharge planning and decrease unnecessary time spent in the hospital. At this time, the AMRTC social worker is not providing competency restoration services Each county has a signed contract in place and are only billed if they had an individual at AMRTC during the billing period. An additional social worker is assigned to the Olmsted Adult Detention Center and is fully funded by Olmsted County levy dollars. Previously, this position was funded half through the *Whatever It Takes* grant and half through levy dollars; however, after significant cost savings noted in the pilot community competency restoration program, the county agreed to fully fund the position. The *Whatever It Takes* team provides competency restoration services to individuals in a variety of settings, including detention centers, IRTS facilities, CARE facilities, or in the individual's home or community setting. On average, the team provides services to 20-25 people per year. Between 60-70% of these individuals require competency restoration services, in the hospitals and/or in the community. Because of the expansion of the pilot project into a fully functioning community competency program, the team purchased the MacArthur Competency Assessment Tool to guide treatment, measure outcomes, and determine if an early examination is appropriate.

The task force will continue to examine the pilot programs, their effectiveness, and the implications for expansion. Any growth in resources must be tailored to the communities they serve. Solutions in the Metro area will not be the same as those for rural communities, and care must be taken to avoid unintended consequences of new legislation, without appropriate foresight for the impacted communities.

The Sequential Intercept Model (SIM) is a tool that was developed by Policy Research Associates and published in 2005 by the GAINS Center for Behavioral Health and Justice Transformation through the Substance Abuse and Mental Health Services Administration. "The SIM was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.[5]" The task force used the SIM to map out potential areas of intervention that may affect people who have been or may be at risk for being found incompetent to stand trial. The task forced compiled this map in Appendix F and it should not be read as consensus recommendations, but rather a working document to inform the future work of the task force.

[5] https://www.prainc.com/sim/

To support recommendations the task force will:

- Further explore the current gaps in the mental health system to identify the root causes and solutions for all communities.
- Collect data on the effectiveness of the various Minnesota diversion programs, engage stakeholders further on the barriers they face in operating programs, and recommend solutions to strengthen and grow these programs for all communities.
- Examine root causes and of barriers to treatment in jail settings, specifically around screening and referral procedures, medication management, improving access to care, and discharge and re-entry.
- Explore practical and effective training and education for court officials and continue to identify processes for refining and improving the timeliness and quality of examinations.
- Develop recommendations for funding and procedures for community competency restoration programs that are scalable for all Minnesota counties.

B. Analysis of current trends relating to competency restoration referrals by counties and the impacts of diversionary projects

Data Collected: The task force collected available data and information from the State Court Administrator's Office and the Department of Human Services concerning the number of individuals with a Rule 20.01 order per county from 2014-2018 and the number of admissions to a state operated facility for a finding of incompetence from 2017-2019. This data was compared to different factors per county such as population, poverty rates, opioid prescription rates, and homelessness.

Preliminary Analysis: The data reviewed by the task force indicates several points of interest geographically and demographically. Three counties in Minnesota emerged as "outliers" when analyzing the number of individuals with a Rule 20.01 order from 2014-2018[6]. Cass, Goodhue, and Polk County all remained consistently in the top ten counties for individuals per capita with a Rule 20.01 order from 2014-2018. Figures 4, 5, and 6 show these counties again appear as outliers in data representing the number of individuals admitted to a state operated facility after a finding of incompetence from 2017-2019 with the inclusion of Clay County as a new outlier for admissions. Clay County only appeared on the top ten list for Rule 20.01 orders in 2018.

Cross-referenced with U.S. Census standards for a Metropolitan Statistical Area (MAS), Polk and Clay County's high statistics may be explained by their bordering towns in North Dakota which comprise an MSA. The U.S. Census Bureau defines an MSA as, "A Core Based Statistical Area associated with at least one urbanized area that has a population of at least 50,000[7]." Goodhue county remains as the only outlier as a county with high

[6] Appendix B

[7] https://www.govinfo.gov/content/pkg/FR-2010-06-28/pdf/2010-15605.pdf

numbers or Rule 20.01 orders and admissions per capita, not in an MSA; however, Polk County's admissions are statistically significant compared to other MSA's.

The task force engaged stakeholders in these counties to inquire about the experience of court officials and social service workers concerning individuals found incompetent to stand trial. These findings were consistent with the task force's analysis of available resources and the gaps in care. The following issues were identified by the surveyed counties as possible reasons for higher numbers:

- Increase in prevalence rate of mental illnesses especially among youth and more people seeking care.
- Increased potency and use of substances of abuse as co-occurring disorders with mental illnesses.
- Individuals who lack insight to voluntarily seek treatment.
- Inadequate timely access to the correct level of mental health care.
- Discharge from inpatient hospitalization without adequate community supports and limited access to acute care.
- Workforce shortages of rural providers and culturally competent providers for culturally diverse communities.
- Lack of long-term housing with intensive supports and lack of affordable housing.
- Incomplete crises response systems, raising the risk for criminal justice responses to mental health needs
- High levels of poverty.

Conversely, Blue Earth and Nicollet County were outliers for relatively few admissions and Rule 20.01 orders per capita, especially considering their status as an MSA. Both counties represent urban populations but have remained consistently low in orders and admissions. The Yellow Line Project is the diversion program that serves Blue Earth County and is one of the oldest and most established programs in the state. The task force will continue to analyze available data and the impact of diversion projects in Minnesota.

Figure 4

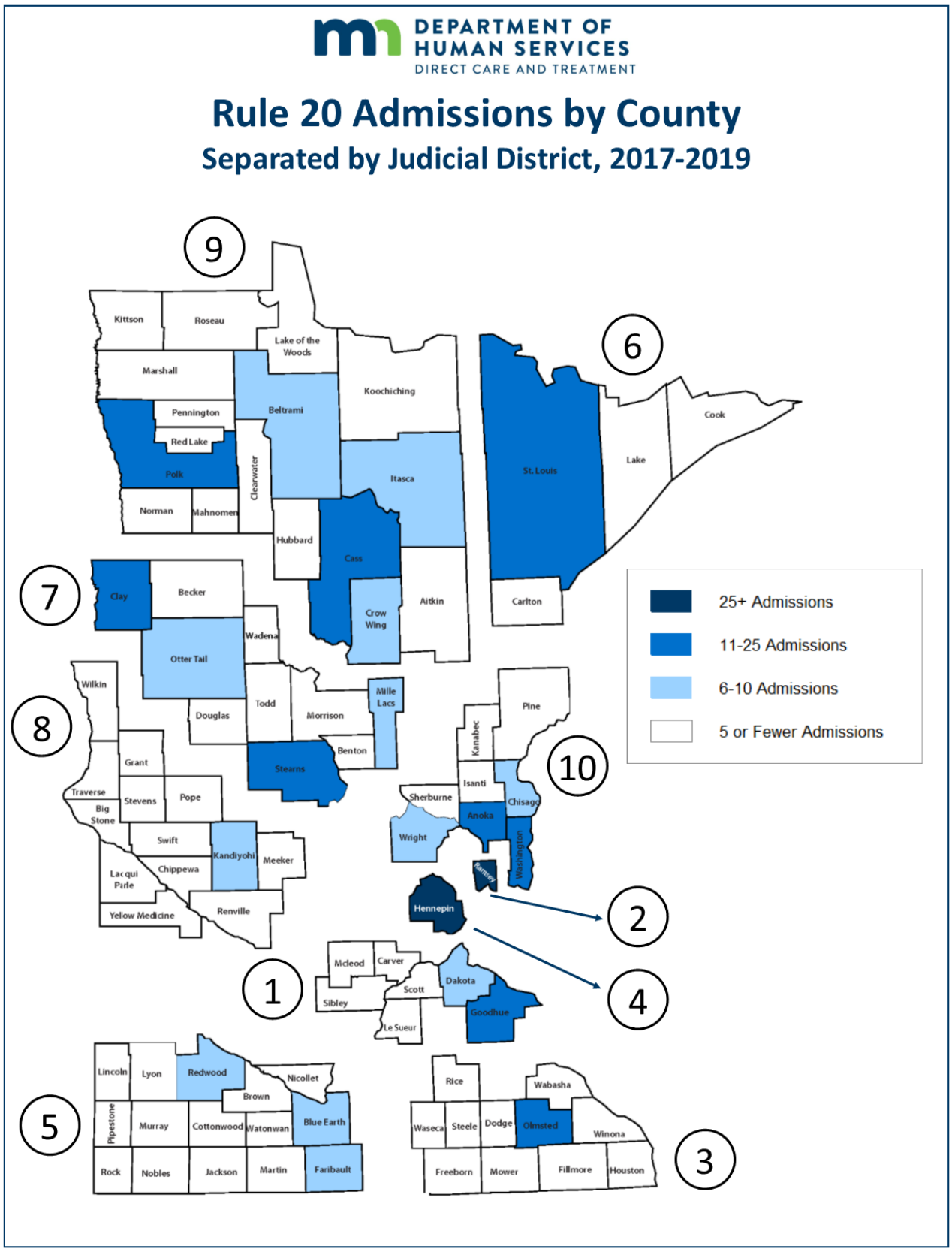

DEPARTMENT OF HUMAN SERVICES
DIRECT CARE AND TREATMENT
Rule 20 Admissions by County
Separated by Judicial District, 2017-2019
9
Kittson
Roseau
Lake of the Woods
Marshall
Koochiching
Pennington
Beltrami
Red Lake
Polk
Clearwater
Itasca
Norman
Mahnomen
Hubbard
Cass
Crow Wing
Aitkin
6
St. Louis
Lake
Cook
Carlton
7
Clay
Becker
Wadena
Otter Tail
8
Wilkin
Douglas
Todd
Morrison
Mille Lacs
Benton
Stearns
Grant
Traverse
Stevens
Pope
Big Stone
Swift
Kandiyohi
Meeker
Lac qui Parle
Chippewa
Yellow Medicine
Renville
10
Pine
Kanabec
Isanti
Chisago
Sherburne
Anoka
Wright
Washington
Ramsey
Hennepin
2
1
Mcleod
Carver
Scott
Dakota
Sibley
Goodhue
Le Sueur
4
5
Lincoln
Lyon
Redwood
Nicollet
Brown
Pipestone
Murray
Cottonwood
Watonwan
Blue Earth
Rock
Nobles
Jackson
Martin
Faribault
Rice
Wabasha
Waseca
Steele
Dodge
Olmsted
Winona
Freeborn
Mower
Fillmore
Houston
3
25+ Admissions
11-25 Admissions
6-10 Admissions
5 or Fewer Admissions

Image Description: Figure 4. A map of Minnesota separated by Judicial District showing the number of Rule 20 admissions per county from 2017 to 2019. Counties with five or fewer counties are white. Counties with six to ten admissions are shaded in the lightest blue. These counties are Beltrami, Blue Earth, Chisago, Crow Wing, Dakota, Faribault, Itasca, Kandiyohi, Mille Lacs, Otter Tail, Redwood, and Wright. Counties with eleven to twenty-five admissions are shaded darker blue. These counties are Anoka, Cass, Clay, Goodhue, Olmsted, Polk, St. Louis, Stearns, and Washington. Counties with more than twenty-five admissions are shaded darkest blue. These counties are Hennepin and Ramsey.

Figure 5

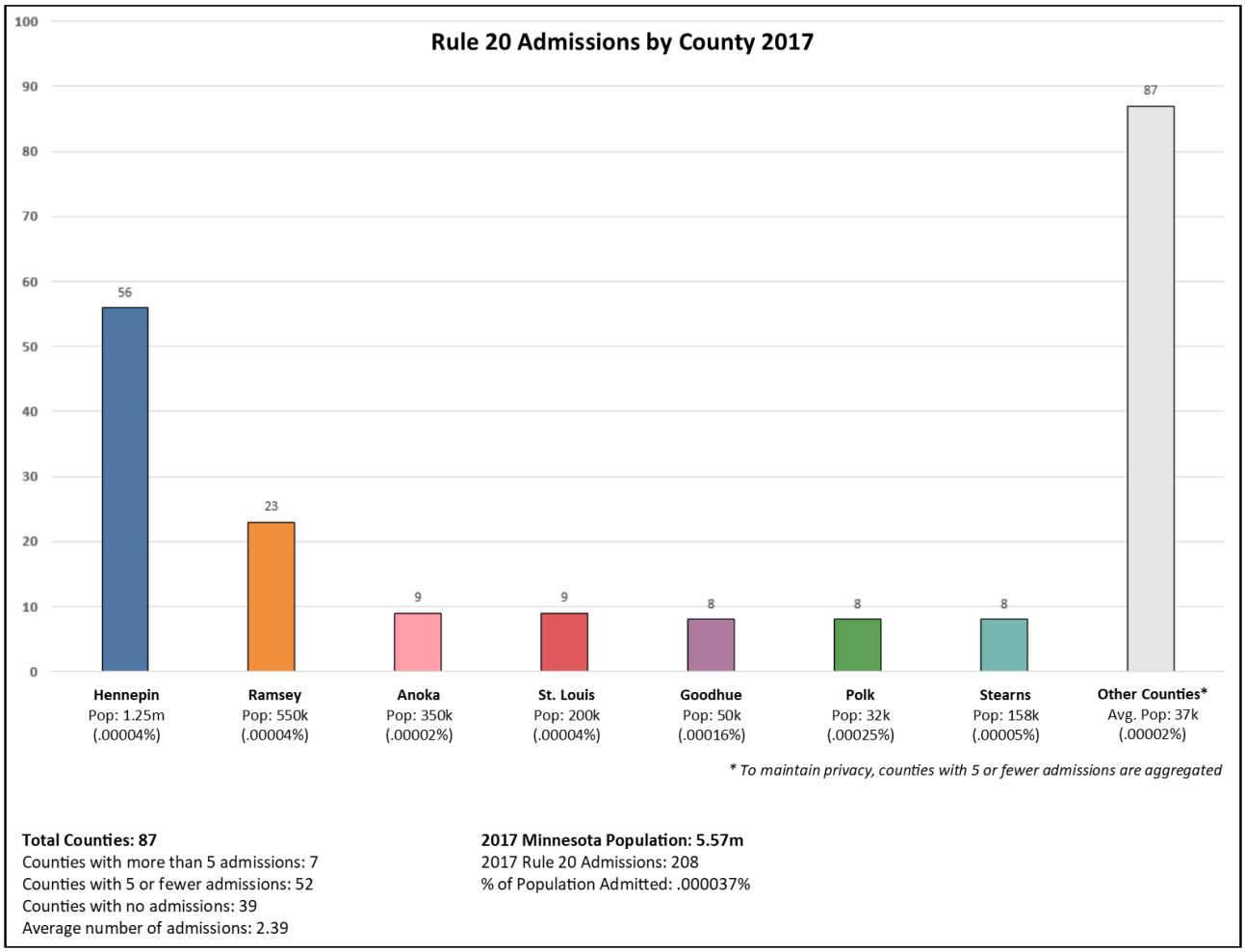


Image Description: Figure 5. A bar graph showing the number of Rule 20 admissions by county in 2017. Hennepin County had 56 admissions. Ramsey County had 23 admissions. Anoka County had 9 admissions. St. Louis County had 9 admissions. Goodhue County had 8 admissions. Polk County had 8 admissions. Stearns County had 8 admissions. The remaining other counties with five or fewer admissions are aggregated to maintain privacy and combined for 87 admissions.

Figure 6

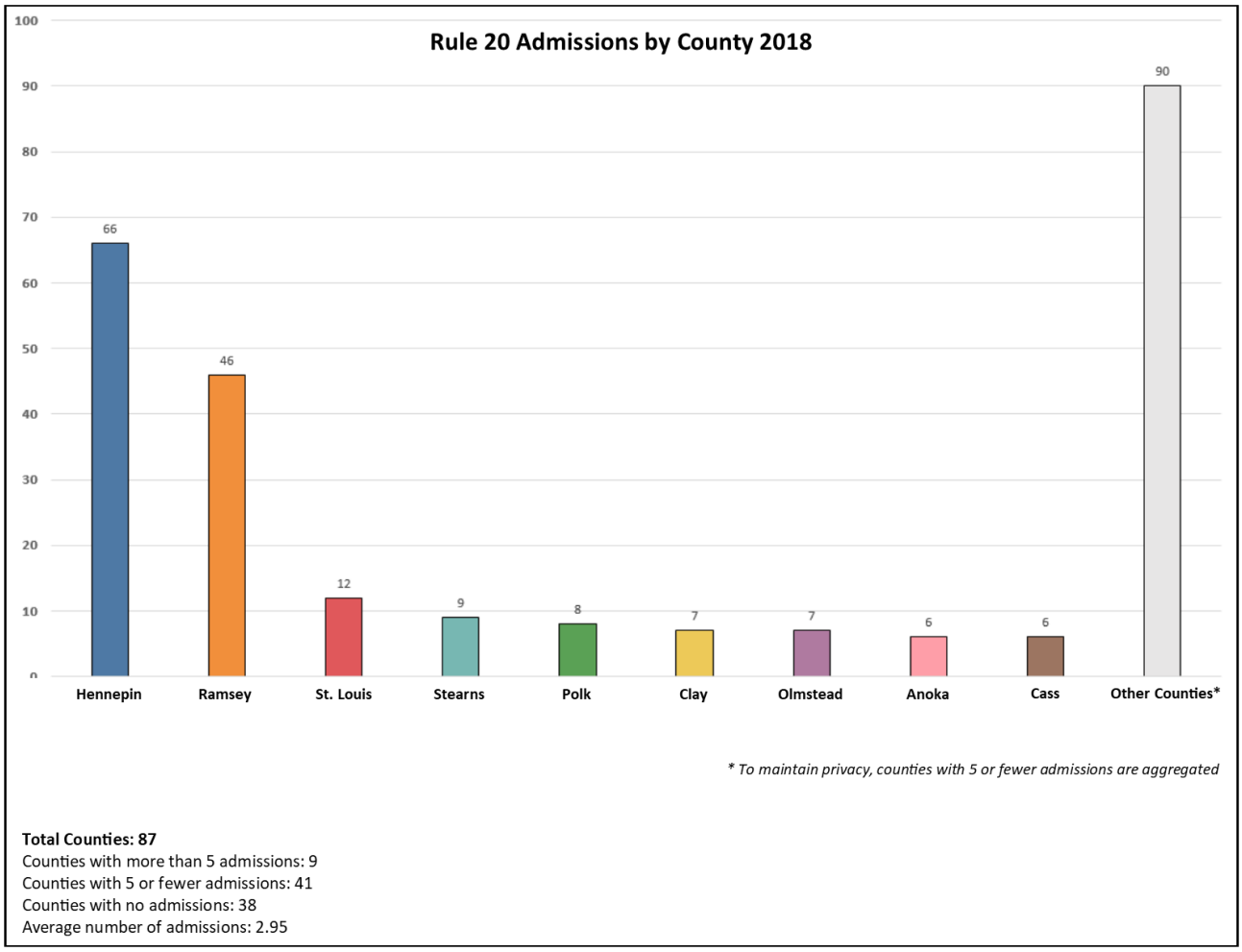


Image Description: Figure 6. A bar graph showing the number of Rule 20 admissions by county in 2018. Hennepin County had 66 admissions. Ramsey County had 46 admissions. St. Louis County had 12 admissions. Stearns County had 9 admissions. Polk County had 8 admissions. Clay County had 7 admissions. Olmsted County had 7 admissions. Anoka County had 6 admissions. Cass County had 6 admissions. The remaining other counties with five or fewer admissions are aggregated to maintain privacy and combined for 90 admissions.

C. Analysis of selected case reviews

The task force received case studies submitted by the Central Minnesota Mental Health Center and Hennepin County, and testimony from the task force member with direct competency experience, Catherine Moore, and an anonymous member of the public who submitted testimony through NAMI Minnesota.

Analysis of the submitted case studies reveals several consistencies with the task force's analysis of available resources:

- Increased use of substances of abuse as co-occurring disorders with mental illnesses.
- Individuals who lack insight to voluntarily seek treatment.
- Inadequate timely access to the correct level of mental health care.
- Discharge from inpatient hospitalization without adequate community supports and limited access to acute care.
- Lack of long-term housing with intensive supports and lack of affordable housing.
- Incomplete crises response systems, raising the risk for criminal justice responses to mental health needs.

The case studies submitted by mental health providers all included individuals with co-occurring disorders and charges of drug possession, trespassing, aggravated robbery, or assault. One individual spent 30 days in treatment at AMRTC, was returned incompetent to a treatment facility where they incurred new assault charges.

The testimony submitted to the task force showed similar gaps in the mental health system and the criminal justice system. In both cases of submitted testimony individuals tried for months to receive adequate care to recover from their mental illnesses and substance use disorders. In one case the individual was on a waiting list for residential drug treatment and was returned to jail for violating probation and remained there for two months waiting for a Rule 20 examination. In the other case the individual needed detox and substance abuse treatment and experienced a gap by the county mobile crisis team who would not transfer them for detox, which escalated to a law enforcement interaction and new charges. Additionally, they had an Order for Protection filed against them further removing them from the support they had to aid in their recovery. This individual estimated they had $6,000 in costs related to their charges, testing, and additional housing needs.

The constant cycle of moving from hospital to jail was common to all the case studies reviewed. This back and forth happened several times in all the case studies and served to further decompensation. The severely limited resources of jails to create a therapeutic environment also contributed the decompensation of these individuals.

D. Review of competency restoration throughout the Unites States

The DHS Forensic Evaluation Department workgroup convened and conducted literature searches relating to competency restoration across the nation.

Competency Restoration Overview: The field of restoration has changed in the last 40 years (Fitch, 2014). Historically, competency restoration was entirely inpatient, but in the last decade there has been a push toward outpatient or jail-based restoration services (Fitch, 2014). States across the country are seeing increases in competency evaluations and restoration cases, struggling with increasing numbers of restoration cases in state hospitals, long waitlists, and MH inpatient beds decreasing. In response, many states have created a range of competency restoration services, including: inpatient, outpatient, jail-based and community-based.

Inpatient Competency Restoration: Inpatient restoration is the most successful, yet most expensive, form of competency restoration. All states appear to have a form of inpatient restoration and restoration success rates varied from 77% to 90% (Gowensmith, et al, 2016; Cochrane, et al., 2013; Danzer, et al, 2019) A longer length of stay in restoration (LOSR) is associated with a higher rate of competence in some studies. Thirteen states shared data on the costs of inpatient competency restoration, with a range from $300 to $1,000 per day and an average of $603 per day per patient (Gowensmith, et al, 2016). The mean LOSR was 73 days (Danzer, et al, 2019). Total expenses ranged from $21,900 to $73,000 per case. Average cost would be $44,019 per case based on this data.

Outpatient Competency Restoration (OPCR) Programs: Outpatient programs are generally defined as community-based although older research often combined jail-and community-based competency restoration programs. Newer studies have separated these distinct competency restoration types. The DHS workgroup found 35 states allow for Outpatient Competency Restoration Programs, however only 16 states have an outpatient formal program. There is no uniform system of Outpatient Competency Restoration – even within most states, making analysis difficult. Most states have selection criteria for Outpatient Competency Restoration, which include: misdemeanor offenses, non-violent offense, general psychiatric stability, medical stability, stable living environment, and willingness to participate in treatment, among others. Generally, OPCR is a cost saving way to implement competency restoration. OPCR rates are on average lower by typically 10% or less, depending on study, with savings averaging between $10,000 and $60,000 per defendant. LOSR in outpatient settings was inconsistent in the research with some studies reporting much shorter times compared to inpatient (half the time), while others reported longer restoration periods (twice as long).

Jail-Based Competency Restoration: Jail-based restoration is the least expensive modality but does not account for those sent to inpatient if unrestored. The workgroup found nine states with programs (Gowensmith, et al, 2016) consisting of two program types:

- **Full scale**: complete restoration program typically with designated unit
- **Time limited:** restoration services until they can be admitted inpatient.

Restoration rates were 55-86% with costs ranging from $42 to $222 per day and a mean LOSR of 57.4 days. The literature cited that people who remained unrestored in jail were typically admitted to inpatient. Total costs ranged from $2,411 to $12,742 per defendant, however, this again does not include inpatient costs when they were required (Danzer, et al, 2019). A different study showed highly varied rates of restoration from 45% to

86.7% (Wik, 2018). Full Scale programs appeared to be overall more successful, although people who received time-limited jail-based restoration while waiting for inpatient services tended to experience a better continuum of care.

After an extensive literature search, more information was needed, and the workgroup created an 18-item questionnaire that was submitted to the National Association of State Mental Health Program Directors ListServ, with follow up inquires made directly when needed. The responses are detailed in Appendix D.

Forensic Navigators: In response to the growing issue of people found incompetent to stand trial, some states have implemented forensic navigator programs. Forensic navigators are generally employed by the human services division of a state and act as intermediaries for people who must navigate both the mental health and criminal justice systems. Many of these programs have been implemented in response to the growing number of people found incompetent to stand trial. The task force is aware of these programs in Colorado, Missouri, Washington, and Wisconsin. Further research is necessary to determine the impact of such programs and possible implementation in Minnesota.

V. Preliminary report recommendations

Final recommendations of the Community Competency Restoration Task Force will be presented in the Final Legislative Report due to the Legislature on February 1, 2021.

The following preliminary recommendations reflect the task force's findings that no single solution can be applied to resolve the issues surrounding this topic. The scope of the task force's mandate to develop recommendations is broad and any final recommendations will involve a multipronged approach to improve outcomes and use resources efficiently to avoid unintended consequences and unfunded mandates. Topics for further exploration and preliminary recommendations from the Community Competency Restoration Task Force to date include:

- Increase prevention and diversion efforts. The task force will continue to explore ways to:
    - Increase access to the continuum of mental health treatment and services
    - Address workforce and provider shortages in rural and culturally diverse communities
    - Address disparities in criminal justice responses and accessibility of mental health care in diverse communities
    - Address parity enforcement to increase access to mental health care
    - Update the civil commitment statute so that individuals can be engaged voluntarily before commitment or justice involvement
    - Increase and expand existing diversion programs, implement them at scalable levels, and evaluate their impact.
- Clarify the roles and responsibilities of state and county entities relating to competency restoration. The task force will further research the most effective ways to implement solutions for counties and regions with varying resources.
- Identify process improvements for reducing the amount of time individuals remain in the criminal justice system. The task force will continue to explore ways to:
    - Assess the impact of forensic navigators in other states and possible implementation in Minnesota
    - Change rules to create scheduled review hearings for "gap" cases as a possible mechanism to engage individuals whose charges will be dismissed but cannot be committed to reduce recidivism and high utilization.
    - Expand pilot programs in Minnesota to expedite timelines of examinations and competency proceedings
    - Increase opportunities for education for court officials and increased cross-discipline collaborations between mental health and criminal justice professionals to further understanding and system improvement.
- Ascertain funding needs for community-based competency restoration services across continuums of care and secure resources. The task force will examine how to expand current pilot outpatient competency restoration programs in Minnesota and explore ways to provide responsive competency restoration services at multiple levels to meet individual needs.

- Establish key measures to track outcomes and expected timelines for implementation to assess whether progress is being made.

VI. Appendix

A. Task Force Membership

The Community Competency Restoration Task Force is comprised of 25 members:

- Cathryn Middlebrook: Minnesota Sentencing Guidelines Commission representative
- David Hutchinson: Minnesota Sheriff's Association representative
- Dr. Katheryn Cranbrook: State Court Administrator representative
- Dr. KyleeAnn Stevens: Direct Care and Treatment Services representative
- Dr. Raj Sethuraju: organizations representing racial and ethnic groups overrepresented in the justice system representative
- Tarryl Clark: The Association of Minnesota Counties representative
- Mark Bliven: designated by the Commissioner of the Department of Corrections Commissioner Paul Schnell
- Gertrude Matemba-Mutasa: the Commissioner of Human Services representative
- Richard Lee: Minnesota Association of Community Mental Health representative
- William Ward: the Minnesota Board of Public Defense representative
- Andy Skoogman: Minnesota Chiefs of Police Association representative
- Timothy Carey: Minnesota County Attorney Association representative
- Dr. Ian Heath: Minnesota Hospital Association representative
- Leah Kaiser: Minnesota Association of County Social Service Administration representative
- Tami Lueck: Minnesota Association of County Social Service Administration representative
- Michael Woods: Ombudsman for Mental Health and Developmental Disabilities representative
- Harlan James Gilbertson: Minnesota Psychological Association representative
- Dr. Michael Trangle: Minnesota Psychiatric Society representative
- Monette J. Berkevich: Jail Administrator representative
- Becky Graves: a reentry representative
- Sheila Novak: a crime victim representative
- Catherine Moore: a person with direct competency experience representative
- Molly Hicken: governor appointed member
- Sue Abderholden: a mental health organization representative
- Eren Sutherland: designated state protection and advocacy representative

B. Minnesota Available Data

2014 Most Individuals with 20.01 Per Capita

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Lincoln	5,788	4	7	63.8	10%
Martin	9,420	6	6	27	8%
Goodhue	46,480	27	6	57.5	10%
Kittson	4,440	2	5	41.7	10%
Lyon	25,746	11	4	54.8	14%
Beltrami	45,770	19	4	67	21%
Carlton	35,576	14	4	99.1	14%
Cass	28,570	11	4	42.2	17%
Polk	31,545	12	4	78.8	13%
Mille Lacs	25,862	9	3	89.5	13%

2015 Most Individuals with 20.01 Per Capita

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Cook	5,219	4	8	1.6	11%
Marshall	5,456	4	7	47.9	25%

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Polk	31,529	22	7	71	13%
Lake	10,634	7	7	32.1	13%
Aitkin	15,715	10	6	98.7	12%
Koochiching	12,889	8	6	68.6	15%
Goodhue	46,611	27	6	51.1	11%
Lake of the Woods	3,925	2	5	71.7	9%
Wadena	13,879	6	4	155.3	16%
Cass	28,718	12	4	35.9	17%

2016 Most Individuals with 20.01 Per Capita

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Traverse	3,354	3	9	56.6	9%
Lake of the Woods	3,883	3	8	68.2	8%
Goodhue	46,717	36	8	46.9	11%
Martin	9,317	6	6	24	8%
Houston	18,834	12	6	23.4	10%
Pennington	14,244	9	6	74.8	9%

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Cass	28,895	18	6	31.2	16%
Polk	31,647	17	5	64.1	13%
Rock	9,484	5	5	59.6	11%
Lyon	25,684	12	5	49.5	14%

2017 Most Individuals with 20.01 Per Capita

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Polk	31,720	28	9	55.8	12%
Faribault	13,671	11	8	46.7	12%
Cass	29,327	23	8	24.7	15%
Goodhue	46,562	35	8	41.7	11%
Traverse	3,333	2	6	38.5	11%
Pine	29,192	17	6	53.9	14%
Marshall	5,572	3	5	30.6	23%
Martin	9,351	5	5	21.1	8%
Houston	18,761	10	5	21.7	9%
Lake of the Woods	3,802	2	5	63.5	7%

2018 Most Individuals with 20.01 Per Capita

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Mille Lacs	26,080	23	9	N/A	N/A
Martin	9,384	8	9	N/A	N/A
Goodhue	46,540	38	8	N/A	N/A
Hubbard	21,350	17	8	N/A	N/A
Cook	5,390	4	7	N/A	N/A
Pine	29,490	21	7	N/A	N/A
Polk	31,627	20	6	N/A	N/A
Cass	29,470	18	6	N/A	N/A
Clay	63,963	38	6	N/A	N/A
McLeod	19,822	11	6	N/A	N/A

The task force also reviewed the counties with the highest total individuals with Rule 20.01 orders.

2014 Most Individuals Total with 20.01

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Hennepin	1,210,720	377	3	47.8	13%
Ramsey	529,506	154	3	48.9	17%

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Anoka	342,612	92	3	61.6	8%
St. Louis	200,840	58	3	29.6	11%
Dakota	411,507	57	1	59.3	8%
Stearns	153,326	48	3	67.4	13%
Olmsted	150,201	44	3	36.5	9%
Washington	249,109	34	1	60.7	6%
Goodhue	46,480	27	6	57.5	10%
Beltrami	45,770	19	4	67	21%

2015 Most Individuals Total with 20.01

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Hennepin	1,221,703	439	4	43.2	13%
Ramsey	533,677	189	4	46	17%
Anoka	344,838	106	3	57.3	8%
St. Louis	200,381	72	4	30.6	11%
Dakota	414,490	69	2	54	8%
Olmsted	151,388	48	3	33.3	9%

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Stearns	154,446	44	3	63.5	14%
Washington	251,015	34	1	57.5	5%
Wright	131,361	27	2	56.7	6%
Goodhue	46,611	27	6	51.1	11%

2016 Most Individuals Total with 20.01

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Hennepin	1,237,604	438	4	38.6	12%
Ramsey	540,653	190	4	42	16%
Dakota	418,432	90	2	48.4	7%
St. Louis	199,744	86	4	28	10%
Anoka	348,652	76	2	52.1	7%
Stearns	155,732	62	4	55	14%
Washington	253,128	49	2	53	5%
Olmsted	153,039	47	3	28.9	9%
Goodhue	46,717	36	8	46.9	11%
Wright	132,598	30	2	52.8	6%

2017 Most Individuals Total with 20.01

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Hennepin	1,249,512	509	4	33.5	12%
Ramsey	546,317	249	5	36	15%
Dakota	422,580	103	2	43	7%
Anoka	352,674	82	2	44.9	7%
St. Louis	199,922	77	4	23.4	9%
Olmsted	155,849	68	4	27.3	9%
Stearns	157,660	67	4	48.2	13%
Washington	256,905	49	2	47.8	5%
Goodhue	46,562	35	8	41.7	11%
Polk	31,720	28	9	55.8	12%

2018 Most Individuals Total with 20.01

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Hennepin	1,261,104	524	4	N/A	N/A
Ramsey	552,232	286	5	N/A	N/A
Dakota	428,558	96	2	N/A	N/A

County	Population	20.01 Individuals	Individuals Per Capita	Opioids Prescribed	Poverty
Anoka	357,851	89	2	N/A	N/A
Olmsted	157,446	63	4	N/A	N/A
Washington	261,512	62	2	N/A	N/A
Stearns	159,258	56	4	N/A	N/A
St. Louis	200,261	50	2	N/A	N/A
Goodhue	46,540	38	8	N/A	N/A
Clay	63,963	38	6	N/A	N/A

Data concerning homelessness was collected by Continuum of Care Regions as set by the U.S. Department of Housing and Urban Development. The breakdown of regions by county are shown below:

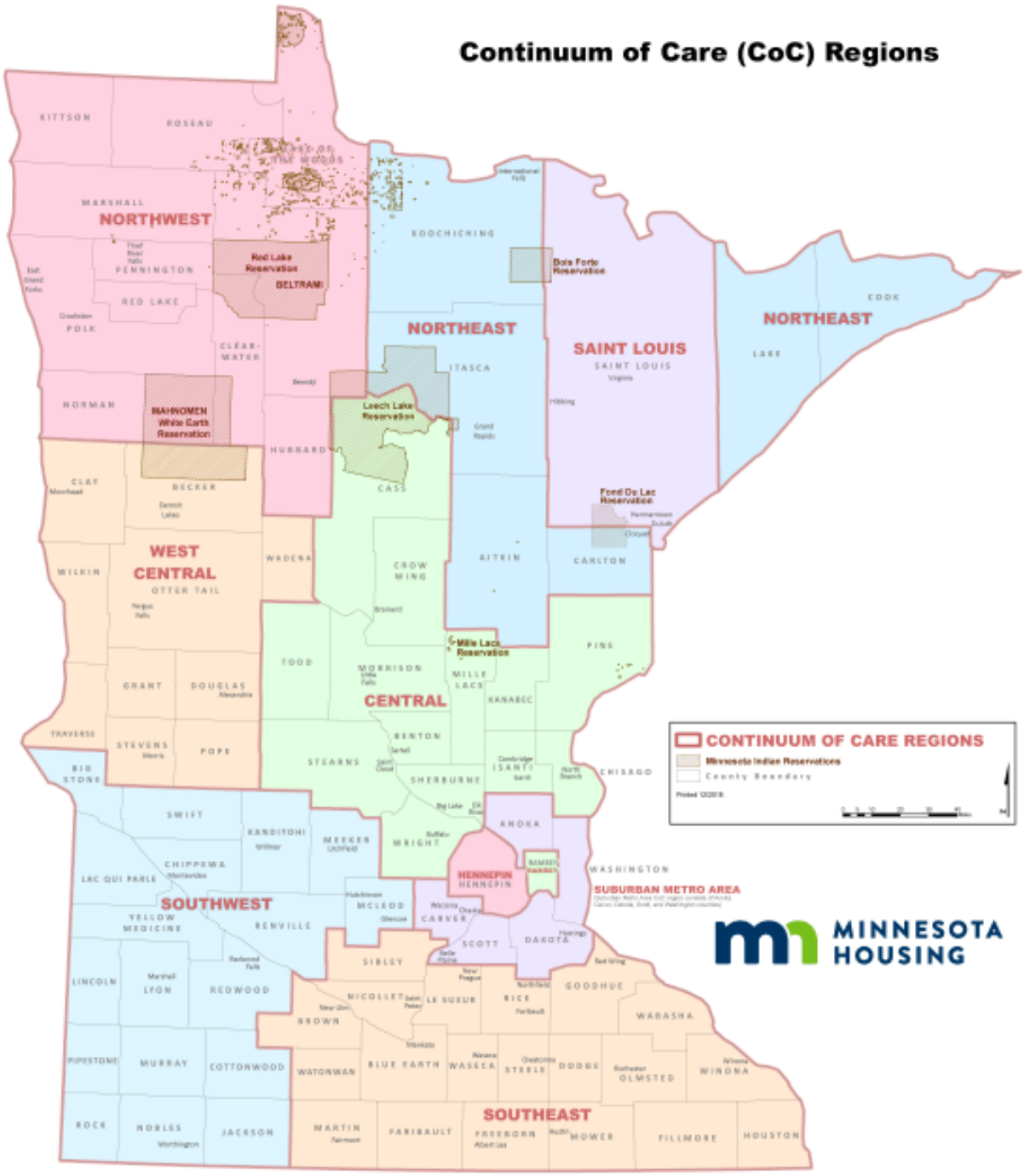

Continuum of Care (CoC) Regions
NORTHWEST
NORTHEAST
SAINT LOUIS
NORTHEAST
WEST CENTRAL
CENTRAL
SOUTHWEST
SUBURBAN METRO AREA
SOUTHEAST
HENNEPIN
CONTINUUM OF CARE REGIONS
Minnesota Indian Reservations
County Boundary
MINNESOTA HOUSING

Image Description: A map of Minnesota delineating Continuum of Care Regions as set by the U.S. Housing and Urban Development. The Northwest Region includes Beltrami, Clearwater, Kittson, Lake of the Woods, Marshall, Mahnomen, Norman, Pennington, Polk, Red Lake, and Roseau. The Northeast Region includes, Cook, Itasca, Koochiching, and Lake. The West Central Region includes Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, Wadena, and Wilkin. The Central Region includes Aitkin, Benton, Carlton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, and Wright. The Southwest Region includes: Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, and Yellow Medicine. The Southeast Region includes Brown, Blue Earth, Dodge, Faribault, Filmore, Goodhue, Houston, Le Sueur, Martin, Mower, Nicollet, Olmsted, Rice, Sibley, Steele, Wabasha, Waseca, Watonwan, and Winona. The Suburban Metro Area includes Anoka, Carver, Dakota, Scott, and Washington. Hennepin, Ramsey, and St. Louis are their own regions.

Number of Homeless Individuals per 10,000 people	2014	2015	2016	2017	2018
Hennepin	31	26	25	24	24
Ramsey	28	26	25	26	26
Southeast	7	6	6	8	7
Dakota, Anoka, Washington, Scott, Carver	6	5	5	4	5
Northeast	16	5	6	8	7
Central	8	10	9	12	8
Northwest	15	13	15	15	14
West Central	9	10	9	9	10
St. Louis	21	24	26	25	21
Southwest	7	5	5	4	2

Individuals with Rule 20.01 Cases	2014	2015	2016	2017	2018
Hennepin	377	439	438	509	524
Ramsey	154	189	190	249	286

Individuals with Rule 20.01 Cases	2014	2015	2016	2017	2018
Southeast	175	187	205	246	254
Dakota, Anoka, Washington, Scott, Carver	208	235	248	264	280
Northeast	37	59	41	34	49
Central	145	177	219	230	228
Northwest	47	64	65	74	80
West Central	30	42	56	66	90
St. Louis	58	72	86	77	50
Southwest	41	42	54	54	68

The following tables were provided by the Minnesota Judicial Branch and show the number of individuals found incompetent to stand trial under Rule 20 on a felony by Minnesota Judicial District from 2013-2019. Note: data prior to 2015 may be an undercount due to changes in the relevant court processes. Note: counts of MNCIS party records are provided, which may over-count individuals. Note: individuals may be counted in more than one district or county; Grand Total provides distinct statewide count.

Data as of 1/2/20

Judicial District	2013	2014	2015	2016	2017	2018	2019
1st Judicial District	**6**	**22**	**25**	**33**	**42**	**45**	**45**
Carver County	0	1	2	4	2	1	4
Dakota County	4	13	15	19	26	23	22
Goodhue County	1	5	5	5	11	11	12

Judicial District	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
McLeod County	1	0	1	1	1	3	1
Scott County	0	3	2	3	3	5	5
Sibley County	0	0	0	1	0	3	1
2nd Judicial District	**24**	**41**	**46**	**37**	**47**	**81**	**77**
Ramsey County	24	41	46	37	47	81	77
3rd Judicial District	**14**	**18**	**23**	**23**	**30**	**28**	**42**
Dodge County	2	1	0	0	0	1	2
Fillmore County	1	0	0	1	**0**	2	**0**
Freeborn County	1	3	3	0	0	3	2
Houston County	1	2	0	3	2	1	3
Mower County	0	1	0	0	4	1	1
Olmsted County	4	4	7	10	12	13	15
Rice County	2	2	2	4	7	2	8
Steele County	1	2	5	1	2	2	4
Wabasha County	0	0	0	1	0	0	3
Waseca County	0	0	0	0	0	1	0
Winona County	2	3	6	3	3	2	4
4th Judicial District	**63**	**98**	**102**	**107**	**134**	**149**	**197**

Judicial District	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Hennepin County	63	98	102	107	134	149	197
5th Judicial District	**1**	**8**	**13**	**13**	**26**	**29**	**35**
Blue Earth County	0	5	7	5	6	5	7
Brown County	0	0	0	1	1	3	3
Cottonwood County	0	0	0	1	0	0	0
Faribault County	0	0	2	2	6	4	1
Jackson County	0	0	0	0	1	1	2
Lincoln County	0	1	0	0	0	0	1
Lyon County	0	1	3	2	1	2	3
Martin County	0	1	0	2	3	1	4
Murray County	0	0	0	0	1	0	0
Nicollet County	0	0	0	0	4	3	3
Nobles County	0	0	0	0	0	1	4
Pipestone County	0	0	0	0	0	1	4
Redwood County	1	0	1	0	2	2	4
Rock County	0	0	0	0	0	5	0
Watonwan County	0	0	0	0	1	1	0
6th Judicial District	**14**	**16**	**22**	**20**	**19**	**24**	**19**

Judicial District	2013	2014	2015	2016	2017	2018	2019
Carlton County	1	1	1	0	1	2	1
Cook County	0	0	0	0	0	4	1
Lake County	0	0	0	1	0	0	1
St. Louis County	13	15	21	19	18	18	16
7th Judicial District	**8**	**18**	**19**	**31**	**30**	**43**	**43**
Becker County	0	0	0	2	1	2	0
Benton County	0	2	4	1	3	0	1
Clay County	2	2	3	8	6	7	9
Douglas County	0	0	0	1	2	1	4
Mille Lacs County	0	2	0	0	2	10	2
Morrison County	1	0	1	0	0	3	3
Otter Tail County	1	1	1	2	4	4	6
Stearns County	4	11	8	16	8	15	15
Todd County	0	0	0	1	3	0	2
Wadena County	0	1	2	0	1	1	1
8th Judicial District	**0**	**3**	**6**	**8**	**13**	**14**	**12**
Chippewa County	0	1	0	2	0	0	0
Grant County	0	0	0	0	0	0	1

Judicial District	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Kandiyohi County	0	1	3	4	9	7	7
Lac qui Parle County	0	0	0	0	0	1	0
Meeker County	0	0	1	2	3	2	0
Renville County	0	1	2	0	1	1	0
Stevens County	0	0	0	0	0	0	1
Swift County	0	0	0	0	0	1	0
Traverse County	0	0	0	0	0	0	1
Wilkin County	0	0	0	0	0	1	2
Yellow Medicine County	0	0	0	0	0	1	1
9th Judicial District	**12**	**24**	**29**	**30**	**29**	**38**	**42**
Aitkin County	0	1	4	2	0	0	1
Beltrami County	2	6	6	6	5	1	7
Cass County	2	7	6	5	1	13	4
Clearwater County	1	0	0	0	1	2	0
Crow Wing County	0	0	0	5	5	5	8
Hubbard County	0	1	0	1	2	3	4
Itasca County	4	3	6	3	2	6	4
Koochiching County	2	2	2	1	0	0	2

Judicial District	2013	2014	2015	2016	2017	2018	2019
Lake of the Woods County	0	0	0	0	1	0	1
Mahnomen County	0	2	2	1	1	1	2
Marshall County	0	0	1	0	0	1	1
Pennington County	1	0	0	3	2	3	5
Polk County	0	2	2	2	9	4	3
Roseau County	0	0	1	1	0	0	0
10th Judicial District	**23**	**28**	**29**	**27**	**44**	**60**	**59**
Anoka County	12	14	15	8	18	19	19
Chisago County	2	3	3	1	6	4	4
Isanti County	3	2	0	1	1	2	4
Kanabec County	1	0	0	0	0	1	2
Pine County	0	2	0	3	2	5	5
Sherburne County	1	1	1	2	3	7	1
Washington County	4	5	7	12	10	16	15
Wright County	0	1	3	0	4	6	9
Grand Total	**165**	**274**	**314**	**322**	**408**	**505**	**562**

The following table was provided by the Minnesota Judicial Branch and shows the number of individuals found incompetent to stand trial under Rule 20 on a felony by race from 2013-2019

Note: results by race are suppressed if they represent fewer than 10 individuals, indicated by "<10"

Race	2013	2014	2015	2016	2017	2018	2019
American Indian or Alaska Native	12	10	16	17	18	27	25
Asian	<10	10	12	15	19	25	25
Black or African American	56	87	91	103	110	130	150
Hispanic	<10	11	13	15	24	26	23
Multiracial	<10	<10	<10	<10	18	17	20
Native Hawaiian or Other Pacific Islander	<10	<10	<10	<10	<10	<10	<10
Other	<10	<10	<10	<10	<10	<10	10
Refused/Unavailable	22	31	43	30	44	61	64
White	54	114	125	127	170	212	245
Grand Total	**165**	**274**	**314**	**322**	**408**	**505**	**562**

In January 2018, the Minnesota Judicial Council convened a workgroup of judges, attorneys, examiners, directors, county and state human services representatives, public stakeholders, and Minnesota Judicial Branch staff to examine how the courts respond to cases impacted by people with mental illnesses and provide recommendations on judicial education efforts, working with examiners, and mitigating the financial impact on the Branch. The Psych Services Judicial Workgroup met until November 2019, with the purpose of analyzing and providing recommendations on the Court's response to people suffering from mental illnesses in court proceedings and explore modifications to the current Psychological/Psychiatric Examiner Services Program structure. The following data were shared with the Community Competency Restoration Task Force by the workgroup and detail trends around Rule 20.01 orders and civil commitments from 2016-2018.

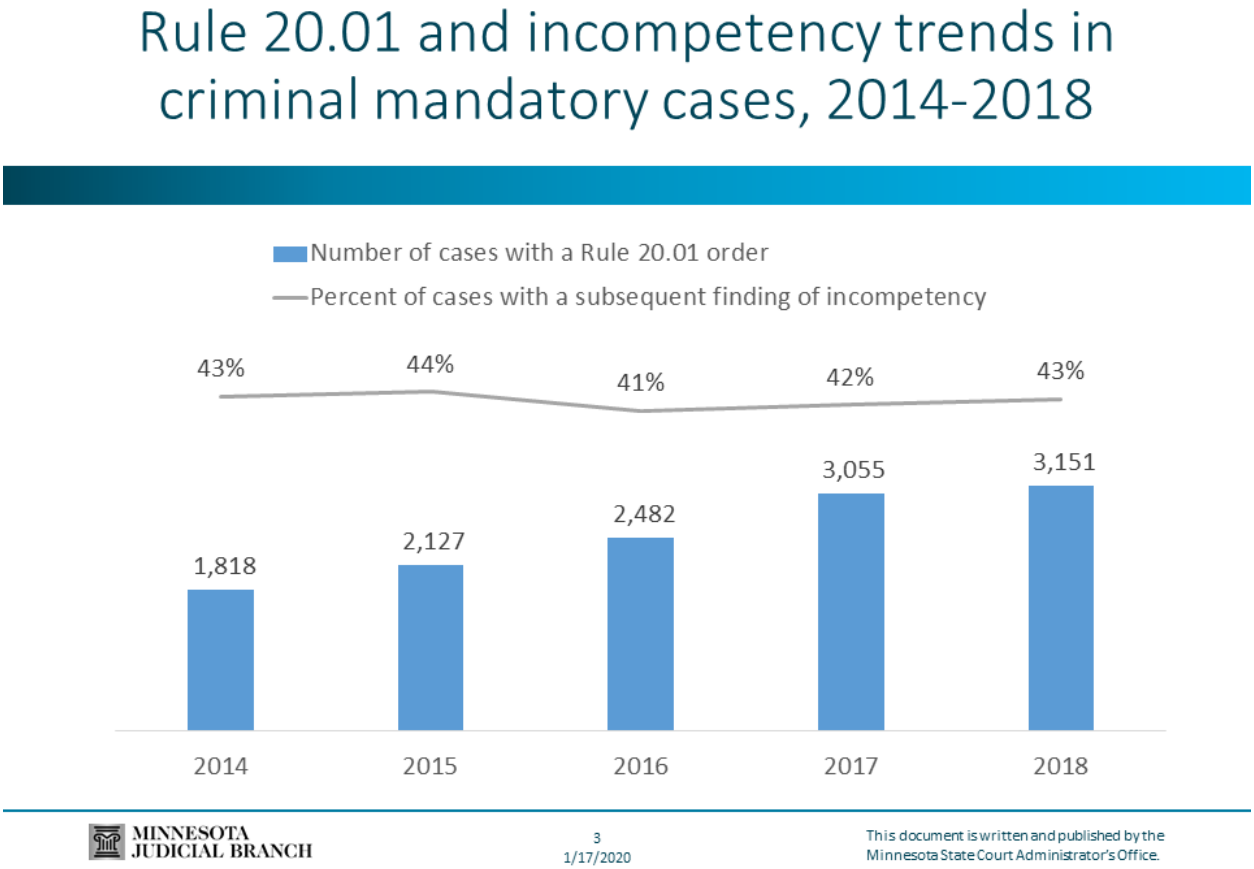


Image Description: A bar graph showing the Rule 20.01 and incompetency trends in criminal mandatory cases from 2014 to 2018. In 2014 1,818 cases had a Rule 20.01 order and 43% of those cases had a subsequent finding of incompetency. In 2015, 2,127 cases had a Rule 20.01 order and 44% of those cases had a subsequent finding of incompetency. In 2016, 2,482 cases had a Rule 20.01 order and 41% of those cases had a subsequent finding of incompetency. In 2017, 3,055 cases had a Rule 20.01 order and 42% of those cases had a subsequent finding of incompetency. In 2018 3,151 cases had a Rule 20.01 order and 43% of those cases had a subsequent finding of incompetency.

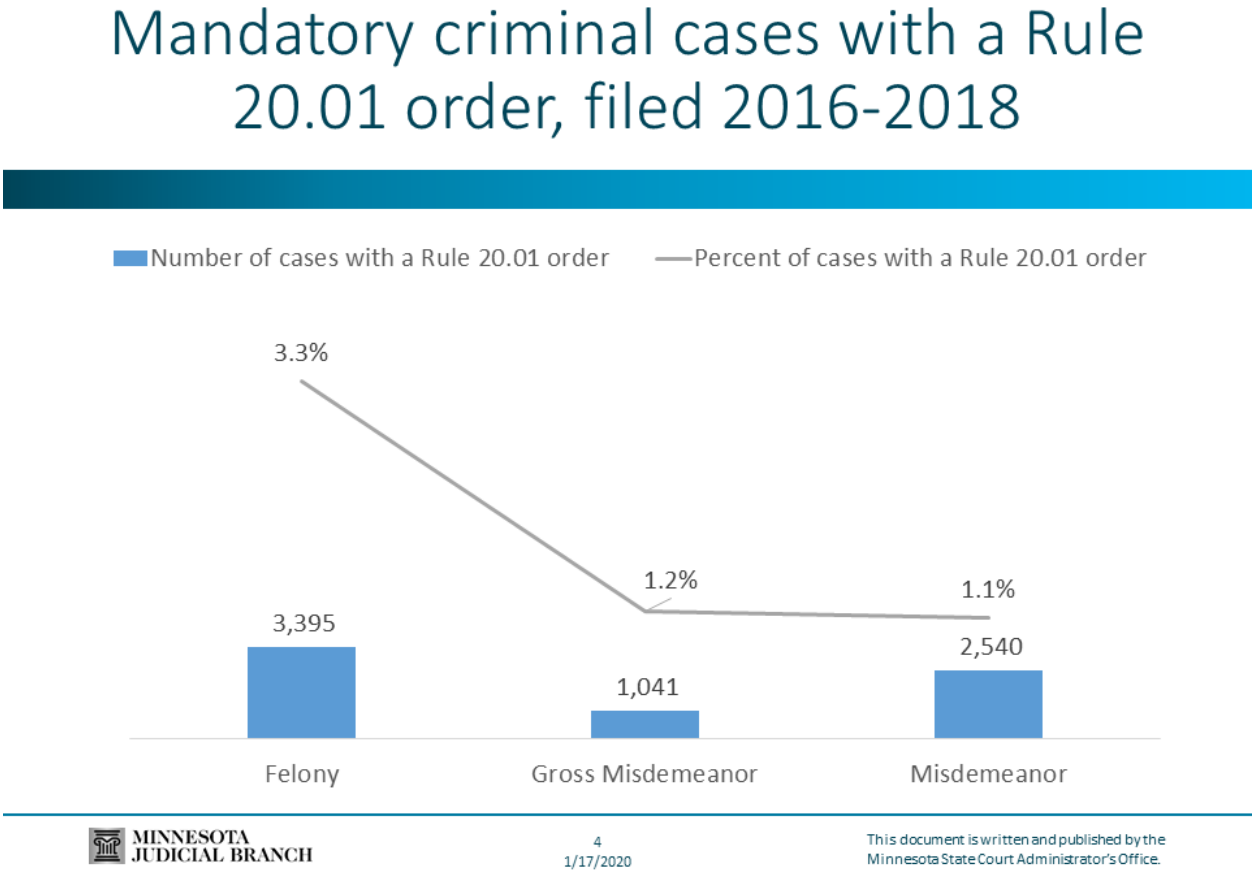


Image Description: A bar graph showing mandatory criminal cases with a Rule 20.01 order by criminal charge from 2016 to 2018. 3,395 Felony cases, 1,041 Gross Misdemeanor cases and 2,540 misdemeanor cases had a Rule 20.01 order.

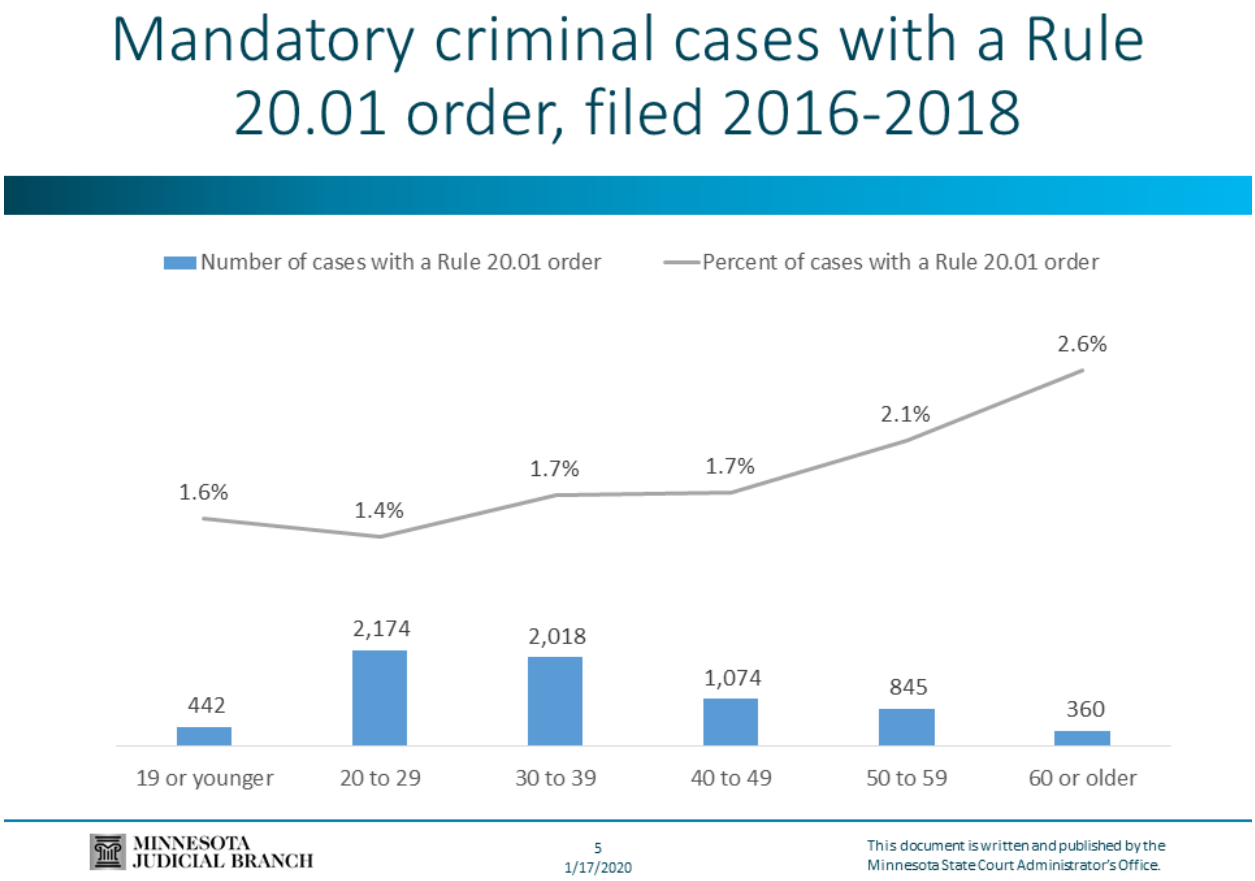


Image Description: A bar graph showing mandatory criminal cases with a Rule 20.01 order by age from 2016 to 2018. 442 cases with a Rule 20.01 order were 19 or young. 2,174 were 20 to 29 years-old. 2018 were 30 to 39 years-old. 1,074 were 40 to 49 years old. 845 were 50 to 59 years old. 360 were 60 or older.

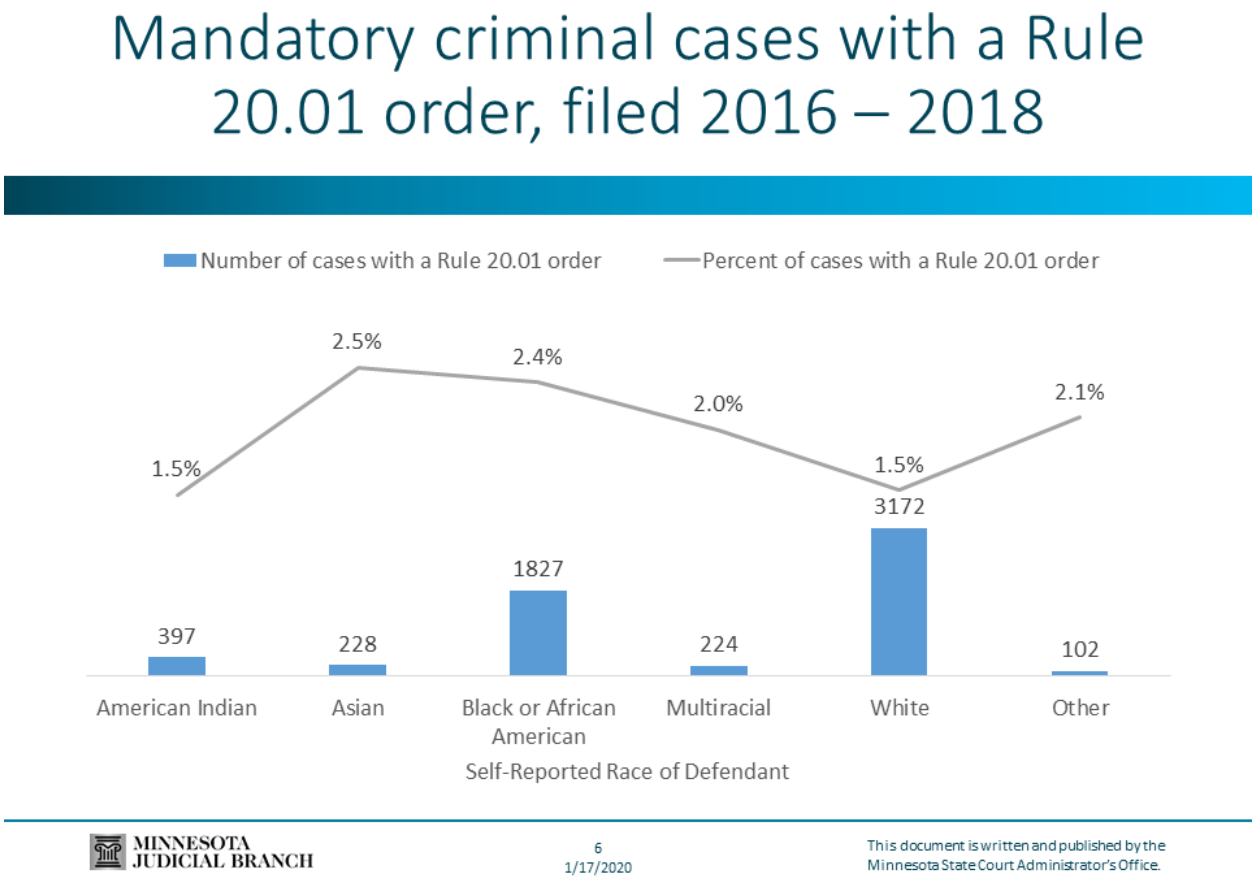


Image Description: A bar graph showing mandatory criminal cases with a Rule 20.01 order by race from 2016 to 2018. 397 cases with a Rule 20.01 order were American Indian people. 228 were Asian. 1827 were Black or African American. 224 were multiracial. 3172 were white. 102 were other.

Trends in Civil Commitment filings

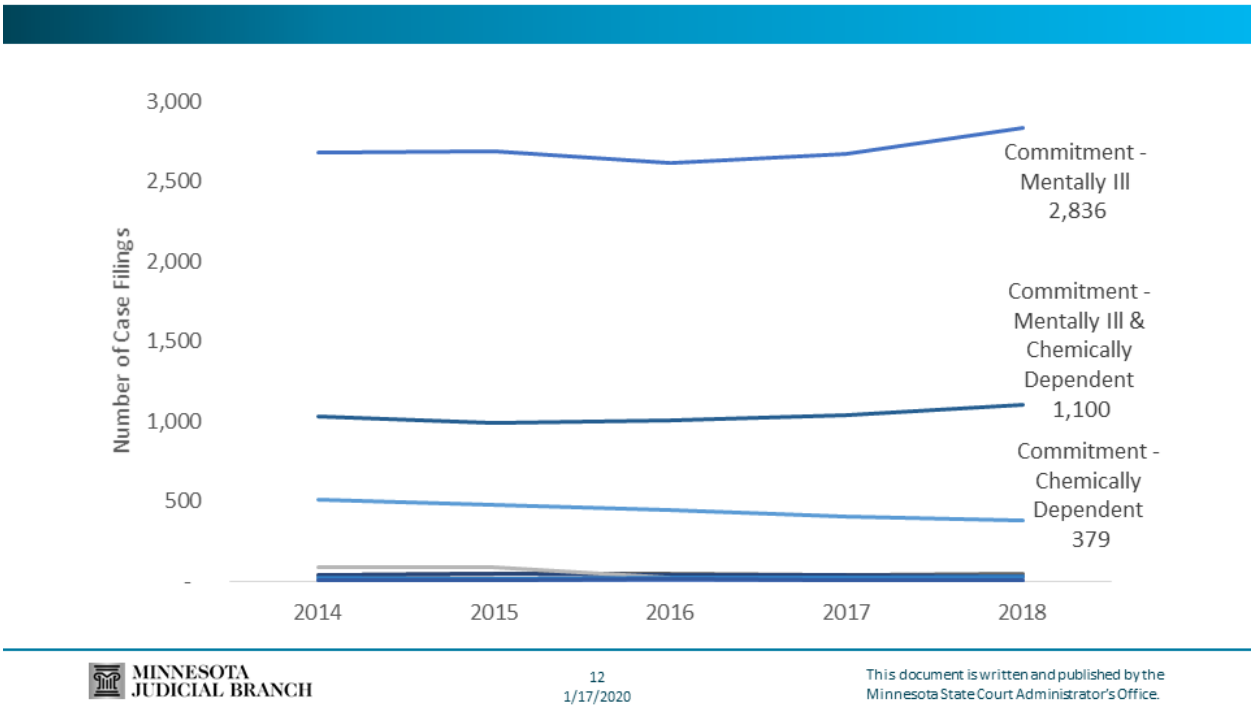


Image Description: A line graph showing trends in civil commitment filings from 2014 to 2018. 2,836 commitments were filed for mentally ill. 1,100 commitments were filed for mentall ill and chemically dependent. 379 commitments were filed for chemically dependent.

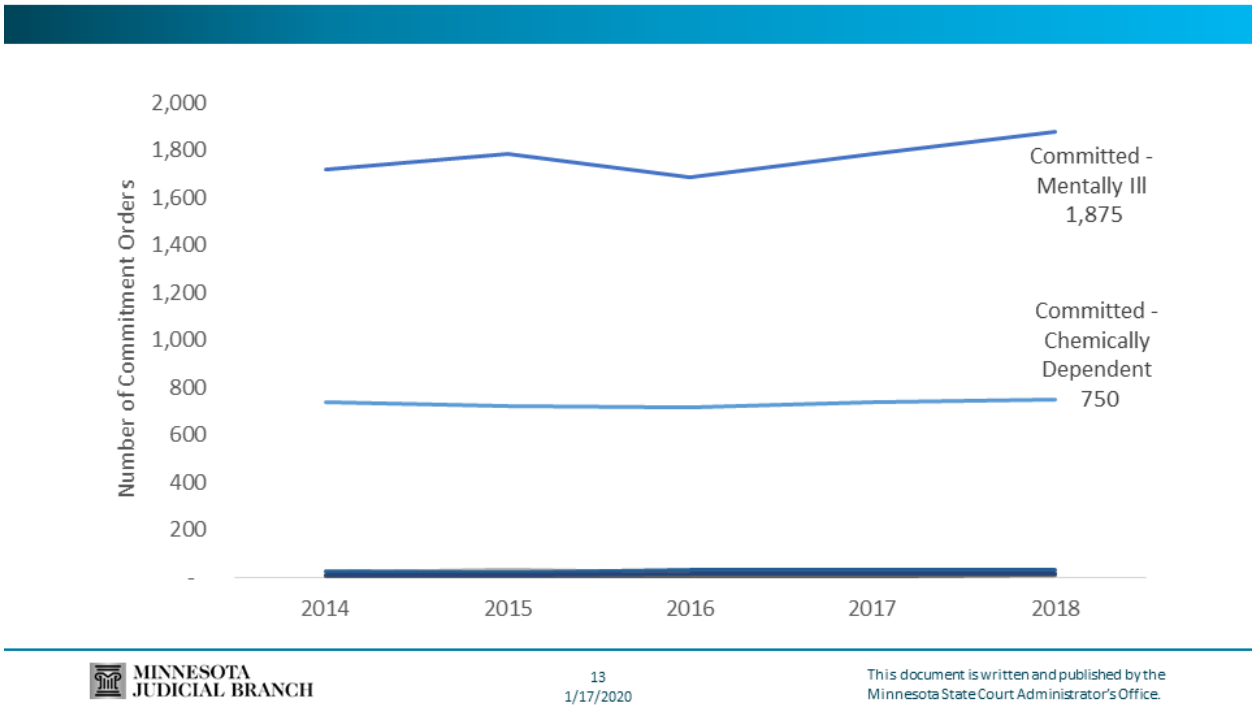


Image Description: A line graph showing trends in civil commitment orders from 2014 to 2018. 1875 orders were issued for mentally ill commitment. 750 orders were issued for mentally ill and chemically dependent commitments.

Mandatory criminal cases with multiple Rule 20.01 orders, filed 2016 - 2018

	Number of cases with at least one Rule 20.01 order	Number of cases with multiple Rule 20.01 orders	Percent of cases with multiple Rule 20.01 orders
1st District	601	124	21%
2nd District	908	189	21%
3rd District	578	112	19%
4th District	2,054	435	21%
5th District	297	38	13%
6th District	401	104	26%
7th District	616	96	16%
8th District	139	25	18%
9th District	600	144	24%
10th District	782	126	16%
Statewide	6,976	1,393	20%

Image Description: A data table showing the number of mandatory criminal cases with multiple Rule 20.01 orders from 2016-2018 by judicial district. In the 1st Disctrict, 601 cases had at least one Rule 20.01 order, 124 had multiple Rule 20.01 orders, thus 21% of all cases with a Rule 20.01 order had multiple orders. In the 2nd Disctrict, 908 cases had at least one Rule 20.01 order, 189 had multiple Rule 20.01 orders, thus 21% of all cases with a Rule 20.01 order had multiple orders. In the 3rd Disctrict, 578 cases had at least one Rule 20.01 order, 112 had multiple Rule 20.01 orders, thus 19% of all cases with a Rule 20.01 order had multiple orders. In the 4th Disctrict, 2,054 cases had at least one Rule 20.01 order, 435 had multiple Rule 20.01 orders, thus 21% of all cases with a Rule 20.01 order had multiple orders. In the 5th Disctrict, 297 cases had at least one Rule 20.01 order, 38 had multiple Rule 20.01 orders, thus 13% of all cases with a Rule 20.01 order had multiple orders. In the 6th Disctrict, 401 cases had at least one Rule 20.01 order, 104 had multiple Rule 20.01 orders, thus 26% of all cases with a Rule 20.01 order had multiple orders. In the 7th Disctrict, 616 cases had at least one Rule 20.01 order, 96 had multiple Rule 20.01 orders, thus 16% of all cases with a Rule 20.01 order had multiple orders. In the 8th Disctrict, 139 cases had at least one Rule 20.01 order, 25 had multiple Rule 20.01 orders, thus 18% of all cases with a Rule 20.01 order had multiple orders. In the 9th Disctrict, 600 cases had at least one Rule 20.01 order, 144 had multiple Rule 20.01 orders, thus 24% of all cases with a Rule 20.01 order had multiple orders. In the 10th Disctrict, 782 cases had at least one Rule 20.01 order, 126 had multiple Rule 20.01 orders, thus 16% of all cases with a Rule 20.01 order had multiple orders. Statewide, 6976 cases had at least one Rule 20.01 order, 1393 had multiple Rule 20.01 orders, thus 20% of all cases with a Rule 20.01 order had multiple orders.

C. Survey of Jail Administrators

Below is a summary of responses from twenty surveyed jail administrators. Three of the jails were in the Metro area and seventeen were rural communities.

Q: What steps do you take after someone has screened positive on the mental health screening tool? Who provides mental health services in your jail? What does it include – medications? Therapy? Is the formulary open or limited?

- 9 of the 20 surveyed jails contract for psychiatric services, 4 with MeND Correctional Care, 4 with Advanced Correctional Care (ACH), 2 with Nystrom & Associates (1 used both MeND and Nystrom accounting for a total of 9).
- 9 of the 20 jails work with county or community providers either in the jail or by transporting inmates to service locations. Services varied anywhere usually based on need from full time psychiatric nurses to limited hours per week and limited bi-monthly psychiatric telehealth services. 3 administrators explicitly mentioned mobile crisis teams coming out to their jails.
- 2 jails were unspecific about who services their jail.
- 11 of the 20 jails provided therapy in jail, 2 of those 10 by tele-medicine, 1 jail mentioned group therapy, 3 jails did not offer therapy, and 5 did not answer.
- 9 of the 20 jails stated their formularies were open, 2 of those 9 explicitly said they try to continue meds that patients already have when incarcerated. The status of formularies for privately contracted services was unclear.

Q: Do you enforce Jarvis Orders? What is your experience with involuntary administration of medication?

- 1 of the 20 surveyed jails said they would enforce a Jarvis order, but very rarely. 2 said they take people to the hospital for Jarvis Orders.

Q: Do you administer injectables?

- 11 of the 20 jails said they do administer injectables. This may be confounded because some the administrators mentioned insulin so it's unclear if they administer injectables for psychiatric medication. 7 of the 11 who said they would administer injectables were privately contracted (MeND, ACH, or Nystrom).

Q: Do you partner with community providers or county human services to provide treatment or other services or for discharge planning?

- 16 of the 20 jails mentioned some sort of relationship with community partners.
- 3 of the 20 jails mentioned social workers who work in the jail.

- 3 of the 20 jails have Reentry Assistance Programs.
- 4 of the 20 jails mentioned working with nurses or jail staff for discharge planning.
- 3 of the 20 work with community mental health providers.
- 3 of 20 replied yes but did not specify their relationships.

D. National Association of State Mental Health Program Directors Questionnaire

All 50 states were contacted individually. Responses were received from 30 states: Alabama, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Kansas, Maine, Massachusetts, Minnesota, Missippi, Nebraska, New Mexico, New Hampshire, New York, North Carolina, Ohio, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

Questionnaire Results:

Question 1: Does your state offer competence restoration programming of any kind?

- 27 state responded that they offer competency restoration programming.
- 3 states (North Dakota, Alabama, and New Hampshire) did not respond to this question

Question 2: Does your competency statute allow for outpatient community competency restoration?

- 19 of 30 states (63%) have a competency statute that allows for outpatient competency restoration
- Yes = Alabama, Arkansas, Colorado, Connecticut, Georgia, Idaho, Maine, Mississippi, Ohio, Tennessee, Virginia, Washington, Wisconsin, Wyoming, New York, Indiana, Florida, Utah, and Texas
- No = Kentucky, Massachusetts, Minnesota, Nebraska, New Hampshire, North Carolina, North Dakota, South Carolina, West Virginia, Kansas, and New Mexico

Question 3: Does your state have a civil commitment category for treat to competency or other type of commitment?

- 16 of 30 states have a civil commitment category for treat to competency that is separate from a criminal court rule or statute that requires individuals to undergo competency restoration
- Yes = Alabama, Connecticut, Georgia, Massachusetts, Idaho, Maine, South Carolina, Wisconsin, Wyoming, Tennessee, Virginia, New York, Kansas, Indiana, Florida, and Texas

Question 4: Does your state currently have a community competency restoration program?

- 14 of 30 states have a formal community competency restoration program
- Yes = Alabama, Arkansas, Colorado, Connecticut, Georgia, Ohio, Tennessee, Virginia, Washington, Wisconsin, Wyoming, Florida, Utah, and Texas
- No = Idaho, Kentucky, Maine, Massachusetts, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, South Carolina, West Virginia, Kansas, New York, Indiana, New Mexico, and Texas
- North Dakota did not respond

Question 5: What are your types of restoration sites (inpatient, community-based, jail-based, or other (describe)?

- 27 of 30 states have inpatient competency services (90%)
- 10 of 30 states have jail-based competency services (33%)

- 14 of 30 have community-based competency services (46%)

Question 6: If inpatient, number of sites?

- 27 of 30 have inpatient competency services
- The number of sites per state ranges from 1 site (Utah, New Mexico, Nebraska, Kentucky, West Virginia, Arkansas, Wyoming, Mississippi, Connecticut, South Carolina) to as many as 9 sites (Texas)

Question 7: If community outpatient, who is eligible to participate in this option?

- Requirements included a combination of the following:
    - On bond
    - Non-violent
    - Psychiatrically stable or medication compliant
    - Has transportation
    - Willing to participate
    - No substance abuse history
- Responsible agencies included: Department of Mental Health/DHS (most common); privately contracted providers; combination of case management (monitors stability) and DMH (prepares reports to court); and discretion of community (some county-run, some privately run)

Question 8: If jail based, who is eligible to participate in this option?

- Responses from states varied, and included:
    - Typically, individuals who are not bond eligible but also don't meet imminent risk or need for inpatient hospitalization
    - Individuals who appear restorable, medically stable, willing to take medications, and do not require hospital level of care
    - Anyone in jail
    - Arkansas allows for a therapist from DMH to come to the jail to provide service

Question 9: Who determines where the defendant receives treatment (court, evaluator, DHS or other)?

- In some states this may be the court or judge, the evaluator, DMH/DHS, or a combination of two or more.
- In most states, the evaluator provides an opinion as to appropriate treatment options and the judge makes the final determination.

Question 10: Who/what entity funds your restoration programming?

- In most states, the state's DMH/DHS is responsible for restoration costs for inpatient, community-based, and jail-based restoration services.
- 3 states referenced the use of Medicaid/private insurance, local funding by county boards, and the DMH through appropriations.

Question 11: What are the options for defendants who are deemed unrestorable (i.e. dropped charges, commitment, remain IST, etc.)?

- Options varied quite considerably from dismissal of charges, referral for civil commitment, case-by-case analysis, and/or return to community to live independently with or without supports in place.

Question 12: What types of charges are mandated to receive competency treatment (i.e., felonies, gross misdemeanors, etc…)?

- Some states only mandate felonies, while other states mandate all levels of offenses
- States that mandate felonies include: Alabama, Tennessee, Minnesota (as well as gross misdemeanors), Mississippi, West Virginia, and New Mexico
- States that mandate all levels include: Connecticut, Georgia, South Carolina, Main, North Carolina, Wyoming, Arkansas, Idaho, Virginia, Nebraska, Colorado, Ohio, New York, Kansas, Indiana, Florida, Utah, and Texas
- In Washington, felonies receive competency restoration treatment. Misdemeanors are eligible for competency restoration treatment, if the state can establish a compelling reason that restoration would in the interests of public safety (this was a change in law for misdemeanants effective July 28, 2019).

Question 13: How frequently do defendants need to be re-evaluated? Is the timeframe mandated by law/statute or policy?

- Range from 29 days to 1 year
- Typically occurs between 3 – 6 months
- Timeframe is mandated by law or statute in 97% of respondent states

Question 14: What is the average time to attain competency?

- Average time to attain competency ranged from 70 days to 180 days

Question 15: What percentage attain competence if known?

- Range between 40% (community-based, New Hampshire) to 98% (inpatient, Idaho)

Question 16: Do you have a waitlist for your IST beds?

- States with no waiting list: Connecticut, Tennessee, North Carolina, Minnesota, West Virginia, Virginia, Massachusetts, Colorado, Indiana.
- While some states have no waiting list, Washington has a 348 person waiting list.
- The majority of individuals awaiting placement remain in custody or out on bond.

Question 17: Are criminal pre-trial IST defendants routinely evaluated for community diversion options?

- About ½ of the states responded that there is some form of diversion attempted.
- Of those states, the diversion typically occurs by the examiner offering opinion as to where the individual would best be served.

Question 18: What program or initiative has been impactful in your state in addressing the numbers of competency restoration cases?

- Tennessee responded: “From the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) Forensic Report FY19: “The statutory requirement that an outpatient evaluation be conducted prior to an inpatient evaluation, and the requirement that an inpatient evaluation can only be ordered when the outpatient evaluator recommends an inpatient evaluation is an effective means for preventing unnecessary forensic admissions and preserving scarce inpatient resources for persons most in need.”
- Virginia responded: “Despite our long-standing outpatient restoration services, the state hospitals are still seeing increases in restoration cases. In FY19, 42% of all forensic admissions in the state were for inpatient restoration. The Code change that required admission of IST orders within 10 days definitely has had an impact on our system. Our Code requires the evaluator to recommend inpatient versus outpatient restoration, which we hope reduces the number of inappropriate inpatient orders. Our Code also created a forensic oversight program. The manager provides education to courts and evaluators about when outpatient restoration may be the best recommendation. We hope that we will begin to see reductions in inpatient IST orders.”
- Georgia responded: “Encouraging diversion, medication referral and re-evaluation as appropriate, and making calls of nonrestorability or malingering at the time of initial competency evaluation.”
- Washington responded: “The development and operation of three restoration treatment facilities, working closely with the two state hospitals to provide more timely admissions, the hiring of more evaluators and support staff and planning for outpatient competency restoration along with forensic navigators, peer support and housing assistance throughout the state. The development of a contempt settlement agreement.”
- Ohio responded: “Stepping Up Program, Sequential Intercept Mapping, CIT – Crisis Intervention Training for law enforcement and specialty officers; Assisted Outpatient Treatment and outpatient commitment. Diversion is done upstream.”

General Comments on the Questionnaire:

- “Outpatient evaluators can attempt to divert a defendant from an inpatient referral by seeing the defendant for competency training (they can be reimbursed for two additional sessions). Between 75-100% of those receiving competency training were diverted from inpatient evaluations.”
- “We are a disaster. We have outpatient restoration, but nobody does it right. They see someone and they are on bond or in jail for petty charges, and we recommend they can be restored outpatient short term. The defendants go in community, and we have community Master’s level folks see them. The services they provide are not consistent, not well followed up on, and not well supervised. Examiners have to go to court at the 90 day mark and we can’t say how the defendant has been doing because we can’t read the notes and they have only been there once per month.”

Wisconsin Model: As part of a competency evaluation, Wisconsin Forensic Unit opines what level of placement/service is most appropriate for the defendant (inpatient or outpatient) when they find someone incompetent to stand trial. Under their WSS 971.14(5)(a)(1) statute after finding of incompetence by the court, defendants are committed to DHS for custody and care. Individuals are then assessed by a DHS contractor (Behavioral Consultants, Inc [BCI], who operates outpatient program) to determine placement. The court can desire outpatient program placement, but ultimately the determination is up to BCI. If a defendant agrees to

participate and meets criteria, outpatient competency restoration starts immediately. The general parameters for acceptance (though it appears not all are required to be accepted):

- refrain from drug/alcohol use
- no immediate danger to self or others, general psychiatric stability, reliable transportation, stable housing
- willingness to participate.

Treatment is individualized on a case-by-case basis. If outpatient restoration is deemed not appropriate, BCI will contact the court and warrant is issued. The defendant is then prioritized for inpatient treatment.

E. DHS Forensic Evaluation Department Workgroup References

Cochrane, R. E., Herbel, B. L., Reardon, M. L., & Lloyd, K. P. (2013). The Sell effect: Involuntary medication treatment is a “clear and convincing” success. Law and Human Behavior, 37(2), p. 107-116. doi: 10.1037/lhb0000003

Danzer, G. S., Wheeler, E. M. A., Alexander A. A., & Wasser, T. D. (2019). Competency restoration for adult defendants in different treatment environments. Journal or the American Academy of Psychiatry and the Law, 47(1), p. 1-14. doi: 10.29158/JAAPL.003819-19

Fitch, W. L. (2014). White paper: Forensic mental health services in the United States. National Association of State Mental Health Program Directors.

Gowensmith, W. N., Frost, L. E., Speelman, D. W., & Therson, D. E. (2016). Lookin’ for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges. Psychology, Public Policy, and Law, 22(3), 293-305. doi: 10.1037/law0000088

Melton, G. B., Petrila, J., Poythress, N. G., Slobogin, C., Otto, R. K., Mossman, D., & Condie, L. O. (2018). Psychological evaluations for the courts: A handbook for mental health professionals and lawyers (4th ed.). New York, NY, US: Guilford Press.

Musgrove, L. M., Gowensmith, W. N., Hyde, J. N., & Wallerstein, L. P. (2018). Program evaluation and outcomes of an outpatient competency restoration program. Graduate School of Professional Psychology: Doctoral Papers and Masters Projects. 329.

Wik, A. (2018). Alternatives to inpatient competency restoration programs: Community-based competency restoration programs. Retrieved from http://www.nri-inc.org/

Wik, A. (2018). Alternatives to inpatient competency restoration programs: Jail-based competency restoration programs. Retrieved from http://www.nri-inc.org/

F. The Sequential Intercept Model

The Sequential Intercept Model (SIM) is a tool that was developed by Policy Research Associates and published in 2005 by the GAINS Center for Behavioral Health and Justice Transformation through the Substance Abuse and Mental Health Services Administration. "The SIM was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.[8]" The task force used the SIM to map out potential areas of intervention that may affect people who have been or may be at risk for being found incompetent to stand trial. The task forced compiled the map below and it should not be read as consensus recommendations, but rather a working document to inform the future work of the task force.

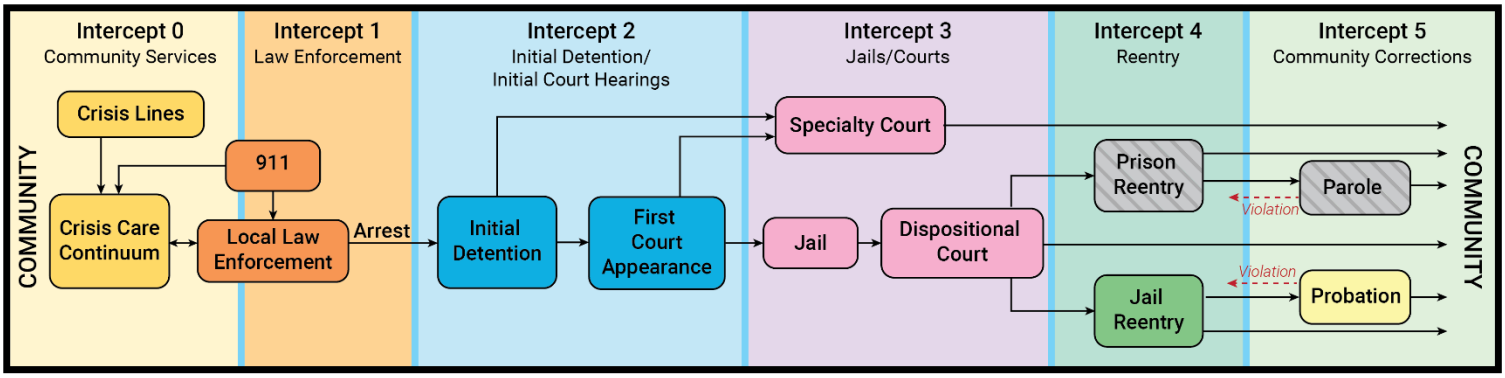


Image Description: The Sequential Intercept Model. Intercept 0 Community Services. Intercept 1 Law Enforcement. Intercept 2 Initial detention/Initial Court Hearings. Intercept 3 Jails/Courts. Intercept 4 Reentry. Intercept 5 Community Corrections.

Intercept 0 Community Services Crisis Lines Crisis Care Continuum	**<u>Increase Access to Community Mental Health Services</u>** **Long-term Supportive Housing:** Increase funding for Housing with Supports for Adults with Serious Mental Illness and Bridges Housing. **Ensure Access to Proper Levels of Care:** People living with mental illnesses need timely access to the correct level of care including, crisis homes, IRTS, and secure facilities for high-needs and forensic patients. **Provider Rates:** Stabilize mental health reimbursement rates across providers and locations and create incentives for high needs and complex services. **Address Workforce Shortages:** Beltrami County has used grant funds to provide scholarships to students in mental health fields as incentive to work in their community. Other incentives can

[8] https://www.prainc.com/sim/

	come in the forms of loan forgiveness and alternative licensing for culturally competent and diverse professionals. **Increase Coordination of Information Sharing Across Systems:** Create standard practices for releasing records and medication information when patients transition across systems, i.e. from jails to state operated facilities, etc. **<u>Expand Mobile Crisis Team Use and Collaboration</u>** **Centralized Access to Mobile Crisis Teams:** Minnesota recently expanded the ****Crisis** number to all counties. 911 should also play an integral role in referring people to crisis services (see below, Intercept 1). **Co-responder Models:** Some law enforcement agencies contract with community mental health providers or county social services to have social workers and members of mobile crisis teams respond to calls with law enforcement officers to assist in crisis situations and deflect or divert people. **Tablets and Telehealth**: Provide tablets and telehealth services so law enforcement can connect quickly with mobile crisis teams. **Peer Specialist Co-responders:** Peer specialists are individuals with lived experience recovering from a mental illness who have been certified by the state to offer support and encouragement for people with mental illnesses. Peer specialists can co-respond with law enforcement to offer an unarmed and de-escalating presence that is often more effective in mental health crises.
Intercept 1 Law Enforcement Dispatch	**<u>Increase Pre-Arrest Diversion Programs and Collaborations</u>** **911 Warm Handoff to Mobile Crisis Team:** 911 dispatch should be trained to understand and recognize mental health crisis situations that do not require law enforcement and dispatch mobile crisis teams. Ramsey County has implemented this approach. approach. **Stearns County CAT Team**: Multi-agency team of law enforcement and social services meets weekly to discuss high utilizers and strategize to sustainably meet high needs and reduce justice involvement. The CAT Team has streamlined information sharing across systems. **West and South St. Paul Mental Health Coordinated Response**: Community Engagement Officers from the police department work together with a Dakota County Social Worker to follow up with clients after a crisis to connect them to services in a less heightened environment. **Duluth Police Department Mental Health Unit**: The Duluth Police Department has an embedded social worker that responds with officers to service calls to connect individuals to services and divert them from arrest. **<u>Increase Law Enforcement Mental Health and Crisis Training</u>**

	Mental Health and Crisis Training: Law enforcement should be trained to understand mental illnesses and trained in de-escalation techniques, ideally the full 40-hour Crisis Intervention Training (CIT). Amend POST Board licensing requirements to require 4 of the current 16 hours of "Crisis Response, Conflict Management, and Cultural Diversity" training to be crisis intervention and mental health crisis training. The POST Board should work with DHS and mental health stakeholders to create a list of approved entities and scenario based training courses, and the board should provide a report to the legislature documenting the use of training funds, compliance with standards, and evaluations of the effectiveness of training. **Online CIT Training**: Continue implementing online CIT training for law enforcement agencies that would suffer staffing issues if officers take the full 5-day, 40-hour course. Any online course should still require in-person scenario training. This is also a great option for 911 dispatch to be trained. **Cultural Competency:** As communities of color are disproportionately represented at all points in the justice system, law enforcement agencies must be culturally responsive to the needs of diverse communities. This is especially important in responding to different communities in mental health crisis.
Intercept 2 Initial Detention Initial Court Hearings	**Increase Pre-Trial Diversion** **The Yellow Line Project**: Embeds a social worker to screen individuals *pre-booking* to divert and connect them to services. The project works closely with the mobile crisis team and can coordinate services pre-arrest and follow up with incarcerated individuals. **Require Mental Health Assessments:** All jails are required to perform a mental health screen at booking but follow up and care varies greatly if someone scores positive on a mental health screen. Jails should be required to provide assessments if someone scores positive on a mental health or substance use disorder screen and provide for timely referral to treatment. In order to adequately identify people in need of treatment, screeners and screening practices must be culturally competent. **Bail Reform**: No one should be detained pre-trial based on their ability to pay a cash bail. California has multiple programs where families are organized to advocate for the pre-trial release of their loved ones, and leaders from these programs have been in conversation with some Minnesota stakeholders. Defendants in custody typically have worse outcomes in their cases and a defendant living with a mental illness may experience an interruption in treatment that may greatly affect their competence at trial. New Jersey has passed comprehensive bail reform that assumes release unless the prosecutor can prove safety risk and they have seen pre-trial detention go down significantly. St. Louis County has an Intensive Pretrial Release Program, but they still struggle with interruptions in insurance and access to treatment for their clients. **Minnesota Pretrial Assessment Tool (MnPAT):** The Minnesota Judicial Council's Pretrial Release Initiative, one of the Strategic Initiatives of the Branch, is aimed at studying evidence-based tools for use by judges making pretrial release decisions. Minnesota Judicial Council policy 524: Pretrial Release Evaluation, adopts the use of a statewide pretrial evaluation form and Minnesota Pretrial Assessment Tool (MNPAT) and directs the use of pretrial risk assessment tools in Minnesota District Courts. The assessment tool is meant to ensure that judges have the most predictive and least biased information, providing accurate, objective, and useful information for pretrial release

	decisions. The Minnesota Judicial Council established the Pretrial Release Initiative Implementation Steering Committee to implement the statewide pretrial risk assessment tool and form. Implementation was completed in late 2018. The Steering Committee included public and private attorneys, probation representatives and law enforcement, court administration, and judges.
Intercept 3 Jails Courts	**<u>Expand and Ensure Jail Care</u>** **Stearns County Jail Collaboration**: CentraCare, Central Minnesota Mental Health Center and the county jail collaborate to maintain a continuum of care before booking, during incarceration, and after release. **Incentivize Community Mental Health Provider Partnerships in Jails:** Utilizing community mental health providers in jail treatment increases access to a seamless continuum of care, including case management, therapy, and better medication management upon release from a jail facility. Even if jails contract with private health care providers, mental health should have its own dedicated division and providers and should collaborate with community providers to ensure medication continuation during and after incarceration. **Medication Assisted Treatment (MAT)**: Medical providers in jails should be trained to continue MAT during and after incarceration. St. Louis County has received a grant to pilot a MAT planning initiative in their jail. **Enforce Jarvis Orders (Court Ordered Involuntary Medication) in Jails**: Jails should create policies to ensure that formularies and medical providers will administer long acting injectables and medication under Jarvis orders. **<u>Increase Court Education and Expand Treatment Courts</u>** **Court Education:** Judges and attorneys should have a basic understanding of mental illnesses and the components of the mental health system. This should allow for greater access to treatment when judges make important decisions about bail and release and decrease decompensation in jail and subsequent incompetence. **Forensic Navigators:** In response to the class action lawsuit about detaining people found incompetent, Washington state legislation has created "Forensic Navigators" who are essentially forensic case managers for people who have been referred for a competency evaluation. They assist people in navigating treatment and outpatient competency restoration and act as liaisons to the court to make information sharing easier and advocate for diversion when possible. Missouri also has a statewide Community Mental Health Liaison program that works between the justice system and mental health system. Peer Specialists are particularly effective in these roles. **Expand Treatment Courts:** Mental health and drug courts can be expanded as avenues for people to access treatment instead of incarceration. Treatment courts must be implemented with care, so that criminal charges do not exacerbate a person's situation and so that pleading guilty to a crime is not a primary way to receive treatment.

Forensic Examiner Report Templates: The State Court Administrator should establish a policy that requires all Mandated Services examiner reports to be filed using a pre-determined examiner report template. The template should provide readers with a consistent format and headers, use common language, list statutorily required questions, but provide flexibility for examiners to provide additional information as necessary.

Make Evaluation Process More Efficient

Pre-Screening: St. Louis County has reduced costs and backups in the system by screening people by a trusted forensic examiner before ordering a full evaluation.

Create Rule 20 Specific Dockets: Multnomah County in Oregon has a specialized docket for defendants at risk for being found incompetent. Individuals can be referred from the jail streamlining the process. The centralization of the docket allows for greater expertise in attorneys and judges and better results for people who may be found incompetent. The docket has a standing staff meeting to coordinate decisions for defendants often including social service workers and health care providers to discuss the possible best environment if a person needs to be restored to competency. The staff meeting also reassures prosecutors that defendants will be engaged with treatment if charges are dismissed. Multnomah County also created a **Rapid Evaluation Process** where the county uses funds to reserve regular slots for trusted forensic examiners to perform competency evaluations and return reports within two weeks. They have also created orders and trained staff to quicken data and record sharing across agencies. The process has seen a reduction in jail stays waiting for evaluations from an average of 30 days to 5 days.

Fourth District Same Day Evaluations Pilot: In the 4th Judicial District, Psychological Services implemented a successful pilot which has since become a permanent program (now the Targeted Misdemeanor Rule 20 program). The program successfully reduced time to resolution, examiner hours and cost to the court. The program involved having an examiner on call who interviewed misdemeanor defendants either on the same day as the Rule 20 order if the defendant was residing in the community, or within two days if detained. The 4th District is exploring avenues to broaden the scope of the program in ways that do not result in an increase in contested hearings, as that would detract from the positive results experienced. This must be approached carefully due to the highly adversarial setting of criminal court.

Video Evaluations and Hearings: In some rural areas transport for evaluations comes at great cost both financially and to the wellbeing of the defendant. Evaluations and court hearings through ITV can be used in appropriate settings to reduce this cost.

Information Sharing Order: Dakota County Social Services worked with the District Court to create a specialized order that requires county case managers to be notified of any criminal court hearings to allow for greater communication and advocacy and to avoid interruption of treatment.

Intercept 4 Reentry	**<u>Increase Re-Entry Planning and Services Coordination</u>** **Jail Social Workers, Mental Health Coordinators, and Re-Entry Specialists:** The Region 5+ Comprehensive Re-Entry Program has put a social worker in the jail of every county jail in the region (Cass, Crow Wing, Morrison, Todd, Wadena, Aitkin) to provide screening, diversion, and early intervention as well as re-entry planning to reduce recidivism and increase connection to treatment. Dakota County has a Mental Health Coordinator and Carlton County has a Community Based Coordinator that work in the jails. Many jails have Re-Entry Assistance Programs and some partner with Community Mental Health Centers like the Human Development Center in Lake County. These programs should be especially focused on re-enrolling people in MA and connecting people to housing services.
Intercept 5 Community Corrections	**<u>Reduce Recidivism</u>** **Warrants:** If someone misses a court date, they will likely be issued an arrest warrant. Being re-arrested for failure to appear in court can interrupt a person's treatment and increase the likelihood that they may decompensate in jail. Often warrants are issued by mail, which can be an unreliable way to contact a person with a serious mental illness. Some counties have had success in offering text reminders of court dates, but many innovations could still be explored.