



OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Mental Health Services in County Jails

MARCH 2016

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Members of the Legislative Audit Commission:

Local law enforcement officers frequently encounter individuals whose behaviors indicate that they may be mentally ill. Sometimes the officers try to get these individuals evaluated or treated at a hospital; in other cases, they bring them to jail to face criminal charges. Regardless of whether the individuals end up in jail or in the community, they may need ongoing services and support to avoid further contact with the criminal justice system.

In Spring 2015, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate mental health services for persons taken into custody by law enforcement. We concluded that these services—both in jail and in the community—are not what they should be, and the solutions to this problem will require actions by both state and local officials. In addition, we think there is a need to streamline court processes for individuals deemed mentally incompetent to stand trial, and there should be a broader array of treatment options for restoring their competence.

Our evaluation was conducted by Joel Alter (project manager), Will Harrison, and KJ Starr. We received full cooperation from the state departments of Corrections and Human Services, the State Court Administrator's Office, county sheriffs, county human services officials, and many others.

Sincerely,

Handwritten signature of James Nobles in black ink.

James Nobles
Legislative Auditor

Handwritten signature of Judy Randall in black ink.

Judy Randall
Deputy Legislative Auditor

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Summary

Weaknesses in community-based and jail-based mental health services place at risk the well-being of persons with mental illness taken into custody by law enforcement.

Key Facts and Findings:

- Problems with service availability in Minnesota’s adult mental health system have persisted for years, limiting peace officers’ options for referring persons with mental illness they take into custody. (p. 26)
- The Department of Corrections has not collected reliable data from jails on the number of inmates assessed for mental illness. However, our surveys of sheriffs suggest that one-third of jail inmates may be on medications for a mental illness. (pp. 20, 21)
- State rules do not adequately address some important areas of jail-based services, including mental health assessment of inmates following admission to jail. (pp. 46, 55)
- Most sheriffs and county human services directors believe that jail inmates should have better access to psychiatric services, counseling, and case management than they now have. (p. 46) In addition, these officials widely believe that the number of beds in Minnesota’s mental health facilities—particularly secure inpatient beds—is inadequate to meet current needs. (p. 29)
- There is limited compliance with a state law that requires discharge planning for sentenced jail inmates with mental illness. (p. 66)
- Contrary to law, some Minnesota defendants deemed mentally incompetent to stand trial remain in jail while awaiting court action on their possible civil commitment to competency treatment. Many incompetent defendants do not ultimately receive treatment to restore their competency. (pp. 83, 88)
- A 2013 law (the “48-hour law”) that gives jail inmates priority for placement into Department of Human Services (DHS) facilities has not always worked as intended, and it has limited the access of other patients to the Anoka-Metro Regional Treatment Center. (pp. 92-94)

Key Recommendations:

- The Legislature, DHS, and counties should fund and implement a more comprehensive set of community-based mental health services. (p. 41)
- DHS, with legislative support, should relocate some Anoka-Metro Regional Treatment Center patients who do not need hospital care so that this facility can better serve patients with challenging behaviors. (p. 42) The Legislature should fund DHS’s community behavioral health hospitals so they can use more of their licensed beds and provide a better resource for law enforcement. (p. 43)
- The Legislature should authorize a streamlined judicial process for individuals deemed incompetent to stand trial to be placed into treatment or referred to county social services. (p. 86) If the Legislature retains the current process, however, it should specify a time limit in law for incompetent inmates to remain in jail while awaiting commitment. (p. 90)
- The Legislature should amend state law to require mental health assessments of persons who remain in jail at least 14 days. (p. 56)
- The Legislature should amend state law to allow jails that have proper staffing and training to administer medications involuntarily, pursuant to a court order. (p. 62)

Report Summary

Minnesota’s county jails house persons taken into custody by law enforcement who have not yet had a criminal trial. They also confine persons who have sentences of up to one year. Courts have ruled that jails may not show “deliberate indifference” to inmates with serious medical issues, including mental health problems.

The Minnesota Department of Corrections (DOC) requires jails to report information on the number of inmates referred for mental health evaluations. However, the data collected have not been complete or reliable, and we recommend that the department ensure better reporting. Lacking good information on how many jail inmates have mental illness, we solicited information from county sheriffs about their inmate populations. Their estimates suggested that at least one-third of jail inmates take medications for a mental illness.

Among persons who received publicly funded services in Minnesota for a serious mental illness in 2014, at least 18 percent had an arrest in 2013 or 2014, and at least 10 percent had a conviction in those years.

Limited availability of community and state-operated mental health services affects persons taken into custody.

In 1987, the Legislature passed the Minnesota Comprehensive Mental Health Act, and it set a target of full implementation by 1990. But, today, many mental health services remain unavailable—as indicated by the Department of Human Service’s (DHS’s) own analyses and by our surveys of county sheriffs and human services directors. As a result, law enforcement has limited options when

they take someone with mental illness into custody, or when they seek treatment during or after an inmate’s stay in jail.

Community hospital psychiatric beds are often full, partly because they have had problems discharging patients to state-run psychiatric facilities. In 2015, it typically took more than 50 days for community hospitals to place someone in the Anoka-Metro Regional Treatment Center. A contributing factor is that jail inmates receive priority for placement at Anoka under a 2013 law (the “48-hour law”), limiting Anoka’s ability to serve others. For example, 42 percent of Anoka’s June 2015 patient population came to Anoka from a jail, up from 12 percent two years earlier. Nearly half of the patients in Anoka’s “competency restoration” program (for persons deemed incompetent by a court to stand trial) did not require the hospital level of care that Anoka provides.

Meanwhile, DHS’s smaller psychiatric hospitals have had significant staffing reductions, and they are now operating well below their capacity.

There is no single solution to improving community services for persons with mental illness who come into contact with law enforcement. As a first step, DHS, the Legislature, and counties should continue to address service availability problems in the state’s mental health system. Second, the Anoka-Metro Regional Treatment Center needs to be available for patients who need inpatient mental health care in a secure setting. Transferring many of that facility’s competency restoration cases to other locations would be helpful. Third, the Legislature should fully fund DHS’s behavioral health hospitals so more of their beds are available in the communities they serve, including for persons taken into custody by law enforcement who have not been committed by a court to treatment.

Where possible, counties should formalize arrangements with community or state-run hospitals to help ensure that there will be places for persons who need inpatient care while in jail (or instead of going to jail).

State rules for jails inadequately address some mental health issues.

DOC has adopted rules that govern jail practices. These rules are consistent with some standards adopted by the corrections profession, but there are important areas in which the rules and standards do not align.

For example, professional standards suggest that jails should assess the mental health of inmates within prescribed periods after admission; state rules have no such requirements. Professional standards recommend the development of treatment plans for inmates with mental illness, but state rules do not require this. We recommend that DOC update its jail rules. In some areas—like mental health assessment—we think the Legislature should amend state law to ensure prompt implementation of changes.

Services in jails for persons with mental illness are limited.

In surveys we conducted, a majority of Minnesota’s sheriffs and county human services directors said that jail inmates with mental illness should have better access to psychiatric services, counseling, and case management services.

DOC’s jail inspections have identified general issues that could affect inmates with mental illness. For example, 40 percent of jails’ most recent inspection reports cited problems with the jails’ ongoing checks on inmates’ well-being. Also, DOC often cited jails for

inadequacies in staffing, training, and programming, which could adversely affect persons with mental illness.

Since 2000, there have been more than 50 suicides and 770 suicide attempts in Minnesota jails—some potentially preventable, according to DOC reviews. Litigation related to jails’ services for inmates with mental illness have been infrequent, but some settlements related to inmate suicides or self-harm have been large.

Some jail inmates do not comply with their prescribed medications. Minnesota law has provisions that allow for involuntary administration of antipsychotic medication in certain situations. The law does not explicitly authorize these practices in jails, and jails rarely pursue this option. Further, state law only allows courts to authorize involuntary medication for individuals who have been court-committed to treatment (or for whom such commitments are under consideration). However, medications may help some individuals manage their illnesses so that commitments are unnecessary. We recommend that the Legislature consider statutory changes that would allow jails that have proper staffing and training to administer medications involuntarily at a court’s direction.

Inmates with complaints about mental health services have limited recourse. Just as there is a state ombudsman who investigates problems related to mental health services in human services facilities, we recommend that the Legislature consider establishing an ombudsman focused on investigating issues related to mental health services in correctional or detention facilities.

State law requires DOC to develop a “model discharge planning process” for certain jail inmates with mental illness. However, there has been limited compliance among counties with the law’s discharge planning requirements.

Incompetent defendants often remain in jail and are not always treated to restore competency.

Under state law, individuals may not be criminally tried if they lack the mental ability to consult with attorneys, understand court proceedings, or participate in their defense. Thus, courts have procedures for evaluating defendants, and courts may determine that individuals are “incompetent” to stand trial.

In Minnesota, unlike most states, a person deemed incompetent must subsequently go through a separate commitment process to be placed in treatment intended to restore competency. The median time for determining competency in cases we reviewed was 50 days, and this was followed by a median time of an additional 20 days for a decision on civil commitment.

State law says that individuals who are awaiting court decisions on their commitment cannot be in jail, unless a court finds this necessary to protect the life of the individual or others. But we found that 63 percent of incompetent defendants we tracked were in jail while awaiting commitment decisions—typically for at least a week. Counties should develop placement options so that incompetent individuals awaiting civil commitment do not sit in jail.

Minnesota’s standard for civil commitment is higher than the standard for incompetency. We found that in most cases where someone was found incompetent, no commitment petition was filed or the court did not commit the person. These individuals may simply have been released from custody, and it is unclear whether their mental health issues were addressed.

We recommend that the Legislature create a special commitment process so that persons charged with felonies or gross misdemeanors who are found incompetent could be immediately placed by a court in competency treatment. Those deemed incompetent for misdemeanor charges would be referred to a county human services agency for follow-up.

We also recommend that DHS implement competency restoration services in a full range of settings. Currently, nearly all such services are provided in DHS’s high-security inpatient facilities, which may not be necessary for all cases.

The “48-hour law” has not always worked as intended.

In 2013, the Legislature passed a law that required prompt placement of civilly committed jail inmates into DHS facilities. This law has mostly applied to persons deemed incompetent to stand trial and subsequently committed to treatment.

The law requires placements to occur within 48 hours, but it is unclear in law whether this is computed from the commitment order or DHS’s notification of the order. Courts have not always provided timely notification to DHS.

As of August 2015, about one-fourth of all individuals subject to the 48-hour law had not been placed within 48 hours of DHS’s notification of the order. There were various reasons for noncompliance; in some cases, the DHS commissioner chose not to comply due to concerns for staff and patient safety.

We recommend statutory changes to clarify how the 48-hour law should be administered, and to clarify whether there are circumstances in which DHS is not required to comply with the law.

Introduction

Across the nation, people have questioned whether jails and prisons have become the “new asylums” for persons with mental illness.¹ States—including Minnesota—have closed large state-run hospitals in recent decades, and there has been speculation that increased numbers of persons with mental illness have ended up in correctional facilities.

Although it is unclear exactly how the number of persons with mental illness in jails has changed over time, there is no question that these facilities have significant numbers of inmates with mental illness. Jails—and, more broadly, the state’s correctional, judicial, and human services systems—face the challenge of dealing with these individuals in ways that respect their constitutional rights and address their mental health needs. In April 2015, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate mental health services for people taken into police custody. We asked the following questions:

- **Do state-operated or community-based mental health services provide viable placement options when law enforcement officials take individuals with mental illness into custody?**
- **Do jails provide legally required mental health services and follow recommended practices in the correctional field?**
- **How timely are civil commitments and competency determinations for people with mental illnesses who are facing criminal charges?**
- **To what extent has the Minnesota Department of Human Services (DHS) complied with the law requiring placement of certain jailed individuals in DHS facilities within 48 hours? What have been the consequences of this law?**

Our report focuses on individuals who have diagnosable mental illnesses—that is, illnesses having symptoms and behaviors that are consistent with generally accepted diagnostic criteria.² There are a wide range of diagnosable mental illnesses—some of them are depression and bipolar disorder, which may be characterized by persistent sadness or mood fluctuations; schizophrenia, which may involve distorted awareness or thinking; and disorders characterized by feelings of panic or anxiety. Mental illnesses may have varying levels of severity and impairment. Some individuals with mental illness may, at certain times, present significant challenges to jails and treatment facilities—for example, posing a danger to themselves or others. This report pertains to individuals representing the full range of diagnosable mental illnesses because (1) any of them might benefit from services or treatment and (2) if untreated, any of them might experience challenging symptoms or

¹ For example, see Douglas Shenson, Nancy Dubler, and David Michaels, “Jails and Prisons: The New Asylums?” *American Journal of Public Health* 80, n. 6 (1990): 656; Public Broadcasting System, “The New Asylums,” <http://www.pbs.org/wgbh/frontline/film/showsasylums/>, accessed December 10, 2015; and Gary Fields and Erica Phillips, “The New Asylums: Jails Swell with Mentally Ill,” *The Wall Street Journal*, September 25, 2013, <http://www.wsj.com/articles/SB1000142412788732345510457901266424550546>, accessed October 26, 2015.

² The authoritative diagnostic tool in the United States is the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*, which was most recently updated in 2013.

behaviors. Appendix A contains federal and state definitions of mental illness that may be applicable in certain circumstances, and Chapter 1 has the statutory definition of a “person with mental illness” that is used in Minnesota for civil commitments.

The scope of our evaluation included aspects of services provided by county jails and by mental health services in the community. In jails, we focused primarily on services and processes prior to criminal sentencing, although many of the jails we examined also house sentenced offenders. In addition, we examined the availability of community-based mental health services, which may address mental health symptoms before crises arise, provide alternatives to jail, treat some individuals who are in jail, and provide support after individuals leave jail.

Through interviews and written information requests, we solicited input from the state departments of Corrections and Human Services; county organizations, including sheriffs’ offices and human services departments; community and state-run hospitals; mental health advocates; and representatives of the judicial system, such as judges, county attorneys, and public defenders. We toured five jails and three state-operated mental health hospitals. At the Anoka-Metro Regional Treatment Center, we met with nine patients who spent time in jail prior to their commitment to Anoka.

We conducted statewide surveys of two groups: (1) county sheriffs whose offices operate jails and (2) county human services directors whose offices administer community mental health services.³ These surveys requested opinions of the respondents, as well as factual information about jail-based mental health services.

We analyzed several large databases for this evaluation. We obtained court data from the State Court Administrator’s Office on individuals who were the subject of criminal cases filed between July 2009 and June 2015 and who also (1) had orders for evaluations of their competency to stand trial or (2) were the subject of civil commitments or requests for civil commitment.⁴ We obtained data from the Department of Human Services regarding persons classified as having “severe mental illness” at any time during 2011 through 2014, based on the programs in which they participated. For this population, we then obtained data from the Bureau of Criminal Apprehension regarding those individuals’ criminal histories. We accessed a Department of Corrections’ database to review jail inspection reports, information on jail incidents (such as suicides), and records of individuals’ detention histories in jails. In addition, we obtained a variety of other data, such as data on jails’ admissions and mental health referrals, and data on admissions to state-operated hospitals.

We reviewed professional standards relevant to inmates with mental illness, focusing primarily on those adopted by the American Correctional Association and National

³ We received responses from 73 sheriffs (94 percent) and 74 county human services offices (99 percent); one of the human services respondents completed only a limited number of the questions. Some sheriffs received assistance from jail staff in completing the surveys, but we asked that the opinions expressed in the survey responses represent those of the sheriff. For our survey of human services directors, we allowed the directors to determine whether to complete the survey themselves or delegate it to staff in their agencies with expertise in mental health issues.

⁴ We obtained court data for cases in which individuals were assessed for incompetence due to either mental illness or mental deficiencies. The data did not distinguish which of these (mental illness or mental deficiencies) was the basis for a given incompetence motion or finding, so we examined all such cases in our analyses.

Commission on Correctional Health Care.⁵ We reviewed relevant statutes, state rules governing jail operations, and state rules of criminal procedure. We also reviewed the policies and procedures adopted by a sample of 12 individual jails, which we selected partly to ensure that we included jails of various sizes and from various parts of the state.⁶

We reviewed federal and state court cases that were pertinent to mental health services in correctional facilities. We also obtained from county attorneys throughout the state information on jail-related lawsuits that were settled or decided between January 2012 and July 2015.

Finally, we collected and reviewed research literature in a variety of areas. For instance, we looked at past research about the extent of mental illness in jails, and about the relationship between mental illness and criminality. We also looked at past reports regarding the adequacy of community-based mental health services in Minnesota.

⁵ The main sets of standards we used were American Correctional Association, *Core Jail Standards* (Alexandria, VA, 2010); and National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008). Both sets of standards state that they are intended to apply to jails of any size.

⁶ We reviewed policies for jails in the following counties: Beltrami, Freeborn, Hennepin, Kandiyohi, Morrison, Pine, Pipestone, Ramsey, Rice, St. Louis, Traverse, and Wright. In Hennepin and Ramsey, we limited our review to the jails that house inmates prior to trial.

Chapter 1: Background

This chapter provides readers with context for considering services in jails for people with mental illness. We discuss the processes by which individuals may be taken into custody by law enforcement, and the roles played by jails and the courts when this occurs. We examine the legal obligation of jails to provide mental health services, based on past court rulings. In addition, we examine available information about (1) the extent of criminal behavior among persons with mental illness and (2) the extent to which individuals in jail have mental illness. Because we found problems with some data collected by the Minnesota Department of Corrections and the state court system, we offer recommendations to address these issues.

KEY FINDINGS IN THIS CHAPTER

- **Courts have established that inmates have a constitutional right to adequate mental health care in certain circumstances.**
 - **At least 10 percent of persons who received publicly funded services in Minnesota in 2014 for a serious mental illness had a conviction in 2013 or 2014 for a criminal offense.**
 - **The Minnesota Department of Corrections has not collected reliable data from jails on the number of inmates referred for mental health evaluations. Information we collected from sheriffs suggested that perhaps one-third of jail inmates are on medications for a mental disorder.**
-

COUNTY JAILS

Minnesota law authorizes county boards to construct and maintain jails “at the expense of the county.”¹

Jails hold two main categories of people: (1) persons taken into custody by law enforcement who have not yet been tried in court on criminal charges, and (2) persons who have received criminal sentences of up to one year of incarceration.

Persons who receive criminal sentences of more than one year are placed in the custody of the Minnesota Department of Corrections (DOC) for confinement in prison.² In contrast, locally operated jails confine persons sentenced to one year or less.³ Jails also confine

¹ *Minnesota Statutes* 2015, 641.01.

² *Minnesota Statutes* 2015, 609.105, subd. 1.

³ *Minnesota Statutes* 2015, 609.105, subd. 3.

“pre-adjudicated” individuals—that is, persons who have been taken into custody by law enforcement but have not yet been charged, and persons awaiting court action on their criminal cases.

There are 87 county-operated jails for adults in Minnesota, and elected county sheriffs operate most of them. Most county jails house a combination of pre-adjudicated and sentenced inmates.⁴ Nine counties do not operate their own, single-county jails; these counties rely entirely on cooperative arrangements with other counties for detention services.⁵ Four counties operate more than one jail.⁶

In 2014, there were nearly 191,000 admissions of adults to Minnesota county jails. As of late 2015, jails serving adults in Minnesota had a licensed capacity of 9,875 beds, and about 76 percent of those beds were in use.⁷ Many stays in jail are short in duration, such as a few hours or a few days. On the other hand, some individuals stay in jail for weeks or months waiting for court action on a criminal case, or serving jail sentences for criminal convictions.

Counties bear most of jail inmates’ health services costs, including the costs of mental health care.

State law requires county boards to pay for medical services provided to jail inmates.⁸ Minnesota’s Medicaid program generally does not pay for health care provided to incarcerated individuals, but it may cover inpatient costs if an inmate is transferred to a hospital for care or treatment.⁹

DOC collects information from counties on actual expenditures at jails throughout the state, but the data do not allow a precise estimate of jails’ health services expenditures generally or mental health services specifically. This is because jails do not report to DOC the salaries and benefits of jail employees who provide health services (such as nurses) separately from the salaries and benefits of other jail employees. Jails reported spending more than \$28 million in 2014 on health services (including things like health services contracts, prescriptions, and hospital visits), which was nearly 9 percent of total jail expenditures, but this did not include the costs of jail employees who provided health services.

⁴ Among the 87 jails, 2 (called “adult detention centers”) only house individuals whose criminal cases have not yet been adjudicated, and 4 (called “adult correctional facilities”) only house individuals who have already been sentenced. Adult correctional facilities are operated by county corrections agencies, not county sheriffs.

⁵ These counties are: Big Stone, Dodge, Grant, Mahnomen, Polk, Pope, Red Lake, Rock, and Stevens. Two of these counties (Polk and Red Lake) do not operate single-county jails but participate jointly with another county to operate a jail that serves all three counties.

⁶ These counties are: Anoka, Hennepin, Ramsey, and St. Louis. In addition to these counties, some counties operate a jail of their own and also jointly operate a jail that serves multiple counties.

⁷ The Department of Corrections also determines the “operating capacity” of each jail. Depending on the jail’s age and design, DOC calculates the operating capacity as somewhat less than the licensed capacity. As of late 2015, jails were using 84 percent of their operating capacity.

⁸ *Minnesota Statutes* 2015, 641.15, subd. 2. In some circumstances, the jail may be reimbursed for health care expenses by the inmate or the inmate’s insurance.

⁹ *Minnesota Statutes* 2015, 256B.04, subd. 23. In addition, inmates may be eligible for MinnesotaCare coverage prior to adjudication if they meet various financial and non-financial eligibility requirements.

State law directs DOC to license and inspect county jails.¹⁰ DOC has promulgated rules that establish minimum standards that jails must meet; most of these rules were last updated in 2013.¹¹ State law requires DOC to conduct compliance reviews of jails at least once every biennium; in practice, DOC annually reviews jails that have had histories of compliance problems.¹² In mid-2015, we reviewed the most recent inspection reports of jails throughout the state, and about 30 percent were on an annual inspection schedule.

JAILS' MENTAL HEALTH SERVICES

There is a wide range of diagnosable mental illnesses. For example, there are mood disorders, such as depression or bipolar disorder; illnesses characterized by hallucinations or delusions, such as schizophrenia; anxiety disorders; eating disorders; autism; and post-traumatic stress disorders. Mental illnesses may have varying levels of severity and impairment, and the symptoms of any individual may be more disabling at some times more than others.

The primary function of a jail is to safely detain individuals taken into custody by law enforcement or sentenced by the courts. Although many inmates have mental health problems, jails are not licensed as mental health treatment facilities. However, state rules require jails to have written policies that provide for the delivery of health care services, including medical, dental, and mental health services.¹³

Jails around the state rely on a mix of arrangements to provide mental health services, including private health care companies, local public health agencies, individual providers, and their own staff.

Exhibit 1.1 shows which staff primarily provide various types of services in jails throughout the state, according to our statewide survey of sheriffs whose offices operate jails.¹⁴ Jails rely almost exclusively on jail-employed correctional officers or sheriffs' deputies for mental health screening at the time someone is first brought to jail. Sometimes this initial screening identifies issues that should be considered before the jail "classifies" the inmate—that is, determines how the inmate will be assigned to housing units or programs in the jail. If the inmate requires closer review prior to these classification decisions, this is often done by correctional officers or deputies. However, it may also be done by jail nurses or health services providers with which the jail contracts. On occasions when inmates receive complete mental health assessments, these are most often done by health services contractors or community health care providers (such as hospitals, clinics, or individual

¹⁰ *Minnesota Statutes* 2015, 241.021, subd. 1.

¹¹ *Minnesota Rules*, Chapter 2911, published December 20, 2013.

¹² *Minnesota Statutes* 2015, 241.021, subd. 1.

¹³ *Minnesota Rules*, 2911.5800, subp. 1, published December 20, 2013.

¹⁴ We requested that 78 sheriffs who operate county jails complete our survey. We received responses from 73 sheriffs (94 percent). Some sheriffs received assistance from jail staff in completing the surveys, but we asked that the opinions expressed in the survey responses represent those of the sheriff.

Exhibit 1.1: Staff Primarily Responsible for Various Tasks Related to Mental Health Services in Jails, According to County Sheriffs

For each task below, the table shows the percentage of jails that assigned this task primarily to each category of staff.

Staff Primarily Responsible for Task	Intake Screening	Additional Review, ^a Before Inmate Classification	Complete Mental Health Assessment	Prescribing Medications	Administering Prescribed Medications	Individual Counseling Regarding Mental Health Issues
Jail-employed correctional officers or deputies	97%	42%	0%	0%	78%	0%
Jail-employed nurses	0	23	11	4	3	4
Jail-employed mental health staff	0	1	8	4	0	12
Health services contractor	1	19	32	42	11	45
Local public health agency	0	5	14	7	4	8
Community health care providers	0	5	29	38	1	18
Other ^b	1	3	0	1	3	5
Service not provided	0	0	5	3	0	7
TOTAL	100%	100%	100%	100%	100%	100%

NOTES: Percentages may not sum to 100 due to rounding. Three of the sheriffs responding to the survey only operate jails that can hold individuals up to 72 hours, so their experience with certain tasks may be limited.

^a Respondents were asked to indicate which staff were primarily responsible “for closer review of the inmate’s condition or needs prior to inmate classification or placement.” Responses pertain to inmates screened at intake as having possible mental health issues.

^b Sheriffs sometimes marked “Other” if more than one category of staff was primarily responsible for the task. Also, some sheriffs marked “Other” if a volunteer or intern was the primary provider of a task.

SOURCE: Office of the Legislative Auditor, survey of sheriffs whose offices operate jails, August to October 2015 (N=73).

providers). Five percent of sheriffs said that complete mental health assessments are “not provided.”¹⁵

We also asked about responsibility for medication practices. The sheriffs reported that prescriptions are usually written by jails’ health services contractors or community health care providers; however, 3 percent of sheriffs said that this service was “not provided.”¹⁶ Jails’ correctional officers or deputies have primary responsibility for daily administration of medications to inmates, according to the sheriffs.

In addition, we asked sheriffs to identify which staff provide individual counseling of inmates at their jails regarding mental health issues. The most common response was that

¹⁵ Of the four sheriffs who responded that mental health assessments are “not provided,” one operates a jail that is only authorized to hold individuals for up to 72 hours, excluding holidays and weekends; jails operated by the other three sheriffs are authorized to hold individuals for longer periods.

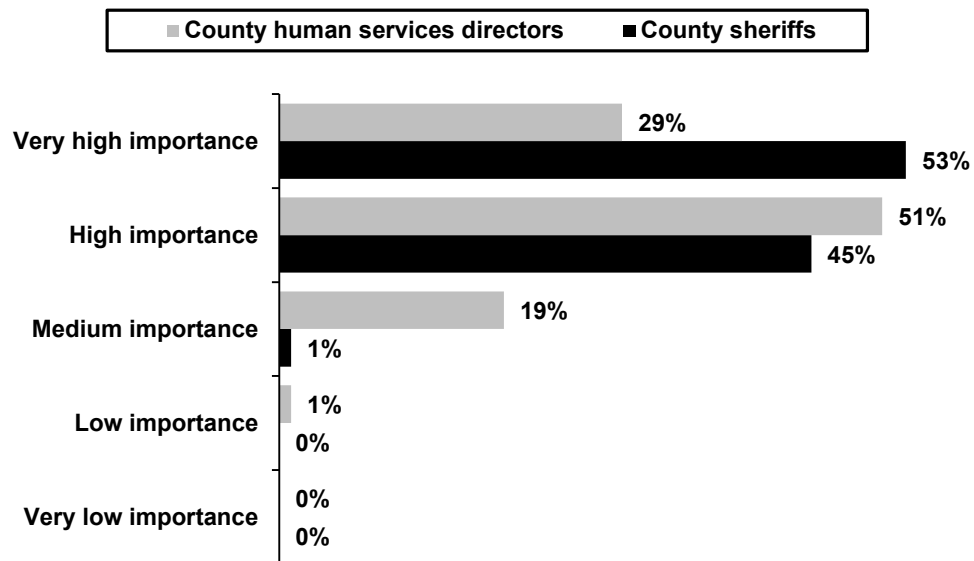
¹⁶ Of the two sheriffs who responded that medication prescribing is a service that is not provided to inmates at their jails, one operates a jail that is only authorized to hold individuals for up to 72 hours, excluding holidays and weekends.

the jail’s health services contractor provided counseling (45 percent). Seven percent of sheriffs said that individual counseling at jails was not provided.¹⁷

Most counties’ sheriffs and human services directors said that the challenge of dealing with individuals with mental illness in Minnesota jails is a pressing issue.

In addition to surveying sheriffs in counties that operate jails, we surveyed county human services directors throughout the state.¹⁸ Both groups expressed an urgent need to address the challenges presented by jail inmates with mental illness. About 99 percent of sheriffs said that, compared with other challenges facing their jails, the issue of inmates with mental illness is of “high” or “very high” importance (see Exhibit 1.2). Among county human services directors, 79 percent said that, compared with other mental health issues affecting their counties, the issue of inmates with mental illness is of “high” or “very high” importance.

Exhibit 1.2: How the Issue of Persons with Mental Illness in Jails Compares with Other Issues, Based on Surveys of Local Officials



NOTES: Both groups were asked to assess the importance of the issue of people with mental illness taken into custody by law enforcement. Sheriffs were asked to assess how this issue compared with other challenges facing their county jails, and human services directors were asked to assess this issue against other mental health issues facing counties. Totals may not sum to 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, surveys of county human services directors (N=73) and county sheriffs (N=73), August to October 2015.

¹⁷ Of the five sheriffs who responded that individual counseling is not provided to inmates at their jails, two operate jails that are only authorized to hold individuals for up to 72 hours, excluding holidays and weekends.

¹⁸ We sent surveys to 75 county human services directors, and we received completed surveys from 73 (97 percent). In some cases, the county human services director asked a staff person (such as the county mental health director) to respond on the director’s behalf.

Inmates with mental illness can present a variety of challenges. Some have been arrested for serious crimes and cannot be transferred for outside treatment without making special arrangements for ongoing security. Others are taken into custody for minor offenses—perhaps disturbing the peace or public urination—and may have ended up in jail because treatment facilities for mental illness were unavailable. Some inmates with mental illness are vulnerable to attack by other inmates, while some exhibit behaviors that place themselves, other inmates, or jail staff at risk of harm. Below, we discuss processes that may be pursued by law enforcement officials, the courts, and others when individuals with mental illness are taken into custody.

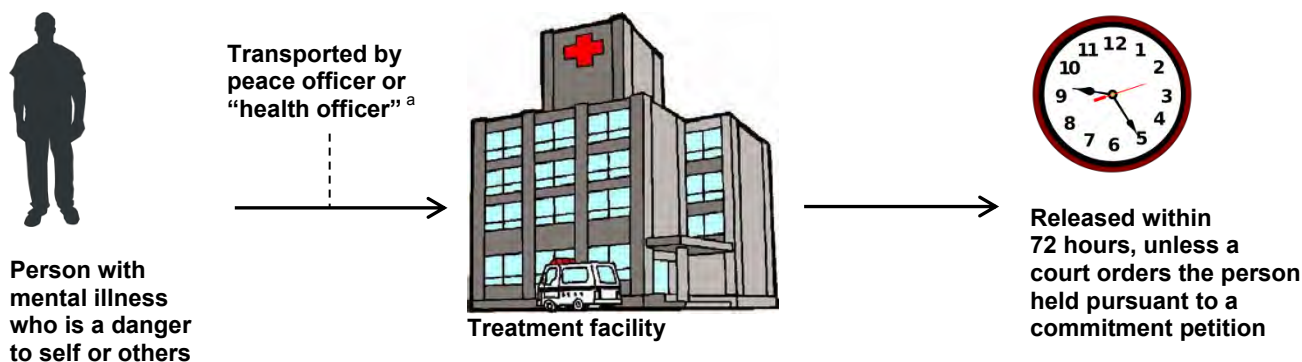
LEGAL PROCESSES FOR PERSONS TAKEN INTO CUSTODY BY LAW ENFORCEMENT

People with mental illness who come into contact with law enforcement may follow a variety of paths. In this section, we discuss some of the key processes for admitting these people into treatment or pursuing options through the criminal justice system.

Emergency Holds

When individuals are experiencing mental health crises, law enforcement officials can use “emergency holds” to get them into safe environments—such as the psychiatric unit of a hospital—where they can be professionally assessed and referred to appropriate services. As shown in Exhibit 1.3, if a peace officer has reason to believe that an individual is mentally ill and may pose a danger to self or others, the officer may take the person into custody and transport the person to a physician or treatment facility.¹⁹ State law requires the officer to apply for the person’s admission to the treatment facility, specifying the

Exhibit 1.3: Emergency Admissions for Mental Illness



^a A “health officer” is a physician, psychologist, social worker, registered nurse in a hospital emergency room, psychiatric or public health nurse, advanced practice registered nurse, or others designated in *Minnesota Statutes* 2015, 253B.02, subd. 9.

SOURCE: Office of the Legislative Auditor, based on review of *Minnesota Statutes* 2015, 253B.05.

¹⁹ *Minnesota Statutes* 2015, 253B.05, subd. 2(a). The person may also be taken into custody and transported by a “health officer”—for example, a physician, psychologist, social worker, registered nurse in a hospital emergency room, psychiatric or public health nurse, or advanced practice registered nurse.

reasons the person was taken into custody.²⁰ State law does not require a treatment facility to admit a person for emergency care and treatment.²¹

This type of admission is known as an “emergency admission” or a “72-hour hold.” An individual may be held under an emergency admission for up to 72 hours, and state law prohibits the issuance of consecutive emergency hold orders for the same individual.²² By law, persons subject to emergency holds have a right to a medical examination within 48 hours of admission.²³ They also have a right to request that their status be changed to a voluntary admission rather than an emergency hold; an advantage of a voluntary admission is that it is not subject to the statutorily specified time constraints of an emergency hold.²⁴ The treatment facility must notify the law enforcement agency that transported the individual to the facility if the facility releases the individual during the 72-hour hold period. A person subject to an emergency hold may be kept involuntarily in the treatment facility beyond the 72-hour period if a court orders this.²⁵

Arrests

State law authorizes peace officers to make arrests. Arrest means “taking a person into custody that the person may be held to answer for a public offense.”²⁶ Criminal offenses include:

- Felonies, which are punishable by a sentence of imprisonment for more than one year.
- Gross misdemeanors, which are punishable by a sentence of up to one year in jail and/or a fine up to \$3,000.
- Misdemeanors, which are punishable by a sentence of up to 90 days in jail and/or a fine up to \$1,000.

Persons under arrest who remain in law enforcement custody are often the responsibility of the county sheriff, although some municipalities operate jails authorized to provide short-term detention.

Some arrests are made in response to warrants issued by judges, while some are not. Exhibit 1.4 summarizes the procedure for arrests made with warrants. After a judge receives a complaint (signed by a prosecutor) specifying the nature of the alleged crime, the

²⁰ *Minnesota Statutes* 2015, 253B.05, subd. 2(a).

²¹ In fact, staff from the state’s most populous county (Hennepin) expressed concern to us that the hospital that used to routinely admit individuals from that county on 72-hour holds has increasingly refused to do so.

²² *Minnesota Statutes* 2015, 253B.05, subds. 3(a) and 3(e). According to *Minnesota Statutes* 2015, 253B.05, subd. 3(a), the 72-hour period does not include Saturdays, Sundays, or legal holidays.

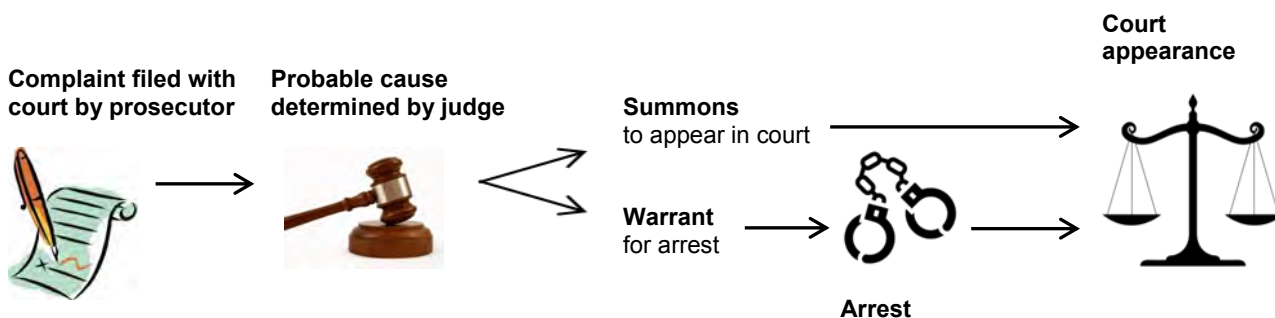
²³ *Minnesota Statutes* 2015, 253B.05, subd. 2b, does not specify the nature of the medical examination.

²⁴ A request to change an admission to a voluntary admission may be granted by the head of the treatment facility.

²⁵ The court may issue such an order if someone has filed a petition for the person’s civil commitment, which we discuss later in this chapter.

²⁶ *Minnesota Statutes* 2015, 629.30, subd. 1. *Minnesota Statutes* 2015, 629.30, subd. 2, also authorizes private individuals, customs officers, and immigration officials to make arrests.

Exhibit 1.4: Procedure for Arrest with a Warrant



NOTES: A summons, rather than a warrant, must be issued unless there is substantial likelihood that the defendant will fail to respond to a summons, the defendant's location is not reasonably discoverable, or an arrest is necessary to prevent imminent harm to anyone. An arrested person must appear before a judge within 36 hours of the arrest, not counting the day of the arrest, or as soon as a judge is available. Persons given a summons must appear in court at the time stated in the summons.

SOURCE: Office of the Legislative Auditor, based on review of *Minnesota Rules of Criminal Procedure*, 2.01, 2.02, 3.01, 3.02, and 3.03, effective March 1, 2015.

judge may issue a warrant indicating that there is “probable cause” to believe the person named in the complaint committed the offense. When a peace officer arrests someone pursuant to a warrant, the person may be detained in jail or released (depending on the terms of the warrant) until the person can appear in court before the judge.²⁷ This court appearance must occur within 36 hours of the arrest, not counting the day of the arrest, or as soon as a judge is available.

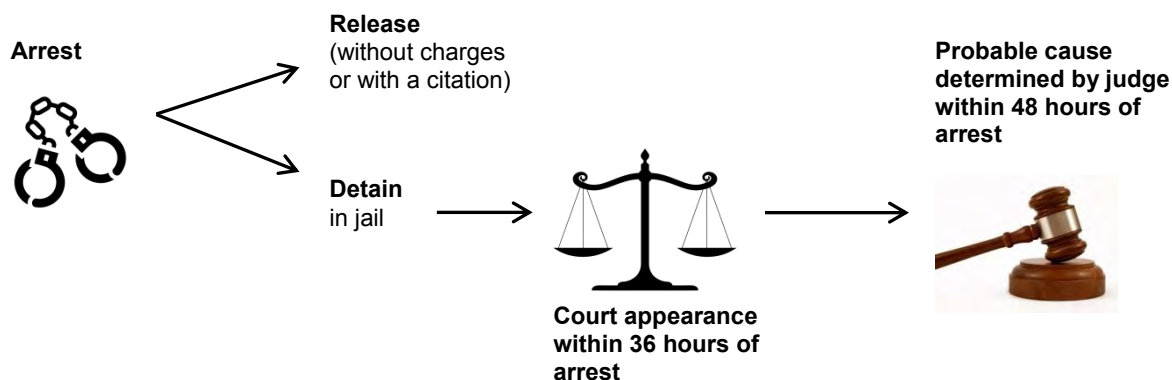
Exhibit 1.5 summarizes the procedure for arrests made without warrants; these could occur, for example, when a peace officer observes a crime in progress. In these cases, the law enforcement agency making the arrest has greater discretion about whether the arrested individual should be jailed or released. A person taken into custody for a misdemeanor must be given a “citation”—a document that specifies the criminal charges—and released, unless it appears that: (1) the person must be detained to prevent harm to self or others, (2) further criminal conduct will occur if released, or (3) it is likely that the person will not respond to a citation (such as appearing in court at the specified time). For a person arrested for a gross misdemeanor or felony, law enforcement has discretion to decide whether to issue a citation and release the person, except in cases where any of the three circumstances mentioned in the previous sentence exist.

If a person is arrested without a warrant, the arrested person must appear before a judge within 36 hours of the arrest or as soon as a judge is available.²⁸ If the person remains in jail following arrest, the judge must determine within 48 hours of the arrest whether there is probable cause that the defendant committed the offense. If, during this period, the court

²⁷ The arrest warrant specifies the amount of bail and any other conditions of release. In some cases, the judge issues a “summons” rather than a warrant—for example, if the offense is a misdemeanor punishable only by a fine. A person issued a summons is not detained in police custody.

²⁸ The 36 hours does not include the day of the arrest, Sundays, and legal holidays. Prior to the appearance, the arrested person may be released by law enforcement in response to an order from a judge or prosecutor, or after law enforcement determines that further detention is not justified.

Exhibit 1.5: Procedure for Arrest without a Warrant



NOTES: An arrested person who is not released must appear before a judge within 36 hours of the arrest or as soon as a judge is available. The 36 hours does not include the day of the arrest, Sundays, and legal holidays.

SOURCE: Office of the Legislative Auditor, based on review of *Minnesota Rules of Criminal Procedure*, 4.02 and 4.03, effective March 1, 2015.

determines that there was no probable cause (or makes no determination at all regarding probable cause), the defendant must be released.

For persons who have been arrested (with or without a warrant) and either detained or given a citation, court rules authorize law enforcement to bring the person to a medical or mental health facility if the person appears to be “incapable of self-care.”²⁹ The person could presumably be admitted on a 72-hour hold, although court rules do not specify this.

A defendant may plead guilty or not guilty to the criminal charges. The defendant may also plead not guilty by reason of mental illness or mental deficiency, thus asserting a lack of responsibility for criminal actions due to underlying mental conditions.

Competency Process

The prosecutor, defense counsel, or judge may challenge the defendant’s mental competency to stand trial. Exhibit 1.6 provides an overview of this process. State law says: “No person having a mental illness or cognitive impairment so as to be incapable of understanding the proceedings or making a defense shall be tried, sentenced, or punished for any crime.”³⁰ We discuss more about what this means in Chapter 4.

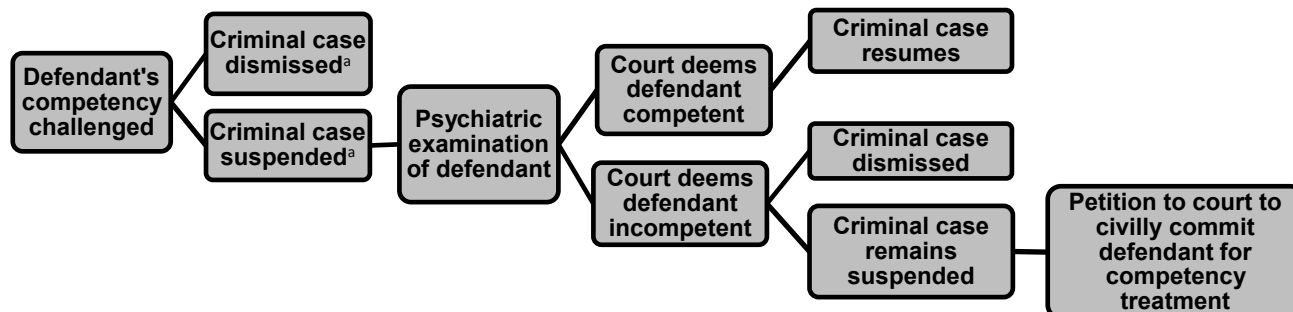
If the judge determines there is reason to doubt the defendant’s competency, the judge must suspend the criminal case—so the defendant’s mental condition can be examined—or dismiss it altogether.³¹ Examinations must be conducted by persons who have

²⁹ *Minnesota Rules of Criminal Procedure*, 6.01, subd. 6, effective March 1, 2015. The rules do not clarify what “incapable of self-care” means, except that it could relate to either a mental or physical condition.

³⁰ *Minnesota Statutes* 2015, 611.026.

³¹ In a misdemeanor case, the judge may dismiss the case “unless dismissal would be contrary to the public interest.” *Minnesota Rules of Criminal Procedure*, 20.01, subd. 3(a)(3), effective March 1, 2015.

Exhibit 1.6: Court Process for Defendants Suspected of Mental Incompetence



NOTE: This represents a simplified depiction of the sequence of steps outlined in court rules for the competency determination process.

^a If the judge determines there is reason to doubt the defendant's competency, the court process differs, depending on whether the case is a felony, gross misdemeanor, or misdemeanor. See Exhibit 4.1 in Chapter 4 for additional details.

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Rules of Criminal Procedure*, 20.01, effective March 1, 2015.

qualifications specified in state law.³² The court makes the final decision regarding the defendant's competency to stand trial after considering the results of the examination and any other information presented to the court.³³ If the court deems the defendant competent, the criminal case proceeds. If the court deems that a defendant facing misdemeanor charges is incompetent, the criminal case is dismissed. If a defendant facing felony or gross misdemeanor charges is found incompetent, the charges are suspended and the court is required to commence civil commitment proceedings against the defendant (unless the person is already under commitment).³⁴

A determination that a person is incompetent to stand trial does not mean that the person is not guilty due to mental illness. Persons deemed incompetent have been judged unable, at the moment, to understand the court process or participate in their defense. Incompetent individuals may be held accountable by a court if their competency is restored by participating in a treatment program.

Civil Commitment Process

Individuals who are mentally ill may be involuntarily committed to treatment by the courts if they meet the statutory criteria shown in Exhibit 1.7. Commitments may be pursued for individuals with mental illness regardless of whether they face criminal charges. But, as indicated above, courts are required to pursue civil commitment for defendants charged with felonies or gross misdemeanors whose criminal cases have been suspended due to a finding of incompetence.

³² *Minnesota Statutes* 2015, 253B.02, subd. 7, says that an examiner must be a licensed physician, an advanced practice registered nurse certified in mental health, a licensed physician assistant, or a licensed psychologist with a doctoral degree or who became a licensed consulting psychologist before mid-1975.

³³ *Minnesota Rules of Criminal Procedure*, 20.01, subd. 5(f), effective March 1, 2015.

³⁴ *Minnesota Rules of Criminal Procedure*, 20.01, subd. 6(b)(1), effective March 1, 2015.

Exhibit 1.7: Statutory Definition of “Person Who is Mentally Ill,” for Purposes of Civil Commitment

A “person who is mentally ill” has:

- An organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand;
- Instances of grossly disturbed behavior or faulty perceptions; and
- A substantial likelihood of physical harm to self or others, as demonstrated by:
 - (1) A failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment;
 - (2) An inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probably than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness unless appropriate treatment and services are provided;
 - (3) A recent attempt or threat to physically harm self or others; or
 - (4) Recent and volitional conduct involving significant damage to substantial property.

SOURCE: *Minnesota Statutes* 2015, 253B.02, subd. 13.

Chapter 4 discusses the civil commitment process in more detail. Once a request for commitment has been filed in district court, the court may order the individual held at a treatment facility for “observation, evaluation, diagnosis, care, treatment, and, if necessary, confinement.”³⁵ State law defines a “treatment facility” as “a hospital, community mental health center, or other treatment provider qualified to provide care and treatment for persons who are mentally ill, developmentally disabled, or chemically dependent.”³⁶

A court-appointed examiner assesses the mental condition of the person who is subject to a commitment petition. To make a commitment, the court must find “by clear and convincing evidence” that the person is mentally ill and that there “is no suitable alternative to judicial commitment.”³⁷ The court must commit the person to “the least restrictive treatment program or alternative programs which can meet the patient’s treatment needs.”³⁸ Alternatively, the court may commit the person to the commissioner of human services, and the commissioner determines where the individual should be placed for treatment.

INMATES’ CONSTITUTIONAL RIGHTS RELATED TO MENTAL HEALTH CARE

In this section, we discuss key court cases that have addressed the rights of inmates to receive medical services, including mental health care.

³⁵ *Minnesota Statutes* 2015, 253B.07, subd. 2b.

³⁶ *Minnesota Statutes* 2015, 253B.02, subd. 19.

³⁷ *Minnesota Statutes* 2015, 253B.09, subd. 1(a). The standard of “clear and convincing” proof requires a court to conclude that there is a high probability that the evidence presented in support of a position is true. This is a relatively high standard in civil cases. The typical standard of proof in a civil action—a “preponderance” of evidence—merely requires that the facts more likely than not prove the case they are supporting.

³⁸ *Ibid.*

Court decisions have established that inmates have a right to adequate health care—including mental health care—under the U.S. Constitution in certain circumstances.

In a 1976 case, the U.S. Supreme Court said: “An inmate must rely on [government] authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.”³⁹ In that case, the Court said there are situations in which denial of adequate medical care to convicted prisoners constitutes cruel and unusual punishment, in violation of the Eighth Amendment of the Constitution.⁴⁰

However, this decision—and others that followed—have generally said that violations of inmates’ constitutional rights to care are those that meet certain strict conditions. According to the Supreme Court, a constitutional violation of a prisoner’s right to care must demonstrate an official’s “deliberate indifference” to an objectively “serious” medical need.⁴¹ The Court has said that prison officials must have a “sufficiently culpable state of mind” to be found deliberately indifferent—“a state of mind more blameworthy than negligence.”⁴² Similarly, the Court has said that a serious medical need is one that places the inmate at “substantial risk of serious harm.”⁴³

While the constitutional rights of *convicted prisoners* stem from the Eighth Amendment’s prohibition on cruel and unusual punishment, the constitutional rights of *pretrial detainees* come from the Constitution’s Fourteenth Amendment. The Fourteenth Amendment prohibits the state from depriving individuals of “life, liberty, or property, without due process of law.”⁴⁴ The Supreme Court has said that “the due process rights of a [pretrial detainee] are at least as great as the Eighth Amendment protections available to a convicted prisoner.”⁴⁵ According to the Court, pretrial detainees may face the conditions and restrictions that come with incarceration, “so long as those conditions and restrictions do not amount to punishment, or otherwise violate the Constitution.”⁴⁶

The federal appellate court serving Minnesota has ruled that the U.S. Supreme Court’s standard of “deliberate indifference” applies to pretrial detainees. In a 2006 case related to a Minnesota jail, the court said “deliberate indifference is the appropriate standard of

³⁹ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

⁴⁰ *Estelle* at pp. 104-106 (1976).

⁴¹ *Estelle* at p. 104.

⁴² *Farmer v. Brennan*, 511 U.S. 825, 834-835 (1994). The Eighth Circuit Court of Appeals—which serves Minnesota—has stated that legal proof of deliberately indifferent prison health care requires evidence of more than even “gross negligence.” (“Gross negligence” involves a reckless and perhaps conscious disregard for the safety or lives of others.) See *Poaloii v. Correctional Medical Services*, 512 F.3d 488, 499 (8th Cir. 2008), quoting *Estate of Rosenberg v. Crandell*, 56 F.3d 35, 37 (8th Cir. 1995).

⁴³ *Farmer* at p. 834.

⁴⁴ *The Constitution of the United States*, Amendment 14.

⁴⁵ *County of Sacramento v. Lewis*, 523 U.S. 833, 849-850 (1998), quoting *City of Revere v. Massachusetts General Hospital*, 463 U.S. 239, 244 (1983). The Court also said: “Since it may suffice for Eighth Amendment liability that prison officials were deliberately indifferent to the medical needs of their prisoners, ... it follows that such deliberately indifferent conduct must also be enough to satisfy the fault requirement for due process claims based on the medical needs of someone jailed while awaiting trial” (p. 850).

⁴⁶ *Bell v. Wolfish*, 441 U.S. 520, 536-537 (1979).

culpability for all claims that prison officials failed to provide pretrial detainees with adequate food, clothing, shelter, medical care, and reasonable safety.”⁴⁷

Courts have also ruled that inmate mental health care is a component of medical care. An analysis in a legal journal concluded that the courts have made “no logical distinction between the right to medical care for physical ailments and the right to mental health care for psychological or psychiatric impairments.”⁴⁸ For example, in 1977, a federal appellate court said that an inmate is entitled to mental health treatment if the person has a serious but treatable mental disease, and if “the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.”⁴⁹ More recently, the U.S. Supreme Court upheld a lower court’s order to release many prisoners in California, due to overcrowding that undermined the prison system’s ability to provide adequate mental health care.⁵⁰ Also, in a case often cited by other courts, a Texas court found “deliberate indifference” to medical needs throughout the Texas prison system, and the court identified “minimally adequate” mental health services the prisons should provide—including, for example, systematic efforts to assess inmate mental health treatment needs and sufficient numbers of trained mental health professionals.⁵¹

The courts have used a high standard—deliberate indifference to inmates’ serious needs—to evaluate the constitutionality of prison and jail health care, but there are additional reasons why it may be challenging for inmates to win cases alleging inadequacies in care. First, the courts have shown considerable deference to the judgments of corrections officials. The U.S. Supreme Court has ruled that prison and jail regulations that infringe on the constitutional rights of either convicted inmates or pretrial detainees are valid if they are “reasonably related” to legitimate correctional objectives.⁵² Second, federal and state laws enable government officials and employees to claim immunity from liability in certain situations.⁵³

⁴⁷ *Butler v. Fletcher*, 465 F.3d 340, 345 (8th Cir. 2006), cert. denied, 550 U.S. 917 (2007). Most appellate courts nationally have applied the Supreme Court’s standard of “deliberate indifference” to pretrial detainees, according to Jennifer Bandlow, “Constitutional Standards for the Care of Pretrial Detainees,” *Los Angeles Lawyer* (March 2011): 13-17. The author said these courts “seem to find that unless the pretrial detainee has a serious medical condition that is treated with deliberate indifference, he or she has no constitutional right to even ‘reasonable’ medical care” (p. 15).

⁴⁸ Connie Mayer, “Survey of Case Law Establishing Constitutional Minima for the Provision of Mental Health Services to Psychiatrically Involved Inmates,” *New England Journal on Criminal and Civil Confinement* 15, n. 2 (1989), 244-245.

⁴⁹ *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977). Other federal cases in which a court has declared the constitutional right of inmates to mental health care include: *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754 (3d Cir. 1979); *Hoptowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982); *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984); and *Partridge v. Two Unknown Police Officers*, 791 F.2d 1182 (5th Cir. 1986).

⁵⁰ *Brown v. Plata*, 131 S.Ct. 1910, 1947 (2011).

⁵¹ *Ruiz v. Estelle*, 503 F.Supp. 1265, 1330, 1339 (S.D. Tex. 1980) aff’d in part, rev’d in part, 679 F.2d 1115 (5th Cir. 1982), modified in part, 688 F.2d 266 (5th Cir. 1982).

⁵² *Turner v. Safley*, 482 U.S. 78, 89 (1987), regarding convicted prisoners. Cases involving pretrial detainees include *Bell* at p. 535, 539, and *Florence v. Board of Chosen Freeholders*, 132 S.Ct. 1510, 1515 (2012), quoting *Turner* at 78, 89.

⁵³ A full discussion of the circumstances—as established in statutes and case law—in which government officials and employees may be immune from liability is beyond the scope of this report, but immunity can affect the ability of claimants to prevail in litigation.

CRIMINALITY AMONG PERSONS WITH MENTAL ILLNESS

Because our evaluation focused on the interaction between people with mental illness and the criminal justice system, we looked at available information regarding the relationship between mental illness and crime or violence. Appendix B highlights key findings from national research.

In addition, we examined the recent criminal histories of people who received publicly funded services in Minnesota for mental illness. Specifically, we obtained identifying information from the Minnesota Department of Human Services for individuals classified as having a “serious mental illness,” using the federal definition shown in Appendix A. These classifications were based on the individuals’ clinical diagnoses and the publicly funded programs in which they received services.⁵⁴ We then obtained data on arrests and convictions for each of these individuals from the Minnesota Bureau of Criminal Apprehension (BCA).

Among persons who received publicly funded services in Minnesota for a serious mental illness in 2014, at least 18 percent were arrested in 2013 or 2014, and at least 10 percent were convicted in those years.

It is possible that the actual arrest and conviction rates for this population were higher than what we report above, for several reasons. First, law enforcement is not required to report all types of misdemeanors to BCA. Some mental health advocates told us that peace officers have increasingly taken persons into custody for lower-level “livability crimes,” such as trespassing or public urination; state law does not require law enforcement to report all of these types of offenses to BCA.⁵⁵ Second, BCA’s criminal history data do not include information on arrests or convictions if BCA did not receive fingerprints for the offense. Third, the data only include arrests or convictions that occurred in Minnesota, and some of these people may have been arrested or convicted in another state.⁵⁶

For individuals in our analysis who were convicted of a crime over the two-year period we examined, we looked at the most serious type of offense for which they were convicted.

⁵⁴ The federal definition requires that individuals classified as seriously mentally ill have “functional impairments” that substantially interfere with or limit major life activities. The Minnesota Department of Human Services does not have an independent measure of functional impairment, but department staff said that participants in each of the following programs would have such an impairment: assertive community treatment; adult rehabilitative mental health services; dialectical behavioral therapy; inpatient psychiatric services; intensive residential treatment services; crisis services; adult day treatment; and targeted case management. Participation in jail-based mental health services—by itself—would not qualify someone as having a functional impairment.

⁵⁵ *Minnesota Statutes* 2015, 299C.11, subd. 1, requires law enforcement agencies to report information to BCA related to felonies, gross misdemeanors, and targeted misdemeanors. “Targeted misdemeanors” are defined in *Minnesota Statutes* 2015, 299C.10, subd. 1(e).

⁵⁶ In addition, BCA relies on the accuracy of reported names and other personal information when identifying criminal history records for individuals. If an individual had an arrest or conviction that was recorded using a different name and/or date of birth, and if BCA was not aware that this information represented an alias for that individual, this arrest or conviction would not be reflected in our analysis.

For 36 percent of the persons we tracked, the most serious offense was a felony; for 25 percent it was a gross misdemeanor, and for 36 percent it was a misdemeanor.⁵⁷

A small subgroup of the population we examined had multiple arrests during the two-year period we reviewed. About 500 individuals—which was about 6 percent of the individuals we tracked who were arrested at least once during the two-year period—were arrested more than five times during that period. The largest number of arrests we saw during this two-year period for any individual was 70.

Overall, the data indicate that a subgroup of Minnesotans with serious mental illnesses have recent criminal records, reflecting a variety of types of offenses. However, as indicated in Appendix B, past research suggests that most of the crimes committed by persons with mental illness are not directly caused by mental health symptoms.

MENTAL ILLNESS IN JAIL INMATES

In recent years, reports and articles have described jails and prisons as “the new asylums,” suggesting that large proportions of inmate populations have mental illness.⁵⁸ Appendix C provides an overview of U.S. research literature regarding the prevalence of mental illness in (1) the general population and (2) the jail population. In general, the studies suggest that mental illness among jail inmates is more prevalent than it is in the general population. However, studies have arrived at widely varying estimates of the proportion of jail inmates with mental illness, depending on the research methods used.

We examined several sources of Minnesota data related to the extent of mental illness among persons in jail, as discussed in the sections below.

Jail Referrals for Mental Health Evaluations

For several years, DOC has required jails to report quarterly on the number of inmates for which the jails have sought mental health evaluations. DOC began to require this reporting after the 2007 Legislature required jails to screen for mental illness using a DOC-approved tool.⁵⁹ The screening tools authorized by DOC provide guidance to jails about the

⁵⁷ The number of persons with convictions in each of these categories for this time period was: felonies (1,564), gross misdemeanors (1,055), and misdemeanors (1,553). In addition to these categories, the most serious offense for less than 1 percent of the individuals in our analysis was a “petty misdemeanor.” (A petty misdemeanor is a low-level offense that does not constitute a crime under Minnesota law and cannot result in a sentence of jail time.) For about 2 percent of those in our analysis, BCA was unable to calculate the person’s conviction level based on the sentencing information in its records.

⁵⁸ For example, see Douglas Shenson, Nancy Dubler, and David Michaels, “Jails and Prisons: The New Asylums?” *American Journal of Public Health* 80, n. 6 (1990): 656; Public Broadcasting System, “The New Asylums,” <http://www.pbs.org/wgbh/frontline/film/showsasylums/>, accessed December 10, 2015; and Gary Fields and Erica Phillips, “The New Asylums: Jails Swell with Mentally Ill,” *The Wall Street Journal*, September 25, 2013, <http://www.wsj.com/articles/SB1000142412788732345510457901266424550546>, accessed October 26, 2015.

⁵⁹ *Laws of Minnesota 2007*, chapter 54, art. 6, sec. 17, as codified in *Minnesota Statutes 2015*, 641.15, subd. 3a.

circumstances in which an inmate should be referred “for further mental health evaluation.”⁶⁰

We found that the Minnesota Department of Corrections (DOC) has not collected complete, reliable data from jails on the number of inmates referred for mental health evaluations.

We analyzed DOC’s records on the number of inmates referred for mental health evaluation. Some of the reports submitted by counties have not included plausible numbers. For example, we observed that ten jails had instances in the past several years in which the annual number of inmates reported as referred for mental health evaluations was greater than the jail’s total number of admissions for that year. On the other hand, many jails had quarters or entire years for which they reported no referrals for mental health evaluations.

We brought these issues to DOC’s attention, and DOC acknowledged that the data collected are unreliable. DOC said it would provide additional training to jails and monitor the numbers reported by jails more closely.

RECOMMENDATION

If the Department of Corrections continues to collect information on the number of inmates referred for mental health evaluations, it should monitor the accuracy of this reporting as part of its ongoing compliance reviews of jails.

Minnesota law does not require DOC to collect information from jails on the number of inmates referred for mental health evaluations. However, legislators and corrections officials sometimes ask about the extent of mental illness among jail inmates, and DOC initiated this data collection on its own.

As with any data that DOC requires jails to report, DOC should ensure that the reporting requirements are clear to jail staff, and it should regularly review the data submitted by jails to ensure their integrity. It appears that DOC has not provided sufficient oversight for many years since it started requiring jails to report on their number of mental health referrals. DOC should only continue to collect data from jails on the mental health referrals of inmates if it can ensure that the data are meaningful and accurate.

Inmates Taking Medications for Mental Health Conditions

Medications are an important part of treatment for many people with mental illness. Lacking definitive DOC data on the number of persons in jail assessed as mentally ill or referred for mental health services, we sought information from sheriffs about the extent to which inmates have prescriptions for mental health-related medications.

⁶⁰ As discussed in Chapter 3, DOC has authorized three screening tools. Each of the tools has its own instructions to jails regarding when to refer an inmate for a mental health evaluation. For example, one of the tools says that a referral should be made if the inmate reports ever having been hospitalized for a mental health problem or currently taking a prescribed medication for a mental health problem. In addition, this tool says that an inmate should be referred if the inmate responds “yes” to at least two of the other six questions on the screening tool or if the screener feels such a referral is necessary for other reasons.

At least one-third of Minnesota jail inmates take medications for a psychiatric condition or mental disorder, according to estimates provided to us by sheriffs.

We asked each sheriff that operates a jail to estimate for their jail the percentage of current inmates that take at least one medication for a psychiatric condition or mental disorder. We instructed the sheriffs to include in their estimates medications for illnesses such as schizophrenia, depression or other mood disorders, anxiety, attention deficit hyperactivity disorder, autism, bipolar disorders, borderline personality disorders, post-traumatic stress disorders, or eating disorders. We did not independently assess the accuracy of the sheriffs' estimates. For each jail, we weighted the survey response by the average daily inmate population for that jail during September 2015. Using this weighted measure, we estimated that 36 percent of inmates statewide were on psychiatric medications.⁶¹ If this percentage is applied to the total number of adults in Minnesota jails as of September 2015, this would mean that about 2,700 persons with mental illness were in jail on a given day. Mental health advocates noted that the sheriffs' estimates would understate the number of inmates with mental illness if some of these inmates are not prescribed or given medications in jail that they should be taking for their symptoms.⁶²

Defendants Referred for Evaluations of Mental Competency

A person arrested for a criminal offense cannot be tried in court if the person lacks the ability to (1) rationally consult with legal counsel or (2) understand court proceedings or participate in the defense due to mental illness or deficiency.⁶³ If a prosecuting attorney, defense attorney, or judge questions the mental competence of a defendant, any of these parties may request an evaluation of the defendant—by a court-appointed assessor—before the criminal case proceeds. After receiving the results of the assessment, the court determines whether the individual is competent to stand trial.

Minnesota has seen a recent increase in the number of criminal cases in which the court has ordered an examination of the individual's competency to stand trial.

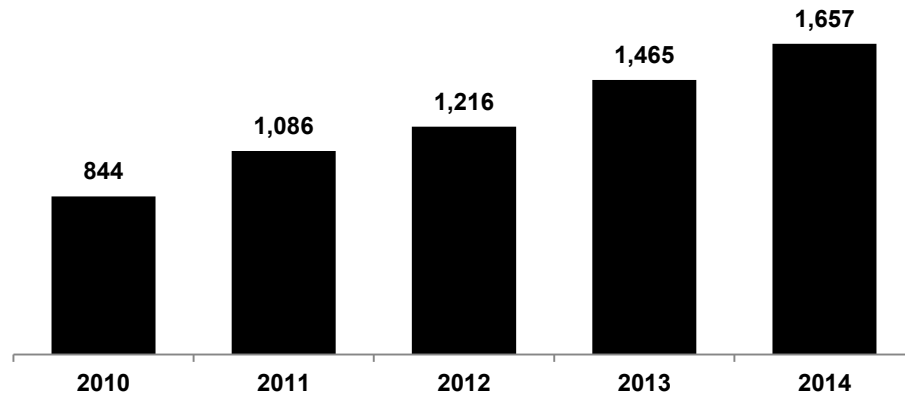
We obtained and analyzed statewide data from the State Court Administrator's Office related to all criminal cases that had orders for competency evaluations. Exhibit 1.8 shows that the number of such cases grew from 844 in 2010 to 1,657 in 2014, a 96 percent increase.

⁶¹ We also calculated the median percentage reported by the responding sheriffs, which may indicate the share of inmates in a typical jail that are on psychiatric medications. The median response was 35 percent.

⁶² Regarding our survey responses, DOC commented that inmates are sometimes prescribed mental health medications for non-mental health problems, such as sleep disorders. Our survey question asked sheriffs to estimate the percentage of inmates "taking at least one medication for a psychiatric condition or mental disorder."

⁶³ *Minnesota Rules of Criminal Procedure*, 20.01, subd. 2, effective March 1, 2015.

Exhibit 1.8: Number of Criminal Cases with Court Orders for Competency Evaluations, 2010-2014



NOTE: The data reflect cases in which the order for a competency evaluation was reported by the court into the Minnesota Court Information System.

SOURCE: Office of the Legislative Auditor, analysis of State Court Administrator's Office data.

Besides looking at the number of cases with motions requesting competency evaluations, we wanted to consider how many of these cases resulted in court determinations that the defendant was incompetent. This would help us to determine whether there has, in fact, been a recent increase in the number of defendants with mental issues, or at least the identification of more such issues by the courts. Unfortunately, we found that the data in the courts' management information system were incomplete.

Minnesota courts have not recorded the findings of many competency evaluations in the courts' electronic statewide information system, so trends in the total number of criminal defendants determined to be mentally incompetent are unclear.

In 2005, Minnesota completed a lengthy transition of its trial court system. Over a period of years, the state assumed financial and management responsibility for these courts from the counties. Among the intended changes was uniformity in court policies and practices, including the way information on court cases is collected into a central database (the Minnesota Court Information System, or MNCIS).

In our review of MNCIS data, we found that only 58 percent of the 2010-2014 criminal cases with court orders for competency evaluations had electronic records indicating the findings of these evaluations. There may be some instances where it makes sense that a decision on a defendant's competency had not been recorded—for instance, in recent cases where such a finding had not yet occurred.⁶⁴ However, it does not make sense that such instances would occur in more than 40 percent of cases for which a competency evaluation

⁶⁴ The percentage of criminal cases with an order for a competency evaluation for which the courts reported a competency finding was somewhat higher in the more recent years of the period for which we analyzed data than for the earlier years.

had been ordered. We looked at differences among counties in the extent to which they recorded findings on defendants' competency in MNCIS, and some counties were much better at recording such findings. Eight counties recorded findings for at least 75 percent of the criminal cases with orders for competency evaluations, while 52 counties recorded findings for 25 percent or fewer of these cases.⁶⁵

RECOMMENDATION

The State Court Administrator's Office should ensure that court officials throughout the state comprehensively record findings of competency determinations in the Minnesota Court Information System.

Judicial branch officials told us that the courts have paper records of the findings of incompetency decisions, but we think it is important to have complete data on these decisions in the courts' statewide electronic information system. Without such data, it would be very difficult to systematically analyze trends in the number of defendants deemed incompetent—for example, whether the number of such defendants is growing statewide, whether some parts of the state are making incompetency findings more than others, or what types of criminal charges the defendants faced when they were deemed incompetent to stand trial. We recommend that the State Court Administrator's Office provide additional guidance and training to court officials statewide to ensure that these decisions are properly recorded.

⁶⁵ The eight counties that reported findings related to defendants' competency for at least 75 percent of their cases from 2010 through 2014 were Freeborn, Goodhue, Hennepin, Houston, Itasca, Ramsey, Steele, and Winona.

Chapter 2: Availability of Community Services

The availability of mental health services in Minnesota communities—outside of jails—can affect individuals whose actions bring them into contact with the criminal justice system. For instance, police—after trying unsuccessfully to find community-based crisis services for individuals with mental health symptoms—may instead bring them to jail. Jail staff that are unable to deal with inmates’ mental health symptoms in jail may seek specialized services outside of jail, perhaps at community hospitals. Also, when people with mental illness are released from jail, they may need ongoing access to mental health services in the community. The box on this page provides an example of a case that created challenges for one Minnesota community.

Example of Challenges Faced by Law Enforcement Officials When Dealing with Persons with Mental Illness

In the middle of a winter night in 2015, law enforcement officials in a western Minnesota county took a woman into custody. She was naked and on top of a pick-up truck on the side of a highway; at the time, the air temperature was below zero. She was brought to a local hospital, which contacted the Minnesota Department of Human Services to check for psychiatric hospital beds in the state. None were available. The local hospital would not admit the woman on an emergency hold because it did not think it could address her needs. Law enforcement decided to hold the woman on criminal charges in jail rather than releasing her to the streets. The woman had been civilly committed for mental illness several times previously, and the court again committed her.

This chapter discusses the overall adequacy of the adult mental health system outside of jail, based on prior studies and our surveys of county human services officials and sheriffs. In addition, we discuss the ability of state-operated and community hospitals to address the needs of individuals with mental illness, and we discuss the potential for diverting individuals with mental illness to places other than jail. We offer recommendations at the end of the chapter.

KEY FINDINGS IN THIS CHAPTER

- **Community-based mental health services for adults are not sufficiently available in Minnesota, and the state’s shortage of secure inpatient beds may affect the number of persons with mental illness being taken to jail.**
 - **It has become increasingly difficult to admit individuals needing inpatient psychiatric services into state-run hospitals, partly because jail inmates committed by the courts for competency restoration receive priority for placement.**
 - **Both the state and counties bear some responsibility for improving the availability of services for persons with mental illness taken into custody by law enforcement officials.**
-

OVERALL AVAILABILITY

In 1987, the Legislature passed the Minnesota Comprehensive Mental Health Act.¹ The act directed the state commissioner of human services to “create and ensure a unified, accountable, comprehensive mental health service system.”² It said that each county board of commissioners “must develop fully each of the treatment services and management activities” shown in the box on this page by January 1, 1990.³ The act set priorities for service development following the act’s passage; the top priorities were “locally available emergency services” and “locally available services to all persons with serious and persistent mental illness and all persons with acute mental illness.”⁴ The commissioner of human services was charged with supervising and coordinating the development of local services by county boards.

Nearly 30 years after passage of the state’s adult mental health act, Minnesota’s statewide system of adult mental health services still has many weaknesses.

We reviewed several recent reports prepared by (or for) the Minnesota Department of Human Services (DHS) regarding the state’s existing mental health services. One 2015 DHS report focused specifically on services for criminal offenders with mental illness, and it rated the availability of ten adult mental health services in the community.⁵ On a statewide basis, DHS rated all of these services as having “limited service availability.”⁶ DHS also examined the availability of the services in each of 16 regions, and it reported that in no region of the state did more than two of the ten services meet demand. The report said: “The gaps in the mental health system clearly contribute to a larger number of individuals with mental illness entering the criminal justice system.”⁷ The report also said that Minnesota’s “chronic shortages of certain types of mental health professionals, especially

Service Areas Mandated by the Minnesota Comprehensive Mental Health Act

- Education and prevention services
- Emergency services
- Outpatient services
- Community Support Program services
- Residential treatment
- Acute care hospital inpatient treatment
- Regional treatment center inpatient services
- Screening for inpatient and residential treatment
- Case management

Source: *Minnesota Statutes* 2015, 245.466, subd. 2.

¹ *Laws of Minnesota* 1987, Chapter 403.

² *Laws of Minnesota* 1987, chapter 403, art. 2, sec. 16.

³ *Laws of Minnesota* 1987, chapter 403, art. 2, sec. 21. In *Laws of Minnesota* 1987, chapter 403, art. 2, sec. 19, the act said that the state human services commissioner shall require development of each of the act’s prescribed services “within available resources.”

⁴ *Laws of Minnesota* 1987, chapter 403, art. 2, sec. 19.

⁵ Department of Human Services, *Offenders with Mental Illness* (St. Paul, January 2015), 21. The services were: adult rehabilitative mental health services; assertive community treatment teams; case management; inpatient psychiatric hospitalization; intensive residential treatment; medication management; mobile crisis services; partial hospitalization; permanent supportive housing; and residential crisis services.

⁶ The other rating options were “service meets demand” and “no provider is located in this area.”

⁷ DHS, *Offenders with Mental Illness*, 22. The report said that when law enforcement takes persons with mental illness into custody, “there are two main options available to law enforcement—the Emergency Room or the local jail” (p. 30).

psychiatrists and other qualified psychiatric care providers,” have contributed to inadequate responses to the needs of people with mental illness in jails.⁸

We also reviewed a 2015 report in which DHS assessed the availability of programs for older adults, persons with disabilities, and persons with mental illness, as well as a consultant’s report that DHS used to draw its conclusions.⁹ For mental health services (both for adults and children), DHS concluded that “very few services” met or exceeded demand.¹⁰ The reports by DHS and its consultant provided evidence that there were more service deficiencies in mental health services than in services for older adults and persons with disabilities. DHS’s report highlighted “core gaps” in the availability of psychiatric hospitalization, permanent supportive housing for persons with mental illness, and psychotropic medication prescription and management. In surveys done by DHS’s consultant, most counties did not identify any strategies that were underway to address gaps in mental health services. In addition, the consultant reported that, according to its survey of counties, adults with mental health conditions usually went to the hospital or did not receive services at all if the services they were seeking were not available.

In the surveys we conducted of county sheriffs and human services directors, we also heard many concerns about the availability of community mental health services. Exhibit 2.1 summarizes the opinions expressed by survey respondents. Both groups overwhelmingly said that inpatient care and state-run facilities for competency restoration or mental health commitments were typically unavailable in a timely manner. Sheriffs and human services directors differed in their assessments of the availability of some services—particularly nonresidential support services and mobile crisis services—but majorities of both groups said there were problems with service availability in most of the service categories addressed in our surveys.

DHS officials told us that funding has not been sufficient to implement comprehensive mental health services across the state. They said that new funding immediately following the 1987 Minnesota Comprehensive Mental Health Act was not enough to ensure development of the services specified in the legislation. DHS noted that the 2007 Legislature made significant investments in mental health services and required the state’s Medical Assistance program to cover key mental health services. However, DHS said subsequent budget cuts curtailed the state’s progress toward a full array of services.

It is worth noting that the 2015 Legislature appropriated additional funding for some parts of the adult mental health system for the current biennium. The Legislature appropriated an additional \$8.6 million for mental health crisis services for the biennium and \$1.3 million for assertive community treatment services.¹¹ In addition, the 2015 Legislature provided funding to increase the Anoka-Metro Regional Treatment Center’s 95-bed capacity to 110

⁸ *Ibid.*, 19.

⁹ Department of Human Services, *Status of Long-Term Services and Supports: Legislative Report* (St. Paul, August 2015); Wilder Research, *DHS Gaps Analysis Study: Statewide Report* (St. Paul: Department of Human Services, August 2015), <http://mn.gov/dhs/partners-and-providers/continuing-care/data-measures/gaps-analysis/index.jsp>, accessed February 1, 2016.

¹⁰ DHS, *Status of Long-Term Services and Supports*, 19.

¹¹ *Laws of Minnesota 2015*, chapter 71, art. 2, secs. 3, 24, 25, and 42, and the legislative tracking document regarding the appropriations in this bill. “Crisis services” are services available around the clock, seven days a week, for persons having mental health crises or emergencies. “Assertive community treatment services” are intensive, nonresidential mental health services provided by teams of multidisciplinary staff around the clock, seven days a week.

Exhibit 2.1: Local Officials' Views Regarding Availability of Mental Health Services

Service	Percentage of sheriffs who said the service was:		Percentage of human services directors who said the service was:	
	Always, almost always, or often available	Sometimes, rarely, or never available	Always, almost always, or often available	Sometimes, rarely, or never available
Nonresidential support services ^a	24%	61%	78%	22%
Residential crisis services	29	60	36	64
Mobile crisis services	28	58	60	40
Medication management	<i>Not asked</i>		56	42
Treatment for people with dual diagnosis of chemical dependency and mental illness	<i>Not asked</i>		17	82
<i>For persons not booked into jail or court-ordered to a hospital:</i>				
Inpatient care at community hospital	15	83	18	82
Inpatient care at state-run community behavioral health hospital	4	88	3	96
<i>For persons booked into jail but not court-ordered to a hospital:</i>				
Inpatient care at community hospital	11	88	4	92
Inpatient care at state-run community behavioral health hospital	4	92	0	99
<i>Pursuant to a court order:</i>				
State-run Competency Restoration Program (St. Peter or Anoka)	15	78	15	66
State-run facilities for persons committed as mentally ill (Anoka or community behavioral health hospitals)	13	83	7	84

NOTE: The percentage of respondents who replied "don't know or no opinion" for each service area are not shown.

^a Examples of these services include the Community Support Program, adult rehabilitative mental health services, and assertive community treatment teams.

SOURCE: Office of the Legislative Auditor, surveys of county sheriffs ($N=71$ to 73 , depending on the question) and county human services directors ($N=72$ to 73), August to October 2015.

beds.¹² Service expansions in response to 2015 legislative appropriations were still in progress at the time we conducted our surveys, so the survey responses might have understated the availability of certain services.¹³

Some mental health advocates have questioned the need for additional beds in Minnesota's mental health facilities. For example, a 2014 article by the executive director of the National Alliance on Mental Illness's Minnesota chapter said that adding more beds would not fix Minnesota's mental health system, and that Minnesota's main mental health shortcoming was a lack of community-based mental health services rather than a lack of

¹² *Laws of Minnesota* 2015, chapter 71, art. 14, sec. 2, subd. 6(a).

¹³ For example, the 2015 Legislature appropriated funding for expansion of residential crisis services in Minnesota, and in early 2016, DHS issued a request for proposals to develop these services.

beds in facilities.¹⁴ The article pointed out—as has our office previously—that there are no definitive standards for how many psychiatric beds Minnesota should have.¹⁵ The appropriate number of beds depends partly on what other services are available. A state with strong nonresidential mental health services (such as mobile crisis teams) might need fewer inpatient beds than it would require if its nonresidential services were weaker.

State and local human services officials, as well as county sheriffs, perceive that the number of beds in Minnesota’s mental health facilities is inadequate to meet current needs.

As noted earlier in this chapter, DHS’s 2015 assessment of existing services said that inpatient mental health beds for adults were among the least available mental health services in the state.¹⁶ Our surveys asked sheriffs and county human services directors to identify the service for people with mental illness who come in contact with the criminal justice system for which there is the “most pressing” need. The response of large shares of county sheriffs (68 percent) and human services directors (45 percent) was secure inpatient psychiatric care for individuals without court commitments.¹⁷ In addition, when our surveys asked whether there was a need for more beds in non-jail facilities for people with mental illness, 100 percent of sheriffs and 97 percent of county human services directors responded that there is. Others—including representatives of Minnesota county and community hospital associations—also expressed concern to us that there are not enough mental health beds in Minnesota to meet existing needs.

In a 2013 report, our office recommended that DHS-operated facilities play a “safety net role by providing high-quality services to address gaps in the [state’s] service system.”¹⁸ During 2015, we discussed DHS’s role with the agency’s medical director for state-operated services. He estimated that DHS needs at least 50 to 80 additional beds (hospital or other) in facilities it operates to address existing placement problems in the state’s mental health system. Citing recent waiting lists for DHS beds, he said the situation had “reached a new level of chaos and crisis.” Later in this chapter, we discuss state-operated facilities in further detail, and we offer recommendations regarding the state’s adult mental health system.

COMMUNITY HOSPITALS

In this report, we use the term “community hospital” to refer to hospitals not run by DHS that have psychiatric units. These hospitals represent a mix of private and government-operated facilities, and most are nonprofit organizations. When police take individuals into

¹⁴ Sue Abderholden, “Mental Health: It’s Top-Notch Community Services, Not More Beds, That We Need,” *MinnPost* (July 15, 2014), <https://www.minnpost.com/community-voices/2014/07/mental-health-its-top-notch-community-services-not-more-beds-we-need>, accessed June 1, 2015.

¹⁵ Office of the Legislative Auditor, Program Evaluation Division, *State-Operated Human Services* (St. Paul, February 2013), 123. Key federal data comparing states’ number of psychiatric hospital residents have focused only on the number of residents in state-operated facilities.

¹⁶ DHS, *Status of Long-Term Services and Supports*, 19-20.

¹⁷ These percentages do not include a number of sheriffs and human services directors who picked multiple services—rather than a single one—for the “most pressing need,” including secure inpatient care.

¹⁸ Office of the Legislative Auditor, *State-Operated Human Services*, 118.

custody who are suspected of having a mental illness, they often bring them to the nearest community hospital. In addition, jails may refer inmates with mental illness to community hospitals if their behaviors require more intensive services than the jail can provide.

Community hospital psychiatric beds are often full, partly because they have had difficulties discharging individuals to state-run facilities.

There are approximately 1,000 psychiatric beds in Minnesota's community hospitals.¹⁹ Data from the Minnesota Hospital Association indicate that more than 80 percent of Minnesota's non-DHS psychiatric beds were occupied during 2014. In contrast, the association told us that the occupancy rate for all hospital beds in the state is 40 percent and declining. Thus, beds in psychiatric units are much more likely to be filled than other types of hospital beds. Significant expansions of community hospital psychiatric bed capacity are unlikely; hospital officials told us their psychiatric units often cost more to operate than they generate in revenue.

Hospital staff also told us that the occupancy rate data actually overstate the availability of beds in hospital psychiatric units. This is because some seemingly available psychiatric bed space is intentionally left unfilled by hospitals when they have patients with particularly challenging behaviors. For example, a hospital with double rooms in its psychiatric unit might leave some beds unfilled if there is concern about putting persons who are acting aggressively with persons who might be vulnerable to abuse or need a quiet environment to help their recovery.

Law enforcement officials told us that they often take individuals to far-away hospitals—including those in other states—due to the unavailability of psychiatric beds in community hospitals. This may be inconvenient for the families of the individuals, and sheriffs' offices usually bear the cost of inmate transportation. For example, the jail administrator for a south-central Minnesota county told us:

When someone from the public is evaluated at the emergency room at the local hospital there seems to be only one option for placement, Avera [McKenna Hospital] in Sioux Falls. This process turns into numerous and expensive transports [by law enforcement] before placement is determined.

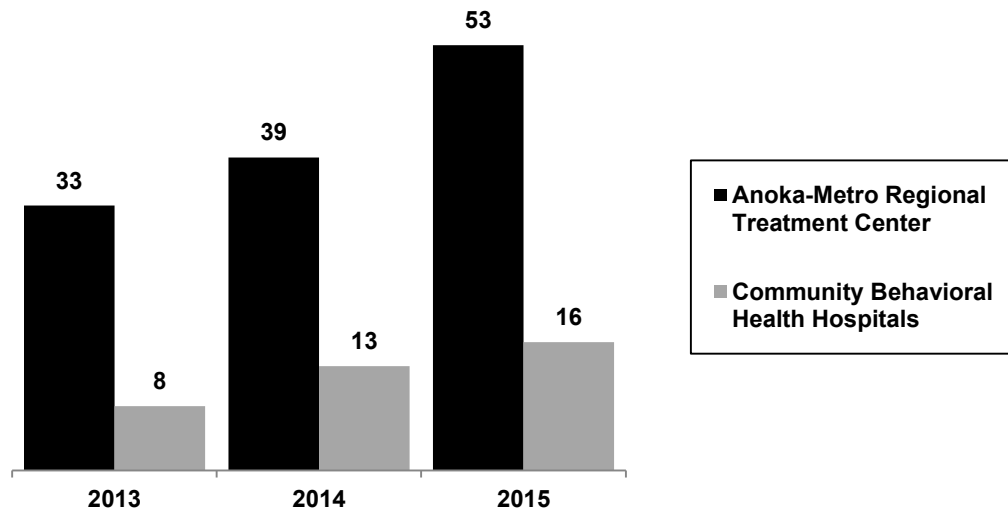
One reason that community hospitals' psychiatric beds are largely filled is because those facilities have had difficulty making timely transfers of patients to state-operated psychiatric hospitals. (As discussed in the next section, DHS operates eight hospitals: the Anoka-Metro Regional Treatment Center and seven "community behavioral health hospitals.") Community hospitals specialize in short-term care for persons who can be stabilized quickly, but they sometimes are unable to handle patients who become aggressive or have challenging behaviors.

Exhibit 2.2 shows that patients with civil commitments who were referred from community hospitals to Anoka-Metro Regional Treatment Center typically waited more than 50 days for admission in 2015, which was much higher than in the two previous years. There were three transfers from community hospitals to Anoka in 2015 that each took more than 200 days from the date of referral; in 2012 through 2014, no such placement took longer

¹⁹ In 2013, community hospitals had a total of 946 nonpediatric mental health beds that were not in intensive care units.

than 139 days. One community hospital administrator told us that patients’ mental health sometimes worsens while waiting for transfers to DHS facilities, and he has experienced significant staff turnover due to the hospital’s inability to transfer aggressive patients out of the hospital. As we discuss in the next section and in Chapter 4, a 2013 law (the “48-hour law”) gave priority for placement in DHS facilities to certain jail inmates; this has resulted in an increase in the number of persons placed at Anoka directly from jail. In contrast, individuals who are in community hospitals with civil commitments to DHS do not receive similar priority for placement in DHS facilities.

Exhibit 2.2: Median Number of Days that Persons in Community Hospitals with Civil Commitments Waited to Get Admitted into DHS Hospitals, 2013-2015



NOTES: The waiting periods shown reflect the days that elapsed between a community hospital’s date of referring a patient to the Department of Human Services (DHS) and the date when the patient was actually admitted to a DHS facility. Cases are grouped in years based on their admission dates. 2015 data were for admissions to DHS facilities from January 2015 through mid-November 2015.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

Community hospital patients who were referred to DHS’s community behavioral health hospitals in response to civil commitments have also been waiting longer for placements. In 2015, patients referred by a community hospital to DHS typically waited 16 days before admission to a DHS community behavioral health hospital. This was twice as long as in 2013. At least in part, this probably reflected reductions in community behavioral health hospitals’ bed capacities, which we discuss in the next section.

At least one county—Ramsey—has a formal arrangement with a community hospital that gives priority for secure inpatient beds to persons awaiting court actions and for jail inmates.

In Chapter 4, we discuss how there have been many instances in which persons awaiting decisions on civil commitment remained in jail, contrary to state law. Ramsey County has a

contract with Regions Hospital in St. Paul, partly to address this issue.²⁰ Under the contract, Regions gives placement priority, where possible, to persons with pending court motions for competency evaluation or civil commitment who need evaluation, diagnosis, or treatment. The contract also specifies that Regions will provide two “jail cells”; these are locked rooms that are available for jail inmates who require hospitalization in a secure setting. All of the placements covered by the contract are considered hospital placements and may be eligible for Medicaid coverage.²¹ We are not aware of other formal arrangements with a community hospital in Minnesota that provide a county with similar assurance that it will have secure inpatient beds for persons in jail or awaiting court actions.

STATE-OPERATED FACILITIES

Since the first state hospital opened in 1866, state-run facilities have been a key part of the state’s mental health system. For decades, state hospitals served people with mental illness, developmental disabilities, or chemical dependency. By 1960, the state hospitals had more than 16,000 patients. But patient advocates’ concerns about the large size and restrictiveness of these institutions, along with the development of new medications, contributed to dramatic reductions in the populations of state hospitals (renamed “regional treatment centers” in 1985). By 2008, the Legislature closed all but one of the regional treatment centers. Starting in 2006, the Legislature opened a group of ten smaller mental health hospitals around the state, each with a 16-bed capacity.²²

Today, DHS operates 13 facilities for adults with mental illness, as shown in Exhibit 2.3. The largest of these facilities—the Minnesota Security Hospital—primarily serves persons committed by the courts as “mentally ill and dangerous.” Contrary to its name, the Minnesota Security Hospital is licensed as a residential treatment facility, not as a hospital. It provides extended residential treatment for mental illness in a secure setting. DHS also operates four smaller, less secure residential facilities for persons with mental illness; these are licensed as “intensive residential treatment services.”²³

Among DHS’s 13 facilities are 8 acute-care psychiatric hospitals. The largest is the Anoka-Metro Regional Treatment Center (AMRTC). It is licensed for 175 beds, but it has not been staffed and funded to serve more than 110 patients since fiscal year 2010.²⁴ In addition, DHS operates community behavioral health hospitals in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, Rochester, and St. Peter; each has a licensed capacity of 16 beds. Persons served in facilities with 16 or fewer beds may qualify for reimbursement under the federal Medicaid program, while persons served in larger facilities do not.²⁵

²⁰ Ramsey County will pay Regions about \$904,000 in 2016 for the services described in the contract.

²¹ As noted in Chapter 1, the only health care costs of incarcerated persons that can be funded by Medicaid are the costs incurred when inmates are transferred to a hospital for inpatient care.

²² Three of these community behavioral health hospitals have since closed or been converted to other types of DHS facilities.

²³ As of November 2015, there were 26 facilities in Minnesota licensed as “intensive residential treatment services” that were operated by organizations other than DHS.

²⁴ In fiscal year 2009, AMRTC was budgeted to serve 168 patients per day.

²⁵ Federal law does not authorize Medicaid coverage of mental health care for persons ages 21 to 64 who receive treatment in acute or long-term mental health institutions serving 17 or more patients.

Exhibit 2.3: Facilities Operated by the Department of Human Services (DHS) for Adults with Mental Illness

Facility or Facility Type	Description	Number of Facilities	Number of Licensed Beds
Minnesota Security Hospital	Secure residential treatment facility for individuals civilly committed as mentally ill and dangerous. Also houses part of DHS's program to restore competency for persons deemed not competent to stand trial.	1	412
Anoka-Metro Regional Treatment Center	Psychiatric hospital providing acute care to adults with mental illness. Also houses part of DHS's program to restore competency for persons deemed not competent to stand trial.	1	175
Community Behavioral Health Hospitals	16-bed hospitals providing short-term, acute psychiatric care to adults with a mental illness.	7	112
Residential Treatment ^a	Community-based facilities that provide intensive residential treatment to adults with mental illness.	4	64
Total		13	763

^a The Department of Human Services refers to these facilities as "Minnesota specialty health systems" as well as "intensive residential treatment services" (IRTS).

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data, November 2015.

Recent Changes in DHS-Operated Hospitals

This section focuses primarily on DHS's hospitals: the seven community behavioral health hospitals and the Anoka-Metro Regional Treatment Center. These hospitals are intended mainly to provide acute care and stabilization of intensive mental health symptoms, rather than longer-term services in a residential setting. These facilities treat many individuals who are not facing criminal charges, but they are also a potential resource when police take someone with mental illness into custody, when a jail inmate needs inpatient treatment, or when a court commits someone deemed incompetent to stand trial.

During the past three years, DHS has reduced the operating capacity of its psychiatric hospitals.

DHS's seven community behavioral health hospitals are licensed for a total of 112 beds, and they operated near capacity a few years ago.²⁶ But, as of mid-September 2015, they had a total of 63 patients—or just over half of capacity. DHS officials told us they reduced the staffing of these hospitals in early 2015 after they discovered unsustainable spending in various parts of DHS's state-operated services. Thus, in recent months, these hospitals have been operating with capacities of 8 to 11 beds, rather than 16 beds. DHS told us that it will not be possible to operate these facilities at their 16-bed capacity without new legislative funding.

In addition, the Anoka-Metro Regional Treatment Center's number of patients reached a historic low during 2015. The facility's population was fairly constant between April 2010

²⁶ For example, in fiscal year 2012, the community behavioral health hospitals' average occupancy was 89 percent of total bed capacity.

and October 2014, with average daily patient populations ranging between 101 and 112.²⁷ Starting in late 2014, the average patient population began dropping, and the average number of patients totaled just 92 in May 2015. The decline occurred during a period when Anoka had a patient population that, on average, had more challenging behaviors than its previous patient populations (discussed below). The 2015 Legislature appropriated an additional \$4.1 million annually to increase Anoka’s operating capacity from 95 to 110. By late 2015, Anoka was again operating with a capacity of about 110 patients.

The composition of the patient populations at DHS’s psychiatric hospitals has changed significantly. Of particular note, a much larger share of the Anoka-Metro Regional Treatment Center’s patients now arrive at the facility directly from jails.

At DHS’s community behavioral health hospitals, there have been two important changes in the patient population, both related to the reduced capacity in these hospitals. First, nearly all admissions to these hospitals are now for persons who have been civilly committed by a court as mentally ill.²⁸ In 2011, only 32 percent of admissions to these hospitals were in response to court commitments. DHS told us that the hospitals’ increased use of their beds for court-committed individuals has made these hospitals less available to people “off the streets”—for example, persons who voluntarily seek placement or who are referred to the hospital for a 72-hour hold. Second, these hospitals have been increasingly serving statewide rather than regional needs. The Legislature has expressed interest in having each of these hospitals serve patients from the region in which it is located. But with reductions in the capacity of community behavioral health hospitals, patients have increasingly been placed at whatever facility has an available bed—not necessarily the facility closest to the patient’s home.²⁹

At Anoka-Metro Regional Treatment Center, an increased proportion of the patient population today consists of persons sent to Anoka from jails. This change has occurred since implementation of the 48-hour law (discussed further in Chapter 4), which required DHS to place certain jail inmates in a DHS facility within 48 hours of their civil commitment for a mental illness. As shown in Exhibit 2.4, 42 percent of Anoka’s patient population as of June 2015 came to Anoka directly from jails, up from 13 percent two years earlier.³⁰ Most of the persons admitted to Anoka from jail have gone into Anoka’s Competency Restoration Program—for persons deemed incompetent by a court to stand trial. As of late October 2015, 17 of the 37 patients (46 percent) in Anoka’s Competency Restoration Program did not require a hospital level of care, according to Anoka staff. DHS officials told us that many of the individuals in this program could receive their treatment in settings other than a secure, acute-care hospital, if such options were available.

²⁷ This is based on the average daily census for each month, which is computed by summing the number of patients in the hospital on each day of a month and dividing by the number of days in the month.

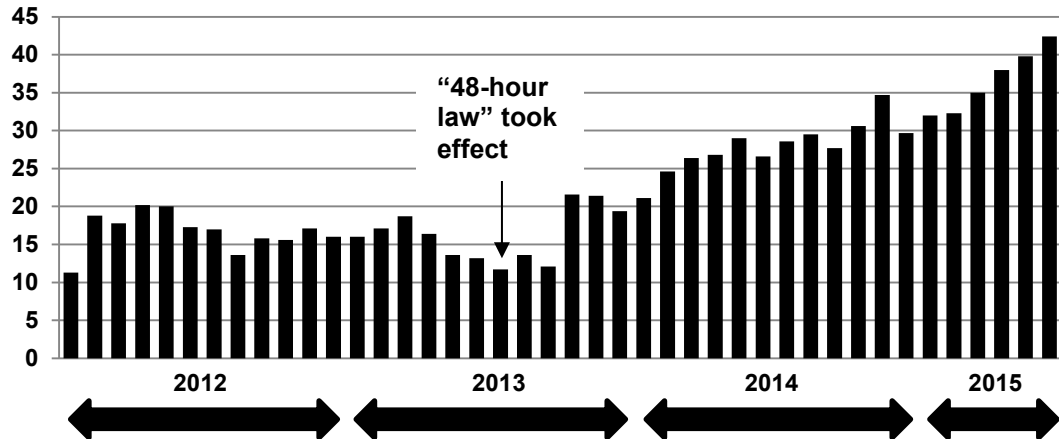
²⁸ Some persons are civilly committed as mentally ill in association with a criminal case, while others are not. Directors of community behavioral health hospitals told us that they rarely admit patients directly from jails. These hospitals usually do not admit persons on emergency holds or persons committed by a court for competency restoration.

²⁹ Placing patients at hospitals far from their homes can make it inconvenient for family members to visit them, and it may complicate the process of planning services the patients will receive in their home communities following discharge from the hospitals.

³⁰ In 2015 (as of late October 2015), admissions from jails accounted for 48 percent of all of Anoka’s admissions; in 2012, admissions from jails accounted for about 17 percent of all of Anoka’s admissions.

Exhibit 2.4: Percentage of Anoka-Metro Regional Treatment Center Patients Who Had Been Admitted to the Facility from Jail, January 2012 to June 2015

Percentage of All Patients



NOTE: The chart shows the percentage of the facility population on the first day of each month that had been in jail immediately prior to their date of admission.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

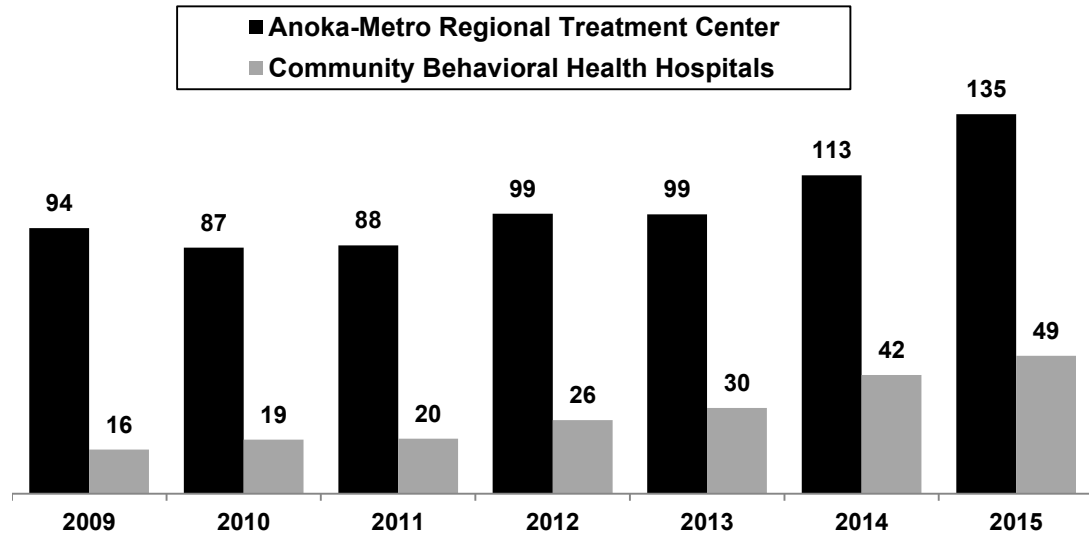
We also looked at measures of the staff time required by individual patients at Anoka. Anoka staff regularly classify patients based on their “acuity,” which indicates how much nursing time an individual patient requires. Patients who threaten harm to themselves or others, require assistance with activities of daily living, or show little ability to control their behaviors require more staff time than other patients, and thus have higher acuity ratings. We found that the average acuity ratings of patients increased at Anoka between 2012 and 2015 in five of the hospital’s six living units. This means that Anoka’s patient population became more challenging over time.³¹

Patients are now staying much longer in DHS’s hospitals than they did a few years ago, partly reflecting difficulty finding adequate discharge options.

Exhibit 2.5 shows trends in the average amount of time individuals spend in DHS hospitals. In the community behavioral health hospitals, the average length of stay for a patient has tripled—from 16 days in 2009 to 49 days in 2015. At Anoka-Metro Regional Treatment Center, the average length of stay grew from 99 days in 2013 to 135 days in 2015 (a 36 percent increase in two years). This may partly reflect the increases in more challenging patients (specifically, more civilly committed patients at DHS’s community behavioral health hospitals and more patients with more hard-to-manage behaviors at Anoka).

³¹ Staff at the Anoka facility also expressed concern to us that some patients arriving from jail are challenging to treat because of their criminal or antisocial attitudes. The staff are trained to deal with severe and complex mental illnesses, but they said some criminal attitudes are not treatable with mental health treatment, and patients with these attitudes can harm a facility’s therapeutic environment.

Exhibit 2.5: Average Length of Stay (in Days) in DHS-Operated Psychiatric Hospitals, 2009-2015



SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

However, DHS officials said this also reflects difficulties finding adequate placement options for patients ready to be discharged.³² Our office recommended in a 2013 report that DHS “ensure the availability of placement options for individuals ready to leave state-run facilities,” but DHS and counties continue to struggle to address this problem.³³ At the Anoka-Metro Regional Treatment Center, from January 2014 to mid-2015, 35 percent of all days of hospital care were devoted to patients who did not require hospital level of care. The 2015 Legislature amended state law to require counties to pay 100 percent of costs at Anoka for each day that a patient no longer requires hospital level of care, so this problem is having a direct fiscal impact on counties, too.³⁴ This change created a stronger financial incentive for counties to develop or arrange for community-based placement options. It is too early to evaluate the impact of the 2015 statutory change.³⁵

Longer lengths of stay at DHS facilities also reduce the total number of individuals who can be admitted to these facilities. This—combined with the capacity reductions discussed earlier—has added to the difficulties getting individuals placed in DHS hospitals.

³² For example, it can be challenging to find community placements for patients with criminal histories, and there have been more of these patients at Anoka in recent years.

³³ Office of the Legislative Auditor, *State-Operated Human Services*, ix.

³⁴ *Laws of Minnesota 2015*, chapter 71, art. 4, sec. 2, as codified in *Minnesota Statutes 2015*, 246.54, subd. 1. Previously, counties paid 75 percent of the cost beyond the 60th day, which the 2013 Legislature had increased from 50 percent of the cost beyond the 60th day. County representatives told us that the 2015 changes have resulted in a large increase in county costs of placements at Anoka and state nursing facilities. They also expressed concern that counties do not have a formal mechanism to appeal a facility’s determination that a person in one of these facilities no longer needs hospital care.

³⁵ It is worth noting, however, that the Legislature’s 2013 statutory increase in the percentage of costs that counties were required to pay for placements at Anoka (referenced in the previous footnote) did not have the intended impacts; the percentage of Anoka patients who did not require hospital level of care remained high.

Ability to Handle Difficult Patients

DHS-operated facilities exist, at least partly, to serve patients that other service providers in the state cannot (or choose not to) serve. This mission is not specified in statute for all DHS-run facilities, but DHS is on record supporting this mission for the services it operates.³⁶

As noted earlier, a challenging patient population at Anoka in recent years led the facility to reduce the number of beds it fills; the 2015 Legislature then increased the facility's appropriation to restore its capacity to 110 beds. The Anoka facility is large enough that it can readily move staff from one unit to assist other units, if problems with a patient arise. However, DHS's other psychiatric hospitals are not similarly equipped to deal with difficult patients.

Since their development about a decade ago, DHS's community behavioral health hospitals have been unable to effectively deal with patients who have aggressive or challenging behaviors.

In a 2012 report, DHS said that the staffing and building configurations of its 16-bed hospitals "do not allow for the security needed to serve aggressive patients."³⁷ It called the inability of these 16-bed hospitals to manage difficult patients "a significant gap in Minnesota's continuum of care."³⁸ In a 2013 report, our office recommended that DHS add security to at least two of the community behavioral health hospitals to enable them to admit individuals with very challenging behaviors.³⁹

Some officials within DHS told us that community behavioral health hospitals should, with proper staffing, be expected to handle very aggressive patients. However, others believe that these hospitals simply have too few staff (particularly during overnight hours) to deal effectively with difficult patients.⁴⁰ A DHS report concluded that enhancing a single 16-bed hospital to handle difficult patients would be feasible but expensive—costing at least \$1.7 million more per year than the existing facility.⁴¹ The recent reductions in staffing levels at all community behavioral health hospitals have made it even more difficult for these facilities to handle aggressive patients.

³⁶ *Minnesota Statutes* 2015, 246.0136, subd. 1, says that DHS's state-run "enterprise activities"—that is, those services that are financially self-supporting—should care "for vulnerable people for whom no other providers are available"; however, most of DHS's state-run facilities are not financially self-supporting, so this mission applies to only a small portion of DHS's services. But in DHS's official response to Office of the Legislative Auditor, *State-Operated Human Services*, the DHS commissioner supported clarifying state law to state that the role of DHS's residential and inpatient facilities is to serve individuals who cannot be adequately served by other providers.

³⁷ Department of Human Services, *Report on the Utilization of the Community Behavioral Health Hospitals* (St. Paul, March 30, 2012), 24.

³⁸ *Ibid.*, 23.

³⁹ Office of the Legislative Auditor, *State-Operated Human Services*, 125.

⁴⁰ For example, a community behavioral health hospital currently may have as few as three or four direct care staff per shift. If a patient requires restraint, it can be difficult for staff to do this while meeting the needs of other patients.

⁴¹ Department of Human Services, *Evaluation of the Feasibility to Comply with OLA's Recommendation to Enhance Security at a Community Behavioral Health Hospital to Serve More Challenging Patients* (St. Paul, October 2013).

An alternative to enhancing security at the community behavioral health hospitals would be to send more of the challenging patients who are referred to DHS to the Anoka-Metro Regional Treatment Center. The Anoka hospital—because it is much larger than the 16-bed hospitals—has more staff available at any given time to deal with difficult situations that arise. But relying on Anoka to serve the state’s most challenging patients only makes sense if the hospital can admit and treat those patients without significant delays. This is not now the case, except for those patients admitted pursuant to the 48-hour law. Later in this chapter, we recommend a change that is intended to allow for more prompt admissions to Anoka.

OPTIONS FOR DIVERTING INDIVIDUALS FROM JAIL

Individuals taken into custody by law enforcement may be “diverted” from jail at various points. For example, if law enforcement takes someone into custody for loud or belligerent behavior in public, that person could be:

- Transported to a mental health treatment or evaluation facility instead of being booked into jail.
- Booked into jail but then released (perhaps to a treatment program) without charges being filed.
- Charged with disorderly conduct but subsequently released (perhaps to a treatment program) with criminal charges dropped before the case goes to trial.

One form of diversion available in three Minnesota counties (Hennepin, Ramsey, and St. Louis) is a mental health court. Defendants may be referred to the jurisdiction of a mental health court before trial or after a conviction, and the court monitors the defendant’s compliance with court-imposed conditions, such as taking prescribed medications. Defendants who comply with mental health court requirements may have their charges dismissed or reduced. We did not evaluate Minnesota’s mental health courts. However, we considered the need for alternative facilities or treatment programs for persons with mental illness who have been taken into custody.

Most county officials we surveyed see a need for facilities where people with mental health symptoms could be initially diverted from jail, although research on the impact of such facilities is mixed.

In our statewide surveys of sheriffs and county human services directors, we asked the following question: “In your opinion, is there a need to develop local or regional secure holding facilities where someone with mental health symptoms could be brought by law enforcement for evaluation and referral—either as an alternative to initial placement in jail or for inmates who exhibit problems while in jail?” Ninety-six percent of sheriffs and 61 percent of county human services directors said there is a “significant need” for this type of diversion option. In addition, 4 percent and 29 percent, respectively, said there is “some need.”

A sampling of the comments we heard from local officials includes the following:

Often times, the person [taken into custody] either did not commit a crime, or committed a relatively minor crime due to the underlying issues of their mental health and jail is not...the best option to help the individual, but

may be the only option available to Law Enforcement at the time. We need to have a secure facility to bring them [to] that is not jail, where they are safe from self harm or harming others and can receive the proper help they need. (*Northern Minnesota county sheriff*)

Deputy costs to do these transports would need to be evaluated to see if it is cost-effective. This would depend on [the diversion facility's] location, as we can sit in our local emergency room and still be available for calls in the county. (*Northern Minnesota county jail administrator*)

The concern with [diversion facilities] is where would the person go afterward? It seems like this might create another bottleneck in the process? They would fill up and become another crowded hospital type setting. (*Twin Cities area county mental health administrator*)

Often times our residents who are displaying mental health symptoms and are more behaviorally difficult to manage are refused admittance to a hospital based on their behavior. (Given the number of health and mental health care workers who have been seriously harmed, the reluctance to admit is understandable.) However, we often cannot find a place for our residents in need of a secure place which can handle...their mental health and behavioral needs. Unfortunately, they then remain in jail for protection reasons, but then their mental health needs are not being addressed. (*Northern Minnesota county human services director*)

A 2009 review of past research on jail diversion found that diversion programs can reduce the time that people with mental illness spend in jail but have had little impact on subsequent criminal activity.⁴² In more recent years, some researchers have suggested that expanded mental health treatment options may be an appropriate strategy for some people who otherwise end up in jails, but they have questioned whether recidivism among persons with mental illness would be reduced without addressing underlying risk factors for re-offense—such as substance abuse, problems with anger control, and criminal attitudes.⁴³

Currently, there is no model for a secure mental health diversion facility in Minnesota, although county and state officials have discussed options. The 2014 Legislature authorized DHS to convene a working group to study, among other things, “the efficacy of a facility that would serve as a central point for accepting, assessing, and addressing the needs of offenders with mental illness brought in by law enforcement as an alternative to arrest or following arrest.”⁴⁴ The working group considered the possibility of recommending a “central receiving center” for this purpose, but its members instead preferred development of sustainable funding for mental health urgent care services throughout the state.⁴⁵

⁴² Frank Sirotych, “The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence,” *Journal of the American Academy of Psychiatry and the Law* 37, n. 4 (2009): 461-472.

⁴³ Jennifer Skeem, Patrick Kennealy, John Monahan, Jillian Peterson, and Paul Appelbaum, “Psychosis Uncommonly and Inconsistently Precedes Violence Among High-Risk Individuals,” *Clinical Psychological Science* 4, n. 1 (2016): 40-49; Peterson, Skeem, Kennealy, Beth Bray, and Andrea Zvonkovic, “How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders with Mental Illness?” *Law and Human Behavior* 38, n. 5 (2014): 438-449; and Skeem, Sarah Manchak, and Peterson, “Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction,” *Law and Human Behavior* 35, n. 2 (2011): 110-126.

⁴⁴ *Laws of Minnesota* 2014, chapter 312, art. 29, sec. 13.

⁴⁵ DHS, *Offenders with Mental Illness*, 30-32.

The 2015 Legislature gave a grant to Beltrami County to implement “a comprehensive mental health program,” including services to persons “under arrest or subject to arrest who are experiencing a mental health crisis.”⁴⁶ Beltrami is still determining what services the county will provide and how it will financially sustain these services after the state grant is spent. DHS is required by law to issue a report to the Legislature on Beltrami’s project by November 2017.⁴⁷

Exhibit 2.6 shows issues that would have to be considered prior to developing a mental health diversion facility. Local officials have considered developing such a facility—for example, in Beltrami County (using the state grant) and in Kandiyohi County (where county officials and DHS discussed the possibility of creating a secure mental health facility in an unused wing of a county jail). However, it has proven challenging to resolve issues involving multiple levels of government, multiple agencies, and unspecified funding streams, especially when there is no existing model for such a facility.

Exhibit 2.6: Issues That Would Need to be Addressed Prior to Development of a Mental Health Diversion Facility

Issue	Discussion
Licensure	<ul style="list-style-type: none"> • The facility could be either a mental health facility (licensed by DHS) or a detention facility that provides specialized health care services (licensed by the Department of Corrections). • The licensing agency would determine the appropriate licensure category and any variances from standard licensing provisions that would be required. For example, licensing provisions could address the circumstances in which restraint or seclusion could be used.
Administration	<ul style="list-style-type: none"> • The facility could be operated by a county, a group of counties, or the state.
Funding	<ul style="list-style-type: none"> • State officials told us that a mental health facility that is physically connected to a jail would probably not be eligible for Medicaid reimbursement; a standalone facility could be eligible. • For persons subject to commitment petitions or emergency holds, counties are financially responsible in state law for the cost of temporarily confining them for observation, evaluation, diagnosis, treatment, and care.^a However, the state could play a role in funding facilities serving other types of persons, or in helping to build a comprehensive statewide mental health system.
Service population	<ul style="list-style-type: none"> • It would be necessary to determine which types of individuals this type of facility would divert from the criminal justice system—for example, diversion prior to arrest, prior to criminal charging, or prior to commitment or trial. A diversion facility could also provide a secure alternative to hospital placement for someone needing care that a jail could not provide. • If persons are placed at the facility involuntarily (incarcerated or under civil commitment), this might require a “secure” facility that prohibits egress. • A facility could serve individuals from a single county, a region, or the state as a whole.
Services	<ul style="list-style-type: none"> • Possible services include: evaluation and diagnosis; medication administration and monitoring; mental health treatment; or referral for services.

^a *Minnesota Statutes* 2015, 253B.045, subd. 2.

SOURCE: Office of the Legislative Auditor.

⁴⁶ *Laws of Minnesota* 2015, chapter 71, art. 2, sec. 41.

⁴⁷ *Ibid.*

RECOMMENDATIONS

There is no single solution to the problem of how best to serve persons with mental illness who come into contact with law enforcement or the criminal justice system. Some of these persons have committed serious criminal offenses and must remain in jail for public safety reasons or as part of their criminal sentences. In these cases, jails must provide or arrange for appropriate mental health services. However, improved mental health services in the community may help to prevent some persons with mental illness from going to jail or address the needs of persons awaiting court action on criminal or civil cases.

RECOMMENDATION

Consistent with the requirements of the state’s comprehensive adult mental health act, the Department of Human Services, counties, and Legislature should ensure that Minnesota has a comprehensive adult mental health system, including a sufficient number of both residential and nonresidential services.

Our evaluation did not look at how Minnesota’s mental health system serves all adults with mental illness. Rather, we looked at how the mental health system serves one sizable group of persons with mental illness: those taken into custody by law enforcement. This population—whether before, during, or after incarceration—may use the full array of adult mental health services mandated by state law.

The observations about the adult mental health system we solicited in our surveys and interviews mirrored the conclusions reached in previous reports by DHS. Specifically, we concluded—as have others—that the adult mental health system is not working as well as it should. Although the Legislature once set a goal of having a comprehensive statewide mental health system by 1990, this system still has significant gaps more than 25 years later.

Providing adequate access to nonresidential mental health services must be part of the solution. With the closure of large, state-run psychiatric hospitals in Minnesota during recent decades, people with mental illness typically rely more on community-based, nonresidential services than they did previously. Thus, for example, it will be important for DHS to monitor the impact of the 2015 Legislature’s increased funding for mobile treatment teams. DHS is also in the process of developing a “forensic assertive care team” that will provide mental health services to prison inmates being released to the Twin Cities metropolitan area.⁴⁸ In the future, DHS may want to consider the viability of establishing such teams to serve persons released from Minnesota jails on a regional basis.

Better access to inpatient and residential mental health beds must also be part of the solution. As discussed in this chapter, there are serious logjams in both state-operated and community hospital beds for psychiatric patients. It is too difficult for people with mental illness to gain timely admission to beds in psychiatric hospitals, and people often stay too long in these beds because there are too few post-hospital options available at the time

⁴⁸ The “forensic assertive care team” that DHS is developing will be designed to serve individuals in the community following their release from prison. The team would help to coordinate care, incorporating information that had been obtained on the individuals by prison-based mental health staff. In addition, DHS is currently working with one county on development of a county-based forensic assertive care team for persons released from jail.

individuals are ready for discharge. Our surveys and DHS's own reports suggest that improved availability of inpatient and residential psychiatric beds should be a top priority.

Addressing weaknesses with the availability of mental health services for adults will require leadership and oversight from DHS, as well as planning and implementation efforts by counties. Expansions of services would also require additional legislative and county funding. Large-scale improvements in the system will not happen overnight, but the Legislature should consider establishing new target dates for full implementation, replacing the 1988 targets set in law by the 1987 Legislature. For example, state law still says: "By July 1, 1988, county boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness."⁴⁹ There are similar provisions—with 1988 implementation dates—for residential treatment services and acute care inpatient services.⁵⁰ DHS officials told us that additional updates to provisions in the statutes governing adult mental health services should occur, although they do not intend to propose changes to the 2016 Legislature.

In addition to making general improvements in the state's mental health system, there is a need for improvements in Minnesota's state-run psychiatric facilities. DHS's facilities should focus on the patients they are uniquely suited to serve, and they should have the ability to admit patients promptly.

RECOMMENDATION

The Legislature and Department of Human Services should consider options for re-locating Anoka-Metro Regional Treatment Center patients who do not require hospital care—particularly those in the Competency Restoration Program—so that this facility would have room for those who do.

If it is impractical for community behavioral health hospitals to serve aggressive or potentially dangerous patients—as some DHS officials told us—then DHS should ensure that there is room for these patients elsewhere. In our view, the logical place for many of these patients is the Anoka-Metro Regional Treatment Center, which has the specialized staff, large size, hospital care, and high security that such patients may require.⁵¹ To make it possible for Anoka to serve more of these patients, we suggest that the Legislature and DHS consider moving all or part of the Anoka facility's Competency Restoration Program to one or more DHS-operated locations elsewhere. During 2015, Anoka served around 40 competency restoration patients at a given time. Moving competency restoration services to new locations would probably result in a net increase in the number of available DHS-operated beds and would require additional legislative funding. However, this action would free up a portion of the Anoka facility's existing beds for patients with more challenging mental illnesses.

⁴⁹ *Minnesota Statutes* 2015, 245.469, subd. 1.

⁵⁰ *Minnesota Statutes* 2015, 245.472, subd. 1; and 245.473, subd. 1. In addition, there are requirements for county boards to provide or contract for sufficient outpatient (*Minnesota Statutes* 2015, 245.470, subd. 1) and community support services (*Minnesota Statutes* 2015, 245.4712, subd. 1) within the county to meet the needs of county residents; these requirements do not specify a due date for implementation.

⁵¹ The DHS-run Minnesota Security Hospital may be an option for some of these individuals, but it is not licensed as a psychiatric hospital. It primarily serves individuals committed as "mentally ill and dangerous"—a type of commitment infrequently used by courts, and one that is different than the commitment as a "person with mental illness" that precedes most placements at state-run psychiatric hospitals. The Minnesota Security Hospital also operates part of DHS's Competency Restoration Program.

Persons deemed incompetent to stand trial may or may not require intensive mental health treatment, hospital care, or a high-security setting. For example, persons deemed incompetent do not necessarily pose dangers to self or others; some might only require educational programs and medication monitoring. In Chapter 4, we recommend that DHS have a continuum of settings in which competency treatment is provided, ranging from outpatient to secure inpatient. Incompetent individuals who do require intense, secure treatment to restore competency could continue to be served at the Minnesota Security Hospital or Anoka-Metro Regional Treatment Center.

We did not assess the impact our recommendation might have on overall staffing needs at Anoka. The 2015 Legislature gave Anoka an increased appropriation that enabled the facility to restore its capacity to 110 beds, but the facility has struggled to fill all of its staff vacancies.

RECOMMENDATION

The Legislature should provide funding that enables DHS's community behavioral health hospitals to use more of their licensed beds.

A decade ago, the Legislature funded a system of new state-run psychiatric hospitals around Minnesota, partly to help Minnesota transition from larger state-run institutions that were closing. These new facilities were designed small (16 beds each) so their patients would qualify for Medicaid reimbursement. But because DHS reduced staffing at these facilities in 2015, they now fill just over half of their capacities.

If community behavioral health hospitals operated closer to their licensed capacities, law enforcement might be able to use these facilities to divert some individuals from going to jail. For instance, if a person commits a low-level crime and exhibits serious mental health symptoms, law enforcement might pursue an emergency hold or voluntary placement in a mental health facility rather than making an arrest. During such a stay, a community behavioral health hospital might evaluate the individual to better assess long-term needs. But community behavioral health hospitals now rarely make these types of admissions, partly because their capacities have been reduced. Nearly everyone admitted to a community behavioral health hospital today has been civilly committed by a court as mentally ill.

We think the Legislature should ensure that community behavioral health hospitals are fully staffed so they can be a stronger resource in Minnesota's mental health system. In some cases, a short-term placement by law enforcement at a state-run or community hospital may help to stabilize a person's mental health, perhaps making an arrest or a civil commitment unnecessary. Also, DHS should consider the possibility of having at least one community behavioral health hospital that can occasionally admit jail inmates who need short-term inpatient care that jails are not equipped to provide.

RECOMMENDATION

Counties should, where possible, formalize arrangements with community hospitals, community behavioral health hospitals, or other facilities, to help ensure that there will be places for persons who need inpatient care while in jail (or instead of going to jail).

Besides the state-level initiatives discussed above, part of the responsibility for improving community mental health services rests with counties.⁵² For example, counties could establish arrangements with community hospitals, community behavioral health hospitals, or other providers for evaluating and treating persons awaiting court actions on criminal or civil cases—similar to Ramsey County’s contract with Regions Hospital, discussed earlier in this chapter. Such arrangements would need to ensure the proper mix of treatment and security.

Counties could also play important roles if they wish to establish diversion facilities for persons taken into custody by law enforcement. We have recommended that the Legislature expand the capacities of state-run mental health facilities as one way of assuring that community and state-run hospitals have more beds available for emergency holds and persons without civil commitments who are taken into police custody. If—beyond this—there is a need for additional facilities to assess or refer persons taken into custody by law enforcement, individual counties or groups of counties could develop such facilities. The 2015 Legislature provided Beltrami County with funding to plan and develop improved mental health services—perhaps including a diversion facility—but with the condition that this planning money would be a one-time state investment; the county will be responsible for developing services sustainable with other resources. It may be reasonable for the Legislature to fund planning or development costs for local jail diversion facilities, but we think that the counties that use the facilities on an ongoing basis should bear their ongoing costs. It is difficult for us to recommend state funding to pay for the operation of diversion facilities at a time when DHS’s community behavioral health hospitals—which could play a role in serving some patients diverted from the criminal justice system—are operating well below their licensed capacities.

A final consideration is whether the Department of Corrections (DOC) or local jails should establish a statewide or regional mental health correctional facility for certain persons with mental illness who are in jail (either before or after sentencing). DOC has a 47-bed mental health unit in its Oak Park Heights prison that treats inmates with mental illness from any of the DOC prisons who require an intensive level of programming or supervision.⁵³ Some persons in county jails might need levels of care and supervision greater than individual jails (or the hospitals they contract with) can reasonably provide.⁵⁴ A specialized treatment facility could be developed by DOC (with legislative funding) or by an individual county or groups of counties (with local funding).⁵⁵ We offer no recommendation on the need for this type of specialized facility because we are not aware of any analysis that indicates—even roughly—how many individuals in Minnesota jails might require the services that such a facility could provide. We think that expanding the capacity of DHS’s state-operated services and improving the state’s adult mental health system are more pressing needs for the Legislature to consider at this time, but a mental health treatment facility for jail inmates might also be a useful statewide or regional resource.

⁵² *Minnesota Statutes* 2015, 253B.045, subd. 2, requires counties to maintain or arrange for temporary confinement of persons awaiting civil commitment, and subd. 4 requires counties to take reasonable measures to assure proper care and treatment of these persons.

⁵³ Occasionally, inmates from jails have been treated at the Department of Corrections’ mental health unit.

⁵⁴ Individuals who are have been civilly committed (some of whom are also in jail) have a right to treatment, according to Minnesota law and case law. *Minnesota Statutes* 2015, 253B.03, subd. 7, says that persons under civil commitment have “the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary.” *Linder v. Commissioner of Human Services*, 394 N.W.2d 824, 827 (Minn. Ct. App. 1986), said that individuals under commitment have a right to treatment, regardless of where they are placed.

⁵⁵ *Minnesota Statutes* 2015, 641.262 to 641.266, authorizes counties to cooperatively establish “regional jails”—for example, to help them provide treatment to individuals in jail.

Chapter 3: Adequacy of Jail Mental Health Services

In Chapter 2, we said that community-based services may have a significant impact on the ability of law enforcement officials to meet the needs of people with mental illness they take into custody. However, jails also bear a responsibility for providing adequate services to persons with mental illness that they confine.

This chapter focuses on jail-based services for inmates with mental illness. We discuss the perceptions of county sheriffs and human services officials about mental health services in jails. We assess the adequacy of statewide rules adopted by the Department of Corrections (DOC), as well as the policies of selected jails. In addition, we discuss DOC's inspections of jails, the extent of jail suicides and their relationship with jail practices, and inmate options for expressing concerns about the mental health services they receive. Overall, we recognize that jails are not licensed treatment facilities, but we think there is room for jails to improve the services they provide to inmates with mental illness.

KEY FINDINGS IN THIS CHAPTER

- **Most sheriffs and county human services directors think that jail inmates with mental illness should have better access to psychiatric services, counseling, and case management.**
 - **State rules for jails inadequately address some key mental health issues—for example, they have vague guidance on jails' mental health assessments, and they do not require treatment plans.**
 - **There is limited compliance with a state law that requires discharge planning for sentenced offenders with mental illness in jail.**
-

ACCESS TO SERVICES

As we discussed in Chapter 1, jails rely on a variety of arrangements to provide mental health services, including private contractors, local public health agencies, individual providers, and their own staff. However, many county law enforcement staff told us that the scope of these services is limited. One jail administrator said: “Most jails only do basic [medication] management for [inmates with mental illness]. There is little to no treatment due to short average stays in jail.” Another jail administrator said: “County jails are not able to provide mental health services needed to properly address the special needs of the individuals.” At one jail that has a special unit for inmates with mental illness, administrators said that this unit mainly protects these inmates from others; the unit provides little mental health care. A sheriff told us that persons taken into custody in his

county who pose a danger to themselves or others may be denied admission to the jail, and he said that inmates do not receive mental health services within the jail itself.¹

We also heard concerns about jail-based mental health services from former inmates and some mental health advocates. For example, some former jail inmates told us that mental health counselors were available in jail, while others said they had little access to counselors or psychiatrists during their jail stays.²

A majority of Minnesota’s sheriffs and county human services directors said that inmates with mental illness should have better access than they now have to psychiatric services, counseling, and case management services in jails.

In our statewide surveys, we asked local officials for their opinions about the adequacy of jail services for persons with mental illness. Specifically, we asked about the services that may be available from five categories of specialized professionals. As shown in Exhibit 3.1, sheriffs and human services directors were especially likely to say that inmates need better access than they currently have to psychiatrists, licensed mental health counselors, and county case managers.

Opinions were more divided about the need for additional nursing services. For example, 48 percent of responding sheriffs said there was a need for jail inmates to have better access to the services of registered nurses, while 45 percent said existing access was adequate. Among county human services directors, 45 percent said jail inmates needed better access to services from registered nurses, while 31 percent said existing access was adequate.

ADEQUACY OF STATE RULES AND LOCAL JAIL POLICIES

Corrections professionals have developed two primary sets of standards that address health care in jails and prisons. These standards—adopted by the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC)—provide guidance about “best practices.” Counties or states may choose whether to seek accreditation of their correctional facilities, based on these standards; they are not required to do so.³ Even if they do not seek accreditation, counties or states may use these standards as a point of reference for the policies they develop for correctional facilities. The ACA and NCCHC both state that their standards are intended to apply to jails of any size.

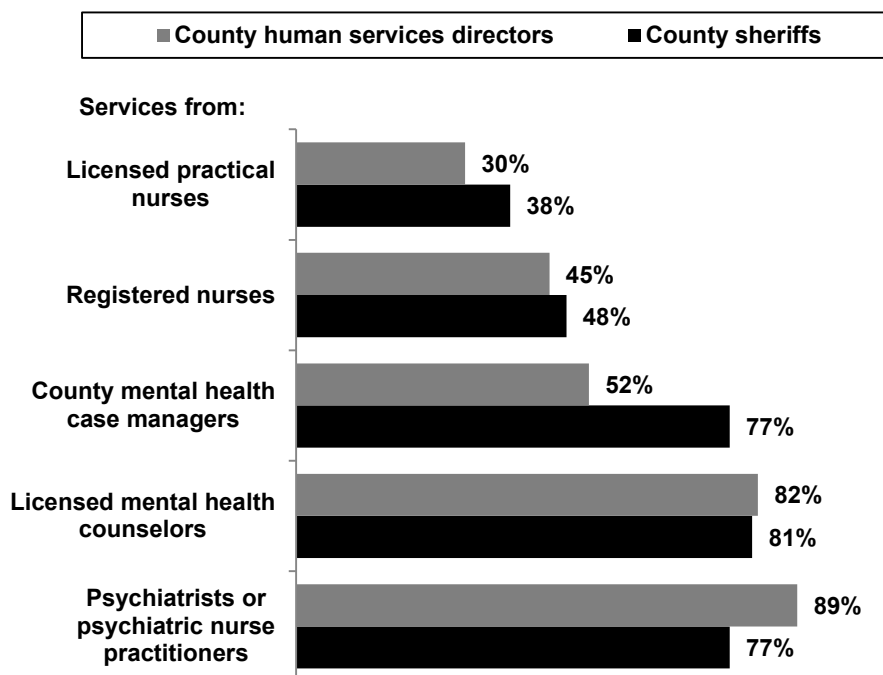
Minnesota rules that establish practices for the state’s jails are consistent with some professional standards related to mental health services in jails, but there are important areas in which they differ.

¹ According to this county’s jail staff, if an inmate in the jail needs a prescription, for example, the inmate would be brought to a hospital to obtain this.

² We spoke with nine former jail inmates who were currently patients at Anoka-Metro Regional Treatment Center.

³ Only one Minnesota jail (a facility for pre-adjudicated adults) is accredited by ACA, and only one jail (a facility for post-adjudicated adults) has NCCHC accreditation.

Exhibit 3.1: Percentage of County Human Services Directors and Sheriffs Who Said Inmates with Mental Illness Should Have Access to More Services from Specialized Staff



NOTES: The officials we surveyed were asked to assess—based on their experience—the access of jail inmates to services from the categories of professionals shown. Shown above are the percentages of respondents who said inmates need access to services “beyond what is currently available to them.”

SOURCE: Office of the Legislative Auditor, surveys of county human services directors ($N=70$ to 72 , depending on the question) and county sheriffs ($N=65$ to 71 , depending on the question), August to October 2015.

We reviewed ACA and NCCHC standards that are pertinent to detainees with mental illness, and we compared these standards with state rules for jails adopted by the Minnesota Department of Corrections (DOC). Most of these rules were most recently updated in 2013.⁴

Exhibit 3.2 shows examples of areas in which state rules related to mental health services in jails are largely consistent with professional standards. For example, ACA and NCCHC standards both require correctional facilities to designate a “health authority,” and state rules require each jail to specify a “health authority” who is licensed to practice medicine. The rules require the health authority to oversee development of written policies and procedures for medical, dental, and mental health care, and the health authority must review these annually. Although there are some differences in the wording of the professional standards and Minnesota rules, we concluded that the state rules on this topic substantially agree with the relevant professional standards.

⁴ The state’s administrative rules for jails are in *Minnesota Rules*, Chapter 2911, most of which were published December 20, 2013.

Exhibit 3.2: Examples of Areas in Which State Rules for Jails Largely Conform to Professional Standards Related to Jail-Based Mental Health Services

Topic Area	Conformity of Rules with Professional Standards
Responsible Health Authority	Professional standards suggest that jails designate a “health authority” responsible for mental health services. State rules align with this standard in that they require that one person or agency licensed to practice medicine will be responsible for developing a facility’s policies and procedures for delivery of mental health care to inmates.
Clinical Autonomy	Standards suggest that clinicians be solely responsible for clinical decisions. State rules specify that the responsible psychiatrist or qualified psychologist is solely responsible for clinical judgments related to mental health.
Policy and Procedures	Standards suggest that jails have policy and procedure manuals, which must be reviewed annually. State rules require this, too.
Credentialing	Standards suggest that jails rely on properly credentialed staff for health care services. State rules require “health care personnel” to be licensed nurses, nurse practitioners, physicians, or physician assistants.
Staffing Plan	Standards suggest that jails develop staffing plans that specify sufficient staffing levels. State rules require facilities to develop such plans and review them annually.

SOURCE: Office of the Legislative Auditor, based on comparison of American Correctional Association and National Commission on Correctional Health Care standards with *Minnesota Rules*, Chapter 2911, published December 20, 2013.

We also found topic areas in which Minnesota rules do not align with professional standards related to mental health, and Exhibit 3.3 provides key examples. For instance, professional standards suggest that jails develop individualized treatment plans for inmates with mental illness.⁵ These plans might address treatment goals and objectives, care instructions for health care and other staff, patient testing and evaluation, and medications. Minnesota rules for jails do not require or even discuss treatment plans. Later in this chapter, we discuss in greater depth several areas in which Minnesota rules do not align with professional standards.

We supplemented our review of state rules by looking at the mental health-related policies adopted by a sample of 12 Minnesota jails.⁶ We focused on topic areas in which state rules did not meet professional standards, and this allowed us to see whether the jails’ policies came closer than the DOC rules to aligning with the standards.

Policies adopted by individual jails sometimes go beyond the requirements of state rules, but many jail policies do not fully align with standards for mental health care adopted by the corrections profession.

⁵ American Correctional Association, *Core Jail Standards* (Alexandria, VA, 2010), Standard 1-CORE-4C-07 (Chronic Care); and National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-G-03 (Treatment Plans).

⁶ We reviewed policies for jails in the following counties: Beltrami, Freeborn, Hennepin, Kandiyohi, Morrison, Pine, Pipestone, Ramsey, Rice, St. Louis, Traverse, and Wright.

Exhibit 3.3: Examples of Areas in Which State Rules for Jails Do Not Align with Professional Standards Related to Jail-Based Mental Health Services

Topic Area	Conformity of Rules with Professional Standards
Treatment Plans	Standards suggest that jails should develop individualized treatment plans for inmates with mental illness. Minnesota rules for jails do not require treatment plans.
Mental Health Assessment	Standards suggest that mental health assessments should be completed within prescribed time periods. State rules do not require such assessments, as discussed later in Chapter 2.
Privacy of Care	Standards suggest that jails' mental health services be conducted in private settings. State rules only require that jails' intake procedures occur in private.
Inmate Deaths	NCCHC standards suggest that deaths of patients with mental illness or suicides be reviewed within 30 days to determine the appropriateness of mental health care provided and any changes needed in policy, procedures, or practices. State rules do not require jails to review any inmate deaths.
Health Care Monitoring of Segregated Inmates	Standards suggest that inmates who are assigned to cells that are segregated from other inmates be regularly monitored by health services staff or mental health professionals. State rules do not address—nor do they require individual jails' policies to address—such monitoring of segregated inmates.
Reviews of Clinician Performance	Standards suggest that jails conduct or arrange for reviews of the performance of health professionals, periodically or in response to adverse events. Minnesota rules for jails do not address this.
Quality Assurance Reviews	Standards suggest that jails conduct health care-related quality assurance reviews or continuous quality improvement studies. There are no comparable requirements in state rules for jails.
Mental Health Education	Standards suggest that inmates have access to health education, training in self-care, and wellness programs. State rules do not address these topics.
Health Care Liaison	Standards suggest designation of someone to coordinate health service delivery when health professionals are not on site. State rules authorize but do not require such liaisons in jails without full-time health care personnel.

SOURCE: Office of the Legislative Auditor, based on comparison of American Correctional Association and National Commission on Correctional Health Care standards with *Minnesota Rules*, Chapter 2911, published December 20, 2013.

An example of an area in which individual jail policies are more specific than the state rules for jails is the frequency with which suicidal inmates must be personally observed by jail staff. State rules require jails to observe all inmates at least once every 30 minutes, with “more frequent observation” required for inmates who may harm themselves.⁷ The state rule is more vague than the National Commission on Correctional Health Care standard, which requires staff checks of potentially suicidal inmates at least every 15 minutes.⁸ We found that 9 of 12 jails' policies specified intervals between 5 and 15 minutes for the checks

⁷ *Minnesota Rules*, 2911.5000, subp. 5, published December 20, 2013.

⁸ National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-G-04 (Suicide Prevention Program).

of suicidal inmates, so the policies of these jails were more in line with professional standards than were state rules for jails.⁹

Likewise, individual jails' policies sometimes addressed topics that are in professional standards (and federal or state law) but are not addressed at all in the Minnesota rules for jails. For example, DOC chose not to include any provisions in its rules specifically related to the federal Prison Rape Elimination Act, which establishes requirements for both prisons and jails.¹⁰ DOC decided that state rules on this topic were unnecessary because (1) they would duplicate the requirements of federal law and (2) under the federal law, local practices are subject to federally required audits separate from DOC's regular jail inspections.¹¹ In our review of jail policies in 12 counties, we found that more than half of the counties referenced the federal act in their local policies.

While jail policies often came closer to aligning with professional standards than did state rules, this was certainly not always the case. For example:

- In Exhibit 3.3, we noted that professional standards recommend that jails' health services staff monitor inmates who are segregated from other inmates, and state rules do not address this issue.¹² We found that 3 of the 12 jails whose policies we reviewed explicitly require such monitoring—either for all inmates in segregation or for inmates in certain types of segregation.
- A standard developed by the National Commission on Correctional Health Care says that mental health professionals should provide consultation at disciplinary hearings for inmates.¹³ Such consultation would help the persons conducting the disciplinary hearing evaluate whether the inmate's mental illness contributed to the alleged misconduct. Minnesota rules for jails do not require this type of consultation, and most jails whose policies we reviewed do not either. It is worth noting that DOC policy for state prisons requires consideration during disciplinary procedures of whether an inmate's behavior was caused by mental illness.¹⁴

⁹ The National Commission on Correctional Health Care standards state that persons placed in "clinically ordered seclusion" should be monitored every 15 minutes by "health-trained personnel or health services staff." DOC rules do not specify anyone besides "custody staff" who should monitor potentially suicidal inmates, and we are aware of only two jails that have around-the-clock health services staff on-site.

¹⁰ The Prison Rape Elimination Act of 2003 was intended to help prevent, detect, and respond to sexual assaults of incarcerated persons. The act requires identification of inmates who may be especially vulnerable, potentially including those with mental illness.

¹¹ DOC told us that, although state rules do not address this topic specifically, the department's jail inspectors regularly discuss the federal act's requirements with sheriffs and jail administrators.

¹² Segregation may be done for disciplinary reasons, or to protect or monitor inmates. There has been growing concern about the use of segregation for inmates with serious mental illness. The American Psychiatric Association has adopted the position that (1) prolonged segregation of inmates with mental illness should, with rare exceptions, be avoided and (2) segregated inmates with mental illness should have access to adequate mental health programming and recreation.

¹³ National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-G-06. NCCHC defines a "mental health professional" as a psychiatrist, psychologist, psychiatric social worker, licensed professional counselor, psychiatric nurse, or others who are permitted by law to evaluate and care for patients with mental health needs.

¹⁴ Department of Corrections Policy 303.010 (Offender Discipline), issued June 16, 2015. The policy says a mental health assessment must be considered if staff question whether the offender's conduct was affected by mental illness.

- Professional standards suggest that jails should have a trained health care—or mental health—liaison who can coordinate service delivery to inmates at times when qualified health care staff are not on site. Minnesota rules authorize but do not require the designation of such liaisons, and most jails whose policies we reviewed do not require them either. For jails that have limited health services staff on site, this designation can be important.

In some topic areas, state rules and jail policies could be brought into alignment with professional standards with modest changes. For example, state rules and most jails' policies we reviewed require that jailers receive training in communication skills—however, professional standards suggest that there should be training specifically related to communicating with inmates who have mental illness.¹⁵

RECOMMENDATION

The Department of Corrections should initiate a process to update its state rules for jails—particularly those related to mental health services—to bring them into greater alignment with professional standards.

In our view, there are important areas in which Minnesota rules for jails do not align with standards adopted by the corrections profession. Minnesota is not required to adopt rules that fully comply with professional standards, and DOC told us that few states have jail policies that fully align with professional standards. However, these standards have been adopted by corrections professionals to reflect “best practices” in the corrections field, and they should be carefully considered. While jails have adopted some policies that exceed the requirements of state rules, there are still many instances in which jail policies fall short of professional standards.

Most of the state rules regarding jails were last updated less than three years ago, following a multi-year process. DOC officials told us that changes in rules related to mental health or medical services could probably be implemented more quickly than an update of the entire chapter of rules pertaining to jails. However, if the Legislature prefers to see immediate changes in certain state requirements—rather than waiting for promulgation of new rules—it should consider adopting additional requirements into Minnesota statutes. Later in this chapter, we recommend that the Legislature adopt requirements into law regarding mental health assessments, and this could be an option for other topic areas, too. But, regardless of what actions the Legislature takes, DOC should initiate a rulemaking process to, at a minimum, bring sections of the rules related to mental health care into greater alignment with professional standards.

County officials expressed concern to us that changes in rules could have cost implications for counties. As noted in Chapter 1, counties bear responsibility for most jail costs. County representatives suggested to us that the Legislature consider financial assistance to counties to help implement better jail-based mental health services, while they acknowledged that the Legislature has not previously provided such assistance for jails. We agree that implementation costs should be one consideration in any update of state rules.

¹⁵ National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-C-04 (Mental Health Training for Correctional Officers).

INSPECTION FINDINGS

The Minnesota Department of Corrections inspects each jail in the state at least once every two years. DOC's inspections focus primarily on the jails' compliance with state rules.¹⁶ These rules do not have any sections that focus exclusively on mental health services. One section addresses "inmates with special needs," and inmates with mental illness are one group included in this definition. Several other sections of the rules have provisions that mention inmates with mental illness or would be particularly relevant to this population.

We reviewed the most recent inspection report for each of the state's jails, as of mid-2015. Because state rules for jails have limited requirements pertaining to mental health services, DOC's inspection reports rarely commented specifically on jails' mental health services. However, there were findings in inspection reports that reflected, more generally, on the ability of jails to adequately serve people with mental illness.

Over 40 percent of the most recent inspection reports cited the jails for problems with their ongoing checks on inmates' well-being.

State rules require jail staff to observe, in person, all inmates at least once every 30 minutes.¹⁷ Inmates classified as having "special needs"—including those with mental illness or those who are potentially suicidal—are supposed to be observed more frequently, although the rules do not specify exactly how often. These ongoing checks are intended to help ensure the safety and well-being of the inmate population. As one DOC inspection report said, "It is important for staff to enter the units, not only to ensure the physical well-being of the inmates, but also the psychological well-being of the inmates."¹⁸

Most violations of the rule requiring well-being checks involved jails that failed to conduct checks within the 30-minute standard set in rule. Usually, DOC cited multiple violations at the cited jail. For example, the Faribault County Jail was cited for having 21 checks in a single day in 2015 that were not completed within the specified time, and Aitkin County was cited for 17 in one day in 2014. The Koochiching County Jail was cited in 2014 for "pervasive" problems with well-being checks in several consecutive inspections that have "not shown any significant improvement."¹⁹ Occasionally DOC cited jails for failing to make visual inspections of the inmates, or doing the checks too quickly to adequately ensure that the inmates were alive. At the Ramsey County Adult Detention Center, a 2014 DOC review of logs completed by jail staff suggested that well-being checks were being done in a timely manner, but video from the jail showed that checks were not done in the timely manner reported in the logs. Later in this chapter, we discuss suicides of inmates, and we note that inadequate well-being checks were cited by DOC in many reviews of these cases.

¹⁶ When DOC cites compliance problems in an inspection report, it requires the jail to prepare an action plan showing how it will resolve the problems.

¹⁷ *Minnesota Rules* 2911.5000, subp. 5, published December 20, 2013.

¹⁸ Minnesota Department of Corrections, *Facility Inspection Report for Todd County Jail* (St. Paul, June 10, 2015), 9.

¹⁹ Minnesota Department of Corrections, *Facility Inspection Report for Koochiching County Jail* (St. Paul, June 5, 2014), 16.

Many jails were cited for general issues—inadequate staffing, staff training, or inmate activities and programs, or outdated policies—that could adversely affect people with mental illness.

About one-third of the jails were cited in their most recent inspection report for issues related to inadequate staffing. Sometimes DOC cited jails for having inadequate overall staffing levels; in other cases, certain key positions had not been filled, or jail staff were performing tasks (such as transporting inmates or conducting urinalysis for probation staff) that inappropriately took them from jail duties. Inadequate staffing could affect the ability of jails to give attention to inmates with special needs, such as those with mental illness.

A majority of jails were cited for problems with staff training. These problems ranged from jail-wide training inadequacies to inadequate training for only certain types of staff (such as nurses) to inadequate training plans. At the more serious end of this range, the Sibley County jail was cited in 2014 for repeated failures to provide the required amount of training to its jail staff over a period of several years.

In addition, we found that 38 percent of jails were cited for inadequacies in inmate programs and activities. Structured activities may be especially important for inmates with mental illness, who can become anxious, depressed, or agitated in a jail setting. DOC mostly cited jails for inadequacies in their recreation space, educational services, or substance abuse programs. For example, DOC's inspection report for Swift County said:

A chaplain comes in once a week. That is the only program in the jail.... The facility has no one to provide education.... The facility is unable to find an [Alcoholics Anonymous] volunteer.... There is no recreation space except a small program room.²⁰

Nearly half of jails' most recent inspection reports said that the jails' policies and procedures needed to be updated. Sometimes this reflected inconsistencies between the jail policies and state rules for jails; most of the rules were updated in December 2013. In other cases, jail policies had not been updated for several years, or they did not address important activities (such as those related to the federal Prison Rape Elimination Act).

SELECTED JAIL PRACTICES

Earlier, we noted that state rules for jails and individual jails' policies are not always consistent with professional standards in the corrections field. Below, we discuss jail practices in selected areas in more detail. These are areas in which we think jail services could be provided more appropriately if there were changes in laws, rules, or individual jails' policies and practices. Specifically, we focus on (1) mental health assessments, (2) medication practices, (3) crisis intervention training, (4) inter-agency exchange of information, and (5) planning for inmate discharges from jail.

²⁰ Minnesota Department of Corrections, *Facility Inspection Report for the Swift County Jail* (St. Paul, December 8, 2014), 3-4.

Screening and Assessment

A key first step in getting mental health services to inmates in jail is determining which inmates need these services. This process begins with “screening” when individuals are first admitted to jail. Screening can identify individuals who need a more detailed clinical assessment or a referral for services, and it can help jails to determine inmate housing or security requirements. Minnesota law says:

As part of its intake procedure for new prisoners, the sheriff or local corrections [agency] shall use 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.²¹

In response to this requirement, DOC has directed jails to use any of several mental health screening tools.²²

Each of the DOC-authorized mental health screening tools has received generally favorable reviews in past research.

Each of the screening tools authorized by DOC is brief, ranging from 8 to 12 questions for a new inmate. Examples of questions include: “Have you ever had worries that you just can’t get rid of?” and “Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?” In 2013, a psychiatric journal summarized previous research about mental health screening tools used in correctional institutions. It looked, for example, at the screening tools’ ability to correctly identify individuals who had mental illness. The three screening instruments authorized by DOC were among five identified in the article as “the most promising tools.”²³

According to our statewide survey of sheriffs, nearly all Minnesota jails rely on corrections officers or sheriffs’ deputies to conduct initial screening for mental health issues. The research summary cited above said that each of the tools DOC uses can be administered by health staff or corrections officers.²⁴

While state rules regarding jails’ initial screening practices are mostly consistent with professional standards, the rules regarding jails’ subsequent assessments of inmates are not. Generally, screening should be followed by more detailed assessments or evaluations of inmates. The National Commission on Correctional Health Care suggests that all inmates

²¹ *Minnesota Statutes* 2015, 641.15, subd. 3a.

²² The tools authorized for local use by DOC are the Correctional Mental Health Screen for Men, the Correctional Mental Health Screen for Women, and the Brief Jail Mental Health Screen.

²³ Michael Martin, Ian Colman, Alexander Simpson, and Kwame McKenzie, “Mental Health Screening Tools in Correctional Institutions: A Systematic Review,” *BMC Psychiatry*, 13, n. 275 (October 29, 2013), <http://www.biomedcentral.com/1471-244X/13/275>, accessed October 23, 2015.

²⁴ *Ibid.*, 7. It is worth noting, however, that the professional standards developed by the National Commission on Correctional Health Care suggest that mental health staff, not corrections officers, conduct initial inmate mental health screening; see National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-E-02 (Receiving Screening for Mental Health Needs). ACA standards do not require mental health staff to conduct mental health screening in jails.

receive an initial mental health assessment from mental health staff within 14 days of admission, and inmates positively assessed as having mental health problems should be referred to mental health professionals for further evaluation.²⁵ The American Correctional Association says that each inmate should receive a “comprehensive physical and mental health appraisal” within 14 days of arrival in jail (unless a health appraisal has been completed within the previous 90 days).²⁶ According to the American Correctional Association, this appraisal should include a review of the jail screening results, development of a medical history, a physical examination by a qualified health care provider, and development of an individual treatment plan.

Minnesota rules for jails do not require inmates to receive mental health assessments within a prescribed period of time following admission, contrary to standards developed by the corrections profession.

State rules do not set clear expectations for jails following initial inmate screening for mental health issues. The rules require that, when classifying inmates for purposes of determining their custody levels, housing assignments, and participation in facility programs, jail policies shall consider the results of any “special needs assessment... , which includes a determination of how...mental health needs...may impact on the classification of an inmate and appropriate housing.”²⁷ However, the rules do not actually require facilities to conduct any assessments. The rules require jails to have policies on “postadmission screening and referral for care of inmates with special needs” (including mental illness), but the meaning of “postadmission screening” is unspecified.²⁸ Likewise, the rules require jails to have policies that require “health care follow-up” for inmates with chronic or persistent medical conditions, but the nature of this follow-up is unclear.²⁹ The rules do not require an in-depth mental health appraisal by specialized staff, even for those individuals flagged in initial screening as having potential mental health issues. Also, the rules provide no direction on when postadmission screening, assessment, or health care follow-up should occur.

Overall, the rules provide jails with too much latitude and too little helpful guidance about mental health assessment.³⁰ In our review of 12 individual jails’ policies, we found that

²⁵ National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-E-04 (Mental Health Assessment and Evaluation).

²⁶ American Correctional Association, *Core Jail Standards* (Alexandria, VA, 2010), Standard 1-CORE-4C-11 (Health Appraisal).

²⁷ *Minnesota Rules*, 2911.2600, subp. 1, published December 20, 2013.

²⁸ *Minnesota Rules*, 2911.7100, subp. 1, published December 20, 2013. The rule defines inmates with special needs as those with disabilities, mental illness, and developmental disabilities, as well as individuals who are mentally ill and dangerous.

²⁹ *Minnesota Rules*, 2911.5800, subp. 7, published December 20, 2013.

³⁰ One district court judge commented to us that if a person with mental illness does not arrive at jail with medications or a current prescription, there will be no assessment in jail of the person’s need for medications.

5 jails require that all inmates receive health appraisals within 14 days of admission, although it is unclear how fully these assessments address mental health conditions.³¹

RECOMMENDATION

The Legislature should amend state law to require that inmates who remain in jail for at least 14 days receive an assessment by a mental health professional during that period.

Specialized mental health assessments can help jails to protect inmates with mental illness from self-harm or victimization by other inmates, and they can help identify services the inmates may need in jail or after discharge. In our view, this recommendation is too important to leave to a potentially lengthy state rule-making process. The most recent complete revision of the Minnesota rules for jails took several years, yet it did not include key provisions related to assessment (and other areas that relate to inmates with mental illness) that would reflect good correctional practice.

We recognize that many people are in jail for only a few hours or days, and requiring a complete mental health assessment for everyone who enters jail would be a significant workload burden for jails. However, we think it is reasonable to expect mental health assessments for inmates who remain in jail for at least two weeks. As discussed later in this chapter, this assessment should also identify inmates with a “serious and persistent mental illness,” for purposes of post-sentencing discharge planning, if applicable.

DOC officials estimated as many as 40,000 mental health assessments per year might be required if this recommendation is implemented. However, there are not reliable data on how many of these assessments are already being done each year by jails, so the fiscal impact of this recommendation is unclear.³²

DOC also said that pre-trial defendants in jail cannot be compelled to submit to assessments they do not wish to have completed, and an official for the Minnesota Board of Public Defense confirmed this to us. But, even if some defendants may refuse to be assessed, we still think it is reasonable to set an expectation in rules to have prompt assessments, for those defendants who are agreeable. In fact, the official for the Board of Public Defense told us that defense attorneys generally welcome jails’ efforts to conduct mental health assessments within the first two weeks in jail, while acknowledging that some inmates may not agree to this.

Finally, DOC noted that there is a shortage of psychiatrists and other mental health professionals in Minnesota, and this could inhibit the ability of jails to conduct (or arrange

³¹ In addition to the five jails that require all inmates to have health assessments within 14 days of admission, four jails require an evaluation within 14 days of admission for inmates screened as having a chronic or persistent illness (without specifying whether this might include a mental illness), and three jails require a mental health assessment within 14 days of admission or referral for inmates screened as having mental health issues.

³² In Chapter 1, we said that DOC has not collected reliable information from jails on the number of inmates who have been referred for mental health assessments.

for) additional assessments.³³ This issue deserves close consideration. If the Legislature concludes that workforce shortages would not allow for mental health assessment of inmates within their first two weeks in jail, our preference would be for the Legislature to adopt a more lenient standard (such as assessment within the first three weeks) rather than abandoning altogether the idea of mandatory assessment within a prescribed period.

Medications

For persons with mental illness inside and outside of jail, medications are often an important part of treatment. This section discusses two areas in which we think state policy should provide greater direction to jails.

Continuity of Medications

When someone enters jail, a key challenge faced by jail staff is identifying the person's current prescriptions and, if appropriate, making arrangements for the individual to continue the medications. Adverse health effects can occur if jails do not maintain therapeutic doses of prescribed medications, abruptly discontinue previous prescriptions, or frequently change medication orders.

State rules provide limited guidance to jails regarding the continuation of medications the inmates were prescribed prior to entering jail.

The National Commission on Correctional Health Care recommends the following: "Inmates entering the facility on verifiable prescription medication, including methadone, continue to receive the medication in a timely fashion as prescribed, or acceptable alternate medications are provided as clinically indicated."³⁴

Minnesota rules require that "an inmate's own supply of prescription medications brought into the facility shall be verified prior to dispensing."³⁵ However, the rules do not address whether jails must continue prescriptions that have been verified, nor do they provide a time frame within which jails must verify existing medications or acquire medications for initial administration to new inmates.³⁶

Jails do not necessarily allow inmates to take all prescribed medications. For example, some jail officials told us they usually prohibit prescriptions of narcotics, benzodiazepines,

³³ For additional discussion of the shortage of mental health professionals, see Healthforce Minnesota and Minnesota State Colleges and Universities, *Gearing Up for Action: Mental Health Workforce Plan for Minnesota* (St. Paul and Rochester, MN, January 2015).

³⁴ National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-D-02 (Medication Services). Also, Standard MH-E-02 (Receiving Screening for Mental Health Needs) says: "Prescribed medications are reviewed and appropriately maintained according to the medication schedule the inmate was following before admission, or alternative treatment is initiated and documented."

³⁵ *Minnesota Rules*, 2911.6800, subp. 2, published December 20, 2013.

³⁶ The rules state that a jail's physician, psychiatrist, and psychologist are solely responsible for clinical judgments involving inmates' medical or mental health care. The rules do not specifically state whether the persons who prescribe medications for jail inmates may terminate or change the prescriptions that inmates bring with them to jail.

or medications for sleeping or attention deficit hyperactivity disorders.³⁷ Also, our survey of sheriffs indicated that nearly half of jails use a “formulary” (a list of authorized medications) to guide clinicians’ decisions about which medications may be prescribed to inmates. Use of a formulary is recommended or presumed by professional standards in the corrections field.³⁸ However, mental health advocates expressed concern to us about jails’ limitations on inmate access to certain medications. Such limitations could require inmates to change to a different or less expensive medication when they enter jail, with possible implications for treatment effectiveness or side effects.

Another issue related to continuity of medications is jail practices for providing inmates with prescribed medications at the time they leave jail. We found that:

Some jails do not provide inmates with prescribed medications upon release.

According to state rules, “Prescribed medication shall be given to an inmate or to the appropriate authority upon transfer or release, unless the attending physician decides that in the medical interest of the inmate the medications should not be released with the inmate.”³⁹ The rules do not specify how many days worth of medications the jail must supply. State law says that providing a 30-day supply of “all necessary medications” might be part of a jail discharge plan, but the law does not require this.⁴⁰

Most sheriffs told us they typically provide discharged inmates with a supply of the prescribed medications for mental illness they had received while in jail. However, 6 percent of surveyed sheriffs told us they “rarely or never” provide a supply of such medications at discharge, and 8 percent said they “sometimes” do so.⁴¹ Furthermore, jails vary in the amount of prescribed medications they provide to discharged inmates, ranging from a 3-day to a 30-day supply; some jails provide whatever medications remain on the current prescription.⁴² The language in state rules suggests that physician decisions not to provide inmates with prescribed medication upon release should be made based on individual circumstances, so we are concerned that some jails appear to routinely forgo the practice of giving prescription medications to inmates at the time of discharge.

³⁷ Some jails prohibit these medications because of their potential for addiction or abuse.

³⁸ American Correctional Association, *Core Jail Standards* (Alexandria, VA, 2010), Standard 1-CORE-4C-15 (Pharmaceuticals); and National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-D-01 (Mental Health Pharmaceutical Operations).

³⁹ *Minnesota Rules*, 2911.6800, subp. 3, published December 20, 2013.

⁴⁰ *Minnesota Statutes* 2015, 641.155.

⁴¹ In our review of the Department of Corrections’ recent jail inspection reports, we did not see any reports that cited jails for failure to provide inmates with prescribed medications at discharge.

⁴² Law enforcement officials expressed some concern to us that inmates given a 30-day supply of certain medications upon release from jail might sell them for money.

RECOMMENDATIONS

The Minnesota Department of Corrections should:

- **Amend state rules for jails to specify the maximum time frames in which jails must (1) verify new inmates' existing prescriptions and (2) begin to administer medications under existing or new prescriptions.**
 - **Amend state rules for jails to specify the authority, if any, that jails have to restrict the administration of prescribed medications in jails.**
 - **Ensure, during its jail inspections, that jails are providing inmates with their prescribed medications upon release from jail in a manner that is consistent with state rules.**
-

In our view, existing rules provide too little guidance about the continuation of medications that inmates were taking prior to entering jail. The rules require verification of existing prescriptions, but they should establish time limits for the medication verification and review process (perhaps allowing for exceptions, in certain circumstances), to ensure that inmates receive necessary medications in a timely manner.⁴³ In addition, it may be helpful for the rules to specify how formularies or other restrictions on medications must be implemented—for example, (1) whether the jail's designated "health authority" must approve the formulary, and (2) whether a prescribing doctor may always override the formulary or any restrictions on medications adopted by jail administrators.⁴⁴ Also, it is unclear to us whether all jails are complying with rules that address jails' provision of prescribed medications to inmates when they are released, and DOC inspectors should carefully monitor this.⁴⁵

Involuntary Administration of Medications

Patients with mental illness sometimes resist taking prescribed medications. This may occur because the patients are concerned about the medications' side effects. It may also occur because the patients deny that they are ill or do not fully understand the medications' therapeutic effects. The U.S. Supreme Court has said that inmates have a "liberty interest... in being free from the arbitrary administration of [antipsychotic] medication," but that this must be weighed against the dangers that someone without adequate treatment may pose to self or others.⁴⁶ In other words, the Court recognized the possible benefits of these

⁴³ DOC noted that placing strict time limits on verification of medications would be complicated by the fact that (1) verification can be difficult during non-business hours or when nurses are not available at the jail, and (2) not all inmates are willing to authorize the prescriber to release information to the jail.

⁴⁴ The rules give the responsible physician, psychiatrist, or psychologist sole authority to make clinical judgments related to medical or mental health care. But, without further clarification of the rules, it is unclear whether jail administrators have authority to restrict the use of certain medications—potentially for reasons such as public safety (to prevent the medications' abuse or sale in jail) or to control costs.

⁴⁵ *Minnesota Rules*, 2911.6800, subp. 3, requires jails to have documentation of any instance in which the attending physician decides that medications should not be released with the inmate. We did not review DOC's practices for monitoring compliance with this rule, but inspectors should ensure that there is proper documentation of instances in which inmates are not given their prescribed medications at discharge.

⁴⁶ *Washington v. Harper*, 494 U.S. 210, 211 (1990).

medications, yet it placed restrictions on administration of these medications without the patient's consent. The Court has upheld the involuntary administration of medication to inmates—authorized with or without a judicial hearing—so long as there are appropriate procedural protections.⁴⁷

Many states have adopted laws allowing for involuntary administration of medications without judicial hearings, but it is unclear that such a law in Minnesota would withstand legal challenges.

A recent report said that at least 31 states have established administrative procedures for involuntary treatment consistent with the procedures outlined by the Court in this case.⁴⁸ In Minnesota, however, the state Supreme Court ruled in 1988 that a civilly committed individual's right to privacy under the Minnesota Constitution required judicial approval prior to forced administration of medications in a nonemergency situation.⁴⁹ This case only addressed individuals who have been civilly committed.⁵⁰ However, the case's interpretation of state constitutional requirements suggests that there might be legal challenges if legislation were to authorize administrative—rather than judicial—mechanisms to ensure due process in cases involving forced medications in nonemergency situations.

Minnesota law has provisions that allow for involuntary administration of antipsychotic medication in certain situations. First, the law allows **courts** to order involuntary administration of antipsychotic medication.⁵¹ The law says “the court may authorize the treating facility and any other community or treatment facility to which the patient may be transferred or provisionally discharged, to involuntarily administer the medication to the patient.”⁵² These orders are often called “Jarvis orders.”⁵³ Second, the law authorizes **physicians** to administer medications without a court order in emergency situations. Specifically, the law authorizes “emergency administration” of antipsychotic medication to patients who lack the capacity to make decisions regarding administration of medication.⁵⁴

⁴⁷ For example, the Court expressed satisfaction with provisions that placed decisions in the hands of an independent body that conducted hearings with prior notice in the presence of the inmate and, if desired by the inmate, a lay advisor (*Washington v. Harper*, at pp. 212 and 216). In another case (*Sell v. U.S.*, 539 U.S. 169, 180-181 (2003)), the Court said that there are certain situations in which defendants may be given medication involuntarily as part of treatment aimed at restoring their mental competency to stand trial. For example, the Court said that involuntary medication is appropriate only if it is likely to contribute to the defendant's competence to stand trial, and if its side effects will not adversely affect the defendant's ability to participate in his or her own defense.

⁴⁸ E. Fuller Torrey, Mary Zdanowicz, Aaron Kennard, H. Richard Lamb, Donald Eslinger, Michael Biasotti, and Doris Fuller, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (Arlington, VA: Treatment Advocacy Center, 2014), 103.

⁴⁹ *Jarvis v. Levine*, 418 N.W.2d 139, 140-141, 150 (Minn. 1988).

⁵⁰ The case also did not address involuntary administration of medications in emergency situations.

⁵¹ State law uses the term “neuroleptic” medication; we chose to use the word “antipsychotic” medication in this section. The term “neuroleptic” references the effects of the original antipsychotic medications, which produced apathy, a lack of initiative, and a limited range of emotions in patients who took them. This term is outdated because newer antipsychotic medications do not necessarily have these effects.

⁵² *Minnesota Statutes* 2015, 253B.092, subd. 8(e).

⁵³ The terms “Jarvis orders” and “Jarvis hearings” (the latter references the hearings at which these orders are made) refer to a Minnesota Supreme Court case, *Jarvis v. Levine* 418 N.W.2d 139 (Minn. 1988).

⁵⁴ *Minnesota Statutes* 2015, 253B.092, subd. 3.

If a patient’s treating physician determines that the medication is necessary to prevent serious, immediate physical harm to the patient or others, the medication may be administered on an emergency basis for up to 14 days—and beyond that, if a court has received a request for an order to administer medications.

Jails sometimes have to deal with inmates who refuse to take their medications for weeks—until a civil commitment petition is filed.

Except in emergencies, antipsychotic medications may generally not be administered involuntarily without a commitment petition.⁵⁵ Individuals with mental illness who face criminal charges might never be the subject of petitions for civil commitment—but when they are, those petitions are often not filed for weeks after the arrests. We looked at several years of court data on persons who were the subject of both criminal cases and commitment petitions. We found that the median time from when a person’s criminal case was filed to the commitment petition filing date was 58 days. This means that individuals who refuse to take prescribed antipsychotic medications after entering jail and who are not already subject to commitment petitions may go without medications for extended periods after entering jail.⁵⁶

Minnesota law does not explicitly indicate whether medications may be involuntarily administered in jails, and jails rarely pursue this option.

The law governing involuntary medication says that courts may authorize a “treatment facility” to administer medications involuntarily.⁵⁷ State law defines a “treatment facility” to be “a hospital, community mental health center, or other treatment provider qualified to provide care and treatment for persons who are mentally ill, developmentally disabled, or chemically dependent.”⁵⁸ The law does not specifically state that medications may be involuntarily administered in a jail. Likewise, the law regarding emergency administration of medications makes references to a “treatment facility” and “treating physician” without explicitly stating whether these can apply to a jail or a jail’s physician.

In our survey of sheriffs, we asked what actions their jails might pursue if an inmate refused to take prescribed medications and was a threat to self or others; respondents could select more than one response. Most sheriffs (74 percent) said they might keep the inmate under close observation in jail until the inmate is court-ordered to a different facility. About 49 percent of sheriffs said they might transfer the inmate to a hospital. However, given the limited bed space in treatment facilities such as hospitals—discussed in Chapter 2—it is unclear how quickly jails could initiate transfers of inmates refusing to take medications. Only 4 percent of sheriffs said they would consider seeking a court order to involuntarily

⁵⁵ The section of Minnesota law that authorizes involuntary administration of antipsychotic medication only applies to persons who are (1) civilly committed or are the subject of a commitment petition, or (2) subject to court-ordered early intervention or a petition for early intervention. Based on our interviews, however, the statutory provision for court-ordered early intervention may rarely be used—in fact, some judges we spoke with were unfamiliar with the provision or recalled no cases seeking early intervention. Thus, involuntary medication is an option primarily for persons who are committed or the subject of a commitment petition.

⁵⁶ Jails could seek to have medications administered on an emergency basis, but—as discussed later—jails are unlikely to do this while the person is at the jail.

⁵⁷ *Minnesota Statutes* 2015, 253B.092, subs. 3 and 8.

⁵⁸ *Minnesota Statutes* 2015, 253B.02, subd. 19.

medicate an individual while in jail, and only 1 percent said they might administer medication involuntarily in jail on an emergency basis.⁵⁹ In our interviews, some state and local officials questioned whether jails have legal authority to involuntarily administer medications in non-emergency situations to someone in jail.

We heard concerns that some individuals remain in jail too long without taking prescribed medications. Staff at the Anoka-Metro Regional Treatment Center told us that many jail inmates committed for mental illness arrive at their facility in unstable condition, partly because there were no efforts to administer medications involuntarily while the individuals were in jail. Several patients at that facility also told us of difficulties they had getting medications for their mental illnesses while in jail. A top official with the Minnesota Department of Human Services expressed concern to us about delays in the involuntary administration of medications to jail inmates, stating that untreated inmates (1) put staff at risk for injuries and (2) may be less able to participate in their criminal defense.

RECOMMENDATION

The Legislature should amend state law to specify that emergency administration or court-ordered involuntary administration of antipsychotic medications may occur in jails that have the necessary staffing and skills.

Minnesota's civil commitment law does not explicitly state whether a jail qualifies as a treatment facility that may involuntarily administer medications. Also, it is unclear whether the law authorizes a treating physician employed by or under contract with a jail to order emergency administration of medications. We think the Legislature should clarify these ambiguities.

This is important because there can be cases in which an inmate is too dangerous to place in a hospital or treatment facility for medication administration (or where jail staff would have to continuously guard the inmate at the hospital). Also, there may not be hospital or treatment facility beds available at the time they are needed for jail inmates.

Jails would need sufficient medical staffing and supervision to administer medications involuntarily pursuant to a court order or in emergency situations. Some jails have this capacity—for example, the Hennepin County Adult Detention Center has around-the-clock nursing coverage and several beds that are reserved for inmates with significant medical needs. Many jails do not have these types of resources on site. On occasions when involuntary administration of inmate medications is necessary in a secure environment, perhaps jails that do not have this capability could transfer inmates to jails that are better equipped to do it.⁶⁰

⁵⁹ Some correctional facilities in Minnesota have involuntarily administered medications on site. The Minnesota Department of Corrections' Mental Health Unit (Oak Park Heights prison) obtains orders for involuntary medications; other DOC prisons do not. Ramsey County officials told us they have occasionally obtained orders for involuntary medication, both in the jail's cells and its medical unit.

⁶⁰ DOC noted that jails may be reluctant to accept transfers of inmates from other jails because of the liability the receiving jails may assume.

RECOMMENDATION

The Legislature should consider statutory changes that would allow faster initiation of involuntary medication administration for persons who refuse to take their antipsychotic medications.

Aside from emergencies, state law authorizes forced administration of antipsychotic medications in cases that involve persons who are under civil commitment or are the subject of a commitment petition. However, interested parties may be reluctant to start a civil commitment process that would remove a person's liberties before seeing whether medications effectively address the person's mental health symptoms. Thus, the Legislature should consider amending *Minnesota Statutes* 2015, 253B.092, subd. 1, to allow courts to order involuntary administration of antipsychotic medications in cases where a civil commitment petition has not been filed. An interested party or treatment facility could ask the court to authorize involuntary medication, and the patient would receive the due process that a court hearing provides. Civil commitment petitions are usually not filed for many weeks after a person's arrest. Having a faster process for getting a reluctant patient—including persons in jail—to take their prescribed medications might make some civil commitments unnecessary and address the patient's symptoms more quickly.⁶¹

Crisis Intervention Teams

Within the corrections and law enforcement fields, there is widespread interest in the use of trained "crisis intervention teams" (CITs) to defuse difficult situations involving individuals with mental illness. For example, the National Alliance on Mental Illness (NAMI), International Association of Chiefs of Police, and University of Memphis developed a 40-hour model curriculum to train law enforcement officers. According to NAMI, this training "gives officers more tools to do their job safely and effectively. It helps keep people with mental illness out of jail, and get them into treatment, where they are more likely to get on the road to recovery."⁶² The Minnesota Department of Corrections has trained staff in state prisons to deescalate situations before offenders' behavior gets out of control. Nationally, researchers have concluded that CIT training holds promise but should be the focus of more rigorous evaluation.⁶³

Statewide, sheriffs report that about 13 percent of the law enforcement professionals they employ have completed a week-long CIT training course.

⁶¹ *Minnesota Statutes* 2015, 253B.07, subd. 2a, authorizes simultaneous competency and civil commitment procedures, provided the prosecution and defense attorneys agree to this. The Legislature could speed the commitment process (and, potentially, the involuntary medication process) by mandating in law that the competency and civil commitment processes proceed simultaneously. However, attorneys and interested parties might prefer to delay the civil commitment process until it is clear that this process is necessary.

⁶² National Alliance on Mental Illness, "What is CIT?" <http://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health/What-Is-CIT>, accessed November 13, 2015.

⁶³ Michael Compton, Masuma Bahora, Amy Watson, and Janet Oliva, "A Comprehensive Review of Extant Research on Crisis Intervention Team Programs," *Journal of the American Academy of Psychiatry and Law* 36, n. 1 (2008): 47-55; Amy Watson and Anjali Fulambarker, "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners," *Best Practices in Mental Health* 8, n. 2 (2012): 71-81; and Amanda Cross and others, "An Agenda for Advancing Research on Crisis Intervention Teams for Mental Health Emergencies," *Psychiatric Services* 65, n. 4 (2014): 530-536.

CIT training is intended for various types of law enforcement staff who may encounter persons with mental illness. We did not survey local police departments about the extent to which their officers have completed CIT training. But, as a part of our statewide survey of sheriffs, we asked for information about the extent to which law enforcement professionals in sheriffs' offices—such as patrol staff and jailers—have completed CIT training.

Among sheriffs' offices that operate jails, the extent of staff training in CIT varies considerably. For example, four departments reported to us that at least 40 percent of their professional staff were CIT-trained. This included Swift (56 percent), Olmsted (44 percent), Sherburne (42 percent), and Washington (40 percent) counties. On the other hand, 28 sheriffs (or about 38 percent of those responding to our survey) said their departments had no professional staff who had completed a week-long CIT course.⁶⁴

Many survey respondents said that CIT training is beneficial. One survey respondent said: "CIT training is very valuable. It creates an important awareness for staff on the effects of mental illness on those suffering from it." Another sheriff told us that he is a trained CIT instructor and believes the training has been important for his staff. However, sheriffs said the time and expense of a week-long training session has been an impediment to using it more.

RECOMMENDATION

Each Minnesota sheriff's office should try to ensure that at least some of its jail and patrol staff have had crisis intervention training.

Crisis intervention teams are a promising tool for law enforcement and corrections agencies. But, until there is stronger research evidence of this training's impacts, it seems premature to suggest mandating the training for every law enforcement officer or jailer in Minnesota. Instead, we encourage individual jails to seek this training for at least some portion of their staff. In addition, the Minnesota Sheriffs' Association—which represents all sheriffs' offices in Minnesota—should consult with law enforcement agencies and mental health advocates about the adequacy of existing training, including the possibility of supplementing week-long courses with shorter courses for certain staff.

Inter-Agency Sharing of Information

When people enter jail, it is important for the jails to quickly understand their mental health histories. Jails need to ensure that persons with mental illness receive appropriate living assignments, supervision, medications, and care.

Jails and county human services agencies sometimes—but not always—share information about inmates with mental illness.

For instance, jails do not always notify a county human services agency when someone with apparent mental health issues from that county is in jail. In our statewide survey, 47 percent of sheriffs said they "routinely" convey such information to the human services agency in

⁶⁴ Some sheriffs' offices may have staff that have completed CIT courses of shorter duration; we only asked about the 40-hour training class.

their home county; 34 percent said they occasionally do this, and 18 percent said they do not do this at all. There is no requirement in state laws or rules for such notifications. Regarding cases in which jails incarcerate persons with apparent mental health issues who reside in another county, only 15 percent of sheriffs said that they routinely inform those counties' human services agencies.

In addition, sheriffs said they have had mixed experience getting information from human services agencies about the mental health histories of jail inmates. Thirty-six percent of sheriffs said the human services agency in their home county has “always,” “almost always,” or “often” provided an inmate’s mental health history upon request, while 36 percent said the human services agency “sometimes,” “rarely,” or “never” provided this information.⁶⁵

Federal and state laws place restrictions on disclosure of individuals’ health care records.⁶⁶ Federal law permits “protected health information” to be disclosed—without the individual’s authorization—to jails for various purposes, including providing health care to the individual or protecting the inmates or jail staff.⁶⁷ However, state law is more restrictive than this federal law regarding disclosure of health data on individuals without the individual’s consent, and it does not explicitly address the ability of county human services agencies to share mental health information with jails. For example, the law authorizes “personnel of the welfare system” to share county mental health data with each other “to the extent necessary to coordinate services” for an individual, but the law’s definition of the welfare system does not include jails or correctional facilities.⁶⁸ Also, the law says that mental health data may be shared with “a health care provider” when necessary to coordinate services, but the law defines “provider” as individuals or facilities with specified health care licenses, permits, or registrations.⁶⁹ The latter provision could allow certain health care staff at jails (or staff under contract with jails) to obtain mental health records from counties without an inmate’s consent, but there may be instances in which those staff are not available to make the requests on behalf of jails.

RECOMMENDATION

The Legislature should amend *Minnesota Statutes 2015, 13.46*, to explicitly authorize welfare agencies and jails serving the same individual to share mental health records on the individual.

⁶⁵ The remainder of the sheriffs responded “don’t know” or said their offices have not requested this type of information.

⁶⁶ The main federal law is the Health Insurance Portability and Accountability Act of 1996, or HIPAA (and its related federal regulations in 45 *CFR* secs. 160, 162, and 164), and the main Minnesota provisions are in the Government Data Practices Act (*Minnesota Statutes 2015*, Chapter 13).

⁶⁷ Federal law—mainly HIPAA—defines privacy rules for “protected health information.” But a 2010 report said: “HIPAA permits [protected health information] to be made available to a correctional or other custodial facility for several purposes, including, generally, providing health care and protecting the health and safety of inmates, officers, or other employees of the correctional institution.... This provision in HIPAA permits very broad disclosure of [the information] without the person’s authorization.” See John Petrila and Hallie Fader-Towe, *Information Sharing in Criminal Justice-Mental Health Collaborations* (New York: Council of State Governments Justice Center, 2010), 12.

⁶⁸ *Minnesota Statutes 2015*, 13.46, subds. 1(c) and 7(a)(4).

⁶⁹ *Minnesota Statutes 2015*, 13.46, subd. 7(a)(5); and 144.291, subd. 2(i).

Our surveys indicated that some county human services agencies and jails already share information, and statutes allow this in some circumstances—for example, in cases where the individual consents to have the information disclosed or there is a court order to disclose the information.⁷⁰ However, we think it would be helpful for state law to clearly authorize jails and county human services agencies to share data—without the patient’s consent—in cases where they are serving the same individuals and need to coordinate care or treatment.

Discharge Planning

Standards adopted by correctional professionals suggest that it is important for jails to help inmates with serious mental illness make transitions back to the community when they are released from jail. A standard adopted by the American Correctional Association states: “Prior to release [from jail], inmates with serious health conditions are referred to available community services.”⁷¹ Likewise, the National Commission on Correctional Health Care recommends creation of a discharge plan for each inmate with a serious mental illness, as well as making “appointments for inmates with critical mental health needs for services with community providers.”⁷²

There is limited compliance with a state law that requires discharge planning for sentenced offenders with mental illness in jail.

State law requires the Department of Corrections to develop a “model discharge planning process” for offenders with a serious and persistent mental illness (SPMI) who have received sentences of at least three months and are being released from county jails.⁷³ Appendix A shows the state’s definition of a person with SPMI. State law requires jails to refer persons with SPMI and jail sentences of at least three months to the county human services department 60 days before release. It says the county human services department “may carry out provisions of the [DOC] model discharge planning process.”⁷⁴ The law suggests possible elements of discharge planning, shown in the box on this page.

Possible Elements of Discharge Planning for Inmates

- Assistance in applying for health insurance
- Referral for case management services
- Assistance in obtaining a state photo ID
- Assistance in getting appointments with psychiatrists or other mental health providers
- Providing prescriptions for a 30-day supply of necessary medications

Source: *Minnesota Statutes* 2015, 641.155.

In our statewide survey of sheriffs, we asked respondents about the extent to which their jails or medical providers (1) determine which inmates with sentences of at least three months meet the SPMI definition and (2) refer those who do to a county human services agency. Exhibit 3.4 shows the responses. Only 6 percent of sheriffs said they “always or

⁷⁰ *Minnesota Statutes* 2015, 13.46, subd. 7.

⁷¹ American Correctional Association, *Core Jail Standards* (Alexandria, VA, 2010), Standard 1-CORE-4C-02 (Continuity of Care/Referrals).

⁷² National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-E-10 (Discharge Planning).

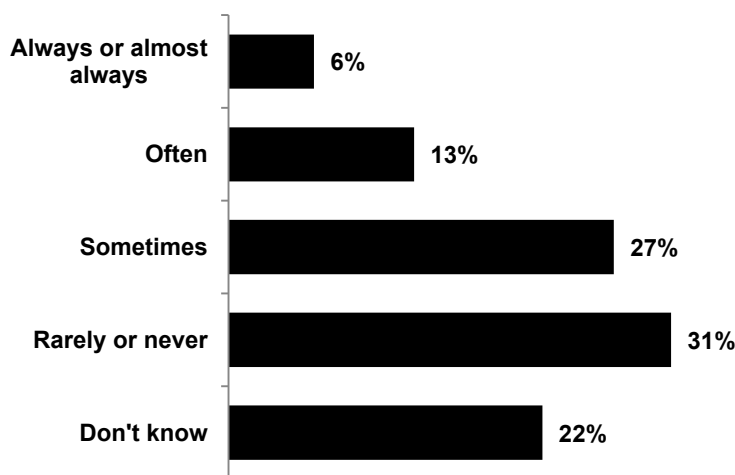
⁷³ *Minnesota Statutes* 2015, 641.155.

⁷⁴ *Ibid.*

almost always” do so. In addition, 38 percent of human services directors we surveyed said they receive no such referrals from their counties’ jails. Human services directors also said that, when jails make SPMI referrals to their agencies, the referrals do not always occur 60 days prior to the inmates’ release, contrary to the requirements of state law.

Exhibit 3.4: Extent to Which Jails Assess Sentenced Inmates for “Serious and Persistent Mental Illnesses” and Refer Them for Discharge Planning

Percentage of Sheriffs Who Said:



NOTES: For this question, sheriffs were given a citation for the statutory definition of a “serious and persistent mental illness” (SPMI) and asked: “For inmates with sentences of three months or longer, how often does your jail or its medical provider(s) determine which inmates meet the SPMI definition and refer those who do to a county agency?” We excluded from the analysis respondents who said their main jail did not have post-adjudication inmates.

SOURCE: Office of the Legislative Auditor, survey of county sheriffs that operate jails, August to October 2015, (N=67).

State rules for jails developed by the Department of Corrections have no references to the discharge planning statute. In fact, the rules have no provisions of any sort that specifically address release planning for persons with mental illness, including guidance for making referrals to other agencies. DOC told us that its rules do not address discharge planning of persons with mental illness because this topic is addressed in a statutory provision. However, DOC also told us that its compliance reviews of county jails focus primarily on the jails’ compliance with state rules rather than their compliance with state statutes.⁷⁵

As noted above, state law directed DOC to develop a discharge planning model for jail inmates. We asked DOC to provide us with information about what was developed in response to this law.

⁷⁵ *Minnesota Statutes* 2015, 241.021, subd. 1, requires DOC to review jails throughout the state “to determine compliance with the minimum standards established pursuant to this subdivision.” The subdivision requires DOC to promulgate rules establishing minimum standards for correctional facilities.

Department of Corrections officials told us they developed a discharge planning model after the law was passed in 2005, but they have not provided guidance to counties recently.

DOC officials said the department developed a model several years ago, and they initially could find no documentation of the model in response to our request to see it.⁷⁶ DOC officials also said the department has not distributed information on its discharge planning model to counties in recent years. Thus, although state law still requires jails to report sentenced offenders with SPMI to county human services agencies for purposes of discharge planning, local officials receive no guidance on discharge planning from DOC.

RECOMMENDATIONS

The Legislature should amend *Minnesota Statutes 2015, 241.021, subd. 1*, to direct the Department of Corrections to monitor and enforce the compliance of correctional facilities with minimum standards, whether those standards are established in state statutes or rules.

The Department of Corrections should amend *Minnesota Rules, Chapter 2911*, to include guidance on discharge planning for inmates with serious and persistent mental illness.

In our view, it does not make sense for DOC to monitor jails' compliance with state rules but not state laws. For example, it is unclear why DOC should monitor compliance with a state rule that prohibits discharging someone from jail during severe weather while ignoring jails' compliance with a statute regarding discharge of people with mental illness.⁷⁷ The Legislature should clarify *Minnesota Statutes 2015, 241.021, subd. 1*, by requiring DOC to review facility compliance with minimum standards that appear either in state statutes or rules. In addition, Minnesota rules for jails should clarify the role of jails in assisting county human services agencies in discharge planning for persons with mental illness.⁷⁸ For instance, jails should identify which inmates are subject to the discharge planning law, inform county human services agencies about these inmates in a timely manner, and share with the agencies basic information about the inmates that may be helpful for developing a discharge plan.

One possible reason that jails have not referred SPMI inmates to human services agencies for discharge planning is that the law does not indicate who should determine whether inmates meet the SPMI definition. With no requirements for mental health assessments in state law or rules, jails may not know which of their inmates are classified as SPMI. Earlier, however, we recommended amending state law to require that all inmates receive a

⁷⁶ When we sent DOC a copy of our draft report to review, DOC found a mental health release planning document that it said was distributed to jails several years ago.

⁷⁷ *Minnesota Rules, 2911.2550, subp. 3*, published December 20, 2013, prohibits discharge of inmates in severe weather.

⁷⁸ Most of the counties whose jail policies we reviewed did not reference the state discharge planning law in their policies. However, some counties have taken important steps to improve discharge planning. For example, Hennepin County has created a multi-disciplinary team to ensure that inmates screened in jail as having high risks of mental health needs receive mental health assessments, have plans for community support services following release, and have applied for health insurance.

full mental health assessment during their first 14 days in jail, if they stay in jail that long. With implementation of this recommendation, jails should have a basis for determining which inmates are SPMI.⁷⁹

SUICIDES

Another measure of the adequacy of jail services is the ability of jails to protect inmates with mental illness from self-harm.⁸⁰ We examined the extent to which there are suicides in jails and the adequacy of jails' responses to suicides. One county jail administrator told us:

Jails have become a “dumping ground” for the mentally ill, and jail staff is tasked with continuously performing 15-minute well-being checks on inmates in suicide smocks. They are NOT trained mental health personnel, but are forced repeatedly into that role, while the inmate goes without needed treatment.

Minnesota rules require jails to report “incidents of an unusual or serious nature” to DOC within ten days of the incident.⁸¹ According to the rules, these include events such as suicides or attempted suicides, homicides, other deaths, serious injuries or illnesses resulting in hospitalization, escapes or attempted escapes, fires, riots, assaults of inmates or staff that result in criminal charges or outside medical attention, injuries to inmates caused by staff restraints, occurrences of infectious diseases requiring isolation, and sexual misconduct.

Our review of state data on jail incidents showed that, between January 2000 and June 2015, there were at least 52 suicides and 773 unsuccessful attempted suicides in Minnesota jails.

We cannot say for certain that the number of suicides and attempted suicides that we tallied based on reports to DOC represent all such incidents that occurred at jails. During our reviews, we identified cases in which certain jails did not report any “incidents of an unusual or serious nature” to DOC over periods of months or years. We assumed that, at a minimum, most jails would periodically have inmates who required hospitalization, so seeing some jails without any reported “incidents of an unusual or serious nature” for long periods raised questions for us about the accuracy of the reporting. We also saw several cases in which jails were cited by DOC inspectors for not fully reporting incidents to DOC as required.

⁷⁹ DOC said that the shortage of mental health professionals in Minnesota could affect the feasibility of implementing this recommendation. Specifically, they noted that only licensed, independent clinical mental health professionals may make a mental health diagnosis. However, such a diagnosis is not necessarily required for designation of a person as SPMI; as indicated in Appendix A, there are several other qualifying criteria that would not require such a diagnosis.

⁸⁰ Courts have ruled that jails have certain responsibilities to protect inmates from self-harm. In a case decided by the federal appeals court that serves Minnesota, the court said that the U.S. Constitution prohibits jail officials from acting with deliberate indifference to a pretrial detainee's suicide risk (*Coleman v. Parkman*, 349 F.3d 534, 538 (8th Cir. 2003)). In a Minnesota case, the court said a jailer has a duty to protect a vulnerable, dependent inmate from self-harm if the risk of self-harm is reasonably foreseeable (*Sandborg v. Blue Earth County*, 615 N.W. 2d 61, 63-65 (Minn. 2000)).

⁸¹ *Minnesota Rules*, 2911.3700, subp. 4, published December 20, 2013.

Besides totaling the number of suicides and suicide attempts, we looked at documents in DOC records related to jail suicides that have occurred since January 2006.⁸² Those records indicated that, for most inmates who committed suicide, the jail reported having no prior knowledge of a mental illness or any earlier suicide attempts.⁸³

Litigation related to jails' services for inmates with mental illness has been relatively infrequent, but most settlements in such cases have involved inmates' suicides or attempts at self-harm.

Inmates or their families with complaints about jail services or practices may file civil actions in court. We asked county attorneys throughout the state to provide us with information on legal actions involving jails that serve adults. Specifically, we asked for information about cases won by the plaintiff or where a settlement was reached between January 2012 and July 2015. We then reviewed cases sent to us by county attorneys to identify any that were potentially related to inmates with mental illness. We identified seven such cases for the period we examined. These cases were settled for a total of about \$4.5 million. The settlements of individual cases ranged from \$15,000 to \$2 million.

Of the seven cases, four involved suicides and a fifth case involved an inmate with mental illness who severely injured himself in jail. These five cases of self-harm represented 94 percent of the total settlement amounts during the period we examined. Such incidents are a reminder of how important it is for jails to properly supervise, care for, and monitor inmates with mental illness or the potential for self-harm. The settlements in these cases also illustrate the potential taxpayer liability when jails do not prevent inmates from harming themselves.

In 41 percent of jail suicides since 2006, DOC cited the jail for a state rule violation.

We reviewed 27 suicides that occurred since 2006, and in 11 the jail was cited by DOC for a rule violation. DOC conducted a review of compliance with state rules in response to each suicide, looking at practices that could have placed the facility at risk for a suicide. For example, DOC looked at jail records for the hours before and after the suicide to see if jail staff conducted checks of all inmates within the minimum 30-minute time frame specified in state rules. Thus, some of the violations found by DOC may have contributed to the deaths; others might not have.

In the 11 suicides in which jails were cited for rule violations, each jail was cited for failure to properly perform well-being checks of inmates. In four suicides we reviewed, jail staff failed to perform any well-being checks over a one- to three-hour period, and this was the period when the suicide occurred.

⁸² We reviewed documents for 27 suicides. We did not review documents for one 2014 suicide that, as of mid-2015, was still under DOC review.

⁸³ According to American Foundation for Suicide Prevention, "Key Research Findings," <https://www.afsp.org/understanding-suicide/key-research-findings>, accessed November 5, 2015, studies have shown that at least 90 percent of people who commit suicide have mental disorders at the time of their deaths. As noted earlier in this chapter, Minnesota rules do not require jails to conduct mental health assessments of inmates. Thus, some of the inmates who committed suicide in Minnesota jails may have had mental illnesses that the jails had not detected.

In several cases, DOC's reviews of inmate suicides found violations of state rules in addition to those related to well-being checks. Specifically, DOC cited some jails for exceeding their authorized number of inmates, not completing mental health screening at the time the inmates were admitted, or not having accurate records of well-being checks.

Reviews of jail suicides in Minnesota have not been as comprehensive and timely as suggested by professional standards.

The National Commission on Correctional Health Care says that each inmate suicide should be followed by multiple reviews of the death, all completed no later than 30 days after the death.⁸⁴ Specifically, the commission calls for (1) an **administrative review** (to see where facility operations, policies, and procedures could be improved); (2) a **clinical mortality review** (to assess the care provided to the patient prior to the death); and (3) a **psychological autopsy** (a review of the decedent's life, focusing on mental health factors that may have contributed to the death).

State rules do not require jails to conduct any specific reviews of inmate suicides (or other deaths). DOC officials told us that they recommend that jails obtain an independent review of inmate deaths, but this is not required in rule. For each jail suicide we reviewed, we examined the documents related to that event that were on file with DOC.

The only external reviews of jail suicides we consistently saw were the compliance reviews conducted by the Department of Corrections. For each suicide, DOC assessed whether there were rule violations associated with the death. These reviews were more limited than those recommended by the National Commission on Correctional Health Care—for example, there was no review of the adequacy of mental health or clinical care given to the inmate.

Although the National Commission on Correctional Health Care recommends that suicide reviews be completed within 30 days, DOC completed only 3 of 27 suicide reviews since 2006 within this period. The median amount of time for completion of a DOC review was 109 days; the longest amount of time for a DOC review was over 400 days. Sometimes delays occurred because jails did not provide DOC with information about the deaths in a timely manner, despite repeated requests.⁸⁵

Earlier, we recommended that DOC update state rules for jails to better reflect professional standards. As part of that update, we think state rules should be amended to require timely external reviews (at a minimum, the reviews done by DOC) of inmate suicides.

⁸⁴ National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-A-10 (Procedure in the Event of an Inmate Death).

⁸⁵ DOC told us that it can take months to get a final medical autopsy report on a death. However, the National Commission on Correctional Health Care says that agency death reviews should not be delayed by a pending autopsy. If the medical autopsy is completed after the clinical review of the death, the clinical review should be appended with information from the autopsy. See NCCHC, *Procedure in the Event of an Inmate Death*, <http://www.ncchc.org/spotlight-on-the-standards-23-3>, accessed February 11, 2016.

INMATE COMPLAINTS

Compared with non-incarcerated people, inmates typically have more limited choices about health care services. Inmates who have access to a mental health counselor or psychiatrist in jail might not have more than one to choose from. If jails do not have specialized mental health staff, they may rely on medical doctors or nurses to address inmates with mental health problems.

Inmates can file complaints about a jail’s mental health services, but these complaints do not necessarily result in an independent assessment of a jail’s services.

Inmates who have complaints about the mental health services they receive in jail—or other jail practices—have several options. First, state rules require each jail to have a written procedure that outlines the process for inmates to submit grievances to jail officials.⁸⁶ This procedure must provide an inmate who files a grievance with at least one opportunity for appealing the grievance decision. The provision in Minnesota rules for a grievance process with one appeal opportunity is consistent with professional standards in the corrections field.

Second, inmates may file lawsuits regarding the services provided by a jail. However, as discussed in Chapter 1, the legal standards for demonstrating to a court that a jail’s services violate an inmate’s constitutional rights to health care can be difficult to meet. Earlier in Chapter 3, we said that there are relatively few lawsuits regarding jail services for persons with mental illness that are won by the plaintiff or result in monetary settlements.

Third, inmates may file complaints against individual health care practitioners with statewide regulatory boards. For example, the Minnesota Board of Medical Practice or the Minnesota Board of Nursing aim to protect public health and safety by assuring that doctors and nurses are competent. These boards would not, however, examine the overall adequacy of health care or mental health services provided by a jail. Rather, they would assess the actions of a specific practitioner.

For many years, Minnesota had a corrections ombudsman who had authority to independently investigate the actions of local jails and state prisons.⁸⁷ This office provided inmates with a complaint mechanism apart from those described above, although we were told that this office focused less of its efforts on jail inmates than on prison inmates. In 2003, the Legislature eliminated this office. In a 2014 report, we discussed the option of re-establishing an independent ombudsman as one way of providing greater oversight of health services in state-operated correctional facilities.⁸⁸ We said that such an office would probably cost the state at least \$250,000 annually. A state corrections ombudsman could also serve inmates in county jails, but this would undoubtedly require larger staffing levels than an office that only served prison inmates.

⁸⁶ *Minnesota Rules*, 2911.2900, published December 20, 2013.

⁸⁷ *Minnesota Statutes* 2002, 245.241 to 241.245.

⁸⁸ Office of the Legislative Auditor, Program Evaluation Division, *Health Services in State Correctional Facilities* (St. Paul, February 2014), 66, 73-76.

RECOMMENDATION

The Legislature should consider establishing a state ombudsman specifically focused on investigating issues related to mental health services in correctional or detention facilities.

Minnesota has an Office of the Ombudsman for Mental Health and Developmental Disabilities that investigates complaints related to human services agencies, facilities, or programs, but this office is not authorized by state law to investigate cases involving corrections or detention facilities.⁸⁹ Just as persons with mental illness in human services facilities may be vulnerable to abuse and neglect, or unable to effectively advocate on their own behalf, the same may be true of inmates with mental illnesses. As we discuss in Chapter 4, these individuals may be in jail for weeks or months while awaiting the resolution of a criminal case, a decision on their competency to stand trial, or action that would lead to their civil commitment.

We think the Legislature should consider various options for establishing an ombudsman function. First, the Legislature could establish a corrections ombudsman whose scope is specifically focused on inmates with mental illness in jails and prisons. Second, rather than creating a new office, the Legislature could amend the statutes of the Ombudsman for Mental Health and Developmental Disabilities, authorizing and funding that office to supplement its existing activities by investigating cases involving inmates with mental illness; those cases are now outside of that office's jurisdiction. Third, the Legislature could re-establish an Ombudsman for Corrections office that would be authorized to investigate complaints from all jail and prison inmates, not just complaints related to mental health services. We think there is justification for either of the first two options, although the cost of these options would need to be explored. The third option would address a more broad-based range of issues than our evaluation examined, and we offer no opinion on this option.

⁸⁹ *Minnesota Statutes* 2015, 245.91 to 245.97.

Chapter 4: Competency and Commitment Processes

When people with mental illness are taken into custody by police, their well-being may depend partly on the mental health services available in the community (discussed in Chapter 2) or in jail (discussed in Chapter 3). In addition, court processes—to determine whether individuals are mentally competent to stand trial, or to commit individuals involuntarily to a treatment program—may also have important impacts on these individuals. This chapter discusses the timeliness and adequacy of these court processes and offers recommendations for improvement. It also discusses the so-called “48-hour law,” which is used mostly for individuals deemed incompetent by a court.

KEY FINDINGS IN THIS CHAPTER

- **Unlike in most states, Minnesota defendants found incompetent by a court to stand trial due to mental illness must undergo a separate commitment process to receive treatment to restore their competency.**
 - **Individuals sometimes remain in jail while they await court action on their civil commitment petitions, which may violate state law, court rules, and the individuals’ constitutional rights.**
 - **A 2013 state law—the “48-hour law”—was supposed to result in prompt placement of certain jail inmates into Department of Human Services treatment facilities, but it has not always worked as intended.**
-

BACKGROUND

For individuals with mental illness taken into police custody, there are three primary ways (shown in the box) in which the person’s mental illness could affect the events that follow in court. First, a defendant could be **found not guilty by reason of mental illness**. In such a case, the defense contends that the defendant was not responsible for criminal actions that resulted from a mental illness.¹ This is commonly called the “insanity defense.” Second, a court could **determine that a defendant is incompetent to stand trial**. If a defendant lacks the capacity—due to mental illness or mental deficiencies—to understand the forthcoming legal proceedings or consult in a rational way with defense counsel, the person may be deemed incompetent. This could

Possible Court Actions Related to a Person’s Mental Illness

1. Found not guilty of a criminal offense by reason of mental illness
2. Found incompetent to stand trial for a criminal offense
3. Civilly committed as a person who is mentally ill—may or may not be related to a criminal case

¹ *Minnesota Statutes* 2015, 611.026, says that persons with mental illness or cognitive impairment “shall not be excused from criminal liability except upon proof that at the time of committing the alleged criminal act the person was laboring under such a defect of reason...as not to know the nature of the act, or that it was wrong.”

result in either a suspension or dismissal of the criminal case. Third, a court could **civily commit a person as mentally ill**. Requests to a court (known as “petitions”) to civilly commit an individual may be filed in connection with criminal charges—for example, after a person has been found incompetent to stand trial or not guilty by reason of mental illness. Alternatively, requests for civil commitment may be filed with a court solely in response to an individual’s mental health symptoms, without connection to a criminal case.²

Our evaluation did not look at the insanity defense, which is rarely used successfully in criminal cases in the United States. However, this section discusses the other two events—competency determinations and civil commitments of persons with mental illness.

Competency to Stand Trial

This section describes the legal standard used to determine competency to stand trial. It also describes the processes by which courts assess the competency of individuals.

Legal Standard

Minnesota law defines what constitutes incompetence to stand trial in the following provision:

No person having a mental illness or cognitive impairment so as to be incapable of understanding the proceedings or making a defense shall be tried, sentenced, or punished for any crime.³

In addition, the Minnesota judicial branch’s rules of criminal procedure provide the following definition of incompetence:

A defendant is incompetent and must not plead, be tried, or be sentenced if the defendant lacks ability to: (a) rationally consult with counsel; or (b) understand the proceedings or participate in the defense due to mental illness or deficiency.⁴

These definitions are broad; for example, they do not specify exactly what it means to “understand the proceedings” of a criminal case.⁵ In practice, court-ordered evaluations of competency often assess the types of things such as those shown in the box on this page.

Examples of Topics That are Usually Addressed in Competency Examinations

- What do the charges against me mean?
- What is the role of the prosecutor, the defense attorney, and the judge?
- What are my plea options, and what would be the consequences of each?
- What will be the sequence of events as the criminal case proceeds?
- What things should I tell my defense attorney?
- Who should I talk with if I don’t understand something in court?
- How should I behave in court?

² Even if someone has been arrested, a county attorney might decide not to file criminal charges in the case and to file a petition for civil commitment instead.

³ *Minnesota Statutes* 2015, 611.026.

⁴ *Minnesota Rules of Criminal Procedure*, 20.01, subd. 2, effective March 1, 2015.

⁵ Case law provides some additional guidance. See Ronald Roesch, Patricia Zapf, Stephen Golding, and Jennifer Skeem, *Defining and Assessing Competency to Stand Trial*, http://www.justice.gov/sites/default/files/eoir/legacy/2014/08/15/Defining_and_Assessing_Competency_to_Stand_Trial.pdf, accessed November 13, 2015.

Process for Determining Competency

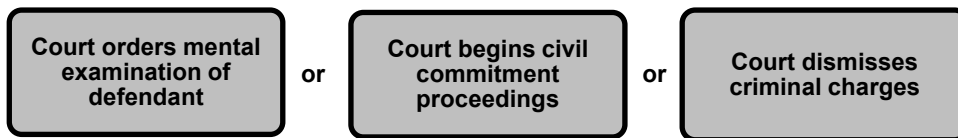
Exhibit 1.6 (in Chapter 1) provided an overview of the competency determination process. A prosecutor or defense attorney may make a motion in court to challenge the competency of a criminal defendant, or the judge may independently challenge a defendant’s competency. The defendant’s consent is not required for the court to consider such a motion. However the process begins, the judge determines whether there is reason to doubt the defendant’s competency. If so, the criminal case must be suspended, and the actions shown in Exhibit 4.1 must be taken.

Exhibit 4.1: Process After Court Determines There Is Reason to Doubt a Defendant’s Competency

For Felony or Gross Misdemeanor Cases

Court orders mental examination of defendant

Options for Misdemeanor Cases



SOURCE: *Minnesota Rules of Criminal Procedure*, 20.01, subd. 3, effective March 1, 2015.

The judge may order the defendant to be examined by a court-appointed examiner, regardless of whether the case involves felony, gross misdemeanor, or misdemeanor charges.⁶ The exam is often done in jail or on an outpatient basis, although the court may order the defendant to a facility for up to 60 days for the exam. The examiner must submit to the judge a written report on the individual’s competence. The judge considers the examiner’s report and any other evidence, and then decides “by the greater weight of the evidence” whether the defendant is competent to stand trial.⁷ If a defendant is found incompetent due to mental illness, the person cannot be ordered to competency treatment unless the person is also civilly committed. Thus, for incompetent persons who are not

⁶ The examiner must be a physician, psychologist, advanced practice registered nurse, or physician assistant, subject to additional requirements specified in *Minnesota Statutes* 2015, 253B.02, subd. 7. One of Minnesota’s judicial districts (Hennepin County) uses its own employees to conduct examinations, while others contract for these services.

⁷ *Minnesota Rules of Criminal Procedure*, 20.01, subd. 5(f), effective March 1, 2015.

already under a commitment order and who still face criminal charges, state court rules say that “the court must commence a civil commitment proceeding.”⁸

Civil Commitment

This section describes the legal standards used to determine whether an individual may be involuntarily committed to treatment. It also describes the processes by which the courts make decisions about whether to make commitments.

Legal Standard

Using criteria established in Minnesota’s civil commitment laws, a court may involuntarily commit a person to treatment as mentally ill. The commitment law’s definition of a “person who is mentally ill” was shown in Chapter 1 (see Exhibit 1.7).⁹ To make a commitment, the court must find that there is no suitable alternative to judicial commitment.¹⁰

The legal standard for civilly committing an individual as mentally ill uses different criteria than the standard for incompetency discussed above. The commitment criteria focus on the individuals’ mental illness and dangerousness to self or others; the competency criteria focus on the impact of mental illness on the defendants’ ability to understand court proceedings or participate in their own defense. Also, for an involuntary commitment, the court must determine that the person is mentally ill and needing commitment “by clear and convincing evidence”—which is a higher legal standard than the “greater weight of the evidence” required to find someone incompetent to stand trial.¹¹ The higher standards required for civil commitment reflect the fact that involuntary commitment typically results in a loss of liberty for the person being committed.

Process for Commitment of a Person with Mental Illness

State law says: “Voluntary admission [to treatment] is preferred over involuntary commitment and treatment.”¹² However, the law establishes a process for court-ordered commitment of persons who need mental health treatment but do not consent to it.

Exhibit 4.2 provides an overview of the commitment process. The process begins with “prepetition screening,” a preliminary investigation by a county human services agency to

⁸ *Minnesota Rules of Criminal Procedure*, 20.01, subd. 6(b)(1), effective March 1, 2015. If a defendant was deemed incompetent and the charge was a misdemeanor, the court rules require that the charge be dismissed.

⁹ The commitment law establishes separate definitions of a “person who is mentally ill” and a “person who is mentally ill and dangerous to the public.” Individuals in either category may pose a danger to others, but to commit someone as “mentally ill and dangerous” requires the court to meet a higher standard—among other things, finding a “substantial likelihood” that the person will try to inflict “serious physical harm” on others. Our discussion in this chapter does not specifically address commitments of persons as “mentally ill and dangerous,” a type of commitment that the courts use far less frequently than commitments of individuals as “mentally ill.”

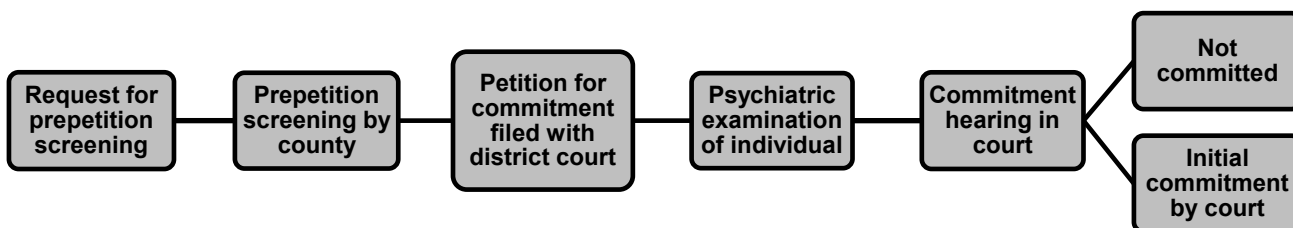
¹⁰ *Minnesota Statutes* 2015, 253B.09, subd. 1(a). The law requires the court to carefully consider “reasonable alternative dispositions, including but not limited to, dismissal of petition, voluntary outpatient care, voluntary admission to a treatment facility, appointment of a guardian or conservator, or release before commitment.”

¹¹ *Minnesota Statutes* 2015, 253B.09, subd. 1(a), requires courts to make commitment findings by “clear and convincing evidence,” and *Minnesota Rules of Criminal Procedure*, 20.01, subd. 5(f), effective March 1, 2015, requires courts to make competency decisions “by the greater weight of evidence.”

¹² *Minnesota Statutes* 2015, 253B.04, subd. 1.

evaluate whether an individual meets commitment requirements. This screening may be requested by a family member or other “interested person.” As defined in statute, an “interested person” may include a public official, local welfare agency, health plan that is providing coverage for the individual, legal guardian, spouse, parent, legal counsel, adult child, next of kin, or other person designated by the client.¹³

Exhibit 4.2: Process for Civil Commitment of Individuals as Mentally Ill



NOTES: This represents a simplified depiction of the sequence of steps outlined in statutes for civil commitments, from the request for prepetition screening to the court’s initial commitment decision. State law requires the court to have a hearing on a petition within 14 days of the petition’s filing, although this may be extended by the court for up to an additional 30 days “for good cause.” Statutes do not indicate what might constitute “good cause.”

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2015, Chapter 253B.

After prepetition screening, an interested person can file a petition for an individual’s commitment in district court.¹⁴ The petition must request any court actions necessary to ensure that the person takes medications related to their mental illness, if such medications have been recommended by the treating physician.

Once a petition has been filed, the court must appoint someone to conduct a psychiatric examination of the individual. If criminal charges are pending, the examiner may simultaneously evaluate the individual for civil commitment and competency to stand trial, but only if the prosecutor and defense counsel agree that simultaneous examinations are appropriate.¹⁵

State law says that persons subject to the commitment law—including persons who are the subject of commitment petitions—may not be confined in a jail or correctional facility.¹⁶ However, the law authorizes “temporary confinement” in other types of facilities at county expense—for the purposes of observation, evaluation, diagnosis, treatment, and care.¹⁷

¹³ *Minnesota Statutes* 2015, 253B.02, subd. 10. A screening team’s recommendation for commitment must be submitted to the county attorney.

¹⁴ If the prepetition screening did not recommend commitment, an interested person may still file a petition for commitment, and the county attorney decides whether to proceed with the petition.

¹⁵ *Minnesota Statutes* 2015, 253B.07, subd. 2a. We heard from some judges that the statutory provision authorizing simultaneous evaluations has been rarely used.

¹⁶ *Minnesota Statutes* 2015, 253B.045, subd. 1. This statute makes an exception to this general provision if the court makes “a finding of necessity to protect the life of the proposed patient or others.”

¹⁷ *Minnesota Statutes* 2015, 253B.045, subs. 2 to 4; and 253B.07, subd. 2b. State law also provides for health plans or DHS to pay for certain costs related to temporary confinement in some situations.

A court hearing on a mental illness commitment petition must be held within 14 days of the petition's filing. For "good cause," the court may extend the date of the hearing up to an additional 30 days.¹⁸

If the court decides to commit an individual as mentally ill, it may commit the person to either the commissioner of human services (thus allowing the commissioner to determine the state-operated facility at which to place the individual) or to a specific treatment program.¹⁹ If the court commits the person to a specific program, it must do so to the least restrictive program that can meet the individual's treatment needs.

For persons civilly committed after being deemed incompetent, commitments are made to the Department of Human Services, which operates the state's only "competency restoration" programs to which these individuals have been committed.²⁰ Treatment programs that are aimed at restoring a person's competency to stand trial often include educational components, focused on teaching defendants about the court process. In addition, these programs often try to ensure that participants comply with prescribed medications.

The initial commitment of a person with mental illness begins on the date of the court order, and it cannot exceed six months. When the first commitment expires, the court may continue the commitment for up to 12 months at a time.

ISSUES WITH THE COMPETENCY PROCESS

We took a closer look at how the competency process works in practice. In this section, we discuss issues related to its timeliness, the extent to which incompetent individuals are committed to treatment, and the settings in which treatment is provided.

Timeliness

Before we discuss our analysis of court data regarding the timeliness of the competency process in detail, it is useful to consider general perspectives we heard from local officials about the timeliness of court processes for individuals with mental illness. We conducted statewide surveys of two groups: (1) county sheriffs who operate the jails, and (2) county human services directors, whose agencies oversee community-based mental health services.

Most sheriffs and county human services directors said they would like to see faster ways to resolve criminal cases or make placements so that inmates with mental illness spend less time in jail.

¹⁸ *Minnesota Statutes* 2015, 253B.08, subd. 1(a). The statutes do not indicate what might constitute "good cause."

¹⁹ *Minnesota Statutes* 2015, 253B.09, subds. 1(a) and 1(c).

²⁰ Recently, Hennepin County started its own competency restoration program for individuals who are not competent to proceed in the criminal system but are willing to receive voluntary mental health treatment without being ordered to treatment through the civil commitment process. If these individuals succeed in voluntary treatment, the court may not have to commit them to the state for treatment, including competency restoration. All parties in the criminal and civil cases must agree to the person's participation in the county program. Hennepin County has targeted its competency restoration program toward persons who were in jail at the time they were determined incompetent to stand trial.

In our surveys, 97 percent of sheriffs and 63 percent of county human services directors said that, in their opinion, there should be faster ways to resolve cases involving inmates with mental illness, thus reducing the time spent in jail. In our discussions with state and local officials and reviews of research literature, we heard concerns that the confinement and isolation of jail can be especially challenging for people with mental illness and may sometimes worsen mental health symptoms. Inmates with mental illness may also be vulnerable to victimization in jail. Furthermore, some research suggests that persons with mental illness may be more likely than other inmates to be segregated while incarcerated. In addition, individuals are constitutionally entitled to a speedy trial, including during cases in which their competency to stand trial is assessed.²¹

Most sheriffs expressed concern about the amount of time that people suspected of having mental illness spend in jail, regardless of the types of charges filed against them. Exhibit 4.3 shows, for example, that 78 percent of sheriffs said that persons with mental illness charged with higher level crimes (felonies or gross misdemeanors) always, almost always, or often spend too much time in jail waiting for the court to make competency determinations.²²

The process for determining individuals' competency to stand trial and refer them to treatment requires multiple court decisions and can be lengthy.

Two separate decisions must be made by a court to place someone into a competency restoration program: (1) a decision that the person is incompetent to stand trial and (2) a decision that the person should be civilly committed. If a court finds an individual to be incompetent to stand trial, this finding is not by itself a basis in Minnesota for involuntary commitment to a program to restore the individual's competency. Individuals deemed incompetent—unless they are already under a civil commitment—must be subsequently committed by a court as mentally ill to be placed into a program for competency restoration.

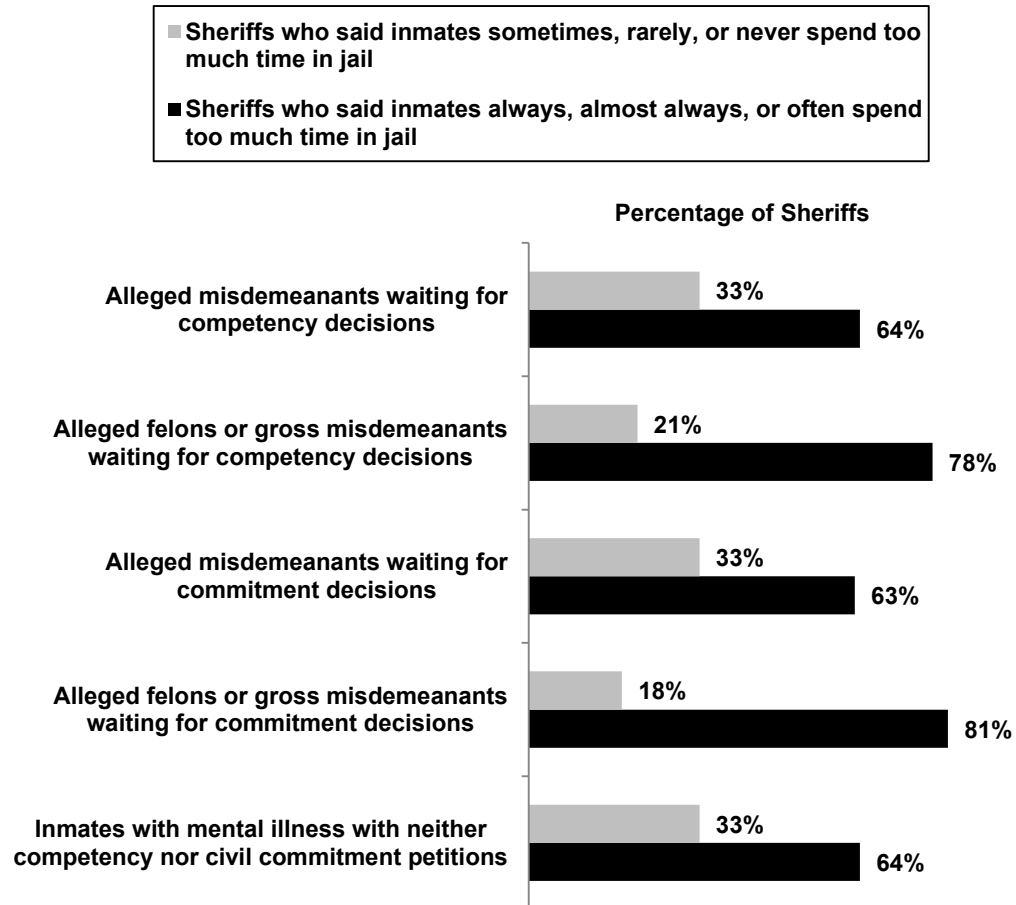
Minnesota is one of just a few states that require a mental health commitment—separate from the court's competency determination—to compel a person to participate in competency treatment.²³ In most states (and the federal government), a finding of

²¹ The Sixth Amendment of the U.S. Constitution says: "In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial..." In 2009, a Minnesota court overturned the conviction of a man due to court delays in determinations of his competency to stand trial. A court examiner concluded that the defendant was incompetent, but the court did not make a competency determination and the man then remained in jail for three months before a commitment petition was filed. *State v. Faulkner*, No. A07-1877, Minn. App. Unpub. LEXIS 227, 2009 WL 510807 at *1, 16 (Minn. Ct. App., Mar. 3, 2009), review denied (Minn. May 27, 2009).

²² When asked the same questions, county human services directors were much less likely than sheriffs to say that the categories of inmates shown in Exhibit 4.3 spent too much time in jail. However, 24 to 38 percent of the responding human services directors answered "don't know or no opinion" on these questions, perhaps suggesting that, as a group, human services had less direct experience with this issue than the sheriffs. Court staff told us they would like to have more timely court processes, if possible, but they also said it takes time for various steps in the court process to occur—such as finding a competency examiner, arranging for the examination, and having the examiner prepare a report for the court.

²³ The 2014 Legislature amended state law to allow simultaneous competency and civil commitment examinations in certain circumstances, but some judges told us this has not yet been used very often.

Exhibit 4.3: Sheriffs' Opinions about the Time Spent in Jail by Inmates Who May Have Mental Illness



SOURCE: Office of the Legislative Auditor, survey of county sheriffs, August to October 2015 (N=73).

incompetency can, by itself, be a basis for involuntary placement of the individual to treatment.²⁴

Minnesota's judicial process for getting a person with mental illness into competency treatment typically takes several weeks. We reviewed court data for criminal cases in which competency motions were made during 2010 through 2014. We limited our review to cases in which the courts reported dates for both the order for a competency evaluation and the court's decision on competency.²⁵ The median time it took from a court's order for a competency evaluation to the court's competency finding was 50 days. Once this

²⁴ Robert Miller, "Hospitalization of Criminal Defendants for Evaluation of Competence to Stand Trial or for Restoration of Competence: Clinical and Legal Issues," *Behavioral Sciences and the Law*, 21 (2003): 369-391, notes that some states *require* judges to place incompetent defendants, while some merely *authorize* this. Regarding federal provisions, see *18 U.S. Code*, sec. 4241 (2012).

²⁵ As noted in Chapter 1, we found that the courts' statewide electronic database contained findings for only 58 percent of the criminal cases with orders for competency evaluation during this period.

occurred, the second step—the court’s decision on whether to civilly commit the person to a treatment program—took a median of 20 additional days.

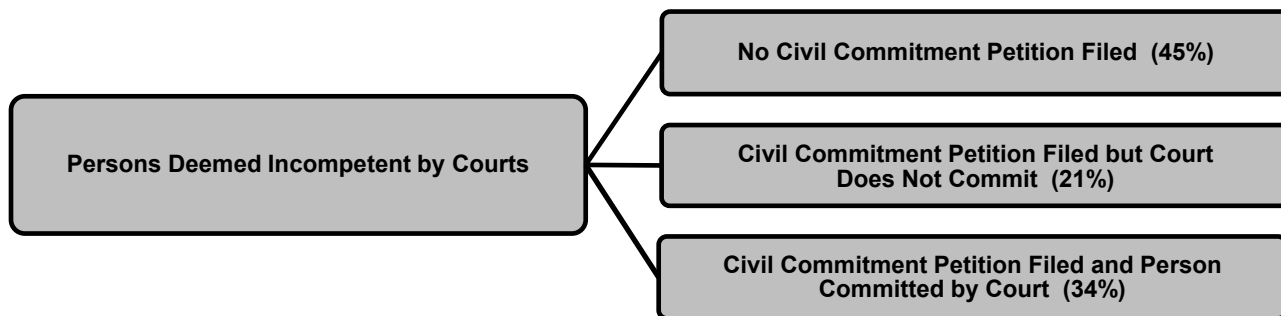
Referral to Treatment

A court’s designation of a criminal defendant as incompetent to stand trial does not automatically lead to that person’s commitment to a treatment program. The standards established in state law to civilly commit someone as mentally ill are more difficult to meet than the standards established in state court rules for determining that someone is incompetent to stand trial. For example, someone who is found incompetent cannot be committed by a court if the person does not pose a danger to self or others.

Many defendants deemed legally incompetent to stand trial do not receive treatment to help them achieve competency.

We examined court data (2010 through 2014) on 1,545 instances in which individuals were found incompetent to stand trial.²⁶ Exhibit 4.4 summarizes what happened next in these cases. In 34 percent of these cases, the person was committed by the court and presumably entered treatment to restore competency.²⁷ But in the remaining 66 percent of these cases, one of two things happened: (1) no one filed a petition to commit the incompetent person or (2) a commitment petition was filed, but the court did not decide to commit the individual, based on information provided in the commitment hearing.²⁸ In these cases,

Exhibit 4.4: Actions Taken by Minnesota Courts Following Incompetency Determinations, 2010-2014



NOTES: The analysis was based on 1,545 competency determinations in 2010 to 2014. The analysis required assumptions to determine which individual commitment cases were related to individual incompetency cases and to eliminate duplicate cases, so the percentages in this exhibit represent estimates.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Courts Information System data.

²⁶ Some of the individuals whose cases we reviewed had more than one instance during this period in which they were found incompetent to stand trial and then had a commitment petition filed.

²⁷ The 34 percent figure includes seven cases in which the person was committed for chemical dependency rather than mental illness.

²⁸ As we noted earlier in this chapter, commitment petitions may be filed by an “interested person.” As defined by statute, this could be a local welfare agency, health plan that is providing coverage for the individual, legal guardian, spouse, parent, legal counsel, adult child, next of kin, or other person designated by the client.

there was no legal basis to involuntarily treat the individual's incompetency. Again, because the statutes specify different standards for determining that someone is incompetent and involuntarily committing a person to treatment, it is very possible for the courts to determine, based on the circumstances of a case, that someone who has been found incompetent does not meet the standard for civil commitment.

There was some relationship between the seriousness of the criminal charges individuals faced and what occurred after they were deemed incompetent. For example, incompetent persons charged with felonies were much more likely to be civilly committed than were incompetent persons who had been charged with misdemeanors.²⁹ Still, there were sizable numbers of incompetent persons facing felonies for whom commitment petitions were never filed or for whom commitments did not occur.³⁰

Local officials told us that incompetent individuals that are not committed to a treatment program to restore their competency may simply be released from custody.³¹ These individuals are sometimes referred to by local officials as "gap cases," because they can fall through the cracks of the criminal justice and mental health service systems. Many may not receive treatment to restore competency or address their mental illnesses. In 2014, the state's most populous county (Hennepin) started assigning county caseworkers to certain jail inmates with mental health issues, including individuals subject to competency motions. Hennepin County began this initiative in an effort to ensure that these individuals could get access to social services and apply for health care coverage, particularly in the event that they would not be civilly committed by a court. In other counties, individuals deemed incompetent but not civilly committed might be released from custody without receiving treatment or services.

We could not conclusively track statewide trends in the number of "gap cases" over time, due to the large amount of missing data on competency decisions in court data.³² However, our analysis of statewide court data for persons charged with crimes indicated that the number of orders for competency evaluation statewide has increased faster than the number of civil commitment cases for mental illness. Between 2010 and 2014, the number of court orders for competency evaluations increased approximately 87 percent, while the number of commitment petitions for mental illness increased approximately 44 percent.³³ This raises the possibility that growing numbers of incompetent defendants have been released without having been civilly committed into treatment programs. Without having complete statewide data on the outcomes of competency motions, however, we cannot be certain.

²⁹ About 40 percent of incompetent persons facing felony charges were civilly committed, compared with 22 percent of incompetent persons facing misdemeanor charges.

³⁰ Of the 936 individuals we tracked who were charged with at least one felony, there was no commitment petition filed for 391 of them; 174 were the subject of a commitment petition but they were not committed.

³¹ As noted earlier, state rules of criminal procedure stipulate that if a person is found incompetent to stand trial, misdemeanor charges against the person must be dismissed, and felony or gross misdemeanor charges must be suspended.

³² In Chapter 1, we reported that Minnesota's statewide electronic court information system often does not indicate the outcome of motions to determine a defendant's competency to stand trial.

³³ In our analysis, we excluded orders for competency evaluation and commitment petitions that appeared to be duplicates in the court records. The percentage increase in the number of orders for competency evaluation reported here is different from the increase in orders for competency evaluation reported in Chapter 1 because some individuals may have had more than one criminal case with the same order for competency evaluation.

Restrictiveness of Competency Treatment

State law says that courts should commit individuals to the “least restrictive treatment program or alternative programs which can meet the patient’s treatment needs.”³⁴ The law directs courts to consider a range of treatment alternatives, including nonresidential, residential, and hospital settings. The court may also commit a person to the commissioner of human services rather than to a specific program, leaving it to the commissioner to then determine where to place the individual. State law gives the commissioner no specific guidance for deciding where to place a committed individual.

Minnesota’s almost exclusive reliance on secure inpatient facilities to provide competency restoration treatment appears to be inconsistent with statutory requirements for commitments to the “least restrictive” programs.

DHS officials told us that nearly all persons involuntarily committed for competency restoration have been sent to one of two secure inpatient facilities: the Minnesota Security Hospital in St. Peter or the Anoka-Metro Regional Treatment Center.³⁵ The Anoka facility is in extremely high demand as the only state-operated hospital that has sufficient staffing to handle individuals with the most serious mental health symptoms and aggressive behaviors.³⁶ As of late October 2015, however, 46 percent of the individuals at Anoka for competency treatment did not, according to Anoka staff, require a hospital level of care.

Some DHS officials noted that many court commitment orders for competency restoration contain language that requires placement of the individuals in a “safe and secure” setting.³⁷ However, they said that some people in the state’s competency restoration services could be treated in less restrictive places than the Anoka-Metro Regional Treatment Center and Minnesota Security Hospital. Even if such less restrictive placements are not realistic at the beginning of the commitment, they might be reasonable at a later stage.

Recommendations

As discussed above, the process for committing a person to competency treatment can be lengthy. Under Minnesota’s court rules of criminal procedure, persons found incompetent must have the criminal charges against them dropped or suspended.³⁸ If a court does not commit such persons to competency restoration treatment, their criminal cases would have no basis for proceeding, and they might not be referred by a county for voluntary treatment of their mental health issues. Local officials expressed concern that these individuals frequently reappear in the criminal justice system at a later date.

³⁴ *Minnesota Statutes* 2015, 253B.09, subd. 1(a).

³⁵ DHS officials told us they have occasionally worked with the courts to serve persons committed for competency restoration at home or in small residential treatment facilities.

³⁶ The Minnesota Security Hospital in St. Peter is called a hospital, but it is not licensed as one.

³⁷ However, it is worth reiterating that *Minnesota Statutes*, 2015, 253B.09, subd. 1(c), gives the commissioner of human services authority to designate the location of a person committed to the commissioner.

³⁸ *Minnesota Rules of Criminal Procedure*, 20.01, subd. 6(b), effective March 1, 2015.

RECOMMENDATION

The Legislature should amend *Minnesota Statutes 2015, Chapter 253B*, to:

- **Create a commitment category specifically for competency restoration. Courts would be authorized in law to commit an individual to competency treatment based solely on a court finding of incompetency, without having to go through a separate commitment process.**
 - **Require that individuals deemed incompetent but no longer facing criminal charges be referred to their county human services agency for follow-up.**
-

Specifically, we recommend that courts be authorized to involuntarily commit individuals facing felony or gross misdemeanor to competency treatment as soon as they are deemed incompetent by the court. Under court rules, persons deemed incompetent to face felony or gross misdemeanor charges have those charges suspended but not dismissed. Creating a commitment category for this population would help to expedite the process of getting individuals into treatment to restore competency. Individuals would not have to wait (perhaps in jail, as described later in this chapter) for completion of a separate commitment process. Implementation of this recommendation may also help to ensure that more of the individuals who continue to face criminal charges after being found incompetent to stand trial will be placed in a competency restoration program.

In contrast, state rules of criminal procedure require the dismissal of charges against individuals who faced misdemeanor charges and were deemed incompetent. We recommend that the Legislature adopt a statutory provision that would require these individuals be referred to county human services following their incompetency determination. Even though criminal charges have been dropped, these individuals may still benefit from mental health services, such as case management or treatment. The incompetency finding provides an opportunity to link these individuals to services on a voluntary basis.

For the individuals who would be subject to the new commitment category, we recommend that state law be amended to stipulate that a person be held for a period of time no longer than is reasonably required to determine whether the individual can be made competent.³⁹ A person who cannot be made competent would have criminal charges dropped and be released, although the person could still be committed by a court as mentally ill. Among persons discharged from the DHS Competency Restoration Program in 2013 or 2014, about

³⁹ In *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), the U.S. Supreme Court said that “a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.”

85 percent were deemed competent by a DHS psychologist.⁴⁰ Persons who entered this program in fiscal year 2014 spent a median of 142 days in the program.⁴¹

Implementing these recommendations could have fiscal impacts, although we did not make specific estimates. If state law is amended to allow courts to place incompetent persons in treatment without having to meet existing state standards for civil commitment, it is possible that the state's competency restoration programs would have to accommodate more referrals for treatment.

RECOMMENDATION

For persons committed to the commissioner of human services for competency restoration, DHS should have a continuum of placement options that it can choose from, rather than just high-security settings.

State statutes do not specifically require DHS to place committed individuals in the least restrictive setting that can meet their needs, but the commitment statute imposes this requirement on commitments the courts make to specific programs, and it seems reasonable for DHS to apply this same or a similar standard. A 1999 U.S. Supreme Court ruling that addressed states' placement of individuals with mental disabilities said that "unjustified isolation... is properly regarded as discrimination based on disability."⁴² In addition, placements of certain individuals into less restrictive competency restoration programs, where appropriate, might be less expensive than placements in high-security settings. If an individual committed to DHS for competency restoration requires placement in a secure setting to protect others from that person's behaviors (or to protect the individual from others), DHS would still have the option of placing that person in its secure St. Peter or Anoka facilities. But if an individual could be served safely in a less-secure setting, DHS should have these options available.

PERSONS IN JAIL WHILE COMMITMENT DECISIONS ARE PENDING

The population of individuals who have been civilly committed by a court as mentally ill includes some people who were facing criminal charges when the court considered the commitment petition and some who were not. For those who faced criminal charges—especially those committed to a competency restoration treatment program—it can take weeks or months from the time of arrest until the time of the commitment decision. We used statewide court data to examine the time that elapsed between the time when

⁴⁰ This percentage was calculated based only on persons whose competence was deemed "restored" or "not restorable" by a DHS psychological evaluator; DHS said the courts rarely challenge the opinion of the evaluator. A few individuals were not included in this calculation because their charges were dropped during their stay in the program, their discharge from the program was approved by a court, or they returned to jail prior to program completion.

⁴¹ This median reflects the total amount of time the individuals sent to the Competency Restoration Programs at the Minnesota Security Hospital in St. Peter or the Anoka-Metro Regional Treatment Center spent at those facilities. Individuals stay at these facilities until a suitable discharge location is found, and sometimes this means staying beyond the completion of the program.

⁴² *Olmstead v. L.C.*, 527 U.S. 581, 597 (1999).

prosecutors filed a criminal case in a court and when a commitment decision occurred. Over a five-year period (2010 to 2014), the median elapsed time was 75 days.

Defendants may spend all or part of the time they are awaiting trial in jail. Courts may order defendants released from custody without bail so long as the court determines they are not a public safety risk and they are deemed likely to appear in court. Alternatively, a court may determine that a defendant who poses a public safety or flight risk may only be released if the defendant complies with conditions set by the court.⁴³ Defendants who do not comply with the court's release conditions wait in jail to appear in court.

Some criminal defendants have been held in jail awaiting civil commitment after being deemed mentally incompetent by the courts, which may be contrary to state law, court rules, and inmates' constitutional rights.

State law says:

Except when ordered by the court pursuant to a finding of necessity to protect the life of the proposed patient or others or as provided under [Minnesota Statutes 2015, 253D.10], no person subject to the provisions of [the civil commitment chapter] shall be confined in a jail or correctional institution.⁴⁴

In other words, persons who are under civil commitment—as well as those for whom the court is considering a request for commitment—may not be incarcerated unless so ordered by a court for the purpose of protecting human life. However, state law directs counties to “maintain or provide” non-jail facilities that can temporarily confine such individuals for observation, evaluation, diagnosis, treatment, and care.⁴⁵

In addition, jails do not have clear authority to hold someone who is not subject to criminal prosecution. If a court determines that a person facing criminal charges is incompetent to stand trial, the charges against the person must be suspended or dismissed, according to court rules, depending on the nature of the alleged offenses.⁴⁶ Thus, persons who have been found incompetent and are awaiting a court decision on commitment as a mentally ill person do not have a clear basis for being in jail.

Courts in some other jurisdictions have ruled that holding incompetent individuals in jail for prolonged periods is a violation of the U.S. Constitution. In Chapter 1, we said that the courts have established high standards for demonstrating evidence of constitutionally inadequate care or treatment in prisons or jails; courts have generally required evidence that

⁴³ The conditions may include: (1) a person or organization agrees to supervise the defendant; (2) the court imposes restrictions on the defendant's travel, associations, or residence during the period of release; (3) the court requires the person to post an appearance bond, cash deposit, or other security; or (4) the court imposes other conditions to assure the defendant's reappearance in court.

⁴⁴ *Minnesota Statutes* 2015, 253B.045, subd. 1. *Minnesota Statutes* 2015, 253D.10, is in a chapter of statutes related to civil commitment and treatment of sex offenders.

⁴⁵ *Minnesota Statutes* 2015, 253B.045, subd. 2.

⁴⁶ *Minnesota Rules of Criminal Procedure*, Rule 20.01, subd. 6, effective March 1, 2015. It is worth noting that the notion of “suspended” charges appears to be established entirely in court rules of criminal procedure, not in state statutes. The state criminal code (*Minnesota Statutes* 2015, Chapter 609) has provisions regarding the “dismissal” but not the “suspension” of criminal charges.

the facilities were “deliberately indifferent” to the serious health care needs of the inmates. But in an Oregon case, the Ninth Circuit Court of Appeals upheld a lower court’s injunction ordering the state to transfer incompetent individuals to a treatment facility and out of jail within seven days of the court’s finding of incompetence.⁴⁷ The Court said that the “deliberate indifference” standard does not solely govern the constitutional due process rights of incompetent criminal defendants.⁴⁸ Similarly, a district court required the State of Washington to move individuals from jail to competency services within seven days of a court order for competency treatment, consistent with a policy established by that state’s legislature.⁴⁹ The court said:

A seven-day limit is required by the Constitution because of the gravity of the harms suffered by [incompetent defendants] during prolonged incarceration—harms which directly conflict with [their] rights to freedom from incarceration and to the competency services which form the basis of their detention, and also directly conflict with the State’s interests in swiftly bringing those accused of crimes to trial and in restoring incompetent criminal defendants to competency.... Each additional day of incarceration causes further deterioration of [incompetent individuals’] mental health, increases the risks of suicide and of victimization by other inmates, and causes illness to become more habitual and harder to cure, resulting in longer restoration periods or in the inability to ever restore that person to competency.⁵⁰

These court rulings raise questions about the constitutionality of keeping incompetent persons in jail for extended periods. The cases are not binding in Minnesota and have circumstances unique to the jurisdictions in which they occurred, but a Minnesota court could look to them for persuasive value.

Using statewide court records, we identified criminal defendants in Minnesota who were found incompetent in 2014 and were then the subject of a petition for civil commitment. We used a Department of Corrections detention database to determine whether these individuals were in jail during the period of time when they were awaiting commitment. We found that about 63 percent of incompetent individuals were in jail for all or part of the period between the date the commitment petition was filed and the date of the court’s commitment decision. Of those incompetent persons who were in jail while awaiting commitment, 72 percent remained in jail for at least seven days during this waiting period.⁵¹

It is possible that, in some of the cases we reviewed, persons with commitment petitions remained in jail because there were court orders that required this.⁵² However, the law

⁴⁷ Oregon Advocacy Center v. Mink, 322 F.3d 1101, 1105 (9th Cir. 2003).

⁴⁸ *Ibid.*, at pp. 1120-1121.

⁴⁹ Trueblood, et al. v. Washington State Department of Social and Health Services, et al., Case No. C14-1178 (W.D. Wash 2015).

⁵⁰ *Ibid.*, at pp. 18-19.

⁵¹ Among incompetent persons who were in jail while awaiting a court’s decision on commitment, 85 percent remained in jail for more than two days during this period.

⁵² The statewide data we obtained on the dates of various court actions and events did not enable us to determine which orders were issued pursuant to *Minnesota Statutes* 2015, 253B.045, subd. 1—that is, orders directing individuals to stay in jail to protect the life of the commitment petition subject or others. We would have been able to determine this only by reviewing court documents related to individual cases.

authorizes these orders only in extreme cases (“to protect the life of the proposed patient or others”), so it seems unlikely that the courts issue these orders often. In fact, officials in the state’s most populous county (Hennepin) told us they do not ever receive court orders requiring that a person with mental illness remain in jail. If this is true statewide, there may have been many instances in which persons with mental illness have been held in jail in violation of state law.

Incarcerating persons with mental illness who are no longer the subject of criminal prosecution may place counties and jails at risk of legal action. In our survey of sheriffs, 88 percent expressed concerns about their legal authority to hold someone in jail under suspended criminal charges after the individual is found incompetent. As noted earlier, state law authorizes the temporary confinement of such individuals in *non-jail* facilities, as arranged by counties. In addition, 66 percent of responding sheriffs said that too many people with mental illness who do not pose a threat to public safety are jailed. If the Legislature does not immediately implement our earlier recommendation—to create a new commitment category in law that would allow courts to immediately place individuals in competency restoration treatment following a court finding of incompetency—then the Legislature should adopt the following recommendation.

RECOMMENDATION

The Legislature should amend state law to specify a time frame in which counties should move non-dangerous inmates whose criminal charges have been suspended due to incompetency determinations to non-jail facilities while awaiting civil commitment decisions.

Once a court determines that a defendant is incompetent to stand trial, that individual should be promptly placed somewhere other than jail. (As under current law, the exception would continue to be instances in which the courts order individuals to be jailed, due to the danger those individuals pose to the lives of themselves or others.) Just as the Department of Human Services has two days to place someone whose court order falls under the state’s “48-hour law,” counties should have a statutorily specified time period for placing persons deemed incompetent who are awaiting civil commitment decisions.

In our view, state law clearly gives counties the primary responsibility for individuals subject to commitment petitions who require “temporary confinement” in a place other than jail. State law requires county social services agencies to “take reasonable measures to assure proper care and treatment” for these individuals.⁵³ The law also says that counties—individually or in groups—must “maintain or provide by contract a facility for confinement of persons held temporarily for observation, evaluation, diagnosis, treatment, and care.”⁵⁴ Some county officials have contended that the law only requires them to make arrangements for such services (for example, by having a contract with a facility), claiming that the law does not require counties to guarantee that beds will be available at the times they are needed.

⁵³ *Minnesota Statutes* 2015, 253B.045, subd. 4. Also, *Minnesota Statutes* 2015, 253B.03, subd. 7, says that individuals “receiving services” under [the commitment law] have a right to “proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision necessary.”

⁵⁴ *Minnesota Statutes* 2015, 253B.045, subd. 2.

Our recommendation would add a time frame to existing law, with the intent of ensuring that incompetent individuals are not held in jail for extended periods of time. To provide additional assurance that this actually occurs, the Legislature should consider (1) establishing civil penalties in law for instances in which counties keep incompetent persons in jail too long; and (2) clarifying in *Minnesota Statutes* 2015, 253B.045, that county arrangements for the “temporary confinement” of individuals awaiting commitment must be sufficient to meet the needs of individuals from the county who require these services.

Implementing this recommendation might require development of a more comprehensive set of community-based or state-operated service options than currently exists. In Chapter 2, we discussed the limitations of existing community mental health services in Minnesota. If it is unrealistic to implement this recommendation immediately, the Legislature should consider making this statutory change effective at some point in the future—for example, by July 1, 2018. In the meantime, DHS should monitor and coordinate the efforts of counties to implement more comprehensive mental health services.

THE 48-HOUR LAW

The 2013 Legislature passed a statutory provision intended to speed the placement of certain jailed individuals with civil commitments into facilities operated by the Department of Human Services (DHS).⁵⁵ This provision is commonly referred to as the “48-hour law.” The law identifies four categories of civil commitments or judicial orders for which placements of jailed individuals must occur within 48 hours. Exhibit 4.5 shows the categories. It is worth noting that the first two of these categories relate to cases in which the criminal charges may yet be prosecuted, while the latter two categories relate to cases in which the criminal case has ended.

A large majority of cases subject to the 48-hour law have involved individuals deemed incompetent to stand trial and subsequently committed to DHS for competency treatment.

Exhibit 4.5 shows the extent to which cases subject to the 48-hour law have fallen under each of the four categories specified in law. Through August 2015, 217 of 260 cases (83.5 percent) covered by the 48-hour law were cases in which a defendant was deemed incompetent to stand trial and sent to DHS for treatment. The next most-used category—with only 6 percent of cases covered by this law—involved defendants committed to DHS to receive inpatient assessments of mental health or mental capacities.

Earlier in this chapter, we noted that individuals sometimes remain in jail after being found incompetent by the courts; the 48-hour law might be one reason. This law creates a potential incentive to keep an incompetent individual in jail until the court makes a decision about whether to civilly commit the individual to treatment. If the person is subsequently committed to the state for competency treatment and is in jail at the time of the court decision, that person receives priority for placement in a state facility. In contrast, if the

⁵⁵ *Laws of Minnesota* 2013, chapter 108, art. 4, sec. 11, as codified in *Minnesota Statutes* 2015, 253B.10, subd. 1.

person has been moved to a community hospital or other non-jail facility after being determined incompetent, the person would not be given priority for placement in

Exhibit 4.5: Persons Subject to the “48-Hour Law”

Statutory Criterion for Placement in a Department of Human Services Facility Within 48 Hours	Percentage of Individuals Subject to 48-Hour Law Since July 1, 2013
1. Defendant was ordered confined in a state hospital for an examination related to (a) competency to stand trial or (b) a criminal defense of mental illness or mental deficiency	6.2%
2. Defendant was committed by the court to the commissioner of human services for treatment to restore competency to stand trial	83.5
3. Person was found not guilty of criminal charges by reason of mental illness and is under commitment by the court (or has been ordered detained in a facility pending completion of the commitment proceedings)	5.0
4. Person was committed to the commissioner of human services after dismissal of criminal charges	<u>5.4</u>
TOTAL (N=260)	100.0%

NOTES: The data in the exhibit reflect individuals subject to this law through August 2015. Percentages do not sum to 100 percent due to rounding.

SOURCE: *Minnesota Statutes* 2015, 253B.10, subd. 1(b); and Minnesota Department of Human Services data.

treatment—potentially delaying admission to a state facility for weeks. (See our discussion of community hospital placements in Chapter 2.)

State law does not specify exactly how the 48-hour time frame for placement should be measured, and some courts have not promptly notified DHS about cases subject to the law.

The law says that patients who meet one of the four categories shown in Exhibit 4.5 “must be admitted to a service operated by the commissioner [of human services] within 48 hours.”⁵⁶ The law does not specify the starting point for this time frame—that is, whether compliance should be measured as 48 hours from the time of the court’s order or 48 hours from the time DHS receives notification of that order.

For tracking purposes, DHS has computed how long it takes to make placements from the time DHS staff are notified of the order. DHS knows the date of the court order, but it does not know the exact time on that date when the order occurred.

To review the timeliness of court notifications, we examined data related to cases referred to DHS under the 48-hour law between late July 2015 and late October 2015. Specifically, we examined the date of the court order and the date DHS was notified of the order. We found that in 14 of 53 cases we examined (26 percent), DHS received notification of the

⁵⁶ *Minnesota Statutes* 2015, 253B.10, subd. 1. The law specifies that placements must occur within 48 hours and does not exclude weekends or holidays in this calculation.

order at least two calendar days after the order occurred.⁵⁷ Thus, sometimes 48 hours had already elapsed by the time DHS became aware of individuals who were subject to the “48-hour law.”

One of every four placements subject to the 48-hour law has failed to occur within 48 hours of the time when DHS was notified of the court order.

As mentioned above, DHS has no ability to make placements until the court formally notifies DHS of a case that is subject to the 48-hour law, so DHS tracks compliance with the law from the time it is notified of an order (not from the date when the order occurred). We obtained DHS’s tracking data to examine the timeliness of past placements under the 48-hour law. If the Legislature intended to ensure that placements occur within 48 hours of the court order, then the DHS data we used for this analysis would understate the extent of noncompliance with the 48-hour law.

Using the DHS data from July 2013 through August 2015, we observed that some cases greatly exceeded the 48-hour law’s timeline for placement. In 22 of the 259 cases (8 percent) that were subject to the 48-hour law during the period we reviewed, it took at least 100 hours (that is, more than four days) for a placement to occur. The longest time for a placement was a case in which an individual was not admitted to a DHS facility until 177 hours (more than a week) had elapsed from the time that DHS became aware of the relevant court order.⁵⁸

There have been various reasons for noncompliance with the 48-hour law, including lack of available beds at DHS facilities, lack of timely transportation to treatment facilities by local law enforcement, and DHS staff errors. For example:

- On July 15, 2015, at 3:30 p.m., DHS was notified of a court order regarding a Winona County jail inmate. The inmate was not placed at the Minnesota Security Hospital until July 20 at 4:15 p.m., or 121 hours later. DHS said it did not have available beds during this period. In the meantime, the jail’s sheriff said the inmate required one-on-one monitoring, threw his meals, and disrupted the entire jail. The sheriff said: “Every day his condition worsened. We were unable to provide the level of mental health care he truly needed. The staff did the best they could with him under the circumstances. We really needed to move him out of our county jail sooner than we did.”
- DHS was notified of a court order on February 19, 2015, at 3:05 p.m. The person was not admitted to a DHS facility until February 26 at 10:20 a.m., or 163 hours later. DHS contacted Hennepin County just before 5 p.m. on Friday, February 20, to request transportation of the individual to a treatment facility. The county was unable to transport the individual over the weekend. The Hennepin County sheriff told us that, on Monday, February 23, DHS changed the location of the placement

⁵⁷ DHS staff told us that, in some cases, courts have not initially provided DHS with the language from the courts’ commitment or criminal orders that indicates to DHS that these cases were subject to the 48-hour law. DHS does not start the 48-hour clock for a case until it receives the language in the court order. In 2 of the 53 cases we reviewed, seven calendar days elapsed before DHS became aware of court orders subject to the 48-hour law and had the necessary documentation.

⁵⁸ For placements at DHS facilities of individuals in jail who are not subject to the 48-hour law, most of these placements have occurred within seven days, according to DHS records.

from a facility in the Twin Cities area to a Fergus Falls hospital. It took several days for Hennepin County to get the individual transported to this more distant location.

- On January 30, 2015, at 10:55 a.m., DHS was notified of a court order committing a person to the Minnesota Security Hospital. The person was not admitted to the facility until February 5, 2015, at 2:08 p.m., or more than 147 hours later. DHS told us there was a misunderstanding by the DHS staff person responsible for the admission process in this case, and no one requested the person's admission to the facility until February 4. Law enforcement from St. Louis County was then unable to transport the individual until the next day. DHS attributed the initial delay to staff error, and it subsequently reassigned responsibility for Minnesota Security Hospital admissions to DHS's central preadmissions unit to prevent this type of mistake.

In 2015, the Commissioner of Human Services willfully failed to comply with the 48-hour law in some cases.

Starting in April 2015, the DHS Commissioner said that she would limit admissions to Anoka-Metro Regional Treatment Center (AMRTC), including admissions mandated by the 48-hour law. In a letter, the Commissioner said:

Our medical director informs me that meeting the 48-hour mandate would result in an egregious compromise of safety. Because of the already high level of acuity at [Anoka-Metro Regional Treatment Center], it would not be safe for incoming or current patients, or our staff, to add patients at this time.⁵⁹

In Chapter 2, we discussed the Anoka facility in greater detail, and we confirmed that the facility did, in fact, experience an influx of more challenging patients over a period of time leading up to the commissioner's letter. However, the 48-hour law does not specify any circumstances under which DHS may be exempted from full compliance with the law.

The Commissioner's concern for the safety of patients and staff at Anoka-Metro Regional Treatment Center was understandable. But delays in placing individuals into treatment at Anoka may have increased county jails' risks, potentially affecting the health or safety of the patient, fellow jail inmates, and jail staff.

⁵⁹ Lucinda Jesson, Commissioner, Department of Human Services, letter to whom it may concern, April 24, 2015. The term "acuity" is used at the Anoka facility to refer to the staffing requirements to serve patients. Patients that the facility deems to have higher acuity levels are ones that require higher levels of staffing.

RECOMMENDATIONS

The Legislature should:

- **Amend state law to require district courts to inform DHS of court orders subject to the 48-hour law on the same day the courts issue those orders.**
 - **Amend state law to clarify that DHS has 48 hours from the time DHS is notified to make a placement under the 48-hour law.**
 - **Consider whether to authorize in law any circumstances in which DHS would not be required to comply with the 48-hour law.**
-

Earlier in this chapter, we recommended amending statutes to authorize courts to immediately place in treatment individuals charged with felonies or gross misdemeanors who are deemed incompetent by the court. In our view, this would result in a more streamlined court process for getting these individuals into treatment. In case the Legislature does not make this change immediately, we also recommended that the Legislature take steps to ensure prompt placement in non-jail facilities of incompetent individuals awaiting action on commitment petitions. We made these recommendations to try to expedite the placement of incompetent individuals into treatment.

The 48-hour law represented the 2013 Legislature's effort to assure that certain types of persons would get placed in state-run facilities promptly, and our three recommendations above are intended to clarify administration of this law. To ensure accountability for the Legislature's goal of speedy placements, the Legislature should clarify that courts should immediately report orders to DHS that are subject to this law, and that the 48-hour clock should begin as soon as DHS is notified.

We also think the Legislature should consider whether state statutes should authorize any exceptions to full compliance with the 48-hour law. DHS considered the best interests of its own staff and patients when it refused to comply fully with the 48-hour law in 2015, but we think exceptions to this law should not occur unless explicitly authorized in statute.

List of Recommendations

- If the Department of Corrections continues to collect information on the number of inmates referred for mental health evaluations, it should monitor the accuracy of this reporting as part of its ongoing compliance reviews of jails. (p. 20)
- The State Court Administrator’s Office should ensure that court officials throughout the state comprehensively record findings of competency determinations in the Minnesota Court Information System. (p. 23)
- Consistent with the requirements of the state’s comprehensive adult mental health act, the Department of Human Services, counties, and Legislature should ensure that Minnesota has a comprehensive adult mental health system, including a sufficient number of both residential and nonresidential services. (p. 41)
- The Legislature and Department of Human Services should consider options for re-locating Anoka-Metro Regional Treatment Center patients who do not require hospital care—particularly those in the Competency Restoration Program—so that this facility would have room for those who do. (p. 42)
- The Legislature should provide funding that enables DHS’s community behavioral health hospitals to use more of their licensed beds. (p. 43)
- Counties should, where possible, formalize arrangements with community hospitals, community behavioral health hospitals, or other facilities, to help ensure that there will be places for persons who need inpatient care while in jail (or instead of going to jail). (p. 43)
- The Department of Corrections should initiate a process to update its state rules for jails—particularly those related to mental health services—to bring them into greater alignment with professional standards. (p. 51)
- The Legislature should amend state law to require that inmates who remain in jail for at least 14 days receive an assessment by a mental health professional during that period. (p. 56)
- The Minnesota Department of Corrections should:
 - Amend state rules for jails to specify the maximum time frames in which jails must (1) verify new inmates’ existing prescriptions and (2) begin to administer medications under existing or new prescriptions.
 - Amend state rules for jails to specify the authority, if any, that jails have to restrict the administration of prescribed medications in jails.
 - Ensure, during its jail inspections, that jails are providing inmates with their prescribed medications upon release from jail in a manner that is consistent with state rules. (p. 59)
- The Legislature should amend state law to specify that emergency administration or court-ordered involuntary administration of antipsychotic medications may occur in jails that have the necessary staffing and skills. (p. 62)

- The Legislature should consider statutory changes that would allow faster initiation of involuntary medication administration for persons who refuse to take their antipsychotic medications. (p. 63)
- Each Minnesota sheriff's office should try to ensure that at least some of its jail and patrol staff have had crisis intervention training. (p. 64)
- The Legislature should amend *Minnesota Statutes* 2015, 13.46, to explicitly authorize welfare agencies and jails serving the same individual to share mental health records on the individual. (p. 65)
- The Legislature should amend *Minnesota Statutes* 2015, 241.021, subd. 1, to direct the Department of Corrections to monitor and enforce the compliance of correctional facilities with minimum standards, whether those standards are established in state statutes or rules. (p. 68)
- The Department of Corrections should amend *Minnesota Rules*, Chapter 2911, to include guidance on discharge planning for inmates with serious and persistent mental illness. (p. 68)
- The Legislature should consider establishing a state ombudsman specifically focused on investigating issues related to mental health services in correctional or detention facilities. (p. 73)
- The Legislature should amend *Minnesota Statutes* 2015, Chapter 253B, to:
 - Create a commitment category specifically for competency restoration. Courts would be authorized in law to commit an individual to competency treatment based solely on a court finding of incompetency, without having to go through a separate commitment process.
 - Require that individuals deemed incompetent but no longer facing criminal charges be referred to their county human services agency for follow-up. (p. 86)
- For persons committed to the commissioner of human services for competency restoration, DHS should have a continuum of placement options that it can choose from, rather than just high-security settings. (p. 87)
- The Legislature should amend state law to specify a time frame in which counties should move non-dangerous inmates whose criminal charges have been suspended due to incompetency determinations to non-jail facilities while awaiting civil commitment decisions. (p. 90)
- The Legislature should:
 - Amend state law to require district courts to inform DHS of court orders subject to the 48-hour law on the same day the courts issue those orders.
 - Amend state law to clarify that DHS has 48 hours from the time DHS is notified to make a placement under the 48-hour law.
 - Consider whether to authorize in law any circumstances in which DHS would not be required to comply with the 48-hour law. (p. 95)

Federal and State Definitions of Mental Illness

APPENDIX A

There are various definitions of mental illness in state and federal laws and regulations. Exhibit 1.7 of this report presented the definition of a “person who is mentally ill” that appears in Minnesota law for purposes of making civil commitments. In this appendix, we present three additional definitions that are commonly used: (1) the definition of “mental illness” that appears in Minnesota’s Adult Mental Health Act; (2) the definition of “serious mental illness” that appears in federal regulations; and (3) the definition of “serious and persistent mental illness” that appears in Minnesota law for purposes of determining eligibility for case management and community support services.

Exhibit A.1: Federal and State Definitions of Mental Illness

State definition of mental illness

Mental illness is “an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner [of human services], and that seriously limits a person’s capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

Source: *Minnesota Statutes* 2015, 245.462, subd. 20.

Federal definition of an adult with a serious mental illness

An adult with a serious mental illness meets both of the following criteria:

1. During the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM); and
2. Has had functional impairment as a result of this disorder which substantially interferes with or limits one or more major life activities.

Source: *Federal Register*, 58, n. 96, published May 20, 1993, 29425.

Continued on next page.

Exhibit A.1: Federal and State Definitions of Mental Illness (Continued)

State definition of an adult with serious and persistent mental illness

An adult with mental illness (see state definition above) who meets at least one of the following criteria:

1. Has had 2 or more episodes of inpatient care for mental illness in the preceding 24 months;
2. Has experienced a continuous psychiatric hospitalization or residential treatment exceeding 6 months duration in the preceding 12 months;
3. Has been treated by a crisis team 2 or more times in the preceding 24 months;
4. Has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder and a significant impairment in functioning and a written opinion from a mental health professional in the last three years stating that the person—without ongoing case management or community support services—is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the first two criteria;
5. Has, in the last three years, been civilly committed by a court as a person who is mentally ill (or has had the commitment stayed or continued); or
6. Is eligible under one of the first five criteria but the specified time has expired and has a written opinion from a mental health professional in the last three years stating that the person—without ongoing case management or community support services—is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the first two criteria.

NOTE: The law also has a provision that enables adults age 21 or younger to meet the statutory definition if they were eligible as a child for case management or community support services in accordance with *Minnesota Statutes* 2015, 245.4871, subd. 6.

SOURCE: *Minnesota Statutes* 2015, 245.462, subd. 20.

Research on Mental Illness and Criminality

APPENDIX B

For many years, researchers have explored the relationship between mental illness and crime or violent behavior. The findings of the research have been complex and sometimes conflicting. One detailed review of previous studies concluded that “though significant contributions have been made, our knowledge of the precise nature of the relationship between mental disorder and violence and crime is still embryonic.”¹

Research appears to suggest that most crimes committed by persons with mental illness are not directly caused by mental health symptoms.

Research has suggested that some people with mental illness commit crimes or violence as a direct outgrowth of mental health symptoms, such as hallucinations or delusions.² One analysis of more than 200 studies said there is “strong support” in the research for a relationship between psychosis and violence, although it said that, summarized across the studies, the calculated effect of psychoses on the likelihood of violence was “small.”³ Researchers have tried to distinguish between actions that occurred within psychotic episodes and those that did not. Studies—using various approaches and definitions—have concluded that 4 to 11 percent of crimes or violent incidents by persons with mental illness were directly related to their psychoses.⁴

¹ Frank Sirotych, “Correlates of Crime and Violence Among Persons with Mental Disorder: An Evidence-Based Review,” *Brief Treatment and Crisis Intervention* 8, n. 2 (2008): 188.

² Some studies have not analyzed or discussed in detail the nature of the crimes committed. However, the public risk someone poses (for example, from committing a more serious crime or causing personal injury) can be an important consideration when law enforcement decides whether to place someone in jail or refer them to an alternative setting (such as a hospital or treatment facility).

³ Kevin Douglas, Laura Guy, and Stephen Hart, “Psychosis as a Risk Factor for Violence to Others: A Meta-Analysis,” *Psychological Bulletin* 135, n. 5 (2009): 687 and 692. This analysis said that the range of impacts found in these studies was large, and thus “the range in conclusions about psychosis and violence makes complete sense” (p. 692).

⁴ John Junginger, Keith Claypoole, Ranilo Laygo, and Annette Crisante, “Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses,” *Psychiatric Services* 57, n. 6 (2006): 879-882; Jillian Peterson, Jennifer Skeem, Eliza Hart, Sarah Vidal, and Felicia Keith, “Analyzing Offense Patterns as a Function of Mental Illness to Test the Criminalization Hypothesis,” *Psychiatric Services* 61, n. 12 (2010): 1217-1222; John Monahan and Henry Steadman, “Extending Violence Reduction Principles to Justice-Involved Persons with Mental Illness,” in *Using Social Science to Reduce Violent Offending*, ed. Joel Dvoskin, Skeem, Raymond Novaco, and Douglas (New York: Oxford University Press, 2012), 245-261; and Peterson, Skeem, Patrick Kennealy, and Beth Bray, “How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders with Mental Illness?” *Law and Human Behavior* 38, n. 5 (2014): 439-449. The latter study said that 7.5 percent of crimes by persons with a serious mental illness were “completely related directly to [mental health] symptoms”; another 10.7 percent were “mostly” related to symptoms.

Recent research also suggests that there are few individuals with mental illness whose violent actions are *always* preceded by psychoses. In other words, while some individuals appear to commit crimes or violence as a direct result of their mental health symptoms, those same individuals typically commit at least some other crime or violent act that appears to be unrelated to their mental health symptoms.⁵ This has led some researchers to conclude that programs that focus primarily on addressing offenders' mental health symptoms may have limited impact on criminal recidivism.

Studies suggest that strong risk factors for crime and recidivism may be shared by offenders with and without mental illness. These risk factors include things such as criminal histories, peers prone to criminal activity, substance abuse, and antisocial behaviors or thoughts. For example, studies have found that persons with mental illness and co-occurring substance abuse or dependence have higher rates of violence than persons with mental illness alone.⁶

⁵ Skeem, Kennealy, Monahan, Peterson, and Paul Appelbaum, "Psychosis Uncommonly and Inconsistently Precedes Violence Among High Risk Individuals," *Clinical Psychological Science* 4, n. 1 (2016): 40-49; and Peterson, Skeem, Kennealy, and Bray, "How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders with Mental Illness?" *Law and Human Behavior* 38, n. 5 (2014): 439-449.

⁶ For example, see Eric Elbogen and Sally Johnson, "The Intricate Link Between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions," *Archives of General Psychiatry* 66, n. 2 (2009): 152-161; and Richard Van Dorn, Jan Volavka, and Norman Johnson, "Mental Disorder and Violence: Is There a Relationship Beyond Substance Abuse?" *Social Psychiatry and Psychiatric Epidemiology* 47, n. 3 (2012): 487-503.

Research on the Prevalence of Mental Illness in the General Population and Jails

APPENDIX C

A number of research studies conducted throughout the U.S. have estimated the proportion of the jail population with mental illnesses. These estimates vary, depending on the methods and definitions used. For example, a larger share of the jail population has self-reported mental health symptoms than has clinically diagnosed mental health disorders, according to past studies. Estimates also vary depending on their time frames; for example, studies have identified larger proportions of the jail population that have experienced mental illness at some point in their lives, compared with the proportions of inmates who have current or recent mental illnesses. In addition, studies vary in the array of illnesses they have included in the definition of “mental illness.” For example, some studies have included substance abuse disorders in the definition of mental illness, while others have not.

In the general population, studies have estimated that 4 to 6 percent of adults nationally have a “serious” mental illness within a 12-month period, and 19 to 25 percent of adults have any sort of mental illness within a 12-month period.

Two large-scale studies have estimated the proportion of adults in the general population nationally that have a “diagnosable” mental illness—that is, an illness that could be diagnosed as a mental illness, using accepted diagnostic definitions.¹ One study interviewed more than 9,000 adults between 2001 and 2003, and another interviewed about 45,000 adults for a report issued in 2013.

The estimates referenced above of the proportions of persons in the general population with mental illness do not include substance abuse disorders in the definition of mental illness. The two studies used somewhat different definitions of “serious” mental illness, but mental illnesses categorized as “serious” generally had more symptoms or greater functional impairment than other mental illnesses.

Studies have indicated that jail inmates have a greater prevalence of mental illness than the general population.

¹ For a summary of the findings of these studies, see Erin Bagalman and Angela Napili, *Prevalence of Mental Illness in the United States: Data Sources and Estimates* (Washington, DC: Congressional Research Service, March 9, 2015). The studies were the National Comorbidity Survey Replication and the National Survey on Drug Use and Health.

Several noteworthy studies have examined the extent of mental illness in jail inmates—some for the nation as a whole, and some for limited geographic areas. A 2006 federal study—based on interviews with about 7,000 jail inmates—found that 63 percent of male jail inmates and 75 percent of female jail inmates had self-reported symptoms or histories of a mental health problem in the previous 12 months.² This study did not assess the severity of these problems, and some of the inmates identified in the study as having mental health problems may not have had clinical diagnoses. Also, the study counted mental health symptoms that may have been due to substance abuse, bereavement, or medical problems. Thus, one article commented that the estimates in this large federal study “may best be thought of as an upper limit of mental health problems (not psychiatric illness *per se*).”³

More rigorous studies were done in Cook County, Illinois, in the 1980s and 1990s.⁴ Those studies found that more than 6 percent of male inmates and more than 12 percent of female inmates had severe psychiatric disorders over a two-week period.⁵ The Cook County studies—which used rigorous methods and focused on inmates with *severe* and *current* mental illnesses—represented the lower boundary of mental illness prevalence estimates we reviewed. The Cook County studies also found that rates of severe mental illness among jail detainees were, for the most part, significantly higher than rates among the general population, after controlling for demographic differences.⁶

² Doris James and Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates* (Washington, DC: U.S. Bureau of Justice Statistics, September 2006 and revised December 2006).

³ Robert Trestman, Julian Ford, Wanli Zhang, and Valerie Wiesbrock, “Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut’s Jails,” *Journal of the American Academy of Psychiatry and the Law* 35, n. 4 (2007): 491.

⁴ There have been multiple articles discussing the results, authored by Linda Teplin, Karen Abram, and Gary McClelland—individually or in combination.

⁵ The results of the Cook County studies are summarized in Henry Steadman, Fred Osher, Pamela Robbins, Brian Case, and Steven Samuels, “Prevalence of Serious Mental Illness Among Jail Inmates,” *Psychiatric Services* 60, n. 6 (June 2009): 761-765.

⁶ Linda Teplin, “The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program,” *American Journal of Public Health* 80, n. 6 (1990): 663-669; and Teplin, Karen Abram, and Gary McClelland, “Prevalence of Psychiatric Disorders Among Incarcerated Women, I. Pretrial Jail Detainees,” *Archives of General Psychiatry* 53 (1996): 505-512. The latter study said that rates of mental disorders were higher among jailed females than females in the general population for all types of disorders except schizophrenia, schizophreniform disorder, and panic disorder. Some research has indicated that female inmates are more likely than male inmates to have certain disorders, such as affective disorders, anxiety, or post-traumatic stress disorders.



Minnesota Department of **Human Services**

February 22, 2016

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the report from the Office of The Legislative Auditor on mental health services in county jails. We are pleased that the Office of The Legislative Auditor provided such a comprehensive report on an area of grave concern. Overall, the report provides an excellent overview of the current provision of mental health services in the jail setting and provides sensible recommendations on areas for improvement.

The Department of Human Services (Department) is in full support of the systematic provision of mental health services in jail settings. As stated in the report, individuals in jails have a right to an individualized treatment plan and access to medications necessary to treat serious mental illness. The Department supports the development and implementation of consistent standards across the state that would allow individuals with mental illness in the jail setting to have needed care.

We agree that a strong community mental health system is a critical strategy in preventing incarceration of people with mental illness. In 2015 the Legislature appropriated \$46 million to support a variety of services to build Minnesota's community mental health services. Key among these initiatives is Crisis Intervention Training for law enforcement officers, the availability of mobile crisis teams and the use of residential crisis beds. The Mental Health division is currently awarding funding for additional training for law enforcement officers across the state to support individuals in psychiatric crisis in ways that can avoid placement of those with mental illness in jails. Recent awards for mobile mental health crisis teams allow funding for crisis teams across the state that can provide alternatives to placing those with mental illness in jail settings. Additional awards have recently been distributed for residential crisis beds across the state ensuring that individuals experiencing acute psychiatric symptoms who are placed in jail as a protection will have a more appropriate refuge.

The audit recommendations are consistent with the direction the Department is currently taking to reduce the placement of those with mental illness into jails. Forensics Assertive Community Treatment teams are a promising practice being developed with the Department's support. Additionally, the Department provides funding for mental health courts in three counties in the state of Minnesota through the Federal Block Grant. Mental health courts can provide judicial interventions sensitive to the needs of individuals experiencing mental illness.

We also believe the report offers good recommendations for our Direct Care and Treatment services. As you know, improving care and treatment for people in our facilities is a critical priority for the Department. We agree that we need to devote the limited psychiatric hospital beds at the Anoka Regional Treatment Center to their full and best use. We agree with your recommendations for alternative approaches to Competency Restoration services and are exploring alternatives that will not only free up beds at Anoka but also provide a continuum of placement options for Competency Restoration.

Future steps suggested in the audit provide a roadmap for new legislative initiatives. Many topics listed in the report will be considered for legislative initiatives this year and in coming years.

Thank you again for the professional and dedicated efforts of your staff during this audit. The Department's policy is to follow up on all audit findings to evaluate the progress being made to resolve them. Progress is monitored until full resolution has occurred. If you have any further questions, please contact Gary L. Johnson, Internal Audit Director, at (651) 431-3623.

Sincerely,

A handwritten signature in cursive script that reads "Emily Johnson Piper".

Emily Johnson Piper
Commissioner



Office of the Commissioner

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February 17, 2016

James R. Nobles
Office of the Legislative Auditor
Room 140 Centennial Building
658 Cedar Street
St. Paul, MN 55155-1603

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the findings and recommendations reported as a result of the recent audit report *Mental Health Services in County Jails*. We very much appreciate your office's professional and thorough review while conducting research in preparation for this report. Below please find our response to the recommendations identifying the Minnesota Department of Corrections in the report.

Report Recommendations

- 1. If the Department of Corrections continues to collect information on the number of inmates referred for mental health evaluations, it should monitor the accuracy of this reporting as part of its ongoing compliance reviews of jails. (p. 20).*

Agree with recommendation: The department will provide additional direction and clarification of information that should be reported regarding referrals for mental health evaluations. This instruction will be provided through regional jail administrator meetings and the annual Minnesota Sheriffs' Association Jail Administrator's Conference, to be held in September 2016. Since not all jail administrators attend these meetings and conferences, the department will also send the

direction/clarification via email distribution, as well as provide it during inspection activities.

In addition, inspectors will more closely monitor data reported by the jail facilities, and require corrective action as deemed appropriate to facilities that are not providing data according to reporting requirements.

Person Responsible – Tim Thompson, Director of Inspection and Enforcement Unit

Implementation Date – Upon completion of training of jail administration – October 2016

2. *The Department of Corrections should initiate a process to update its state rules for jails – particularly those related to mental health services – to bring them into greater alignment with professional standards. (p. 51)*

Agree with recommendation.

Person Responsible – Tim Thompson, Director of Inspection and Enforcement Unit

Estimated Completion Date – It is anticipated the Department would initiate the rule promulgation process by Fall 2016.

3. *The Minnesota Department of Corrections should:*

- *Amend state rules for jails to specify the maximum time frames in which jails must (1) verify new inmates' existing prescriptions and (2) begin to administer medications under existing or new prescriptions.*
- *Amend state rules for jails to specify the authority, if any, that jails have to restrict the administration of prescribed medications in jails.*
- *Ensure, during its jail inspections, that jails are providing inmates with their prescribed medications upon release from jail in a manner that is consistent with state rules. (p.59)*

Agree with recommendation.

Person Responsible – Tim Thompson, Director of Inspection and Enforcement Unit

Estimated Completion Date – It is anticipated the Department would initiate the rule promulgation process by Fall 2016 (bullets 1 and 2).

Estimated Completion Date – This is an ongoing process and is discussed with facilities during inspections. The Department will continue to cite facilities for non-compliance with the rules (bullet 3).

4. *The Department of Corrections should amend Minnesota Rules, Chapter 2911, to include guidance on discharge planning for inmates with serious and persistent mental illness. (p. 68)*

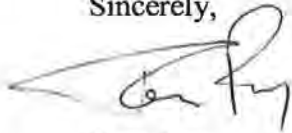
Agree with recommendation.

Persons Responsible – Tim Thompson, Director of Inspection and Enforcement Unit;
Nanette Larson, Director of Health Services

Estimated Completion Date – It is anticipated the Department would initiate the rule promulgation process by Fall 2016.

Thank you again for your recommendations and the opportunity to respond. We value your audit work and the improvements that will be generated in the way we provide services in our county jails as a result of this report.

Sincerely,



Tom Roy
Commissioner

C: Ron Solheid, Deputy Commissioner
Lisa Wojcik, Assistant Commissioner

Forthcoming OLA Evaluations

Agricultural Utilization Research Institute (AURI)
Department of Natural Resources: Deer Population Management
Iron Range Resources and Rehabilitation Board (IRRRB)
Minnesota Teacher Licensure
MnDOT Highway Project Selection

Recent OLA Evaluations

Agriculture

Agricultural Commodity Councils, March 2014
“Green Acres” and Agricultural Land Preservation Programs, February 2008
Pesticide Regulation, March 2006

Criminal Justice

Mental Health Services in County Jails, March 2016
Health Services in State Correctional Facilities, February 2014
Law Enforcement’s Use of State Databases, February 2013
Public Defender System, February 2010
MINNCOR Industries, February 2009
Substance Abuse Treatment, February 2006

Education, K-12, and Preschool

Special Education, February 2013
K-12 Online Learning, September 2011
Alternative Education Programs, February 2010
Q Comp: Quality Compensation for Teachers, February 2009
Charter Schools, June 2008

Education, Postsecondary

Preventive Maintenance for University of Minnesota Buildings, June 2012
MnSCU System Office, February 2010
MnSCU Occupational Programs, March 2009

Energy

Renewable Energy Development Fund, October 2010
Biofuel Policies and Programs, April 2009
Energy Conservation Improvement Program, January 2005

Environment and Natural Resources

Recycling and Waste Reduction, February 2015
DNR Forest Management, August 2014
Sustainable Forest Incentive Program, November 2013
Conservation Easements, February 2013
Environmental Review and Permitting, March 2011
Natural Resource Land, March 2010
Watershed Management, January 2007

Government Operations

Mineral Taxation, April 2015
Minnesota Board of Nursing: Complaint Resolution Process, March 2015
Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs, March 2014

Government Operations (continued)

Helping Communities Recover from Natural Disasters, March 2012
Fiscal Notes, February 2012
Capitol Complex Security, May 2009
County Veterans Service Offices, January 2008

Health

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