Task Force on Priority Admissions to State-Operated Treatment Programs

Report and Recommendations to the Minnesota Legislature

02/12/2024

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Executive Summary

The current state of mental health services in Minnesota is underdeveloped and insufficient to meet the current demand for those with high acuity mental health needs. The Task Force acknowledges recent investments to community-based services, yet those with the most significant needs require immediate investments in inpatient, residential and community-based services so they may receive the right services at the right time. There are serious consequences to inaction, most importantly the human cost but also the negative impacts to our hospital and public safety systems.

Introduction

The Task Force on Priority Admissions to State-Operated Treatment Programs was established by the Minnesota Legislature in 2023 to review and evaluate the impact of the state's Priority Admissions Law. The Priority Admissions law mandates the prioritization of individuals into state-operated treatment facilities under specific conditions. The task force was directed to:

- Evaluate the impact of priority admissions under Minnesota law of the State's ability to serve all individuals in need of care of state-operated services;
- Analyze the impact of priority admissions on the mental health system in the State of Minnesota;
- Provide recommendation for improvements or alternatives to the current priority admissions requirements; and
- Identify and provide recommendations for providing treatment to individuals referred under the priority admissions requirements as well as other individuals in the community who require treatment at a state-operated treatment program.

State Statute

The current requirements of priority admission under Minn. Stat. sec. 253B.10, sub. 1(b) directs the Minnesota Department of Human Service to prioritize admission of patients to a state operated treatment program within 48 hours who are:

(1) Ordered confined in a state-operated treatment program for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

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

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

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

In 2023, the Minnesota Legislature amended the Priority Admissions statute to provide clarity that when individuals are subject to the Priority Admissions law they shall be admitted to a state-operated treatment program within 48 hours when it is determined that a medically appropriate bed is available. The 2023 amendment, which added the requirement of the determination "that a medically appropriate bed is available," was made effective May 25, 2023, but has a sunset clause and will expire on June 30, 2025.

Stakeholder Interest

Although the intent of the Priority Admissions law was to reduce the number of individuals in custody waiting for limited spaces in secure treatment facilities, the effect created additional concerns not only for the increased population of those waiting in jails with mental illnesses but delaying the admission for individuals in need of state-operated services in hospitals and other community settings. The current result is that too many people with mental illnesses in jails, hospitals, and the community wait, sometimes for weeks or months, for admission to intensive state-operated services or to appropriate treatment services in less restrictive community-based settings.

Law enforcement, counties, courts, prosecutors and defense attorneys, community hospitals, advocates for those with mental illness, and DHS all have a unique perspective and vital stake in the discussion. Each has important and distinct (and often overlapping) roles and responsibilities in addressing the needs of people with mental illness who are involved in the criminal justice system.

This shared issue for all stakeholders requires thoughtful solutions that create a combined and agreed upon process for all stakeholders involved to address the problem rather than creating an environment where stakeholders are in a position to compete for limited resources, or the burdens are shifted from one stakeholder to another.

In establishing this Task Force, the Legislature recognized the need for a more thoughtful examination of the issues and more workable solutions for everyone involved. The Task Force brought key stakeholders together to take a thorough look at how the Priority Admissions law affects all parties individually and the mental health system as a whole and to consider whether permanent changes to the law may be warranted.

Recommendations

The Task Force concludes the state needs to increase access to mental health treatment across the board for all people living with mental health disorders. This includes increasing access at all levels of care – both state-operated programs and community-based programs. The state must also increase access to care for people with mental illnesses in jails while waiting for an appropriate level of care. While solutions have a financial cost, the State of Minnesota is facing increasing intangible costs to the people negatively impacted by an underfunded mental health system. The Task Force recommends that swift action in all these areas collectively be taken to address the crisis state of our mental health system, as there are no other solutions available to address the problem. Simply declining to act or by removing the requirement for placement within 48 hours will not address

the underlying systemic problems described in this report. If the critical lack of available capacity across the system is not addressed, the humanitarian and constitutional issues previously raised will only worsen, and any change to the Priority Admissions law will be systemically ineffective in meeting the current and increasing demand. Any change to the Priority Admissions law must be accompanied by increases in inpatient, residential and community outpatient services. Long-term solutions are necessary to meet growing future needs. In the meantime, the state must expand capacity now in ways that immediately impact the backlog of civilly committed people awaiting appropriate court-ordered treatment.

The Task Force recommends several changes to address these issues, including:

- Immediately begin to increase capacity of Direct Care and Treatment;
- Form Joint Incident collaboration to actively facilitate discharges for DCT patients;
- Approve an exception to the Priority Admissions law;
- Create and implement new Priority Admissions criteria to the Direct Care and Treatment facilities;
- Increase access to services provided in the community;
- Provide funding to administer mental health medications to individuals in custody;
- Relieve counties of some cost for individuals awaiting transfer to other DCT facilities;
- Expedite Minnesota's Section 1115 Waiver Application for Individuals in custody; and
- Increase Forensic Examiner accessibility.

The Task Force emphasizes that these recommendations must be implemented collectively to address the crisis state of Minnesota's mental health system. Failure to act will not address the underlying systemic problems described in this report and will only worsen the humanitarian and constitutional issues raised in this report.

Acknowledgements

The Priority Admissions Task Force members wish to thank the Legislature for directing the work of the Task Force. It has allowed for a close examination of the issues for stakeholders and provided an opportunity to collaboratively propose solutions to these complex matters.

Introduction

The Task Force on Priority Admissions to State-Operated Treatment Programs was established by the Minnesota Legislature in the 2023 regular session to review the state's Priority Admissions law, also known as the 48-hour law. Specifically, the mission of the task force is to evaluate the impact of the requirements of Priority Admissions under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b) and provide recommendations to the legislature on how to improve on the requirement and process to better assist all stakeholders involved.

Statute and Scope of Work

Enacted in 2013, the Priority Admissions Law (Minn. Stat. sec. 253B.10, sub. 1(b)), more commonly known as the 48-Hour Law, requires the Commissioner of the Minnesota Department of Human Services (DHS) to prioritize individuals being admitted from county jails into a state-operated treatment facility who are:

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

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

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

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

During the 2023 regular session, the Minnesota Legislature amended the Priority Admissions Law to clarify that patients subject to the statute shall be admitted to a state-operated treatment program within 48 hours when it is determined that a medically appropriate bed is available. The 2023 amendment was made effective May 25, 2023, but has a sunset clause and will expire on June 30, 2025. Simultaneously, the Legislature established the Task Force. Human services finance and policy bill, SF2934, 93rd Legislature (2023), Chapter 61, Article 8, Section 13.

The law requires the Task Force to evaluate the impact of these requirements for priority admissions on:

(1) The Department of Human Services;

(2) Individuals referred for admission and care at state-operated treatment programs, including both individuals referred for priority admission under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), and individuals not referred according to such priority admissions requirements; and

(3) The mental health system in Minnesota, including community hospitals.

The members of the Priority Admission Task Force were instructed to complete the following tasks:

(1) Evaluate the impact of the priority admissions required under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), on the ability of the state to serve all individuals in need of care in state-operated treatment programs by analyzing:

    (i) The number of individuals admitted to state-operated treatment programs from jails or correctional institutions according to the requirements of Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), since July 1, 2013;
    (ii) The number of individuals currently on waiting lists for admission to state-operated treatment programs;
    (iii) The average length of time an individual admitted from a jail or correctional institution waits for a medically appropriate bed in a state-operated treatment program, compared to an individual admitted from another location, such as a community hospital or the individual's home; and
    (iv) County-by-county trends over time for priority admissions under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b);

(2) Analyze the impact of the priority admissions required under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), on the mental health system statewide, including on community hospitals;
(3) Develop policy and funding recommendations for improvements or alternatives to the current priority admissions requirement. Recommendations must ensure that state-operated treatment programs have medical discretion to admit individuals with the highest acuity and who may pose a risk to self and others, regardless of referral path; and
(4) Identify and recommend options for providing treatment to individuals referred according to the priority admissions required under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), and other individuals in the community who require treatment at state-operated treatment programs.

Required Task Force Report

The Task Force is then required to submit a report to the legislature by February 1, 2024. The report must be submitted to the legislative committees with jurisdiction over public safety and human services and include recommendations on:

(1) Proposals to amend Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), to improve the priority admissions requirements and process;

(2) Ways to ensure that state-operated treatment programs have medical discretion to prioritize the admission of individuals with the most acute clinical and behavioral health needs or who pose a risk to self and others, regardless of referral path;

(3) Additional ways to meet the treatment needs of individuals referred to state-operated treatment programs according to the priority admissions required under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), and other individuals in the community who require treatment at state-operated treatment programs; and

(4) Any other relevant findings, research, or analyses conducted or produced by the task force under subdivision 6.

The Task Force then expires on June 30, 2024, immediately after that legislative session for which the report is provided.

Task Force Members

The Priority Admissions Task Force was instructed to allow for the appointment of 18 members to complete the responsibilities assigned. Seventeen members were appointed. The task force members include:

- **Jodi Harpstead**, Commissioner, Minnesota Department of Human Services, Co-Chair
- **Keith Ellison**, Minnesota Attorney General, Co-Chair
- **Dr. KyleeAnn Stevens**, Executive Medical Director, Direct Care and Treatment Administration, DHS, a member representing Department of Human Services Direct Care and Treatment services who has experience with civil commitments, appointed by the Commissioner of Human Services
- **Tarryl Clark**, Stearns County Commissioner, a county representative, appointed by the Association of Minnesota Counties
- **Bryan Welk**, Cass County Sheriff, county sheriff, appointed by the Minnesota Sheriffs' Association
- **Angela Youngerberg**, Blue Earth County Human Services Director of Business Operations, a county social services representative, appointed by the Minnesota Association of County Social Service Administrators
- **Kevin Magnuson**, Washington County Attorney, a county attorney, appointed by the Minnesota County Attorneys Association
- **Taleisha Rooney**, Manager, Emergency Behavioral Health Team, North Memorial Hospital, a hospital representative, appointed by the Minnesota Hospital Association
- **Sue Abderholden**, Executive Director, Minnesota Chapter of the National Alliance on Mental Illness (NAMI Minnesota), a member appointed by the National Alliance on Mental Illness Minnesota

- **Doug McGuire**, Attorney Coordinator, Hennepin County Commitment Defense Project, a member appointed by the Minnesota Civil Commitment Defense Panel
- **Jinny Palen**, Executive Director, Minnesota Association of Community Mental Health Programs (MACHMP), a member appointed by the Minnesota Association of Community Mental Health Programs
- **Dr. Eduardo Colón-Navarro**, Chief of Psychiatry, Hennepin County Medical Center, a member appointed by the Minnesota Psychiatric Society
- **Lisa Harrison-Hadler**, Ombudsman, Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities, the ombudsman for mental health and developmental disabilities
- **Nicholas Rasmussen**, member of the public with lived experience directly related to the Task Force's purposes, appointed by Gov. Tim Walz
- **Heidi Heino**, member of the public with lived experience directly related to the Task Force's purposes, appointed by Gov. Tim Walz
- **Miranda Rich,** a member appointed by the Commissioner of Corrections from an organization that represents racial and ethnic groups that are overrepresented in the criminal justice system.
- **Dr. Dionne Hart**, a member appointed by the Commissioner of Corrections from an organization that represents racial and ethnic groups that are overrepresented in the criminal justice system.

A third seat on the Task Force designated for a member from an organization that represents racial and ethnic groups that are overrepresented in the criminal justice system was not appointed by the Commissioner of Corrections.

Guiding Principles

Members discussed several guiding principles to help ensure the findings and recommendations ultimately provide a roadmap for policymakers to help solve the issues related to access to appropriate mental health services in this population. These principles include, but are not limited to the following:

Lack of timely access and capacity are a problem.

The Priority Admissions statute was enacted to address the problems of lack of timely access and inpatient capacity at DCT. The Priority Admissions statute was not the principal problem and did not create the situation that exists today. The problems of lack of access and capacity existed prior to the creation of the law and continue to persist. As the Task Force considers its work, members will focus on both the impact of the statute, but also the trends of demand on services and changes in inpatient and community capacity of services. The many systemic factors that result in changes to access and capacity shall be reviewed, discussed, and considered from the perspectives of all Task Force members as recommendations are formulated.

All people living with mental health disorders are entitled to have care when and where they need it.

People who have been civilly committed should have access to the court-ordered treatment they require to achieve recovery.[1] Meaningful access to mental health treatment for those most in need should not require criminal justice involvement as a prerequisite for admission. Similarly, jails are not a replacement for mental health hospitals or secure treatment facilities, nor are hospitals and emergency rooms. People in the community without access to care deserve care as well, perhaps most urgently. Acute care hospitals and emergency rooms are not the right place for people needing extended care.

Transparency builds trust.

Improving transparency and understanding of decision-making processes among different systems can help encourage solution-oriented conversations in a manner that all can engage in problem solving. The task force is grateful for the tours which were provided for several task force members. All members toured Anoka Metro Regional Treatment Center and a small group including task force members were provided the opportunity to tour Anoka County Jail and Hennepin Healthcare Medical Center. This helped to provide a richness to the discussions.

Honest appraisal of need.

Recommendations of the Task Force should not be constrained by budgetary limitations. While we recognize that funding implications influence decisions, policymakers should have before them an honest appraisal of what is necessary to build out the mental health system. Nonetheless, the recommendations do take fiscal responsibility into consideration as the recommendations are inherently more cost effective than the alternative of extensive litigation with Court enforced settlement agreements or construction of one or more new facilities. Additionally, simply shifting costs from one agency to another, such as from the state to counties, is not appropriate.

Patients are people first.

Solutions must safeguard the constitutional and humane treatment of some of the most vulnerable individuals within our state. No system or decision-making process is perfect. The inevitability of mistakes should be embraced with procedures that allow for both accountability and correction.

Prioritize strategies with effective outcomes.

Recommendations that are clear, succinct and have proven results are what the task force shall prioritize to provide policymakers with a guide of what changes can help achieve observable and positive outcomes on our state's mental health system.

[1] Of note, individuals confined to correctional facilities have a constitutional right to health care (Estelle v. Gamble, 429 U.S. 97, 97 S. Ct. 285 (1976).

Prioritization is in the implementation.

Recommendations include direct strategies to provide policymakers with a guide of what programs, when paired together, can help achieve observable impact on systems in the immediate, medium, and long-term future.

Cooperation as a cornerstone.

No one system or stakeholder can meet the needs of those who need them most. We must collaborate to do so. Therefore, recommendations include strategies for state-operated programs, community-based services, jail-based services, and hospital systems.

Background on the Priority Admissions Law

Minnesota Statutes Chapter 253B regarding civil commitments allows for a person to be civilly committed to the care of the Commissioner of the Department of Human Services for the purpose of receiving needed treatment and care. The statutory process for civil commitment is lengthy and extensive, often involving multiple licensed physicians, court appointed counsel, and judicial oversight. In 2010, the average wait time for admission to the Anoka-Metro Regional Treatment Center (AMRTC), the largest state-run psychiatric hospital, was 19 days. By 2013, the average wait time jumped to 30 days and the time from the commitment order to placement had grown unacceptably long. Among those most affected by the increased time it could take to be admitted to a state-operated psychiatric hospital were people with mental illnesses being held in jails yet had not been convicted of a crime.

Counties, county sheriffs in particular, were concerned about the negative impact increasing wait times was having on those living with mental illnesses in their custody and raised concern with advocates and state lawmakers alike. Inmates with untreated mental illnesses, as their conditions worsened behind bars, posed an increased danger to themselves, other inmates, and corrections staff. Jail was not suited for the treatment of many who belonged in a secure psychiatric facility where they could get the timely professional treatment they needed.

When implemented in the summer of 2013, the Priority Admissions Law was intended to help law enforcement officials cope with the rising number of individuals with mental illnesses accused of crimes, being held in jail, and to get them quickly into a court-ordered treatment facility.

The solution to the backlog in jails that emerged from the state Capitol was the Priority Admissions Law. The amendment to the civil commitment law, which required the Minnesota Department of Human Services (DHS) to admit patients to a state-operated treatment program within 48 hours of civil commitment. Specifically, the law requires the Commissioner to prioritize patients being admitted from jail or a correctional institution who are:

(1) Ordered confined in a state-operated treatment program for an examination;

(2) Under civil commitment for competency treatment and continuing supervision;

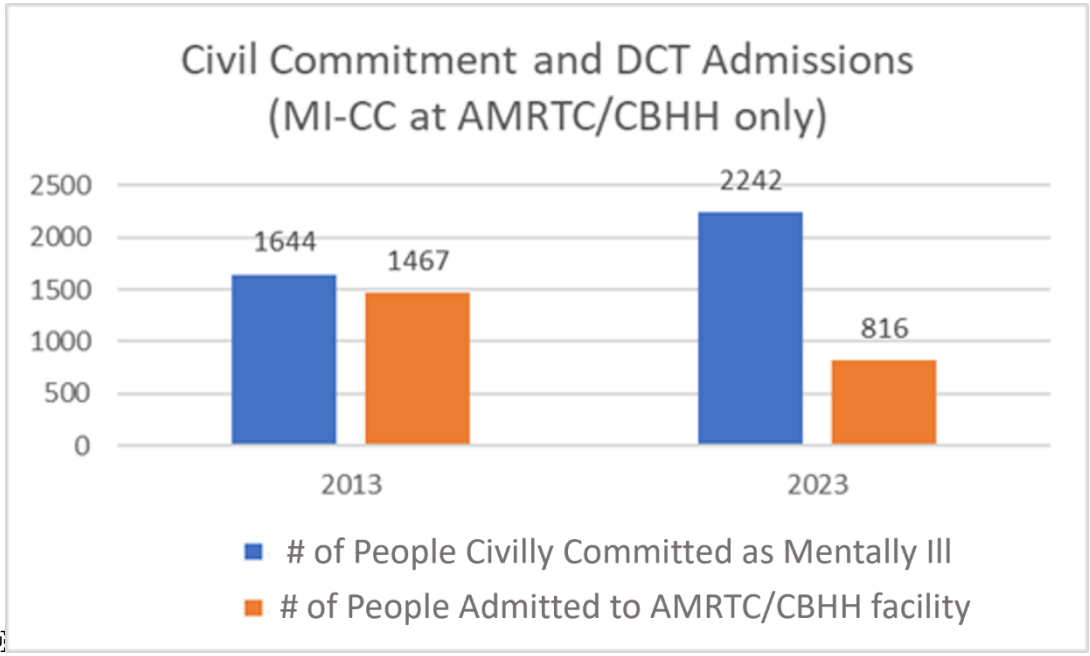
(3) Found not guilty by reason of mental illness; or

(4) Committed to the Commissioner after dismissal of the patient's criminal charges.

Under the Priority Admissions law, these patients were given priority over all other patients who were waiting for admission to a state-operated treatment facility.

For the first few years, the Priority Admissions statute resulted in quicker hospitalizations once a person met the statutory criteria. However, the number of those meeting the criteria for priority admission was small compared to today.

Data shows that the number of people meeting the statutory criteria has significantly increased each year since 2013. Commitments for a person who poses a risk of harm due to mental illness have risen by more than 36 percent during the period, from 1644 in 2013 to 2242 in 2023. The highest point during this period was in 2022 with 2288 commitments. Civil commitments for people who have a mental illness and are dangerous to the public (MI&D) have risen by 50 percent during the same period, from 28 in 2013 to 42 in 2023.



Wait Times are Worse Now than Before

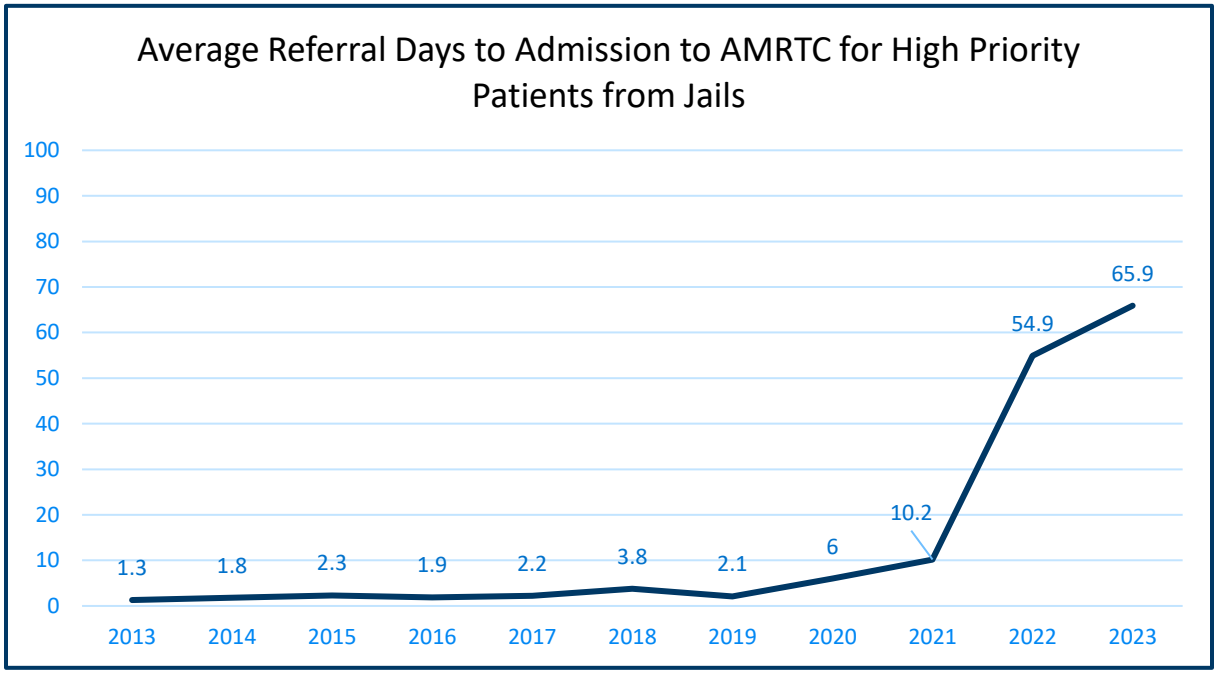
To many supporters, the Priority Admissions statute was a common-sense solution. However, the Minnesota Department of Human Services, which oversees the state-operated mental health system, expressed strong concern from the outset that there were not enough psychiatric beds or staff to accommodate the expected surge in admissions that would stem from the law. Sheriffs also warned in the years following the enactment of the law that DHS needed to increase the number of beds at its facilities to handle not only current backlog but

the increasing number of people being civilly committed. Those predictions have proven true. Capacity has not kept up with demand.

The wait times in jail are the longest they have ever been. The number of people in custody whose condition is worsening continues to increase as are the number incidents of self-harm and harm to staff and others in the jail setting. The statute has not solved the problem of prolonged wait times for admission from jails despite admissions under this statute occupying over 80% of Anoka Metro Regional Treatment Center and 40% of the Community Behavioral Health Hospital beds.[2]

In addition, patients in community hospitals and other settings waiting for admission to DCT programs are waiting much longer. Most individuals in these settings are unable to be admitted to DCT programs entirely since the Priority Admissions statute was enacted.

Average Referral Days to AMRTC for High Priority Admissions



The data shows the Priority Admissions statute did, in fact, result in prompt hospitalizations once a person met the statutory criteria for several years, specifically until 2021 when wait times dramatically increased. This increase was due to several factors, including Covid restrictions, workforce shortages, increased number of

[2] Of those at AMRTC not admitted under the Priority Admission Law, 87% were emergency transfers from other DCT programs unable to safely treat those patients.

admissions for those committed as MI&D creating more DNMC days. This all resulted in a reduction of capacity and increased wait times.

Lengthy Process

It is important to understand the time that elapses between when someone living with a mental illness is arrested until they are committed when the Priority Admission Law applies. Basically, a person is arrested for a crime and booked into jail. A court official raises the issue of the person being competent to stand trial and files a motion. The person is examined by a forensic psychologist or psychiatrist.[3] If the person is found incompetent to stand trial, they are referred to Prepetition Screening to determine if they meet the criteria for commitment. If they do, then the county attorney files for commitment and a court hearing is held. If the court commits the person, then the Priority Admission statute kicks in. As one can imagine, all these proceedings can take weeks, if not months, while the person in jail waits for required forensic evaluations and court hearings to take place. While there, individuals are often not receiving any or appropriate mental health treatment.

Unintended Consequences

In a little more than a decade since its implementation, the statute, despite its earlier benefits, has also produced some very serious and unintended consequences.

Increased Injuries Due to Higher Concentration of People in Facilities with Significant Symptoms

By 2014, the first full year after the law went into effect, the number of staff injuries due to patient aggression doubled at AMRTC, the primary facility to treat patients admitted under the law. By spring of 2015, patient assaults on staff significantly increased, primarily attributed to patients admitted from jails. The law itself did not make patients aggressive, but it increased the concentration of highly symptomatic patients who are more prone to aggressive behavior in a single setting. Labor unions demanded safer working conditions. Meanwhile, AMRTC had to reduce census in order to effectively support the population and had limited capacity to admit aggressive patients residing in community hospitals, which are not well equipped to manage the behaviors.

Today, injuries caused by patients acting aggressively remain a top concern at DHS-operated facilities. Controlling such incidents relies in large part on the ability to limit the number of patients admitted at any given time, lower patient census, and increase the staff-to-patient ratios at times when patients are highly symptomatic and are exhibiting aggressive or challenging behaviors.

Decreased Community Access to Treatment

Because the statute prioritized those in jails committed to DHS for treatment, there has been little room left for patients in hospitals and members of the community who also have been civilly committed for treatment and

[3] Forensic psychologist or psychiatrist complete specialized residency and fellowship training to be qualified do these sort of assessments.

care. The law has also significantly transformed the patient population in the seven state-operated psychiatric hospitals for adults. Today, 83 percent of patients at AMRTC have been admitted from jail under the Priority Admissions law. As many as 40 percent of all patients at the six state-operated Community Behavioral Health Hospitals (CBHHs) have been admitted under the law.

Each year, hundreds of Minnesotans with serious mental illnesses who would have been treated at AMRTC or the CBHHs before implementation of the Priority Admissions law have little or no chance of ever being admitted today. This leads to people having longer stays in a community hospital and people experiencing boarding in the ER. It interrupts people being able to flow through the necessary levels of care.

Conflicts with Medical Judgment and Safe Practice

The law interferes with the medical judgment of highly trained psychiatrists because it requires DHS to admit people from jails, instead of admitting people based on the judgments of DHS' medical professionals. These professionals have the necessary expertise and experience to determine which patients should be admitted to state-operated hospitals based on medical criteria, such as the severity of their conditions, and other relevant factors, not based solely on their presence in jail.

As the number of priority admissions from jails has more than tripled since 2014, the lack of sufficient capacity and the statute have placed DHS-operated treatment facilities in an untenable position. When the agency's psychiatric hospitals are full, DHS cannot admit new patients until there are open beds appropriate for their conditions and an appropriate level of staffing to care for them safely, as demanded by federal and state regulations as well as ethical medical practice.

Legal Consequences

DHS has been the subject of several individual and class-action lawsuits seeking to force the Commissioner of Human Services to admit patients waiting in jails, even when no clinically appropriate beds are available.

Litigants have brought lawsuits in state and federal court seeking to compel DHS to admit patients waiting in jails to a state-operated treatment facility. In addition, litigants have also sought monetary damages. Some courts have issued orders to compel admission to state-operated treatment facilities or to provide reports regarding wait times on behalf of plaintiffs or on their own as part of commitment proceedings. The Minnesota Court of Appeals has reversed orders to compel admission and reporting requirements due to lack of personal jurisdiction because DHS is not a party to civil-commitment proceedings. Additionally, DHS has argued it is unable to comply with an order to compel immediate admission because state treatment facilities are operating at capacity and no medically appropriate bed is available in the time frame ordered. Courts have dismissed most claims that DHS has violated the constitutional rights of jailed plaintiffs by not complying with the admission of the individual within 48 hours after meeting the admission criteria under the Priority Admissions law. However, two federal courts have indicated that a civilly committed person's inability to challenge a DHS determination that a person does or does not fall within criteria of the Priority Admissions Law could violate the Fourteenth

Amendment's procedural due process protections.[4] One of those federal courts dismissed the complaint but allowed plaintiffs to replead their due process claim after acknowledging that such a claim may exist as a matter of law.[5]

Nevertheless, continued litigation remains a constant reality.

Minnesota is not alone in facing judicial scrutiny over access to mental health treatment. Many states are faced with litigation regarding this issue. In *Trueblood v. Washington State Department of Social and Health Services* regarding waitlists for state hospital beds, the court found that "[o]ur jails are not suitable places for the mentally ill to be warehoused while they wait for services. Jails are not hospitals, they are not designed as therapeutic environments, and they are not equipped to manage mental illness or keep those with mental illness from being victimized by the general population of inmates. Punitive settings and isolation for twenty-three hours each day exacerbate mental illness and increase the likelihood that the individual will never recover." [6] The state was to provide competency evaluations within 14 days, and restoration services within seven days of the court ordering them. Despite efforts to expand access in Washington, the state has not been able to meet these standards and is facing ongoing litigation and penalties.

A Problematic Solution

The Priority Admissions Law attempted to reduce the number of patients waiting in jails for limited spaces in state operated treatment facilities. But applying that protection only to patients in jails rather than increasing capacity has proven unsuccessful.

Even as patients admitted from jails have filled AMRTC and taken up more than one-third of the treatment capacity at the CBHHs, jails continue to be strained by an ever-growing population of people in custody with mental illnesses and priority admissions waiting lists are the norm.

Although people with mental illnesses waiting in jails were prioritized for admission over people with mental illnesses in hospitals, both typically wait an inordinately long time for access to mental health treatment facilities as demand continues to outpace secure treatment capacity. Today, far too many people living with mental illnesses in jails, hospitals, and the community wait, sometimes for weeks or months, for admission to state operated services or to appropriate treatment services in less restrictive community-based settings.

Inadequate capacity at state-operated treatment facilities combined with far too few community-based step-down treatment options for patients who no longer need a hospital level of care have effectively blocked access

[4] *See Chairse v. Dep't of Human Services*, 23-CV-355, at 11-12 (D. Minn. Sept. 14, 2023) (denying motion to dismiss plaintiffs federal and state procedural due process constitutional claims); *Dalen v. Harpstead*, 23-CV-1877, at (D. Minn. Jan. 16, 2024) (dismissing plaintiffs' complaint without prejudice).

[5] *Dalen v. Harpstead*, 23-CV-1877, at (D. Minn. Jan. 16, 2024) (dismissing plaintiffs' complaint without prejudice).

[6] Id. At 2 Trueblood et al v. Washington State DSHS, No. 2:2014cv01178, at 2 (W.D. Wash. Dec. 2018)

to appropriate treatment for most others within the state. Further, emergency rooms and acute care hospitals are forced to keep a growing number of patients waiting for placement for increasingly long periods of time, in some cases as long as a year or more, while rendering beds inaccessible, and putting staff at risk. The lack of available treatment options ultimately made the Priority Admissions solution ineffective and had the unintended consequence of restricting access to treatment for everyone. DCT currently lacks sufficient capacity to respond to the growing number of patients subject to the statute and patients waiting in hospitals and in the community. The number of unserved patients in the community is unknown. However, what is known is there is a significant issue with effective flow of admissions to and discharges from DCT programs.

The Priority Admissions Law has not solved the problem it was intended to solve. The conditions that brought the law about have grown worse – and over time have resulted in a cascade of other problems.

The Task Force brings key stakeholders together to take a thorough look at how the law affects all parties individually and the mental health system as a whole and to consider whether permanent changes to the law may be warranted. This shared problem requires thoughtful solutions that do not pit stakeholders against each other or merely shift the burdens from one stakeholder to another. In establishing this Task Force, the Legislature has recognized the need for a more thoughtful examination of the issues and more workable solutions for everyone involved. This task force presents an unprecedented opportunity to reconsider the law's goals and effects – and the underlying conditions in the state's mental health system that make the current course of action untenable and irresponsible.

Prior Reports and Recommendations

There have been many recent task forces and studies on how to adequately build the mental health system in Minnesota, and some current Priority Admissions Task Force members have also participated in these past efforts. Most recently, the Community Competency Restoration Task Force (CCRTF), which was empaneled in 2020-21, provided an extensive list of recommendations in its report.

In reviewing the recommendations of the CCRTF and many other reports, several common themes have emerged:

- Early intervention is key. Ensure that people receive the right level of care at the right time in the right place to prevent hospitalizations, jail, suicide, and suffering.
- Expand county mobile crisis teams, crisis beds, and psychiatric emergency rooms. Increase the collaboration on the local level between crisis teams.
- Ensure no wrong door with 911 and publicize new 988 availability for emergency assistance.
- Improve access along the entire continuum of care – hospital beds, residential, crisis beds, intensive community care. Ensure mental health services are reimbursed at a level that pays for the cost of care – including having higher rates and ensuring that private insurance pays for needed services (parity).
- Develop protected transport across the state.

- Address the need for all types of housing – affordable and supportive – integrated with treatment and other social supports, especially for those with difficult rental histories or who are justice involved.
- Address the mental health workforce shortages and lack of diversity in treatment providers.
- Promote greater collaboration on the local level.
- Increase capacity to provide integrated services to people with co-occurring mental illnesses and substance use disorders.
- Provide funding for counties to pilot voluntary engagement services under Minn. Statute § 253B.041, including funding for data collection and analysis of measures, outcomes, and possible cost savings.
- Provide funding for diversion programs and create incentives for community partnerships.
- Remove barriers to providing mental health treatment in jails.

Several recommendations from the Community Competency Restoration Task Force and prior reports have been partially implemented:

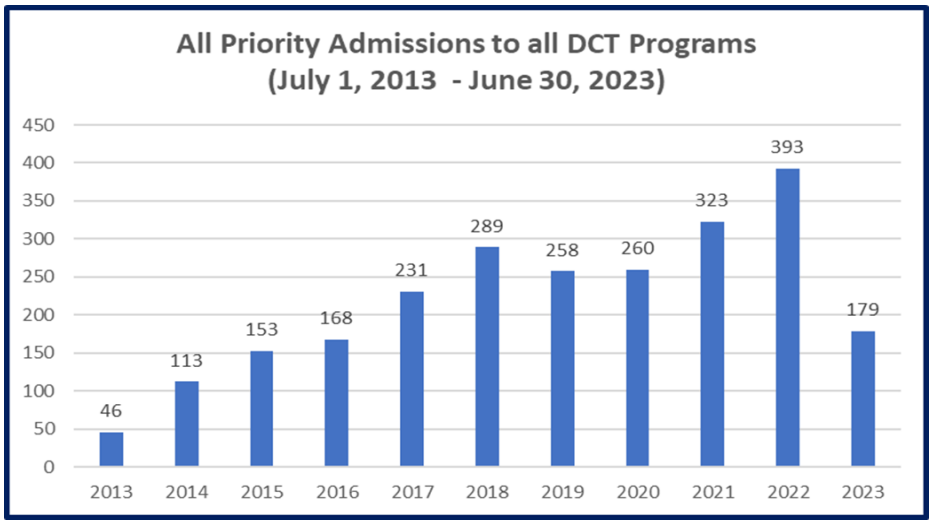
- Mobile mental health crisis teams cover all 87 counties and there are several crisis beds. However, funding is not adequate to fully divert people from the criminal justice system, and the statewide funding for crisis teams is less than the budgets of police departments in major cities in Minnesota.
- Telehealth and telephonic health are being used but there is limited access for people who do not have access to reliable internet.
- Protected transport (nonemergency medical transportation) is a Medicaid benefit but there are only a couple of vehicles operating statewide.
- Increased funding in key housing programs has increased access for people with mental illnesses, but unmet needs are great.
- Several pieces of legislation have passed to address the workforce crisis. (See Appendix 2).
- The 988 suicide and crisis line is being implemented although it's based on area code and is not geographically based (a federal issue).
- Enforce parity with insurance plans to increase access to mental health care. (Partially implemented)
- Invest in landlord risk mitigation funds to decrease the perception of risk about renting to people with mental illnesses or criminal records.
- Provide additional funding and expand the use of DHS grants to pay for supervision of BIPOC trainees and traditional healers in American Indian communities.

- Provide funding to pay for continuing education credits for BIPOC mental health professionals to become supervisors.
- Expand the definition of a mental health practitioner so that providers who utilize students completing a practicum or internship can bill for services and support both the provider and student.
- Increase funding for loan forgiveness programs for BIPOC mental health professionals and professionals serving rural and other underserved communities and expand programs to include Licensed Alcohol and Drug Counselors.
- Require mental health licensing boards to have representation from rural, BIPOC, and underrepresented (racial and ethnic) communities.
- Convene a task force on culturally informed and responsive mental health to create a more diverse workforce and meet the needs of all Minnesotans.
- Require at least six hours of training and continuing education on culturally informed practice for all mental health professionals and practitioners including cultural competence and humility.

Current Trends and Statistics

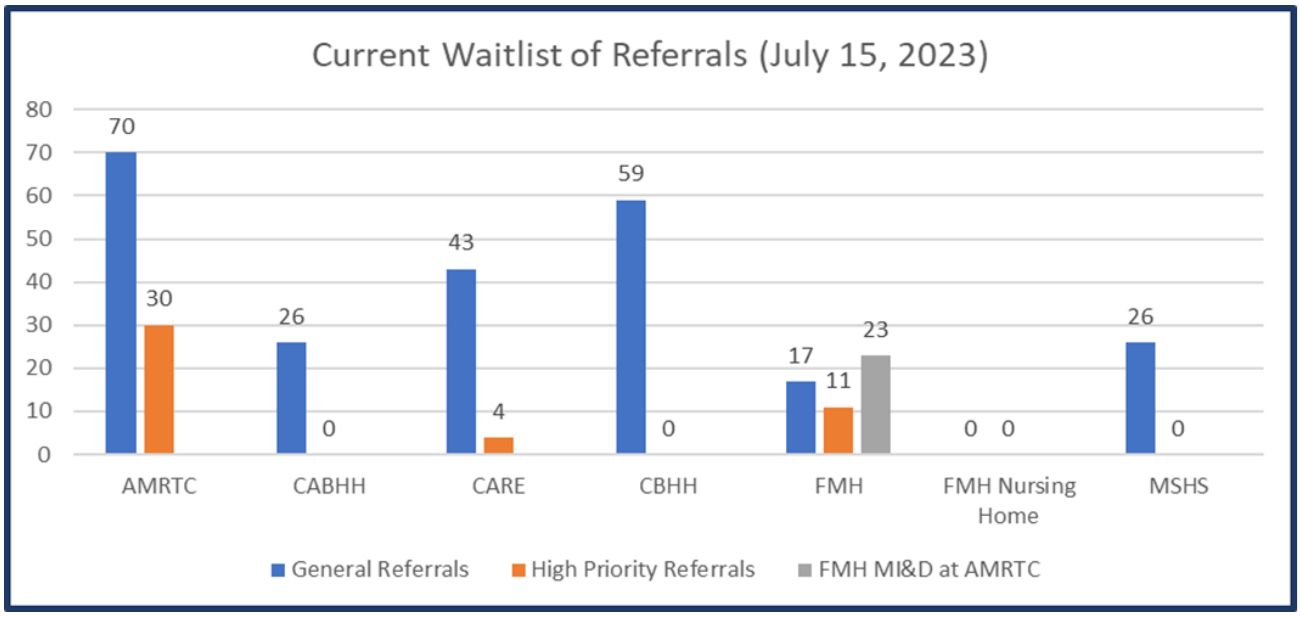
The Task Force members reviewed data and trends related to admissions, waitlists, referral sources, by state and by county as directed by the legislature. The most salient information is included here, with additional data included in Appendix 1.

Priority Admissions to all DCT Programs



This graph illustrates admissions made under the Priority Admissions statute to all DHS-operated treatment programs since the law's inception on July 1, 2013.

Current Waitlist for Referrals to DHS-Operated Programs



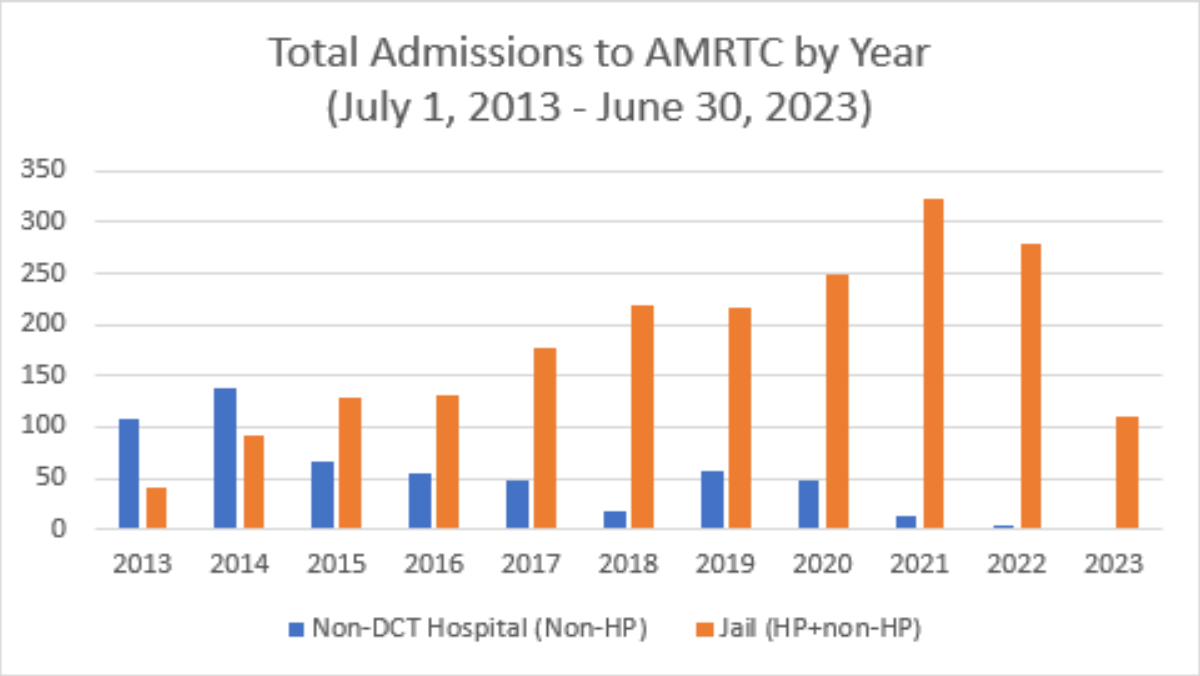
This graph illustrates the waitlists for DHS-operated treatment programs on July 15, 2023. The numbers are a snapshot on this date and time and can rise and fall from day to day as patients are discharged and new patients are admitted. High Priority Referrals and General Referrals are depicted separately on the graph. Those two numbers combined represent the total waitlist at each facility. For example, AMRTC has 70 general referrals and 30 high priority referrals for a total waitlist of 100 at that facility.

The graph does not include Community-Based Services or the Minnesota Sex Offender Program because these DHS-operated programs are not typically sites for Priority Admission referrals.

Acronym Key:

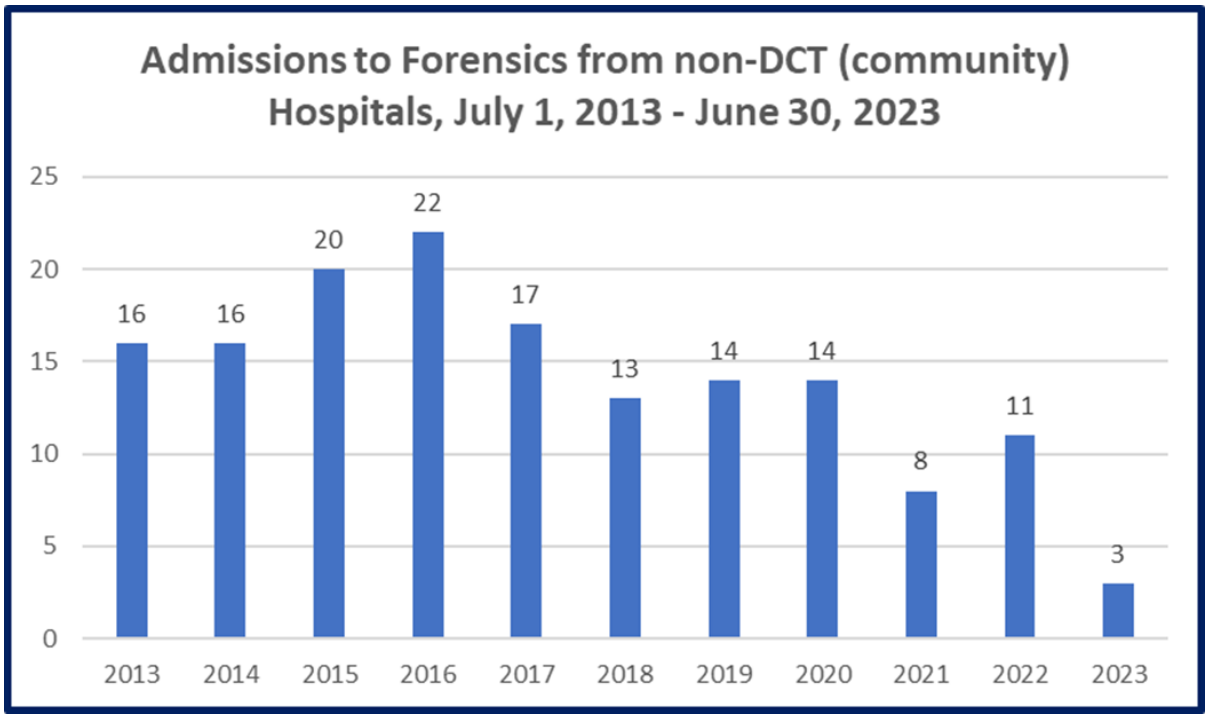
- AMRTC – Anoka-Metro Regional Treatment Center
- CABHH – Child and Adolescent Behavioral Health Hospital
- CARE – Community Addiction Recovery Enterprise
- CBHH – Community Behavioral Health Hospitals
- FMHP – Forensic Mental Health Program (known in statute as the Minnesota Security Hospital)
- MSHS – Minnesota Specialty Health System

Admissions to Anoka-Metro Regional Treatment Center



Admissions to the Anoka-Metro Regional Treatment Center from community hospitals have declined sharply due to the Priority Admission statute. AMRTC is the largest state-operated psychiatric hospital and the facility most able to treat highly symptomatic patients who have complex and difficult-to-treat mental illnesses. Shown here is the overlay of admissions to AMRTC from jails in the same period.

Admissions to the Forensic Mental Health Program from Community Hospitals



Prior to March of 2021, the Forensic Mental Health Program occasionally accepted referrals from community hospitals when needed. However as of March 20, 2021, the FMHP only admits individuals civilly committed as Mentally Ill and Dangerous. Admissions from community hospitals since that time reflect individuals who have had their provisional discharges revoked and must return to the FMHP by statute.

Discussion and Analysis

Demand for Services

Demand for mental health services has grown over many years, and more people living with mental illnesses were confined too in the criminal justice system, leading to the Priority Admissions law in 2013. Since then, the number of individuals civilly committed under various commitment types has continued to grow. Amidst fragmented systems of care, the opioid epidemic, and increasing levels of criminal justice involvement for those with mental health concerns has led to the backlog of people in need of critical mental health services across the country and in our home state.

At this time, placement within DCT programs for those in jail meeting the priority admissions criteria is not based on clinical need or individual circumstances, but rather based on the statutory obligation to prioritize those admitted from jails within 48 hours of when a medically appropriate bed is available. This results in inequitable access to state operated services, despite recognition that those in jails suffering from acute mental health symptoms require timely and robust care. Other variables impacting DCT admissions include the process of adding individuals to wait lists, the information shared with DCT at the time of referral, and difficulties in

discharging patients to community settings or the Forensic Mental Health Program in St. Peter. Families have also been told to call the police because their loved one with significant illness can effectively only get into a DCT facility if they are placed in jail.

DCT Capacity and Access

There is insufficient capacity in DCT programs, despite the extensive and successful efforts by DCT to streamline processes, efficiently utilize existing resources, and expand transition options. If the problem is characterized through a business process lens, it would be summarized as a significant amount of demand and a concerning lack of supply. For some programs, there are more individuals on the waiting list than there are beds in the program. This is due primarily to two separate but related factors. First, the extraordinary demand for services across the state for all levels of services ranging from secure to residential. Secondly, DCT is unable to discharge or transfer existing patients into an appropriate care level setting once stabilized. These factors result in avoidable days in DCT settings, and costs to the counties, referred to as Does Not Meet Criteria (DNMC) days. Despite several efforts aimed to reduce these days, the issues persist due to lack of community capacity. Without added community placement options, DCT is unable to admit and meet the needs of individuals with highly acute symptoms who do require intensive treatment for longer than expected time periods. Additionally, shortages in staffing have contributed to census limitations. It is well known this bed shortage generates significant costs across multiple state and local agencies, jails, and community hospitals that runs well into the millions annually.

Community Capacity and Access

Minnesota has made important investments in community-based services for mental health over the years, yet despite these efforts there remain many individuals who lack access to timely appropriate levels of care in the community. Additional community-based services including early intervention, crisis support, short- and long-term residential treatment and housing, and other therapeutic services are needed statewide. An inability to access services such as these decrease the likelihood that (1) security and safety can be established and (2) that the individual is able to be treated in the least restrictive community setting. Due to shortages of community-based settings, some people are forced to live or receive care in settings that do not adequately align with their needs. The cares are either less than or greater than what is clinically recommended, simply because any care is superior to none. Additionally, workforce shortages have resulted in wait lists for outpatient services and an insufficient supply of home-based service providers make independent living a daily challenge for many. This reality can lead to inadequate support of individuals in community settings until their condition deteriorates to the point when hospitalization is needed, symptoms contribute to criminal justice involvement, or they reside on the fringes of society where their needs go unmet.

Treatment Capacity in Jails

It is common for individuals in custody to not have access to sufficient mental health care services due to several factors. Some of these include lack of mental health professional services within jails, lack of access to mental health medications, and capacity to make informed healthcare decisions by those experiencing significant symptoms of mental illness. Most relevant to this report is the reluctance of many county jails to administer

neuroleptic medication pursuant to a court order. The Office of the Legislative Auditor examined this issue in a report published in 2016. In that report they recommended "the Legislature consider statutory changes that would allow jails that have proper staffing and training to administer medications involuntarily at a court's direction." Despite a statute change in 2020 which made it clear that jails could administer involuntary medications, there has been little advancement in this effort. Factors such as workforce shortages, lack of medical training, contracted medical staff not offering the service, and legal concerns regarding use of physical restraint to safely administer the medications continue to be barriers that jails face with this topic. Between delays in court processes and admissions, many people are waiting in jails for weeks or months, sometimes while being held in isolation, without access to appropriate treatment for their symptoms. There is no statutory barrier to the provision of mental health medications, but there are significant practical barriers which must be addressed. The fundamental purpose of a jail is not to serve as a specialized mental health treatment facility. There will continue to be people who are civilly committed yet do not meet hospital level of care that need to remain in jail, and the current barriers for treatment for those individuals can be overcome with the right investments.

The Cost of Doing Nothing

The undeniable price of doing nothing will be borne by the people waiting to access the mental health services they need. The steep and immeasurable human cost will worsen, and due to the inability to provide treatment we are forced to stand by and watch people's mental health deteriorate. Without an increase in inpatient, residential, and community-based services the number of those waiting will continue to rise dramatically. The measurable cost of inaction include increased litigation, the costs of boarding people in hospitals and jails, and the increasing unrealistic demands on public safety responding to community crises that could have otherwise been prevented.

Recommendations

The Task Force concludes that the state needs to increase access to mental health treatment at all care levels. This includes increasing access at all levels of care – such as state operated programs and community-based programs. We must also increase access to care for people with mental illnesses in our jails. While solutions are costly, we are facing increasing demands with an underfunded system. The Task Force recommends that swift action in all these areas collectively be taken to address the crisis state of our mental health system, as there are no other solutions available to address the problem. If the critical lack of available capacity across the system is not addressed, the humanitarian and constitutional issues previously raised will only worsen, and any change to the Priority Admissions Law will be systemically ineffective in meeting the current and increasing demand. Any change to the Priority Admissions law must be accompanied by increases in inpatient, residential and community outpatient services. The recommendations below are the most important and effective solutions to solve this problem.

Recommendation I: Immediately Begin to Increase Direct Care and Treatment Capacity and Access

Immediately begin to increase bed capacity and access to services by Direct Care and Treatment in all levels of care, with priority given to expanding capacity within the Forensic Mental Health Program, Anoka Metro Regional Treatment Center, and Community Behavioral Health Hospitals to provide relief to hospitals and jails which are holding individuals awaiting the specialized treatment of DCT. The Task Force recommends that work begin immediately to increase the capacity of the Forensic Mental Health Program by 10-20%, and capacity at the Anoka Metro Regional Treatment/Community Behavioral Health Hospital level of care be increased by 20%. Increased capacity can be achieved through the addition of beds and staffing, renovation, construction, reallocation of beds and staff, or a combination of all these. Task force members will reassess the impact and set metrics to measure the progress added capacity has made in comparison to demand as part of the activities outlined in Recommendation IV.

Examine the utilization of beds at the Forensic Mental Health Program to identify opportunities for most effective utilization of secured programming. This may include revised admission, revocation, and discharge criteria and practices.

Develop and fund DCT's transitional support resources which can assist in transitioning individuals out of inpatient settings, thus increasing community capacity.

WHY THIS IS IMPORTANT: This recommendation to expand access to services provided by DCT is critically important. Without expansion, any of the other recommendations will not yield results that will be felt systemically. Boarding in emergency departments will continue to rise, people will continue to be held in jail without due process, and vulnerable Minnesotans will remain untreated. FMHP beds are the most specialized and secure in the state and are unable to be replicated in the private sector. The rate of admissions is far exceeding the rate of discharges.

Recommendation II: Joint Incident Collaboration

Start a Joint Incident Collaboration including county, community providers, and DHS and DCT partners to engage in arranging discharges more actively for DCT patients who are ready for discharge.

WHY THIS IS IMPORTANT: The single biggest barrier to accepting individuals into DCT for treatment is the lack of ability to discharge those who are medically stable for discharge, but for whom there are barriers to discharge. We must work with urgency to move patients who are ready for discharge out of DCT and into community settings. This structure would be in addition to, and in coordination with, the multiple efforts that are already underway by DCT and county partners to reduce barriers to discharge and move patients into more appropriate settings. This effort would have no state budget impact, save counties DNMC fees, and be the most direct way to increase DCT capacity.

Recommendation III: Approve an Exception to the Priority Admissions Law

Immediately approve an exception to the Priority Admissions Statute for up to 10 civilly committed individuals waiting in a hospital to be added to the Priority Admissions waitlist at DCT, with admissions being managed according to the prioritization framework recommended below.

WHY THIS IS IMPORTANT: The task force has heard about many individuals who are in dire need of DCT services who are currently waiting in hospitals receiving treatment which is not sufficient and/or is so prolonged as to impact capacity of that hospital substantially. By creating an exception for a limited number of individuals while other recommendations are being implemented, we offer immediate relief to those who have been waiting at least 6 months and/or whose symptoms can only sufficiently be treated by DCT. Additionally, this will allow community hospitals to admit more patients to their behavioral health units.

Recommendation IV: Create and Implement New Priority Admissions Criteria to DCT Facilities.

Any change to the Priority Admissions law must occur simultaneously to or following the immediate increase in capacity at DCT as referenced in Recommendation I, above.

Amend Minnesota Statute, section 253B.10, subdivision 1, paragraph (b) to improve the priority admissions requirements and process.

Individuals civilly committed as Mentally Ill, Chemically Dependent, Mentally Ill and Dangerous, and Developmentally Disabled will be prioritized by physicians in the DCT Executive Medical Director's Office for admission to Direct Care and Treatment programs into medically appropriate beds using an established prioritization framework which takes several factors into account. This publicly available framework for prioritization of admissions will allow for transparency in decision-making, an equitable way to prioritize admissions, and decisions to depart from these criteria must be justified. These will include but are not limited to:

- Length of time spent on a waitlist for DCT admission.
- Intensity of treatment needed due to medical acuity.
- Provisional discharge status
- Current safety of the individual and others in the proximal environment.
- Access to/or lack thereof to essential or court-ordered treatment in a non-DCT environment.
- Other negative impacts to the referring facility, such as the number of beds unavailable because of caring for the referred individual.
- Any relevant federal prioritization requirements.

A panel of members from the Priority Admission Task Force will review deidentified data quarterly for one year following implementation of this new framework to ensure the prioritization framework is carried out in a fair

and equitable manner. Additionally, the members will advise the Commissioner of Human Services on the effectiveness of changes to priority admissions. At the end of the year, this task will fall to a newly established Quality Committee, which will provide a routine report to the DCT Board of Directors. DCT will utilize a utilization management process for admission prioritization which provides an additional review of admissions and provide an avenue for requests for reconsideration by interested parties.

DCT will allow individuals to be on a waitlist for multiple DCT facilities at the same time, if available, to ensure responsive and timely admissions.

WHY THIS IS IMPORTANT: Any changes made relative to the Priority Admissions Statute will not create additional bed capacity in DCT facilities, nor will it reduce the waitlists for admission to DCT facilities. Arguably, it will increase the waitlists as hospitals that have stopped referrals in the past years will resume making referrals once again, providing a more accurate picture of bed capacity demands than the current wait list demonstrates. However, it is important to allow transparent access for individuals to access state services without the inadvertent systemic criminalization of mental illness we now see. Additionally, allowing access to DCT facilities will allow community hospitals to treat more individuals safely.

Recommendation V: Increase Access to Services Provided in the Community

Increased access to community services will prevent the need for hospitalization and facilitate successful discharge planning when leaving a hospital setting. Recommended actions include:

- Expand access to Intensive Residential Treatment Services (IRTS) level of care to allow locked programming and expand the length of treatment beyond 90 days. Work with physicians and mental health providers and the counties to address other barriers that exist with development of this unique level of service, including having MinnesotaCare pay room and board costs. Work with the Minnesota congressional delegation to have CMS allow Medicaid for locked IRTS facilities.
- Fund services at levels recommended in the current Rate Study to retain current providers and encourage development of new providers.
- Fund voluntary engagement pilot programs and study their efficacy.
- Support strategies to decrease the timeline for the completion of MN Choices assessments.
- Expand access to Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) by expanding the number of teams available across the state and eliminate the host county contract.
- Expand First Episode of Psychosis programs and pilot First Episode of Bipolar Disorder programs to provide intensive treatment and supports to people with schizophrenia, schizoaffective disorder, and bipolar disorder. People with these disorders often end up in our criminal justice system.

- Focus on alternatives to police responses by building and stabilizing funding for crisis response teams, publicizing 988, and fully implement Travis' Law.
- Support mental health workforce through increasing compensation, providing free supervision, expanding training opportunities for integrated substance use disorder and mental illnesses, and developing measures to reduce violence in the workplace.
- Expand the sick and safe law to included mental health leave benefits for frontline workers.

WHY THIS IS IMPORTANT: Community-based care comprises most services available to individuals with mental illnesses. The recommendations for community-based care can be utilized to address both the input (proactive prevention) and output (community stabilization) facets of the causal factors. It is also understood that hospital bed capacity expansion alone will not address the state's long term mental health needs.

Recommendation VI: Administer Medication in Jails

Jails are not a replacement for mental health hospitals or secure treatment facilities, and it is not our recommendation that they become so.

- Provide funding mechanisms to effectively administer mental health medications to individuals in jail custody. Funding would pay for training, the medication, the services of an individual qualified to deliver the medication and monitor the individual, and any related administration costs.
- Funding should be provided for DHS/DCT to create a service to support efforts to access mental health medications in jails when appropriate. This will include provision of expert consultation, education, coordination, and determination of suitable providers for involuntary medication administration.
- An inmate receiving a mental health medication in the jail shall not have an obligation for a co-payment as required under 641.15 subdivision 2.

WHY THIS IS IMPORTANT: Providing access to necessary health care to individuals in custody is a constitutional right, and that includes court ordered medications. There are jails unable to safely administer psychotropic medications due to not having trained medical professionals available accompanied with complexities related to the use of restraints, if needed to administer the medication in a safe manner. There is a widespread lack of understanding of best practices around medication administration, and no mechanism to support these efforts. DHS/DCT is uniquely suited to help support statewide efforts, if funded to do so. By leveraging their expertise and resources, DHS/DCT can play a pivotal role in implementing and promoting best practices in involuntary mental health medication administration across the state. This recommendation has the possibility to significantly prevent the need for hospitalization of some individuals, improve safety within jails, decrease recidivism, and improve outcomes for people living with mental illnesses.

Recommendation VII: Relieve Counties of Certain DNMC Costs

Relieve counties of DNMC costs for individuals awaiting transfer to DCT programs when the Executive Medical Director's office deems the individual meets criteria for that program and DCT is the only provider that can

reasonably serve that person. Additionally, relieve counties of DNMC costs when awaiting transfer to a Department of Corrections Facility. Further, redirect and reinvest DNMC payments to support development of community services.

Amend statute to relieve counties of the financial burden of Does Not Meet Criteria costs for individuals who are awaiting transfer to other DCT programs or DOC facilities when that program or facility is the only program that can reasonably serve that individual as determined by the Executive Medical Director's office. Because counties are unable to influence the discharge timeline they should not be penalized under these circumstances.

Redirect county DNMC payments to the DHS budget instead of the current pathway to the state's general fund.

DHS will then permit counties access to the DNMC payments returned to the general fund to expand the scope of community services to successfully support individuals in community settings.

WHY THIS IS IMPORTANT: Counties are required to use local property tax dollars to support the costs of some individuals being cared for by the state's Direct Care and Treatment system. Counties are charged for 100% of the cost of care when an individual is in a DCT and no longer meet medical criteria. This is problematic when the person can only reasonably be served by another DCT program and there are no openings available, or must return to a DOC facility to serve a sentence. Counties have no ability to influence the discharge timeline. Without a change, counties will continue to pay millions of dollars to the general fund for circumstances beyond their control. Additionally, by permitting counties to use the dollars they are spending for DNMC fees to expand community capacity, they will reduce reliance upon state resources for future needs.

Recommendation VIII: Expedite Section 1115 Waiver Application for Individuals in Custody.

DHS should complete the application for an 1115 Medicaid Demonstration Waiver to facilitate individuals in custody to receive Medicaid benefits so that treatment can be subsidized within a correctional setting and allow for robust discharge services to be arranged. The waiver should focus on allowing access to Medicaid for individuals in custody within 90 days of release and all individuals in pre-trial status.

WHY THIS IS IMPORTANT: Unlike many other states in the nation, Minnesota has not yet submitted a Section 1115 Waiver even though the federal government has encouraged states to do so. Research has shown the positive health outcomes of individuals who are able to transition into or out of jail with health care in place, with significant positive results for individuals with substance use disorders and other chronic health conditions. The process for approval is a lengthy, with the negotiation process between the state and the federal government lasting months or years.

Recommendation IX: Increase Forensic Examiner Accessibility

To increase the pool of forensic examiners and reduce the associated wait time, the rate of reimbursement for forensic examiners who conduct Rule 20 examinations should be increased. The rate of pay should be commensurate with the time to complete the examination and the associated liability that the examiner holds. Additionally, introduction of efficiencies in the Rule 20 process, such as screening examinations, should be implemented.

WHY THIS IS IMPORTANT: Forensic examiners possess a unique skill set and level of training to perform this service to the courts. Lack of commensurate pay for this work serves to limit the pool p of qualified examiners and slows the process for weeks, if not months. This is a rate limiting step in the Rule 20 process, and without examiner capacity increasing, people will continue to wait regardless of what other measures are implemented.

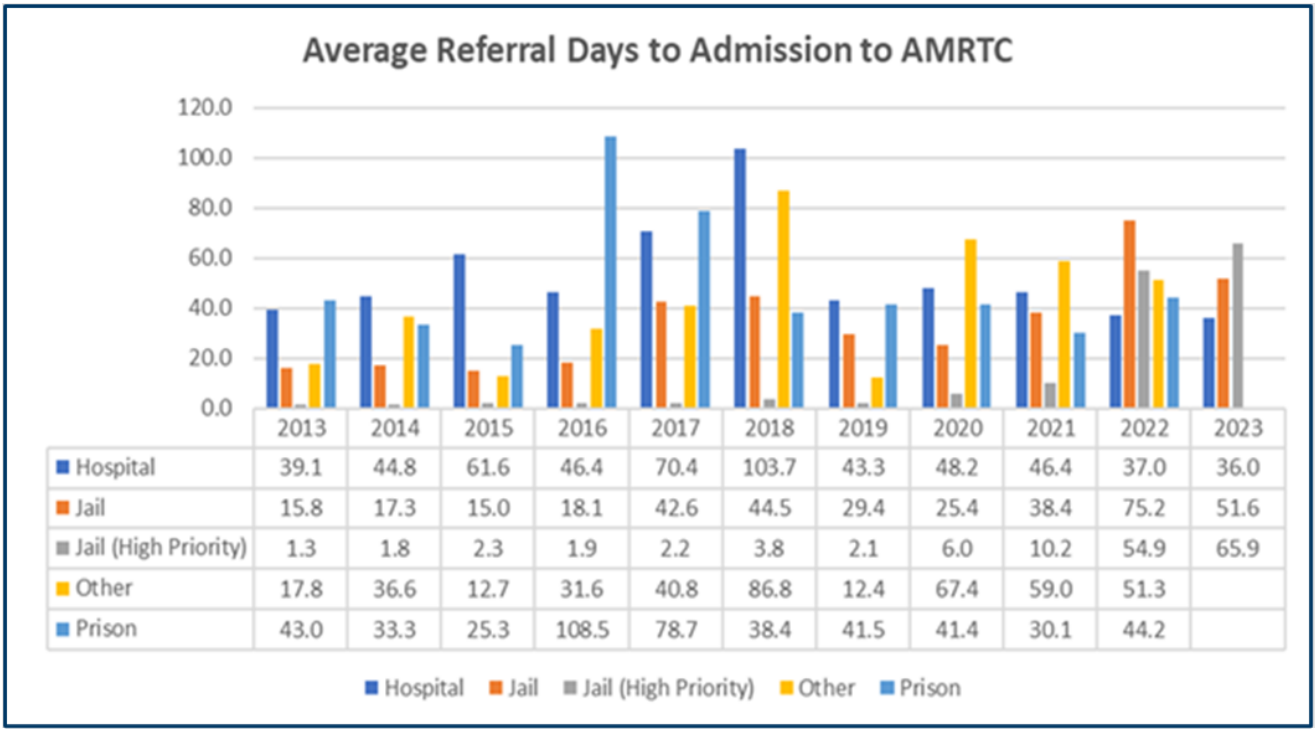
Appendix 1: Other Key Data

Priority Admissions Referrals by County, January 2020 thru June 2023

The following table shows the number of admissions by county from January 2020 through June 2023, by year and cumulatively. To protect patient privacy, counties that referred 10 or fewer individuals in any given year or cumulatively are reflected by Not Reportable (N/R). Counties with no referrals in any given period are represented by 0.

County	2020	2021	2022	2023	Total	County	2020	2021	2022	2023	Total
Hennepin	65	96	113	42	316	Le Sueur	NR	NR	NR	NR	NR
Ramsey	46	100	114	43	303	Lyon	NR	NR	NR	0	NR
St Louis	12	18	28	NR	67	Mahnomen	NR	0	0	0	NR
Dakota	10	15	12	NR	45	Marshall	0	0	NR	0	NR
Clay	NR	18	NR	NR	38	Martin	NR	NR	NR	0	NR
Cass	13	NR	11	NR	36	McLeod	NR	NR	NR	0	NR
Stearns	NR	11	11	NR	32	Meeker	0	NR	NR	NR	NR
Anoka	NR	NR	NR	NR	27	Mille Lacs	0	NR	0	0	NR
Olmsted	NR	NR	NR	NR	19	Morrison	0	NR	NR	0	NR
Blue Earth	NR	NR	NR	0	17	Murray	NR	0	NR	0	NR
Goodhue	NR	NR	NR	NR	17	Nobles	NR	NR	NR	0	NR
Wright	NR	NR	NR	NR	17	Norman	0	0	0	NR	NR
Beltrami	NR	NR	NR	NR	15	Otter Tail	NR	NR	NR	NR	NR
Crow Wing	NR	NR	NR	NR	13	Pennington	NR	0	NR	0	NR
Itasca	0	NR	NR	0	13	Pine	NR	NR	NR	0	NR
Scott	NR	NR	NR	NR	13	Pipestone	0	0	NR	0	NR
Mower	NR	NR	NR	NR	12	Polk	NR	NR	0	NR	NR
Aitkin	NR	NR	NR	NR	NR	RedWood	0	NR	NR	NR	NR
Becker	0	NR	0	NR	NR	Renville	0	NR	0	0	NR
Benton	NR	0	NR	NR	NR	Rice	NR	NR	NR	NR	NR
Big Stone	0	NR	0	0	NR	Roseau	0	0	NR	0	NR
Brown	0	NR	NR	0	NR	Sherburne	0	0	NR	0	NR
Carlton	NR	NR	0	NR	NR	Sibley	NR	NR	0	NR	NR
Carver	NR	NR	NR	NR	NR	Steele	NR	NR	NR	0	NR
Chisago	NR	NR	NR	NR	NR	Stevens	0	0	NR	0	NR
Clearwater	0	0	NR	NR	NR	Swift	0	0	NR	0	NR
Cook	0	NR	NR	0	NR	Todd	0	0	NR	0	NR
Cottonwood	NR	NR	0	0	NR	Traverse	0	0	0	NR	NR
Dodge	NR	NR	0	NR	NR	Wabasha	NR	NR	NR	0	NR
Douglas	NR	0	NR	NR	NR	Wadena	0	NR	NR	0	NR
Faribault	NR	NR	NR	NR	NR	Waseca	0	0	0	NR	NR
Fillmore	0	NR	NR	0	NR	Washington	0	NR	NR	0	NR
Freeborn	NR	NR	NR	NR	NR	Watonwan	0	0	NR	0	NR
Grant	NR	0	0	0	NR	Wilkin	0	0	NR	0	NR
Houston	NR	NR	NR	0	NR	Winona	0	NR	NR	NR	NR
Hubbard	NR	NR	NR	NR	NR	Yellow Medicine	NR	0	0	NR	NR
Isanti	NR	NR	NR	0	NR	Chippewa	0	0	0	0	0
Jackson	NR	0	NR	0	NR	Kanabec	0	0	0	0	0
Kandiyohi	NR	NR	NR	0	NR	Lincoln	0	0	0	0	0
Kittson	0	0	0	NR	NR	Nicollet	0	0	0	0	0
Koochiching	NR	NR	NR	NR	NR	Pope	0	0	0	0	0
Lac Qui Parle	0	0	NR	0	NR	Red Lake	0	0	0	0	0
Lake	0	NR	0	0	NR	Rock	0	0	0	0	0
Lake of the Woods	0	NR	0	0	NR	Total	259	388	421	170	1238

Average Referral Days to Anoka-Metro Regional Treatment Center



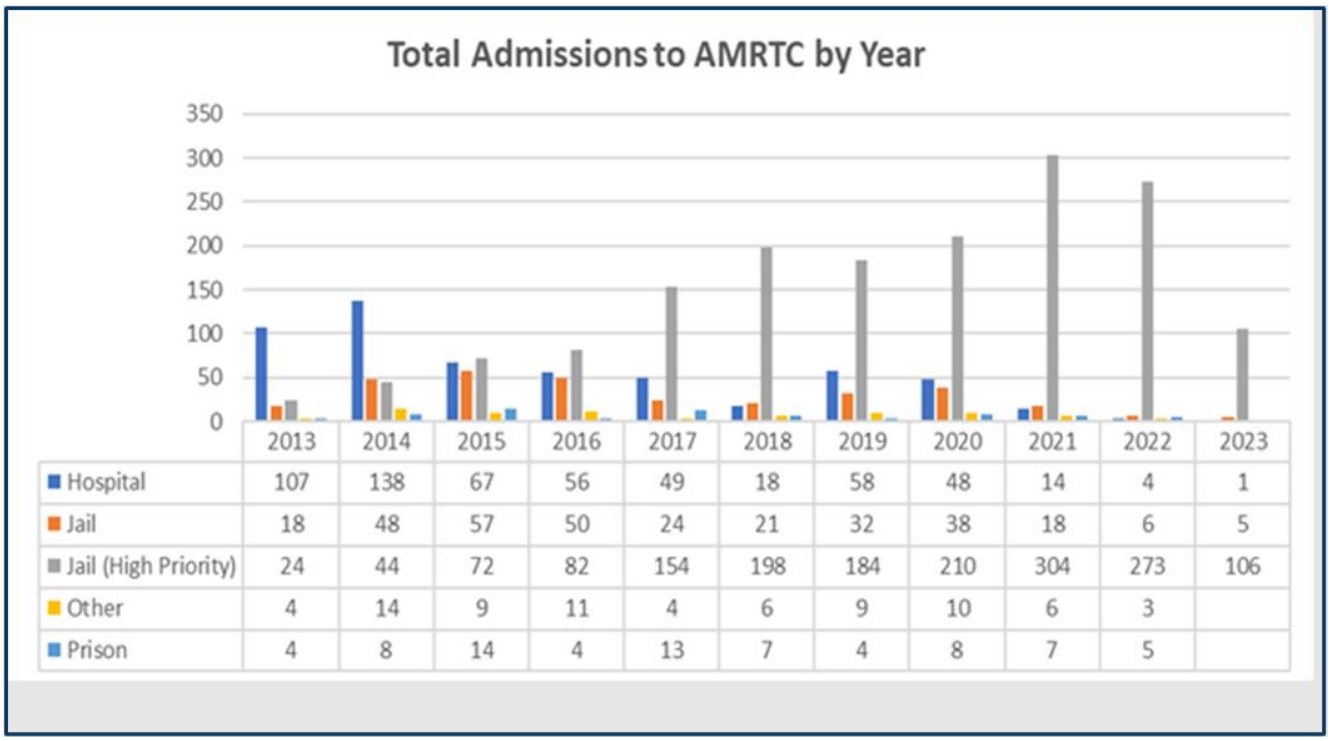
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Hospital	39.1	44.8	61.6	46.4	70.4	103.7	43.3	48.2	46.4	37.0	36.0
Jail	15.8	17.3	15.0	18.1	42.6	44.5	29.4	25.4	38.4	75.2	51.6
Jail (High Priority)	1.3	1.8	2.3	1.9	2.2	3.8	2.1	6.0	10.2	54.9	65.9
Other	17.8	36.6	12.7	31.6	40.8	86.8	12.4	67.4	59.0	51.3	
Prison	43.0	33.3	25.3	108.5	78.7	38.4	41.5	41.4	30.1	44.2	

The graph depicts the average number of days individuals spent on the waiting list before admission to Anoka-Metro Regional Treatment Center (AMRTC) between July 1, 2013, and June 30, 2023. The start date was calculated by the date of referral for all admissions except for those admitted under the Priority Admission Statute, which was calculated from the date the court order making them a priority admission was received. The date of a court order for non-priority admission referrals does not accurately represent the time a referral is on the waitlist because Central Preadmissions (CPA) does not record the date the court order was received for all these referrals and that may or may not be the day of referral.

Those admitted from the "other" category include individuals in community-based settings such as Intensive Rehabilitative Treatment Services (IRTS) facilities, detoxification facilities, private residences, homeless shelters, and others. Those admitted from jail include individuals in jail at the time of admission but who do not qualify for priority admission status. Those admitted from prisons reflect individuals under civil commitment referred for admission to AMRTC following completion of their sentence.

Acronym Key: AMRTC – Anoka-Metro Regional Treatment Center

Total Admissions to Anoka-Metro Regional Treatment Center by Year



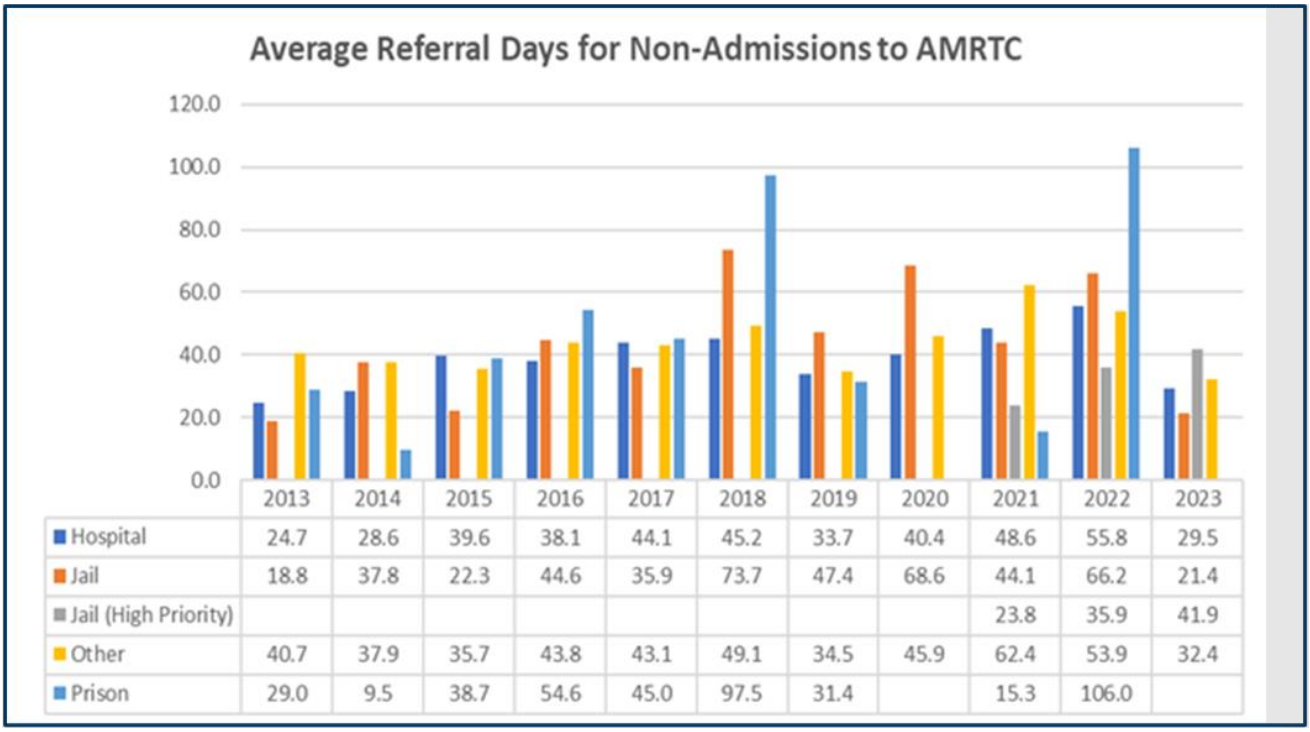
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Hospital	107	138	67	56	49	18	58	48	14	4	1
Jail	18	48	57	50	24	21	32	38	18	6	5
Jail (High Priority)	24	44	72	82	154	198	184	210	304	273	106
Other	4	14	9	11	4	6	9	10	6	3	
Prison	4	8	14	4	13	7	4	8	7	5	

Number of admissions to Anoka-Metro Regional Treatment Center between July 1, 2013, and June 30, 2023. Starting in January 2022, DHS's other Mental Health and Substance Abuse Treatment Services (MHSATS) programs, including the Community Behavioral Health Hospitals and the Community Addiction Recovery Enterprise (CARE) programs began to admit medically appropriate priority admission referrals. As a result, starting in January 2022, priority referral admissions to AMRTC do not represent the total priority admission referrals admitted to MHSATS programs. Also note that a small number of priority admissions are admitted to the Forensic Mental Health Program. Those admissions are not reflected here.

Those admitted under the "Other" category include individuals in community-based settings such as Intensive Rehabilitative Treatment Services (IRTS) facilities, detoxification facilities, private residences, homelessness, and others. Those admitted from jail include individuals in jail at the time of referral but who do not qualify for priority admission status. Those admitted from prisons reflect individuals under commitment referred for admission to AMRTC following completion of their sentence.

This chart shows that the total number of people AMRTC has been able to admit from community settings has decreased significantly over time as AMRTC has increased the number of priority referrals it is able to safely admit and treat.

Average Referral Days for Non-Admission to Anoka-Metro Regional Treatment Center

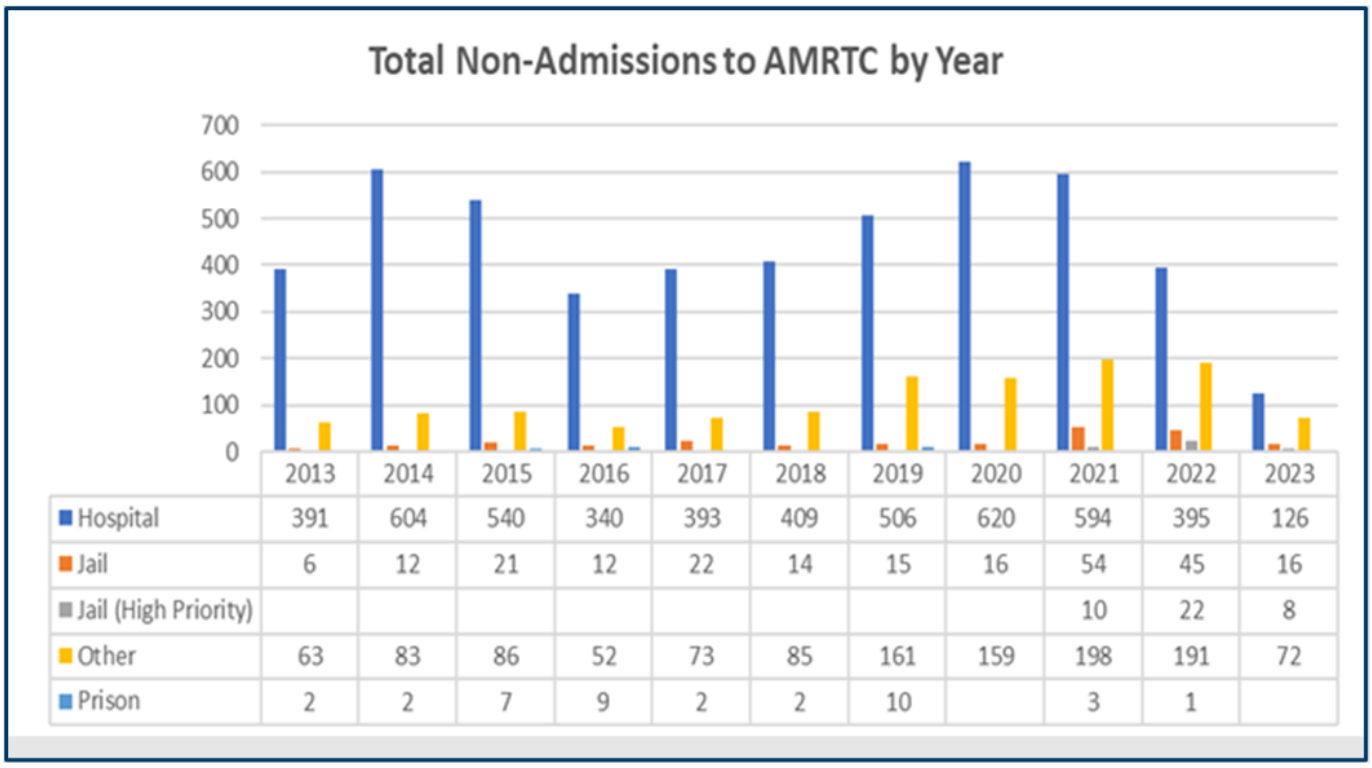


	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Hospital	24.7	28.6	39.6	38.1	44.1	45.2	33.7	40.4	48.6	55.8	29.5
Jail	18.8	37.8	22.3	44.6	35.9	73.7	47.4	68.6	44.1	66.2	21.4
Jail (High Priority)									23.8	35.9	41.9
Other	40.7	37.9	35.7	43.8	43.1	49.1	34.5	45.9	62.4	53.9	32.4
Prison	29.0	9.5	38.7	54.6	45.0	97.5	31.4		15.3	106.0	

This graph shows the average length of time individuals spent on the waitlist for admission to the Anoka-Metro Regional Treatment Center before being removed from the waitlist between July 1, 2013, and June 3, 2023. It details the time spent on the waitlist for those who were never admitted to AMRTC for various reasons, such as an alternative placement being identified rendering admission to AMRTC unnecessary, or a civil commitment being dropped.

The chart shows a significantly higher number of days on a waitlist for community referrals before another disposition is achieved as compared to priority referrals. In the past three years, more priority referrals have also been removed from the waitlist prior to admission.

Total Non-Admissions to Anoka-Metro Regional Treatment Center by Year



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Hospital	391	604	540	340	393	409	506	620	594	395	126
Jail	6	12	21	12	22	14	15	16	54	45	16
Jail (High Priority)									10	22	8
Other	63	83	86	52	73	85	161	159	198	191	72
Prison	2	2	7	9	2	2	10		3	1	

This graph illustrates the number of individuals referred to Anoka-Metro Regional Treatment Center and placed on the waitlist who were ultimately not admitted to AMRTC for various reasons between July 30, 2013, and June 30, 2023. Trends to note include reduced number of referrals by community hospitals since 2019. Because the decrease in non-admissions over the past three years is not attributable to increased community admissions (see chart 2), this decrease represents a reduction in the absolute number of referrals made to DCT from these sources.

Appendix 2: Other Report Recommendations

DHS Crisis Report (2023)

- Address issues with transportation
- Provide leadership and support for multi-agency collaboration and coordination by following SAMHSA best practice guideline.
- Collaboratively provide education and address concerns around the implementation of Travis's Law and 988 utilizations
- A model crisis system should involve a multi-layered approach, including "co-responder" models.
- Consider expanding the role of the LGSW in mobile crisis teams and transport holds.
- Increase and enforce CIT for law enforcement officers.
- Invest in alternatives to emergency departments and increase crisis bed availability.
- Increase utilization of technology through improved broadband capabilities and compatible telehealth platforms.

Recommendations on Strengthening Mental Health Care in Rural Minnesota. Workgroup of the Rural Health Advisory Committee (2021)

- Increase awareness of mental health needs and resources
- Increase Mental Health First Aid training in rural populations.
- Launch targeted and culturally specific public awareness campaigns.
- Include mental health related phone numbers, including the National Suicide Prevention Line, the Minnesota Crisis Text Line, and local mental health crisis phone numbers, on public facing materials, including city and county websites, health care provider websites, and insurance cards.
- Increase access to mental health services in rural communities.
- Strengthen telehealth in rural communities by supporting policies that expand broadband and support compatible platforms.
- Support regional and local solutions to increasing transportation for people experiencing a mental health crisis.
- Strengthen the rural mental healthcare system.
- Improve response time in rural areas by allotting funding to help increase staffing, including peer specialists.
- Support sustainability by expanding reimbursement to include:
- Phone screens that result in crisis team interventions
- Use of a complexity billing code in appropriate situations
- Identified spaces, such as community buildings, that can be used when crisis team members feel unsafe meeting a patient in a remote area.
- Train crisis teams in both mental health and substance use disorders
- Develop regional recruitment efforts that introduce youth to a wide variety of healthcare careers.
- Extend the careers of retiring workers by supporting them in working part-time and/or via telehealth.

- Increase support for inpatient psychiatric beds.
- Increase supportive housing and shelter services for adults and youth (increased shelter funding for youth).
- Support Collaboration between Stakeholders.
- Support collaboration between first responders and crisis teams. Specific examples include law enforcement using iPads to access mobile crisis teams and contracting with crisis teams to embed social workers into first responder teams.
- Implement protocols that prompt emergency department and inpatient units to coordinate with mobile crisis teams when a patient is discharged back into the community so that the crisis teams can offer support through a stabilization plan.
- Encourage and ensure that there is representation from local government bodies, tribal nations, and members of the mental health care workforce at local government meetings and/or coalitions.
- Support health systems overburdened by patients presenting in the emergency department with mental health crises through creative staffing models, such as an emergency department sitter program and/or increased use of peer specialists.
- Decrease barriers to training by implementing flexible training and graduate school schedules, increasing access to and affordability of supervisory hours, and increasing loan forgiveness for mental health professionals (partially implemented)
- Expand the reach of mental health care by supporting collaboration between primary care providers and mental health professionals (partially implemented

Governor's Task Force on Mental Health, Final Report, November 15, 2016

Recommendation #1: Create a comprehensive mental health continuum of care.

The state should adopt a wide definition of the mental health continuum of care to include mental health promotion and prevention, early intervention, basic clinical treatment, inpatient and residential treatment, community supports, and crisis response services. The state should collaborate with partners and stakeholders to undertake systematic planning to improve availability and access to mental health services and mental health promotion activities in the continuum. Responsibility for ongoing system assessment and planning, service development, and quality management should be assigned, along with the funding and staffing to fulfill those functions.

Recommendation #2: Strengthen governance of Minnesota's mental health system. A Minnesota Mental Health

Governance Workgroup should be convened to make recommendations to the governor and Legislature about improvement and possible redesign of governance structures for mental health activities and services in Minnesota. This should include researching other state and national models, defining governance roles and responsibilities, defining safety net functions, defining appropriate regional boundaries, and assigning roles and responsibilities to particular agencies, organizations, or individual positions and suggesting changes to those bodies if necessary. The resulting governance structure should include a clear oversight structure with

responsibility, accountability, and enforcement for ensuring access to mental health services and activities for all Minnesotans. It should also maintain a quality improvement infrastructure, support innovation, align funding mechanisms with responsibilities and accountabilities and sustain the governance function.

Recommendation #3: Use a cultural lens to reduce mental health disparities.

State agencies should convene a workgroup of people from American Indian tribes, communities of color, and other cultural backgrounds to detail strategies for improving mental health services and activities for communities experiencing mental health disparities. These should include ways to support and grow culturally specific providers, make the entire system more trauma-informed, and supplement the existing medical model with culturally informed practices. (There is a workgroup, there have been several)

Recommendation #4: Develop Minnesota's mental health workforce.

The governor and Legislature should continue to support development of Minnesota's mental health workforce, including implementation of the recommendations in "Gearing Up for Action: Mental Health Workforce Plan for Minnesota." The Department of Human Services (DHS) and the Minnesota Department of Health (MDH) should work with the Mental Health Steering Committee (responsible for the Mental Health Workforce Plan) to ensure progress on those recommendations. (Group last reviewed two years ago)

Recommendation #5: Achieve parity.

In general terms, "parity" is the concept that people should have access to mental health services under the same conditions that they have access to other health care services. The recommendation to the governor and Legislature to expand the capacity of the Departments of Commerce and Health to review health plans' alignment with parity laws and enforce those laws was partially implemented. Data should be systematically reported and tracked to identify when insurers are not following parity laws, consequences should be significant and swift, and solutions should be implemented in a timely way. In addition, the state should require that private insurers cover the same mental health benefits that are funded through Minnesota's Medical Assistance and MinnesotaCare programs. This will improve access to mental health services and make it easier to achieve parity by promoting more standardized benefits across the coverage spectrum.

Recommendation #6: Promote mental health and prevent mental illnesses.

The governor and Legislature should support efforts to build robust mental health promotion and prevention capacity within the state. Infrastructure and programs should be developed to fight stigma and build public understanding of mental health and well-being, strengthen community capacity to address system needs and gaps especially for vulnerable populations, and address adverse childhood experiences and trauma throughout the lifespan.

Recommendation #7: Achieve housing stability.

Because housing stability is a critical factor in mental health, the governor and Legislature should ensure that affordable housing—including housing with supports where needed—is available to all individuals and families to ensure both the access to and the effectiveness of mental health care. This should include funding for

additional affordable housing development for low-income Minnesotans and supports and protections targeted to people with mental illnesses.

Recommendation #8: Implement short-term improvements to acute care capacity and level-of-care transitions.

There should be an expectation that mental health and substance use disorder care is as accessible as physical health care. The governor and Legislature should fund and assign responsibility for several short-term solutions to the patient flow problems implicit in the shortage of inpatient psychiatric beds. These can help ameliorate the situation and build collaborative capacity while longer-term, more extensive solutions are developed. The strategies include expansion of community-based competency restoration, strengthening community infrastructure, making changes to the civil commitment process, expanding options for parents and children, supporting efforts to reform addiction treatment, and assessing the impact of increases in the counties' share of payments for stays at state-operated hospitals. (Whatever it takes grants) DHS should convene a workgroup to facilitate ongoing collaboration around these solutions.

Recommendation #9: Implement short-term improvements to crisis response.

The governor and Legislature should fund and assign responsibility for several short- 4 term improvements to Minnesota's system for responding to mental health crises. These extend ongoing work in the crisis response system and build further capacity and collaboration across the state. They include building Crisis Intervention Team skills and experience into pre-service training for law enforcement, providing additional resources where people already seek help, improving collaboration between mental health and criminal justice, improving data sharing and collaboration, implementing telehealth solutions, and making further improvements to community services.

Offenders with Mental Illness (2015)

- Create sustainable funding methods for mental health urgent care services. Urgent care services include mental health crisis assessment, access to crisis psychiatry, chemical health screening, and crisis stabilization services.
- Encourage local jurisdictions to have regular meetings between law enforcement and mental health communities to facilitate dialogue and collaboration, identify trends, and address barriers.
- Continue medication for inmates after discharge.
- Establish a sustainable payment rate for mobile crisis services that covers not only face-to-face contact but other necessary service elements such as telephone/text support, engagement in treatment, service coordination, and travel.
- Require insurance plans operating in Minnesota to include crisis response services as a benefit or identify another method to compensate crisis programs for uncompensated services to people with private health insurance coverage. (done)
- Define crisis response services as a preventive mental health service with no co-pays.
- Develop uniform service standards and training for mobile crisis teams. (Pretty much)
- Include training and protocols for mobile crisis teams on how to work with law enforcement.

- Establish a single statewide phone number for mental health crisis services that links to local crisis resources (implemented).
- Explore use of GPS to enable monitoring of location and assure improved dispatching of mobile crisis teams.
- Clarify statute to indicate that mental health crisis teams can be dispatched in addition to law enforcement and/or other responders (implemented).
- Provide training to 911 operators on the role of crisis response services.
- Address issues related to unsustainability for room and board costs for residential crisis providers.
- Increased funding for the stabilization component of crisis services.
- Establish a mental health urgent care in the west metro and other geographic areas where it could be beneficial and sustainable.
- Offer incentives for expanded use of Crisis Intervention Team (CIT) training.
- Promote CIT as an advanced training.
- Develop a one-day CIT training.
- Provide additional training for how to respond to returning veterans who are in crisis.
- Integrate mental health into the educational coursework for law enforcement focusing on basic education about mental illnesses and de-escalation skills training.
- Utilize video and scenario-based training where possible.
- Integrate mental health and crisis de-escalation into required annual "use of force" training (Implemented).
- Develop a Peace Officers Standards and Training (POST) model policy on responding to a mental health crisis. The POST Board develops, coordinates, and approves continuing education programs for peace officers and part-time peace officers.
- Educate law enforcement and emergency medical responders about the role/value of mental health urgent care.
- Develop a tool for law enforcement to facilitate better communication with health care professionals.
- Develop processes for clear communication when law enforcement is handing off an individual to a health care facility.
- Develop a systemic, real-time bed-tracking of available crisis residential beds and hospital beds (Implemented).
- Utilize health information exchange to better share information, with person's consent and assure that privacy safeguards are in place.
- Increase resources for mental health services in jails.
- Expand existing models for interagency collaboration between county social services and jails to other communities.
- Increase resources for probation to ensure reasonable caseloads, training, and access to pre-trial services.
- Develop capacity to perform necessary mental health assessments and facilitate timely access to records for individuals in jail to inform decisions around charges, pre-trial release, and potential diversion options.

- Establish more mental health courts.
- Establish discharge teams in jails to connect persons with community resources.
- Integrate peer specialists into jail discharge programs.
- Incorporate housing assistance into jail discharge planning.
- Invest in the creation of supportive housing options.
- Get medical consent forms as early as possible in the booking process.

Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services (2010)

Levels of Care Workgroup recommendations include:

- Community capacity, both acute care and community-based services, must be developed and implemented before reducing capacity within the State Operated Services system.
- Service level agreements need to be developed between acute care and community-based providers [governing the transition of shared clients between levels of care] and protocols established to monitor and evaluate said agreements.
- For the target population, a model of intensive case coordination should be developed and funded. This model has case coordinators as active members of the treatment team and not merely brokering services.

Neurocognitive Services Workgroup recommendations include:

- People should be empowered to direct their lives and the services they need to live where and how they want to live. To accomplish this, it may be necessary to:
- Work to relax categorical funding and eligibility structures.
- Educate people about the services that are possible (not just those that currently exist or are readily available)
- Allow people to have greater ability to control the resources allocated to them and have choice of who provides the services they receive.
- People should feel encouraged to consider employment and have meaningful jobs with support available as needed. To accomplish this, it may be necessary to:
- Make employment services available to all individuals interested in employment, regardless of their identified potential for work by professionals.
- Encourage employers to consider creative options for employees, including telecommuting, flexible schedules, an array of employment options and focus on getting to know the person and their needs as an employee; and,
- Minimize financial disincentives related to working.

Access of Care Workgroup recommendations include:

- Robust mobile adult and children ‘s crisis teams should be accessible across the state and should be able to provide services collaboratively with emergency departments, jails, and detention centers.

- Mobile Crisis Team Services should be reimbursable when provided in emergency departments, jails, and detention centers.
- Collaboration psychiatric consultation should exist from screening in a primary care to variety of community, chronic and acute care settings (partially implemented).
- Collaborative psychiatric consultation should be available psychiatrist to psychiatrist to bridge continuity of service needs between acute and community-based levels of care.
- Address the difficulty of recruiting or attracting mental health professionals who are willing to work on crisis teams.
- Provide additional training to crisis teams that provide services to both children and adults to ensure that they understand the parent's perspective.

Housing with Services Workgroup recommendations include:

- A statewide housing with services analysis is needed that examines on a regional basis the availability of supportive and affordable housing; the service availability; needs of persons with a serious mental illness in the region; and the community capacity to develop, fund, and manage housing with services.
- The Phase I Target Population should be individuals with serious mental illness and complex needs must meet the following diagnostic, service, and housing criteria: mental health service Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) rating of 4 or 5; and the individual does not meet medical necessity for inpatient hospitalization; and has complex, or multiple, service and support needs that are essential to be met in order for the person to obtain and retain housing; and the individual has a demonstrated history of being unable to retain housing; or there is a documented history that makes the person ineligible for a housing subsidy, rental voucher, or unable to obtain affordable housing.

Getting there with Dignity (Transportation) Workgroup recommendations include:

- All regions should establish a psychiatric responder round table which would promote collaboration between ambulance services, law enforcement, mental health mobile crisis intervention services and other transportation entities involved in the medical transportation of persons who need quick access to mental health treatment.
- The role of the mobile crisis intervention team should be clarified to include assessing the individual 's need for emergency hospital services, acute care hospital treatment, crisis residential stabilization services, or Community Behavioral Health Hospital services and determine the most appropriate means of transportation to get the individual to the service.

Mental Health Acute Care Needs Report (2009)

- Develop a process that objectively establishes an agreed upon set of metrics to determine- on an ongoing basis- pressure points in the system that are creating barriers to smooth transition across all levels of care.
    (i) Convene a working group of behavioral health representatives from hospitals, counties, managed care organizations, providers, Minnesota Hospital Association and Minnesota

Department of Human Services to design standard metrics regarding access. This group would also recommend a process to quantitatively monitor the data on a regular basis and to re-allocate resources to ensure adequate safety, access, quality, and fiscal efficiencies. This would begin in the Twin Cities metropolitan area and would begin on July 1, 2009.

- Design a chronic care model of treatment and services across the service array for the growing numbers of individuals with multiple and challenging diagnoses and complex co-morbidities including medical care and cognitive deficits.
    (i) Convene a working group to review national studies addressing acute and continuing care management for adults with clinically complex issues and develop a business plan by December 2009 that includes service design, regulatory changes, and funding requirements.
    (ii) Realign funding and regulatory silos for persons with co-occurring mental illness and substance use/abuse - learn from strategies developed by the Co-Occurring System Improvement Grant currently administered by DHS.
    (iii) Explore the feasibility of specialized psychiatric acute care inpatient and community-based intermediate care settings designed to serve individuals with a serious mental illness and co-morbid medical conditions.
    (iv) Create incentives such as the ability to call in a mental health professional to do a temporary care plan or to fund staff to provide time limited one-to-one observations for unstable clients.
    (v) Work with nursing home organizations and the Minnesota Department of Health as a regulatory body to address nursing facilities' reluctance to admit or transfer back to their facility individuals with medical conditions who also have a mental illness.
    (vi) Implement a disease management methodology that would assure continuity of critical professional services across levels of care delivery.
- Address procedural and programmatic/policy areas that create barriers to smooth transitions across levels of care.
    (i) Create a single treatment plan across all service categories.
    (ii) Create uniform data practices, including standard release of information, for use across all service categories.
    (iii) Align Minnesota Data Privacy laws with HIPAA.
    (iv) Require case managers to arrange annual physical exams for their clients and establish protocols to assure that this occurs.
    (v) Explore continuation funding for expansion of the Mental Health Drug Assistance Program that has successfully reduced hospitalizations.
    (vi) Conduct a survey of referral sources to Community Behavioral Health hospitals (CBHH) including suggestions to improve utilization of this service.
    (vii) Review existing protocols and develop greater uniformity in placement criteria by piloting the LOCUS level of care criteria for community-based services, beginning July 2009 with expansion statewide by January 2011.
    (viii) Examine the current Medicare requirements that limit expansion of partial hospitalization to certain populations and determine if an alternative option exists.

(ix) Develop a working group of key stakeholders to develop strategies and recommendations for greater use of advance directives, shared decision-making approaches and service models as alternatives to civil commitments.

(x) Develop a standardized intake form for Intensive Residential Treatment (IRT) and Assertive Community Treatment (ACT) teams that is used statewide.

(xi) Conduct a comprehensive housing needs assessment that addresses the range of housing options from independent living arrangements to housing with supports for those in need of 24-hour oversight and monitoring.

(xii) Conduct an analysis by the Office of the Ombudsman for Mental Retardation and Mental Health on the data they are collecting on suicides and make recommendations on approaches to improve access to mental health services.

- Improve access to the full array of intensive mental health services, especially during non-business hours, weekends, and holidays.

(i) Implement a single phone number to access crisis services and educate families, 911 operators, emergency department staff, community-based providers about this number as well as information about crisis services and their availability.

(ii) Monitor the expectation that Assertive Community Treatment (ACT) teams will be at full capacity by July 2009 and accepting direct referrals from hospitals.

(iii) Assure that direct referrals to Intensive Residential Treatment (IRT) facilities for individuals who have health care insurance will be operational by July 2009. Monitor on an ongoing basis, that access to this service is not being restricted by requirements for a case manager prior to admission. Counties will retain the ability to triage individuals and to be involved with admission decisions for individuals who are uninsured.

(iv) Fund 45-day operating subsidy contracts to community hospitals with psychiatric acute care inpatient capacity in the Twin City metropolitan area to serve individuals who are uninsured or under-insured. This option is currently in place for Greater Minnesota hospitals as well as in other states.

(v) Expand Crisis Intervention Team (CIT) training for law enforcement and dispatch staff to cover all regions of the state and require that CIT be incorporated into day-to-day operations.

(vi) Streamline barriers and approvals on weekends and nights for short term alternative service assessment at emergency departments regarding risk level, crisis bed access, funds for temporary housing and medications and on-line access to apply for Medicaid.

Appendix 3: Individual Task Force Member Perspectives

The diverse representation of the task force membership ensured key stakeholder perspectives were included throughout the process. Each member, additionally, was invited to provide a brief comment about the impact of the Priority Admissions law on impacted individuals, themselves, their organization, and/or community. Of note, not all members chose to include comments.

- Jodi Harpstead, Commissioner, Minnesota Department of Human Services, Co-Chair (No comments)

- Keith Ellison, Minnesota Attorney General, Co-Chair (No comments)

- **Dr. KyleeAnn Stevens, Executive Medical Director, Direct Care and Treatment Administration, DHS**

  Direct Care and Treatment (DCT) has a unique perspective for how the state supports people with mental illnesses. DCT is an important part of a complex system of care, and we are proud to serve those who cannot be served elsewhere. The current priority admissions law states DCT must first serve individuals referred from jails, even when it means denying care to others. DCT continually works to be better, more efficient, more collaborative. There are barriers we simply cannot overcome alone. The demand for services continues to increase; we have challenges getting people to the next level of care, which sometimes don't exist. Every day we hear from stretched jail staff, overextended hospitals, frustrated attorneys, and worried families. The DCT team shares their worry and would like to focus on these issues as part of the larger system. We would like to spend less time deliberating impossible decisions because of this law and more time working with our partners in healthcare, corrections, and communities to serve as many people as we can to the best of our ability. Our thanks to the legislature for this opportunity to make meaningful change.

- Tarryl Clark, Stearns County Commissioner (No comments)

- **Bryan Welk, Cass County Sheriff**

  The 48-hour admission rule for civilly committed respondents confined in jail initially offered hope for timely treatment of their mental illnesses, as required by both constitutional and statutory mandates. However, the reality of extended incarceration without appropriate care has exposed the systemic inadequacies in meeting their needs. Despite efforts to compel the Commissioner of Human Services to adhere to treatment requirements, prolonged stays in jail without proper intervention persist. This failure not only violates their constitutional rights but also perpetuates a cycle of deterioration in their mental health. The crisis of insufficient institutional and community beds further exacerbates the situation, leaving these individuals languishing without the necessary treatment. Their plight highlights a dire need for prioritization and additional resources to address the mental health needs of this marginalized group effectively. The 48-hour rule, though a step forward in acknowledging their rights, underscores the urgent need for systemic reforms and increased allocation of resources. Only through

concerted efforts to prioritize this vulnerable population and provide adequate mental health care can we begin to rectify the injustices they face and uphold their rights to dignified treatment.

- **Angela Youngerberg, Blue Earth County Human Services Director of Business Operations**

  Having had the privilege of working within Minnesota's mental health system for many years, I've seen great successes in building community-based care where it had not, but also witnessed the inpatient and residential systems become overwhelmed with demand. The 48-hour rule was enacted to protect the constitutional rights of people in jail that were court ordered to receive the treatment they needed – and it worked – for about 10 years until the demand for forensic services exceeded capacity. Unfortunately, this left other people waiting for care. Changing the law should happen, but not without an expansion in inpatient, residential and community-based bed and service capacity. Once the law changes, the pendulum will swing and the risk of it swinging too far is real. Solutions must balance constitutional rights and health care needs. I have witnessed Direct Care and Treatment staff and leadership do an exceptional job of improving processes to make efficient and effective use of existing resources and program capacities. It is time, overdue, for additional resources. DCT must be allowed to expand hospital capacity focusing on forensic bed and staffing capacity, and the state must expand community resources for people transitioning out of higher levels of care.

- **Kevin Magnuson, Washington County Attorney**

  "I'd rather they be in a prison than in a hospital." This mentality assumes a person with mental illness is fine in jail despite decompensating rapidly. Jail, even with advanced mental health resources, is still a jail, holding people in incarceration-like conditions very different than the conditions of a hospital. The assumption that jails can substitute for psychiatric hospitals is one the task force seeks to eliminate. After the Legislature recognized the backlog crisis in jails a decade ago and enacted the 48-hour law, expected investment in DCT treatment capacity never came. The Legislature, having not adequately addressed the problem then, returns to the same but worse situation. The solutions have not changed, and the Legislature should not repeat the mistake of triaging limited beds among the ever-growing population of patients in jails and hospitals who desperately need them. The inability to solve all mental health problems at once has long paralyzed well-intentioned, knowledgeable people. But progress comes with immediate action on the urgent crises we can resolve now one step at a time. As commitments continue to skyrocket, DCT's backlog only worsens without real solutions. This Legislature should enable DCT to expand immediately while we look to fund other long-term solutions.

- **Taleisha Rooney, Manager, Emergency Behavioral Health Team, North Memorial Hospital**

  The Priority Admissions law impacts hospitals/emergency departments in the following ways:

  - Lack of access to DCT services (due to prioritization of jails in 48 hr. rule) results in extremely long lengths of stay for patients in emergency departments and/or inpatient behavioral health units.
  - Increased high-risk discharges to community

- Increased risk for volatile, aggressive, or violent behaviors for patients, hospital staff & community members
- Staff burnout and exiting healthcare further contributing to workforce shortage.
- Clinical needs can go undertreated or untreated when hospitals cannot provide specialized care DCT can (substance use disorder treatment, individualized behavior management, etc.)
- Major financial impact on health care systems when boarding patients long-term.

- **Sue Abderholden, Executive Director, Minnesota Chapter of the National Alliance on Mental Illness**

  The priority admissions law has negatively impacted the "flow" of our mental health system. When the only people who can be admitted to DCT are people from the jails who are deemed incompetent and are committed - the entire system backs up. People who are in an inpatient psychiatric unit stay longer because they cannot be admitted to DCT. This leads to people in the ER waiting longer for a bed to open, boarding in the ER, or being discharged from the ER without connecting to the right level of services. We have heard families being told that if their loved one needs to go to DCT to call the police and have them arrested. Adding DCT beds cannot be the sole solution. We must look at the mental health care we provide in jails. We must look at every point in our continuum (outpatient, crisis, residential) and work harder at intervening early with the appropriate intensity.

- **Doug McGuire, Attorney Coordinator, Hennepin County Commitment Defense Project**

  While representing civilly committed respondents confined in jail, we have employed without success several means to attempt to force the Commissioner of Human Services to exercise the constitutionally and statutorily required treatment for the mental illness precipitating the commitment. Needless to say, we were extremely pleased with the 48-hour rule which worked briefly. Now our clients have been spending months in jail without appropriate treatment despite the 48-hour rule. We are now facing another crisis due to inadequate institutional and community beds for committees. Our clients are languishing without treatment for mental illness in violation of their constitutional rights which causes further permanent deterioration of their mental health. The 48-hour rule was a start to protect their rights but has only made clear the inadequacy of the system that can only be rectified by prioritizing this group of citizens and allocating additional resources to treat them in the manner they deserve.

- Jinny Palen, Executive Director, Minnesota Association of Community Mental Health Programs (No comments)

- **Dr. Eduardo Colón-Navarro, Chief of Psychiatry, Hennepin County Medical Center**

  The Priority Admissions Law has made access to inpatient DCT beds impossible, leading to ongoing treatment of patients with need for longer term inpatient care in acute units with no access to the outside, limited short term programming, and resulting in overflows into our Emergency Room service (APS). Lack of access to secure beds has created incredible security challenges, managing patients with significant aggression, including some with MI and D designation, in a setting that does not provide the desired security and resulting in increased injury to staff. Lack of access to CD beds in DCT creates

prolonged waits in our inpatient psychiatry units, as well as medical units in the general hospital. Stabilization of psychiatric needs is followed by either prolonged waits or return to the community with outpatient programming that is often insufficient.

- **Lisa Harrison-Hadler, Ombudsman, Minnesota Office of the Ombudsman for Mental Health, and Developmental Disabilities**
- We have seen numerous impacts on the mental health system since the implementation of the priority admissions rule. Most notably, over time, this rule has resulted in Anoka Metro Regional Treatment Center (AMRTC) being generally inaccessible to individuals not coming from jails, but nonetheless in acute need of AMRTC's level of care, with no comparable settings existing to fill that void. People unable to access medically necessary care promptly on a systemic basis has resulted in ripple effects throughout the mental health service system, particularly for those stuck in community hospitals and ERs for weeks, months, or longer until an appropriate discharge plan can be identified and a bed available. Further exacerbating the barriers to timely access to the right care in the right setting, those beds are unavailable for other individuals in need of inpatient care. Despite the priority admission requirements, people in jails are waiting far too long without access to appropriate care; even in the best of circumstances, the competency and commitment processes take weeks. Access to community-based services, which may prevent a crisis leading to hospitalization or incarceration, is limited due to long waitlists for services. Solutions to these complex issues must be multi-faceted and include meaningful increases in care capacity in all settings – DCT, jails, and the spectrum of community-based services.

- **Nicholas Rasmussen, general member, appointed by Gov. Tim Walz**

  While in a community hospital on being civilly committed I was added to the waitlist for AMRTC. I am of the understanding this was due to the desire to have a plan in place should I not stabilize in a timely manner. By late September of 2016 I was made aware of my presence on the waitlist and that I would be sent to AMRTC if alternative plans were not made soon. It is my understanding the Priority Admissions Statute was in place and despite my being located outside of a jail setting entry to AMRTC seems to have been possible. In my case, I was stable enough to be placed into an IRTS setting without needing the level of care available at AMRTC. However, that is not true for all patients and having a clear plan in place for community hospitals to be able to transfer patients to a different level of care when needed seems important and appropriate. As does appropriate and timely care for individuals coming from a jail setting.

- **Heidi Heino, member of the public with lived experience directly related to the Task Force's purposes, appointed by Gov. Tim Walz**

  After seeing the impact of the priority admission law in our state, it has become clear that much work is needed to alleviate the congestion in the system. Currently, as the law stands, it applies great pressure on treatment resources, causing a backlog and a waiting list for patients to receive the correct level of care. The most acute patients may not receive treatment in the correct setting or level of care, like being housed in an ER, which prevents the patient from moving toward healing and other patients from being

treated at that facility. People experiencing mental health crises will go to an ER and either be released, but follow-up care may not be sought, which leads to a cycle of going to the hospital or being housed until a bed opens up at a treatment center. If the person is arrested, they have a better chance of getting placed. The increasing need for mental health care is putting stress on our hospitals, community-based treatment, and jails (not to mention the staff). More needs to be done to unclog the system or divert less acute patients to better outpatient treatment programs and relieve stress on the system.

- **Miranda Rich, member from an organization representing racial and ethnic groups that are overrepresented in the criminal justice system, appointed by the commissioner of the Department of Corrections.**

  The negative ramifications of the Priority Admissions statute trickle down beyond psychiatric units and emergency departments, as med surg units serve as overflow for psychiatric patients who then occupy beds needed for patients with medical needs, which in turn backs up ICUs and E.Ds. Patients held on inappropriate units are at higher risk of harming themselves and others and often decompensate as they're not receiving the level of psychiatric care needed. Many staff are unnecessarily assaulted due to inappropriate placement of psychiatric patients. Psychiatric patients occupying beds on med surg units for weeks because of these backups result in significant harm to other patients and the hospital's financial status. E.g., in December 2023 at HCMC, 155+ transfer requests including 38 trauma transfers were refused due to lack of capacity. With only two safety net hospitals in Minnesota and two level 1 trauma [for adults] hospitals in the metro, this means many patients are unable to access the care they need. Reimbursement is low for psychiatric patients on inappropriate units, much lower than reimbursement for the emergency department, ICU, and med surg patients we turn away. This financial toll results in staffing shortages, moral injury, insufficient funding for needed training and equipment, etc.

- **Dr. Dionne Hart, member from an organization representing racial and ethnic groups that are overrepresented in the criminal justice system, appointed by the commissioner of the Department of Corrections.**

  As a physician working in multiple community settings, I have a unique perspective on the impact of the priority admissions law. Every day, I treat patients who are both severely mentally ill and dangerous, thus need a full spectrum of mental health services within a correctional setting. Yet, when working in an emergency treatment unit (ETU), I am challenged with monitoring patients for many days even weeks while waiting an inpatient psychiatric bed. In the ETU, it is often necessary to develop alternate plans for voluntary patients in a crisis due to the significant backlog. The Priority Admissions Law was a well-intended effort to more appropriately address the needs of justice involved patients living with mental health disorders but unintentionally led to delays in care for other patients living with mental health disorders. The Priority Admissions Law is not solely responsible for the backlog of patients in emergency settings, but the rule exacerbated long standing access issues within Minnesota's mental health system. All patients living with mental health disorders regardless of their location should receive timely treatment based primarily upon their clinical needs as determined by a physician or other mental health

professional. I am honored to have served on this task force to develop solutions to address the needs of all patients living with mental health disorders in an equitable and timely manner.

Appendix 4: Summary of Task Force Meetings

Meeting One

The first meeting of the task force was convened July 20, 2023, at the Anoka Metro Regional Treatment Center. Members went on a tour of the hospital prior to the meeting to help inform their understanding of acute admissions to DCT. Members reviewed the priority admissions law and members shared how the process typically works. Data related to admissions and waitlists to DCT programs was reviewed, and members shared their impressions of the tour at AMRTC. The co-chairs and some members also shared their impressions of a tour at the Anoka County Jail and the Hennepin Healthcare Medical Center Emergency Department that took place the previous day. Members were asked to submit responses to several questions related to the impacts of the Priority Admission Law, policy and funding recommendations, and options for providing treatment.

Meeting Two

The second meeting of the task force was held September 18, 2023, at the Shakopee Community Center. Key data was reviewed regarding the number and location of state operated programs as well as more detailed information about the waitlist for a state operated bed, and discussion was had about processes for admission preceding enactment of the Priority Admission law. A flowchart was reviewed for individuals going through the criminal justice system and civil commitment processes, and Sue Abderholden reviewed key recommendations from other workgroups and task forces. The remainder of the meeting was spent discussing the recommendations members provided. In conclusion, members were asked to submit their "10 best ideas" to help narrow the scope of recommendations prior to the next meeting.

Meeting Three

Meeting Three was convened on October 30, 2023, at the Shakopee Community Center. Tasks at this meeting included a review of other contemporaneous workgroups and committees, including the Hospital Decompression Task Force. Commissioner Harpstead previewed the Department's proposal to expand capacity within Direct Care and Treatment.

Task force members reviewed the Task Force Idea Generator, a generalized qualitative grouping of responses, from Ten Best Ideas submitted by task force members. They then participated in a grouping and ranking exercise facilitated by Quality leaders from Direct Care and Treatment. Task force members self-selected into one of two groups to further explore ideas for needs and future direction. Members were selected to form a report drafting team to begin writing this document. They included Commissioner Harpstead, Sue Abderholden, Dr. Eduardo Colón-Navarro, Kevin Magnussen, and Angela Youngerberg. This team would be supported in this process by Direct Care and Treatment staff.

Meeting Four

Meeting Four was convened on December 20, 2023, at the MN Department of Human Services in St. Paul. Members discussed the importance of making recommendations which are most likely to be impactful, as well

as being mindful of the need to be concise in the report recommendations. Members were presented with two drafts of potential recommendations for consideration and spent the meeting discussing these. A need was identified for a subgroup to discuss possible approaches to expand access to involuntary medications for those in jails and they will meet in advance of the next task force meeting. A more detailed report will be drafted for consideration prior to the next task force meeting which will incorporate discussion points from this meeting.

Meeting Five

Meeting Five was convened on January 30, 2024, at the State Capitol. Reports were received from the medications in jail settings and report drafting workgroups. Members focused first on areas requiring discussion and consensus, including guiding principles, framework for prioritization and monitoring, treatment in jails, and management of DNMC costs. The remaining time was spent reviewing language in the report and suggestions were noted. Members will be given the opportunity to provide specific feedback on the report. The report will then be finalized and sent to members for a vote to approve via email. Members agreed on a suggested date of February 12, 2024, for final submission to the Legislature.

Meeting Six

Meeting Six was convened February 9, 2024, at the Direct Care and Treatment building in Vadnais Heights. Three members participated via Webex. Discussion was had about two additional recommendations which were brought forth since the previous meeting as well as discussed changes to the report via member comments. Areas which did not have consensus also warranted additional discussion. A preliminary vote was held, which indicated a majority of members supported the report as written. After additional discussion and a short recess, additional discussion was had, and a final vote of members in attendance was unanimous to support the report with a caveat that final language would need to be approved.

Appendix 5: Task Force Idea Generator

Taskforce Idea Generator Worksheet Responses (Generalized Qualitative Grouping)

1. **Bed Capacity and Access**
   - Increase bed capacity in state operated services.
   - Create incentives for partnerships that address the capacity crisis (for example, enhanced payments to hospitals or other providers that care for people at the state-operated level of care).
   - Expand capacity for inpatient and community based "beds" along the continuum of needs.
   - Increase bed capacity in state operated services by expanding the multi-disciplinary workforce.
   - Increase accessibility to state operated facilities specifically for inpatient mental health & emergency departments by building more beds/facilities including long term and permanent placements for patients with severe and chronic behavioral health needs, creating a specialized unit and/or building a “fast track” system for patients boarding in community hospital settings.
   - Add capacity at DHS in a variety of service types.
   - Increase the number of beds categorized as Community Behavioral Health Hospital beds. These beds are critical to provide services to mentally ill adults who are most often civilly committed and in rural Minnesota. Community hospitals in most rural areas of the state are not equipped, nor have the specialized resources to serve this population.
   - Increase the number of beds within the Forensic Mental Health Program. Individuals in this program have unique needs that are not served well in other areas of the mental health system. The security, monitoring, and length of treatment are factors that cannot be addressed through other hospitals. FMHP capacity has been overflowing and taking up critical resources within AMRTC. A substantial number of beds in FMHP are needed to accommodate new admissions (including initial evaluations), ongoing placements, and to address the short term needs of former FMHP patients who need to return to FMHP to receive hospital-level health care, as medically indicated. Efforts for expansion should be addressed in all three areas.

2. **Admissions to a DCT facility**
   - Implementation or changes to policy, legislation, or procedures regarding priority admissions. The person who needs the DCT bed the most gets it. Create collaborations between DCT, community mental health providers to provide care while someone is in jail waiting to be deemed incompetent to stand trial. And let's implement the new CR law!
   - Allow all hospital patients who are civilly committed to DCT onto the list for admission to AMRTC, and/or allow a patient from a community hospital to be admitted for every 3-4 patients from jails.
   - The admissions process must clearly articulate the standards for triaging and prioritization of individuals. Agreed upon benchmarks should be established to help guide prioritization determinations as well as guide discussions about where the system continues to fail to meet aspirations. Similarly, the discharge process must consist of understandable and definable criteria so that the process is more transparent and acceptable as evidence of appreciable stabilization. An

approachable review process should be agreed upon to allow for reconsideration of reasonably disputed determinations.

- Refresh the Central Pre-Admissions "Wait List" policies/procedure to be a more sophisticated process which allows patients awaiting hospital or bed placement to be not limited to one wait list, but to allow a triage and bed/facility placement process that is responsive to patient acuity. This should align with DHS's desire to allow medical triage to influence patient placement. The caveat is that medical triage should not assume a person's placement in another facility (such as a jail) is "safe" or receiving treatment that they are not. The success of this recommendation will be significantly dependent on an increase in DCT bed access, capacity, and availability. 10.26.23 2 3.

3. Right Level of Care at the Right Time

- Study and address the gap in assessments where people who do not meet criteria for mentally ill and dangerous are deemed not sick enough for state-operated services and are released back into the community.
- Change the process for admission decisions to consider clinical needs of patients in jails, hospitals, and state operated services and the continuum of care available, and how shifting patients from a hospital could free space to care for more patients from jails.
- Prioritize admissions to state operated programs based on clinical need, not location.
- Create a 3rd party team for case review of patients in DCT system to increase accountability and transparency. Purpose of this group would be to review patients within DCT system and identify areas of opportunity for expedited treatment/discharge.
- Prioritize admittance into state operated services by clinical need, not the mechanism they are being referred from.
- Those with the highest level of need should be prioritized for admission; irrespective of their current location (i.e. hospital or jail). To ensure fairness and equity in this process; however, clear assessment criteria/tools and some sort of due process provision should be incorporated.

4. Mental Illness Programming and Treatment Changes

- Adopt and offer models of care in all DCT facilities that embrace specialty care for co-occurring disorders. All too often patients require transfer from one DCT facility to another to address their co-occurring health care needs (including mental health, substance use disorder, and intellectual and developmental disability disorder). It is widely studied and documented that through providing integrated care a more complete recovery of co-occurring illnesses is possible. Technology may assist in providing specialized care in more remote facilities, or facilities experiencing workforce concerns. Relocating the services to the patient is more efficient and effective than moving the patient to the services.

5. Mental Illness Treatment in Jail Setting

- Require and fund/incentivize mental health care for those in jails, in particular access to medication and the prompt initiation of a Jarvis petition for clients with known neuroleptic medication needs, at

the time of the civil commitment petition, as outlined in MN Statute 253B.07. This could include partnerships between jails, local community mental health centers, and DHS.

- Increase the level of psychiatric support in jails to go beyond strictly medication and provide therapeutic interventions as well. • Provide expanded treatment and mental health services in jails.
- Provide resources to jails so they may be able to safely enforce Jarvis Orders for administration of neuroleptic medication. Most jails are not staffed with the level of nursing needed for the enforcement of a Jarvis Order, and most jails have such a small need for this that staffing in this way is not efficient or even realistic. When individuals are without their neuroleptic medications for any period, the likelihood of psychiatric decompensation is high, often resulting in the need for hospitalization. Options to be made available to jails include: (1) State funding should be offered to jails so they may contract with a medical provider to provide 24/7 access to services (nursing, etc.) to administer neuroleptic medications under a Jarvis Order and (2) State response teams should be developed using medical expertise to provide onsite response to jails that do not have medical resources to enforce Jarvis Orders. This option may be essential for remote, smaller, or jails with infrequent need or a lack of local medical resources.
- While capacity is being built out at state facilities, a regional pilot project should be created to ensure that individual sin jail, awaiting placement in a state facility, can get the necessary treatment jails can reasonably provide. This pilot project would require funding to allow for additional capacity in select regional jails, the creation of a diagnostic team inclusive of medical and mental health professionals, and incentives for smaller 10.26.23 3 counties to transport this population to a regional pilot project location. There should continue to be a reasonable time benchmark for placement.

6. Work Force and Staff Development

- Support workforce development for mental health workers by offering scholarships for education to build the future workforce, increases in pay for those already in the state's workforce, and providing "emergency" pay bonuses to mental health workers in high acuity settings outside of state-operated treatment centers until reimbursement rates increase to a point that higher wages are sustainable from organizations' own budgets.
- Study attrition in jail and mental health workers (Why exactly are individuals leaving this field and what might have helped them stay?) and incorporate workforce strategies to address burnout for both jail and medical staff.
- Provide comprehensive training and ongoing education for direct care providers in community mental health settings and group homes on topics such as mental health symptomology, behavior management, de-escalation, early intervention, etc. while also increasing wages to encourage longevity and investment in the field.
- Increase training, technical assistance, and on-site supports to improve workforce abilities. Working with individuals with complex needs requires specialized training and support, and all too often we rely on a workforce that is under-trained and under-paid. To broaden the ability for people exiting hospitals to live successfully in the community, more training and supports are needed for the workforce that cares for them. Themes are present among many individuals discharging from

facilities like AMRTC or CBHH's, and the workforce could greatly benefit from more training, technical assistance and on-site supports from expert teams. The following categories were identified by a DCT/County workgroup as themes: trauma-informed care, legal/forensic services, emotional dysregulation, cultural-specific supports, traumatic/acquired brain injury, vocational services, and more.

7. **Funding**
    - Expand state operated preadmission services to include mental health providers and liaison workers to triage referrals and assign workers to assist with placement and diversion.
    - Incentivize hospitals, jails, and outpatient programs to provide competency attainment services.
    - Redirect funds collected from counties for the AMRTC per section 246.54 from the bottom line of the general fund to jail and hospitals boarding high needs patients waiting for state-operated services.
    - Bolster funding to create more secure treatment spaces in hospitals or other providers to support higher need patients who may pose a risk to staff and patients.
    - Permanent funding mechanisms for providers to develop and maintain services to support behavioral health needs.
    - Expand funding for voluntary engagement services.
    - Complete the Behavioral Health Provider Rate Study and consider legislative proposals for funding to add capacity to a variety of community provider types across Minnesota.
    - In the meantime, add funding to the Acute Transitions Team in DHS to build a tracking sheet of patients needing to be transitioned out of hospitals and into other community settings and to offer counties and providers needed investments in buildings and staff to allow them to admit these patients.
    - If funding is needed to implement changes to the priority admissions process, provide suggestions of where funding shall be focused to best effect change. Increase funding for community providers so that they can serve more people who have complex needs.
    - Seek federal authority and federal funding match (FFP) for providing services to address social determinants of health needs - housing, nutrition, transportation, care coordination/ engagement, etc.
    - Seek the ability to cover services to help folks being released from incarceration connect with services, as much as 90 days before release, under Medicaid.
    - Establish infrastructure building allocations that are available to counties to develop innovative, local, and specific solutions for serving individuals being discharged from the Forensic Mental Health Program. Utilizing 10.26.23 4 the AMHI structure for these allocations, which should be voluntary for AMHIs or counties to opt-in or optout, would be a potential funding pathway. This could be funded by returning 100% of the county-share of Does Not Meet Criteria days that are currently paid by counties to the state's general fund for days patients are in a state facility and do not meet medical criteria for hospitalization. This county cost is unique to Minnesota and was enacted to incentivize counties to expedite discharge of individuals from state facilities. With over ten years of data showing that the ability for an individual to be discharged from a state facility to the

community is not fully within the control of the county (there are often many factors), this cost share should be stricken from law. Additionally, the funds contributed by the county should be returned to the county to develop community capacity. This would be one potential funding source for building infrastructure.

- Fund voluntary engagement services designed to get people the help they need to avoid hospitalization or incarceration.
- Provide permanent, stable, sufficient funding for providers to develop and maintain services to support behavioral health; thereby expanding the mental health workforce to ensure systemic capacity to care for all without extended wait lists unnecessarily delaying needed care.

8. Community Services (non-DHS-DCT operations)

- Fund state programs to provide enhanced services in the community such as consultation teams, outpatient services, and diversionary support.
- Increase reimbursement rates for community hospitals who are boarding long-term patients and/or offer flexible funding for patients who are challenging to place.
- Increase number of flexible/secure IRTS settings & invest in sustainability in community settings by authorizing higher rates.
- Implement early intervention & community outreach programs for patients identified in diversion process before involvement in civil commitment process.
- Additional ways to meet the treatment needs of those referred to and waiting priority admissions as well as other individuals in the community who require treatment at state-operated treatment programs.
- Get MA to pay for locked IRTS facilities. It's not that people need state operated programs they need more secure settings for longer periods of time. Create those.
- Increase capacity to discharge clients ready to move from inpatient/ acute care by: Improve outpatient FFS Medical Assistance rates to accommodate living wages: (1) Increase our RBRVS system to Medicare rates and align MN's RBRVS with Medicare, (2) Geographic Practice Cost Indices (GPCIs) - Implement regional adjustors that increase or decrease RVU factors based on assumed regional cost differences, (3) Conversion Factor - Implement GPCI-adjusted RVUs multiplied by base dollar amount to calculate total reimbursement, (4) Policy adjusters-Similarly to the RBRVS, implement policy adjustors to recognize difference in resource use for some provider types, services, and/or settings by adjusting the relative values or RVUs that are applied to the base dollar amount, (5) Transition non-CPT-based services to tier one, including services billed with a CPT code but not paid under RBRVS and those services currently billed with a non- CPT code but that could be converted to a CPT code, and (6) Streamline behavioral health services billed under HCPC H or S codes.
- Minnesota should continue to reform policies that promote the development of innovative housing models for individuals with mental illness and/or complex behavioral needs. (1) Funding and licensing models for housing and residential-based care can be highly complex. How Minnesota's Unitary Residence and Financial Responsibility Act (Minn. Stat. §256G.01-.12) is applied in each situation creates additional considerations that counties must make as development of such housing

models or use of public funding are often influenced or decided by local governments. As housing policy blends with treatment and service policy, there are some models that are more likely than others to be accepted by local governments, due to the likelihood of high service need individuals moving into certain counties and therefore the local government becoming financially responsible for many of their services and cares. In many instances, the use of "excluded time" language has mitigated many of the concerns in these scenarios. Further consideration of "excluded time" designations with services may give local governments confidence to consider expansion of housing 10.26.23 5 and services for individuals with complex needs. (2) Minnesota has continued to make progress with the state's Olmstead Plan, which has resulted in improved quality of life for people with disabilities. However, a lack of community housing or placement options for individuals leaving state hospitals or facilities has been a reality that many are working to resolve. Many of these individuals also have disabilities to consider when looking at housing options. There are times when the goals of these two efforts appear to be at odds, or there is a lack of technical understanding as to how to navigate them successfully. For example, the concept of a mid-to-large scale housing development (apartments with leases) for adults with mental illness could be designed where it is financially feasible to incorporate specialized 24/7 staffing available to individual tenant's clash with the state's Olmstead plan as it generally is not viewed as an integrated setting. DHS should enhance technical assistance and funding opportunities to developers and local governments about how to expand housing options that provide housing and services that meet the clinical and behavioral needs of individuals with complex needs.

- The state should expand their Community Supports Services/Synergy team. The expertise of this team is needed with many more individuals than its current capacity can manage. This team begins their work with individuals while hospitalized and assists with the transition to community-based placement by providing on-site support, technical assistance, and training to the support teams in the community to assure a successful transition.
- Improve long-term community placement options/resources to help resolve the flow problem in state operated and hospital/ER programs. This may include targeted expansion of DCT programs, incentivizing and supporting private providers in serving these populations, and resolving the locked/secure IRTS issues.

9. Community Mental Illness Crisis Management

- Any other thoughts, suggestions, or requests to address the impact of priority admissions to the state, county, or treatment programs. Earlier intervention would help - meet people's needs before there is a crisis - like with voluntary engagement
- Invest in EIDBI services and others that work with parents to know how to support their high-needs children without hospitalization.
- Mandate comprehensive mental health training for community law enforcement as well as officers within jail system to be provided by mental health providers from local community providers, hospital, etc.

- Grow our community-based services to build the continuum to prevent escalation to needing inpatient and/ or discharge to 'step-down' residential and outpatient care.

10. Statute Modification

- Modify the 48-hour rule to allow the hospitals who now have patients stuck in them to also access DCT services.
- Initiate involuntary medication procedures at the time of commitment when someone lacks decision-making capacity to reduce delays in treatment.
- Remove "duplication of service" statutes that don't allow patients to have ACT teams while living in group homes, being on CADI, etc.
- Implement Medical Assistance-covered court-ordered treatment.
- The qualifications necessary to be a Rule 20 examiner must be examined and a robust certification program should be implemented to ensure timeliness of reports and quality of the exams and reports. There has been difficulty getting timely Rule 20 evaluations, resulting in delays in the process and in receiving necessary health care. Additionally, concerns about the quality of reports are increasing. Simply, the pool of qualified examiners is not large enough to address the need in the state and steps need to be taken to address current barriers. (1) Examiners should have to qualify through a robust certification process that ensures an examiner is qualified to give an expert opinion in the area. The process must be more than a review of applicable standards or review and should mirror certification programs in other jurisdictions. With a robust certification program, licensing requirements can be reconsidered. To increase the pool of trained examiners it is recommended that additional professional licensures be allowed to provide examinations with the 10.26.23 6 expectation that they have received the required certification on the topic area. (2) Reimbursement rates for these examiners should be increased as many private examiners have opted to no longer provide the service due to the rate not being commensurate with the time to complete the examination and the associated liability that the examiner holds. Any reduction in private examiners will increase the responsibility of the state to provide examiners, who are already backlogged.
- Minnesota should expedite a Section 1115 Medicaid Demonstration Waiver application to allow incarcerated individuals to access to proper health care in jails and begin active consideration and evaluation of submitting a Section 1115 Medicaid Demonstration Waiver to update Medicaid's prohibition on paying for mental health treatment delivered in institutions for mental disease. (1) "The Social Security Act, Sec. 1905(a)(A) prohibits the use of federal funds and services, such as Children's Health Insurance Program (CHIP), Medicare and Medicaid, for medical care provided to 'inmates of a public institution." While this language was intended to prevent state governments from shifting the health care costs of convicted prison inmates to federal health and disability programs, it has an unintended impact on local jail detainees who are in a pre-trial status and have not been convicted of a crime." (excerpt from Naco.org website) Minnesota has not yet submitted a Section 1115 Medicaid Demonstration Waiver unlike many other states in the nation. The federal government has encouraged states to propose innovative Section 1115 waivers that will expand coverage, address whole-person care, work to reduce health disparities, and address topics of special interest to states. Many states have submitted waivers, and some have been approved,

Minnesota should look broadly across the nation to learn from the states that have already submitted waivers. States such as California or Washington have received approval for their waivers which allow incarcerated individuals access to certain health care services up to 90 days prior to release from incarceration. Oregon has submitted a waiver which is currently pending approval, requesting adults and youth who are incarcerated and committed receive Medicaid benefits for the duration of their commitment. And (2) The same federal act prohibits Medicaid to pay for care in Institutions for Mental Disease (IMD), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds. This federal law prohibits paying for medically necessary psychiatric care based on the size of the facility, not the type of medical care that can be provided. In a time where workforce, access, and clinical expertise are all in short supply, we should be considering how we design systems to treat mental illness like any other health condition. It is recommended that Minnesota consider applying for a waiver from the federal government to allow for short-term stays in psychiatric hospitals regardless of size, so that we may expand access to psychiatric beds and leverage expanded models of medical care that are more efficient and responsive to today's workforce shortages and access needs. Currently, 18 other states have applied for a waiver from the IMD payment exclusion and have been approved or are pending approval.

11. Changes to Forensic Mental Health Program

- Revise discharge criteria at the Forensic Mental Health Program in St. Peter to allow medical discretion, rather than the Special Review Board, courts, and counties. Similarly, allow those committed MI&D to be revoked to settings outside of FMHP, when appropriate, based on individual needs and circumstances.
- Reduce delays attributable to forensic mental health (MSH) by reducing length of stay, change conditional discharge processes, and allowing different providers to serve the population when appropriate.

12. Changes to Competency Restoration

- Implement competency restoration.
- Support key recommendations coming out of the Competency Restoration Task Force and resource the recommendations swiftly so that systemic relief may be felt. The Competency Restoration Task Force extensively reviewed the systems relating to individual caught up in both the mental health and criminal justice systems. The number of recommendations make outlining them in this document unrealistic, however, this task force should review those recommendations for areas of agreement and achievability. Such key recommendations should be supported and implemented.
- Fully implement the new competency restoration law 10.26.23 7

13. Physical Plant/Infrastructure

- Recognize that, while we as a society do not want to return to institutionalization practices that existed prior to the deinstitutionalization movement, there are some individuals who need long-term and even lifelong care in state-operated services, and these individuals are instead cycling between homelessness, hospitals, treatment facilities, and jails. In addition to expanding capacity

for state-operated services such as those delivered at AMRTC, we need to create a space like AMRTC that is designed for long-term care for our patients who cannot live safely in any environment that currently exists in our community. • Additional investments in our hospital infrastructure should be considered to allow hospitals to staff and handle patients who end up "boarding" in hospitals.

- Establish a new level of service for residential beds that exists between hospitalization and long-term community placement for individuals that require an extended level of psychiatric treatment and have security or behavioral needs. A "secure IRTS" model has been explored, but the private provider community is not stepping into this space due to funding, liability, and clinical model concerns. The state should develop and provide a level of service in this space which provides secure, extended treatment and care for a length of time up to 6-12 months. Individuals having success in a setting like this would undoubtedly provide some confidence for private community providers to accept them into their homes for long term housing.
- Make sustained investments into our community-based behavioral health system to build or maintain infrastructure for services - mobile crisis response, children's and families, mental health support services in housing, etc.

14. Changes to Internal DCT Processes

- Hospital systems must have a transparent process for Utilization Management and Review, which is a process that evaluates appropriateness and medical necessity of treatments and facilities provided to patients on a case-by-case basis according to CMS standards. In concurrent utilization management review models (similar to what DCT does), the patient's progress, prognosis, treatment plan, and other data are reviewed to determine if the individual does or does not meet criteria to remain hospitalized. In many hospital systems, this is completed by a third party as a form of quality assurance. In the current DCT system, this is conducted by DCT employees, most often mental health professionals. It is recommended that the state consider contracting with a third-party to conduct utilization reviews and reassign the high-demand mental health professionals to fill the numerous MHP vacancies in the DCT system. This recommendation achieves three goals: (1) reducing the possibility of a conflict of interest (the state determines when a person no longer meets criteria for hospitalization, triggering a financial responsibility in which the counties must pay the state for cost of care for any days remaining in the hospital), (2) achieving higher quality of care through assurance of the most effective treatment and better data, and (3) utilizing current state employees to fill vacancies due to workforce shortages.
- Reduce administrative reporting burden - excess assessments, data reporting, administrative documentation - that does not provide clinical utility or benefit the clients allow licensed clinicians to exercise their clinical discretion in treatment: (1) Eliminate level of care assessments requirements, (2) Remove added narrative requirements to treatment planning, and (3) Reduce required frequency of reporting and updating assessments, records and planning documents.

15. Other

- Ask the Acute Transitions Team in DHS to also identify systemic issues they find in their work and to develop proposals to address them – such as, county reluctance to offer rate exceptions for high-needs patients; lack of funding for bariatric equipment; unclear guardianship responsibilities.