Recommendations Draft 12.17.2023

The Task Force concludes that the 48-hour rule itself is not problematic; its pure intention is to assure timely access to essential mental health services for some of Minnesota's most vulnerable, and most complicated to serve individuals. The fundamental flaw with the implementation of the 48-hour rule is that there simply is not enough inpatient mental health bed capacity to serve the volume of people in need regardless of if they are in a jail, an emergency department, or in the community. Without adequate capacity, logjams of patients awaiting court-ordered care have occurred at virtually every level of inpatient mental health care. The logjams have now reached the end of the line, Minnesota's most secure hospital, Forensic Mental Health Services, where mentally ill and dangerous individuals are waiting 9-12 months to be admitted.

The Task Force recommends that swift action be taken to address the crisis state of our mental health system, as there is no other systemic stopgap accessible to address the problem.

Immediate (action needed within 6 months):

1. **Create and implement new Priority Admission criteria to DCT facilities**. Amend Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), to improve the priority admissions requirements and process:
    a. Permit admission to a DCT facility to be based on the use of a standardized patient prioritization tool (PPT) which includes factors such as acuity of condition, intensity of treatment needed, provisional discharge status, and current safety of the individual or others in the proximal environment (including public safety), and access (or lack thereof) to essential or court-ordered treatment in the facility /location for which the person is being held.
    b. Creation of an oversight council to review admission and capacity data on a quarterly basis to assure admissions are occurring in a systematic, fair, and equitable manner. The work of the council is to advise the Commissioner of Human Services and eventually the Hospital Board for Direct Care and Treatment on the effectiveness of priority admissions. Council members shall be reflective of organizations and/or disciplines represented under the Priority Admissions Task Force. The Council shall serve as an appeals option for interested parties to the admissions wait list and will provide oversight of the Central Pre-Admissions prioritization process. Available data will include reports from DCT, the courts, Minnesota Management and Budget (MMB) and other sources to capture a real-time and accurate view of systemic flow of patients and determination of service needs.
    c. Restructure the DCT wait list to be more responsive to access needs and allow individuals to be listed on more than one facility wait list.

    AND

2. **Increase DCT services and bed capacity**. Immediate additions to DCT capacity are needed, and any feasible addition will not meet (or exceed) the current capacity demands, yet it will provide significant relief to hundreds of Minnesotans who are presently waiting for care. Beds are needed in the following DCT facilities:

a. Forensic Mental Health Program (FMHP)
b. Anoka Metro Regional Treatment Center (AMRTC) with capacity that is flexible in nature. AMRTC is uniquely situated with staffing that can accommodate a range of treatment needs that can flex as patient demands fluctuate.
c. Community Behavioral Health Hospital (CBHH)
d. Community Support Services Team to transition individuals out of inpatient settings, thus increasing community capacity.

**Recommendations 1 & 2 must be authorized concurrently. If bed capacity is not expanded, there will not be sufficient support to make changes to the current priority admissions statute.*

3. **Relieve counties of DNMC costs** so that counties may address local mental health and other service needs.

4. **Fund two options for jails to effectively utilize Jarvis orders for involuntary neuroleptic treatment** through:
    a. Deployment of state-staffed rapid response teams and technology, or
    b. A state-funded allocation to jails to provide neuroleptic administration within jails.

    **It is vital that both options be made available as the success depends on flexibility with local implementation.*

5. **DHS expedite submission of an 1115 Waiver** for some incarcerated individuals to receive Medicaid benefits. This was funded through the 2023 legislative session and needs to be accelerated by the department.
6. **Fund a pilot project for voluntary engagement services**, and measure outcomes through MMB's Results First impact evaluation team.
7. **Authorization of a rate study for behavioral health services**.

Short Term (Action needed within 6-18 months):

1. **Begin modeling a wholistic vision for mental health services in Minnesota which addresses service capacity, including inpatient hospital bed capacity.**
    a. Use the American Psychiatric Association model to determine number of beds needed to meet inpatient care demands, in both state and community hospital settings [Psychiatry.org - Psychiatric Bed Crisis Report]
    b. Creation of a Mental Health Oversight Commission responsible for vision setting and strategic planning duties.
    c. Evaluation of service capacity need, and setting of target service levels, along with strategies to address gaps in the current service continuum through development of new/enhanced services:

(graphic- DHS website)

    d. Expand IRTS access by including locked programming and longer-term stays dependent on clinical need.
    e. DHS bolster their technical assistance efforts to expand innovative housing models.
2. **Increase Rule 20 Examiner availability** through increased rates and the creation of a new certification program.
3. **Revise discharge criteria at Forensic Mental Health Program in St. Peter** to allow medical discretion at discharge, rather than the Special Review Board process. With this, a prioritization of admittance to FMHP will occur if the provisional discharge is revoked.
4. **Transition the DCT Utilization Management team** to an independent, contracted, third party to assure fairness and transparency in decision making *(this may be eliminated if county DNMC costs are relieved, listed in Immediate #3).*

Long Term (Action needed 18+ months and beyond):

1. **Implementation of rate study findings** in "Immediate" section.
2. **Explore funding and modeling for psychiatric emergency rooms** / intensive care units in community/hospital settings.