DEPARTMENT OF HUMAN SERVICES
DIRECT CARE AND TREATMENT

Priority Admissions Review Panel

Report and Recommendations to the Minnesota Legislature

February 1, 2025

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Introduction

The Review Panel on Priority Admissions to State-Operated Treatment Programs was established by the Minnesota Legislature in 2024 to review and evaluate the priority admissions timeline in order to minimize litigation costs, maximize capacity in and access to state-operated treatment programs, and address issues related to individuals in jails and correctional institutions awaiting admission to state-operated treatment programs. The Review Panel was also directed to advise the commissioner of the Department of Human Services on the effectiveness of the priority admissions framework and priority admissions generally and review de-identified data quarterly for one year following the implementation of the framework to ensure that it is implemented and applied equitably. The Review Panel is required to submit a report to the legislative committees with jurisdiction over public safety and human services by Feb. 1, 2025. The report must include legislative proposals to amend Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), to modify the 48-hour priority admissions timeline.

State Statute

The current "Priority Admissions" statute in Minn. Stat. sec. 253B.10, sub. 1(b) directs the Minnesota Direct Care and Treatment (DCT) agency to prioritize civilly committed patients being admitted from jail or a correctional institution or who are referred to a state-operated treatment facility for competency attainment or a competency examination under sections 611.40 to 611.59 for admission to a medically appropriate state-operated direct care and treatment bed based on the decisions of physicians in the executive medical director's office, using a priority admissions framework.

In 2023, the Minnesota Legislature amended the Priority Admissions statute to provide clarity that when patients are subject to the priority admission 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.

Recommendations

The Priority Admissions Review Panel supports the following recommendations:

Recommendation 1: Expand access to care.

Recommendation 2: Extend the sunset provision for two years during which time the Legislature must develop DCT and community capacity.

Recommendation 3: Increase data sharing and transparency.

Recommendation 4: Provide basic mental health care in jails.

Recommendation 5: Continue "Does Not Meet Criteria (DNMC)" payment relief to counties for clients in certain situations.

Recommendation 6: Renew the exception for up to 10 patients from community-based hospitals to be prioritized for admission to a DCT bed.

Acknowledgements

The Priority Admissions Review Panel members wish to thank the Legislature for directing the work of the Review Panel. 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 Review Panel on Priority Admissions to State-Operated Treatment Programs was established by the Minnesota Legislature in 2024 to review and evaluate the priority admissions timeline in order to minimize litigation costs, maximize capacity in and access to state-operated treatment programs, and address issues related to individuals awaiting admission to state-operated treatment programs in jails and correctional institutions. The Review Panel was also directed to advise the commissioner on the effectiveness of the framework and priority admissions generally and review de-identified data quarterly for one year following the implementation of the priority admissions framework to ensure that the framework is implemented and applied equitably. The Review Panel is required to submit a report to the legislative committees with jurisdiction over public safety and human services by Feb. 1, 2025. The report must include legislative proposals to amend Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), to modify the 48-hour priority admissions timeline.

Statute and Scope of Work

The current "Priority Admissions" statute in Minn. Stat. sec. 253B.10, sub. 1(b) directs the Minnesota Direct Care and Treatment (DCT) agency to prioritize civilly committed patients being admitted from jail or a correctional institution or who are referred to a state-operated treatment facility for competency attainment or a competency examination under sections 611.40 to 611.59 for admission to a medically appropriate state-operated direct care and treatment bed based on the decisions of physicians in the executive medical director's office, using a priority admissions framework. The framework must account for a range of factors for priority admission, including but not limited to:

> (1) the length of time the person has been on a waiting list for admission to a state-operated direct care and treatment program since the date of the order under paragraph (a), or the date of an order issued under sections 611.40 to 611.59;
>
> (2) the intensity of the treatment the person needs, based on medical acuity;

(3) the person's revoked provisional discharge status;

(4) the person's safety and safety of others in the person's current environment;

(5) whether the person has access to necessary or court-ordered treatment;

(6) distinct and articulable negative impacts of an admission delay on the facility referring the individual for treatment; and

(7) any relevant federal prioritization requirements.

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 of 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 Priority Admissions Task Force (See: human services finance and policy bill, SF2934, 93rd Legislature, Chapter 61, Article 8, Section 13.). The Task Force provided a report and recommendations to the Legislature on Feb. 12, 2024.

Following the Task Force report, the 2024 Legislature further amended the Priority Admissions law to include the framework process described above. The Legislature at that time also directed the Commissioner of Human Services to appoint a "Review Panel" with the same members of the Task Force and an additional representative representing DCT union staff.

The Review Panel is directed to:

- Evaluate the 48-hour timeline for priority admissions.
- Develop policy and legislative proposals related to the priority admissions timeline. The proposals must be aimed towards:
    - Minimizing litigation costs.
    - Maximizing capacity in DCT programs.
    - Maximizing access to DCT programs.
    - Addressing issues related to individuals in jails and correctional institutions awaiting admission to DCT programs.

• Submit a report by Feb. 1, 2025, that includes legislative proposals to change the 48-hour priority admissions timeline.

• Advise the commissioner on the effectiveness of the priority admissions framework and priority admissions in general.

• Review de-identified data on a quarterly basis for one year after the framework is implemented.

Review Panel Members

The Priority Admissions Review Panel was instructed to appoint all members of the Priority Admissions Task Force, and one member who has an active role as a union representative for DCT staff. The Review Panel members are:

- **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.
- **Lynn Butcher,** a member who has an active role as a union representative representing staff at Direct Care and Treatment.

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 mental health treatment and care. The statutory process for civil commitment is lengthy and extensive, often involving multiple licensed mental health professionals, court-appointed counsel, and judicial oversight.

The original Priority Admission statute required the Commissioner to prioritize for admission patients being admitted from jail or a correctional institution who were:

- Ordered confined in a state-operated treatment program for an examination;
- Under civil commitment for competency treatment and continuing supervision;
- Found not guilty by reason of mental illness; or
- Committed to the Commissioner after dismissal of the patient's criminal charges.

The Priority Admissions Task Force's February 2024 report details the history and background of the Priority Admissions law. The Task Force report notes that at the time the law was being considered, the average time of 30 days from the commitment order to placement in a state-operated psychiatric hospital was unacceptably long. Among those most affected by the delay were people with mental illnesses being held in jails, even though they had not been convicted of a crime. Proponents hoped that the Priority Admission statute would spur significant investment in both DCT and community-based treatment capacity as well as investment in measures to reduce the number of people needing mental health care and treatment in jail. When passed in 2013, the law was intended to speed admissions for people waiting in jails for treatment. DCT was able to meet demand for a few years, but the number of people referred under the statute increased dramatically in the 10-year period since the law was enacted and admissions waiting lists resulted. The Priority Admission law did not solve the problem of lack of access to mental health care and treatment for people in jail.

The Task Force report also described the unintended consequences of the Priority Admission law, which included increased injuries for DCT staff due to higher concentrations of clients with significant symptoms;

decreased access to care and treatment at DCT for people in the community; pressure to admit people in conflict with sound medical judgment; and numerous lawsuits.

In response to the Task Force's February 2024 report, the 2024 legislature amended the Priority Admission statute to (1) include a larger population of people eligible for priority admission; and (2) require Direct Care and Treatment to prioritize people on its waiting list for admission using a framework process that takes into consideration a variety of factors.

The language of the new statute includes new populations in the high-priority categories. First, the statute includes all people who are civilly committed and in jail or a correctional institution, not just those with incompetency findings or evaluations which often result in people needing to be in jail or a correctional institution longer due to the length of the evaluation. Second, the statute includes all people with court orders under sections 611.40 to 611.59. Finally, the new statute includes all people civilly committed as mentally ill and dangerous, not just those in jail or a correctional institution. The new statute continues to prioritize individuals in jails and not in hospitals or in the community, although the review panel acknowledges there are instances in which individuals in community-based hospitals or in the community also need this level of inpatient mental health care.

Prior Report and Recommendations

The 2024 Priority Admissions Task Force report detailed previous efforts and studies on how to adequately build the mental health system in Minnesota, including a discussion of the Community Competency Restoration Task Force. The Priority Admissions Task Force report itself made nine different recommendations to improve access to mental health care and treatment in conjunction with the Priority Admissions law. These nine recommendations and action taken on them are as follows:

- Immediately begin to increase capacity of Direct Care and Treatment. Specifically, the Task Force recommended an immediate increase of Forensic Mental Health Program (FMHP) beds by 10 % to 20% and a 20% increase in bed capacity at the Anoka Metro Regional Treatment Center (AMRTC) or Community Behavioral Health Hospitals (CBHHs). This equated to a minimum immediate increase of 36 to 72 beds at the FMHP and 41 additional beds at AMRTC or the CBHHs.
    - DHS pursued and obtained legislative approval during the 2024 session to close a substance use disorder program in St. Peter and repurpose the facility to add 16 more beds to the FMHP. This will result in 16 additional Forensic beds available once the transition is complete.
    - The FMHP's Ironwood Unit was re-opened, resulting in 14 additional beds becoming available for use. Although extremely helpful, these beds were already budgeted for and are not considered new.
    - DCT's Community-Based Services (CBS) division is developing an Integrated Community Supports (ICS) program that will allow for at least 12 admissions to a less acute care setting. These should be considered community-based placement options.

- DHS submitted a bonding bill proposal during the 2024 session for $60 million to demolish the "Miller Building" and design, build, furnish, and equip a new building on the AMRTC campus to provide an additional 50 residential treatment beds. The proposal was not included in the Governor's 2024 Capital Budget Recommendations and the Legislature did not pass a bonding bill. However, the Legislature provided funding to design the new facility.

- Form Joint Incident collaboration to actively facilitate discharges for DCT patients.
  - DHS, county, community, and hospital providers accomplished this without legislative direction.
  - Several efforts were undertaken to reduce the number of individuals not meeting hospital criteria at AMRTC from more than 40% of the patient population to 26% as of January 24, 2025.

- Approve an exception to the Priority Admissions law.
  - An exception for up to 10 hospital admissions in 253B.10 was passed in 2024. As of 1/29/2025 five individuals from community hospitals have been admitted to DCT, with additional admissions planned.

Create and implement new Priority Admissions criteria to Direct Care and Treatment facilities.

- A new framework process was passed in 2024.
- DCT began implementing its new framework process for priority admissions on July 1, 2024. The framework is currently being reviewed internally and externally by stakeholders, including the Review Panel.
- The Legislature also required additional reporting requirements for program selection and admission notifications. DCT implemented these notifications by July 1, 2024.

Increase access to services provided in the community.

- Legislation clarified that payments for assertive community treatment and intensive residential treatment services are based on medical necessity.
- Legislation established an engagement services pilot grant program at the Department of Human Services to provide grants to counties or certified community behavioral health clinics to intervene early to prevent people from experiencing a crisis and needing hospitalization or ending up in a jail.
- The Legislature slightly increased rates for mental health services after Jan. 1, 2025.

• Administer Medication in Jails

- The 2024 Legislature appropriated funding for a pilot program to fund mental health medication for people in jail. This pilot program is currently in the development stage.
- The 2024 Legislature also appropriated funding for a DCT jail consultation pilot to increase access to mental health medication for people in jail and assist jails in obtaining added resources. This consultation pilot is currently being implemented.

- Relieve counties of certain DNMC costs.

- The 2024 Legislature passed revisions to relieve counties for costs associated with individuals awaiting transfer to other DCT facilities.

•Expedite Minnesota's Section 1115 Waiver Application for Individuals in custody

- DHS plans to pilot the 1115 Waiver in four adult jails identified in coordination with county agencies through a competitive request for proposal process.

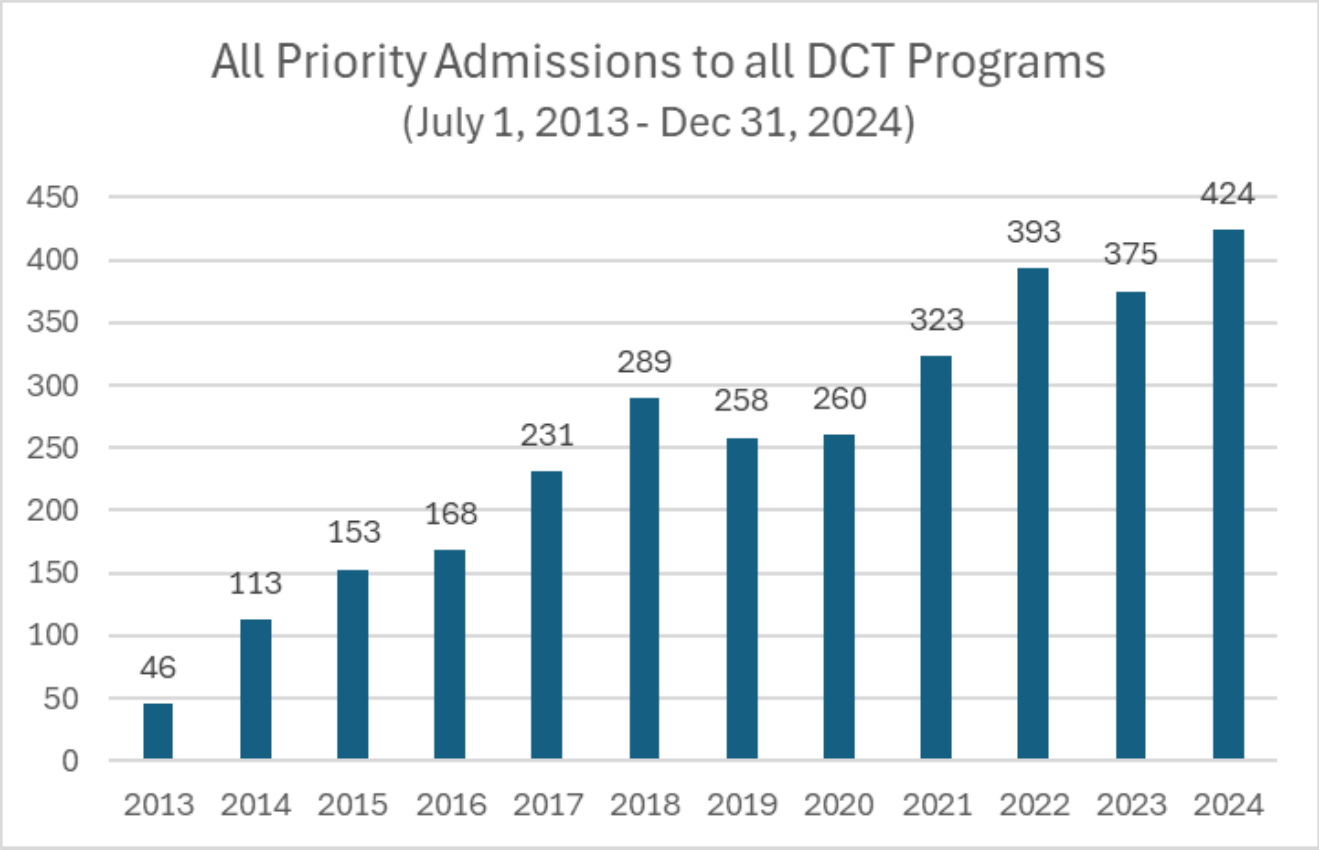
• Increase Forensic Examiner Accessibility

- Payment rates for DCT Forensic Examiner services will increase on March 1, 2025.

Current Trends and Statistics

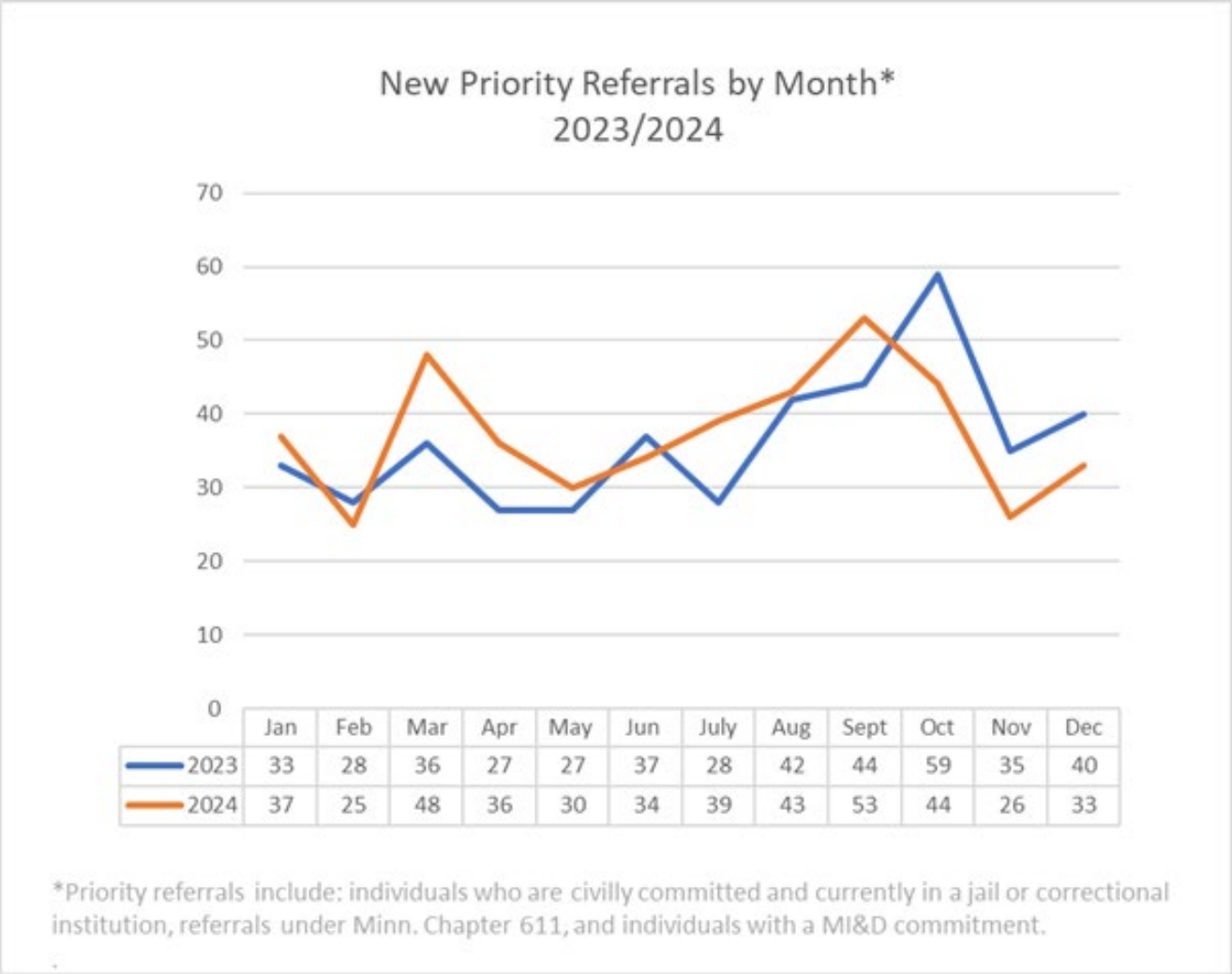
The Review Panel members reviewed data and trends related to admissions, waitlists, and referral sources. The most salient information is included here, with additional data included in Appendix A.

Priority Admissions to all DCT Programs



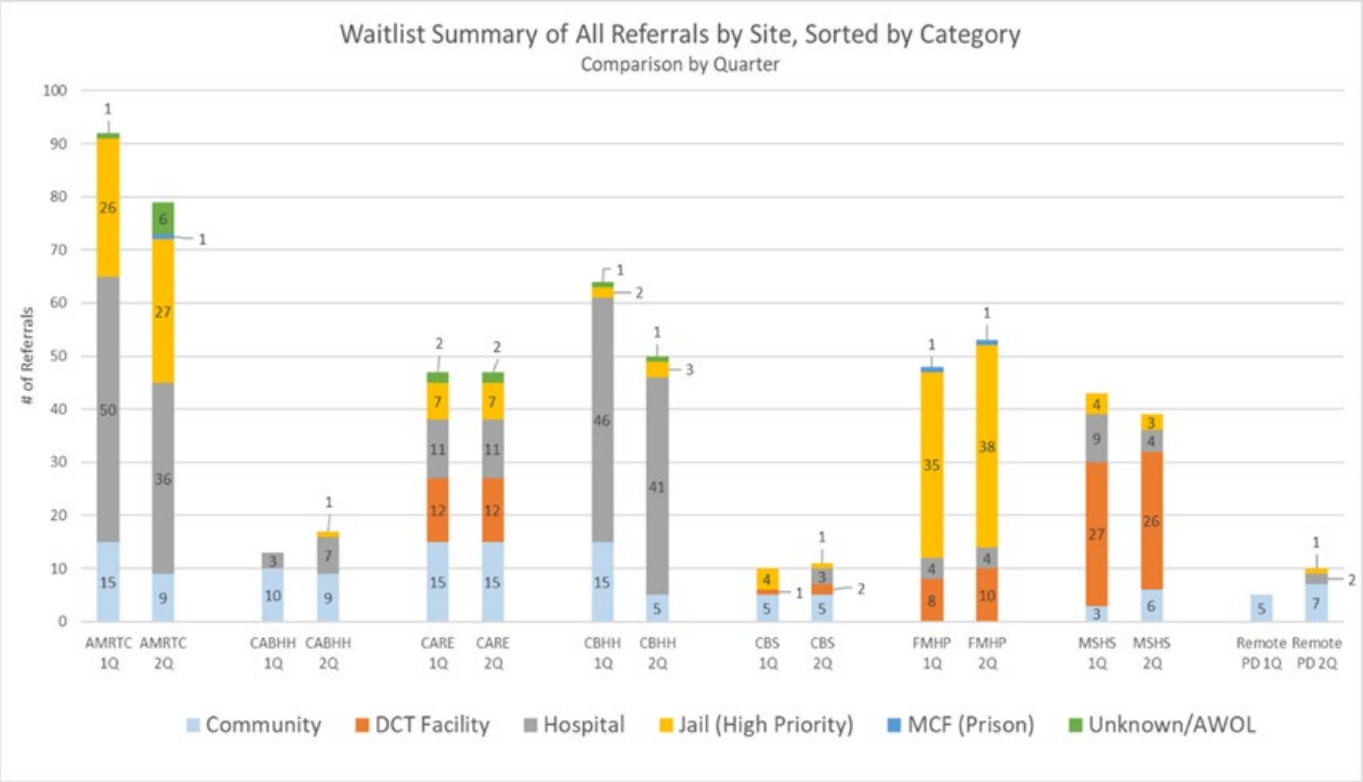
This graph illustrates admissions made under the priority admission statute to all DHS-operated treatment programs since the law's inception on July 1, 2013. Data shows that there has been a substantial increase in referrals and admissions to DCT programs under this law year over year.

Priority Referrals to all DCT Programs



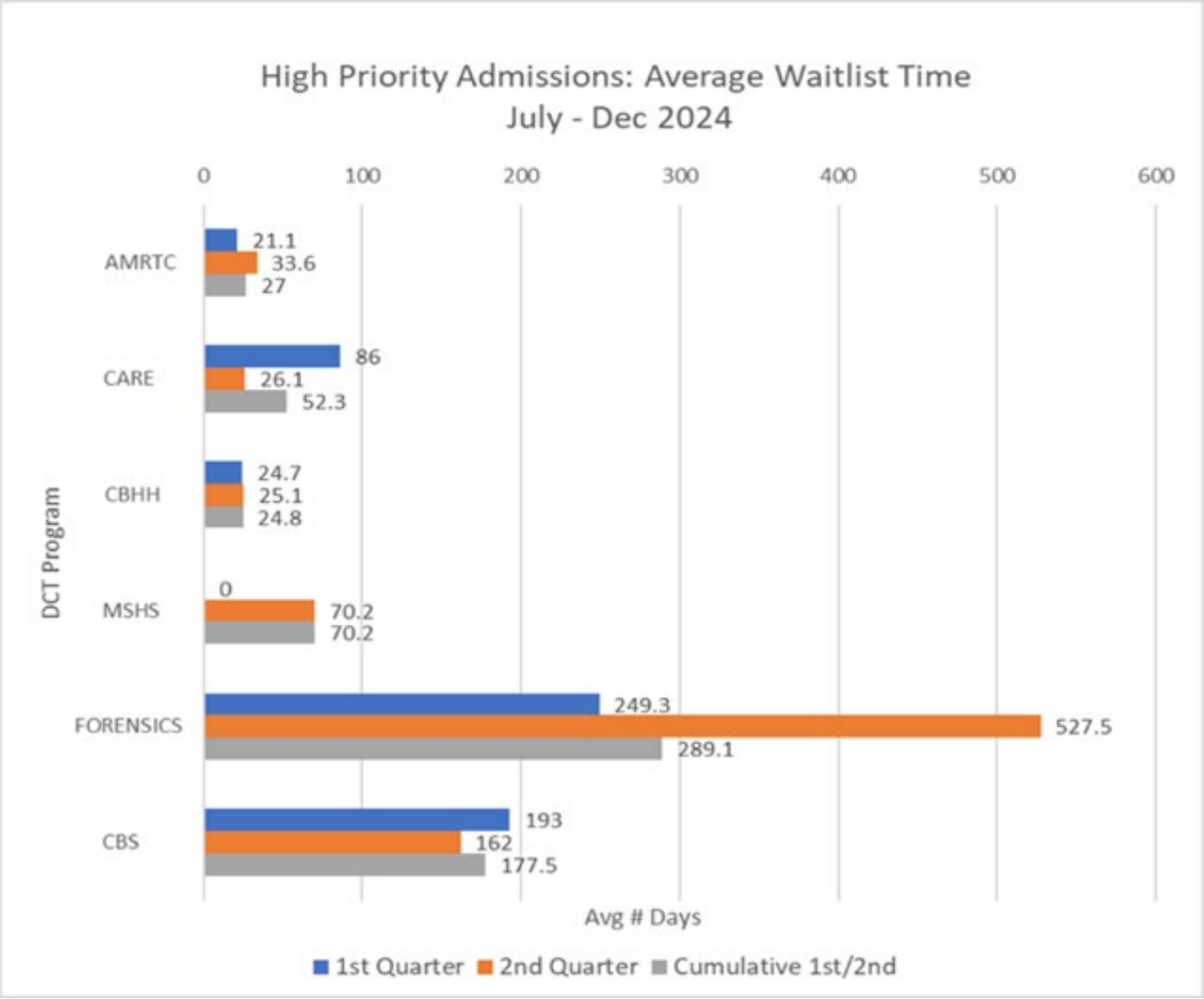
This graph reflects High Priority referrals for admission to DCT programs over a two-year period, demonstrating an overall increase in referrals under the statute.

Waitlist Summary from All Sources



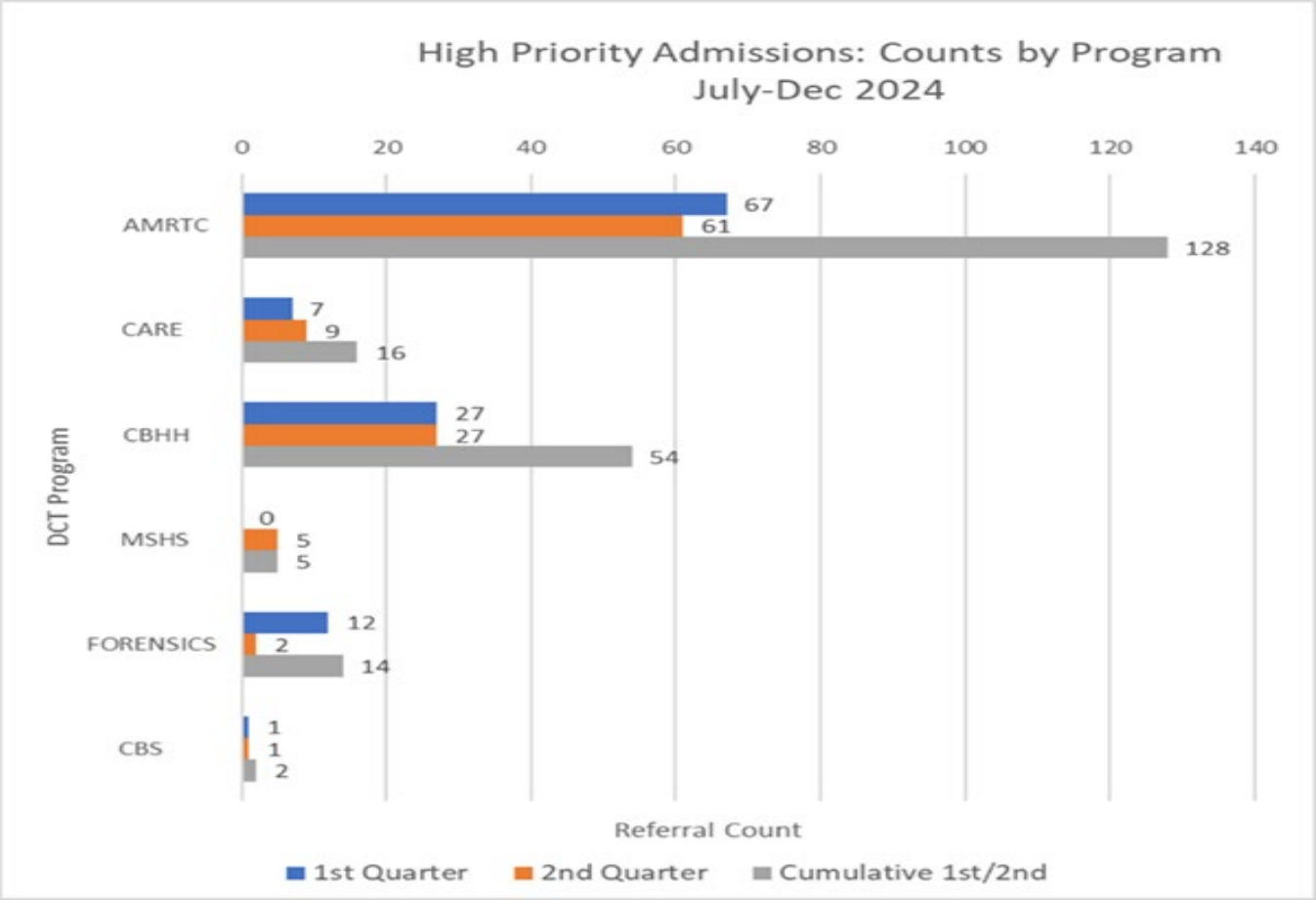
This graph reflects waitlist referrals between July 1, 2024, and December 31, 2024, separated by quarter. AMRTC means Anoka Metro Regional Treatment Center; CABHH means Child and Adolescent Behavioral Health Hospital; CARE means Community Addiction Recovery Enterprise; CBHH means Community Behavioral Health Hospital; CBS means Community-Based Services; FMHP means Forensic Mental Health Program; MSHS stands for Minnesota Specialty Health System; and Remote PD refers to individuals who were provisionally discharged without first coming to a DCT facility.

Average Waitlist Time for Priority Admissions



This graph reflects the average wait times for admission between July 1, 2024, and December 31, 2024. Wait time for admission to DCT hospitals (AMRTC and CBHHs) are below 30 days. The highest waitlist time is for the Forensic Mental Health Program, followed by Community-Based Services.

Number of Priority Admissions by Program



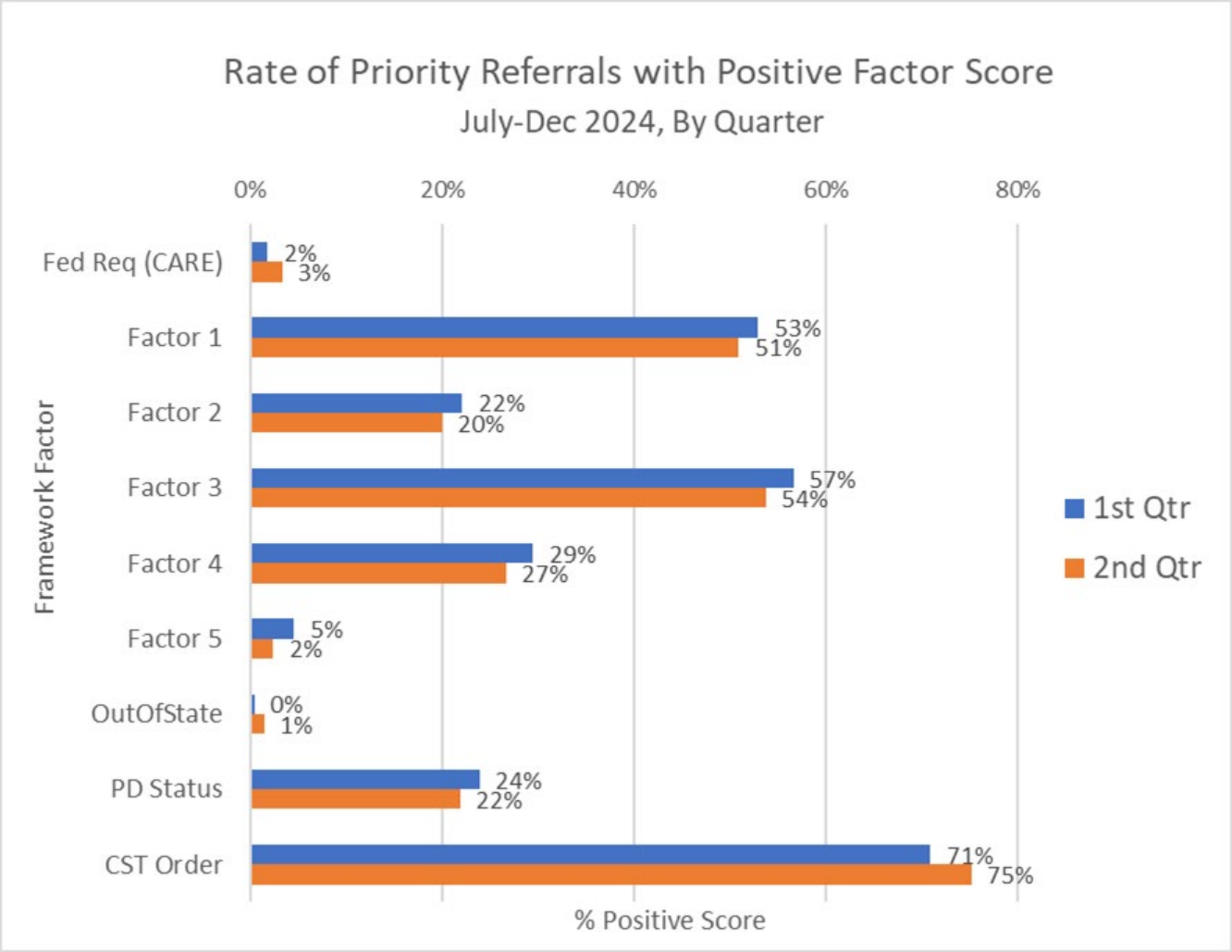
This graph reflects the number of admissions to each of the above programs for the same period as previous tables. Most admissions took place at DCT hospitals (AMRTC and CBHHs).

Priority Admissions Framework Factors

	Weighted Factors	MHSATS	Forensics	CBS	Scoring
Factor 1	Intensity of treatment needed due to clinical acuity	45%	5%	10%	0 = Stable, low acuity, or responsive to current treatment 1 = Urgent, high acuity, or unresponsive to current treatment
Factor 2	Current concerns for safety of the individual and/or others in the proximal environment	25%	20%	20%	0 = No risk or adequately mitigated/managed risk 1 = Ongoing or imminent risk either unmanaged or despite mitigation efforts
Factor 3	Access to/or lack thereof to essential or court ordered treatment in a non-DCT environment	20%	30%	30%	0 = Appropriate treatment available and adequate 1 = Appropriate treatment unavailable or insufficient
Factor 4	Other negative impacts to the referring facility, such as the number of beds unavailable because of caring for the referred individual.	10%	10%	30%	0 = Standard resources utilized 1 = Extraordinary resource allocation needed, or negative impacts are present
Factor 5	NGMI Finding	0%	35%	10%	0 = No 1 = Yes
	Other Factors/Non-Weighted				
A, B, C, - option	Federal Prioritization Requirement (CARE Only) - A (Pregnant and IV Using)				Yes/No
	Federal Prioritization Requirement (CARE Only) - B (IV Using, not Pregnant)				
	Federal Prioritization Requirement (CARE Only) - C (Pregnant, non-IV Using)				
	Client has active PD Status /Order for Return to DCT				
	Referral from Out of State Jail				
	Incompetency/Eval Order (CST)				

This table represents the factors that now must be considered when prioritizing admissions under the Priority Admissions Statute to DCT programs. Factors for each referral are scored as 0 or 1, weighed based on a percentage applicable to the intended service, and combined with days spent waiting for a total score which is used to prioritize admissions. Different weights have been selected for each program as the programs differ in the service provided. Of note, extenuating circumstances and limitations on operational capacity may, at times, adjust admissions decisions. MHSATS means Mental health and Substance Abuse Treatment Services, Forensics refers to the Forensic Mental Health Program, and CBS refers to Community Based Services.

Factor Scoring Results



This graph reflects the frequency with which referrals score positively (meaning a score given as 1) on each of the factors reflected in the key above. Data to date indicates most referrals have an order for competency to stand trial, need high intensity of treatment due to clinical acuity, and lack access to essential or court-ordered treatment in a non-DCT environment.

The Effect of Litigation and Deadlines on Wait Times in Other States

Minnesota has already experienced some costly litigation related to its admissions waitlist. For insight into how much potential litigation could impact the state, the Review Panel reviewed data compiled by a DHS program consultant that examined whether other states' competency restoration laws mandate a timeframe for admission to a state-operated facility for jailed defendants who are incompetent to stand trial and whether there was litigation in other states over jail wait times for admission to state competency restoration programs. The research was conducted using internet sources and Westlaw in September and October 2024. Methods did

not include review of court documents or case law. Research covered the 50 states and the District of Columbia. The research is a survey of publicly available information and not an exhaustive exploration of the issue.

Like Minnesota, states nationwide are experiencing growth in the number of detained individuals found incompetent to stand trial and required by law or a court to be admitted to a state facility. As of 2023, these patients occupied most state hospital beds in the nation, a 58 percent increase since 2010.[1] By 2021, most state hospitals maintained wait lists of individuals court-ordered for restoration of competency to stand trial.[2] The research found reports in 32 states of wait times and/or bed shortages for competency restoration in state facilities.[3] Moreover, 24 states have experienced litigation over wait times.[4] Reducing wait times for people held in jail without a conviction is a nationwide effort.

The research showed that as of October 1, 2024, only 12 states had deadlines for admissions to state facilities from jail. Some of these deadlines are imposed by statute, and some are imposed by court decision. Research also identified two additional admission deadlines: one that expired in 2022 when court jurisdiction ended and one that will go into effect in January 2025 when court jurisdiction will begin.[5] 48 hours (Minnesota) was the shortest deadline found in statutes. Other time periods for admission were: 7 days, 10 days, 14 days, 15 days, 21 days, 28 days, 30 days and 60 days.

At least 24 states have experienced litigation over timelines for admission to state facilities. Seven states are currently under court jurisdiction related to admissions times for state programs. In addition, six states are currently involved in litigation which could result in court jurisdiction. Two states were previously under court jurisdiction which later terminated. Frustration with the lack of beds, resulting in people not guilty of a crime being held in jails, is palpable in other states as well as in Minnesota.

For ten of the states with current admission deadlines, research identified information about average wait times in jail before admission to a state competency program. All but Oregon and Washington currently have significant delays. Oregon and Washington are in current compliance with court ordered consent decrees, which has reduced wait time to 5.4 in Oregon and 5.2 or 7 days depending on the hospital in Washington. Oregon has been in litigation since 2002. Additionally, after a contempt fine of $100,000,000 because of its inability to meet

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[1] "Prevention Over Punishment," Treatment Advocacy Center Research Report, January 2024, p. , 8.

[2] "Leading Reform: Competence to Stand Trial Systems; A Resource for State Courts," National Judicial Task Force to Examine State Courts' Response to Mental Illness, 2021.

[3] See table

[4] See table

[5] See table. UT had a 14-day court-imposed timeframe until court jurisdiction ended in 2022. OK will have a 21-day court-imposed timeframe when the court orders final approval of a consent decree in January 2024.

the timeframe due to demand for IST services, Washington dramatically reduced wait times and the state intends to spend nearly $1.3 billion on acquiring new psychiatric beds to be compliant with the consent decree.

Litigation Costs

Litigation is unquestionably expensive. The Review Panel reviewed a DHS report regarding government attorney billing data for how much money DHS has spent in legal fees on priority admissions-related litigation. That estimate showed that more than $611,000.00 has been spent on litigation thus far in Minnesota. However, legal fees can also be burdensome for those in jails seeking to enforce the court order committing them to the care of DHS for treatment at a secure state psychiatric facility. For example, the law firm of Gustafson & Gluek has reportedly spent nearly $900,000.00 of its own money in fees thus far litigating a single pro bono civil rights case with multiple plaintiffs in state and federal court. Notably, Minnesota has not yet reached the point where such litigation has resulted in ongoing expensive discovery and possible court jurisdiction over the state efforts to remedy waitlist times.

Discussion and Analysis

Introduction

This section describes content of the Review Panel's discussion on minimizing litigation costs, maximizing capacity and access to DCT and other programs and the impacts of a statutory deadline for admission.

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. 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 in Minnesota and nationwide.

Following the 2024 amendments to 253B.10, the number of people eligible for priority admission to Direct Care and Treatment has grown. This is due to the addition of newly eligible populations of people subject to a civil commitment in jail but without an incompetency for NGMI finding, people with referrals for admission under Chapter 611, and people with MI&D commitments who are currently in community hospitals. DCT has not received a significant number of people referred under Chapter 611 as of December 1, 2024, as courts have just begun to implement it. DCT cannot predict how likely this population is to increase the number of people on its waitlists.

Given the expansion of individuals eligible for priority admission, DCT anticipates an increase in the average time it will take for admission. There are more people in need of DCT services than those waiting in jails, and the

percentage noted above would undoubtedly be higher if these individuals were factored into the growth percentage.

Minimizing Litigation Costs

Prior to the addition of the "medically appropriate bed" language added in 2023, DHS faced a significant litigation burden regarding timely admission to DCT programs. Public defenders, public service organizations, and pro bono attorneys have brought much of this litigation trying to get people out of jails and into the psychiatric care the court ordered. Inclusion of the "medically appropriate bed" language has noticeably reduced the litigation burden. If the "medically appropriate bed" language sunsets as currently scheduled, the Review Panel expects that the costs of litigation will increase substantially and, according to DCT, divert significant funds and critical staffing time away from patient care, decreasing DCT's overall resources and capacity to serve patients. The Review Panel further recognizes that without significant expansion of DCT capacity, community capacity, and jail resources to eliminate or greatly reduce wait times, the potential for litigation will always be looming as a mechanism to protect and enforce individuals' civil liberties.

Data reviewed by the Review Panel suggests that statutory timeframes and the resulting individual lawsuits do not solve the larger problem of wait times in jail. Most states are unable to meet mandatory timeframes because of steep increases in the number of detained people with incompetency findings that are required to be admitted to state-operated competency restoration programs. On the other hand, it was only after a contempt fine of $100 million that Washington state formulated a plan to spend nearly $1.3 billion on acquiring new psychiatric beds to address the problem. It took a court-imposed consent decree for Oregon to reduce its average wait to 5.4 days. With wait times already reduced to 5.2 and 7, the director of Washington's Department of Social and Health Services' division in charge of compliance with the settlement agreement has said that the department is on an "amazing trajectory" and it is his "optimistic hope" to reach anywhere from 85% to 90% compliance.[6] The Review Panel agrees that Minnesota should direct its limited resources to upfront capacity development rather than spending it on contempt fines and litigation.

Additionally, the absence of a mandatory admission deadline alone does not appear to prevent litigation. States without statutory admission deadlines also get sued over long waiting periods in jail, often resulting in court-imposed timeframes the states are unable to meet, despite lengthy periods of court supervision and enforcement that can include costly fines and sanctions. Focus on complying with hard deadlines also may divert resources and attention from implementing more effective measures to reduce jail wait times. Therefore, the Review Panel concludes that significant expansion of DCT capacity, as well as investment in community capacity and jail resources, so as to enable humane and constitutionally adequate waiting times and conditions must accompany any changes to the mandatory admission deadline.

The panel acknowledges that the best way for DHS to avoid litigation costs is to eliminate the impetus for the lawsuits in the first place: the lack of capacity at DCT to admit people in jails, many of whom have not been

[6] Washington Faces Steep Path Closing Mental Health Bed Gap for Jailed Defendants, posted: October 16, 2023.

convicted of a crime, into a state-treatment facility. The panel also acknowledges that DCT does not appropriate funds to establish and maintain the needed number of treatment beds. However, jails are not treatment facilities and do not provide the same care and treatment as a DCT facility. DCT has provided its services the best it can with the resources provided. However, the Legislature should factor into DCT's budget any costs, fines, or monetary damages DCT incurs as a result of a petitioner's efforts to be transferred from jail to a state facility as required by law.

Maximizing Capacity in and Access to State-operated Treatment Programs

Consistent with the current statutory requirement that people are admitted within 48 hours of a medically appropriate bed being available, DCT does not currently operate with excess bed capacity. While DCT has strained to safely admit an increasing number of people eligible for priority admission over the past 11 years, the data discussed above show that DCT cannot indefinitely admit increasing numbers of people from its priority admissions waitlist and is, in fact, at capacity in all areas within present resources. At this point, DCT would require significantly more physical capacity and workforce to substantially increase the rate at which it can admit people eligible for priority admissions.

Because DCT is a highly regulated health care provider, overcrowding could result in sanctions that limit DCT's ability to provide services. As discussed at the Review Panel, DCT faces significant regulatory risk if it admits more people than it can care for safely and effectively. DCT health care facilities are strictly regulated by state and federal oversight agencies including the Minnesota Department of Health, the Centers for Medicare and Medicaid Services, and the Minnesota Department of Human Services.

These agencies have the authority to impose significant sanctions up to and including licensure termination if facility operations do not comply with required patient rights and care and treatment standards. For example, in 2016, as a result of its high admissions rates, AMRTC was subject to a Systems Improvement Agreement by CMS, which jeopardized DCT's CMS funding. Additionally, DCT facilities are regulated by the Occupational Health and Safety Administration, which requires that DCT facilities are safe for staff. Adverse regulatory actions could result in fines, lost payments, and licensure limitations and terminations. Any of these would significantly reduce DCT's ability to provide services to people eligible for priority admission.

The Review Panel also discussed the impacts to DCT medical professionals that could result from laws that would impose unsafe admissions to DCT. Overcrowding and burdensome litigation could result in poor retention of critical professional staff necessary to safely oversee and administer DCT facilities.

Recommendations

Review Panel members unanimously agree that no one should be experiencing a serious mental illness in jail or a correctional institution without appropriate care. Lack of access negatively impacts people and strains local resources. The Review Panel members also agree that there is not a simple solution. As was indicated in the last report by the Priority Admission Task Force, the state needs to increase access to all levels of care while addressing the treatment needs of people who currently are held in jails and correctional institutions without a

conviction. We need to ensure that people living with mental illnesses in jails have access to the appropriate level of care, whether it's medication, outpatient level of care, residential care, or the level of care provided at DCT. *And* we must look at how to prevent people with mental illnesses from becoming involved in the criminal justice system by increasing access to care in the community, including crisis services, earlier intervention, outpatient care, residential, or the level of care provided at DCT.

The recommendations in the 2024 report remain necessary and carried over to this report. While progress was made during the 2024 Legislative session, more must be done. This report also makes new recommendations. Here are the key issues facing the Review Panel. The recommendations below are all necessary jointly, not in isolation.

Recommendation 1: Expand Access to Care

We are experiencing a "front" and "back" door issue. The long waiting list and waiting times for DCT experienced by people living with mental illnesses in jail or correctional institutions cannot be addressed just by expanding capacity at DCT.

At the request of the Review Panel, DCT has estimated the potential cost to address the care of the nearly 350 individuals currently on the priority admission wait list. DCT's rough estimate of nearly $800 million includes planning, design and construction costs for two facilities totaling approximately $525 million and ongoing operational costs of $245 million. This rough estimate is based on today's financial trends, current expenditures in 2024, and the existing waitlist as of January 2025. While it is helpful to illustrate the level of investment that is required, the estimate should not be taken as a refined cost projection, which would require far more detailed project plans and calculations to arrive at a precise cost estimate. Note that these costs reflect DCT capacity as the sole solution to the issue of the priority admissions waitlist.

Estimated Costs for Building Capacity to Treat 350 More Patients

Facility and Location	Beds Needed	Planning, Design and Construction	Annual Operating Costs
Anoka Metro Regional Treatment Center (Anoka)	50	$75 million	$45 million
Forensic Mental Health Program (St. Peter)	300	$450 million	$200 million
Totals	350	$525 million	$245 million

While increasing DCT capacity is vitally important, it cannot be the only solution. Access to care in the community and in jails and correctional institutions remain key. DCT has reported that up to 30% or more of patients currently residing in its care could be served elsewhere, but there are not community-based options to support those individuals. An increase of 30% in community-based care would significantly improve DCT's ability transfer patients who are ready for discharge to appropriate community settings and admit new patients who need DCT's level of care. Additionally, community placement options and resources should focus on prevention efforts, mitigating the use of jails and correctional facilities, as well as community hospitals.

During the last legislative session, lawmakers passed several recommendations to increase access to care and support earlier interventions. These included clarification of the language for locked IRTS Medicaid eligibility, funding for the voluntary engagement pilot project, moving forward with the 1115 Medicaid Waiver, increasing rates slightly for community providers, and providing some funding for inpatient care.

The Review Panel recommends that the Legislature continue to increase funding to expand DCT capacity, early intervention programs, and alternatives to a law enforcement response by doing the following:

- Fund the addition of a 50-bed facility on the campus of Anoka Metro Regional Treatment Center.
- Increase Medicaid rates for community and hospital providers.
- Increase funds for the First Episode of Psychosis and First Episode of Bipolar Disorder Programs.
- Increase funding for mobile crisis teams.
- Establish a task force on transport holds and provide education to law enforcement on transport holds.

Recommendation 2: Extend the Sunset Provision for Two Years During Which Time the Legislature must Develop DCT and Community Capacity

The Review Panel members agree that the sunset provision in 253B.10 subd. 1 (e) should be extended for a period of two years, which must be conditioned on funding to increase capacity at DCT and in the community.. DCT needs to retain the language regarding having a medically appropriate bed available and the Review Panel seeks to maintain engagement in the review implementation of the priority admission language. Specifically, panel members wish to review progress on the original recommendations made by the Priority Admissions Task Force in 2024. These included:

- 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;

- Increase Forensic Examiner accessibility.

Review Panel members understand that the 48-hour timeline is not feasible at this time. Compared to other states, Minnesota has the shortest timeline to admit patients to its state-operated treatment programs. However, there is also strong sentiment among members that removing the timeline entirely would eliminate the urgency with which DCT and the Legislature expand access to services. Identifying an alternative timeline rather than 48-hours was also seen as problematic because members wanted a realistic goal that would preclude people living with mental health disorders confined to a jail or correctional institution without essential services.

Members reached a consensus around extending the sunset provision for two years in order to invest in expanded capacity in DCT and the community, and to measure progress and impact of the changes. This keeps the focus on increasing access but also eliminates the unrealistic expectation that great changes or progress could be made in a single year. Quarterly data would be required to be shared with members to measure the impact of changes and to inform future legislation and timelines. Data to be shared may include priority admission waitlist data, engagement by the admissions team, priority notices, and time spent on a waitlist for DCT admission, among other data elements as needed.

Recommendation 3: Increase Data Sharing and Transparency

The Review Panel recommends that by Jan. 1, 2026, DCT will publish a publicly accessible dashboard on its referral data on its website. The dashboard will include deidentified data on how many individuals are on DCT waitlists and how long the shortest, average, and longest wait times are for admission to DCT facilities. The dashboard will include data to illustrate the numbers of referrals and admissions, waitlists, and length of time on waitlists, framework category data, and referral sources. The dashboard will be updated quarterly.

Additionally, relevant admissions policies and contact information for the DCT Central Preadmissions Department shall be made readily available on the publicly accessible site. Individuals and their representatives who are accepted for placement at DCT but who remain on a waitlist should receive information about their relative placement on the waitlist (such as top, mid, or bottom of waiting referrals) when such information does not jeopardize the health or wellbeing of the individual. Review Panel members understand that the DCT waitlist is a constantly evolving entity, and various factors impact an individual's placement on the list. Transparency about the process is likely to be most helpful, even amid uncertainty.

Recommendation 4: Provide Basic Mental Health Care in Jails

While people are in jail, they have a right to treatment. The Review Panel recognizes that most jails do not and should not provide the same level of mental health care services provided by state-operated specialized mental health facilities. However, even a basic level of care provided at jails would be meaningful. This would consist of services, whenever possible, generally at the level provided by a community-based provider. By providing this level of care we can prevent people from decompensating and needing a higher level of care. The Department of Corrections is currently updating the rules governing jails. The last legislative session funded a pilot for DCT to

provide antipsychotic medications, including injectables, in several jails. We do not have results from the project yet.

The Review Panel recommends that the Legislature provide necessary funding to:

- Encourage collaboration between community mental health centers and CCBHCs to provide outpatient level of mental health care in the jails and correctional institutions.
- Continue DCT's County Correctional Facility Support Pilot program continue and expand the pilot into the future.
- Provide long-acting injectable antipsychotic medication and related health care costs for jails and correctional facilities.

Recommendation 5: Continue Does Not Meet Criteria (DNMC) Payment Relief to Counties for Clients in Certain Situations

Counties are responsible to pay the state for the cost of care for patients who remain in a Direct Care and Treatment hospital after they no longer meet medical criteria for hospitalization. Previous legislation has supported cost relief to counties when situations exist where counties have no authority or ability to influence the timeline surrounding discharge of the person from the hospital. Critical statutory language is due to sunset as of June 30, 2025, and would create an unnecessary and exorbitant cost burden to counties with no systemic or personal value. Specifically, Minnesota Statutes 246.54 Subd 1a (d) and 246.54 Subd 1b (c) state the county is not responsible for the cost of care for a person who is civilly committed, if the client is awaiting transfer: (1) to a facility operated by the Department of Corrections; or (2) to another state-operated facility or program, and the Direct Care and Treatment executive medical director's office or a designee has determined that the client meets criteria for admission to that state-operated facility or program; and the state-operated facility or program is the only facility or program that can reasonably serve the client.

The Review Panel, as well as members of a county-state workgroup, agree that additional language to Minnesota Statute 246.54 Subd 3 that allows for the Commissioner to waive DNMC charges to counties in certain situations should include a provision for Direct Care and Treatment to review situations where the county has no authority to approve a new placement upon discharge from a DCT bed and determine if a downward adjustment to the charge is appropriate.

Recommendation 6: Renew the exception for up to 10 community-based hospital patients to be prioritized for admissions to a DCT bed.

In 2024, the Legislature approved a recommendation by the Task Force to allow a one-time exception for up to 10 hospitalized patients to be prioritized for priority admission to help relieve the significant pressures faced by community hospitals to care for people with significant symptoms and challenging behaviors. This exception has proven beneficial for community hospitals to help support more people in the community. As of the date of this report, five of the 10 possible exceptions have been utilized. The Review Panel recognizes the benefit of continuing this exception annually for the next biennium, to be reviewed again at that time for ongoing needs.

Appendix 1: How Other States Address Admission Wait Times

DEPARTMENT OF HUMAN SERVICES
DIRECT CARE AND TREATMENT

How Other States Address Admission Wait Times and Bed Shortages in State-Operated Mental Health Treatment Facilities

Introduction

In 2024, the Minnesota Legislature established the Priority Admissions Review Panel to evaluate the 48-hour timeline for priority admission to Direct Care and Treatment (DCT) facilities from a jail or correctional facility.[7] Among other things, the law requires the Panel to evaluate the 48-hour timeline in order to minimize litigation costs.[8] Since the establishment of the timeline in 2013, DCT has experienced an increasing amount of litigation over admissions that did not occur within 48 hours.

Like the rest of the nation, Minnesota is experiencing growth in the number of detained individuals found incompetent to stand trial (IST) and required by law or a court to be admitted to a state facility. As of 2023, these patients occupied most state hospital beds in the nation, a 58 percent increase since 2010.[9] By 2021, most state hospitals maintained wait lists of individuals court-ordered for restoration of competency to stand trial.[10] Our research found reports in 32 states of wait times and/or bed shortages for competency restoration in state facilities.[11] Moreover, 24 states have experienced litigation over wait times.[12]

Purpose of research

This research examined whether other states' competency restoration laws mandate a timeframe for admission to a state facility for jailed defendants who are incompetent to stand trial. Research also explored whether there

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[7] Laws 2024, Ch. 125, Art. 2, Sec. 7(a).

[8] Id. at Sec. 7(a)(1).

[9] "Prevention Over Punishment," Treatment Advocacy Center Research Report, January 2024, p. , 8.

[10] "Leading Reform: Competence to Stand Trial Systems; A Resource for State Courts," National Judicial Task Force to Examine State Courts' Response to Mental Illness, 2021.

[11] AL, AK, CA, CO, GA, IN, IA, HI, IL, KY, LA, MD, MA, MI, MN, MS, MO, MT, NV, NH, NM, NC, OH, OK, PA, SD, TN, TX, UT, VA, WI, WY.

[12] AK, AL, CA, CO, GA, IN, KA, KY, LA, MD, MN, MT, NH, NM, NV, NC, OK, OR, PA, SD, TX, UT, VA, WA.

was litigation in other states over jail wait times for admission to state competency restoration programs. This research is not a legal analysis and should not be construed as legal advice.

The research is meant to help the Panel evaluate the 48-hour timeframe and litigation costs by comparing and evaluating the impact of timeframes in other states. The accompanying "Timeframe and Litigation Table" summarizes the research.[13] The Table shows whether a state has a timeframe for admission to a state competency restoration program, whether there is litigation over timeframes, and additional information, such as reports about jail wait times and states' responses to the issue. The Table is best viewed in Web Layout.

Methods of gathering data

Other states' competency restoration laws present the closest comparison to Minnesota's priority admission statute, which historically has prioritized civilly committed referrals with incompetency finding for admission, and currently prioritizes both civilly committed referrals in jail and incompetency referrals under Minnesota Statutes chapter 611.40 *et. seq*.[14]

Beth Sullivan, a DCT program consultant, conducted internet and Westlaw research in September and October 2024. Methods did not include review of court documents or case law. Research covered the 50 states and the District of Columbia. The research is a survey of publicly available information and not an exhaustive exploration of the issue.

Findings

The research identified twelve states with current timeframes for admitting a detainee found incompetent to stand trial to a state competency restoration program.[15]

Six states have statutes with a timeframe, two of which codify court-imposed timeframes.[16] Seven states with timeframes are currently under court supervision.[17] One state is not under court supervision but has a timeframe set by a state Supreme Court decision.[18] Research also identified two additional timeframes: one that

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[13]See Timeframe and Litigation Table.

[14]Although Minn. Stat. 253B.10 as amended in the 2024 legislative session now requires the Commissioner to prioritize referrals ordered to competency attainment under Minn. Stat. 611.46, DCT has not received any referrals solely under 611.46 without a commitment as well as of October 15, 2024.

[15] AL, CA, CO, IL, LA, MD, MN, NV, OR, TX, VA, WA.

[16] CO, IL, MD, MN, VA and WA have statutory timeframes. The statutes in CO and WA codify court-imposed timeframes.

[17] OR, WA, LA, TX, CA, CO, and AL.

[18] NV.

expired in 2022 when court jurisdiction ended and one that will go into effect in January 2025 when court jurisdiction will begin.[19] The table below shows all 14 timeframes, 12 of them current, one expired, and one yet to take effect. Timeframes are shown from shortest to longest.

Timeframe	State	Imposed by statute or court or both	Currently under court supervision
48 hours	Minnesota	Statute *Minn. Stat. 253B.10, Subd. 1(b)*	No
7 days	Oregon	Court	Yes
7 days	Nevada	Court (no longer under consent decree, but the Nevada Supreme Court upholds lower court orders for admission within 7-day timeframe).	No
7 – 14 days	Washington	Both (statute codified court timeframe) *R.C.W. 10.77.068* Statute disallows actions for contempt or sanctions for exceeding the timeframe. *RCW 10.77.068(9)*	Yes

[19] UT had a 14-day court-imposed timeframe until court jurisdiction ended in 2022. OK will have a 21-day court-imposed timeframe when the court orders final approval of a consent decree in January 2024.

10 days	Virginia	Statute (enacted 2 years after wrongful death settlement)[20]	No
10 days	Maryland	Statute (enacted after state found in contempt).[21] *MD Code, Criminal procedure, section 3-106(c)(2)*	No
14 days	UT (until 2022)	Court (jurisdiction ended in 2022)	No
15 days	LA	Court	Yes
21 days	Oklahoma (beginning January 2025)	Court (Final Order on consent decree scheduled for January 2025)	Not yet
21 days	Texas	Court	Yes
28 days	California	Court	Yes
28 days	Colorado	Both (statute codified consent decree) *CO Code 16-8.5-111(f)(1); 16-8.5(19), (20)*	Yes

[20] Judge signs off on $3 million settlement for Jamycheal Mitchell's jail death | 13newsnow.com

[21] Left to 'languish': Jailed Marylanders in need of psychiatric treatment are waiting for months (msn.com)

30 days	Alabama	Court	Yes
60 days	IL (if bed available)	Statute *IL Code 5-104-17(b)*	No

Litigation

The Timeframe and Litigation Table shows the states for which litigation has been identified. Of the 14 states that have or have had or will have timeframes, the only state for which litigation was not identified is Illinois.[22] Illinois has a 60-day admission requirement, but only if a bed is available.[23]

In addition, 24 states have experienced litigation over wait times for admission to a state competency restoration program.[24] Eleven of them have had timeframes imposed as a result.[25]

Three main types of litigation were identified: 1) class actions; 2) actions for contempt and sanctions; and 3) motions to dismiss criminal charges. Class action litigation may result in prolonged court jurisdiction and supervision over state programs for competency restoration.

Seven states are currently under court jurisdiction.[26] In addition, six states are currently involved in litigation which could result in court jurisdiction.[27] Two states were previously under court jurisdiction which later terminated.[28]

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[22] See Timeframe and Litigation Table.

[23] "The Department shall admit the defendant to a secure facility within 60 days of the transmittal of the court's placement order, unless the Department can demonstrate good faith efforts at placement and a lack of bed and placement availability." IL Code 5-104-17(b).

[24] AK, AL, CA, CO, GA, IN, KA, KY, LA, MD, MN, MT, NH, NM, NV, NC, OK, OR, PA, SD, TX, UT, VA, WA. See Timeframe and Litigation Table.

[25] AL, CA, CO, LA, MD, NV, OK, OR, TX, UT, WA. See Timeframe and Litigation Table.

[26] AL, CA, CO, LA, OR, PA, WA.

[27] IN, KA, MN, NC, SD, TX.

[28] NV and TX.

Compliance with timeframes

For ten of the states with current timeframes, research identified information about average wait times in jail before admission to a state competency program.[29] All but Oregon and Washington currently have significant delays. Though in current compliance, Oregon has been in litigation since 2002.[30] As for Washington, the state paid over $100,000,000 in contempt fines during its first four years under court supervision because of its inability to meet the timeframe due to demand for IST services.[31]

State	Timeframe	Average Wait Time in Jail[32]	When Timeframe Imposed
Alabama	30 days	Over 300 days (February 2024 data)	2020
California	28 days	Current average wait time not identified. 2024-25 Governor's Budget Estimate reported 804 on the waitlist for IST services in 2023 – 24.[33]	On October 6, 2023, the Alameda Superior Court again modified interim benchmarks and the final deadline for compliance with the 28 days is March 1, 2025.[34]

[29] AL, CA, CO, LA, MD, NV, OR, TX and WA.

[30] See Timeframe and Litigation Table.

[31] Oregon_Mink-Bowman_9th_Neutral_Expert_Pinals_Report.pdf; Trueblood Monthly Report to the Court Appointed Monitor, September 30, 2024, p. 8 (current average wait time); California Incompetent to Stand Trial Solutions Workgroup Report of Recommended Solutions, November 2021, p. 7 (contempt fines). Information on Washington's compliance efforts is available at Trueblood et al v. Washington State DSHS | DSHS.

[32] Sources for average wait times are available on the Timeframe and Litigation Table.

[33] dsh.ca.gov/About_Us/docs/2024-25_Governors_Budget_Estimate.pdf, Section C9, pages 2 – 3. The California IST treatment continuum includes jail-based competency treatment, state hospital admission, a community inpatient facility, Forensic Assertive Community Treatment, Conditional Release program, Community-based restoration, and diversion. Id. at p. 3.

[34] Id., Section C9, page 1-2.

Colorado	28 days	95 – 126 days (February 2024 data)	2019
Illinois	60 days	Average wait time not identified. In 2022, the Illinois Legislature mandated that the Department of Human Services develop a strategic plan to improve access to inpatient psychiatric beds in state-operated mental health facilities for individuals needing a hospital level of care.[35]	Unknown
Louisiana	15 days	6.8 months (January 2024 data)	2016
Maryland	10 days	53 days (July 2024 data)	2018
Minnesota	48 hours	Average wait time not identified	2013
Nevada	7 days	100 + days (March 2024)	2008
Oregon	7 days	5.4 days (April 2024 data)	2003
Texas	21 days	200 days (non-secure unit) 531 days (secure unit) (2024 data)	2007
Virginia	10 days	Average wait time not identified. From March through July 2023, 508 defendants were delayed	2017

[35] Strategic Plan for Inpatient State-Operated Psychiatric Hospital Capacity and Access September 2023.

		admission to state hospitals for competency restoration.[36]	
Washington	7 days	5.2 days at Washington State Hospital; 7 days at Eastern State Hospital.[37]	2017

Report Limitations

Available information about litigation underreports the actual amount of litigation. On-line and Westlaw searches identify publicized or appellate cases, but not actions in state district courts. In Minnesota, for example, there have been many contempt actions in state district court, but these actions are identifiable only if they draw media attention or are appealed and thus available on Westlaw.

Additionally, on-line searches did not identify current wait times for all the states with timeframes. Nor did research include a review of court compliance reports in states under court supervision. Finally, the research did not include contact with state personnel for information about litigation and wait times.

Conclusions

The research suggests that timeframes result in litigation costs and do not solve the problem of wait times in jail. Most states are unable to meet mandatory timeframes because of steep increases in the number of detained ISTs required to be admitted to state-operated competency restoration programs.

Additionally, the absence of a mandatory timeframe does not prevent litigation. States without timeframes also get sued over long waiting periods in jail, often resulting in court imposition of a timeframe the state is unable to meet, despite lengthy periods of court supervision and enforcement that can include costly fines and sanctions.

Paradoxically, the focus on complying with timeframes may divert resources and attention from implementing more effective measures to reduce jail wait times.

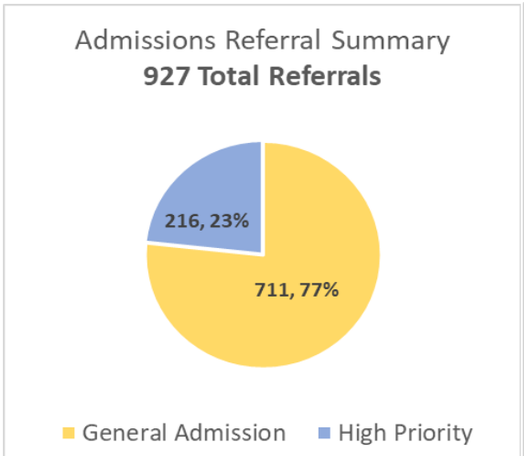
[36] Commonwealth of Virginia Report to the Governor and the General Assembly on Virginia's State Psychiatric Hospitals, December 11, 2023, p. iv.

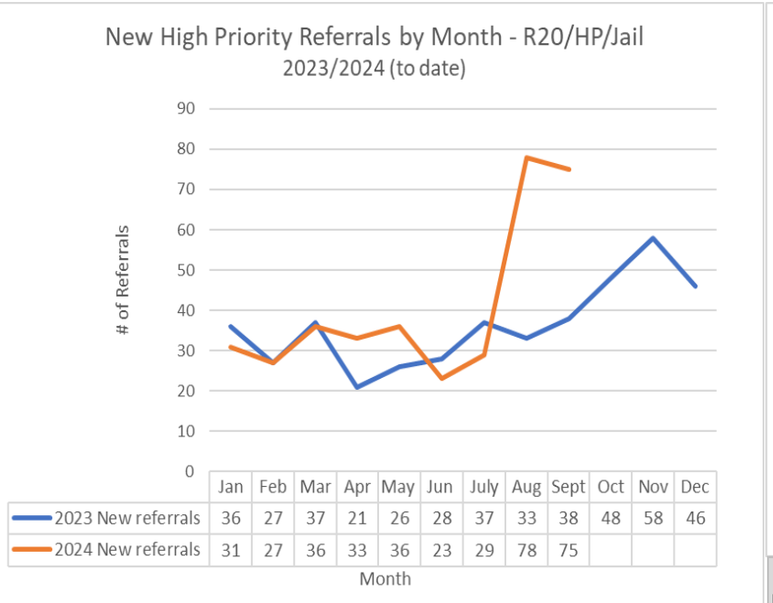
[37] Trueblood Monthly Report to the Court Appointed Monitor, September 30, 2024, p. 8.

Appendix 2: Priority Admissions Framework Quarterly Dashboard Reports

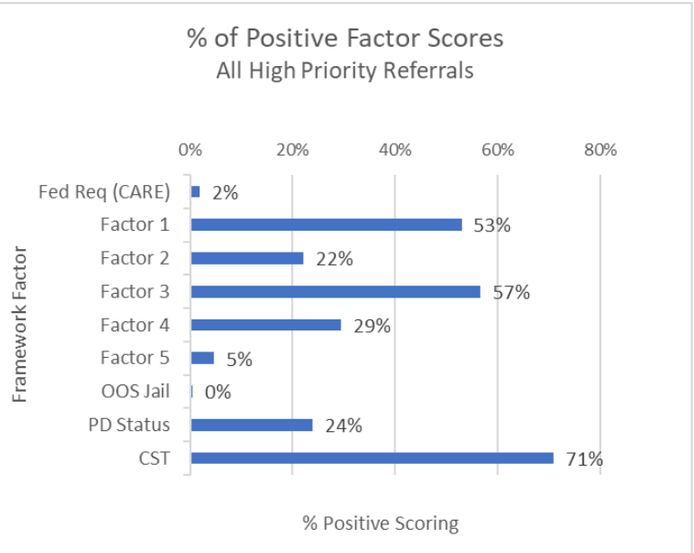
DCT Priority Admissions Framework – Quarterly Data

7/1/24 – 9/30/24





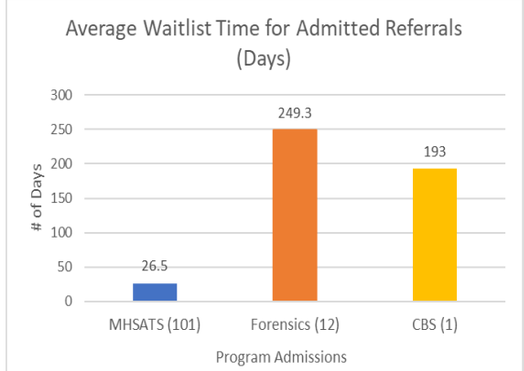
	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
2023 New referrals	36	27	37	21	26	28	37	33	38	48	58	46
2024 New referrals	31	27	36	33	36	23	29	78	75			

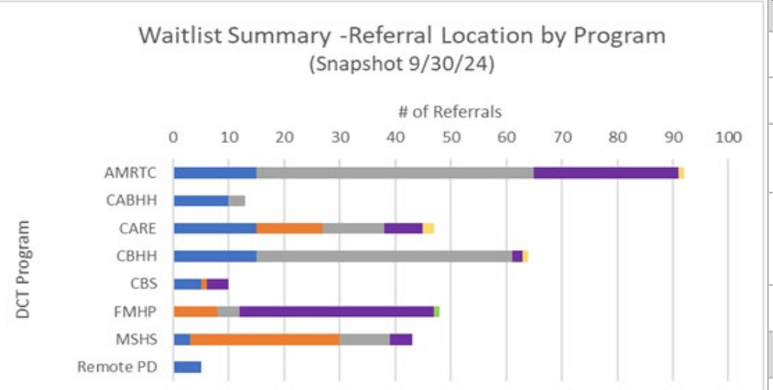


Active Waitlist

Not including referrals who are Not Releasable (NR)

	Count	Avg (days)	Range (days)
MHSATS	31	22.5	4-87
Forensics	38	218.8	35-607
CBS	3	150.3	110-209
QTR Total	**72**	**131.4**	**4-607**
Median		61.5	
Active NR	9	88.6	10-186





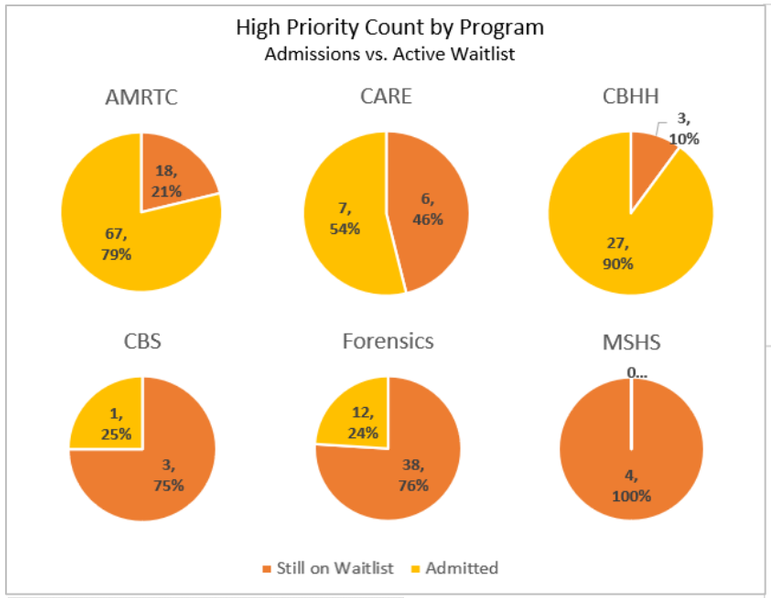
	Remote PD	MSHS	FMHP	CBS	CBHH	CARE	CABHH	AMRTC
Community	5	3	0	5	15	15	10	15
DCT Facility	0	27	8	1	0	12	0	0
Hospital	0	9	4	0	46	11	3	50
Jail (High Priority)	0	4	35	4	2	7	0	26
MCF (Prison)	0	0	1	0	0	0	0	0
Unknown/AWOL	0	0	0	0	1	2	0	1

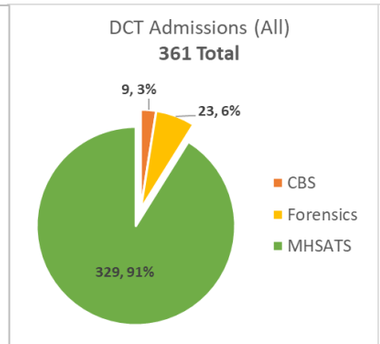
Factor Key	Weighted Factors	Weight	Scale 0 = Lower urgency/Not applicable 1 = Higher urgency/Applicable
Factor 1	Intensity of Treatment Needed Due to Clinical Acuity	10%	0 = None or Low/Stable 1 = High/Urgent
Factor 2	Current Safety of the Individual and other in the proximal environment	20%	0 = None or Managed 1 = Unmanaged/ Imminent risk of harm
Factor 3	Access to/or lack thereof to essential or court ordered treatment in a non-DCT environment	30%	0 = Available 1 = Not available
Factor 4	Other negative impacts to the referring facility, such as the number of beds unavailable because of caring for the referred individual.	30%	0 = None 1 = Present
Factor 5	NGMI Finding (for referrals w/out incompetency orders or evals)	10%	0 = No 1 = Yes
	Other Factors/Non Weighted		
A, B, C, - option	Federal Prioritization Requirement (CARE Only) - A (Pregnant and IV Using)		Yes/No
	Federal Prioritization Requirement (CARE Only) - B (IV Using, not Pregnant)		
	Federal Prioritization Requirement (CARE Only) - C (Pregnant, non-IV Using)		
	Client has active PD Status /Order for Return to DCT		
	Referral from Out of State Jail		
	Incompetency/Eval Order -Comptency to Stand Trial		

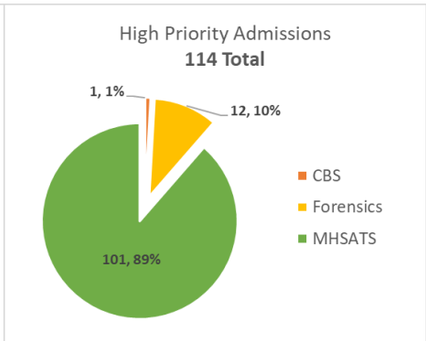
Version 2.2 updated 07/09/24

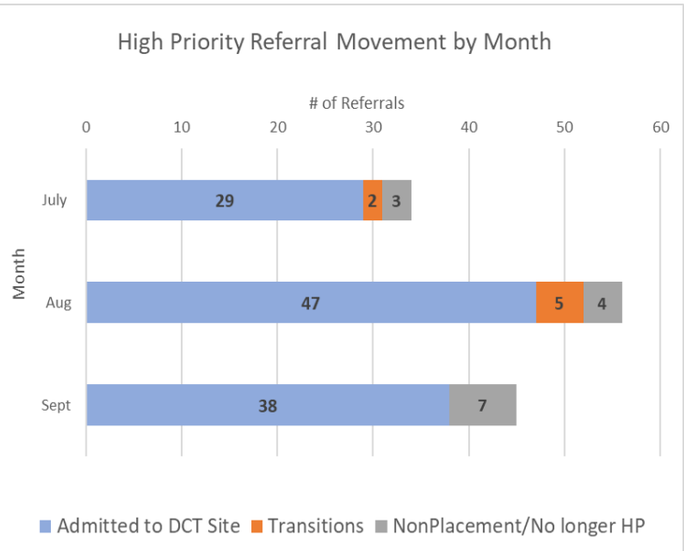
DCT Priority Admissions Framework – Quarterly Data

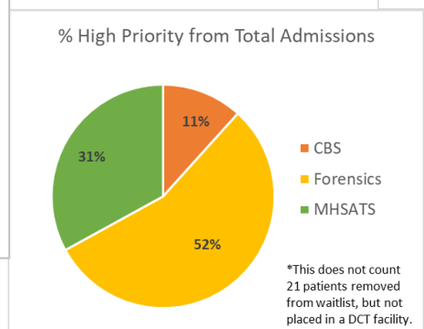
7/1/24 – 9/30/24

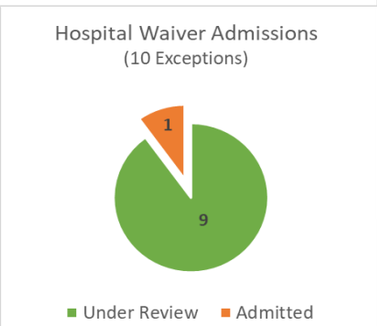












ACRONYMS:

AMRTC – Anoka Metro Regional Treatment Center
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CST -Competency to Stand Trial

Admissions Case Study Examples:

SHORTEST WAIT

1 day - MI&D in community needing revocation of PD and returned to FMHP

LONGEST WAIT

792 days - Part of wait time includes time receiving care at AMRTC before returning to jail; sent to FMHP
842 days - Part of wait time includes time receiving care at AMRTC before returning to jail; sent to FMHP

Active Waitlist Case Study Examples:

LONGEST WAIT

607 days - Received care and treatment at AMRTC prior to returning to jail
556 days - Complex diversion - awaiting community placement

Key Points:

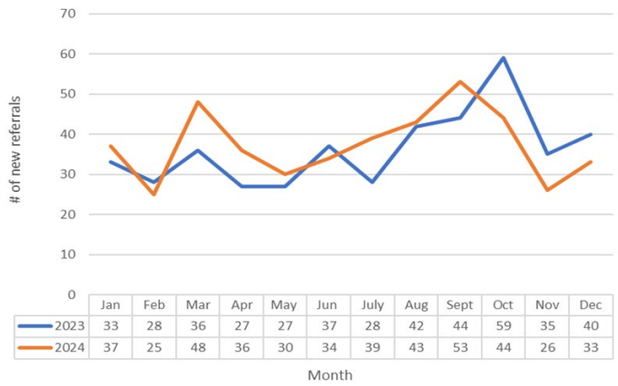
- 23% of all referrals managed thru Central Pre-Admissions were high priority.
- 32% of all DCT Admissions were high priority.
- At the end of the quarter, there were 72 high priority releasable referrals on the active waitlist.
- Referrals doubled or more than doubled over the previous year in August and September due to expanded eligibility for priority admission.

Note: under 253B.10 subd. 1(b)(1) DCT calculates waitlist times based on the time a person has a commitment order that was received by Central Pre-Admissions for a referral to a DCT program. In some cases, this may include times when the person was on a waitlist but not in jail, such as the time a person with an MID commitment spent at AMRTC before being returned to jail; or the time a committed person spent in the community prior to going to jail.

DCT Priority Admissions Framework – Quarterly Data Dashboard

10/1/24 –12/31/24

New High Priority Referrals by Month - R20/HP/Jail - REVISED* 2023/2024

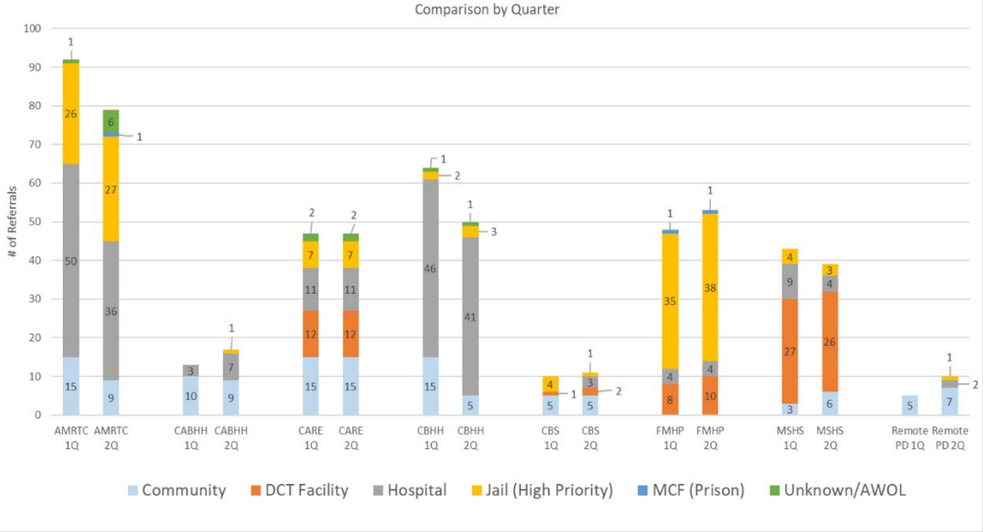


	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
2023	33	28	36	27	27	37	28	42	44	59	35	40
2024	37	25	48	36	30	34	39	43	53	44	26	33

*Revised data compared to 9/30/24 quarterly report. Counts were recalculated across reporting system to ensure consistency with classification categorization.

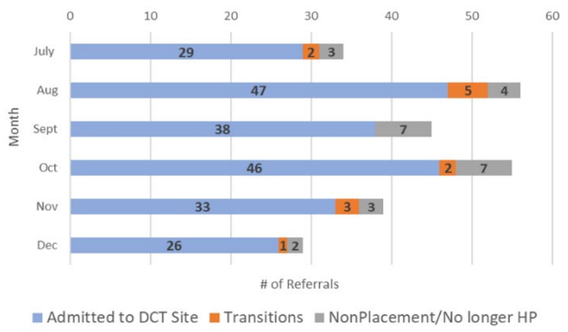
Waitlist Summary of All Referrals by Site, Sorted by Category

Comparison by Quarter



High Priority Referral Movement by Month

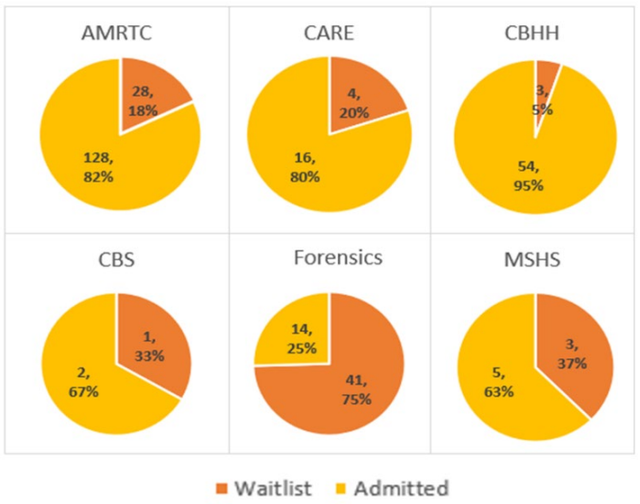
July-Dec 2024



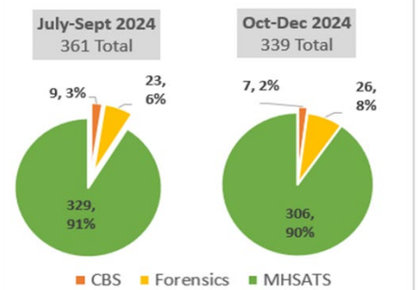
High Priority Referral Count by Program

Admissions vs. Active Waitlist, July-Dec 2024

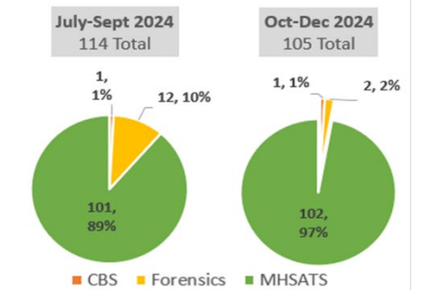
*(*Does not take into account non-releasable or Transitions referrals)*



DCT Admissions (In-patient)



High Priority Admissions

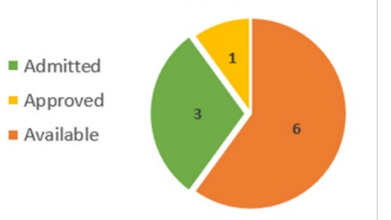


High Priority Referral Active Waitlist

Releasable Referrals	1st Qtr Snaphot 9/30/24			2nd Qtr Snaphot 12/31/24		
	Count	Avg *(days)*	Range *(days)*	Count	Avg *(days)*	Range *(days)*
MHSATS	31	22.5	4-87	39 (↑)	34.8	1-202
Forensics	38	218.8	35-607	41 (↑)	250	4-648
CBS	3	150.3	110-209	1 (↓)	36	-
Qtr Total	**72**	**131.4**	**4-607**	**81 (↑)**	**143.8**	**1-648**
Non-Releaseable or Transitions	10	167.5	10-878	6 (↓)	187.2	27-699

Hospital Waiver Admissions: 10 Exceptions

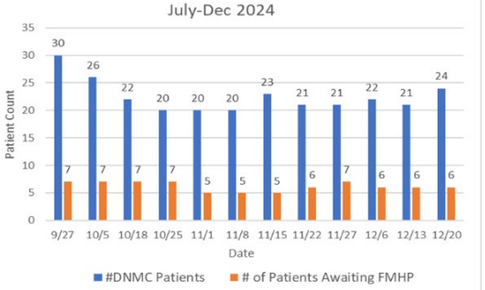
*As of 12/31/24



*As of report date 1/14/25: 4 Admitted

AMRTC: DNMC by Count

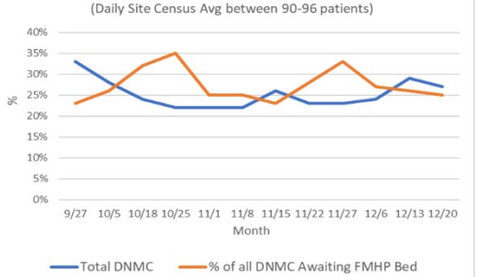
July-Dec 2024



AMRTC: DNMC by Percentage

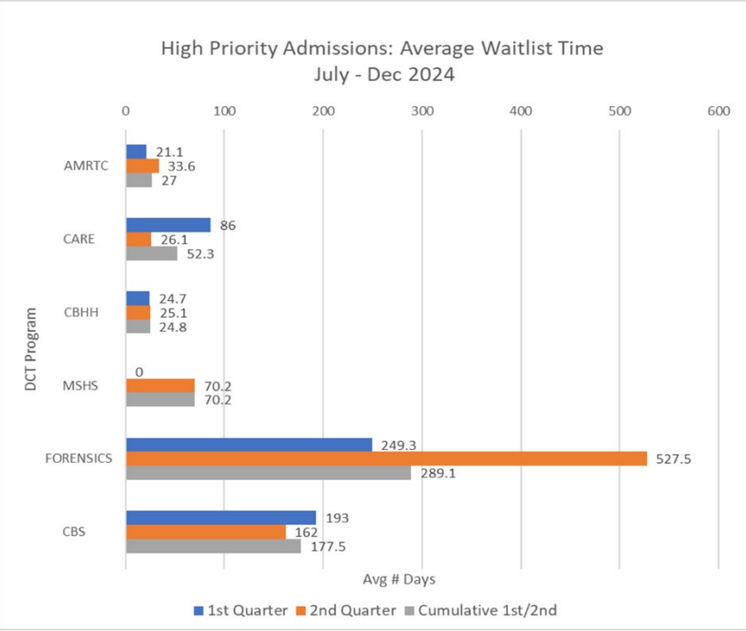
July-Dec 2024

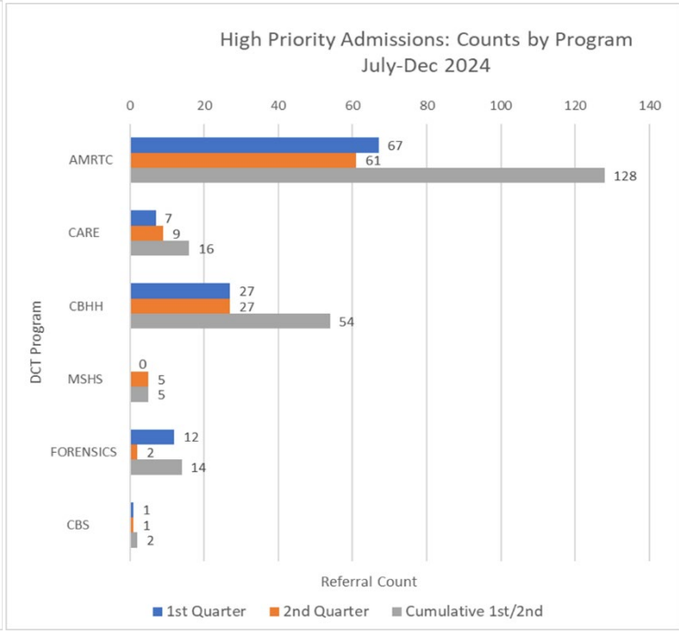
(Daily Site Census Avg between 90-96 patients)



DCT Priority Admissions Framework – Quarterly Data Dashboard

10/1/24 –12/31/24





Key Points:

Comparing 1st and 2nd quarter:

- DCT general in-patient admissions decreased (361 -> 339).
- Slight decrease in high priority admissions (114 -> 105).

- In 2nd quarter, the shortest wait time for an admit was 3 days (Jail admit to CBHH).
- In 2nd quarter, the longest wait time for an admit was 536 days (Hospital admit to Forensics).
- The longest wait time for a patient still on waitlist as of Dec 31, 2024 was 648 days (complex diversion awaiting community placement).
- At the end of the year, there were 81 high priority releasable referrals on the active waitlist.

Note: under 253B.10 subd. 1(b)(1) DCT calculates waitlist times based on the time a person has a commitment order that was received by Central Pre-Admissions for a referral to a DCT program. In some cases, this may include times when the person was on a waitlist but not in jail, such as the time a person with an MID commitment spent at AMRTC before being returned to jail; or the time a committed person spent in the community prior to going to jail.

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DNMC - Does Not Meet Criteria
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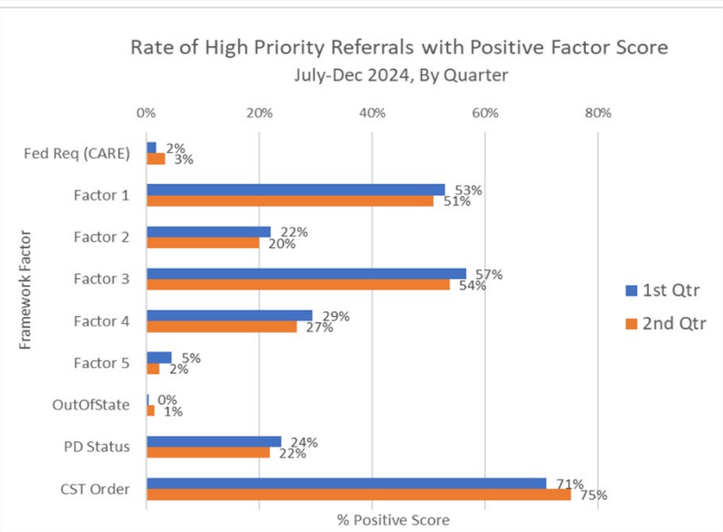

UPDATED FRAMEWORK FACTOR KEY (As of Jan. 1 2025)

Weighted Factors		MHSATS	Forensics	CBS	Scoring
Factor 1	Intensity of treatment needed due to clinical acuity	45%	5%	10%	0 = Stable, low acuity, or responsive to current treatment 1 = Urgent, high acuity, or unresponsive to current treatment
Factor 2	Current concerns for safety of the individual and/or others in the proximal environment	25%	20%	20%	0 = No risk or adequately mitigated/managed risk 1 = Imminent risk either unmanaged or ongoing risk present despite mitigation efforts
Factor 3	Access to/or lack thereof to essential or court ordered treatment in a non-DCT environment	20%	30%	30%	0 = Appropriate treatment available and adequate 1 = Appropriate treatment unavailable or insufficient
Factor 4	Other negative impacts to the referring facility, such as the number of beds unavailable because of caring for the referred individual.	10%	10%	30%	0 = Standard resources utilized 1 = Extraordinary resource allocation needed, or negative impacts are present
Factor 5	NGMI Finding	0%	35%	10%	0 = No 1 = Yes