SENATE
COUNSEL,
RESEARCH, &
FISCAL ANALYSIS

BILL SUMMARY

S.F. No. 1492 – Civil Commitment Coordinating Division

Author: Senator Ron Latz

Prepared by: Priyanka Premo, Senate Counsel (priyanka.premo@mnsenate.gov)

Date: March 18, 2025

Overview

S.F. 1492 establishes the Civil Commitment Coordinating Division within the Office of the Attorney General, establishes a Civil Commitment Advisory Committee, requires counties to complete diversion studies, requires the civil commitment coordinator to administer grants to counties and provide reports to the legislature, and appropriates a to-be-determined amount to the attorney general.

Summary

Section 1 (8.37; Civil commitment coordinating division) establishes the Civil Commitment Coordinating Division and requires the attorney general to appoint a civil commitment coordinator. The civil commitment coordinator must maintain the Civil Commitment Advisory Committee; provide guidance regarding engagement services, outpatient civil commitment, and provisional discharge; advocate for increased statewide capacity for engagement services, outpatient civil commitment, and provisional discharge; provide technical assistance to those charged with monitoring civilly committed participants; aggregate and analyze data; educate the public; administer diversion study grants; and administer engagement services, outpatient civil commitment, and provisional discharge grants.

The attorney general must establish the Civil Commitment Advisory Committee to advise the civil commitment coordinator. The committee must consist of 11 to 20 members, including the attorney general, the chief executive officer of Direct Care and Treatment, the commissioner of public safety, a member representing district court judges, a member representing district court administrators, a member representing counties, a member who was previously civilly committed, and a family member of a person currently or previously civilly committed. Members serve without compensation.

Section 2 (8.38; Diversion studies) requires each county to conduct diversion studies, in accordance with uniform guidelines set by the civil commitment coordinator, and provide diversion study data and narratives to the civil commitment coordinator by October 1, 2027,

and every two years thereafter. A diversion study must examine the county's behavioral health system's capacity to divert people who have a mental illness, developmental disability, or chemical use disorder away from the criminal justice system and into treatment. The civil commitment coordinator must submit a report to the legislature by April 1, 2028, and every two years thereafter, summarizing county-level data related to diversion studies, and must establish a diversion study grant program for counties to develop an action plan.

Section 3 (8.39; Engagement services, outpatient civil commitment, and provisional discharge grants) requires the civil commitment coordinator to establish engagement services, outpatient civil commitment, and provisional discharge grants to provide counties with supplemental funding to expand the capacity to provide these services. All grantees must use a portion of the awarded funds for certain purposes, as determined by the civil commitment coordinator, including education, outreach, hiring additional staff, and supplemental funding for engagement services, outpatient civil commitment, and provisional discharge. By October 1, 2027, and every two years thereafter, all grant recipients must submit to the civil commitment coordinator deindentified data on individuals who received engagement services, were civilly committed, were accepted into a treatment facility or community-based treatment program, or were provisionally discharged. The civil commitment coordinator must evaluate the impact of supplemental funding and submit a report to the legislature by April 1, 2028, and every two years thereafter.

Section 4 (Appropriation; civil commitment coordinating division) appropriates a to-be-determined amount in fiscal years 2026 and 2027 from the general fund to the attorney general for the Civil Commitment Coordinating Division and requires specific uses for the appropriation, including for an additional staff members to serve as the civil commitment coordinator, data analytic services, and a public awareness campaign.

Section 5 (Appropriation; diversion study grants) appropriates a to-be-determined amount in fiscal years 2026 and 2027 from the general fund to the attorney general for diversion study grants.

Section 6 (Appropriation; engagement services, outpatient civil commitment, and provisional discharge grants) appropriates a to-be-determined amount in fiscal years 2026 and 2027 from the general fund to the attorney general for engagement services, outpatient civil commitment, and provisional discharge grants.

The Minnesota Star Tribune

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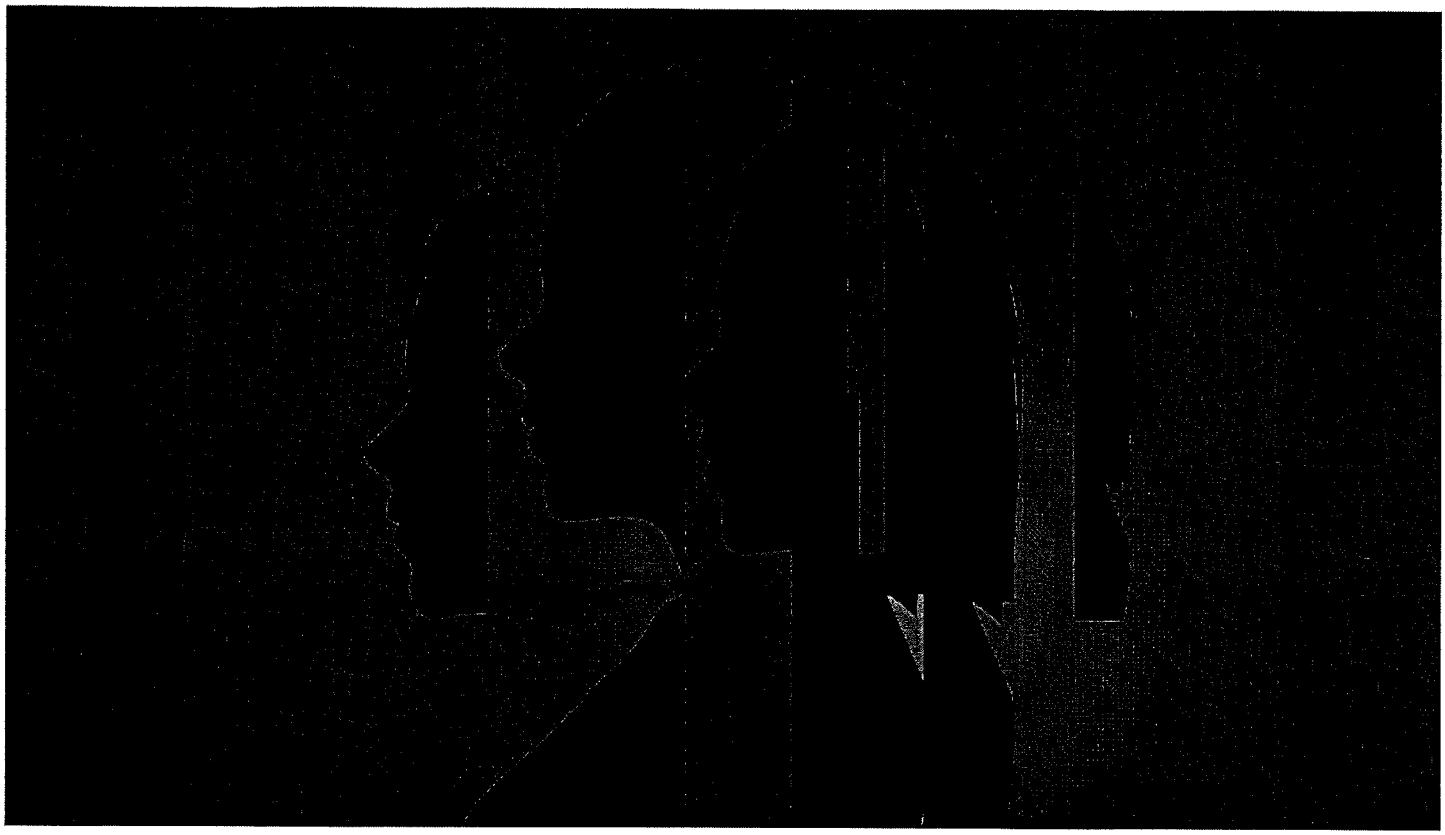
COMMENTARIES

Minnesota's mental health system is failing the ill

A bipartisan update to existing law, explained by the legislators proposing it.

By multiple authors

MARCH 9, 2025 AT 5:29PM



"The Treatment Advocacy Center (TAC), a national organization that works to eliminate barriers to care for people with serious mental illness, rates Minnesota's civil commitment statute as the best in the nation. Our structure is exemplary; our follow-up, unfortunately, is not," the writers say. (iStock)

Opinion editor's note: *Strib Voices publishes a mix of guest commentaries online and in print each day. To contribute, click here.*

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This article was signed by several members of the Minnesota Legislature. Their names are listed below.

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Sleeping outside during Minnesota winters can be deadly. It can also be cruel. Despite exhaustive efforts by his loving family, Jeremy was sleeping in a cold alley when a garbage truck ran over his legs, inflicting compound fractures. Jeremy has schizophrenia. He has no insight into the fact that he has a terrible brain disease. He was civilly committed. Say what?

The whole purpose of going through the trauma of obtaining court-ordered treatment is to provide care even when the person's brain doesn't allow them to know they need it. We need more accountability to ensure that the few people who meet this high bar don't fall

between the cracks.

We Republican and Democratic legislators are offering legislation to address this. We believe this is the year for taking bipartisan stock of how our mental health system is failing people who need it the most. People like Jeremy who are dangerous enough to themselves or others to qualify for civil commitment surely fit that category and need our help.

The Treatment Advocacy Center (TAC), a national organization that works to eliminate barriers to care for people with serious mental illness, rates Minnesota's civil commitment statute as the best in the nation. Our structure is exemplary; our follow-up, unfortunately, is not. TAC's data shows that people who receive follow-up after court orders have very different outcomes from those who don't. States with good follow-up save money, another goal that interests us and many Minnesotans across the state.

Last session the Legislature funded a few engagement pilots designed to help people in mental health crisis before they reach the high bar for civil commitment or commit a crime, sadly a common door for entering the mental health system. We know that providing earlier help can save brains from deteriorating, while also saving lives and money.

The legislation we introduced last week, SF 1492, will build on our excellent civil commitment statute and the engagement pilots. The bill creates an oversight coordinating division within the Attorney General's Office that is charged to ensure the system is accountable for our residents with the most serious mental illnesses. The division will collect data so we know on a statewide basis where civilly committed people end up and how they fare. Where are the weak points where people fall out of the system? Should there be better communication with courts between six-month civil commitment appearances? Are the engagement pilots helping?

The division coordinator, working with a broad-based advisory committee, will advocate for better cross-jurisdictional ways to help our most vulnerable populations, people like Jeremy. We believe our bill is a commonsense way to do so, and to save lives and money, without trampling on civil liberties, simply bolstering and ensuring the effectiveness of the excellent civil commitment statute we already have in place.

This article was signed by state Sens. Ron Latz, DFL-St. Louis Park; Rich Draheim, R-Madison Lake; Jim Abeler, R-Anoka; Paul Utke, R-Park Rapids; Carla Nelson, R-Rochester; Nick Frentz, DFL-North Mankato; John Hoffman, DFL-Champlin; Tou Xiong, DFL-Maplewood, and state Rep. Peter Fischer, DFL-Maplewood.

NASW
National Association of Social Workers

MINNESOTA CHAPTER

Senator Ron Latz, Chair
Judiciary and Public Safety
March 17, 2025

Chair Latz and Judiciary and Public Safety Committee Members,

On behalf of the National Association of Social Workers, MN Chapter (NASW-MN), we are writing to express our opposition to SF1492, establishing a Civil Commitment Coordinating Division within the Office of the Attorney General.

We acknowledge the intent to improve Minnesota's civil commitment process; however, we believe this bill duplicates work already effectively managed by the Minnesota Department of Human Services (DHS) and other initiatives like the Yellow Line Project, the Stepping Initiative, and the 19 Adult Mental Health Initiatives covering all counties. We feel SF1492 will:

- **Duplicate Efforts:** The voluntary engagement grant has already been funded and evaluated through DHS. Creating a new division within the Office of the Attorney General is redundant and diverts critical resources from existing programs.
- **Lack of Broad Representation:** The advisory committee proposed within the Office of the Attorney General does not reflect the diverse perspectives of those traditionally involved in commitment and community mental health issues. This lack of diversity and experience will limit the effectiveness and responsiveness of the new division.
- **Create Jurisdictional Concerns:** The AG's office has not traditionally been involved in the commitment act. Services provided under outpatient commitment fall under the jurisdiction of DHS, not the AG's. Shifting these responsibilities would create confusion and inefficiencies in service delivery.

NASW-MN urges you to reconsider the passage of SF 1492 and instead focus on bolstering the Sequential Intercept Model, which is widely used to divert individuals with mental health issues from the criminal justice system and strengthen initiatives aligned with this model. This would be far more effective than establishing a new division within the AG's office.

We appreciate your service and work on this important issue. Thank you for your consideration.

Sincerely,

Karen E. Goodenough, PhD, LGSW
Executive Director
NASW-MN

Minnesota Psychiatric Society

Improving Minnesota's mental health care through education, advocacy, and sound psychiatric practice, and achieving health equity.

March 17, 2025

Dear Chair Latz and members of the Senate Judiciary and Public Safety Committee,

I am the President of the Minnesota Psychiatric Society (MPS) and write to you today to express MPS opposition for SF 1492 creating a new commitment process under the authority of the Minnesota Attorney General's Office.

The Minnesota Psychiatric Society is an organization of over 450 Child, Adolescent, and Adult Psychiatrists who provide clinical care, research, and education on mental health. We have long been involved in Minnesota's commitment process including participation in multiple task forces convened to revise the law. Clinically, our members who work in Emergency Departments and hospitals routinely decide which of our patients meet the criteria for a 72-hour hold, a commitment, a Jarvis petition, and/or forced ECT. In addition to treating such patients in outpatient offices and community mental health centers, outpatient psychiatrists work with specialty teams including ACT teams, First Episode Psychosis teams to keep committed patients stable post discharge.

Your choice to add an agency which is not currently involved or at most only a minor player is problematic and duplicative. The role requires an agency to have significant expertise – both clinically and fiscally, to address this aspect of patient care and safety. The solution must include the ability to manage committed patients, to reliably communicate with the relevant parties, to pay for adequate resources to meet the service demand, AND to publicly report in real time how they are doing so the legislature can hold them accountable.

We are writing this to share our opinions on SF 1492:

1. It strikes us that the biggest missing element in improving the system is accountability
2. Currently depending on where and when the patients enter the mental health system, the authority/accountability/payment could be the county mental health workers/ county budget, it could be private practice clinicians/private insurance (or county community crisis team or community mental health center/county budget, it might be jail/county corrections
3. We share the frustration felt by patients, families, case managers, and many other clinicians when previously stable patients either get worse or (more frequently) get lost to follow-up. We typically rely on county case managers to stay in touch with their patients, their patients' families, their clinicians (including us) and the courts. We know they are overburdened and at times it takes a lot of time, effort and energy to find their patients. (county budget)
4. DHS has the authority/payment of treating patients when they are committed until they are discharged and then the accountability shifts primarily back the county

Sincerely yours,

Mark Frye, MD
MPS President

Michael Trangle, MD, DLFAPA
MPS Legislative Chair

2738 Evergreen Circle, St Paul, MN 55110 • Phone: 651-407-1873 • www.MnPsychSoc.org

Dear Members of the Senate Judiciary and Public Safety Committee:

NAMI Minnesota is opposed to SF 1492. When the major changes to the commitment act were adopted in 2020 it reflected the consensus of a committee of over 20 people. This committee had representation from every point of contact with the commitment act: people with mental illnesses, family members, advocates, defense attorneys, county attorneys, hospitals, community mental health providers, psychiatrists, pre-petition screening, county human services, sheriffs, DHS, and more. We identified problems with the commitment act and its implementation and worked hard to find solutions. The end result is a commitment act that is recognized by the Treatment Advocacy Center as an excellent law.

SF 1492 had none of that input or engagement and thus there are confusing components.

- We don't understand why the voluntary engagement grant is placed under the AG's office when it is funded and evaluated through DHS. DHS will be issuing the RFP shortly and grantees will be required to evaluate the project and promote it in their community. It's duplicative to have the AG office involved in this program.
- The advisory committee does not reflect the broad group of people that have been traditionally involved in commitment and community mental health issues, including advocates, hospitals, etc. We don't understand why the AG would be responsible for appointing so many of the members. There are existing committees that are looking at these issues, including the priority admissions panel, the MI&D task force, and the State Advisory Committee on Mental Illness.
- The Sequential Intercept Model is the "gold standard" used to identify how to divert people with mental illnesses out of the criminal justice system. We already know of projects that work, such as the Yellow Line Project. Twenty-one counties have become involved in the Stepping Initiative where they use the sequential intercept model to see where they can divert people along the path to jail. Why not just encourage more counties to become involved in this initiative, which has proven to be successful instead of starting a new data project? An example of the model used in the competency restoration task force is attached.
- One of the most successful ways to divert people from the criminal justice system is our county mobile crisis teams. They were given one time money last session, and that money doesn't continue into this next biennium. Fund what works.
- There are 19 Adult Mental Health Initiatives covering all counties in the state. AMHIs use state grant funds to fill gaps in coverage, including services and supports that are not covered by insurance. Their goal is provide consistent and effective care to people with serious mental illnesses. In 2024 a study was done to catalog the evidence-based practices provided in AMHIs. They already report to DHS on the services provided and how funding is used. It would be duplicative to have counties submit another report to the AG's office. An example of compiling what is available is attached.
- The Ombudsman for Mental Health and Developmental Disabilities contains the Civil Commitment Training and Resource Center (CCTRC). The CCTRC was developed to assist persons who want training and information regarding the Civil Commitment and Treatment Act. CCTRC provides individualized training, information, referral, and advocacy. The AG's office has not traditionally been involved in the commitment act.
- Outpatient commitment is established in our commitment statute. The services provided under outpatient commitment fall under the jurisdiction of DHS not the AG's office. We don't need outreach to facilities to take people who are committed, they need funding in order to increase staffing in order to meet people's needs and to develop locked IRTS.

NAMI Minnesota takes thousands of calls every year on a wide range of topics, including commitment. The major issues we are hearing are the following:

- Police not willing to do transport holds due to changes in the use of force law
- People being discharged, while committed, to shelters because housing isn't available and because they have a bed in the hospital, they don't rise to the top of the priority list in the housing programs
- Workforce challenges, with community and counties finding it hard to hire and train case managers
- If people do not follow the treatment plan, hospitals won't take them unless they meet medical criteria and there is nowhere else to take them
- Lack of intensive services such as ACT teams, CADI waivers, supportive housing

Through the competency restoration task force and the priority admissions task force, which had representation from the groups previously mentioned on both task forces, there are a number of recommendations that actually address the current issues we are seeing with implementation of the commitment act. Please see the attachments for the recommendations.

The more recent passage of the following items will help address this issue.

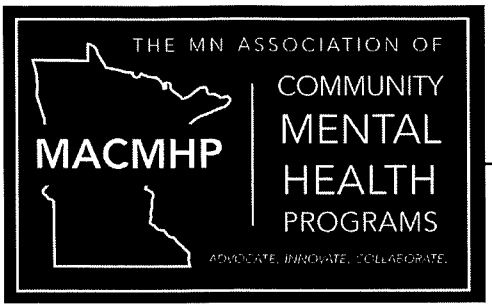
- Implementation of voluntary engagement grants (passed in 2024, RFP coming out soon)
- Developing locked IRTS (residential facilities). Issue cleared up with CMS so hoping to see movement on this issue. Funding was available for start-up.
- Rate increases for community mental health providers so that they can hire more people and increase access. Small increase last session.
- Implementation of the competency restoration overhaul. Forensic navigators will connect people with misdemeanors who have a Rule 20 to services and support to divert them from jail in the future
- Creating of model discharge plans from jails to prevent future involvement
- Stable funding for 988

This session, the Mental Health Legislative Network has several bills:

- Fund jail diversion programs and social workers in the jail
- Develop a task force just on transport holds
- Fund protected transport so crisis teams don't need to rely on police for transport holds
- Fund re-entry coordination programs
- Fund mobile crisis services to have a mental health response to a mental health crisis
- Expand first episode of psychosis programs and start a first episode of bipolar disorder program
- Increase rates
- Maintain audio only
- Expand case management eligibility
- Increase funds for Housing with Supports for Adults with Serious Mental Illnesses
- Fund jail diversion grants for people with mental illnesses and substance use disorders

The work to build our mental health system is ongoing. Adding another committee in an agency that does not oversee or fund the mental health system is not advisable at this time.

Sue Abderholden, MPH
Executive Director
NAMI Minnesota



Minnesota Association of Community Mental Health Programs

Senator Ron Latz, Chair
Judiciary and Public Safety Committee
MN State Senate
Friday, March 21, 2025

Dear Chari Latz and Committee Members

On behalf of the Minnesota Association of Community Mental Health Programs – MACMHP - I am writing to share our concerns with SF 1492 – creating a Civil Commitment Coordinating Division.

The MACMHP is a statewide association of 38 community-based mental health and substance use programs that serve culturally diverse, low-income, uninsured individuals without access to recovery services throughout Minnesota. We ensure that effective mental health treatment and recovery support services are available to all individuals with mental illnesses and substance use disorder regardless of their insurance status or ability to pay.

When the major changes to the commitment act were adopted in 2020, it reflected the consensus of a committee of over 20 representative groups - people with mental illnesses, family members, advocates, defense attorneys, county attorneys, hospitals, community mental health providers, psychiatrists, pre-petition screening, county human services, sheriffs, DHS, and more. The committee identified problems with the commitment act and its implementation and worked hard to find solutions. MACMHP was among the representative groups.

The Competency Restoration Task Force and the Priority Admissions Task Force – of which community mental health programs are represented and consists of many of these same interests represented on both task forces, including MACMHP - developed a number of recommendations that address the current issues we are seeing with implementation of the commitment act. The major issues we are hearing are the following:

- Lack of transport holds due to changes in the use of force law;
- People are discharged, while committed, because they had a bed in the hospital they don't rise to the top of the priority list in the housing programs;
- Workforce challenges;
- Lack of intensive services such as ACT teams, CADI waivers, supportive housing

There are recommendations from both of those task forces that have been put forth in bills the last few years that would help address some of the problems we are experiencing. This includes:

- Medicaid rate increases for community mental health providers to sustain (and increase) access to care
- Implementation of voluntary engagement grants (passed in 2024, RFP coming out soon)
- Developing locked IRTS (residential facilities)
- Forensic navigators who will connect people with misdemeanors who have a Rule 20 become connected to services and supports to divert them from jail in the future
- Funding for jail diversion programs and social workers in the jail
- Develop a task force just on transport holds

- Fund protected transport so crisis teams don't need to rely on police for transport holds
- Eliminating the moratorium on hospital psych beds
- Creating of model discharge plans from jails to prevent future involvement
- Funding re-entry coordination programs
- Funding 988 and mobile crisis services to have a mental health response to a mental health crisis
- Expanding first episode of psychosis programs and start a first episode of bipolar disorder program
- Current task force on mentally ill and dangerous (MI&D) commitment

The mental health community is actively working to build our mental health system, especially for people with serious mental illnesses.

We have the following concerns with SF 1492:

- Placing the engagement grant work under the Attorney General when grants are part of the DHS budget
- The advisory committee does not reflect the broad group of people that have been traditionally involved in commitment and community mental health issues, including advocates, hospitals, etc. The priority admissions task force is continuing to meet, as is the MI&D task force and the State Advisory Committee on Mental Illness
- Outpatient commitment is established in our commitment statute. The services provided under outpatient commitment fall under the jurisdiction of DHS not the Attorney General. Providers need funding in order to increase staffing and that additional funding would have to be in rates because under Medicaid laws you can't simply add grant money to the rates.

Unfortunately, SF1492 does not reflect how the mental health system currently operates and poses confusing new requirements for providers and individuals. We urge the Committee to implement current Civil Committee Task Forces' recommendations and make investments into our state's active mental health system models as opposed to moving the authority and funding to a new, unrelated office of the state.

Sincerely

Jin Lee Palen
Executive Director

MINNESOTA
OFFICE OF OMBUDSMAN
FOR MENTAL HEALTH AND
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March 18, 2025

Dear Members of the Senate Judiciary and Public Safety Committee,

The Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) has a statutory mission to promote the highest attainable standards of treatment, competence, efficiency, and justice for persons receiving services for mental illness, developmental disabilities, substance use disorder (SUD), or emotional disturbance. We advocate for clients' rights, health, and well-being; monitor service delivery systems; and provide recommendations for systemic improvements.

OMHDD would like to express our significant concerns for SF 1492. Among other things, the legislature assigned the responsibility for the state's Civil Commitment Training and Resource Center (CCTRC) to OMHDD in MN Statute 245.94. We provide training on the Civil Commitment and Training Act to law enforcement, counties, hospitals, and other stakeholders throughout the state. We are often contacted for technical assistance in individual situations, provide information, referral to best practices, resources, and advocacy before, during, and after civil commitment. We receive inquiries from counties, county attorneys, state operated services, clients, family members, and others.

In 2020, as both the CCTRC and the ombudsman's office with jurisdiction over services for people with mental health, developmental disabilities, and substance use disorders, OMHDD participated with a broad group of stakeholders, including counties, attorneys, law enforcement, hospitals, DHS, DCT, and others to consider needed changes to the Civil Commitment Act. Including all the necessary perspectives and voices in the discussion was critical to achieving much needed improvements to the civil commitment statutes, including the establishment of voluntary engagement services, services OMHDD believes will play a critical role in diverting people from civil commitment and jails.

The funding for voluntary engagement services occurs via grants administered by DHS. It is our understanding that the RFPs for those grants have not yet been but will be issued soon, with DHS retaining responsibility to include contract deliverables and evaluation of engagement services as part of the contracting process. OMHDD has significant concerns about moving these services we have long advocated for away from DHS and its purview over additional services and supports that may be sought for person as part of the engagement service delivery. OMHDD envisions that engagement services are not a standalone service – rather, they are a bridge to connecting people with other mental health and SUD services such as case management, Adult Mental Health Rehabilitation Services, Home and Community-Based Services, inpatient and outpatient SUD treatment services, and more. DHS, as the entity overseeing these other services and as the contract holder, is best positioned to retain oversight over engagement services.

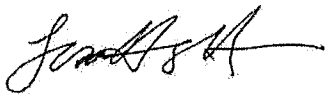
OMHDD is also aware of, and participating in, a number of other discussions surrounding the Civil Commitment and Treatment Act, including the Priority Admission Task Force, Priority Admission Review Panel, and Mentally Ill and

Dangerous Task Force. OMHDD believes it is premature to make sweeping structural changes to engagement services as these are not yet even available and, as such, we have no data or information with which to make informed choices on changes that may be needed. We believe it most prudent to allow these groups to complete their work and their recommendations be implemented prior to making major changes.

OMHDD recognizes that Minnesota's civil commitment processes and oversight mechanisms include challenges before us – paramount among them is the lack of *timely* access to services and supports to avoid the need for commitment, how to support people in the community on provisional discharge plans, and some of the other provisions SF 1492 seeks to address. We appreciate the role of the Attorney General's office and the valuable resource it is. However, OMHDD believes that what Minnesota needs to address some of the underlying issues in SF 1492 is investment in the mental health, disability, and SUD service continuum. We need sustainable rates to address the workforce shortage crisis impacting nearly all service sectors, case management continuity of care, to develop additional service settings including locked Intensive Residential Treatment Settings, full implementation of the new competency restoration services and forensic navigators, stable funding for mobile crisis teams, and to build Minnesota's mental health system capacity. We need sufficient providers willing and with the capacity to serve individuals in our communities, before, during, and after commitment. OMHDD is concerned that SF 1492 is duplicative of the work of our existing statutorily established Civil Commitment Training and Resource Center. We also have concerns about completely separating civil commitment from the broader group of stakeholders with deep expertise working with community mental health supports and services and the agency that regulates them.

Thank you for your consideration of these concerns. I welcome any opportunity for further discussion on how best to address the broader issues surrounding civil commitment.

Sincerely,



Lisa Harrison-Hadler
Ombudsman
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MENTAL HEALTH Minnesota
An affiliate of Mental Health America

Mental Health Minnesota is the voice of lived mental health experience.

We carry that declaration forward as we work to advance mental health and well-being for all, increase access to mental health treatment and services, and provide education, resources and support across Minnesota.

Dear Senator Latz and Members of the Senate Judiciary and Public Safety Committee,

On behalf of Mental Health Minnesota, I am writing to share our concerns with SF1492.

Significant changes to the commitment act were adopted by the Legislature in 2020, those changes reflected the consensus of a large committee, with representation from every point of contact with the commitment act: people living with mental illnesses, family members, advocates, defense attorneys, county attorneys, hospitals, community mental health providers, psychiatrists, pre-petition screening, county human services, sheriffs, DHS, and more. We identified problems with the commitment act and its implementation and worked hard to find solutions. The end result was a commitment act that is recognized by the Treatment Advocacy Center as an excellent law.

My concerns with SF1492 include:

- Placing a civil commitment coordinating commission under the purview of the Attorney General's office. Civil commitment is overseen by the Department of Human Services (where it belongs). This bill would, in my opinion, continue to link serious mental illness to the judiciary system.

- Unnecessary duplication of effort. Many counties are already engaged in diversion efforts, and steps continue to be taken through legislative appropriations, DHS and counties to implement recommendations from the 2020 changes to the civil commitment law, etc. Why not give these efforts (ex. voluntary engagement) an opportunity to make an impact instead of adding another level of reporting that is confusing and disconnected to the actual work of providing treatment and services?

- The funding that would be necessary to carry out the work of the proposed civil commitment coordinating division. While the level of funding required to implement this bill is not yet known, almost every area of mental health treatment and services that can help address issues related to civil commitment is underfunded. Why direct limited state funding to this commission rather that the implementation of solutions that have already been identified?

In addition to the committee that worked on the changes to the commitment act that was adopted by the Legislature in 2020, the competency restoration task force and the priority admissions task force also put forth a number of recommendations that actually address the current issues we are seeing with implementation of the commitment act, including:

- Law enforcement often is not willing to provide transport holds due to changes in the use of force law;
- People are being discharged, while committed, to shelters because housing isn't available (and because they had a bed in the hospital, they don't rise to the top of the priority list in the housing programs);
- There are significant workforce challenges, making it hard for counties and community providers to hire and train case managers;

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- If individuals under commitment are not following the treatment plan, hospitals won't take them unless they meet medical criteria and there is nowhere else to take them;
- There is a lack of intensive services that are critical to helping individuals under civil commitment (ex. ACT teams, CADI waivers, supportive housing).

There are recommendations from both of those task forces, that have been put forth in bills the last few years that would help address some of the problems we are experiencing. This includes:

- Implementation of voluntary engagement grants (passed in 2024, RFP coming out soon)
- Developing locked IRTS (residential facilities). Issue cleared up with CMS so hoping to see movement on this issue
- Rate increases for community mental health providers so that they can hire more people and increase access
- Forensic navigators who will connect people with misdemeanors who have a Rule 20 become connected to services and supports to divert them from jail in the future
- Funding for jail diversion programs and social workers in the jail
- Development of a task force to address issues related to transport holds
- Funding for protected transport so crisis teams don't need to rely on police for transport holds
- Elimination of the moratorium on hospital psychiatric beds
- Creation of model discharge plans from jails to prevent future involvement
- Funding for re-entry coordination programs
- Funding for 988 and mobile crisis services to ensure a mental health response to a mental health crisis
- Expansion of first episode of psychosis programs and start a first episode of bipolar disorder program
- Current task force on MI&D commitment

The mental health community is actively working to build our mental health system, especially for people with serious mental illnesses. I believe that many of the remaining issues with civil commitment stem from a lack of investment in the mental health system, especially the services that are intended to serve those who have the highest needs. Now is the time to implement and fund the treatment and services that can make a difference.

Thank you for the opportunity to share my concerns about SF1492 with the committee.

Sincerely,

Shannah C. Mulvihill, MA, CFRE
Executive Director/CEO
Mental Health Minnesota

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Hiawatha Valley
MENTAL HEALTH CENTER

Senator Ron Latz, Chair
Judiciary and Public Safety Committee
MN State Senate
Friday, March 21, 2025

Dear Chari Latz and Committee Members

On behalf of Hiawatha Valley Mental Health Center I am writing to share our concerns with SF 1492 – creating a Civil Commitment Coordinating Division.

Hiawatha Valley Mental Health Center is a Certified Community Behavioral Health Clinic in southeastern MN. Today we provide a broad range of behavioral health services and support for all ages. Services include:

- Mental Health Case Management
- Mobile Crisis Services
- Clinic and School Based Mental Health Therapy
- Substance Use Counseling
- Residential Services for Adults
- Medication Management for all ages
- Adult and Children's psychiatric rehabilitating services

When the major changes to the commitment act were adopted in 2020, it reflected the consensus of a committee of over 20 representative groups - people with mental illnesses, family members, advocates, defense attorneys, county attorneys, hospitals, community mental health providers, psychiatrists, pre-petition screening, county human services, sheriffs, DHS, and more. The committee identified problems with the commitment act and its implementation and worked hard to find solutions.

The Competency Restoration Task Force and the Priority Admissions Task Force – of which community mental health programs are represented and consists of many of these same interests represented on both task forces - developed a number of recommendations that address the current issues we are seeing with implementation of the commitment act. The major issues we are hearing are the following:

- Lack of transport holds due to changes in the use of force law;
- People are discharged, while committed, because they had a bed in the hospital they don't rise to the top of the priority list in the housing programs;
- Workforce challenges;
- Lack of intensive services such as ACT teams, CADI waivers, supportive housing

There are recommendations from both of those task forces that have been put forth in bills the last few years that would help address some of the problems we are experiencing. This includes:

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Hiawatha Valley
MENTAL HEALTH CENTER

- Medicaid rate increases for community mental health providers to sustain (and increase) access to care
- Implementation of voluntary engagement grants (passed in 2024, RFP coming out soon)
- Developing locked IRTS (residential facilities)
- Forensic navigators who will connect people with misdemeanors who have a Rule 20 become connected to services and supports to divert them from jail in the future
- Funding for jail diversion programs and social workers in the jail
- Develop a task force just on transport holds
- Fund protected transport so crisis teams don't need to rely on police for transport holds
- Eliminating the moratorium on hospital psych beds
- Creating of model discharge plans from jails to prevent future involvement
- Funding re-entry coordination programs
- Funding 988 and mobile crisis services to have a mental health response to a mental health crisis
- Expanding first episode of psychosis programs and start a first episode of bipolar disorder program
- Current task force on mentally ill and dangerous (MI&D) commitment

The mental health community is actively working to build our mental health system, especially for people with serious mental illnesses.

We have the following concerns with SF 1492:

- Placing the engagement grant work under the Attorney General when grants are part of the DHS budget
- The advisory committee does not reflect the broad group of people that have been traditionally involved in commitment and community mental health issues, including advocates, hospitals, etc. The priority admissions task force is continuing to meet, as is the MI&D task force and the State Advisory Committee on Mental Illness
- Outpatient commitment is established in our commitment statute. The services provided under outpatient commitment fall under the jurisdiction of DHS not the Attorney General. Providers need funding in order to increase staffing and that additional funding would have to be in rates because under Medicaid laws you can't simply add grant money to the rates.

Unfortunately, SF1492 does not reflect how the mental health system currently operates and poses confusing new requirements for providers and individuals. We urge the Committee to implement current Civil Committee Task Forces' recommendations and make investments into our state's active mental health system models as opposed to moving the authority and funding to a new, unrelated office of the state.

Sincerely,

Erik Sievers, Executive Director
Hiawatha Valley Mental Health Center

Mental Health Resources

Senator Ron Latz, Chair
Judiciary and Public Safety Committee
MN State Senate
Friday, March 21, 2025

Dear Chair Latz and Committee Members

On behalf of Mental Health Resources, I am writing to share our concerns with SF 1492 – creating a Civil Commitment Coordinating Division.

Founded in 1976, Mental Health Resources (MHR) is a non-profit 501(c)(3) mental health agency providing community-based mental health services, outpatient co-occurring substance use disorder treatment, and supportive services to nearly 14,000 people with serious and persistent mental illness in 2024 primarily in Ramsey, Dakota, and Hennepin Counties. MHR directly provides recovery-oriented, community-based services that support people with serious and persistent mental illness to live successfully in the community. These services include: Targeted Case Management (TCM) services , Assertive Community Treatment (ACT) , Special Needs Basic Care Coordination (SNBC), Outpatient co-occurring substance use disorder treatment and peer support services, Intensive community based services, In-home therapy through our outreach clinic, Community Support Program (CSP) and drop-in center, and a Housing Voucher Program.

When the major changes to the commitment act were adopted in 2020, it reflected the consensus of a committee of over 20 representative groups - people with mental illnesses, family members, advocates, defense attorneys, county attorneys, hospitals, community mental health providers, psychiatrists, pre-petition screening, county human services, sheriffs, DHS, and more. The committee identified problems with the commitment act and its implementation and worked hard to find solutions.

The Competency Restoration Task Force and the Priority Admissions Task Force – of which community mental health programs are represented and consists of many of these same interests represented on both task forces - developed a number of recommendations that address the current issues we are seeing with implementation of the commitment act. The major issues we are hearing are the following:

- Lack of transport holds due to changes in the use of force law;
- People are discharged, while committed, because they had a bed in the hospital they don't rise to the top of the priority list in the housing programs;
- Workforce challenges;
- Lack of intensive services such as ACT teams, CADI waivers, supportive housing

There are recommendations from both of those task forces that have been put forth in bills the last few years that would help address some of the problems we are experiencing. This includes:

- Medicaid rate increases for community mental health providers to sustain (and increase) access to care
- Implementation of voluntary engagement grants (passed in 2024, RFP coming out soon)
- Developing locked IRTS (residential facilities)
- Forensic navigators who will connect people with misdemeanors who have a Rule 20 become connected to services and supports to divert them from jail in the future
- Funding for jail diversion programs and social workers in the jail
- Develop a task force just on transport holds
- Fund protected transport so crisis teams don't need to rely on police for transport holds
- Eliminating the moratorium on hospital psych beds
- Creating of model discharge plans from jails to prevent future involvement
- Funding re-entry coordination programs
- Funding 988 and mobile crisis services to have a mental health response to a mental health crisis
- Expanding first episode of psychosis programs and start a first episode of bipolar disorder program
- Current task force on mentally ill and dangerous (MI&D) commitment

The mental health community is actively working to build our mental health system, especially for people with serious mental illnesses.

We have the following concerns with SF 1492:

- Placing the engagement grant work under the Attorney General when grants are part of the DHS budget
- The advisory committee does not reflect the broad group of people that have been traditionally involved in commitment and community mental health issues, including advocates, hospitals, etc. The priority admissions task force is continuing to meet, as is the MI&D task force and the State Advisory Committee on Mental Illness
- Outpatient commitment is established in our commitment statute. The services provided under outpatient commitment fall under the jurisdiction of DHS not the Attorney General. Providers need funding in order to increase staffing and that additional funding would have to be in rates because under Medicaid laws you can't simply add grant money to the rates.

Unfortunately, SF1492 does not reflect how the mental health system currently operates and poses confusing new requirements for providers and individuals. We urge the Committee to implement current Civil Committee Task Forces' recommendations and make investments into our state's active mental health system models as opposed to moving the authority and funding to a new, unrelated office of the state.

Sincerely

Ann Henderson

Ann Henderson, CEO
Mental Health Resources
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TOUCHSTONE
mental health

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March 17, 2025

I am writing to share our concerns with SF 1492. When the major changes to the commitment act were adopted in 2020 it reflected the consensus of a committee of over 20 people. This committee had representation from every point of contact with the commitment act: people with mental illnesses, family members, advocates, defense attorneys, county attorneys, hospitals, community mental health providers, psychiatrists, pre-petition screening, county human services, sheriffs, DHS, and more. We identified problems with the commitment act and its implementation and worked hard to find solutions.

Through the competency restoration task force and the priority admissions task force, which had many of the same interests represented on both task forces, there are several recommendations that address the current issues we are seeing with implementation of the commitment act.

The major issues we are hearing are the following:
- Police not willing to do transport holds due to changes in the use of force law
- People being discharged, while committed, to shelters because housing isn't available and because they have a bed in the hospital, they don't rise to the top of the priority list in the housing programs
- Workforce challenges, with community and counties finding it hard to hire and train case managers
- If people do not follow the treatment plan, hospitals won't take them unless they meet medical criteria and there is nowhere else to take them
- Lack of intensive services such as ACT teams and long wait for supportive housing and access to screenings for CADI waivers

There are recommendations from both of those taskforces, that have been put forth in bills in the last few years that would help address some of the problems we are experiencing. This includes:
- Implementation of voluntary engagement grants (passed in 2024, RFP coming out soon)
- Developing locked IRTS (residential facilities). Issue cleared up with CMS so hoping to see movement on this issue
- Rate increases for community mental health providers so that they can hire more people and increase access
- Forensic navigators who will connect people with misdemeanors who have Rule 20 become connected to services and supports to divert them from jail in the future
- Funding for jail diversion programs and social workers in the jail
- Develop a task force just on transport holds
- Fund protected transport, so crisis teams don't need to rely on police for transport holds

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- Eliminating the moratorium on hospital psych beds
- Creating of model discharge plans from jails to prevent future involvement
- Funding re-entry coordination programs
- Funding mobile crisis services to have a mental health response to a mental health crisis
- Expanding first episode of psychosis programs and start a first episode of bipolar disorder program

In other words, the mental health community is actively working to build our mental health system, especially for people with serious mental illnesses. SF 1492 seems a disjointed solution to the challenges of our current commitment process in Minnesota.

We would like to see more coordination with current mental health providers and advocates before this legislation moves forward to discuss these concerns.

We appreciate your work on this complex issue and look forward to further discussions.

Ellie Skelton
Executive Director