DEPARTMENT OF CORRECTIONS

VIA EMAIL
March 26, 2026

Legislative Reference Library
sonars@lrl.leg.mn

In the Matter of the Proposed Permanent Rules Relating to Jail Facilities; Revisor's ID No. R-4445; CAH Docket No. 22-9051-40960

Dear Legislative Reference Library:

The Minnesota Department of Corrections intends to adopt rules relating to jail facilities. We plan to publish the Notice of Hearing in the March 30, 2026, edition of the *State Register*.

We have prepared a Statement of Need and Reasonableness (SONAR). As required under Minnesota Statutes, sections 14.131 and 14.23, we are providing the library with an electronic copy of the SONAR on or before the date we send the Notice of Intent to Adopt Rules with a Hearing.

If you have any questions or concerns, please contact me at tara.rathman@state.mn.us.

Sincerely,

Tara Rathman
Rulemaking Manager

Enclosure: Statement of Need and Reasonableness

STATEMENT OF NEED AND REASONABLENESS

Department of Corrections

Proposed Permanent Rules Relating to Jail Facilities

Revisor’s ID No. R-4445
CAH Docket No. 22-9051-40960

March 23, 2026

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General Information

Availability. All required rulemaking notices and documents, including the SONAR and the proposed rule, are available on the department's rulemaking web page (https://mn.gov/doc/about/rulemaking/). The SONAR has been available for public review since December 1, 2025.

Rule records. You can track this rulemaking proceeding and search past department rulemaking records by using the Minnesota Rule Status System, located on the revisor's office website (https://www.revisor.mn.gov/rules/status/).

Alternative format. If you would like this SONAR in another language or an alternative format, such as large print, braille, or audio, please contact Tara Rathman, Rulemaking Manager, tara.rathman@state.mn.us, 320-241-5537, or the Department of Corrections, 1450 Energy Park Drive, St. Paul MN 55108.

Abbreviations

ACA: American Correctional Association

AJA: American Jail Association

APA: Administrative Procedure Act

CAH: Court of Administrative Hearings

MMB: Minnesota Management and Budget

NIC: National Institute of Corrections

SONAR: Statement of Need and Reasonableness

Table 1. Statute- and rule-level tags

Statute	Rule
Subdivision: 1, 2, 3, etc.; Subdivision 1 and then Subd. 2, Subd. 3, etc.	Subpart: 1, 2, 3, etc.; Subpart 1 and then Subp. 2, Subp. 3, etc.
Paragraph: (a), (b), (c), etc.	Item: A., B., C., etc.
Clause: (1), (2), (3), etc.	Subitem: (1), (2), (3), etc.
Item: (i), (ii), (iii), etc.	Unit: (a), (b), (c), etc.
Unit: (A), (B), (C), etc.	Subunit: i., ii., iii., etc.

Shorthand	Shorthand
Minn. Stat. § 241.021, subd. 1b(a)(1): Minnesota Statutes, section 241.021, subdivision 1b, paragraph (a), clause (1)	*Minn. R. 2911.0900, subp. 1(A)(1):* Minnesota Rules, part 2911.0900, subpart 1, item A, subitem (1)

Unless indicated otherwise, all statutory citations are to the 2024 *Minnesota Statutes* publication, and rule citations are to the 2025 *Minnesota Rules* publication.

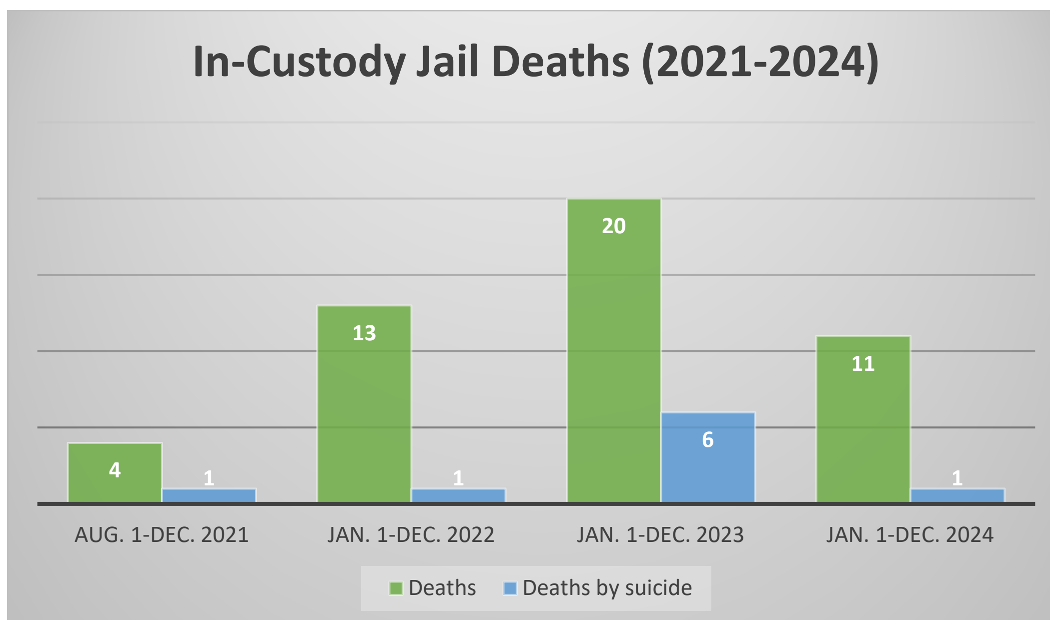
Introduction and Overview

1. People keep dying in Minnesota jails.

A man admitted to jail suffered a life-threatening coma.[1] Another man repeatedly asked to be taken to the hospital, but jail staff ignored his pleas. He died of a perforated bowel.[2] Another man's pleas for help were ignored as his "condition slowly deteriorated over the course of nine days, to the point where he was found on his jail cell floor paralyzed and lying in his own filth."[3]

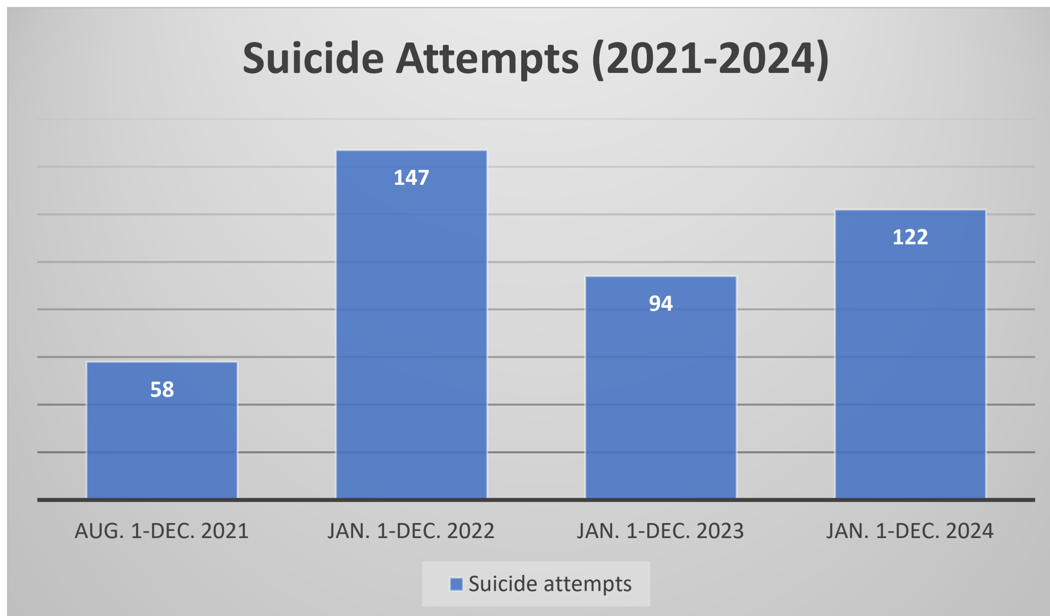
Numerous additional deaths have occurred in Minnesota jails, which the Department of Corrections licenses and inspects. Since late 2021, the department has been required to report on the number of in-custody jails deaths and suicide attempts. The numbers are sobering.[4]

Chart 1. Jail deaths since August 2021



[1] Lauren Leamanczyk, "KARE 11 Investigates: Lawsuit Claims Medical Neglect at Dakota County Jail, *KARE11*, July 18, 2024.
[2] Jeff Day, "Hennepin County Pays $3.4 Million to Settle Lawsuit for Wrongful Death of Jail Inmate Lucas Bellamy, *Minnesota Star Tribune*, November 11, 2024.
[3] A.J. Lagoe, Brandon Stahl, and Steve Eckert, "KARE 11 Investigates: Five Years Without Justice," *KARE11*, September 2, 2023.
[4] This data was reported in the department's annual reports under Minn. Stat. § 241.021, subd. 1f, entitled "Health & Safety in Correctional Facilities." The reports are available online on the department's website and the Legislative Reference Library's database of mandated reports.

Chart 2. Jail suicide attempts since August 2021



According to a 2016 report from the legislative auditor[5], Minnesota jails saw more than 50 suicides and 770 suicide attempts between 2000 and 2016. This high number of suicides reflect how "jails have also in many cases violated minimum safety standards or failed to provide adequate medical and mental health care for their inmates, *about two-thirds of whom are awaiting trial and presumed innocent*."[6]

Even though the department's standards are some of the oldest and most comprehensive in the country, people continue to die in Minnesota jails. The local jail mortality rate (from 2000 to 2019) increased by 11%, with suicide as the leading cause of death.[7] Yet this problem isn't unique to Minnesota. Increased deaths and suicide attempts reflect a nationwide trend, where death rates may be *three times higher* than reported.[8]

[5] Office of the Legislative Auditor, *Evaluation Report: Mental Health Services in County Jails* (St. Paul, March 2016), xi.
[6] Shaila Dewan, "Jail Is a Death Sentence for a Growing Number of Americans," *New York Times*, November 22, 2022 (emphasis added).
[7] E. Ann Carson, *Mortality in Local Jails, 2000-2019 - Statistical Tables* (Office of Justice Programs, December 2021); *see also* Kris Maher and Dan Frosch, "Inmate Suicides Rose Sharply in U.S. Prisons, Jails During Pandemic," *Wall Street Journal*, October 18, 2022.
[8] Marcella Alsan and Crystal Yang, "The Hidden Health Care Crisis Behind Bars: A Randomized Trial to Accredit U.S. Jails" (working paper, National Bureau of Economic Research, January 2025), 1.

There are a number of factors that may contribute to why deaths continue to occur in jails, sometimes under troubling circumstances.

First, in the past 25 years, jails have seen a dramatic change in the health-care needs of those entering jail. And jails have no choice but to try and manage the wide range of behavioral and health problems of incarcerated people, often with limited staffing and resources. Statistics show the depth of the problem.

SUBSTANCE ABUSE & MENTAL HEALTH BY THE NUMBERS:[9]

In Minnesota, **82%** of jails report that over **30%** of their incarcerated population struggle with substance abuse. **68%** of jails report over **30%** of their incarcerated population experiences mental health issues.

About **66%** of people admitted into jail meet the criteria for drug dependence and abuse.

About **26%** of people incarcerated in jail "reported experiences that met the threshold for serious psychological distress."

Around **17%** of incarcerated people have been diagnosed with a serious mental illness.

About **44%** of people in jails had a prior mental health disorder diagnosis by a professional.

Some incarcerated people suffer from both a substance-use disorder and a serious mental illness, which combine to produce a recurring cycle:

> When mental illness is combined with substance misuse, the odds of criminal recidivism and failure in correctional rehabilitation appear to

[9] *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field* (National Sheriffs' Association and National Commission on Correctional Health Care, October 2018); Amanda M. Bunting et al. "Characteristics of Substance Use Screening at Intake in a Sample of U.S. Jails," *J Health Care Poor Underserved* 34, no. 1 (2023): 180-91; *Minnesota Regional/County Jails Consolidation or Merger Study: Final Report* (Justice Planners, December 2024), 5-6; Jennifer Bronson and Marcus Berzofsky, "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12" (Office of Justice Programs, June 2017); Substance Abuse and Mental Health Services Administration, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* (2017); Legislative Analysis and Public Policy Association, *Model Withdrawal Management Protocol in Correctional Settings Act* (June 2021).

> increase multiplicatively. Substance use and mental health disorders are reciprocally aggravating conditions, meaning that continued symptoms of one disorder are likely to precipitate relapse in the other.[10]

Second, jails aren't equipped to clinically treat the health-care conditions of people with substance-use disorders or mental illness, even as "local jails have morphed into some of the largest mental health treatment facilities in the U.S."[11] Compounding the staffing and funding resources that jails require to meet these increased health-care needs is that "there are no national standards for what constitutes necessary medical treatment in jail, and federal courts are split over what level of care is adequate, *especially for people awaiting trial*."[12]

In addition to being unable to control who is admitted into their jails and their needs, jails don't control how long people remain in their jail. The length of stay and number of admissions (including *characteristics* of individuals admitted) are the two main factors that determine a jail's population size: "Although the average length of stay in most jail systems is 10-20 days, more than half of accused offenders are released from jail within a day or two of admission."[13]

A short length of stay combined with increased health-care needs require inventive solutions to protect the health and safety of incarcerated people while also giving jails the flexibility to comply with jail-specific constitutional requirements, as studied and acknowledged by the state's Priority Admissions Task Force:

> 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,

[10] Substance Abuse and Mental Health Services Administration, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings* (2019).
[11] Brianna Bailey, Cary Aspinwall, and Sachi McClendon, "This Company Promised to Improve Health Care in Jails. Dozens of its Patients Have Died," *The Frontier*, July 30, 2024.
[12] *Id.* (emphasis added).
[13] Mark D. Martin and Thomas A. Rosazza, *Resource Guide for Jail Administrators* (National Institute of Corrections, 2004), 11.

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.[14]

2. **The legislature gave the department a clear mandate to revise its jail standards to better protect the health, safety, and welfare of jail staff and justice-involved populations.**

> *"We have a crisis situation in our state and we desperately needed reforms to save lives. People are held in custody for a wide array of reasons—it shouldn't be a death sentence because of a failure to provide basic levels of care."*[15]

Since 1976, the department has had the authority to inspect adult correctional facilities, or jails, for compliance with minimum standards.[16] But until 2021, the legislature had not substantively revised its statutory scheme for half a century. This prolonged regulatory inaction has left jail staff with inadequate guidance that is woefully out of date, resulting in serious health and safety issues—some life-threatening—and subpar treatment of justice-involved populations,[17] resulting in many tragic deaths. The department's authority was ineffective, as one legislator stated, because it was "confusing, vague, and has little teeth."[18] This toothless authority was shown publicly through legislative testimony and media reports. Additionally, the department's rules no longer reflected the changing correctional environment and broader societal changes affecting the health-care needs of incarcerated people.

[14] Minnesota Department of Human Services, *Priority Admissions Review Panel* (Vadnais Heights, February 2025), 22-23.
[15] Stephen Montemayor, "Walz, State Leaders Hail New Safety Standards for Incarcerated," quoting Commissioner Schnell, *Minnesota Star Tribune*, September 18, 2021.
[16] 1976 Minn. Laws, ch. 299, sec. 1.
[17] An in-depth KARE 11 investigation found troubling deficiencies in Minnesota jails, including (1) justice-involved populations being denied constitutionally mandated medical and mental health care, (2) jail staff ignoring national guidelines for investigating and preventing deaths, and (3) falsified jail records and botched state investigations. Brandon Stahl, A.J. Lagoe, and Steve Eckert, "KARE 11 Investigates: Minnesota Fails National Jail Death Standards," *KARE11*, October 12, 2020.
[18] Tim Walker, "Lawmakers Learn About 'Crisis Situation' of Inmate Deaths in State Prisons and Jails," *Session Daily*, February 26, 2021.

The department, spurred by the consequences of archaic and insufficient standards, worked with the legislature and key stakeholders to pass transformational changes in the department's licensing and enforcement capabilities.[19] These changes greatly enhanced the department's ability to improve the standards of confinement and ensure that all justice-involved populations are treated with basic levels of care.

3. The revised minimum standards support the department's mission to transform lives for a safer Minnesota by strengthening the safety and security of incarcerated people, jail staff, and the Minnesota community.

The three main goals of the 2021 legislative changes were to:

a) update minimum standards in jails to comply with best corrections practices, including for correctional health care;

b) increase transparency among all jails and strengthen public trust;[20] and

c) ensure a higher level of accountability for jails and the department when inspecting jails and enforcing minimum jail standards.

For the first time, the legislature mandated 17 specific topics for the department to include in its minimum standards for jails in rule:[21]

a) screening, appraisal, assessment, and treatment for persons confined or incarcerated in correctional facilities with mental illness or substance use disorders;

b) a policy on the involuntary administration of medications;

c) suicide prevention plans and training;

d) verification of medications in a timely manner;

e) well-being checks;

f) discharge planning, including providing prescribed medications to persons confined or incarcerated in correctional facilities upon release;

g) a policy on referrals or transfers to medical or mental health care in a noncorrectional institution;

[19] 2021 Minn. Laws, 1st SS ch. 11, art. 9, secs. 5-16.

[20] For example, the act required the department to report to the legislature various data, including information on facility deaths, reviews of facility deaths, and use of force. For more on the act, see Appendix A.

[21] Minn. Stat. § 241.021, subd. 1(a). The department had already adopted minimum standards on some of these topics.

h) use of segregation and mental health checks;

i) critical incident debriefings;

j) clinical management of substance use disorders and opioid overdose emergency procedures;

k) a policy regarding identification of persons with special needs confined or incarcerated in correctional facilities;

l) a policy regarding the use of telehealth;

m) self-auditing of compliance with minimum standards;

n) information sharing with medical personnel and when medical assessment must be facilitated;

o) a code of conduct policy for facility staff and annual training;

p) a policy on death review of all circumstances surrounding the death of an individual committed to the custody of the facility; and

q) dissemination of a rights statement made available to persons confined or incarcerated in licensed correctional facilities.

Additionally, the legislature required jails to report (a) all deaths of individuals who die while committed to a jail's custody, and (b) all other emergency or unusual occurrences, including suicide attempts or uses of force by jail staff that result in substantial bodily harm.[22]

While the legislature specified minimum standards, equally important was the substantially revised structure for interim sanctions against jails.[23] For example, the legislature recognized that the department greatly needed to overhaul its archaic licensing and revocation authority—now, the department's licensing actions and need for explicit minimum standards in certain areas have been clarified for all stakeholders. This clarification in turn has increased public transparency of department actions.

By passing these bipartisan legislative changes,[24] the legislature—and members of the public who supported it—gave the department a clear mandate to improve its rules on jail facilities and ensure that they reflect the legislature's

[22] *Id.*

[23] *Id*., subds. 1a-1e.

[24] The underlying bill, House File No. 1267, was unanimously passed out of the Public Safety and Criminal Justice Reform Finance and Policy Committee on February 26, 2021, https://www.house.mn.gov/hjvid/92/893490.

intent and public expectations for the department to (a) license and inspect jails, and (b) protect both jail staff and justice-involved populations.

4. The need for the rules is overwhelming.

The department first adopted rules on county and regional jails in 1978. Since then, the department has amended its rule chapter, 2911, three times (1981, 1999, and 2013). Today, much of the original language from half a century ago, 1978 and 1981, remains, lagging behind best standards in correctional practices and correctional health care recommended by nationwide groups such as the American Jail Association, the American Correctional Association, the National Institute of Corrections, and the National Commission on Correctional Health Care.

As part of the 2021 legislation, the legislature required the department to report specific data on the health and safety of incarcerated people in state and local correctional facilities. The data on deaths and suicide attempts continues to show the serious health and safety risks for those incarcerated in jails. In certain situations, the department uses its authority to issue interim sanctions when a jail is failing to substantially conform to minimum standards and to make satisfactory progress toward substantial conformance.

One such example of the department exercising its new sanctioning authority was in January 2023, when the department issued a conditional-license order for Beltrami County jail because staff were preventing or delaying medical transports for incarcerated people who needed medical care.[25] This delay in medical care posed an imminent risk of life-threatening harm to persons incarcerated at the jail.

And in October 2024, the department issued a conditional-license order to Hennepin County jail; since September 2022, eight incarcerated people had died at the jail or after being transported to the hospital.[26] The department found that the jail had "chronic and repeated failure to meet well-being check and staffing requirements."[27]

Besides helping to prevent deaths and suicide attempts, the rules are also needed because of the broader societal and public-health implications. For

[25] Department of Corrections, "Beltrami County Conditional License Order" (January 27, 2023).
[26] Department of Corrections, "Hennepin County Conditional License Order" (October 31, 2024).
[27] *Id.*

example, evidence shows a direct link between jail incarceration and the use of hospital emergency rooms, including how those experiencing homelessness make up 15% of the jail population compared to 0.2% of the US population.[28] This population is at risk immediately preceding and following incarceration, so updated rules establishing better standards of care can help slow this revolving door between incarceration and negative health outcomes.

5. Jails are difficult to regulate because they are all different.

Jails in Minnesota range from two-bed holding facilities in northern Minnesota to metro-area jails holding more than 500 incarcerated people.[29] While 77 counties operate jails, there are 85 jails in Minnesota, with facilities located in 78 counties. This variation is due to some counties having more than one facility and because of one regional jail, the Northwest Regional Corrections Center.

> *"The number of people jailed pretrial has nearly quadrupled since the nineteen-eighties."*[30]

Minnesota jails hold both pretrial and sentenced individuals, with almost 60% of the jail population being held on pretrial status. Depending on a jail's classification, a jail may hold both pretrial and sentenced individuals for a certain period. For example, the rule prescribes six different jail classifications, and both Class I and II facilities can hold incarcerated people for no more than 72 hours or 90 days, respectively. Other jails can hold people for periods according to statute.[31]

Jails don't get to choose who to admit and hold, though four jails in Minnesota contract with Immigration and Customs Enforcement to hold detainees for the federal government.

[28] Vidya Eswaran et al., "Understanding the Association Between Frequent Emergency Department Use and Jail Incarceration: A Cross-Sectional Analysis," *Academic Emerging Medicine* 29, no. 5 (2022): 610.
[29] Minnesota Department of Corrections, *Minnesota Regional County Jails Consolidation Study: Final Report* (Dec. 20, 2024), https://mn.gov/doc/assets/MN%20Regional%20County%20Jails%20Consolidation%20Study%20Final%20Report%2012.20.24_tcm1089-669829.pdf.
[30] Sarah Stillman, "Starved in Jail," *The New Yorker*, April 21, 2025. About 70% of people nationally are held pretrial, according to the Prison Policy Initiative.
[31] *See, e.g.*, Minn. R. 2911.0200, subp. 16 (defining *Class VI facility*): "A facility used to confine presentenced and sentenced inmates for periods of time not to exceed any limits set by Minnesota Statutes."

While jails are funded and overseen through their county, elected county board members, and elected sheriff, jails are run operationally by a jail administrator. The jail administrator oversees the day-to-day operations of the jail and is the department's main liaison for inspection and enforcement matters.

About 27% of people are arrested and admitted to jail more than once,[32] and 95% of incarcerated people return to their communities upon release.

While these differences among jails make the department's regulatory responsibilities difficult, they don't obviate the need for department regulation and for public trust in the state's local correctional facilities.

[32] Eswaran et al., "Understanding the Association," 607.

Summary of Proposed Rule Changes

The department's proposed rules seek to accomplish four main goals.

1. Adopt minimum standards as required under the 2021 legislation.

The 2021 legislation identified and prioritized 17 topics that represent the minimum standards required to protect the health and safety of both jail staff and the incarcerated population.

In turn, the department is proposing requirements for these 17 topics, many of which focus on correctional health care. In developing these requirements, the department sought input from a broad range of stakeholders, both within the executive branch and from external partners.

In some cases, requirements on some of these topics already exist. In other cases, rule contains no guidance on these topics. In every case, the department used its extensive consultation to develop the proposed rules.

2. Clarify vague or ambiguous language.

Both the jails and the department agree that uniformity in regulation is one of the most vital components of any regulating body. Yet much of the original rule chapter contains vague or overly discretionary language that fails to give jails clear notice of department inspection and enforcement standards.

This lack of clarity creates enforcement challenges and may lead to inconsistent rule interpretations and enforcement.

3. Strengthen the jails' policies and procedures.

Nothing in the existing rule explicitly states that a jail must follow their own policies and procedures that govern the jail's management, only that they must have them. This is a regulatory gap. Because the rule is structured to give jails flexibility in how to comply with the proposed minimum standards, the department finds it critical for the rule to explicitly require jails to comply with their individualized policies and procedures.

4. Embedding plain language.

In addition to these three main goals, the department's proposed revision is written in plain language. By using plain language, the department aims to ensure that its requirements are clear and accurate to department staff, stakeholders, and the public. This commitment to plain language complies with

Governor Walz's Executive Order 19-29, which requires state agencies to use plain language "to communicate with Minnesotans."[33]

[33] Executive Order 19-29 (April 5, 2019).

Statutory Authority

In 1976, the legislature gave the department its initial grant of rulemaking authority to inspect jails for minimum standards.[34] The department adopted the initial rules in 1978 with the help of a nine-member advisory task force of five sheriffs and four county commissioners.

The underlying legislation granting the department rulemaking authority was first introduced in the senate,[35] passing 56 to 9 in April 1975. But the senate bill wasn't passed in the house until 1976, when the house amended the bill and passed it 70 to 53. The bill was then repassed by the senate 49 to 3.

The legislature's efforts to establish department regulatory oversight dovetails with regulatory action nationwide, which saw a rapid development of jail standards in other states, beginning in the 1970s.[36] Before the 1970s, "little or no external oversight was exercised over jails. Legal requirements were minimal, and there was almost no enforcement of those that did exist."[37] Lack of oversight precipitated state and federal lawsuits against jails and prisons and, accordingly, court decisions on the constitutional rights of incarcerated people in correctional settings.

It is within this context that the legislature gave the department the statutory authority to adopt rules on minimum standards for jail facilities:

> The commissioner shall promulgate pursuant to chapter 14, rules establishing minimum standards for these facilities with respect to their management, operation, physical condition, and the security, safety, health, treatment, and discipline of persons confined or incarcerated therein.[38]

This bipartisan support that first created the department's rulemaking authority also extended to the 2021 changes, which were included in the public-safety and judiciary omnibus bill, passing 77 to 57 in the house and 45 to 21 in the senate.

[34] 1976 Minn. Laws, ch. 299, sec. 1.

[35] Senate File No. 551. The senate file was lightly amended in committee before being passed by the senate.

[36] *See* Mark D. Martin, *Jail Standards and Inspection Programs: Resource and Implementation Guide* (National Institute of Corrections, 2007).

[37] *Id.*, ix.

[38] Minn. Stat. § 241.021, subd. 1(a).

Regulatory Analysis

As part of its SONAR, the department must analyze eight factors.[39]

1. **A description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.**

1.1. Classes of persons who probably will be affected by the proposed rule.

The department's proposed rules are likely to affect:

a) incarcerated people;

b) licensed county jails, including jail staff such as jail administrators, custody staff, health-care staff, and support and clerical staff;

c) health-care providers that contract with jails to provide health-care services, including local government health agencies;

d) food-service providers that contract with jails to provide food service;

e) county sheriffs, including the Minnesota Sheriffs' Association;

f) county commissioners and county boards;

g) Community Corrections Act administrators;

h) the Association of Minnesota Counties;

i) the Office of the Ombuds for Corrections;

j) the Minnesota Departments of Health and Human Services and Minnesota Direct Care and Treatment;

k) the Minnesota Office of Addiction and Recovery and the Governor's Advisory Council on Opioids, Substance Use, and Addiction; and

l) community-based providers of mental-health treatment and substance-use-disorder treatment.

1.2. Classes that will bear costs from the proposed rules.

The main class that will bear costs will be the jails, which will need to implement the new minimum standards. In turn, these costs will be directly borne by the county board responsible for overseeing the jail. But because many

[39] *Id.* § 14.131.

of the new standards stem from legislative requirements, most new costs stem from the statute, not the rule.

The department believes that a comparable statutory framework was established in the Health Department's assisted-living rules, adopted in July 2021. For this rule, the legislature required the Health Department to adopt rules on 13 topics. As the Health Department argued in its SONAR, most of its rule costs were statutorily derived:

> The vast majority of compliance costs associated with the new assisted living licensure framework originate in Minnesota Statutes, chapter 144G, not in the proposed rules. As described below, the proposed rules only clarify the requirements already imposed on facilities by statute by adding detail where it is lacking in chapter 144G.[40]

The administrative law judge agreed with the Health Department's analysis.[41] And here, the department is following the legislature's directive and adding detail where needed to clarify statutory requirements (though the Health Department operates under a more-comprehensive licensing framework).

Even without this comparison, the department believes that it has conducted a reasonable cost analysis given that each jail and the county in which it operates are different. Costs stem from many factors:

- The jail's classification, size, and supervision style
- The jail's incarcerated population, including health-care needs, length of stay, alternative sentence (work release, sentencing-to-service, etc.)
- The jail's location and associated county, regional, and local resources such as social services, treatment providers, and employment opportunities
- County policies
- Labor costs, including salaries, benefits, and collective-bargaining agreements

Additionally, many of these costs are already expected of jails—that is, jails are legally responsible for doing what the department's proposed minimum

[40] Minnesota Department of Health, *Statement of Need and Reasonableness for Assisted Living Licensure* (December 2020), 12.
[41] OAH 65-9000-37175, *In the Matter of the Proposed Rules of the Minnesota Department of Health Governing Assisted Living Facilities, Minnesota Rules Chapter 4659* (March 29, 2021), 12-16.

standards require. This legal responsibility has been established by state and federal courts, with this duty of care firmly grounded in the Constitution.[42]

1.3. Classes that will benefit from the proposed rule.

> *"Taxpayers ended up paying multimillion-dollar settlement bills for actions that killed off members of their own communities."*[43]

All classes should benefit from the proposed rule, as the department anticipates that the rule amendments will increase the safety and security of jails and jail staff, incarcerated people, and visitors. Public safety will also benefit because the proposed requirements may reduce recidivism and ensure that people returning to the community are healthier and can maintain their continuity of care.

Furthermore, the department must address the impetus behind the revised statutory framework: the department's responsibility to ensure that jails provide basic levels of care to their justice-involved populations and to improve standards of confinement. For jail staff, updated standards will help them safely do their jobs and adhere to best practices in jail administration:

> Jails in states with proactive standards and inspection programs have generally experienced reduced liability exposure, improved conditions, greater professionalism, and greater consistency in operations.[44]

2. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The department has estimated that costs for implementing its proposed rules will be minimal, with most costs stemming from training department inspectors on the new rules and changing inspection procedures to reflect the new rule requirements. The department will cover any costs by using the money appropriated to it under law.[45]

[42] For a good list, *see* Martin, *Jail Standards and Inspection Programs*, 39-44.
[43] Stillman, *Starved in Jail*.
[44] Martin, *Jail Standards and Inspection Programs*, ix.
[45] 2021 Minn. Laws, 1st SS ch. 11, art. 1, sec. 17, subd. 4(c). The department was appropriated $992,000 in fiscal year 2022 and $492,000 in fiscal year 2023 to "expand and improve oversight of jails and other state and local correctional facilities . . ." The $492,000 is continuous funding.

An exception to this cost estimate may be an increase in variance requests and the associated time for inspectors to review these requests or to conduct inspections and investigate complaints related to the new rule requirements. At this time, the department doesn't anticipate hiring more inspectors and believes it can manage the workload with its current inspectors. On the other hand, these costs may decrease if the department responds to less inquiries on ambiguous language or requests for technical assistance on unclear standards.

Other state agencies are not expected to directly see any increased costs, as the department doesn't establish duties for other state agencies. But a few agencies may see indirect costs, if any, and these would be minimal. For example, the department's amendments to food and menu requirements affect the Minnesota Board of Dietetics and Nutrition Practice because they require a dietitian and nutritionist to approve a jail's menu. But a dietitian or nutritionist must already approve a jail's menu, and any changes to this process would not cost more than a minimal amount.

3. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Because the legislature mandated the department to adopt minimum standards and rules on the 17 topics, the department has determined that there are no less-costly or less-intrusive methods for achieving the rule's purpose, which is to improve jail regulations to:

a) protect the public;

b) ensure the safety of everyone living and working in jails; and

c) require jails to provide basic levels of care and service to justice-involved populations—as required under statute and common law.

One approach, which the department ruled out, would've required jails to comply with ACA and NCCHC requirements. Although NCCHC accreditation has been proven to improve health care and to reduce jail deaths, a minority of jails nationwide are accredited.[46] As the department discusses in its analysis of alternative methods, this approach would be more costly for both jails and the department. While the department, in parts of the rule, relies on ACA and NCCHC standards, a wholesale adoption of these standards would be unreasonable both in cost and practicality.

[46] Alsan and Lang, "The Hidden Health Care Crisis Behind Bars,"1.

Instead, the department has established a performance-based approach that provides jails flexibility in accomplishing the rule's purpose and allows jails to apply for a variance for any rule requirement that they may find overly intrusive or burdensome.[47]

4. A description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule.

The department knows of no feasible alternative method to achieve the purpose of the proposed rules, as the legislature has directed it to adopt specific minimum standards for jails. One initial consideration was to require jails to establish policies and procedures on all 17 topics, without any minimal guidance. But given the legislative directive, the department quickly decided against this approach. While the department's proposed guidance on the 17 topics may appear, cumulatively, to be burdensome, the department argues the need and reasonableness for each individual topic.

Additionally, some—but not all—jails have been working to develop policies and procedures on these topics since the 2021 legislation was passed or were already following various requirements that the department is proposing. The department still gives jails discretion to devise their own policies and procedures but provides specific guidance where needed.

Because jails vary in size and population, the department strove for a flexible approach in implementing the legislative mandate, an approach consistent with the rule's current regulatory framework. For example, instead of specifying a one-size-fits-all approach, the department generally requires a jail to develop and follow a policy on a minimum standard. Sometimes, the department adds minimum requirements for the policy; other times, the department refers to the underlying statute if it was detailed enough to not necessitate additional rule standards.

At times, the department considered drafting different standards for jails according to their classification or size. But this is a difficult and time-consuming process, as a state commission recently discovered:

> The commission weighed various options and decided against drafting separate sets of standards for each tier, in part due to the sheer time and information required to do so, but also because many felt that an

[47] *See* Minn. R. 2911.0400.

individualized variance procedure, described below, allowed for greater flexibility and acknowledgment of county budgets, population needs, demographics, or resources.[48]

When the department discussed the rule with jails, there was an inherent tension between the concept of minimum standards and the need for more-specific guidance. Sometimes, the jails preferred that the department provide overly detailed guidance because they questioned how the department would enforce certain standards. Other times, jails wanted the department to give them a wide berth.

While the department acknowledges that the rule has long been one of minimum standards, the department also realizes that the 2021 legislation signaled—and directed—a new approach. This new approach is needed to improve the conditions in jails and to better protect the health and safety of incarcerated people. The department has decided to meld—or balance—these two needs with a hybrid approach: maintain or update minimum standards while providing more direction when needed to prevent deaths (and other serious incidents) and ensure that incarcerated people are treated with dignity and respect.

The department believes that a hybrid model—one that upholds minimum standards while integrating proven best practices from respected national organizations such as the ACA and NCCHC—is the most effective way to achieve the purpose of the proposed rule.

5. **The probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals.**

As stated on page 28, some of the costs stem from statute, not rule; reflect current constitutional requirements; or are minimal because the required minimum standards already exist in statute.

Still, jails may see costs initially increase. Much of a jail's costs stem from two factors: (a) staffing,[49] and (b) a county's contract with its health authority to deliver health-care services. For example, the department anticipates that its

[48] Colorado Jail Standards Commission, *Final Report to the General Assembly* (December 2023), 5.

[49] The National Institute of Corrections estimates that staffing costs represent about 70 to 80% of a jail's annual budget. Martin and Rosazza, *Resource Guide for Jail Administrators*, 69.

proposed changes to well-being checks, particularly requiring 15-minute checks for those with medical concerns, will require some jails to hire additional staff to ensure the jail's safety and security. The department sought to minimize costs, where possible, particularly for smaller facilities. For example, to address dispatch-related staffing impacts, the department is permitting the use of a sole dispatcher—defined as a single staff member responsible for monitoring and coordinating facility communications, including radio traffic and emergency response—provided that the dispatcher has immediate access to two-way radio communication, rather than requiring additional staffing.

But counties have already experienced rising health-care costs because of the increased needs of people admitted to jail. While the department's proposed requirements affect the health care that jails must provide to incarcerated people with mental illnesses and substance-use disorders, the cost to provide health care is already increasing and will likely continue to increase, regardless of whether the department's amendments are adopted.

Each jail is different, and so each jail will have different costs associated with the rule. The department cannot accurately calculate the cost for each jail, but the department can point to its performance-based standards that allow jails the flexibility to meet the intent of the proposed rule and the broader costs to jails and society for not adopting the proposed rule. Additionally, many of the amendments relating to health care could help jails manage their incarcerated population, resulting in improved staffing and retention and, ultimately, reduced costs.

For proposed requirements not associated with the 17 statutorily required topics, the department has estimated the costs for jails in rule where possible. Additionally, each jail can conduct a staffing analysis to help it estimate possible costs if the proposed amendments are adopted.

While the department is constrained in doing a cost estimate for each jail, the department still examined wage data on correctional officers in county jails to help identify staffing costs.

Table 2. Wage data for Minnesota jail correctional officers

Area	Job Vacancies	Vacancy Rate	Median Hourly Wage Offer
Minnesota	316	6.30%	$24.50
Central MN	61	5.50%	$24.59

Area	Job Vacancies	Vacancy Rate	Median Hourly Wage Offer
Northeast MN	25	5.0%	$22.22
Northwest MN	55	9.70%	$23.28
Southeast MN	5	0.60%	$24.56
Southwest MN	63	17.60%	$23.43
7-County Metropolitan Area	106	6.50%	$23.55

Note: The "Vacancy Rate" column means the number of vacancies per 100 jobs in that occupation. The state's overall 2023 job vacancy rate was 5.1%, so a number higher than that means there are more vacancies for that occupation because demand is high or worker supply is low, or both—a vacancy rate higher than 5.1% means a job in that occupation is harder to fill.[50]

6. The probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals.

The impetus for the 2021 legislative changes will not dissipate until the department updates its rules to reflect—when possible—best practices so that justice-involved populations can receive basic levels of constitutionally required care. Updated standards can ensure better results for all affected parties and stakeholders. For example, jail staff can receive more training on topics that can help prevent injury and death among incarcerated people, and local governments and the public can benefit from reduced costs from less litigation and settlements because of poorly trained jail staff.

The rules also fulfill the legislature's intent of implementing reforms that can help save lives while improving standards of confinement and establishing accountability when these standards are not met. When jails fail to meet minimum standards, there are financial costs to the jail and real human consequences to individuals and society as a whole.

[50] Data is from the Department of Employment and Economic Development, accessed November 19, 2024. Data is from two sources: (1) the Job Vacancy Survey, and (2) Occupational Employment and Wage Statistics.

Whether jails are currently meeting their obligations for the incarcerated population can be seen by examining wrongful-death lawsuits from jails in Minnesota and across the country:

- Hennepin County paid **$3.4 million** to settle a lawsuit for a 2022 death in its jail, believed to be one of the largest settlements for jail deaths in Minnesota.[51] This was shortly superseded by a **$3.6 million** settlement for a death in Ramsey County jail.[52]
- Beltrami County paid **$2.25 million** to settle a death from a suicide[53] and paid **$2.6 million** to settle another death.[54]
- A 2021 settlement for a death in Sherburne County paid **$2.3 million**.[55]
- A 2024 settlement for a death in Anoka County paid **$2.75 million**.[56]
- The 2016 OLA report found that for settlements reached between January 2012 and July 2015, seven cases settled for a total of **about $4.5 million**, with the individual cases ranging **from $15,000 to $2 million**.[57]
- A 2024 settlement, **$2 million**, was reached over a woman's death in a North Dakota jail. She died of an overdose when "two correctional officers did not seek medical help despite obvious signs."[58]
- In a single county in California, the county has paid more than **$12 million** to settle death lawsuits for deaths since 2020, with cases still pending.[59]

[51] Day, "Hennepin County Pays $3.4 Million to Settle Lawsuit."
[52] Christopher Magan, "Ramsey County Poised to Pay $3.6 Million to Family of Inmate Who Died of a Brain Bleed," *Minnesota Star Tribune*, April 18, 2025.
[53] Robins Kaplan LLP, "Obtained $2.25 Million Settlement in Jail Suicide Lawsuit in Beltrami County, Minnesota," September 2021, https://www.robinskaplan.com/experience/obtained-over-2-million-settlement-in-jail-suicide-lawsuit-in-beltrami-county-minnesota (accessed July 14, 2025).
[54] Jenny Berg, "Beltrami County, Medical Provider Agree to Pay 2.6M in Jail Inmate's Death," *Minnesota Star Tribune*, March 10, 2023.
[55] *Id.*
[56] Mark Zdechlik and Kirsti Marohn, "Former Anoka County Inmate Reaches Multimillion-Dollar Settlement with County, Medical Staff," *MPR News*, February 5, 2025.
[57] Legislative Auditor, *Mental Health Services in County Jails*, 70.
[58] Jack Dura, "$2M Deal Reached in Lawsuit Over Young Woman's Death at North Dakota Jail in 2020," *Associated Press*, April 4, 2025.
[59] Christopher Damien, "The Deadliest Year Inside One of America's Deadliest Jail Systems," *New York Times*, November 1, 2024.

- A 2023 article analyzing plaintiffs' awards for nationwide jail deaths found a **total of over $292,234,224**.[60]

While these numbers are sobering, the department acknowledges the difficult job jail staff have working in a correctional facility and managing people at their worst. Staffing is a constant issue, with staff shortages compounding the stress of working with people with mental illness, substance-use disorders, and other health-care conditions and needs.

While the department doesn't have the authority to direct how counties fund and ensure safe workplace conditions for their jails, the department hopes that broader statewide solutions will be developed to help jails and their staff provide high-quality care to the incarcerated population, ultimately strengthening the state's public safety.

7. An assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference.

There are no known differences between the proposed rule and federal regulations because there are no federal standards for local jails. To the extent that jails will need to follow federal standards for substance-use-disorder treatment, the proposed rules don't conflict or supersede these standards.

Except for the Prison Rape Elimination Act,[61] there are no specific federal laws applicable to all state jails.

Some federal laws apply to select jails. For example, the three jails that contract with Immigration and Customs enforcement must follow federal laws specific to holding federal detainees.

Additional federal laws may apply to jails that house juveniles. Minnesota jails are not licensed to house juveniles, but there are times that local law enforcement may bring youth who are under 18 years old to jails licensed under the rule chapter. In these limited situations, protections under the federal Juvenile Justice Delinquency Prevention Act apply—for example, provisions on

[60] Taleed El-Sabawi et al., "Dying Inside: Litigation Patterns for Deaths in Jail Custody," *Journal of Correctional Health Care* 29, no. 4 (2023): 275-281.
[61] For a good explanation of the law, *see* Bureau of Justice Assistance, "Prison Rape Elimination Act (PREA)," https://bja.ojp.gov/program/prea/overview (accessed May 12, 2025).

removing a juvenile from jail or separating the juvenile by sight and sound from adults charged or convicted of criminal offenses.

8. An assessment of the cumulative effect of the rule with other federal and state regulations related to the specific purpose of the rule.

With few applicable federal regulations, the cumulative effect of the proposed rule with federal law should be minimal, especially as the department doesn't inspect for a jail's compliance with federal law.

State law governs licensing requirements for health-care professionals as well as food, fire, and construction requirements applicable to a licensed facility. Overall, there should be a minimal cumulative effect from other state regulations, as health-care professionals operate independently under their licensure. While state health and safety codes have a cumulative effect, the department doesn't substantively amend related rule standards.

Additional statutory requirements under Minnesota Statutes, chapters 241 and 641, apply. While these statutory requirements affect jails and have a cumulative effect, the department generally cross-references to statute and doesn't add cumulative requirements. For example, the proposed part on nonconformance (part 2911.0310) cites to 2021 legislative changes and to other statutory sections. The economical cross-references obviate the need to duplicate statutory language and risk a future conflict between statute and rule.

When accounting for the department's proposed amendments, all existing federal and state regulations work together to form a comprehensive licensing and regulatory structure for jails.

Performance-Based Rules

The department must describe how it considered and implemented performance-based standards that emphasize (1) superior achievement in meeting the department's regulatory objectives, and (2) maximum flexibility for the regulated party and the department in meeting these goals.[62]

The department took this legislative directive on performance-based rules to heart. Because both sheriffs and county commissioners are elected officials, they must remain responsive to their constituents and the needs of those in their counties. Without performance-based rules, sheriffs and counties could see escalated, unsustainable costs that could affect their budgets and other services they need and want to provide to their constituents.

At the same time, sheriffs and county commissioners owe a duty of care to people in their jails and are constitutionally required to provide health care and other fundamental rights to the incarcerated population. Because incarcerated people will return to their community, any discussion about the cost of rules must also balance the costs of continued recidivism and the transition from jail to community.

Fortunately, the department's need to balance competing factors was recently tackled by Colorado, which in November 2023 adopted recommended standards for Colorado jails. As the commission tasked with developing the standards noted in its report, there was a need to balance the rights of incarcerated people with safety, security, and costs.[63]

1. Every jail is different.

As the department has discussed, each jail is different, with the following main factors affecting a jail's costs and ability to comply with the proposed rule:

- Average length of stay
- Number of admissions
- Average daily population
- Needs of the incarcerated population
- Location and community resources

[62] Minn. Stat. §§ 14.002, .131.
[63] Colorado Jail Standards Commission, *Final Report to the General Assembly*, 7.

- Jail design and management
- The type of health authority and the unique contract for each jail

One way that the department accounts for these differences is by organizing the rule around minimum standards and the 17 statutorily required topics. So while the rule establishes minimum standards on these topics, the department gives each facility the flexibility to develop its own policy and tailor it to fit its needs and the needs of its incarcerated population. For example, the department requires jails to have a policy and procedure on managing the personal property of incarcerated people. The department prescribes three different minimum standards, but the jail administrator still has discretion when developing their policy and procedure on how they will comply.

A second way in which the department grants flexibility to jails is through the department's variance process. Any jail may apply for a variance from any rule part,[64] and the department offers technical assistance to jails on the variance process[65] and when conducting inspections.

A third way to account for jail differences is to establish minimum thresholds for certain requirements. For example, the department's proposed rules on staffing, sick call, and programming all have different standards that correspond with a jail's annual admissions, design capacity, and classification, respectively.

2. Concerns about costs.

Jails and counties have reasonable concerns about the cost of the proposed rule amendments. These concerns are not new, as both jails and counties have raised these concerns in legislative reports or audits since the 2000s. (Nor are the concerns solely limited to Minnesota, as the Colorado commission learned.[66]) In response to these concerns, the department amended the rule draft (multiple times) and continues to seek to provide jails flexibility with the department's performance-based standards.

[64] Minn. R. 2911.0400.
[65] Minn. R. 2911.0100(A).
[66] *See, e.g.,* Colorado Jail Standards Commission, *Final Report to the General Assembly*, 1: ". . . the topics of funding and resources were continually raised. The commission supports continuing to explore funding solutions to allow full implementation of the standards for all jails, regardless of size."

But as the department argues in the SONAR, there are also legitimate costs for not doing the rule. The department finds its analysis from its 2013 SONAR still relevant and compelling:

> While the probable cost for could be large for a few counties, the need to assure public safety and a timely response to the safe and efficient operation of a facility, as well as emergency circumstances more than justifies these costs. The cost of not adopting these standards could be greater. Prior to May 1978, only guidelines existed in this area. Since these did not have the force and effect of law, compliance was poor. Approximately 38 facilities statewide were condemnable. Compliance is now good, but it is likely that compliance would decrease if the rules were not adopted. Additionally, without the rules the DOC could not meet the legislative intent of Minnesota Statute § 241.021. Consequently, these proposed rule amendments are crafted to meet what is required by law, rather than also what might be desired. This approach by the DOC and the 2911 review committee makes the best use of increasingly limited fiscal resources, and these amendments are the alternative which best addresses this distinction between required and desired.[67]

3. Department consultation and stakeholder engagement.

The department consulted with the Minnesota Sheriffs' Association, jail administrators, and jail health-care staff to discuss the rule and analyze whether the proposed amendments would help the department continue to ensure performance-based rules.

Additionally, the department established two advisory committees, in 2022 and 2024-25, to review the rule draft and recommend changes. These advisory committees were important for the department to gather perspectives on the rule from members of the public and criminal-justice organizations, some of which have federal authority to monitor jails for compliance with federal law.

Because correctional officers and jail administrators aren't health-care experts, the department met with health-care staff from jails and the Correctional Health Division of the Minnesota Sheriffs' Association. This consultation helped the department draft accurate and reasonable rules on correctional health care.

[67] Minnesota Department of Corrections, *Statement of Need and Reasonableness* (April 2013), 6.

Table 3. 2024-25 Advisory Committee

Name	Position	Organization
Pat Eliasen	Cook County Sheriff	Minnesota Sheriffs' Association
Shawn Larsen	Morrison County Sheriff	Minnesota Sheriffs' Association
Pat O'Malley	Wright County Jail Administrator	Minnesota Sheriffs' Association
Andrew Larson	Executive Director	Tri-County Community Corrections
Rick Hodsdon	Legal Counsel	Minnesota Sheriffs' Association
Steve Schmitt	Meeker County Commissioner	Association of Minnesota Counties
Stacy Tufto	Lac qui Parle County Commissioner	Association of Minnesota Counties
Margaret Zadra	Ombudsperson	Ombuds for Corrections
Linus Chan	Director	Detainee Rights Clinic, University of Minnesota
Elliot Butay	Criminal Justice Coordinator	NAMI Minnesota
David Dively and Linda Wolford	Executive Director and Government Relations Director	Minnesota Council on Disability
Eren Sutherland	Supervising Attorney / Monitoring & Investigations	Minnesota Disability Law Center
Brett W. Huber, Sr.	Impacted Family	Business Owner and Former Alaskan State Employee
Michele Garnett McKenzie	Deputy Director	The Advocates for Human Rights

Name	Position	Organization
Guadalupe Lopez	Executive Director	Violence Free Minnesota

When developing the proposed rule changes, the department encouraged its stakeholders to submit comments and encouraged public participation by sharing drafts with the public and soliciting feedback from affected stakeholders and members of the public.

Specifically, the department did the following stakeholder engagement (this is a nonexclusive list):

a) regular communications and updates through the department's rulemaking subscriptions lists;
b) six public advisory committee meetings in 2022, and eight public advisory committee meetings in 2024 and 2025;
c) additional meetings with jail administrators, the Minnesota Sheriffs' Association, and advisory-committee members
d) regular consultation with Tribal Nations through communications by the department's Director of Tribal Relations, written and oral reports at the quarterly meetings of the Minnesota Indian Affairs Council, and a November 2024 presentation at the Weekly Tribal Leader Governor's Office Meeting;
e) presentations in 2024 and 2025 at meetings of the Office of Addiction and Recovery and the Governor's Advisory Council on Opioids, Substance Use, and Addiction;
f) targeted consultation with the Departments of Health and Human Services on provisions relating to substance use disorder and mental health; and
g) additional meetings with advisory committee members, jail staff, and correctional health-care staff.

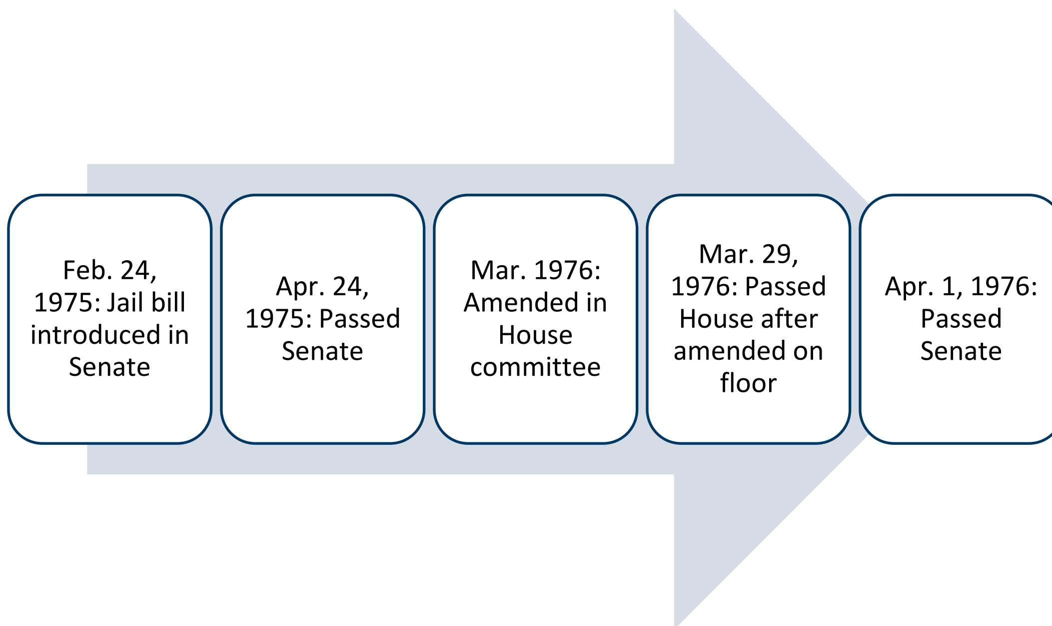
The department wants to highlight an additional point on the advisory committee by discussing the legislative history of jail regulation. When the original senate bill seeking to regulate jails was introduced in 1975, the bill proposed an advisory committee consisting of the department, the Minnesota Sheriffs' Association, and the Association of Minnesota Counties. This advisory committee was tasked with drafting the original rule.

But after the bill was passed off the senate floor and referred to the house, the chair of the Crime Prevention and Corrections Committee (Representative Donald Moe), tried to replace the composition of the advisory committee with

what ended up originally passing: a nine-member committee of sheriffs and county commissioners.

Chair Moe's initial attempt in the house committee failed, and the senate version was amended to include the following composition: "representatives of the criminal justice system, including the Minnesota sheriff's association, the association of Minnesota counties, and county boards."

This composition remained until March 29, 1976, when the amended senate file failed to pass the house floor, 59-67. The bill was then reconsidered the same day after four floor amendments, one of which changed the advisory committee's composition.



The department discusses this legislative history because much of the original rules were crafted solely by county sheriffs and county commissioners, and much of the original rules remain intact today, almost 50 years since they were first adopted. To ensure a more balanced representation on its advisory committee for this fifth rule revision, the department sought to include representatives from criminal-justice organizations, as some house members had originally sought. The department believes that this balanced representation has resulted in greater stakeholder participation and, ultimately, a rule that accounts for all perspectives, not just those of the regulated entities.

Additional SONAR Requirements

1. Consulting with MMB on local government impact.

The department must consult with MMB to help evaluate the fiscal impact and benefits of the proposed rule on units of local governments.[68] To consult with MMB, the department sent MMB the SONAR and proposed rules to help it determine the impact and benefits of the proposed rule on units of local governments.

MMB assessed the overall fiscal impact of the rule but was unable to accurately estimate facility-specific impacts without investing significant time and resources.[69] A more thorough assessment would factor in such things as the size of a facility, supervision style, classification, location, and the individual population of the incarcerated people at each facility. MMB noted that several of the proposed rule changes would introduce new or increased costs for jails. For example, requirements to update or acquire additional equipment – such as two-way radio devices – and to maintain specific supplies, including emergency delivery kits, represents direct fiscal impacts. The need for expanded staff training, specifically for first aid and CPR, would also generate ongoing training expenses.

MMB further recognized jail facilities could experience increased costs tied to operational coverage, such as staffing levels and workloads. Additional financial impacts to jails may arise due to facility health care contracts for services and medical supplies like opioid antagonists. Generally, other increases could result in expanded requirements for nutrition services, including increased costs for contracts with dieticians or nutritionists, and potential changes in food item costs.

Overall, the rules are intended to establish minimum standards for the basic care of incarcerated individuals. Improvements to an incarcerated person's treatment and quality of life can support better outcomes upon release. When facilities meet well-defined expectations, they can reduce their risk of litigation and costly legal settlements stemming from unsafe conditions. MMB emphasized that the rule provides considerable flexibility for agencies in developing their own policies and procedures. While the rule may create an opportunity for fiscal benefits

[68] Minn. Stat. § 14.131.

[69] *See* Exhibit K1.

over time, it also allows jails to retain the option to request variances when specific requirements would create an excessive or burdensome impact.[70]

2. Cost of complying for small business or small city.

The department must determine if the cost of complying with the proposed rule in the first year after the rule is effective will exceed $25,000 for (a) a business that has less than 50 full-time employees, or (b) a statutory or home rule charter city that has less than ten full-time employees.[71]

The cost of complying with the proposed rule will not exceed $25,000 for any business or statutory or home rule charter city because the rules affect county and regional jails, not municipal lockups.[72]

3. Determining whether the rules require local implementation.

The department must determine if a local government will be required to adopt or amend an ordinance or other regulation to comply with the department's proposed rule.[73] The department has determined that the proposed rule does not affect local ordinances or regulations. Jails are regulated by the department, and any relevant local food, fire, or other ordinance isn't affected by the proposed rule.

4. Impact on farming operations.

The proposed rule does not affect farming operations.

5. Witness list.

The department anticipates the following agency and nonagency witnesses will testify at the hearing:

- Paul Schnell, Commissioner
- Mike Garland, Inspector General
- Kristi Strang, Director of Inspections and Enforcement
- Amy Lauricella, Policy and Rulemaking Director
- Tara Rathman, Rulemaking Manager

[70] *See* Exhibit K1.
[71] Minn. Stat. § 14.127.
[72] The department licenses municipal lockups under Minnesota Rules, chapter 2945.
[73] Minn. Stat. § 14.128.

Additional Notice Plan

The department's Additional Notice Plan gives notice to persons or classes of persons that may be affected by the proposed rules. The department will email the rules, SONAR, and Notice of Intent to Adopt Rules to the legislature and everyone registered on the department's rulemaking list.[74] The department did not notify the commissioner of agriculture because the rules do not affect farming operations.

The proposed rules, SONAR, and other notices will be published on the department's rulemaking web page. Additionally, an announcement about the rules will be posted on the home page of the department's website.

The department's Additional Notice Plan complies with the APA because the department will publish notice of the proposed rules and SONAR in the *State Register* and will email copies of the notice, proposed rules, and SONAR to the department's rulemaking list and the following groups:

1) all members of its 2024-25 advisory committee;
2) all jail administrators and sheriffs operating a licensed jail;
3) the Minnesota Sheriffs' Association, including its Correctional Health Division;
4) the Association of Minnesota Counties;
5) all county boards;
6) the State Public Defender for Minnesota and the Minnesota Chief Appellate Public Defender;
7) the Minnesota County Attorneys Association;
8) the Office of the Ombuds for Corrections;
9) the Minnesota Departments of Health and Human Services;
10) Minnesota Direct Care and Treatment;
11) the Minnesota Office of Addiction and Recovery and the Governor's Advisory Council on Opioids, Substance Use, and Addiction;
12) the Local Public Health Association of Minnesota;
13) the Minnesota Social Service Association;

[74] *See id.* §§ 14.14, subd. 1a(a), .116(b).

14) the Minnesota Association of County Social Service Administrators;
15) Advanced Correctional Healthcare, Inc.;
16) NAMI Minnesota;
17) Minnesota Disability Law Center;
18) Minnesota Council on Disability;
19) The Advocates for Human Rights;
20) Detainee Rights Clinic, University of Minnesota; and
21) Violence Free Minnesota.

Rule-By-Rule Analysis

1. Each proposed rule requirement must be needed and reasonable.

The most critical requirement of the SONAR is the rule-by-rule analysis, which explains the department's reasoning behind every proposed rule requirement. For each proposed rule requirement, the department must explain two key elements: why the rule is (1) needed, and (2) reasonable.

A rule is reasonable if it is based on an affirmative presentation of facts and evidence that rationally connect with the department's proposed regulatory choice. The department's proposed regulatory choice does not need to be the "best," but the proposed choice must be one that a rational person could have made and one that is not arbitrary or otherwise devoid of articulated reasons.

2. The rule-by-rule analysis is organized in numerical order of chapter 2911, divided into multiple categories.

At the beginning of each category, the department establishes a general overview of the need for the rule amendments within the category. This overview is meant to better inform the public about the requirements in each category and helps establish—on the record—the department's argument for adopting the proposed rules.

Table 4. Rule-by-rule analysis

Category	Rule Parts
Definitions	2911.0200
Incorporations by Reference	2911.0210
Intended Use and Corrective-Action Plans	2911.0300
Facility Self-Audit	2911.0310
Variances	2911.0400
Staffing Requirements	2911.0900
Training	2911.1000 to 2911.1600
Policy and Procedure Manual; Records	2911.1900 to 2911.2400
Admissions	2911.2525
Discharges	2911.2550 to 2911.2560
Information to Inmates	2911.2700

Category	Rule Parts
Separation and Segregation	2911.2790 to 2911.2880
Programming and Visitation	2911.3100 to 2911.3500
Uniform and Bedding	2911.3650
Emergencies or Unusual Occurrences	2911.3700
Food	2911.3900 to 2911.4800
Response to Resistance and Post Orders	2911.4950 to 2911.5000
Well-being Checks	2911.5010 to 2911.5020
Health Care	2911.5800
Substance-Use Disorders	2911.5810 – 2911.5820
Mental-Health Care	2911.5830 to 2911.5850
Additional Health Care	2911.6000 to 2911.6800
Inmates with Special Needs	2911.7100

Last, the department discusses a detailed rule-by-rule analysis within each rule chapter, arguing for the need and reasonableness of each rule amendment.

Introduction and Definitions (2911.0100 to 2911.0200)

In part 2911.0100, the department clarifies that the rule chapter doesn't apply to the department's state correctional facilities, even though the department has never applied this rule chapter to its facilities and because the APA specifically exempts department facilities from rulemaking.[75] This change makes explicit that the chapter governs local, rather than state, correctional facilities, as recent litigation against the department has sought to extend its provisions to state correctional facilities.

The rest of this section argues for the need and reasonableness of department amendments to definitions used in the rule chapter. Definitions are important in legal drafting because they direct how agencies, regulated entities, and courts must interpret terms used in an agency's administrative rules.

To this end, the department briefly highlights how courts generally interpret words using canons of construction, which are principles that courts use to interpret law.

One category of canons known as semantic canons governs the meaning of words. Semantic canons are instructive because they explain how to interpret language in a legal document—the foundational starting point for legal interpretation. For example, one semantic canon explains how words in legal documents are generally understood in their ordinary, everyday meaning. This canon is "the most fundamental semantic rule of interpretation,"[76] and has been directly expressed by the Minnesota Legislature.[77]

So when the department uses terms such as *stop* or *distress*, a reasonable person would understand that these words have their ordinary meanings, especially *within* the context of an entire sentence, paragraph, or document.[78] This is why agencies or legislatures need not define every word they use when writing law.

[75] Minn. Stat. § 14.03, subd. 3(b)(1); *see also* Minn. R. 2911.0200, subp. 35 (defining *facility*).
[76] Antonin Scalia and Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* (St. Paul: Thomson/West, 2012), 69.
[77] *See* Minn. Stat. § 645.08(1): "Words and phrases are construed according to rules of grammar and according to their common and approved usage . . ."
[78] *State v. Henderson*, 907 N.W.2d 623, 626 (Minn. 2018): "The meaning of a word depends on how it is being used in the context of the statute."

Context is also critical. For instance, another canon instructs that a text, whether an entire statute, section, or sentence, must be construed as a whole, with context as "a primary determinant of meaning."[79] This fundamental need to "harmonize and give effect" to all of a law's parts has been well-recognized by the Minnesota Supreme Court;[80] similarly, associated words bear on one another's meaning.[81] Accordingly, one cannot pluck a word out of its context.

Within this background on canons of construction, the department proposes to amend or add definitions for clarity and guidance. Unless otherwise noted, the terms in this part are rewritten in plain language, for internal consistency, or for grammatical changes.

1. Subpart 2 (administrative separation).

Jails use administrative separation to help safely manage their incarcerated population. The term *segregation* is changed to *separation* to more accurately reflect the term's use, as administrative separation is not solitary confinement. Instead, it is a tool that jails use to protect all incarcerated people and to ensure the jail's security and that of the public.

Because administrative separation involves separating an incarcerated person from general population, this separation should be used only when it is the least restrictive option available. In most cases, "restrictive" refers to physical separation such as placing an incarcerated person in another housing unit.

In some cases, administrative separation will be the *only* option jails have to separate people for safety or security concerns, but every jail and situation requiring administrative separation is different.

The safety or security reasons for separation are described under items A and B. Item A adds new language to reflect that a person may need to be separated for a gang-related reason or because of some other criminal activity that threatens other incarcerated people or the jail's security. This new language is needed to

[79] Scalia and Garner, *Reading Law*, 167; *see also United States Sav. Ass'n v. Timbers of Inwood Forest Assocs.*, 484 U.S. 365, 371 (1988): "A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme-because the same terminology is used elsewhere in a context that makes its meaning clear."
[80] *Jackson v. Mortg. Elec. Registration Sys., Inc.*, 770 N.W.2d 487, 496 (Minn. 2009), citing *In re UnitedHealth Group Inc.*, 754 N.W.2d 544, 563 (Minn. 2008).
[81] This is the associated-words canon. *See, e.g., State v. Robinson*, 921 N.W.2d 755, 759 (Minn. 2019) (examining how the phrase "significant romantic or sexual relationship" "must be read in the context of its surrounding language).

reflect situations when a person must be separated because they pose a public-safety risk—for example, a gang leader's actions could pose a risk to other incarcerated people through possible assaults or by planning to bring contraband such as fentanyl into the facility.

Item B is added to reflect that a person may be placed into administrative separation because of an associated health or safety reason—this is an amended version of the stricken language in item A referring to "an inmate with a mental illness or a developmental disability who is in need of special care."

Because each jail manages administrative separation differently, the department—like other states—cannot comprehensively prescribe the conditions of administrative separation, especially substantive requirements that don't belong in a defined term. These substantive requirements on administrative separation are specified under parts 2911.2790 to 2911.2880.

This definition is also separated into items for structure and readability.

2. Subpart 5a (annual).

This subpart establishes that annual means every 12 months as opposed to a calendar or fiscal year. Both current and proposed rule requirements have various standards relating to annual reviews such as requiring a jail to annually review its policies and procedures. Accordingly, this term is needed to provide consistent guidance to jails and to ensure consistent enforcement.

3. Subpart 5b (assessment for substance-use disorder).

This definition is needed because of the department's proposed rules on the clinical management of substance-use disorders. While a licensed medical provider would diagnose a substance-use disorder, health-care staff such as a registered nurse could assess an incarcerated person to determine any care needed to treat or manage the person's withdrawal symptoms.

Page 209 provides additional context on substance-use-disorder treatment and the use of medication for opioid-use disorder.

4. Subpart 7 (booking).

This subpart is repealed because it's superfluous with the existing terms of *admission* and *intake*.

5. Subpart 8a (care).

Some advisory-committee members requested that the department define *treatment*; while this term was used in previous rule drafts (and current rule), the

department chose to use *care* on the advice of jail staff and jail administrators (*care* is also currently used in the rule).[82]

Except for treatment for substance-use disorders, jails aren't medical facilities capable of providing medical treatment. Regardless, the proposed term identifies the medical care that jails should provide to incarcerated people—and which incarcerated people are constitutionally entitled to—and is aligned with current practice.

6. Subpart 17 (classification).

Subpart 17 makes grammatical and technical changes.

7. Subpart 19a (community-based provider).

This definition is needed because of the department's proposed rules on mental health and the clinical management of substance-use disorders. Under the proposed rules, a jail may contract with a community-based provider to provide mental-health care or care relating to substance withdrawal and substance-use disorders.

8. Subpart 23 (controlled substance).

This term is repealed and replaced with *substance*.

9. Subpart 24 (crowded facility).

This subpart is repealed because it refers to a jail's operational capacity, and the department is repealing requirements on operational capacity in part 2911.0360.

10. Subpart 26 (custody staff).

This term replaces *personnel* with *staff* to make the term consistent with other department proposed changes.

11. Subpart 26a (daily).

This subpart clarifies that *day* means a calendar day, as opposed to a business or working day. The current and proposed rule has various requirements that refer to a day, so this definition is needed for uniform guidance and consistent enforcement.

12. Subpart 29 (disciplinary segregation).

This term is structured into items for readability, with technical changes to clarify the term in relation to the associated rule requirements. For example, item A

[82] *See, e.g.,* Minn. R. 2911.5800, subp. 11, .6200, subp. 1a(B). Treatment, however, is also used in other contexts. *See, e.g.,* Minn. R. 2911.0200, subp. 48, .1500(C).

clarifies that a person may be placed in disciplinary segregation for violating a law while incarcerated, and item B reflects how disciplinary segregation may be needed to protect staff or other persons from an incarcerated person's assaultive behavior.

13. Subpart 29a (DOC Portal).

This term is a shorthand reference to the statutory requirement that the department maintain a detention information system;[83] the department refers to the DOC Portal in rule and is amending its relevant provision under part 2911.2400.

14. Subpart 29b (document).

This term is needed to reflect how most jails use electronic technology such as a jail-management system. The rule has many documentation provisions, so this term reflects current use.

15. Subpart 32a (emergency medication).

This term must be defined because it is used in proposed parts on psychiatric emergencies and involuntary medication administration. The proposed term reflects the rare use of psychotropic medication in jails such as when an incarcerated person's behavior presents imminent harm to others.

16. Subpart 36 (facility administrator).

This subpart is amended to include a facility administrator's designee as part of the definition. This amendment precludes the need to write "the facility administrator or a designee" every time the term is used in the rule.

17. Subpart 39 (health authority).

Subpart 39 is amended to streamline the definition. A health authority is the overarching provider and coordinator of a jail's medical services and "functions to ensure that health services are organized, adequate, and efficient."[84]

Depending on the jail, the health authority could be a licensed physician, a public health authority, or a private company such as Advanced Correctional Healthcare (see Appendix C for more details).

[83] *See* Minn. Stat. § 241.021, subd. 1(a): "The commissioner may require that any or all such information be provided through the Department of Corrections detention information system."

[84] National Commissioner on Correctional Health Care, *Standards for Health Services in Jails*, 5 (2018).

18. Subpart 40 (health care personnel).

This subpart is streamlined to avoid inadvertently limiting who is considered health-care staff covered under all possible licenses or certifications. Statute and state health-licensing boards govern the specifics of the care that a person can lawfully provide under their licensure or certification.

The revisor's office will editorially change this term to "health care staff," which is consistent with both existing and proposed requirements referring to a jail's employees.

19. Subpart 40a (health record).

This subpart clarifies that an incarcerated person's health record includes all of their health care, including dental and mental-health care.

20. Subpart 41 (health-trained staff).

Health-trained staff are essentially treated as custody staff under the rule. This amendment clarifies this and further provides that any assistance that custody staff provide to health-care staff must be done according to the custody staff's training and experience and to any explicit instructions from health-care staff or the health authority.

21. Subpart 52 (limited-use agreement)

This subpart is repealed because the term isn't used in the rule chapter.

22. Subpart 54a (medical emergency).

This new term is needed because of the department's proposed revisions on psychiatric emergencies and involuntary medication administration. The definition is tied to the definition of *emergency care* (*see* unamended subpart 32).

23. Subpart 55a (mental-health professional).

The department defines this term to provide clarity for this subset of health-care staff and for guidance on the department's proposed requirements on mental-health care. The department cross-references to the state's Mental Health Uniform Service Standards Act[85] and identifies the types of mental-health staff that jails may employ or contract with, depending on the scope of services provided in the facility. These include licensed mental-health professionals,

[85] Minn. Stat. §§ 245I.01-.23.

mental-health practitioners, clinical trainees, and certified rehabilitation specialists.

24. Subpart 55b (mental illness).

Because of the statutory directive and the department's proposed rule requirements on mental illness, the department finds it needed and reasonable to define this term. On the suggestion of the National Alliance of Mental Illness, the department cross-references to the definition of mental illness under the Minnesota Comprehensive Adult Mental Health Act.[86]

This cross-reference is consistent with statutory requirements on discharge planning.[87]

25. Subpart 55c (mental-status exam).

This is a needed term to explain the basic level of mental-health care provided to an incarcerated person. A mental-status exam is like a general health-care checkup, where a mental-health professional evaluates a person's reported and observed symptoms:

> The widely accepted approach to mental status examination addresses areas where medical information is gathered from a clinical interview to determine the patient's mental status. This approach is used to identify, diagnose, and monitor signs and symptoms of mental illness. Each component of the mental status examination is designed to assess different areas of mental function, aiming to capture the objective and subjective aspects of mental illness.[88]

After consulting with various correctional mental-health staff, the department determined that a mental-status exam reflects current practice in jails and is more practical (for jails) than other types of mental-health examinations.

26. Subpart 56c (monthly).

As with the newly defined terms of *annual* and *day*, this term is needed to clearly establish how to a count a month as it relates to rule requirements.

[86] *Id.* §§ 245.461-.486.

[87] *Id.* § 641.155, subd. 2.

[88] Rachel M. Voss and Joe M. Das, "Mental status examination," *StatPearls*, April 30, 2024, https://www.ncbi.nlm.nih.gov/books/NBK546682/ (accessed July 10, 2025).

27. Subpart 56d (opiate antagonist).

This definition is needed because of proposed requirements on substance-use disorder and the prevalence of people incarcerated with an opioid-use disorder. A statutory cross-reference is efficient and reasonable.

28. Subpart 58a (prescription medication).

Subpart 58a is amended to remove a quoted statement that appears on a prescribed medication. This statement has changed and may change again, so it's reasonable to paraphrase what the statement may say and prevent the term from becoming obsolete.

29. Subpart 60 (responsible practitioner).

Subpart 60 has two changes. First, it changes the inaccurate term from responsible physician to responsible practitioner. The latter is more accurate because the term includes not only a physician but also other health-care professionals that may constitute a jail's medical provider.

Second, the three additional licensed professionals are clearly stated and replace the previous language of "an individual licensed to practice medicine."

30. Subpart 60a (resources).

The department defines this term to eliminate any potential ambiguity on the term used in the current and proposed rule. Because a jail is most affected by its funding, staffing, and design, the department includes these factors in the definition. This definition is also needed to reflect the differences among jails, as affected by these three factors, and how the factors may limit a jail's compliance with certain proposed requirements.

31. Subpart 65a (segregation area).

Plain-language, clarifying, and conforming changes are made to this definition.

32. Subpart 65d (signature).

This definition is needed to clarify that a signature can be electronic, in addition to a physical signature. This definition conforms with other proposed department changes on electronic documentation.

33. Subpart 67 (inmate with special needs).

This definition is revised to remove the vague *special handling* and to align the definition with the ACA.[89] This definition was discussed at several advisory-committee meetings and was subsequently revised. While some people may note that the definition excludes people who may simply be vulnerable in a correctional setting, administrative separation covers this population, and classification also allows for including vulnerable people.[90] Another important change to this definition is the inclusion of vulnerable adults as defined by statute. This distinction clarifies the difference between those considered vulnerable due to their environment and those vulnerable for statutory reasons.

While the department acknowledges that the terminology itself may be stigmatizing, the term is used in the correctional field, including by NCCHC. Jail staff do not walk around the jail calling people "special needs." Rather, the term is used throughout the rule to guide classification and standards on managing a person's care while incarcerated. Other terms such as *special management area* and *special management inmate* reflect how the adjective "special" is used in other contexts.

The definition is also distinct from *individual with a disability* defined under subpart 45; this definition is narrower than special needs inmate. If organizations such as the ACA, NIC, and NCCHC transition to a different term, the department will consider changing the term in a future rulemaking.

34. Subpart 67a (step-down management).

Step-down management is a correctional practice for transitioning an incarcerated person from restrictive housing such as disciplinary segregation to a less-restrictive setting.[91] In other words, step-down management "gives persons an opportunity to enhance and demonstrate their readiness to return to general population."[92]

[89] The ACA *Performance-Based Standards* defines special needs as a "mental and/or physical condition that requires accommodations or arrangements differing from those a general population offender or juvenile normally would receive." American Correctional Association, *Performance-Based Standards and Expected Practices for Adult Local Detention Facilities*, in cooperation with the Commissioner for Accreditation on Corrections (5th. ed. May 2023).
[90] Minn. R. 2911.2600, subp. 1(I).
[91] *Performance-Based Standards*, 5-ALDF-2F-23; DOC Policy 301.088.
[92] DOC Policy 301.088.

Disciplinary segregation—or solitary confinement—can cause significant health and safety issues for an incarcerated person. Not all jails will have step-down management, but for jails that do, they can tailor their procedures according to their resources.

35. Subparts 68a, 68b, and 68c (substance-related definitions).

These subparts cross-reference to the statutory chapter for health-care facilities that provide substance-use-disorder treatment; because these terms have already been defined, it's efficient to cross-reference to them and use them for the department's proposed language on medical screenings, substance withdrawal, and substance use disorder treatment.

36. Subpart 69 (substantially conform).

This term is repealed because of proposed revisions to part 2911.0300.

37. Subpart 70a (support staff).

This proposed term reflects the current use of the term in rule.[93]

38. Subpart 70b (telehealth).

This definition is needed because of proposed requirements on telehealth. A statutory cross-reference is efficient and reasonable, and the department cites to the 2024 edition of *Minnesota Statutes* because of a temporary change to the definition made in a 2025 session law.[94]

39. Subpart 70c (under the direction of).

This term is needed to clarify that health-trained staff—that is, custody staff—must follow a facility's health-care-related policies and procedures and instructions from health-care staff when providing health-care services such as monitoring for withdrawal, delivering medications, or conducting an incarcerated person's medical screenings upon admission.

40. Subpart 73 (weekly).

As with the newly defined terms of annual and day, this term is needed to clearly establish how to count a week as it relates to rule requirements.

41. Subpart 74 (well-being check).

This term is needed to define what constitutes a well-being check, which is a foundational practice for correctional facilities. The term is also needed to

[93] *See* Minn. R. 2911.0900, subp. 25.

[94] 2025 Minn. Laws, 1st SS ch. 3, art. 8, sec. 9.

comply with the legislature's directive to establish a minimum standard for well-being checks.

The purpose of a well-being check is to ensure the safety of an incarcerated person and the security of all jail inhabitants. It's reasonable for custody staff to directly and physically observe an incarcerated person to verify signs of life—such as chest movement—or to detect visible or audible signs of distress. If a person is in distress, custody staff can then take necessary and appropriate action.

As with the general requirements on well-being checks (*see* page 156), this definition received much discussion in the 2022 and 2024 advisory-committee meetings and in department discussions with jail administrators. Even before this current rulemaking effort, previous department attempts to add this definition resulted in concerns from jail staff.

In the advisory-committee meetings, some members wanted the definition to refer to breathing, skin, or movement. While the department respects these comments, the department finds that its proposed definition is one that jails can follow and that it is broad enough to account for proposals from advisory-committee members suggesting that custody staff should observe breathing or other signs of life.

For example, the proposed definition reflects how some jails currently train their staff, as in Beltrami County, where trained custody staff are trained to "look for signs of distress, self-harm, or harm to others"[95] and to "check for duress."[96] And the department commonly refers to distress in its inspection reports on well-being checks:

> Camera review of twelve well-being checks found five rounds contained checks to be completed at a pace that was too fast to be regarded as a well-being check. *Signs of life such as movement, rise and fall of chest and other signs of life would be difficult to determine at such a quick pace*. A review of past inspections shows facility inspector noted concerns about well-being checks in every facility inspection dating back to 2016. The reoccurring complaint is that checks are being performed at a pace that is too fast or checks exceed 30 minutes.[97]

[95] *Morrison as Trustee for May v. Beltrami County*, Civ. No. 19-1107 (JRT/LIB), 2022 WL 2442363 (D. Minn. July 5, 2022), at 4.
[96] *Id.*
[97] https://mn.gov/doc/assets/Aitkin%20County%20Jail%202022_tcm1089-613470.pdf (emphasis added).

In addition to language on what to observe, other advisory committee members wanted the department to establish standards on the pace of a well-being check. But since well-being-check requirements were first adopted, what constitutes the appropriate pace hasn't been defined in rule.

Prescribing standards on pace in rule is impractical because each well-being check is different, and custody staff may perform hundreds of checks each day. An incarcerated person sitting in a dayroom may not need the same level of observation to confirm signs of visible distress as someone suffering from acute withdrawal in their cell at night. So to reasonably define pace is not only impractical but potentially dangerous as well.

The goal of a well-being check *is well-being*, and the department cannot reasonably dictate an appropriate pace in rule to account for every person incarcerated in a jail and every potential scenario.

Overall, the department finds that its definition, when read together with parts 2911.5010 to 2911.5025, is needed and reasonable.

42. Subpart 75 (withdrawal management).

This definition is needed because of proposed requirements on withdrawal management and the need for jails to provide medical care to assist people in safely withdrawing from alcohol or other substances.

Incorporations by Reference (2911.0210)

Under the APA, state agencies may incorporate by reference into their rules the text from publications and documents that are determined by the revisor of statutes to be conveniently available to the public.[98] An agency may choose to incorporate a document by reference for several reasons:

1. **Accuracy.** A manual, guideline, or similar publication may already sufficiently detail what the agency would otherwise write into a rule.
2. **Economy.** If an agency determines that an incorporation by reference is appropriate, it's more efficient to incorporate a document so that when the document changes, the agency need not have to amend the rule and go through the rulemaking process solely to update unincorporated standards.
3. **Efficiency.** An agency may find it more efficient to justify federal publications or publications from trade groups than to justify each requirement in rule that is based on other publications.

The legislature has detailed minimal requirements that an agency must follow when incorporating documents by reference:

> The statement of incorporation by reference must include the words 'incorporated by reference'; must identify by title, author, publisher, and date of publication the standard or material to be incorporated; must state whether the material is subject to frequent change; and must contain a statement of availability.[99]

Sometimes, agencies incorporate their own publications by reference. For example, in 2021, the Office of Higher Education incorporated its SELF Loan Program Manual by reference.[100] And in 2023, the Department of Transportation incorporated its Minnesota Vehicle Requirements for Special Transportation Services and Limousines by reference.[101]

[98] *See* Minn. Stat. § 14.07, subd. 4.
[99] *Id.*
[100] OAH 60-9031-37587, *In the Matter of the Proposed Rules of the Minnesota Office of Higher Education Governing Supplemental Student Loans, Minnesota Rules Chapter 4850* (September 28, 2021).
[101] OAH 71-9037-38819, *In the Matter of the Proposed Rules of the Department of Transportation Governing Special Transportation Service, Minnesota Rules, Chapter 8840* (April 28, 2023).

CAH has frequently approved an agency's ability to incorporate documents by reference[102] and has cited agencies that have failed to comply with the statutory requirements.[103] The department's proposed incorporations by reference are both needed and reasonable because they provide accurate guidance to jails and the public. The incorporations ensure that facilities are following national correctional standards. Additionally, proposed rule requirements have been based on guidance from these publications:

- **US Departments of Agriculture and Health and Human Services, "Dietary Guidelines for Americans, 2020-2025."**

A licensed dietitian or nutritionist must ensure that food served in a jail complies with federal dietary guidelines for a balanced diet, including Daily Reference Intakes. Existing rule language was based off the 2005 MyPyramid guidelines and 2022 Dietary Reference Intakes.

Location: Part 2911.3900.

- **Department of Corrections, "DOC Portal Unusual Occurrences."**

Facilities must report emergencies or unusual occurrences listed in rule to the department's detention information system, known as the DOC Portal. Currently, the DOC Portal lists the reportable incidents in accordance with the rule chapter.

Location: Part 2911.3700, subpart 4.

- **Substance Abuse and Mental Health Services Administration, "SAMSHA Opioid Overdose Prevention Toolkit."**

This toolkit provides guidance on preventing and responding to an overdose, including medications for reversing opioid overdoses. Compliance with this incorporation is optional.

Location: Part 2911.1300, subpart 2.

- **National Commission on Correctional Health Care, "Standards for Health Services in Jails."**

This publication is the authoritative resource for correctional health-care services and reflects the latest evidence and best practices in meeting professional, legal,

[102] OAH 15-1904-22598-1, *In The Matter of the Adoption of Rules Adopting Plumber Licensing, Certifications, Registration, and Continuing Education* (April 19, 2012), 3.
[103] *See* OAH 71-9037-38819; OAH 11-2200-31142, *In the Matter of the Proposed Rules of the Minnesota Pollution Control Agency Governing Compost Facilities, Minnesota Rules Chapters 7001 and 7035* (June 16, 2014).

and ethical requirements in delivering health-care services in correctional settings. Compliance with this incorporation is optional.

Location: Part 2911.5800, subpart 6.

In previous rule drafts, the department had proposed incorporating the following documents:

- American Correctional Association, *Core Jail Standards*.
- American Society of Addiction Medicine, "Appropriate Use of Drug Testing in Clinical Addiction Medicine."
- Bureau of Justice Assistance and National Institute of Corrections, *Guidelines for Managing Substance Withdrawal in Jails*.
- National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations*.
- National Sheriffs' Association and National Commission on Correctional Health Care, *Jail-Based Medication-Assisted Treatment*.
- Substance Abuse and Mental Health Services Administration, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*.

Jail administrators and sheriffs were concerned about so many incorporations and the difficulties they would have in following them. In response to these concerns and the general rule-writing process, the department was able to remove these documents while still meetings its goal of improving the standards of confinement for incarcerated people with substance-use disorders.

While the department still proposes several incorporations by reference, the department finds that they are limited in how they are used in the rule, including a couple of standards that are discretionary, not mandatory.

Intended Use and Corrective-Action Plans (2911.0300)

This part is updated to reflect 2021 legislative changes to the department's licensing sanctions and to codify the department's inspection practice of corrective-action plans.

1. Subpart 1 (intended use).

Lettered items are added to organize the subpart, and technical changes are made to clarify language. Language in item C is stricken because subpart 5a is being repealed.

2. Subpart 2 (restricted use).

Language on condemnation proceedings is stricken because the department doesn't use condemnation proceedings. The statutory cross-reference is updated to reflect the 2021 legislative changes that amended the department's sanctioning authority, which permits the department to take licensing actions against a jail -including issuing a limited license to effectuate a facility closure - if specific conditions would endanger the security, safety or health of inmates and staff.

3. Subpart 4 (corrective-action plans).

Because of the 2021 legislative changes, the department's sanctioning framework in rule is obsolete. Accordingly, the department proposes to strike the existing language and replace it with the department's long-standing inspection process for its licensed facilities and certified programs: corrective-action plans.

After the department inspects a facility, the department issues a publicly available inspection report. Depending on the inspection, the inspection report may include a corrective-action plan. A corrective-action plan is used as the first option to correct a rule violation, unless other considerations are present.

The department has developed a grid—consistent with the department's statutory sanctioning framework—that indicates when the department will issue a corrective-action plan.

Table 5. Framework for issuing corrective-action plans

Is there an imminent risk of life-threatening harm or serious physical injury to incarcerated people?	Does the facility substantially conform to minimum standards?	Is the facility making satisfactory progress toward substantial conformance?	Licensing action
No	Yes	Yes	Corrective-action plan
No	Yes	No	Corrective-action plan
No	No	Yes	Corrective-action plan

Because a corrective-action plan closely mirrors a correction order under statute, the requirements for a corrective-action plan mirror the statutory requirements for a correction order, as proposed in item B.[104] This proposed language is also consistent with the department's recently adopted rule under chapter 2955.[105]

Corrective-action plans aren't appealable because the department isn't taking action against a jail's license such as by revoking or suspending it. When a jail corrects a rule violation and complies with the corrective-action plan, the correction is publicly available on the department's website.

Item C allows for the department to ensure compliance with any issued corrective-action plan, as a jail's failure to comply with a corrective-action plan may, depending on the violation, be grounds for the department to revoke or suspend the jail's license. This revocation or suspension is appealable under statute (item D cross-references to the statutory sanctioning framework).

[104] *See* Minn. Stat. § 241.021, subd. 1a(a): A correction order must state the standards violated, the findings that constitute a violation, the corrective action needed, and the time to correct each violation.

[105] *See* CAH 22-9051-40735, *In the Matter of Proposed Permanent Rules Relating to Residential Treatment Programs for Individuals Who Have Engaged or Attempted to Engage in Sexually Abusive Behavior* (September 17, 2025).

4. Subparts 5a and 6 (repealed).

4.1. Subpart 5a (rule compliance).

Currently, subpart 5 differentiates between "mandatory" and "essential" rules, where the department requires a facility to comply with 100% of listed rules (mandatory) but only 90% of other listed rules (essential). This is confusing. How should the department calculate compliance with 90% of a rule? And why should a jail be able to pick and choose which health, safety, or security requirements to ignore? In fact, this similar regulatory scheme was cited as a legal defect in the department's 2015 rules on municipal lockups.[106]

Additionally, it's reasonable for a jail, like any other regulated entity, to comply with an agency's entire rule chapter (unless otherwise provided in the rule). A jail can still apply for a variance, and making every requirement mandatory is simpler for jails to follow and for the department to consistently enforce.

4.2. Subpart 6 (appeals).

This subpart is no longer needed or reasonable because of other changes to this part and the department's statutory sanctioning authority. Because corrective-action plans aren't appealable, striking this subpart is reasonable and consistent with the department's recently adopted 2955 rule.

[106] OAH 8-1100-31784, *In the Matter of the Proposed Rules of the Department of Corrections Governing Municipal Lockup Facilities* (December 22, 2014).

Self-Audit (2911.0310)

A jail administrator should identify and address deficiencies in the jail before they result in department licensing actions, lead to a serious health or safety risk, or rise to constitutional violations. Furthermore, jail administrators "have an affirmative duty to be proactive and take the measures necessary to achieve this mission."[107]

One way for a jail administrator to be proactive and guard against litigation risks is to complete a self-audit process:

> Compliance with . . . standards demonstrates a commitment to professionalism on the part of local officials and can significantly reduce the liability exposure of local government to jail litigation by identifying and correcting deficiencies.[108]

While the department believes that self-audits are important, jail administrators questioned the need for requiring self-audits in rule and why these audits must be done annually. Yet these may be reasonable concerns, the department believes that its proposed language is needed and reasonable after responding to the concerns and consequently revising language. For example, the department had initially proposed requiring a jail administrator to conduct self-audits every six months and to gather feedback from staff and incarcerated people.[109]

With the proposed language, the department intends for jails to proactively review their compliance with the rule chapter using department-provided checklists. These checklists are the same lists that its inspectors use when inspecting jails, and the department has previously provided these checklists to jails.

It would be impractical and unduly cumbersome for the department to include the checklist requirements in rule when the language states that the checklists "reflect inspection and policy requirements" in the rule chapter.

While self-audit instruments exist,[110] the department wants the checklists to be uniform—this will allow inspectors to more efficiently check for compliance and

[107] Martin, *Jail Standards and Inspection Programs*, 2.
[108] Martin and Rosazza, *Resource Guide for Jail Administrators*, 14.
[109] *See* proposed rule draft RD4445 (August 3, 2022).
[110] Michael A. O'Toole et al., *Self-Audit Instrument for Administrators of Direct Supervision Jails* (National Institute of Corrections, June 2004). This checklist applies to only direct-supervision jails.

allow the department to discover rule requirements that may require additional department guidance (the department routinely provides guidance in quarterly newsletters and through technical assistance).

Ideally, a jail administrator would perform a self-audit before the jail's next scheduled inspection, but the department wants to give jails flexibility on when to conduct their self-audits.

The audits should be done annually—for jails on a biannual inspection status, this self-audit will be useful for them in the year that the department is not conducting an on-site inspection. And for jails on an annual status, a self-audit is still useful because usually a jail is on an annual inspection status because of citied deficiencies or a statutory licensing sanction.

Even though an annual self-audit is consistent with current rule that requires a jail administrator to review the jail's policies and procedures annually,[111] jails on a biannual inspection status question the need to conduct a self-audit in their non-inspection year. But as the department has argued, self-audits can be instrumental for jail administrators to ensure that their staff are following policies and procedures.

[111] Minn. R. 2911.1900: "This manual shall be made available to all employees, reviewed annually, updated as needed, and staff trained accordingly."

Variances and Emergencies (2911.0400)

A variance is a critical tool that allows a jail to request an exception to a rule requirement. Because some jails have two beds, and others have over 500 beds, the existing and proposed variance requirements provide jails flexibility from the rule when needed.

1. Subpart 1 (variances).

The changes to this subpart will provide flexibility to jails to seek exceptions to a rule requirement.[112]

Jail administrators request, and the department reviews, variances in the DOC Portal. But the current rule doesn't establish how a jail administrator can request a variance and any required information that they must provide in their variance request. This lack of fair notice is unreasonable and hinders the variance application and review process. The department seeks to correct these omitted standards by requiring a jail administrator to provide information about the variance request so that the department can review the request according to existing rule requirements in new item B.

In item A, the proposed language mirrors department variance procedures

(a) under the initial rule,[113]

(b) under the APA,[114]

(c) from another department rule chapter,[115] and

(d) from other agencies.[116]

Subitem (4) on protecting staff and incarcerated people is needed because the department currently evaluates this factor under the new item B.

Under the new item B, the department proposes to amend the 30-day review timeline because a department inspector may need to visit the jail to review the request, or a variance request may require a more-intensive review depending on what is requested.

[112] Minn. Stat. § 14.056, subd. 5.
[113] Corr. 103(A) (1978).
[114] Minn. Stat. § 14.056.
[115] *See* Minn. R. 2955.0070, subp. 1.
[116] *See, e.g.,* Minn. R. 4659.0080, subp. 1.

This 30-day increase is reasonable because the department recently changed this review timeline in its 2955 rule,[117] and it aligns with the APA's statutory review period for variances.

Existing items B and C are stricken because of the department's proposed changes under part 2911.0300 that require jails to comply with the entire rule chapter (see page 65).

2. Subparts 1a to 1c (renewing and revoking variances).

In addition to not providing jail administrators adequate guidance when applying for a variance, the rule also doesn't include standards on renewing variances or the department's ability to revoke a variance if a jail violates its variance conditions. Here, the 30-day requirement is needed to allow the department time to review a jail's current variance and to conduct an inspection, if necessary. Because the department is already familiar with the variance or any alternative measure—as opposed to reviewing a new variance request—the department proposes a 30-day timeline instead of 60 days.

Subpart 1c reflects how variance applications are not subject to appeal consistent with other department rule chapters and the APA.[118] This is also a needed and reasonable change that continues long-standing department practice.

3. Subpart 2 (emergencies).

A jail administrator may suspend *any* rule requirement because of an emergency, which is defined in rule as "a significant incident or disruption of normal facility procedures, policies, routines, or activities."[119] An emergency could be caused by a natural disaster or an unusual or emergency occurrence listed under part 2911.3700. Unlike for variances, however, emergencies are granted on a short-term basis, not to exceed seven days; after seven days, a jail administrator must then request a variance to continue the rule suspension.[120]

While jails may need this flexibility for unforeseen events, the department proposes additional requirements because the existing language doesn't adequately provide the department with enough notice or oversight to

[117] *See* adopted Minn. R. 2955.0070, subp. 3 (this change is not yet updated on the revisor's website. Please see the department's rulemaking docket for the adopted rule).
[118] *See id.*
[119] Minn. R. 2911.0200, subp. 31.
[120] *Id.* 2911.0400, subp. 4.

determine whether a jail is reasonably unable to comply with a rule requirement due to an emergency.

Given that a jail administrator may suspend a rule requirement before notifying the department, it's reasonable for the jail administrator to inform the department of an emergency within 24 hours, not 72 hours. The existing 72-hour requirement was adopted in the initial rule chapter[121] and is now outdated given the changes that have occurred since the late 1970s in jails and changes in the population that jails serve. Additionally, subitem (2) will now require a jail administrator to justify their rule suspension, whereas before notification was the only requirement—this change is also needed for the department to ensure accountability for rule suspensions under this subpart.

Further oversight over any jail-declared emergency is provided in proposed item B. For example, department inspectors can now review a jail administrator's rule suspension using similar review standards for variances; this review will ensure that jails are not declaring an emergency for staff convenience or to otherwise circumvent a rule requirement.

In item C, the department prescribes what happens if an inspector determines that the suspended rule requirement isn't related to the emergency or if it jeopardizes the health, safety, or security of jail staff or incarcerated people. This proposed language ensures that jails are provided fair notice about department actions.

4. Subpart 8 (overcrowding).

This subpart requires a jail administrator to have a plan when the jail becomes overcrowded, which means that the jail has exceeded its approved bed capacity.[122] This plan is necessary because overcrowding can result in increased tension and violence in a jail:

> Jail crowding also becomes a serious and immediate concern when the population exceeds the functional capacity of the jail and basic services are no longer consistently provided. These conditions leave the jail open to significant liability exposure and jeopardize the safety and well-being of both inmates and staff.[123]

Because of the health and safety risks of overcrowding, the department proposes to strike the current requirement requiring a jail to contract with other jails in a

[121] Corr. 103(B)(2).
[122] Minn. R. 2911.0200, subp. 56a.
[123] Martin and Rosazza, *Resource Guide for Jail Administrators*, 53.

125-mile radius (striking this requirement doesn't mean that a jail *must* contract with other jails outside a 125-mile radius). The department enforces a radius limit without clarity on the reasoning or intent behind its adoption. Recent changes with the statutory licensing structure such as conditional-license orders also demonstrate the need to strike this distance to give jails more flexibility to choose their contracted bed space.[124]

The department also amends the existing cross-reference on approved capacity. The department is repealing parts 2911.0360 and 2911.0370; accordingly, only bed capacity and design capacity will remain. Bed capacity is the correct capacity for this cross-reference (2911.0330), and the department makes this change in several other rule parts such as in 2911.0900 (staffing) and 2911.4800 (commissary).

[124] *See, e.g.,* Christopher Magan, "Hennepin County Board Delays Vote on Sheriff's Plan to Reduce Jail Numbers," *Minnesota Star Tribune*, November 19, 2024.

Staffing (2911.0900)

> *"Staffing a jail is expensive. In many jails, staff costs can make up 70 percent to 80 percent of the annual budget. Such a costly resource must be carefully managed, and assessing staff needs and allocating staff in a jail setting are complex tasks."*[125]

Adequate staffing is arguably the most important factor that contributes to a jail's success.[126] For a jail to successfully protect the health and safety of everyone working and living in the jail, a jail administrator must ensure that "sufficient staff, including a designated supervisor, are provided at all times to perform functions relating to the security, custody, and supervision of inmates and as needed to operate the facility . . ."[127]

Although staffing was not included as one of the 17 topics in the 2021 legislation, the department's proposed rule changes have a cumulative effect that require updates to staffing requirements so that jails can comply with the legislature's intent for improving the standards of confinement in jails.

1. Subpart 1a (staffing analysis).

The two main ways that a jail administrator can ensure adequate staffing is to create a staffing plan and to complete a staffing analysis, both of which are recommended by the NIC and ACA. A staffing analysis is a tool to help a jail administrator create their staffing plan:

> A staffing analysis considers all of the elements essential to an adequately staffed jail. A comprehensive staffing analysis should produce a staffing plan that will prevent or resolve any staff deficiencies in the jail.[128]

While current rule requires a staffing analysis for jails only with "a design capacity of more than 60 beds,"[129] the department finds it needed and reasonable to require all jails to conduct an initial staffing analysis (if they

[125] Dennis R. Liebert and Rod Miller, *Staffing Analysis Workbook for Jails*, 2nd ed. (National Institute of Corrections, March 2003), v.
[126] Martin and Rosazza, *Resource Guide for Jail Administrators*, 15.
[127] American Correctional Association, *Core Jail Standards* (1st. ed. 2010), 1-CORE-2A-09; *see also Performance-Based Standards*, 5-ALDF-2A-13, 5-ALDF-2A-14.
[128] Martin and Rosazza, *Resource Guide for Jail Administrators*, 70. The National Institute of Corrections has developed a workbook to help jails conduct a staffing analysis: Liebert and Miller, *Staffing Analysis Workbook for Jails*.
[129] Minn. R. 2911.0900, subp. 1.

haven't already done so) because a staffing analysis is needed to "determine staffing needs and plans."[130] The department cannot find any NIC or ACA standard that exempts smaller jails from conducting a staffing analysis.

If a jail administrator has not previously conducted a staffing analysis before the rule becomes effective, the jail administrator will need to conduct the analysis using current rule requirements under item A, subitems (1) to (4). The department had proposed a 90-day timeline for jails to complete this initial analysis because a staffing analysis can take about eight weeks to complete. The department wanted to allow for an additional four more weeks given other proposed rule requirements that a jail administrator will need to account for when the rule is effective. This 90-day extension was removed, however, because the department instead added a delayed effective date applicable to the entire rule chapter.

To align the rule with ACA standards, the department had proposed requiring jail administrators to conduct a staffing analysis annually. However, jail administrators pushed back, arguing that such analyses are time-consuming and labor-intensive, especially given that many of the factors influencing jail staffing remain relatively stable from year to year. The department agrees that requiring a jail to annually conduct a staffing analysis may be unreasonable; instead, a more reasonable solution is to require a jail administrator to *review* the jail's staffing analysis every year. Depending on the review, a jail administrator can determine if they should amend their staffing plan. This annual review aligns with the current rule that requires a jail administrator to review their staffing plan annually.

The department had proposed requiring jails to submit the staffing analysis to the DOC Portal, consistent with other department requirements in rule and under subpart 1. But because the staffing analysis is a tool for a jail administrator, the department doesn't need to automatically review it, as any changes will be reflected in the staffing plan.

[130] *Performance-Based Standards*, 5-ALDF-2A-13.

2. Subpart 1 (staffing plan).[131]

> *"Revising the staffing analysis and plan will also be necessary when significant changes occur in the context of the jail (physical plant, population levels, employee contracts, etc.). Revisions may be made efficiently by using the initial analysis."*[132]

Using the staffing analysis, a jail administrator can then create a staffing plan to "determine the minimum number and type of staff needed to maintain appropriate levels of safety and security . . ."[133]

Existing rule doesn't prescribe *any* standards for the department to analyze when reviewing a jail's staffing plan. This omission leaves jails without clear guidance on how their staffing plans will be reviewed. To correct this gap and to ensure that the department consistently evaluates the plans, the department proposes standards (such as a facility's compliance with staffing ratios) that will ensure the health, safety, and security of people in a jail. These changes are in items B and D (item A makes plain-language and conforming changes).

In item B, the department keeps the annual-review requirement for a staffing plan but then requires a jail administrator to document the review and to revise the staffing plan as needed to comply with the rule chapter. Documentation allows department inspectors to review for compliance and precludes the need for jails to enter updates into the DOC Portal (as the department had initially proposed).[134]

Additionally, the department will review a facility's staffing plan

(a) at the facility's annual or biannual inspection;

(b) if needed because of complaints or unusual occurrences; or

(c) upon a jail renovation or new construction, which is governed under Minnesota Rules, chapter 2900.

[131] This subpart will be renumbered subpart 1b in editing.
[132] Liebert and Miller, *Staffing Analysis Workbook for Jails*, 23.
[133] Martin and Rosazza, *Resource Guide for Jail Administrators*, 71.
[134] This documentation is an existing requirement as well: "The review shall be documented in written form sufficient to indicate that staffing plans have been reviewed and revised . . ."

Jails are also subject to corrective-action plans or statutory licensing sanctions in case their staffing plans jeopardize the safety or security of staff or incarcerated people.[135]

Because the rule provides insufficient notice to jails on how the department will review a jail's staffing plan, the department proposes two main review standards. First, the staffing plan should comply with the rule's staffing requirements—a staffing plan would be meaningless without this compliance. Second, the staffing plan shouldn't jeopardize the health, safety, or security of jail staff or incarcerated people.

This second subitem replaces language the department had initially proposed requiring a staffing plan to "meet the needs of the population served by the jail." Although this requirement was similar to an existing requirement in this subpart (a staffing plan must be "revised as appropriate to the facility's needs"), jail administrators and other jail staff found that this standard was too vague and arbitrary.

In response, the department decided to replace the proposed language with language that hewed to existing rule and statutory requirements on health, safety, and security.[136] The department finds that these standards provide more clarity for jail administrators, sheriffs, and county boards while ensuring consistency in the rule chapter. Department inspectors can use their subject-matter expertise, as they do with variances and other rule requirements, to review staffing plans by analyzing these criteria.

The last change to item C has the department striking language on what a jail administrator must do after reviewing the jail's staffing plan. As discussed, the department strikes language on a jail administrator revising their staffing plan "as appropriate to the facility's needs." And the department strikes language on a jail's governing body because the department doesn't need to know whether a jail administrator has forwarded the staffing plan to the county board—even if this is a reasonable expectation.

[135] *See, e.g.,* Minn. Stat. § 241.021, subd. 1b(c): "When revoking a license, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons confined or incarcerated in the correctional facility."
[136] *See id.*; Minn. R. 2911.0300, subp. 2: "When conditions do not substantially conform or where specific conditions endanger the health, welfare, or safety of inmates or staff, the facility's use is restricted pursuant to Minnesota Statutes, section 241.021, subdivision 1."

In item D, the department proposes reasonable standards that will provide jails fair notice when a staffing plan is disapproved. Department inspectors already work with jails on any needed changes to staffing plans, and this notice provides jails with needed changes that will ensure compliance with the rule. In subitem (2), the department will also notify the jail administrator of consequences for not correcting its staffing plan to become compliant with rule. The department has used its statutory authority to cite jails for noncompliance through conditional-license orders, so this is a needed and reasonable requirement:

> By failing to meet minimum staffing requirements, Hennepin County ADC is unable to adequately supervise inmates, respond to emergencies, care for the well-being of all inmates, and conduct well-being checks that comply with the rule.[137]

3. Subparts 12 and 14 (jailer/dispatcher).

Currently, seven jails use a jailer/dispatcher as sole supervision.[138] This means that a jail may have only a single correctional officer on duty who is responsible for supervising incarcerated people. At the same time, this correctional officer is responsible for taking 911 calls (dispatcher). The original 1978 rule prohibited this hybrid position when "such assignment is incompatible with or detracts from the responsibilities of custodial functions as required by these rules."[139]

This subpart was last amended in 2013, when the department changed the cutoff for assistance from 15 incarcerated people to 5—this means that when a jail's population exceeds five incarcerated people, the jail must have another correctional officer available to assist. The 2013 amendment was supported by a department-formed advisory committee, and the department received only one comment in opposition, which the department formally responded to as follows:

> It was decided that a sole staff member operating both the jail and dispatch with up to 15 inmates during the day and 25 inmates on the overnight shift was neither safe nor efficient. Explained in greater detail within the SONAR, a maximum number of five inmates were decided upon, as that was a legitimate number for one staff person to evacuate from a facility in the case of an emergency. Further, it was shown that little was

[137] "Hennepin County Conditional License Order"; *see also* "Beltrami County Conditional License Order."

[138] One of the facilities uses the position for overnight shifts only.

[139] Corr. 104(E)(2)(f).

done in the way of training for outside resources to enter the jail/dispatch area if the sole staff member working was incapacitated.[140]

The department finds that the intent behind the original 1978 rule requirement and the 2013 amendment remains true today. Given the changes in jails and in the proposed rule, the jailer/dispatcher position has become a safety and security risk for both the correctional officer and incarcerated people. What happens if a security incident and a 911 call occur simultaneously? Or what if a correctional officer is alone and there is a medical emergency that prevents the officer from performing other jail duties such as well-being checks?

Because of the safety risks, the department initially proposed prohibiting the jailer/dispatcher requirement as sole supervision; this amendment would have required a jail to always have two custody staff members on duty in the jail.

To further evaluate this proposal, the department solicited feedback from the seven affected jails, including cost estimates on the proposed amendment.

The seven affected jails are shown in table 3 by county, classification, and average daily population:

Table 6. Custody-dispatcher facilities

County	Class	2024 ADP
Cook	I (72 hours)	0.18
Kittson	II (90 days)	1
Lac qui Parle	II (90 days)	3.1
Lake of the Woods	I (72 hours)	1.7
Lincoln	III	0.4 (1.15 per jail study)[141]
Murray	I (72 hours)	0.2 (1.11 per jail study)
Swift (overnight only)	III	3.5

Most jails estimated that the proposed revision would cost around $350,000 annually. This cost estimate didn't include fringe benefits or training costs for

[140] Department of Corrections, "Response to Written Comments," August 14, 2013.
[141] See Minnesota Regional/County Jails Consolidation or Merger Study.

newly hired employees. Some jails previewed that they would close if the changes were adopted.

Feedback centered on a half-dozen main themes:

- **Transportation.** Transporting inmates would lead to a shortage in county patrol (sheriff deputies), creating public-safety issues in the county.
  - Depending on the jail location, snowstorms or other weather events could make transportation unsafe for both the patrol deputy and the incarcerated person.
  - There is a significant cost to transport and board incarcerated people at other jails (in some cases, the nearest jail is 80 to 100 miles away).
- **Visitation.** Housing inmates in other counties would cause hardships for families.
- **Boarding.** Other jails may not agree to board a county's incarcerated people.
- **Staffing.** It is already difficult to find and retain staff, even part-time staff.
- **Physical plant.** The dispatch operations inside the jail would need to be reconfigured to allow for additional custody staff.
- **Past practice.** Jails have never had a problem, and the change won't help prevent deaths or other serious incidents.

With this feedback, the department decided to not prohibit sole supervision; instead, the department opted to amend subpart 14 concerning the jail's backup plans.

4. Subpart 14 (backup resource assistance).

Amendments to this subpart are needed and reasonable because the department still has serious safety concerns for jail staff and incarcerated people when sole supervision is used. Existing rule provides no details on the factors jails should evaluate for in their backup plans and how the department should evaluate these plans. This omission is unreasonable, and the department's proposed amendments are needed to correct this omission and ensure the health and safety of jail staff and incarcerated people.

To develop these standards, the department requested current backup plans from the seven affected jails and reviewed the department's previous 2013 revisions, including the rationale behind them – such as procedures for how backup assistance would enter a jail if a lone correctional officer became incapacitated. Some common responses from jails included the following:

- “In emergency situations, deputies as well as applicable emergency personnel will be paged.”
- “. . . benefits from the use of the 800 MHZ trunked public safety radio system. This system provides reliable communication capabilities, allowing the jail to request assistance at any time.”
- “Staff shall carry their portable radio/headset to radio system with them at all times during the emergency, remembering you can use the ‘Emergency Orange Button’ to send an emergency alert over the 800 system.”
- “If circumstances arise that require assistance for the on-duty Jailer/Dispatcher, the Chief Deputy, Jail Administrator, and/or on-duty Deputies/[omitted] PD Officers shall be called to assist.”
- “[Omitted] Police is on 24-7 and can assist if needed.”

Considering what many jails already do compared to the proposed requirements, the department’s proposed requirements will be less costly for jails (compared to the initial proposal) but at the same time accomplish the department’s intent to protect the safety and security of incarcerated people and jail staff:

Table 7. Proposed requirements on backup resources and department justification

Requirement	Justification
Two-way communication device with man-down feature[142]	Most of the seven jails already carry these radios; the man-down feature alerts the backup resource if there is an emergency.
Check-ins and documentation	Because each jail’s backup assistance is different, the department provides flexibility for how often a correctional officer should check in with the backup resource. This ensures that the backup resource will be alerted to an emergency if the correctional officer doesn’t check in. The documentation requirement allows the department to inspect for compliance.
Transferring incarcerated person	Jails already have procedures to meet this requirement.

[142] *See* Air Comm, “Motorola Radio Feature Man Down / Fall Alert,” https://www.aircomm.com/radio-feature/mandown (accessed June 24, 2025).

Requirement	Justification
Backup assistance	Jails use on-call staff, sheriff deputies, or local police departments. Backup resource could include a jail that uses a dispatcher in the jail's control room.
How backup assistance will enter the jail	This proposed change addresses one of the department's concerns from 2013: Because a jail is a secure facility, the jail's policy and procedure will need to prescribe how backup assistance—whether a deputy or local police officer—can enter the facility.

Item B requires the backup assistance to monitor the two-way communication device. Monitoring doesn't need to be constant, as some jails already require backup assistance monitoring the communication device, but the communication device will need to be monitored to align with the scheduled check-ins and to ensure that on-call staff can hear an emergency alert.

Figure 1. Two-way device with emergency alert button

5. Subpart 15 (staff-to-inmate ratios).

"As robust as direct supervision might be, it cannot be treated with indifference or allowed to degenerate too far without serious consequences."[143]

The current rule prescribes staff-to-inmate ratios for jails depending on their design capacity. For jails with a higher design capacity, their ratios depend on the supervision style in their jail: direct supervision, podular, or linear.

Until now, these supervision styles haven't been defined in rule. Accordingly, the department proposes to define these three supervision styles to clarify staffing terms used in this subpart. An excellent description of the supervision styles can be found in the NIC's resource guide, and the department's proposed definitions in item A are based on NIC descriptions.[144]

Figure 2. *Resource Guide for Jail Administrators*, linear and podular

Exhibit 5. Linear Housing Design

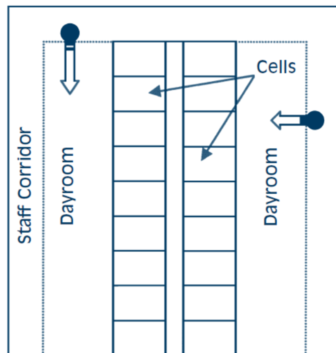
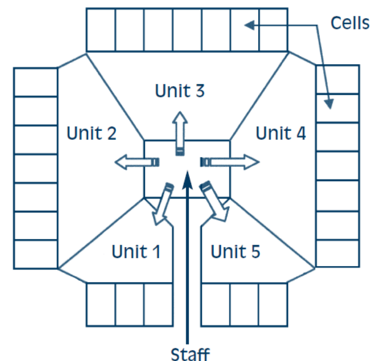
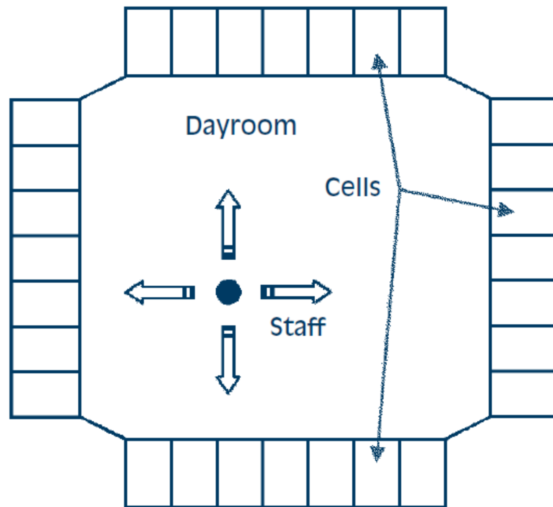


Exhibit 6. Podular Remote Housing Design



[143] Jay Farbstein, Dennis Liebert, and Herbert Sigurdson, *Audits of Podular Direct-Supervision Jails* (National Institute of Corrections, February 1996), 4.
[144] Martin and Rosazza, *Resource Guide for Jail Administrators*, 56-57.

Figure 3. ***Resource Guide for Jail Administrators*****, direct supervision**



In item B, the department amends the staffing-ratio cutoff from a design capacity of 60 to a design capacity of 50. This change more cleanly aligns the 1:25 staffing ratio already required for these jails, and the department estimates that this change won't affect any current staffing plans.

The department also strikes and moves language to item D; currently, this language applies only to jails with a design capacity of 60 or fewer beds. But this requirement should apply to *all* jails for safety and security reasons.

In item C, the department makes technical changes to conform with the change in item B on the staffing-ratio cutoff and makes clarifying changes to the staffing ratios, which were adopted in 2013.

Despite these ratios, the current language states that these ratios are for staff *facilitywide*. The department finds the word *facilitywide* to contradict the intent of the ratios. For example, if a jail has a 1:48 staffing ratio in a direct-supervision dormitory, the intent is that one custody-staff person is supervising no more than 48 incarcerated people. But with *facilitywide*, the jail could arguably have no custody staff supervising incarcerated people in the dormitory as long as custody staff were available elsewhere in the facility. The department finds that this a serious safety and security concern for jail staff and incarcerated people. As such, the word is stricken.

Item D moves existing language from item B to clarify that these requirements apply to all jails. This language is also consistent with another subpart in this

part: “An inmate shall not be detained without custody staff on duty, present in the facility, awake and alert at all times, and capable of responding to emergencies or the reasonable needs of inmates.”[145] This is an important requirement, especially for direct-supervision jails because this supervision style “implies that the officer is in control of the housing unit and in continuous communication with inmates.”[146]

> *“The purpose of direct supervision is not merely to distract a large group of inmates away from inappropriate behavior, but rather to actively supervise and manage inmates to ensure safety and security.”*[147]

The department also adds that custody staff “must be at their assigned posts.” Jails must already have post orders,[148] and a staffing analysis must analyze all security posts and other related factors. This addition is also needed to correct issues that department inspectors have cited in inspection reports. For example, one inspection report found that a jail’s custody staff would take 30-minute breaks when incarcerated people were locked in their cells—this left the unit with no custody staff to supervise incarcerated people, including for well-being checks.[149]

As discussed, this is a serious safety and security concern; if a jail doesn’t have enough staff to allow for staff to be relieved for breaks, the jail is understaffed.

Other changes to item D detail when certain custody staff aren’t included in the ratios. For example, jails may use custody staff known as rovers to escort incarcerated people throughout the jail or custody staff to transport incarcerated people to court or outside medical appointments. These rovers, or escort staff, shouldn’t be counted as part of the staffing ratios because their specialized duties take them away from the facility and their primary supervision role in housing units.

Jails also have dedicated admissions staff—because their primary duty is to book people into jail and conduct the initial medical screenings, these staff aren’t included in the staffing ratios.

[145] Minn. R. 2911.0900, subp. 9.
[146] Farbstein, Liebert, and Sigurdson, *Audits of Podular Direct-Supervision Jails*, 16.
[147] David Bogard, Virginia A. Hutchinson, and Vicci Persons, *Direct Supervision Jails: The Role of the Administrator* (National Institute of Corrections, February 2010), 28.
[148] Minn. R. 2911.5000, subp. 1.
[149] https://mn.gov/doc/assets/Wright%20County%202024_tcm1089-647884.pdf

Subitem (3) cross-references to an existing standard on when a facility may reduce its staffing ratios because of incarcerated people serving an alternative sentence.

Existing item C is stricken because it is superfluous, as jails can already apply for a variance under part 2911.0400. Additionally, the department standards for granting a variance are more comprehensive than the requirement stated here, and eliminating this language ensures consistency for all variance requests.

6. Subpart 17 (escort and admissions staff).

In item A, the department makes plain-language and technical changes on a facility's escort and admissions staff.

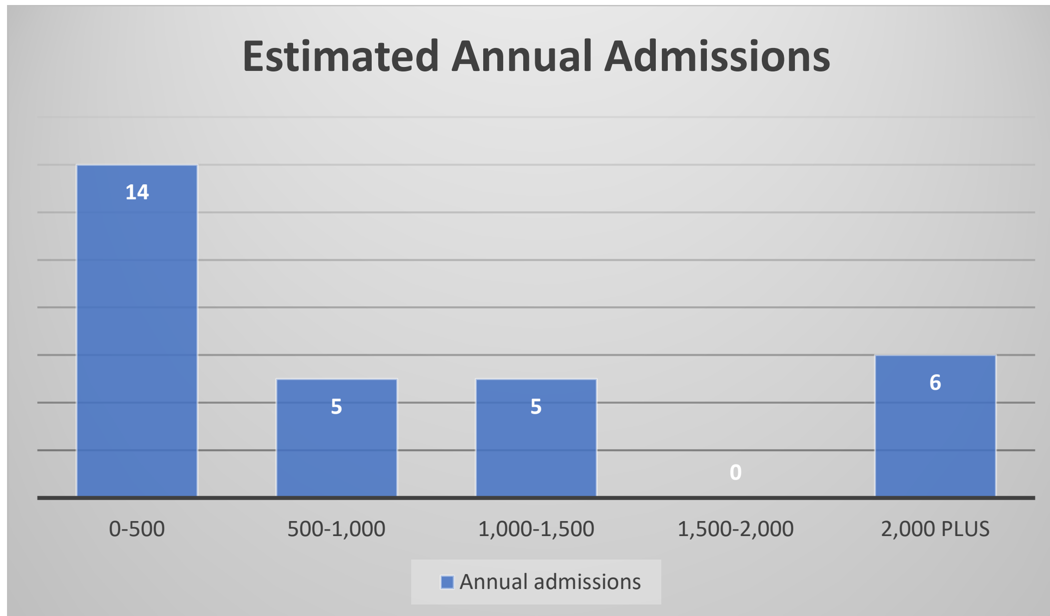
In subitem (2), vague language such as "sufficient" is stricken and replaced with a standard that clarifies what constitutes "sufficient." As with the department's proposed change for staffing plans, the department uses a standard focused on health, safety, and security.

The department had initially proposed tying a jail's admissions staff to a jail's annual admissions. For example, the department had proposed requiring a jail to have at least one admissions staff member per 2,000 admissions per year. This number stemmed from long-standing department practice under its construction rule, and the department anticipated that about 13 jails would be affected.

In response to the proposed requirements, jail administrators were concerned about potential costs and even how in budget negotiations county boards may argue that the jail has more admissions staff than what the department requires in rule. The department understands these concerns and amended the rule accordingly.

The department also removed the requirement of 2,000 annual admissions because jails with less than 2,000 annual admissions could need more admission staff—that is, the number of annual admissions is just one factor for a jail to analyze when determining how many admission staff are needed to ensure the jail's safety and security. For context, a department 2024 survey among jail administrators showed the following distribution of annual admissions among the 30 jails that responded:

Chart 3. Survey of jail admission numbers



The proposed changes for admissions staff are reasonable changes—these staff are also responsible for well-being checks on inmates that stay in intake, passing meals, clothing exchange, supervising time out of cells, and more. These are a lot of duties to put onto these staff,[150] so it's imperative that jails annually review whether they will need more admissions staff and that the department ensures that the jail's safety or security isn't compromised.

7. Subparts 17a to 26.

Subparts 17a to 17c are added to better organize and structure the language. Conforming and technical changes are made in subparts 17a to 26.

In subpart 17a, the department clarifies that the staffing requirements don't apply to mezzanines or tiers, which aren't considered floors. For example, a mezzanine is an elevated surface in a dayroom that incarcerated people walk on.

[150] Because of these responsibilities, some jails like Dakota County have special positions and extra pay for admissions staff.

Figure 4. Example of a mezzanine[151]

Subpart 26 is repealed because it contained duplicative requirements found in subpart 17c (new language in 17c incorporates a safety-and-security requirement from subpart 26).

8. Subpart 27 (control center).

The control center in a jail is a specific post and should be part of a jail's staffing requirements; yet the rule lacks a standard that addresses the need for a correctional officer to be at a control center at all times (even though this is a common practice). This proposed requirement might seem obvious, but the department finds it needed to ensure that the control-room officer isn't responsible for other duties such as leaving the post to conduct well-being checks.

This requirement is also needed because only exterior doors and intercoms are controlled by the control center, and, for security reasons, satellite control stations cannot operate these functions. Satellite control stations are small stations that can hand over controls to the control center but can operate only doors, intercoms, and cameras located within that post's area. Additionally, a control center monitors doors, intercoms, and cameras that may not be assigned to a satellite control station. Accordingly, the staffing requirement exempts satellite control stations, as their duties can be taken over by the control center.

[151] Klein McCarthy Architects, "Kanabec County Jail, Mora, MN," https://kleinmccarthy.com/kanabec-co-jail (accessed June 24, 2025).

Dispatch facilities are also exempt because these facilities have their door controls, intercoms, and other control equipment operated by their local dispatch. In some cases, this is a temporary handover, but in others it is done 24/7. Additionally, not all of these dispatch centers are located within the jail, or they may be located within the same building but not within the secure facility, so the staffing requirement wouldn’t be applicable.

Training (2911.1000 to 2911.1600)

A jail has many functions: Ensuring the safety of incarcerated people, staff, and the public; administering health care to incarcerated people; and providing programming to incarcerated people through community groups and volunteers. Because well-trained staff are more confident in their roles and less likely to leave an organization, training initiatives support retention of skilled and dedicated staff.

Training is also important to ensure that jail staff can adequately respond to emergency situations:

> Training does require resources, but lack of training or poorly planned training can cost the jail (and its community) far more if the jail is sued because staff did not have the knowledge or skills to prevent or handle a suicide, fire, assault, escape, or riot.[152]

And as the department stated in its 2013 SONAR, comprehensive training is an "important measure to reduce the amount and costs of litigation which have resulted from incompletely trained staff."[153]

Much of the rule's original and subsequently amended training requirements stem from the ACA, including requirements for staff orientation, annual training, essential training before independent assignment, and in-service training. Most of the department's proposed revisions make minor changes to update training topics and clarify vague language.

"A highly trained staff is needed to meet the basic objectives of correctional facilities."[154]

1. 2911.1000 (training plan).

This part on training plans and annual training is structured into subparts, with language on in-service training moved into its own subpart (subpart 2) and labeled as annual training. This new subpart 2 on annual training is simplified so that staff are receiving training that is relevant to their position in the jail.[155]

A few plain-language and conforming changes are also made.

[152] Martin and Rosazza, *Resource Guide for Jail Administrators*, 97.
[153] Department of Corrections, 2013 SONAR, 5.
[154] *Id.*
[155] Relevant training is supported by the NIC. *See* Martin and Rosazza, *Resource Guide for Jail Administrators*, 98.

2. 2911.1200 (support staff).

This part prescribes training for requirements for non-custody staff - such as clerical, maintenance, and food workers – with plain-language updates and additional subparts with clear headings.

In subpart 2, the department makes three substantive changes for support staff who have regular or daily contact with incarcerated people.

First, the department strikes language that had required these staff to receive 40 hours of orientation and training *before* being independently assigned. For some staff, this requirement is unnecessary because they may deal primarily with records or maintenance duties for their "regular or daily contact." Additionally, this requirement can make it harder for jails to fill these needed positions. These staff members will still need 40 hours of annual training, but only need training before independent assignment on the listed topics under item B.

Second, the department adds a new training topic and removes a current one. The newly added topic on response-to-resistance regulations and tactics is a needed and reasonable addition because support staff with regular contact work in a jail and need to know how to defend themselves, even when they are in the presence of custody staff. Depending on the staff position, the training is only required as needed for staff to perform their job duties. This new training topic is consistent with the ACA.[156]

And third, the department proposes to strike training on first aid because support staff are generally in the presence of custody staff, who are either certified in first aid and CPR or have received training from a certified instructor. Because most support staff are escorted by custody staff, requiring them to be certified in first aid and CPR would pose an unreasonable cost on jails.

A new subpart 3 moves and combines language from subparts 1 and 2 on annual training requirements for support staff.

3. 2911.1300 (custody staff).

The department updates and consolidates training topics in this part on custody staff, in addition to making similar plain-language changes made in the other training rule parts.

[156] *Performance-Based Standards*, 5-ALDF-7B-08.

3.1. Subpart 2 (required training before independent assignment).

> *"Because correctional personnel are often the first to respond to problems, they must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations, and understand their part in the early detection of illness and injury."*[157]

The training topics that custody staff must receive before independent assignment are substantially revised as follows:

Item C is revised to include training on well-being checks. As described further on page 156, well-being checks are the most-cited rule violation in the department's inspection reports, and noncompliant well-being checks endanger the health and safety of incarcerated people. Inadequate training on well-being checks can result in indeliberate indifference and can jeopardize the rights of incarcerated people.[158]

Item D is updated to recognize that the language refers to people with special needs—as defined by rule.

Item E is updated to ensure that custody staff are being trained on security equipment and, as prescribed by statute, pregnancy restraints.[159]

Item M is updated to require training on jail admissions, a significant topic given the importance of adequately screening a person for health-care concerns upon admission.

Item N strikes language on an employee's right to know, a reference to a federal work requirement that is required elsewhere in law and is replaced with training on the facility's policy-and-procedure manual. Because the manual houses all of a facility's policies and procedures, this is a needed and reasonable change.

Items O and P incorporate requirements from part 2911.1350, which is being repealed (item C language on suicides and item M language on medications are moved here, too). These two items consolidate all the health training required for custody staff. The department also proposes the following revisions:

- Require annual CPR and first-aid training (most jails already do this, and this is a needed and reasonable requirement because not all jails have 24/7 health coverage). For jails that don't have certified custody staff, this

[157] *Standards for Health Services in Jails*, 55.
[158] *Morrison as Trustee for May*, 2022 WL 2442363.
[159] Minn. Stat. § 241.88, subd. 2.

would be a new cost, likely around $100 per staff member.[160] This training would be through the American Red Cross or the American Heart Association, which offers a Heartsaver First Aid CPR/AED course. Subpart 3 further prescribes these training requirements.

This training should also be completed before a staff member is independently assigned to a post. This requirement is both needed and reasonable given that not all jails have 24/7 health-care coverage and considering the health and safety needs of the incarcerated population.

- Training on administering opiate antagonists such as naloxone if it is available for use in the facility. Naloxone blocks an opioid's effects on the brain and can be administered quickly by nonmedical staff.[161] Given the high presence of people with substance-use disorders in jails, this is a needed and reasonable addition.[162] There should also be training on opioid emergency procedures, which is statutorily required.[163]
- More guidance on mental-health training and instruction. While the current language requires training on signs and symptoms, the department also believes that—similar to its proposed suicide-training requirements—that custody staff should be trained on communication skills. This training—recommended by NCCHC—could be as simple as guidance or instruction from a jail's health authority or be covered in other general communication training topics.[164]

[160] For example, the American Red Cross offers an Adult First Aid/CPR/AED blended learning course that "equips students to recognize and care for a variety of first aid breathing and cardiac emergencies involving adults."
[161] For more background on naloxone, *see* Jessie Van Berkel, "Overdose Deaths Drop in Minnesota for First Time in 5 Years," *Minnesota Star Tribune*, October 9, 2024; Jan Hoffman, "Over-the-Counter Narcan Could Save More Lives. But Price and Stigma Are Obstacles," *New York Times*, March 28, 2023.
[162] *See also Standards for Health Services in Jails*, 70: "Given the current epidemic of opiate use and overdose, it is essential that facilities have injectable and nasal naloxone available to reverse an opiate overdose."
[163] Minn. Stat. § 241.021, subd. 1(a)(10).
[164] *See Standards for Health Services in Jails*, 56; National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (2015), MH-C-04.

"It is important that mental health training be maintained for correctional personnel because they are often the first to notice behavioral or emotional changes in inmates that can have a bearing on their mental status."[165]

- Require training on signs of dehydration—a common symptom of substance withdrawal—as it relates to substance use.
- Add additional training requirements on suicides to ensure custody staff know how to respond to a suicidal inmate, communicate with health-care staff, and otherwise help prevent and respond to suicide attempts. With the high levels of suicides and suicide attempts in jails, these are much-needed and reasonable revisions that are consistent with other states and national guidelines.[166]

  NCCHC also prescribes standards for suicide prevention and intervention.[167] NCCHC emphasizes training so that staff can "identify suicidal inmates and immediately initiate precautions."[168] NCCHC notes that high-risk periods for an incarcerated person include upon admission, after new legal problems, or after placement into segregation or single-cell housing.[169] The department's proposed rules on admissions, administrative separation, and disciplinary segregation all seek to reflect these high-risk periods.

"Because suicide is a leading cause of death in correctional facilities nationwide, an active approach to the management of suicidal inmates is recommended."[170]

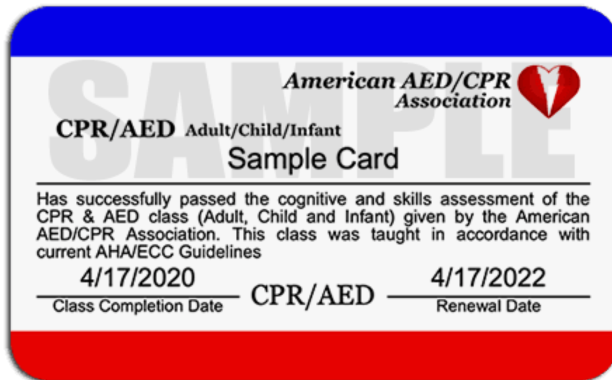
3.2. Subpart 3 (training for first aid and CPR).

Staff are not required to be certified in first aid or CPR; however, the initial and ongoing trainings must facilitated by a certified instructor using a certified training curriculum. The jail should document this training so the department can

[165] *Standards for Mental Health Services in Correctional Facilities*, 49.
[166] *Performance-Based Standards*, 5-ALDF-4C-31; *Core Jail Standards*, 1-CORE-4C-13.
[167] *See Standards for Health Services in Jails*, J-B-05; *see also Standards for Mental Health Services in Correctional Facilities*, MH-G-04.
[168] *Standards for Health Services in Jails*, 39.
[169] *Id.*, 39-40.
[170] *Standards for Mental Health Services in Correctional Facilities*, 112.

determine compliance. While jails provide this training to custody staff, some may not pay the additional fee for a card documenting the training. To ensure uniform standards and consistency, the department has proposed language ensuring custody staff receive equivalent training and retraining as if they were certified.

Figure 5. Sample AED/CPR card



3.3. Subpart 4 (annual training).

Currently, the 16 hours of required annual training for custody staff is the same number of hours required for support staff. While many jails already require more than 16 hours of annual training for custody staff, the department believes that the required hours of annual training should reflect the extensive job duties of custody staff—and 16 hours is insufficient given the rule revisions.

Proposing 20 hours and requiring training on at least four topics is critical to ensuring that custody staff are well-trained to respond to health and security events. For comparison, the department's correctional officers must receive 40 hours of annual training.[171]

For jails that don't provide 20 hours of annual training, this will be a new cost. But the original rule required 24 hours of annual training, so this four-hour increase in training hours is reasonable.

The department chose these four topics because of health, safety, and security reasons. As discussed, well-being checks are critical to ensuring an incarcerated person's health and safety. Similarly, a well-developed admissions process is important so that jail staff can properly classify people entering a jail, including identification of any medical or mental-health needs. . And because not all jails have 24/7 health-care staffing, annual medical and suicide-prevention

[171] DOC Policy 103.410(B)(5).

training is needed. Last, response-to-resistance training is needed to help custody staff protect themselves, others, and the public.

4. 2911.1500 (program staff).

In addition to health-care and custody staff, jails must employ staff responsible for programming.[172] The existing training requirements for program staff correspond with the duties of program staff and reflect how program staff may be alone with incarcerated people for extended periods. Accordingly, the department believes that it is needed and reasonable to require program staff to be trained in first aid and CPR.

While program staff must already receive training in first aid, certification is not required, and this omission poses a health and safety risk to incarcerated people. As for custody staff, jails will see an increased cost to comply with this requirement, about $100 per staff person.

Revisions on annual training and recertification are made in subparts 2 and 3 to be consistent with proposed changes in part 2911.1300 for custody staff.

5. 2911.1600 (training officer).

A jail needs a training officer to oversee the jail's training. The department proposes to replace vague language such as "sufficient detail" with standards that the department can inspect for to ensure compliance with the rule's training requirements. For example, the department proposes that the training records are legible and easily accessible for the department to inspect and that the training topics and hours are documented so that the department can determine compliance.

The records should also be organized so that inspectors can easily and accurately search the records when checking for compliance. Maintaining organized and accurate training records is essential for demonstrating compliance with legal requirements, Chapter 2911 standards, and agency policies. These records verify staff were provided with the tools to perform their duties, which reduces liability, supports effective internal supervision, and ensures the safety, security, and lawful operation of the jail. Documented training records are critical for timely completion of inspections and serve as objective proof that staff were provided with the knowledge and skills to perform their duties, respond to emergencies, protect inmate rights, and uphold professional correctional standards.

[172] *See, e.g.,* Minn. R. 2911.0900, subps. 18 to 21.

Policy and Procedure Manual; Records (2911.1900 to 2911.2400)

A jail's policy-and-procedure manual contains all of the jail's policies and procedures required under rule. Because the information in these policies and procedures governs a jail's administration, the jail administrator and, as needed, the health authority, must review the manual annually, update the policies and procedures if needed, and train staff accordingly.

1. 2911.1900 (policy and procedure manual).

This part is organized into subparts with headings.

1.1. Subpart 1 (manual required).

This subpart requires a jail to have a policy-and-procedure manual. Vague language such as "relevant" is replaced to reflect that the manual must be made available to state and local authorities (such as local food and fire inspectors).

1.2. Subpart 2 (minimum requirements).

Several changes are made in this subpart such as by:

a) adding well-being checks to the list of policies and procedures to be included in the manual; and

b) ensuring that the manual addresses follow-up efforts to suicides and suicide attempts.

These are all needed and reasonable requirements to ensure that important policies and procedures related to health and safety are included in the manual.

Under item R, the department clarifies that the manual should include all policies and procedures required under the rule chapter, not just the listed topics. Because the manual is important for "operating and maintaining the facility,"[173] this is an important change that is both needed and reasonable. The department can provide jails or post on its website a comprehensive list of all policies and procedures listed in rule.

1.3. Subpart 3 (code of conduct).

Under the 2021 legislative changes, a jail must develop a code-of-conduct policy. While the department and advisory committee discovered that this is a

[173] Proposed Minn. R. 2911.1900, subp. 1.

difficult topic to prescribe minimum standards on in rule, the department's proposed minimum standards are reasonable given a jail's function and relation to the community. If needed, a jail administrator could incorporate the county's policy or the sheriff's office policy.

After receiving feedback from the advisory committee, the department clarifies in item A that a staff member's conduct is limited to the staff member's actions while in the jail (the county's or sheriff's office policy could prescribe a more-stringent standard). Any consequences for violating the policy would be governed by county policy and any applicable collective-bargaining agreement.

Most political subdivisions require annual code-of-conduct training, and the department finds it reasonable to also prescribe this requirement in rule.

The department will inspect for compliance to ensure that a jail has a code-of-conduct policy that meets the rule requirements. Training would be verified by examining training records, no different than how the department currently inspects for training requirements.

1.4. Subpart 4 (reviewing manual and staff training).

A jail's policy-and-procedure manual must be updated to reflect any changes to a policy and procedure, and it is needed and reasonable for staff to be trained on the additions as relevant to their job duties. To ensure compliance, the department requires all staff to verify that they have been informed of any change and have been trained on the change as needed. This requirement also applies to health-care-related policies, which is considered a "good management practice."[174]

2. 2911.2100 (facility records).

This part is updated to clarify that a jail's records may be stored either electronically or on paper, or in any other format.

The department added new language under item B to make clear that knowingly altering or withholding records is prohibited, because the department needs accurate and reliable information to carry out its regulatory duties.

[174] *Standards for Health Services in Jails*, 11.

3. 2911.2200 (maintaining records).

This part is streamlined by requiring a jail to maintain readily accessible records according to state law on records and record retention.[175]

4. 2911.2300 (privacy of records).

This part is updated to conform with the Minnesota Government Data Practices Act.

5. 2911.2400 (DOC Portal).

This part on the DOC Portal is structured into subparts for readability.

Because statute already requires the department to maintain a detention information system, there is no need to incorporate the system by reference, and the department instead defines the term under part 2911.0200.

Subpart 2 requires that detention information is entered into the DOC Portal. Only a few jails manually enter this information. For most jails, data such as daily bookings, charging details, and releases is automatically uploaded into the DOC Portal through a jail-management system.

[175] Minn. Stat. §§ 15.17, 138.17.

Admissions (2911.2525)

A well-run admissions process is essential so jail staff can collect important information on a newly admitted person, conduct initial medical screenings, classify the person (custody level, housing assignment, etc.), provide them with importation information on the facility, and more. Comparing a jail's admissions process to a prison's shows a jail's unique challenges and the need to establish a thorough admissions process:

> Although prison intake units are typically busiest during normal business hours, receiving sentenced inmates of one gender with known backgrounds who are in reasonably good condition, the jail intake unit operates 24 hours a day, 7 days a week, *and handles an extremely diverse population*. Arrestees presented for jail intake may be under the influence of drugs or alcohol, be mentally ill, or have infectious diseases, and their behavior may range from violent to subdued and withdrawn. Most are being admitted prior to trial for charges ranging from minor misdemeanors to serious felonies.[176]

Two of the most important components of the admissions process are the medical screenings and classification. Jails use classification to objectively separate incarcerated people into different groups to help safely and securely manage the jail and the jail population. Essentially, classification involves assessing the risks and needs of a person admitted to a jail.

"Given the importance of inmate behavior management in achieving safety and security, it may be viewed as the jail's core function and the jail administrator's primary concern. You should consider all decisions regarding jail operations with respect to their impact on inmate behavior management."[177]

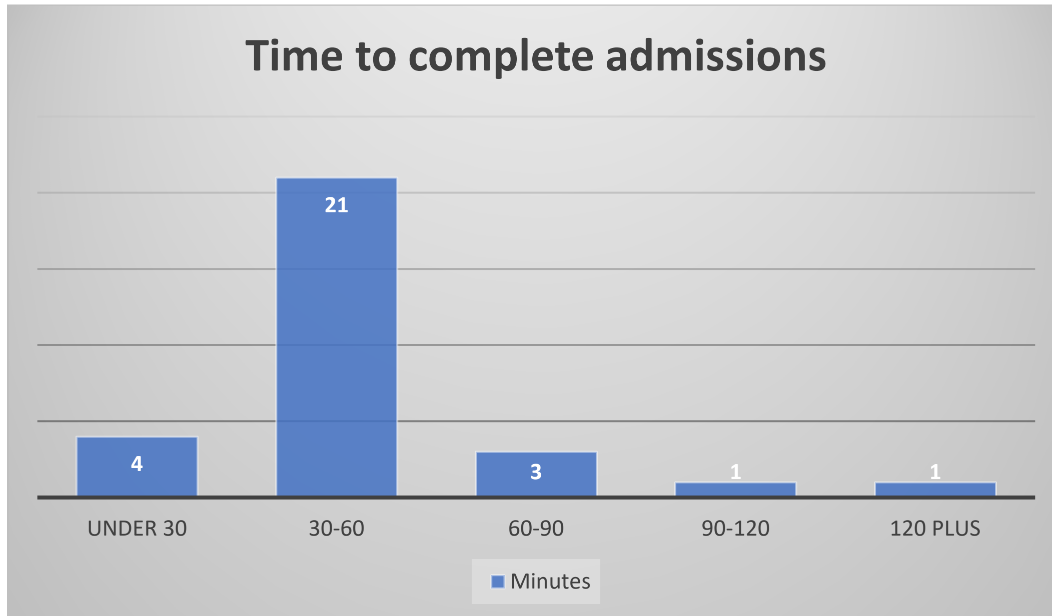
Classification may be informed by the initial medical screenings, and accurate and timely medical screenings are important so that jail staff can identify medical issues and health-care concerns of incarcerated people. Furthermore, given the prevalence of people incarcerated in jails with mental illnesses and substance-use disorders, medical screening must include these screenings, which the department discusses on page 183.

[176] Martin and Rosazza, *Resource Guide for Jail Administrators*, 191 (emphasis added).
[177] *Id.*, 138.

1. Subpart 1 (policy and procedure).

The department's 2024 jail survey found that almost all jails can meet the existing and proposed admissions requirements within two hours (when required by rule).

Chart 4. Jail survey of admission timelines



Although the chart data aligns with the average jail size of the survey respondents (small to medium-sized jails), the department is still confident that it's reasonable to require *initial* attempts to complete the medical screenings within two hours and initial attempts to verify medications within 24 hours (*see* part 2911.6800). Both health screenings and medication verification "enable staff to intervene early to treat withdrawal and to prevent most suicides."[178]

Depending on the incarcerated person and other factors, jails may be unable to complete the medical screenings and prescription verifications according to rule. Consequently, the proposed language provides exceptions for the medical screenings and medication verification, as detailed under subpart 6 and part 2911.6800, respectively.

[178] *Standards for Mental Health Services in Correctional Facilities*, 77.

The department is requiring only several admissions requirements to be completed within two hours[179] and allows for flexibility under item N when jails cannot complete the admissions process for an incarcerated person.

In addition to minor technical and clarifying changes, the department proposes the following admissions requirements:

- The requirement in item A on obtaining a person's emergency medical information is stricken as duplicative because this information is gathered under the medical screenings and the release-of-information form under new subpart 2c.

  Instead of this requirement, new language on prebooking is added. Jails use prebooking forms to learn important health and safety information when booking someone into jail. This information is usually provided by the arresting officer, but the department doesn't have the authority to regulate law-enforcement entities, so the department is requiring jail staff to ask for the prebooking information. This is a needed and reasonable requirement given the risk of suicide and other potential health concerns that a person being booked into a jail may have. Jails should know these health and safety concerns.

- Item E on initial health-care screenings requires jail staff to make *an initial* attempt to conduct both medical and mental-health screenings. This proposed requirement is discussed in more detail on page 101.
- Item F on telephone calls is amended to clarify that these phone calls are for a person to call their attorney or significant other—these are existing requirements under part 2911.3400. Jails that don't allow for these calls in booking will provide the incarcerated person a ten-minute phone card for onetime use.
- For access to showers under item G, requiring access within 24 hours is a more reasonable requirement that reflects how jails operate and the higher need to complete the medical screenings and to gather and verify other important information.
- Under item J, the two-hour requirement for emergency contacts is moved from existing item A; this is a needed and reasonable timeframe, and it aligns

[179] These include an initial attempt to conduct the medical screenings, getting emergency contact information, and presenting the release-of-information form.

with the department's proposed requirement under subpart 2c on the release-of-information form.

- Proposed item N requires jails to document if an incarcerated person refuses to provide booking information under this subpart or is otherwise uncooperative or unable to complete the admissions process. This is a needed addition because of the diverse population in jails, including those suffering from mental illness or a substance-use disorder. Sometimes, a person can be combative, uncooperative, or under the influence. If this happens, the department wants jail staff to document a person's refusal or inability to complete the admissions process.

> *"Mental health and substance use challenges require immediate attention regardless of facility arrangements. The state should implement standardized screening and assessment tools across all facilities while improving data collection and reporting systems. Expanded treatment programming options and development of alternatives to incarceration for individuals with mental health needs emerge as critical priorities."*[180]

2. Medical screenings.

When a person is booked into a jail, jail staff (almost always custody staff) will conduct a brief medical screening to help identify both a person's immediate and long-term health issues—this information helps jails classify incarcerated people and ensures that health-care staff can provide an incarcerated person with any needed care.[181]

For mental-health screening, jails since 2007 have been required to use a commissioner-approved mental-health screening tool.[182] The department's currently approved mental-health screens are the Correctional Mental Health Screen for Men and for Women and the Brief Jail Mental Health Screen. The screenings can be quickly conducted by custody staff (about five minutes), and have been heavily studied, with evidence supporting their use.[183]

[180] *Minnesota Regional/County Jails Consolidation or Merger Study*, 9.
[181] This screening is detailed under Minn. R. 2911.5800, subp. 6.
[182] *See* Minn. Stat. § 641.15, subd. 3a.
[183] Michael S. Martin et al., "Mental Health Screening Tools in Correctional Institutions: A Systematic Review," *BMC Psychiatry* 13 (2013): 275.

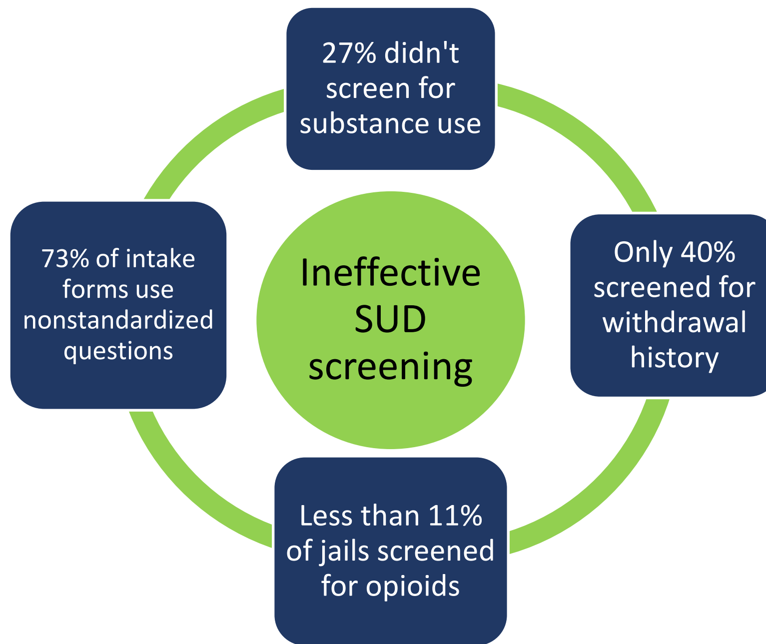
Because about 44% of people in jail have a prior mental-health diagnosis,[184] mental-health screening allows jail staff to identify people with a mental illness, classify them, and refer them for mental-health care if needed. Mental-health screening is the first step in intervention, which is important because "interventions for offenders with mental illness may be effective at improving outcomes while incarcerated and at preventing further crime."[185]

About half of people with a diagnosed mental-health disorder also have a history of nonmedical drug use.[186] Consequently, screening for substance use—covered under part 2911.5800 as part of the medical screening—is needed to identify people with a substance-use disorder and to refer them for care or treatment, if needed. A substance-use-disorder screen is also a life-saving tool in case someone is in withdrawal, where the first 72 hours are the most important.[187]

> *"Neglecting to capture prior overdose events . . . at intake is a costly omission, given that the number of prior nonfatal overdose events has been shown to be the strongest predictor of a subsequent fatal overdose."*[188]

As previously stated, about two-thirds of people in jail have a substance-use disorder, and 54% of sentenced people in jail reported using drugs a month before entering jail.[189] Yet jails are still inadequately screening for substance-use disorders: [190]

[184] *See* nami.org, "Mental Health Treatment While Incarcerated," https://www.nami.org/advocacy/policy-priorities/improving-health/mental-health-treatment-while-incarcerated/ (accessed April 10, 2025); Bronson and Berzofsky, "Indicators of Mental Health Problems."
[185] Bronson and Berzofsky, "Indicators of Mental Health Problems," 1.
[186] Doris J. James and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," Office of Justice Programs (September 2006).
[187] *See* Bureau of Justice Assistance and National Institute of Corrections, *Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals* (Office of Justice Programs, June 2023), 5. This is because withdrawal symptoms usually present within 72 hours after the last opioid use. *See also* Federal Bureau of Prisons Clinical Guidance, *Medically Supervised Withdrawal for Inmates with Substance with Substance Use Disorders* (February 2020), 19.
[188] Bunting et al., "Characteristics of Substance Use Screening," 5-6.
[189] *Id.*, 2.
[190] Bunting et al., "Characteristics of Substance Use Screening."



This initial screening is critical because jail staff can quickly identify people at risk for withdrawal and refer them for medical attention:

> At a minimum, screening for substance use at entry to jail allows for appropriate intervention for possible high-risk withdrawal. While individuals at jails who are not screened may still receive medical attention should withdrawal occur, screening upon entry provides an opportunity to assess and provide treatment to prevent withdrawal before it becomes a medical emergency. Screening should occur for high-risk withdrawal from alcohol, benzodiazepine, opioids, substance use during pregnancy, and substance use among individuals with underlying health conditions. *For these populations, failure to provide medically supervised detoxification creates a heightened risk of death*.[191]

Ideally, screening would be conducted by medical staff because people entering a jail are less likely to disclose illegal substance use to a correctional officer. But requiring medical staff to conduct the screenings would be overly cost-prohibitive for jails, especially smaller and rural ones. Because incarcerated people may be reluctant to accurately share their substance-use history, training (*see* part 2911.1300) on recognizing signs and symptoms of substance use is also important and can help offset any inaccurate or undisclosed substance use.

[191] *Id.*, 5 (emphasis added).

> *"Individuals who misuse substances are rarely accurate in their description of patterns of drug use; they can greatly underestimate or deny their misuse of substances, as well as overstate the extent of their misuse."*[192]

For screening, "research has suggested that screening need not be burdensome or lengthy to provide details that are helpful for assessment and planning purposes."[193] So in the absence of health-care staff conducting the screening, custody staff can still receive useful and life-saving information.

3. Subparts 2 and 2a (data and data practices).

Subpart 2 is simplified by striking superfluous language already covered by the Minnesota Government Data Practices Act; language on privacy is also moved to part 2911.5800, subpart 13.

Subpart 2a is renumbered to be included with other admissions requirements in this part. A term change at the end of the rule will amend *privacy* to *practices*.

4. Subpart 2b (basis for detention).

This subpart is renumbered to combine like admissions requirements.

5. Subpart 2c (release of information).

Statute already prescribes requirements for the intake release-of-information form, a new requirement from the 2021 legislation. This form must be offered to an incarcerated person at intake so that jails can get consent to "release information related to a person's health or mental health condition and when that information should be shared."[194]

Because the statutory requirement already provides detailed guidance, the department adds minimal requirements to supplement the statute and requires the form to be given to an incarcerated person within two hours of admission. This two-hour timeline is consistent with existing rule language that requires a jail to get a person's emergency contact information within two hours of admission.

As with any other health-care record, the form should be maintained by the jail and updated if requested by the incarcerated person. This is a reasonable

[192] Federal Bureau of Prisons, *Medically Supervised Withdrawal for Inmates with Substance Use Disorders*, 2.
[193] *Id.*, 6.
[194] Minn. Stat. § 241.021, subd. 7.

requirement given that this is an authorization form for notifying an incarcerated person's family in case of a medical emergency.

6. Subpart 3 (orientation).

> *"Orientation is an important part of the inmate process as it provides basic and important information to the inmate."*[195]

Current rule and ACA standards require that a newly admitted person is informed of facility rules and regulations before they are placed into a housing unit—this process is known as orientation.[196] An incarcerated person must know their rights in the facility—including basic constitutional rights—and how to comply with facility rules, especially if a rule violation may result in disciplinary segregation.

Despite orientation's importance, department inspectors frequently find that some jails are inadequately—or not at all—documenting incarcerated people receiving orientation. The department has also identified other compliance issues on orientation requirements:

- Jails are not completing orientation during admission.
- Jails are providing a handbook and requiring a signed acknowledgement but are not going through an orientation process.
- Jails are not ensuring that inmates understand the orientation.
- Jails are having incarcerated people sign an acknowledgment form on a tablet, which doesn't allow staff to print or save the acknowledgment.

To correct these problems, the department proposes that incarcerated people sign and date that they have been presented the orientation information (some jails provide a video). This is a needed and reasonable requirement given the important information presented at orientation such as information on visitation, emergency procedures, health care, and more.

The department believes that all incarcerated people should receive orientation, regardless of their anticipated length of stay. And providing an incarcerated person a handbook doesn't suffice, especially because people entering jail can be illiterate or not speak English. Overall, requiring orientation during admission has been a long-standing rule requirement, and the department sees no reasonable need to deviate from it.

[195] Department of Corrections, "Swift County Jail Death Review" (2023).
[196] *Core Jail Standards*, 1-CORE-2A-15; *Performance-Based Standards*, 5-ALDF-2A-25.

Item B is added to clarify which topics should be included in orientation. While most jail handbooks already include the proposed information, this information should—or at least the summary information—be communicated to a person during orientation to inform them of their legal rights (calling an attorney), their health-care rights (making medical requests), and facility procedures (disciplinary consequences for violating a facility rule). The department also wants people to know how to file complaints with the department to ensure better jail accountability and oversight and so that inspectors can investigate accordingly.

Incarcerated people should also be advised of how to get a copy of the facility's handbook after initial orientation such as at a video kiosk. This is important because of the volume of information presented at orientation and the initial destabilizing effect of being admitted into jail.

7. Subpart 4 (personal property).

The substantive change on an incarcerated person's property combines information from part 2911.3600, subpart 7, which is being repealed. All related requirements on personal property are combined in this subpart, including an existing rule that requires incarcerated people to receive their inventory record. The department amends this requirement to provide incarcerated people the option to request their inventory record—as most incarcerated people may not want to keep this information in their housing unit.

8. Subparts 5 (additional admissions information).

This subpart is renumbered to combine like admissions requirements.

9. Subpart 6 (unable to complete admissions process).

> *"Receiving screenings are conducted as soon as possible and without unnecessary delay. Individuals should not be released from the intake area until the receiving screening is complete."*[197]

Jails face an undeniable reality: They have no choice in who they book into their facilities, and so they may have to admit people who may be uncooperative, under the influence, or experiencing a mental-health crisis. Jails may also have multiple admissions at the same time, and uncooperative people can slow down the booking process. But because jail staff gather important information during the admissions process, including the medical screenings, custody staff should

[197] *Standards for Mental Health Services in Correctional Facilities*, 77; *see also Standards for Health Services in Jails*, J-E-02.

make follow-up attempts to have a person complete the admissions process according to a jail's policy and procedure.

Because the initial medical and mental-health screenings are important, the department finds it needed and reasonable that staff continue to attempt the screenings and to document the attempts. To accomplish this, the department originally proposed requiring custody staff to attempt the health screenings every two hours, and this proposal was discussed in length by the committee. During the discussions, jail representatives were concerned that this requirement would create more opportunity for escalation, increase staff workload, and leave jails vulnerable to potential department violations.

At the same time, delays in medical screenings pose serious health and safety risks, as evidenced by departmental reviews of jail deaths, special incidents, and formal complaints. In one case, an incarcerated person was jailed for over 30 days without ever completing their medical screenings. In another case, an incarcerated person died without being booked into jail; he was held in a conference room for about four hours before his medical screening was completed.[198]

Accordingly, the department believes that a reasonable compromise is to require custody staff to *make attempts* to conduct the health screenings at least every six hours. Because most jails schedule 12-hour shifts, this proposed requirement would require two attempts per shift. If custody staff start to attempt the health screenings but still see that someone is under the influence, they should document this as an attempt.

Additionally, the department is proposing that custody staff place incarcerated people who haven't completed the medical screenings on 15-minute well-being checks (*see* page 169). Combined with requiring screening attempts at least every six hours, jails will be better equipped to protect the health and safety of incarcerated people.

The department recognizes that sometimes a person admitted to a jail may not be compliant with the screening process or may be medically unable to complete the screens. And the department doesn't dispute that there are times when a person may be belligerent or incapacitated. In these cases, staff should document why they started to attempt the screenings but couldn't start or finish them. While escalation may occur, the required rule training for custody staff

[198] "Beltrami County Conditional License Order."

equips them with de-escalation techniques when needed. The language doesn’t require custody staff to complete a medical screening in all situations; rather, the department requires attempts and documentation.

Discharges (2911.2550 to 2911.2560)

Unlike in prison, a person may be discharged from jail at any time and for various reasons. This variability and suddenness make it difficult for jails to develop discharge plans for incarcerated people, particularly if the average length of stay is around ten days. Yet discharge planning is critical to ensuring a person's continuity of care, especially if they are receiving mental-health care or substance-use-disorder treatment.

One common way to ensure continuity of care is to provide incarcerated people with their prescribed medication upon discharge. This standard is recommended by the ACA[199] and currently exists in rule.[200]

The NIC further emphasizes medication's importance:

> Another consideration is providing a released inmate with medications for illnesses or mental health conditions that have been treated in the jail. In the absence of legal requirements, best practice for the jail may be to provide medications for a short period until the person can access medical care in the community.[201]

The department's justifications in this section are to part 2911.2560, as only minor technical and conforming changes are made to part 2911.2550.

1. Subpart 1 (discharge planning).

"Continuity of care is required from admission to transfer or discharge from the facility, including referral to community-based providers, when indicated."[202]

The legislature has recognized the importance of discharge planning in jails by directing the department to "develop and distribute a model discharge planning process for every county jail or county regional jail."[203] And the department may develop different plans for "prisoners who have been detained pretrial and prisoners who have been sentenced to jail."[204] The department must also

[199] *Core Jail Standards*, 1-CORE-5B-04.
[200] Minn. R. 2911.6800, subp. 3.
[201] Martin and Rosazza, *Resource Guide for Jail Administrators*, 200.
[202] *Performance-Based Standards*, 5-ALDF-4C-04.
[203] Minn. Stat. § 641.155, subd. 1.
[204] *Id.*

"consult best practices and the most current correctional health care standards from national accrediting organizations."[205]

Because discharge planning is critical for an incarcerated person's continuity of care, the department had originally proposed requiring jails to follow the department's model discharge plan. But feedback from jail administrators and correctional health-care staff made the department reconsider the viability of this proposal, especially for jails holding mostly people on pretrial status.

The department recognizes that discharge planning takes much time, work, and staff resources, so requiring jails to comply with the model discharge plan for every incarcerated person was unreasonable. Additionally, the variable nature of jails, with quick releases or transfers to state correctional facilities, further complicates discharge planning.

At the same time, discharge planning is important, and the department's proposed requirements attempt to conform with current practice[206] and recommendations from the ACA and NCCHC:

- **ACA.** The release procedure should include listing available community resources and providing medications as directed by the health authority.[207]
- **NCCHC.** For those with serious health needs, the following is provided: Reasonable supply of current medications, linkages between the jail and community-based organizations, discussions with patients on follow-up and aftercare, arranging appointments and medications, and exchanging health information.[208]

The department's proposed rule amendments overlap with the need for discharge planning for people who have received mental-health care or substance-use-disorder treatment while incarcerated.[209] The discharge requirements in those rule parts will complement what the department proposes here.

[205] *Id.* The department's model discharge plan was finalized in 2024 and is attached as Appendix E.
[206] *See* Appendix E.
[207] *Core Jail Standards*, 1-CORE-5B-04; *see also Performance-Based Standards*, 5-ALDF-5B-14, 5-ALDF-5B-19.
[208] *Standards for Health Services in Jails*, J-E-10.
[209] *See* proposed Minn. R. 2911.5810-.5830.

2. Subpart 2 (people with serious and persistent mental illness).

Discharge planning for people with a serious and persistent mental illness is also important, as demonstrated by standards from the ACA, NIC, and NCCHC:

- **ACA.** Before release, "inmates with serious health conditions are referred to available community services."[210]
- **NIC.** "Special arrangements may be warranted, including case-management referral or provisions such as mental health appointments and follow-up."[211]
- **NCCHC.** "Referrals are made to specialized clinics or community health professionals or, if appropriate, direct admission to a community hospital may be arranged."[212]

Yet statute already requires jails to develop discharge planning for this population:

> A person with a serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), who has been convicted and sentenced to serve three or more months and is being released from a county jail or county regional jail shall be referred to the appropriate staff in the county human services department at least 60 days before being released. *The county human services department must complete a discharge plan* with the prisoner no less than 14 days before release that may include . . .[213]

Because the legislature directs the county to complete the discharge plan, the department doesn't have the authority to direct what should be included in the plan. But the department believes that it is needed and reasonable for a jail to have a policy and procedure on these plans—this can help facilitate cooperation between the jail and the county and also allows for the department to ensure compliance with the statute through inspection.

3. Subpart 3 (refusal to participate).

This proposed language acknowledges that an incarcerated person may not want a discharge plan or might be uncooperative during the discharge process. This refusal to participate should be documented, as the department proposes for several requirements in the admissions process under part 2911.2525.

[210] *Core Jail Standards*, 1-CORE-4C-02.
[211] Martin and Rosazza, *Resource Guide for Jail Administrators*, 200.
[212] *Standards for Health Services in Jails*, J-E-10.
[213] Minn. Stat. § 641.155, subd. 2 (emphasis added).

Information to Incarcerated people (2911.2700)

Incarcerated people should be able to understand facility policies and procedures, so it's needed and reasonable for incarcerated people who have disabilities, special needs, or don't speak English to understand their rights and responsibilities while incarcerated.

Amendments to part 2911.2700 make technical and conforming changes and add more subparts for structure. As discussed on page 106, subparts 2, 3, and 4 are moved to the admissions rule part to group like provisions.

Administrative Separation and Disciplinary Segregation (2911.2790 to 2911.2880)

> *"There is not a single study of solitary confinement wherein nonvoluntary confinement that lasted for longer than 10 days failed to result in negative psychological effects."*[214]

Solitary confinement first emerged in US correctional facilities in the 1800s, "based on Quaker principles of reflection and penitence."[215] Despite these Quaker principles, solitary confinement didn't work as intended because people would leave correctional facilities with worsened mental illness, more likely to reoffend, and more likely to reoffend with violent crimes. These pernicious effects were recognized by the Supreme Court,[216] which in 1890 characterized the practice as "a further terror and peculiar mark of infamy."[217] As such, by the end of the 19th century, correctional facilities stopped using solitary confinement.[218]

Correctional facilities stopped using solitary confinement because the practice—generally spending 22 to 24 hours a day alone in a small cell—has been found to "cause a wide range of psychological symptoms including insomnia, withdrawal, rage and aggression, depression, hallucinations and thoughts of suicide, even in prisoners who are mentally healthy to begin with."[219]

The deleterious effects of solitary confinement still hold true today even though correctional facilities, starting in the mid-20th century, have reverted to using the practice. This increase has occurred despite solitary confinement being seen as "one of the most severe forms of punishment that can be inflicted on human beings short of killing them."[220] And international and national standards reflect the long-term harm that solitary confinement can cause:

[214] Alexander A. Reinert, *Solitary Troubles*, 93 Notre Dame L. Rev. 927, 959 (2018) (citation omitted).
[215] Erica Goode, "Prisons Rethink Isolation, Saving Money, Lives and Sanity," *New York Times*, March 10, 2012.
[216] *In re Medley,* 134 U.S. 160 (1890).
[217] *Id.* at 170.
[218] Reinert, *Solitary Troubles*, 936.
[219] Goode, "Prisons Rethink Isolation."
[220] Reinert, *Solitary Troubles*, 929 (citation omitted).

- The United Nations Committee Against Torture recommends that solitary confinement is used only in exceptional cases.
- The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) state that solitary confinement should be prohibited for adults with mental or physical disabilities.
- The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders state that pregnant women should never be placed in solitary confinement.
- The United Nations special rapporteur recommends a complete ban on prolonged or indefinite solitary confinement, citing 15 days as the starting point of prolonged solitary confinement because, after that, "some of the harmful psychological effects of isolation can become irreversible."[221]
- The American Psychiatric Association opposes solitary confinement for individuals with a serious mental illness.[222]
- NCCHC argues that solitary confinement for more than 15 consecutive days is "cruel, inhumane, and degrading treatment, and harmful to an individual's health."[223] NCCHC recommends against placing people who are mentally ill or pregnant in solitary confinement.
- Individual states have reformed their use of solitary confinement, including for certain populations such as people who are mentally ill or pregnant.[224]

If international and national standards recommend against using solitary confinement, or at least limiting its use, why do correctional facilities such as jails continue to use it and defend it?

First, jails admit people directly from the community, and sometimes people may be mentally unstable or using illegal substances. In turn, these people may

[221] United Nations General Assembly, A/66/268, "Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," August 5, 2011.
[222] "Restrictive housing of incarcerated adults with serious mental illness, with rare exceptions that involve significant danger to others, should be avoided due to the potential for harm to such individuals." American Psychiatric Association, *Position Statement on Restrictive Housing of Incarcerated Adults with Serious Mental Illness* (July 2023).
[223] National Commission on Correctional Health Care, *Position Statement: Solitary Confinement (Isolation)* (April 2016), 4.
[224] The Correctional Leaders Association & The Arthur Liman Center for Public Interest Law at Yale Law School, *Time-In-Cell 2019: A Snapshot of Restrictive Housing Based on a Nationwide Survey of U.S. Prison Systems* (September 2020); *see also* Appendix F.

become violent, and separating them from the general population may be the only way for jails to protect other incarcerated people and jail staff.

Second, jail administrators may argue that solitary confinement allows them to maintain order and to deter violence and gang activity.[225] A jail's primary function is to protect everyone in the facility and members of the public, and solitary confinement can be a method—sometimes the *only* method—to maintain security and to protect the public.[226]

Third, jails use solitary confinement for protective custody and to prevent vulnerable populations from being victimized.

The department recognizes that there may be times when solitary confinement is needed to protect staff and incarcerated people. But the department also believes that its proposed restrictions on a jail's use of solitary confinement are needed and reasonable given the well-documented evidence of its harms and broader societal costs.[227]

As the defined terms relating to solitary confinement indicate, administrative separation is a classification status assigned to an incarcerated person, while disciplinary segregation is a punitive response to a facility violation. Administrative separation is generally not considered solitary confinement because it must consist of separate and secure housing and is not meant to confine incarcerated people to their cells all day.

The following table illustrates the differences between the two concepts:

[225] While reasonable, deterrence has been proven to be ineffective. *See* Reinert, *Solitary Troubles*, 972. Solitary confinement also makes people more likely to reoffend. *See* Andy Mannix, "Extreme Isolation Scars State Inmates," *Minnesota Star Tribune*, December 4, 2016.

[226] Courts have recognized this use when used to maintain order. *See* Shaun M. Gann and John W. Palmer, *Constitutional Rights of Prisoners*, 10th ed. (Routledge, 2022), 200.

[227] Some of these requirements may help counties that are designing new jails. For example, newer jails may have dedicated mental-health units. *See* Sarah Ritter, "Anoka County, City Deadlocked Over Plans for Bigger Jail Downtown," *Minnesota Star Tribune*, January 4, 2025; "Dakota County Celebrates New Jail Unit for Specialized Care," *Hastings Star Gazette*, March 10, 2025.

Table 8. Differences between administrative separation and disciplinary segregation

-	Administrative Separation	Disciplinary Segregation
Reason	According to objective classification system	Violation of facility rules or immediate safety need
Length	Either long term or short term	Short term (usually)
Privileges (if not otherwise dictated by classification or behavior)	Same as general population	More limited

The department believes that its proposed amendments on administrative separation and disciplinary segregation strike a careful and evidence-based balance between concern for the mental health of incarcerated people and the concerns jails have for the safety and security of all incarcerated people and jail staff.

Well-established research and past incidents in Minnesota jails support these rule amendments. While rare, extreme cases like one in New Mexico, in 2014, demonstrate the need to establish more protections in Minnesota jails. In this case, a mentally ill person was placed in solitary confinement for almost two years. The incarcerated person recently won a $15.5 million settlement for violations of his civil rights.[228]

[228] "$15.5 Million Settlement for Mentally Ill Jail Detainee Held in Solitary Confinement," *Prison Legal News*, 20 (April 2014).

Reason for Placement (2911.2790)

1. Protecting against arbitrary placement.

The proposed requirements in this part protect an incarcerated person from being arbitrarily placed in administrative separation or disciplinary segregation. As the department discusses, this protection is needed because certain populations face significant health and safety risks from prolonged isolation. Because of these health and safety risks, this population—and all incarcerated people—may be placed in administrative separation or disciplinary segregation only on a case-by-case basis and because of a documented health or safety reason.

2. Risks of segregation for certain populations.

Research shows that the three-most-vulnerable populations in a correctional facility include:

a) people with a serious and persistent mental illness or developmental disability;

b) women who are pregnant or postpartum; and

c) transgender or persons who are gender nonconforming.

Both national and international standards recommend against placing a person with a mental illness or developmental disability in disciplinary segregation. Additionally, other states such as Colorado, Massachusetts, and New Mexico prohibit this practice for this population, including the department for its prisons.[229] States and national standards recommend against placement because disciplinary segregation or administrative separation, especially without mental-health care, is an inadequate tool for people undergoing mental-health crises and "can increase the risk of severe medical and behavioral health consequences, including death by suicide."[230]

And research also indicates that this population is more likely to commit violence while incarcerated and to violate facility rules.[231] Separation or segregation does

[229] DOC Policy 301.083.

[230] Legislative Analysis and Public Policy Association, *Model Withdrawal Management Protocol*, 14.

[231] Martin et al., "Mental Health Screening Tools," 275.

nothing to solve the underlying symptoms of those with a mental illness or developmental disability.

> *"Isolating people during extreme mental health crises, due to the lack of a dedicated unit, 'can further deteriorate inmates' mental health.'"*[232]

National standards and other states also prohibit solitary confinement for an incarcerated individual who is pregnant or postpartum.[233] In the proposed language, six weeks was added to be consistent with related statutory requirements.[234]

Placement by gender identity alone is also discouraged.[235] One reason is because transgender and gender nonconforming adults who had negative experiences—such as assault and harassment—with law enforcement commonly reported attempting suicide.[236] So because of the higher prevalence of suicide attempts by transgender Americans (41%) compared to the overall US population (4.6%),[237] a placement decision in administrative separation or disciplinary segregation should be associated with health or safety need.

While the rule doesn't contain standards on how jail staff should determine someone's gender identity, compliance with this rule should conform with how jails follow existing rule requirements and help staff safely manage the jail.[238]

3. Alternative to placement.

The initial rule amendments that the department discussed with the advisory committee had aligned with recommended national and international standards and requirements from other states[239] on limiting administrative separation and disciplinary segregation for vulnerable populations to an immediate security or safety need and when other less-restrictive alternatives were unavailable. For example, other states such as Montana require jail staff to evaluate "alternatives

[232] Ritter, "Anoka County, City Deadlocked."
[233] See Appendix F.
[234] *See* Minn. Stat. § 241.89.
[235] *See also* DOC Policy 301.083(A)(5); *Performance-Based Standards*, 5-ALDF-2F-27.
[236] Ann P. Haas, Philip L. Rodgers, and Jody L. Herman*, Suicide Attempts Among Transgender and Gender Non-Conforming Adults* (American Foundation for Suicide Prevention and the Williams Institute, January 2014), 13.
[237] *Id.*, 2.
[238] *See* Minn. R. 2911.0900, subp. 10, .2525, subp. 1(J), .2600, subp. 1(A); *see also* DOC Policy 202.045.
[239] *See* Appendix F.

to restrictive housing that may be available to safely address the threat posed by the inmate.”[240]

As discussed, the department revised the initial amendments after receiving feedback from the advisory committee and other members of the public.

4. Department changes from previous rule drafts.

The advisory committee was deeply divided on the department’s proposed requirements on administrative separation and disciplinary segregation. The department strongly considered the perspectives of all committee members and even organized a tour of Dakota County’s new mental-health unit. This tour was organized to show how a jail can use dedicated housing units to safely separate people with mental illness from the general population and to provide them mental-health care.

While not all jails have units such as those in Dakota County, the department still believes that jails raise valid points on the necessary role that administrative separation serves.

First, jails have no choice in who they admit into their facilities. A person may have a serious and persistent mental illness, may be elderly and vulnerable, or may not be competent. In these cases, administrative separation may be the only tool a jail can use to protect the safety of this population.

Second, jails are responsible for the safety and security of all incarcerated people in their custody. If an incarcerated person is assaultive or engaging in criminal activity, administrative separation ensures the safety of other incarcerated people.

Third, jails must also be responsible for the health and safety of their staff. Limiting administrative separation could make it harder for jails to protect their staff and, ultimately, keep them as employees.

And fourth, administrative separation is not solitary confinement and is not punitive (in most cases). The department also believes that its proposed requirements in part 2911.2800 and elsewhere in rule provide additional checks to ensure that people in administrative separation are being placed in accordance with the rule and are being adequately monitored to ensure their health and safety.

[240] Mont. Code Ann. § 53-30-703(5)(c) (West 2020); *see also* Colo. Rev. Stat. Ann. § 17-26-303 (West 2023); DOC Policy 301.083.

Administrative Separation (2911.2800)

This part is amended to clarify what administrative separation is and to better establish documentation and review requirements. Jails use administrative separation for incarcerated people who present a danger to others, require protective custody, or cannot safely function in general population because of a mental illness or developmental disability.

1. Subpart 1 (policy and procedure).

Two key components of administrative separation are documentation and review. Well-established documentation and review requirements are important because each decision to place a person in administrative separation "should be based on recent conduct, a medical or mental condition, pending charges, or an inmate's overall record."[241] Because it is more long term and can still pose health risks to incarcerated people, administrative separation should be no longer than needed—that is, the reason for placement or removal must be directly related to the incarcerated person's health or a safety risk.

Consistent with proposed changes under part 2911.2790, a person shouldn't be automatically placed in administrative separation unless there is an unforeseen incident that requires immediate placement. For example, an assault or the need for protective custody could warrant immediate placement in administrative separation. A jail may also have a security concern (such as gang activity) for placing someone in administrative separation.

Additionally, because administrative separation should be used only when there are no available alternatives such as a separate housing unit within general population, custody staff must consider these alternatives before placement.

2. Subpart 2 (separate and secure housing).

Because administrative separation is not punitive, incarcerated people should still have access to facility programs and services. This subpart clarifies the need for this population to continue to have access to programming.[242] Programming is important in jails for both safety reasons and for successfully reintegrating incarcerated people into the community:

[241] Martin and Rosazza, *Resource Guide for Jail Administrators*, 166.
[242] *Id.*, 168.

> Programs keep inmates busy, establish expectations, provide goals for inmates to work toward, and help them recognize their potential for growth. Programs can teach inmates useful skills, provide continuing education, help them overcome substance abuse problems, improve their mental health, give spiritual guidance, improve parenting, help with anger and stress management, and ultimately teach them to change antisocial and criminal behaviors.[243]

For example, in Dakota County, the jail's programming—among other goals—seeks to "reduce recidivism and the criminogenic risk factors"[244] of its incarcerated population. The jail offers programs ranking from anger management to employment readiness to navigating the criminal-justice system.

If custody staff determine that an item or activity should be deprived for an incarcerated person in administrative separation, the deprivation should be related to protecting the incarcerated person, other people in the facility, and the public. Consistent with the proposed language under subpart 1, item B, this requirement is amended to reflect a higher standard of protection for a "serious and immediate" safety or security concern.

Subpart 7 addresses documentation requirements for any item or activity that is deprived.

3. Subpart 4 (policy requirements).

Documentation is critical for jails to monitor incarcerated people in administrative separation, especially to protect their due-process rights for being separated and to ensure their continued need for placement. Both department policy and the NIC recommend seven-day reviews to assess for a person's continued need for separation and whether a person's needs, such as mental-health needs, would necessitate more-frequent reviews.[245] The ACA also recommends seven-day reviews for the first two months of placement.[246]

One important tool that can help custody staff review an incarcerated person's status is a log, which some states and national groups recommend for incarcerated people in administrative separation.[247] A log is important because it

[243] *Id.*, 184.
[244] "Dakota County Jail Programs" (2024), 1.
[245] Martin and Rosazza, *Resource Guide for Jail Administrators*, 167, 169; *see also* DOC Policy 301.083(A)(12).
[246] *Performance-Based Standards*, 5-ALDF-2E-05.
[247] Martin and Rosazza, *Resource Guide for Jail Administrators*, 169; DOC Policy 301.083 (A)(11).

can “communicate essential information across shifts and with professionals working with the inmates.”[248] Logs aren’t a new concept in jails, as the ACA and other states recommend the tool.[249] For example, a South Dakota jail found positive results after creating a log to monitor for positive behavior:

> The log is an officer-driven, easy-to-use tool to acknowledge on a very regular basis when offenders are doing well and provide immediate feedback when they are not. Because the affirmation and disapproval of behaviors is timely and done without the introduction of a formal disciplinary report, it opens up dialog between the offender and staff. Offenders are eager to hear how well they are doing or to talk about how and why they struggled on the prior shift or the previous day. In sum, the log facilitates interactions that help promote prosocial behaviors, such as appropriate response to constructive feedback and how to appropriately engage with staff, and provides an avenue for officers to have real input into inmate performance and progression.[250]

The department originally proposed requiring a log in its December 2024 rule draft, but advisory-committee members and jail staff indicated that they don’t track information of incarcerated people in a single location. While the department still believes that a log or other instrument that houses all relevant information is ideal and beneficial, the department also acknowledges the different documentation systems that jails use and that an incarcerated person’s jail and health records are separately maintained. Ultimately, jails are expected to comply with the rule as they best see fit as long as they document the required items.

The requirements in this subpart are all needed and reasonable to ensure the health and safety of incarcerated people in administrative separation. Documentation allows department inspectors to inspect for compliance and is also needed for jails to perform their seven-day administrative review. Because a person’s behavior or other health-care needs may change, items C and D are needed to ensure that jail staff and health-care personnel will work together—when needed—to monitor a person’s medical needs.

The proposed requirements in item H are needed to further establish review requirements. Jails should already be reviewing for health and safety concerns

[248] Martin and Rosazza, *Resource Guide for Jail Administrators*, 169.
[249] *Core Jail Standards*, 1-CORE-2A-08; *Performance-Based Standards*, 5-ALDF-2E-13.
[250] Barbara Pierce Parker, “Promoting Positive Behavior in Restrictive Housing,” Crime and Justice Institute (Boston, November 2015).

during the seven-day administrative review process because reviewing these concerns can help jails identify possible health-care or safety issues and take preventive action accordingly.

While there may be some overlap with well-being checks, the detailed requirements here are reasonable and needed given the risks of administrative separation, especially for vulnerable populations.

4. Subpart 4a (reviewing administrative-separation status).

This subpart clarifies that an incarcerated person may request that their placement in administrative separation be reviewed, consistent with existing requirements under part 2911.2600 and other jail standards.[251]

5. Subpart 4b (behavior-management plan).

As South Dakota's experience shows, custody staff should interact with incarcerated people to maintain positive behavior, especially compliance with facility policies and rules. One way to help maintain and track this behavior is to develop a behavior-management plan. The department recently adopted similar requirements for its juvenile facilities[252] and has found that while these plans can be resource-intensive, they provide long-term benefits for both the incarcerated person and the jail.

As in other 2911 requirements on behavior and expectations of incarcerated people, jails must clearly establish behavioral expectations for people in administrative separation—this can in turn help ensure incarcerated people comply with facility rules and can help maintain the facility's safety and security.

For people in administrative separation, the department also believes it needed and reasonable to emphasize the continued need for documentation, including any mental-health concerns, as mental health is a common reason that someone may be placed in administrative separation.

The department also acknowledges that not everyone in administrative separation is placed because of a behavioral concern and therefore will not need a behavior-management plan. For example, an incarcerated person may voluntarily prefer administrative separation, or someone may be placed because of a medical reason. And while someone may be separated for a behavioral concern such as criminal activity, the department views this placement reason as

[251] *Core Jail Standards*, 1-CORE-2A-16; Martin and Rosazza, *Resource Guide for Jail Administrators*, 166.
[252] Minn. R. 2960.0740, subp. 2.

more associated with facility security. Excluding these incarcerated people from the requirement can help alleviate staffing concerns and the time spent developing and following these plans.

For those who need a behavior plan, however, the plan should include any available or applicable incentives to help motivate positive, safe behavior. Incentives can vary by facility but could include more recreation time or more telephone privileges. But providing incentives alone without also providing necessary mental health or medical supports may be insufficient to improving behavioral issues stemming from a mental-health diagnosis—this mental-health support is discussed on page 229.

It’s reasonable that the facility administrator reviews the behavior-management plan together with the standard seven-day administrative-review process; reviewing the behavior plan will help the facility administrator determine whether an incarcerated person’s continued placement is needed or if the person has health-care concerns that should be addressed.

While not all incarcerated people placed in administrative separation will transition to general population, for the portion that may transition, a behavioral plan is another tool to generate positive outcomes for them and the rest of the jail.

6. Subpart 6 (protective custody).

This subpart is repealed because the intent is covered under subpart 1 and in the definition of administrative separation.

7. Subpart 7 (deprivation report).

The department clarifies that a jail administrator must approve any continued deprivation of an item or activity usually authorized in administrative separation. This is a needed and reasonable clarification because people in administrative separation should generally have access to the same services and programming as those in general population. The department also clarifies that the deprivation is in relation to a jail’s standard policy and procedure on administrative separation as opposed in relation to items or activities allowed in general population.

There may be situations when custody staff must immediately deprive an item or when a supervisor who can immediately approve the deprivation is unavailable. In these situations, jail staff need flexibility for security or safety reasons, and continued deprivation will be reviewed by the facility administrator and documented.

This subpart shouldn't apply to a person on suicide watch because a facility's policy and procedure will already prescribe suicide precautions on bedding, clothing, etc. and because people on suicide watch are—by nature—already deprived of most items for their safety.

Because the need for suicide watch may vary from person to person, the department doesn't believe it necessary to define this technical correctional term. Each facility has a policy and procedure on suicide watch, and the department has not experienced any difficulties in enforcing the current term used in rule.[253]

8. Conforming changes.

With the change from *administrative segregation* to *separation*, the department is making conforming changes in the following rule parts: 2911.0330, subpart 2; 2911.2500; and 2911.3100, subpart 7.

[253] *See* Minn. R. 2911.5000, subp. 5: "Examples of inmates of a special need classification include those classified as potentially suicidal . . ."

Discipline Plan and Disciplinary Segregation (2911.2850)

This part prescribes standards for disciplinary segregation, with many of the proposed requirements mirroring those for administrative separation. Because disciplinary segregation, or solitary confinement, can result in long-term harm and in more misconduct and recidivism,[254] the proposed requirements are needed to combat the risk of punitive isolation. As with other proposed changes, the rule revisions in this part are supported by international standards, national standards, and state practices.

1. Subpart 1 (discipline plan).

This subpart on a jail's discipline plan makes technical changes and is reorganized into a vertical list.

Items A, B, and C are rewritten to conform to the disciplinary process used in jails and to more logically arrange this process.

Item D is added to require a jail to develop a process for step-down management; this process will be different for each jail, and jails are not required to use step-down management. But because of the risks associated with long-term solitary confinement, a jail should have processes in place to transition a person from disciplinary segregation to administrative separation or general population.

2. Subpart 2 (disciplinary segregation).

> *"A minimum standard is not yet set on the number of days or other conditions that will constitute cruel and unusual punishment in punitive isolation in every situation."*[255]

There are no uniform state standards for establishing explicit limits on the length of solitary confinement. Meanwhile, recent data shows that 58% of incarcerated

[254] Andreea Matei, "Solitary Confinement in US Prisons," Urban Institute (Washington, DC, August 2022), 2. Additionally, prolonged social isolation is "antithetical to the goals of rehabilitation and social integration." National Commission on Correctional Health Care, *Position Statement: Solitary Confinement (Isolation)*, 2.

[255] Gann and Palmer, *Constitutional Rights of Prisoners*, 199.

people in solitary confinement spent more than 15 days in solitary confinement, yet the average length of stay in jail in the same period was 26 days.[256]

For placement lengths, international standards recommend no more than 15 days, some states have limits ranging from 72 hours to 30 days, and other states have no limits. One US city even passed a law that would have banned solitary confinement for incarcerated people that break facility rules.[257] Passed by the New York City Council, this transformational law would have prohibited solitary confinement for more than four hours and required 14 hours of out-of-cell time. Although the ordinance was vetoed by the city's mayor, the proposal shows how public officials are considering concrete solitary-confinement prohibitions.

National jail standards also prescribe confinement limits. For example, the ACA states that:

a) a maximum sanction should be no longer than 60 days;
b) continuous confinement for more than 30 days should be reviewed by the jail administrator; and
c) penalties "should be proportionate to the importance of the rule and severity of the violation."[258]

For purposes of cruel and unusual punishment, courts vary on what length of time triggers a constitutional violation.[259] And length is just one factor for courts to consider, along with cell conditions, deprivation of privileges, and proportionate treatment relating to the committed infraction.

Furthermore, a Minnesota statute prescribes limits on solitary confinement:

> When any prisoner is unruly or disobeys any regulation for the management of jails, the prisoner may be kept in secure confinement as provided in section 641.09.[260]

The referenced statutory section sets limits on solitary confinement for labor violations: "A prisoner may be kept in solitary confinement but shall not be so confined more than ten days for any one offense, nor more than 90 days in

[256] *Calculating Torture: A Report by Solitary Watch and the Unlock the Box Campaign* (May 2023), 12.
[257] Chelsia Rose Marcius, "Adams Blocks Law That Bans Solitary Confinement in New York Jails," *New York Times*, July 28, 2024.
[258] *Core Jail Standards*, 1-CORE-3A-01; *see also Performance-Based Standards*, 5-ALDF-2E-08.
[259] Gann and Palmer, *Constitutional Rights of Prisoners*, 198.
[260] Minn. Stat. § 641.18.

all."[261] While the statute demonstrates how the legislature at one time determined that limits to solitary confinement were necessary, the statutory history also demonstrates that the common vision of solitary confinement (a person confined in dark room with only bread and water) is inaccurate. For both reasons, the department finds its proposed requirements strike a middle ground from the advisory-committee discussions.

The department pivoted from its original proposal of a strict segregation time limit (90 days total according to statute) to a tiered sanctioning framework. The department decided to pivot because most jails already use a tiered sanctioning system for minor, major, and serious violations.

Under the existing rule, each jail determines what it considers a minor or major violation, and the department sees no need to deviate from this when adding the third category (serious).

The department recognizes that there are times when an incarcerated person will need to remain beyond the limits proposed in rule. For example, a serious assault or attempted murder would necessitate extensions for the jail's security and for the safety of jail staff and other incarcerated people.

When an extension is needed, the department's proposed requirements ensure that a facility administrator documents the reason for the extension and any alternatives considered. These are needed and reasonable safeguards given the health risks of extended solitary confinement and because they allow for the department to review for compliance.

Item C reflects the seven-day review process proposed for administrative separation. While current language on disciplinary segregation prescribes a jail administrator to visit an incarcerated person at least every seven days, an in-depth review is required only every 30 days. As discussed on page 123, the department believes that a seven-day review is a needed change because of the health and safety risks of disciplinary segregation and that it's unreasonable to require a seven-day review for administrative separation but not for disciplinary segregation.

The need and reasonableness for requiring a log (or other documentation requirements) are the same for requiring one for administrative separation.

[261] *Id.* § 641.09.

3. Subpart 3 (due process).

This subpart clarifies that the hearing officer for a disciplinary hearing shouldn't have been involved in the underlying incident. This provision ensures neutrality and a fair hearing. Subitem (4) clarifies that an incarcerated person may appeal their alleged violation—this requirement is implied because existing rule requires a hearing and because appealing an alleged violation is a uniform practice among jails.

4. Subpart 3a (review).

This subpart is amended to align with changes made for administrative separation. Existing rule requires a jail administrator or designee to visit an incarcerated person in segregation at least once every seven days (*see* item B), and it's reasonable to require a seven-day review in conjunction with the in-person visit. This provision is also consistent with the ACA, which requires that the reason for placement is reviewed every seven days for the first 60 days.[262]

Because of the harms caused by social isolation, a 30-day review is insufficient to account for the health and well-being of people in segregation. Health-care staff should evaluate any deterioration in a person's health, and jail staff should determine whether a person's positive behavior could allow them to transition to less-restrictive housing or be referred for step-down management.

Given the sensory deprivation that social isolation causes and the related psychological effects, step-down management can help an incarcerated person safely transition from disciplinary segregation back to general population or to a less-restrictive setting. Some larger jails with more resources may provide step-down management as recommended by the NIC, including individual care plans and transition plans, safe transitional housing, and a multidisciplinary team of mental-health staff, custody staff, and case planners.[263] Step-down planning can also include weekly evaluations by jail staff, increased out-of-cell time, increased group interaction, and gradually increased privileges.[264]

But given the nature of and variability among jails, step-down management may not be possible for people immediately discharged from jail or for smaller and medium-sized jails.

[262] *See Performance-Based Standards*, 5-ALDF-2F-04.
[263] *Id.*, 5-ALDF-2E-07.
[264] *Id.*, 5-ALDF-2F-23.

While the department has significantly amended language from previous rule drafts, jails may still oppose the proposed requirements. Yet recommended alternatives to solitary confinement do exist:

- Allow solitary confinement for situations where emergency de-escalation is necessary and is imposed by staff who have are proficient in crisis intervention training (CIT).
- Develop alternatives with program-based interventions and out-of-cell programs.
- Provide comprehensive screening, assessment, and treatment for those with mental illnesses and others most vulnerable to segregation.
- In a worst-case scenario, have the person transferred to a state correctional facility.

5. Subpart 3b (timing for hearing).

This subpart is amended to clarify the 72-hour requirement for holding a disciplinary hearing. Depending on an incarcerated person's alleged violation, the person may not be placed in disciplinary segregation until their hearing, or the alleged violation may not result in disciplinary segregation. But given the punitive nature of this discipline, the due-process requirements under this subpart should apply to *all* alleged violations that may result in disciplinary segregation. (notwithstanding items A and B).

6. Subpart 4 (other limitations).

This subpart on deprivation of privileges is amended to align with changes made for administrative separation. These are needed and reasonable conforming changes to ensure that any deprivation of items are appropriately documented and reviewed.

7. Subparts 6 and 7 (clothing and bedding; records).

This subpart makes minor technical and conforming changes for consistency and plain-language changes. Not all facility rule violations will result in disciplinary segregation and require formal resolution such as a hearing or appeal process. Accordingly, jails don't write detailed discipline reports for more-informal resolutions for minor violations. This could be a burdensome requirement for many jails given the number of minor violations.

8. Subpart 8 (behavior-management plan).

This subpart is amended to align with changes made for administrative separation. The department believes that the same reasoning and need for these

amendments on behavior-management plans (facility security and the safety of all people in a facility) also apply to incarcerated people placed in long-term disciplinary segregation.

Mental-Health Review (2911.2860)

This part establishes standards on an incarcerated person's mental health while in administrative separation or disciplinary segregation. While incarcerated people in administrative separation and disciplinary segregation are entitled to the same health care as those in general population, this proposed language is needed and reasonable because of the vulnerable populations that are housed in administrative separation and disciplinary segregation.

For example, in 2022, an incarcerated person hung themself while isolated in a special housing unit. The person had a history of depression and anxiety and was reported to have had a worsening mode before their death and to have been agitated on the day they died.[265] The proposed standards are needed to help prevent suicides such as these and other serious medical incidents.

1. Subpart 1 (health visits).

This subpart requires health-care staff—which may include a mental-health professional—to visit with an incarcerated person at least weekly to determine whether the person requires mental-health services.[266] Depending on a jail's resources, these visits may occur more frequently.

This visit could be as simple as "cell-door therapy," where a mental-health professional talks with an incarcerated person through a cell door. These visits "are intended to be screening rounds and are not meant to be clinical encounters."[267] Depending on the jail's mental-health staffing and safety concerns, mental-health professionals may meet with an incarcerated person outside the cell in another setting.

This care, or "segregation rounds," is important because "persons in segregated environments are vulnerable to mental illness and often experience irritability, anxiety or depression."[268] Accordingly, segregation rounds allow mental-health staff to "monitor segregated inmates for signs of mental or physical decompensation."[269]

[265] Midwest Medical Examiner's Office, "Medical Examiner's Final Summary" (2020).
[266] This requirement shouldn't be a new practice for jails; *see* Minn. R. 2911.5800, subp. 9(D), on sick call: "If an inmate's custody status precludes attendance at sick call, arrangements are made to provide sick call services in the place of the inmate's detention."
[267] *Performance-Based Standards*, 5-ALDF-2E-02, 5-ALDF-2F-03.
[268] *Standards for Mental Health Services in Correctional Facilities*, 87.
[269] *Id.*

Both NCCHC and the ACA express similar requirements to the department's proposed language. While ideally the amount of monitoring would be tied to the degree or length of isolation, the variation in jail size, location, and resources precludes this level of detail in rule.

This subpart is also similar to statutory requirements for the department's prisons:

> A health services staff member shall perform a daily wellness round in the restrictive housing setting. If a health services staff member indicates symptoms of a mental illness, a qualified mental health professional shall be consulted regarding appropriate treatment and placement.[270]

When a mental-health professional is unavailable, health-care staff should refer an incarcerated person for mental-health care according to the facility's policy and procedure—this may be based on an incarcerated person's signs or symptoms or on other observations.

Sometimes, an incarcerated person may not want to talk with health-care staff or may be belligerent or assaultive. Jail staff should document these situations to help track an incarcerated person's behavior and so that department inspectors can ensure compliance.

2. Subpart 2 (mental-status exam).

This subpart requires that a mental-health professional conduct a mental-status exam for someone who has been in disciplinary segregation for longer than 30 consecutive days (jails without mental-health staff would take the person to a hospital or health clinic). Given the corrosive mental-health consequences caused by long-term segregation, this requirement is needed and reasonable for individuals segregated for serious violations or those whose segregation is extended for major violations.

After the initial mental-status exam, the department had proposed that an incarcerated person receive an exam every seven days because the incarcerated person would be exceeding limits recommended by national and international standards. A seven-day requirement would've also aligned with the seven-day administrative-review process.

But some jails commented that a follow-up mental-status exam should be determined by a mental-health professional—that is, Why require a follow-up

[270] Minn. Stat. § 243.521, subd. 6.

exam if it isn't clinically indicated? The department thinks this is a reasonable comment and adjusted the language accordingly.

The department also discussed whether to require mental-status exams for people in administrative separation—in many cases, people in administrative separation are separated longer than those in disciplinary segregation. But at the same time, people in administrative separation may be placed there for non-mental-health-related reasons, and some jails may have entire units dedicated to housing people in administrative separation.

Accordingly, the department believes that its proposed language in item A is reasonable and that the health visits under part 2911.2860 will help ensure this population receives timely and appropriate mental-health care.

3. Subpart 3 (staff observation).

As with standards for general population on daily health concerns (*see* part 2911.5800, subpart 8), this subpart ensures that any daily mental-health concerns are communicated to the facility administrator. The facility administrator can evaluate these concerns as part of the seven-day review process or earlier when needed. Depending on the concerns, an incarcerated person could be referred to see a mental-health professional or possibly transition out of administrative separation or disciplinary segregation.

With the risk of suicides in jails and for those in disciplinary segregation, concerns on suicidal ideation or self-harm should be tracked and reported.

4. Subpart 4 (documentation).

This subpart establishes needed documentation requirements so that department inspectors can ensure compliance and jail staff are communicating actions taken on a person's mental health with each other and health-care staff.

Commonly, people in jails may refuse to meet with health-care staff—in these cases, staff should document this refusal so that department inspectors can accurately review jails for compliance and better evaluate complaints.

Health Care in Administrative Separation and Disciplinary Segregation (2911.2870)

> *"The personal hygiene of the prisoner, the physical condition of the prisoner, and the physical condition of the isolation cell have been the focal points of most judicial attention in the area of isolated confinement."*[271]

1. Subpart 1 (health care).

Incarcerated people have a constitutional right to health care, and this right doesn't vanish if a person is separated or segregated.

2. Subpart 2 (notification of placement).

Statute, the ACA, and NCCHC all prescribe that health-care staff should be notified when someone is separated or segregated from general population.[272] Health-care staff should be notified so they can:

a) review the incarcerated person's health record for any health concerns; and

b) possibly meet with an incarcerated person to discuss any placement concerns and to monitor for any mental-health signs and symptoms that may be caused by the placement.

Or, as the ACA states, health-care staff are informed so they may "provide screening and review of medical and mental health risk factors."[273]

When needed, health-care staff should share with custody staff concerns about an incarcerated person's placement, such as signs or symptoms to observe or special accommodations that a person may require.

Notification can be done by email or by message through a jail-management system. Because many smaller and medium-sized jails don't have 24/7 health-care coverage, the department doesn't mandate immediate action from health-care staff. Ideally, health-care staff would review an incarcerated person's record *upon* notification. But this requirement isn't realistic for most jails. Yet the need

[271] Gann and Palmer, *Constitutional Rights of Prisoners*, 198.
[272] Minn. Stat. § 243.521, subd. 5; *Performance-Based Standards*, 5-ALDF-2E-02, 5-ALDF-2F-03; *Standards for Mental Health Services in Correctional Facilities*, 86.
[273] *Performance-Based Standards*, 5-ALDF-2F-03.

remains: Health-care staff should review an incarcerated person's placement in administrative separation or disciplinary segregation.

3. Subpart 3 (health and well-being).

Most law or professional standards require housing units to provide conditions "approximate" to those in general population.[274] While this general requirement may be appropriate in statute or national guidelines, the department remains unconvinced that this a clear, objective, and enforceable standard for administrative rules. Accordingly, the department attempts to adopt more-detailed guidance on this common "approximate" standard. Additionally, the department's jail-construction rule (chapter 2900) governs cells and living conditions, which apply to all of a jail's housing units, an area of solitary confinement that has been heavily litigated.[275]

The proposed language is supported by ACA special-management standards.[276] For example, the ACA requires an incarcerated person in special management to receive laundry, barbering, and showering, with exceptions documented.[277] Because of severe mental illness, incarcerated people may be unwilling to shower or may exhibit behavior such a spreading feces in their cell. This unsanitary behavior should be documented.

[274] *See, e.g.,* Minn. Stat. § 243.521, subd. 2.
[275] *See, e.g., Griffin v. Smith*, 493 F. Supp. 129 (W.D.N.Y. 1980).
[276] *Performance-Based Standards*, 5-ALDF-2E-14.
[277] *Id.*, 5-ALDF-2E-15.

Reporting on Administrative Separation and Disciplinary Segregation (2911.2880)

"The absence of quantifiable mental health/substance use data from correctional data systems may itself be one of the central lessons of the current research project."[278]

The legislature requires the department to report data on administrative and disciplinary segregation.[279] As an extension of this requirement, the department proposes that jails also report some of this data to the department for public transparency and to identify additional public-policy solutions to administrative separation and disciplinary segregation. While the department already has the statutory authority to request data from jails and other correctional facilities, establishing this requirement in rule will allow for transparency and consistent enforcement.

Jails must already annually report to the legislature on the number of people placed in segregation,[280] and the department views the proposed amendments as a reasonable extension to further this tracking and reporting. Because incarcerated people have a constitutional right to mental-health care, tracking and reporting this data can help jails and the department protect this right for all incarcerated people.

Requiring the data to be reported to the DOC Portal is consistent with other existing language and proposed rule requirements.

[278] *Minnesota Regional/County Jails Consolidation or Merger Study*, 481.

[279] Minn. Stat. § 243.521, subd. 9.

[280] *Id.*, 241.021, subd. 1f.

Programming and Visitation (2911.3100 to 2911.3500)

1. 2911.3100 (programming).

Programming, or "the constructive scheduling of inmate time,"[281] acts as a powerful incentive because it helps encourage incarcerated people to maintain positive behavior during and after detention.

One type of programming that jails offer is for incarcerated people with substance-abuse issues. Yet the only existing rule reference to substance abuse is in subpart 5, which requires a jail to have a plan for providing chemical-dependency services. This requirement refers to substance-abuse programming, which jails currently offer through groups like Alcoholics Anonymous or Narcotics Anonymous. (This type of programming is distinct from substance-use-disorder treatment under part 2911.5830.)

In subpart 8, the department proposes new language that allows a jail to limit an incarcerated person's access to programming if there is a safety or security reason for doing so (for example, a person is assaultive and poses a safety risk to programming staff). This codifies current jail practice and is consistent with proposed deprivation requirements under parts 2911.2800 to 2911.2850.

Any restriction on an incarcerated person's access to programming should be documented given the importance of programming to incarcerated people and to allow department inspectors to check for compliance.

2. 2911.3200 (visitation).

> *"Family contact is one of the surest ways to reduce the likelihood that an individual will re-offend after release."*[282]

An incarcerated person's ability to maintain communication with their family and friends can help their mental health while incarcerated and support their

[281] Minn. R. 2911.3100, subp. 1.
[282] Bernadette Rabuy and Peter Wagner, *Screening Out Family Time: The For-Profit Video Visitation Industry in Prisons and Jails* (Prison Policy Initiative, January 2015), 1.

transition to the community: "Many studies indicate institutional misconduct and recidivism are lower among those who receive visits while incarcerated."[283]

The proposed requirements in this part are needed and reasonable to advance visitation access because existing rule doesn't outline what constitutes visitation. And because most jails have moved to video visitation and don't offer on-site in-person visitation, the rule must be updated to reflect this existing practice. For example, "when jails implement video visitation, they typically replace through-the-glass visiting booths with a combination of onsite and remote paid video visitation."[284]

While video visitation may result in lower-quality visits, this limitation is offset by requiring jails to offer a free visitation option if off-site video visitation is used. Offering a free visitation option is an important consideration because when jails charge for visitation, they are "charging the families that are least able to afford this additional expense."[285]

While human contact undoubtedly benefits incarcerated people when they visit with their family, purely off-site visitation is seen as harmful, so a jail should offer both in-person and remote video visits[286] because experience shows that "the best way to sell offsite video visitation is to use other forms of visitation to build the demand."[287]

The department doesn't change the existing requirement for jails to offer eight hours of weekly visitation because the department didn't find a need to change this.

The department also wants to be mindful of state and federal efforts around video visitation. For example, the federal government recently capped the cost of video visitation calls and capped the rates that companies can charge for phone and video-calling services (though the Federal Communications Commission has

[283] Susan McNeeley, "In-Person and Remote Video Visitation and Reentry Outcomes Among Those Released During the COVID-19 Pandemic" (Minnesota Department of Corrections, April 2025), 3 (citations omitted).
[284] Rabuy and Wagner, *Screening Out Family Time*, 6.
[285] *Id.*, 10. While department facilities offer contact visitation, free video visitation isn't offered. *See* DOC Policy 302.100.
[286] Susan McNeeley, "In-Person and Remote Video Visitation," 27.
[287] Rabuy and Wagner, *Screening Out Family Time*, 25.

waived its enforcement).[288] Minnesota legislators have also introduced bills on video visitation in jails.[289]

3. 2911.3400 (communication access).

The department proposes conforming changes to this part on telephone access and organizes the part into subparts with headnotes for readability and structure.

Additionally, the department updates the part to account for new technology such as tablets, texters, and video visitation and cross-references to recent statutory requirements that define this newer technology.

The department proposes striking the minimum time limit on phone calls under subpart 4 because most jails contract with Reliance Telephone to offer the technology, and the minimum time limit is consequently outdated because jails offer tablets, texters, and video kiosks.

4. 2911.3500 (volunteers).

This part contains requirements for facility volunteers, which many jails rely on for programming options. In addition to technical and plain-language changes, the department proposes to add specific training topics for volunteers in a facility. Most facility volunteers oversee programming, and because they are in a correctional facility, they should be trained in the proposed topics for their safety and the safety of others working in the facility.

The department estimates that the two required topics will be a minimal cost to jails, as most jails already orient volunteers to a jail's emergency procedures—this orientation is also needed for the volunteers' safety. The department had originally proposed requiring self-defense, but jail administrators questioned what this would entail.

In response, the department clarified that this orientation should include security precautions for working in a jail. This could include instruction on requesting assistance from custody staff or not allowing an incarcerated person to stand between a volunteer and door.

[288] Nazish Dholakia, "The FCC Is Capping Outrageous Prison Phone Rates, But Companies Are Still Price Gouging," Vera Institute of Justice, September 4, 2024, https://www.vera.org/news/the-fcc-is-capping-outrageous-prison-phone-rates-but-companies-are-still-price-gouging. *See also* Sarah Stillman, "Do Children Have a 'Right to Hug' Their Parents?," *The New Yorker*, May 13, 2024.
[289] *See* Senate File No. 4388, Legislative Session 93 (2023-2024).

Uniform and Bedding (2911.3650)

Suicide is the leading cause of deaths in jails,[290] and the most predominant method of suicide is by hanging, with 93% of suicides done by hanging and with 66% of people using bedding as the instrument.[291] To help prevent suicides, the department proposes in item D to move away from sheets, suggesting jails provide incarcerated people blankets instead —this is a safety measure for someone on suicide watch and reflects current practice in most jails. Jails may still provide sheets, but they shouldn't be required to automatically provide them.

In item E, the department strikes language relating to "sufficient comfort." This is a subjective standard that can vary by person, and the department's construction rule and the state's building code govern temperature requirements. This item is also unnecessary because of the amendments to item D.

Item F is amended to reflect that some facilities use a pillow built into a mattress.[292]

The rest of subpart 1 is organized into a vertical list for readability.

[290] *See* Martin and Rosazza, *Resource Guide for Jail Administrators*, 201; Legislative Auditor, *Mental Health Services in County Jails*, 69. One study found that suicides accounted for 30% of jail deaths in 2018. *See* Carson, *Mortality in Local Jails*, 2.
[291] Lindsay M. Hayes, *National Study of Jail Suicide: 20 Years Later* (National Institute of Corrections, April 2010), 44.
[292] Anchortex, "Prison and Detention Mattresses and Pillows," https://www.anchortex.com/collections/cd-mattresses-and-pillows?srsltid=AfmBOoqGKXSjTsCNW2pINWpR9u5gyTHA9nddHVMJJT9s9LiALGtCUKDY (accessed July 18, 2025).

Emergencies and Unusual Occurrences (2911.3700)

Jails must develop plans for emergencies and disasters, including evacuation plans in case of a fire or other emergency. Ensuring continuity of operations and planning for emergencies will help a jail protect the health and safety of people in and outside the jail. The department relies on reporting of emergency and unusual occurrences to review serious incidents, particularly when they result in substantial bodily harm or death. When warranted, inspectors conduct on-site reviews to assess compliance, identify contributing factors, and determine whether corrective actions are needed to avoid future occurrences. In 2025, the department conducted over 40 on-site incident reviews.

1. Subparts 1 to 3 (disaster plan and reviewing emergency procedures).

Technical and plain-language changes are made to subparts 1 and 2 on disaster plans and emergency procedures.

Subpart 3 contains language on promptly evacuating incarcerated people if there is an emergency—because of this duplicative requirement, subpart 3 is repealed and combined with subpart 1, item B.

2. Subpart 4 (emergencies or unusual occurrences).

Under statute, jails must report emergency or unusual occurrences to the department,[293] and this information is reported to the DOC Portal. Item A provides an exception for deaths, which because of 2021 legislative changes must now be reported within 24 hours rather than 10 days like the other occurrences.[294] Other changes to reportable incidents are as follows:

- Subitem (4) is amended to clarify that reportable deaths include those occurring outside the facility when the death follows from an incident that took place while the incarcerated person was detained in the facility. This explicit requirement is both needed and reasonable to ensure compliance with the 2021 statutory directive in section 241.021, subd. 1. It also supports

[293] Minn. Stat. § 241.021, subd. 1: "All facility administrators of correctional facilities are required to report all other emergency or unusual occurrences as defined by rule, including uses of force by facility staff that result in substantial bodily harm or suicide attempts, to the commissioner of corrections within ten days from the occurrence, including any demographic information as required by the commissioner."

[294] *Id.*

timely regulatory oversight by requirement facilities to notify the department, as the licensing authority, of the most serious outcome—death—arising from incidents connected to a licensed facility, as soon as the facility becomes aware of it.

- Subitems (5) and (6) align the incident descriptions with what the department currently uses in the DOC Portal.
- Subitem (7) clarifies that escape attempts include those outside the jail such as if an incarcerated person is at a hospital for care but is still under the jail's custody.
- Subitem (9) is amended to include a definition of 'riot' as it was only used one time in the rule. The added definition incorporates several key elements of a riot while adapting them to the context of a jail facility.
- Subitem (10) on assaults between incarcerated people strikes "criminal charges"; the department doesn't need to know if charges are brought against an incarcerated person by another incarcerated person.
- Subitem (11) clarifies that the department doesn't need to be notified twice when an incarcerated person assaults a staff member. For example, an incarcerated person may spit on a staff member, but this probably won't require outside medical attention. However, criminal charges may also be filed, in which case the criminal charges alert the department that an assault has happened. Yet these charges could be brought months after the incident. In most cases, jails will report the assault because a staff member received outside medical attention, and the department doesn't need to be notified a second time if criminal chargers are later filed.
- Subitem (12) reflects the 2021 statutory changes on use of force and cross-references to the statutory definition that the department currently uses in the DOC Portal.
- Subitem (15) removes unnecessary examples.
- Subitem (16) replaces use of sexual materials with recent statutory requirements on restraining pregnant women. The department doesn't find reporting on sexual materials necessary for its licensing and enforcement—this type of incident would be governed by a jail's rules. Given the legislature's recent changes to ensure the health of safety of pregnant women who are

restrained,[295] the department believes it needed and reasonable for jails to report these incidents.

- Subitems (17) adds a reportable incident that is needed because of other proposed department amendments on emergency medication administration and the constitutional concerns on involuntary medication administration.
- Subitem (18) is a needed and reasonable addition for when incarcerated people refuse to eat and because of the health risks of a hunger strike. The department had previously proposed tying this reporting requirement to an incarcerated person's refusal to eat three consecutive meals, but comments from health-care staff and jail administrators resulted in changing the requirement to nine consecutive meals, including fluids, which is consistent with department policy for its correctional facilities.[296]

In addition to updating the rule for statutory changes, the department also structures the subpart into items and vertical lists. Cross-references are also added to efficiently link to other law.

Because the department cannot predict all emergencies that will occur in jails, it is needed and reasonable to refer to the department's incorporation by reference to allow for related emergency-or-unusual-occurrence additions if needed.

The last item of the list is a standard qualifier used by agencies when adopting rules, and it follows the *ejusdem generis* canon[297]: this ensures that the department cannot arbitrarily add additional items for a jail to report. For example, the department could only add a reportable item that follows the general list of unusual or emergency occurrences (much like the *Sesame Street* song "One of These Things").

3. Subpart 5 (deaths)[298].

A cross-reference is added to this subpart on reporting deaths of incarcerated people within 24 hours of receiving knowledge of the death—this cross-

[295] *See, e.g.,* Minn. Stat. § 241.89.
[296] DOC Policy 301.190.
[297] *See* Scalia and Garner, *Reading Law*, 200: "Courts have applied the rule, which in English law dates back to 1596, to all sorts of syntactic constructions that have particularized lists followed by a broad, generic phrase."
[298] Future rule revision including if an inmate dies "outside the facility while the inmate was receiving medical care stemming from an incident or need for medical care at the facility that occurred while the individual was detained or confined in the facility."

reference reflects 2021 statutory changes on death reviews. The department believes that the current statutory language explaining what is required of a jail when conducting a death review is sufficient guidance and that requiring more than a facility policy is not needed. The department has been overseeing death reviews since summer 2021 and hasn't identified any needed additions in rule except for when an incarcerated person dies outside a jail.

The proposed revision clarifies and strengthens death review requirements and connects to the death reporting requirements in part 2911.3700 part 4.B.(4) to ensure they apply in all cases where an incarcerated person's death stems from a medical event or incident that occurred in a jail, regardless of where the death ultimately occurs or whether custody status changes before death.

The 2021 statutory changes—developed through work with the Minnesota Sheriffs' Association and passed by the legislature with bipartisan support—were intended to ensure consistent reporting, review, and accountability when deaths occur in connection with incarceration. This included a shared understanding that deaths must be reported and reviewed even if the person is removed from the jail for medical treatment.

However, the current statutory phrase "committed to the custody of" has created an unintended loophole. While originally intended to distinguish incarcerated people from visitors, staff, or volunteers, it has been interpreted by some jurisdictions to exclude deaths from reporting and review when custody is transferred-such as when a court orders a nonresponsive person moved to a medical facility. As a result, some jails have declined to report deaths or conduct required death reviews, despite the death clearly stemming from a medical emergency that began while the person was in their care.

This interpretation undermines both the intent of the law and sound public policy. The statute already reflects legislative intent to include these situations by requiring reporting "regardless of whether the death occurred at the facility or after removal . . . for medical care stemming from an incident" at the facility. Allowing a mid-emergency custody transfer to negate reporting and review obligations creates a gap in oversight and prevents the department from identifying risks and preventing future deaths.

Accordingly, this rule language is needed and reasonable as it eliminates the gap by requiring death review whenever a death is connected to an incident or medical need arising during detention, regardless of custodial designation at the time of death. This change ensures consistent statewide practice, establishes clear information gathering requirements jails can rely on following all incidents

resulting in death, and preserves the integrity of death reviews as a critical tool for accountability and prevention.

4. Subpart 8 (critical incident debriefing).

Because an emergency or unusual occurrence, especially deaths, can be traumatic for staff,[299] it is needed and reasonable to require jails to offer critical incident debriefing. This concept is used in department facilities,[300] and some jails already use it:

> Debriefing is a process whereby individuals are given an opportunity to express their thoughts and feelings about an incident (e.g., suicide or attempt), develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms.[301]

In other words, a debriefing from a critical incident can "help identify what went right and wrong during the incident."[302] Because the type of incident dictates whether a debriefing is informal or formal, the department proposes to give jails discretion in how they will provide debriefings, such as a debriefing's structure and time frame after an incident occurs.

The department also provides jails discretion in the types of incidents for offering debriefing and supportive services; the types of incidents refer to emergency or unusual occurrences, which are reportable incidents to the department under subpart 4. Here, the department lists the most-common scenarios that would result in staff stress or trauma such as deaths, suicide attempts, and assaults. A jail administrator may provide critical incident debriefing for other reportable incidents.

Debriefings are also important because they can help jails better respond to future incidents—debriefings should be seen as part of a jail's quality improvement because debriefings "provide an opportunity for officers to comment on how the supervisors can better support or direct them during an incident."[303]

[299] A statutory provision on critical-incident stress management for emergency-service providers defines a critical incident as "an event that results in acute or cumulative psychological stress or trauma." Minn. Stat. § 181.9732, subd. 1(b).
[300] DOC Policy 103.09.
[301] *Standards for Health Services in Jails*, 41.
[302] Police Executive Research Forum, "Post-Critical Incident," https://www.policeforum.org/post-critical-incident (access May 15, 2025).
[303] *Id.*

"Critical incidents can be traumatic events for responding personnel."[304]

While debriefings are important, providing supportive services to affected jail staff is equally important. For example, debriefings or other programs for responding to critical incidents "can have many positive effects on the mental well-being of the participants" and can help a person "maintain a sense of normality" in their reactions.[305]

Each jail and county will have different resources for providing supportive services, so the department gives jails the flexibility to tailor these services to their resources and needs. A jail may rely on a county's employee-assistance program if needed to help ensure compliance with this subpart. At a minimum, the department wants jails to offer supportive services, whether that includes a "seven-step structured group process, led by trained facilitators,"[306] or a referral to an employee-assistance program.

A jail must document any debriefing provided and whether supportive services were offered to identified staff. The department had previously proposed requiring the provided services to be documented, but this could be specific to the staff member and violate their privacy.

While minimal, the requirements in this subpart are needed and reasonable to comply with the 2021 statutory directive and to ensure that the mental health of jail staff is addressed, both for health reasons and for staff retention.

[304] *Id.*
[305] Sanna Korpela and Hilla Nordquist, "Impacts of Post Critical Incident Seminar on Emergency Service Personnel," *Scandinavian Journal of Psychology* 65 (2024): 241.
[306] DOC Policy 103.09.

Food (2911.3800 to 2911.4800)

Incarcerated people have a right to healthful and nutritious food while incarcerated. Nutritious food is a basic human need, and food takes on exaggerated importance for incarcerated people and can help improve the overall jail management and jail environment. The rule's food requirements have undergone substantial revisions during previous rulemaking proceedings, so the department proposes additional revisions to ensure that the requirements stay wedded to best practices and standards. The department also proposes to streamline the language.

1. 2911.3800 (food handling).

All food requirements are subject to the Department of Health's food code and local ordinances.[307] The department inspects for compliance by reviewing documentation from food inspections conducted by the Department of Health or local food inspectors.

2. 2911.3900 (dietary allowances).

Existing food requirements were based on the federal government's 2005 MyPyramid guidelines and the 2002 Dietary Reference Intakes—the intakes refer to a set of values used to plan and assess nutrient intakes of healthy people, and they vary by age and sex.[308] Given the past reliance on federal food standards, the department incorporates the current edition of the federal dietary guidelines by reference to ensure that the food provided conforms with the dietary guidelines and any subsequent revisions.

Other proposed language consolidates and streamlines requirements:

- Current rule requires that specialized diets are approved by a licensed dietitian, and a facility's menu must also be reviewed at least annually by a dietitian or nutritionist. Accordingly, it is needed and reasonable for the department to require a dietitian or nutritionist to approve a facility's overall menu.

[307] *See* the Minnesota Department of Health, *Minnesota State and Local Food, Pools, and Lodging Contacts*, January 14, 2025, https://www.health.state.mn.us/communities/environment/food/docs/license/locals.pdf
[308] *See, e.g.,* National Institutes of Health, "Nutrient Recommendations and Databases," https://ods.od.nih.gov/HealthInformation/nutrientrecommendations.aspx (accessed May 8, 2025).

The department moves these requirements (from parts 2911.4200 and 2911.4300) into this part for consistency and to reflect current practice in jails and how department inspectors review a jail's menu and whether it has been reviewed by a dietitian or nutritionist.[309]

- Jails must already provide three meals to incarcerated people, with at least one meal being a hot entree and no more than 14 hours between meals. These requirements, and other existing requirements, stem from the ACA.[310]
- The department clarifies that menu planning takes into account pregnant incarcerated people and those adhering to religious dietary practices.
- The department requires menu planning that consists of foods and beverages intended for human consumption. This amendment is consistent with the department's proposed language under 2911.4400. The department doesn't consider nutraloaf as food intended for human consumption or appropriate nutritious food. This view is supported by the ACA and the courts under 8th Amendment considerations.[311] For example, nutraloaf could be considered a constitutional violation of cruel and unusual punishment,[312] and it was removed from New York's prisons, in 2015, to widespread acclaim and relief from incarcerated people.[313]

[309] The department consulted with the Minnesota Board of Dietetics and Nutrition Practice, which stated that there was no functional difference between the two professionals except that a dietitian must be registered with the Commission on Dietetic Registration.
[310] *Core Jail Standards*, 1-CORE-4A-01, 1-CORE-4A-06.
[311] Eliza Barclay, "Food as Punishment: Giving U.S. Inmates 'The Loaf' Persists," *NPR*, January 2, 2014; Jackie Cuellar, *Gruel and Unusual: Prison Punishment Diets and the Eighth Amendment*, 107 Minn. Law Rev., 475-527 (2022).
[312] *Hutto v. Finney*, 437 U.S. 678 (1978).
[313] Jesse McKinley, "New York Prisons Take an Unsavory Punishment Off the Table," *New York Times*, December 17, 2015.

Figure 6. Nutraloaf[314]

- Subparts 2 to 4 and 6 to 8 are repealed because they contain recommended food servings, which become obsolete as the federal guidelines change; this isn't a substantive change, as jails will still follow federal guidelines on food servings by having a licensed dietitian or nutritionist approve the menu and review it at least annually.

3. 2911.4000 (food-service review).

This part is updated with technical and conforming changes.

4. 2911.4100 (meals).

This part makes mostly technical and conforming changes. Additionally, some stricken language in subparts 1 and 3 have been moved to part 2911.3900. Examples in subpart 3 have been stricken, as examples aren't considered rules.[315]

A substantive change is made in subpart 1, increasing the requirement that a meal be at least 30% of an incarcerated person's daily caloric intake. The department finds that this 10% increase from the existing requirement is needed and reasonable given that 14 hours are allowed between substantial meals. But an exception is made to allow for smaller meals if jails offer weekend brunch as a meal variation under subpart 3.[316]

[314] Vanessa Barford, "Is it Fair to Punish Prisoners with Horrible Food," *BBC News*, December 18, 2015.
[315] *See, e.g.,* OAH 3-1800-9490-1, *In The Matter of Proposed Adoption of Amendments to Rules of the Department of Human Services Governing MinnesotaCare, Minnesota Rules, Parts 9506.0010 to 9506.0400* (June 1, 1995), 6.
[316] Minn. R. 2911.4100, subp. 3: "A facility may provide a brunch on Saturdays, Sundays, or holidays in lieu of separate breakfast and lunch meals."

Subpart 4 is repealed because it contains the requirement that at least one substantial meal is a hot meal; this requirement has been moved to part 2911.3900.

5. 2911.4200 (therapeutic diets).

This part makes mostly technical and conforming changes and also strikes language that provides examples. Language was added to account for the increased nutritional needs of people who are pregnant or lactating. The National Institutes of Health note that pregnant or lactating individuals require an additional 300 to 500 calories per day compared with their pre-pregnancy intake.[317] This increased nutritional need is further recognized by the U.S. Department of Agriculture's Women, Infants, and Children (WIC) program, which provides food benefits to individuals who are currently pregnant, up to six months postpartum, or breastfeeding for up to one year.[318]

6. 2911.4300 (religious diets).

Along with technical and conforming revisions, this part was updated to incorporate federal law enacted in 2000 regarding the Religious Land Use and Institutionalized Persons Act (RLUIPA).[319] This law safeguards the religious rights of individuals in confinement, including their ability to follow certain dietary restrictions. Under RLUIPA, a sincerely held belief receives the same level of protection as a mainstream or recognized religion, provided it is part of the individual's religious practice or faith. The department considers it both reasonable and needed to comply with federal law by recognizing an individual's sincerely held beliefs, and by treating those beliefs with the same consideration given to dietary practices of traditional or mainstream religions.

7. 2911.4400 (using food as discipline).

The department amends this part to ensure that food isn't used as discipline. For example, jails shouldn't offer incarcerated people different food for disciplinary reasons or food of lesser quality due to placement in administrative separation or disciplinary segregation. This change is consistent with amendments under

[317] Kominiarek MA, Rajan P. Nutrition Recommendations in Pregnancy and Lactation. Med Clin North Am. 2016 Nov;100(6):1199-1215. doi: 10.1016/j.mcna.2016.06.004. PMID: 27745590; PMCID: PMC5104202.
[318] https://www.fns.usda.gov/wic/eligibility
[319] https://www.justice.gov/crt/religious-land-use-and-institutionalized-persons-act

part 2911.3900 and other department rules on withholding basic needs such as a nutritious diet where the department makes clear nutraloaf is not permitted.[320]

8. 2911.4500 (meal supervision).

This part is reorganized into subparts for structure. Subpart 2 is added to include food concerns, including food refusal, as needed to be included in the general facility policy on daily health concerns under part 2911.5800, subpart 8. Food refusal may indicate mental-health issues with a person or signal a hunger strike.

9. 2911.4600 (records and substitutions).

This part is updated with technical and conforming changes.

10. 2911.4800 (commissary).

This part is updated with technical and conforming changes. Subpart 5 is repealed because it is a duplicative requirement.

[320] Minn. R. 2960.0080, subp. 5(A)(4).

Response to Resistance and Post Orders (2911.4900 and 4950 to 2911.5000)

1. 2911.4900 (security inspection).

This part is amended to align with the definition of perimeter security which was already defined in the rule. This change requires weekly security inspections and is needed for consistency with other rules requiring weekly inspections such as for fire and sanitation. To protect public safety and jail staff, jails should conduct weekly inspections of their secure facility.

2. 2911.4950 (response to resistance).

This part on response to resistance makes plain-language and conforming changes. In subpart 1, statutory cross-references are added to clarify existing jail requirements. Item B adds cross-references to three statutory definitions of *harm*.

Subpart 4 changes the inventory requirement for security devices from monthly to weekly—this change is consistent with part 2911.4900.

3. 2911.5000 (post orders).

This part on post orders makes plain-language and conforming changes and removes unenforceable examples.

Subpart 5 on well-being checks is repealed, with new language added in parts 2911.5010 to 2911.5020.

Well-Being Checks (2911.5010 to 2911.5025)

Fundamental to a jail is ensuring the safety and security of incarcerated people. The main procedure for accomplishing this task is a well-being check. As its name indicates, a well-being check is a visual observation of an incarcerated person to ensure that they are alive and well. Well-being checks are essential because they allow custody staff to quickly respond to security concerns and medical emergencies, including suicides, the leading cause of death in jails.

Because incarcerated people have a right to medical care and protection from harm, well-being checks are needed to "vindicate these rights and to prevent the harms protected by them."[321] And well-being checks are a fundamental component to not only an incarcerated person's physical health but to their psychological well-being as well.

Despite being essential to ensuring the safety and security of incarcerated people, well-being checks are the most-cited rule violation by department inspectors. Outside audits have confirmed this widespread noncompliance:

- A 2016 OLA audit found that 40% of the department's inspection reports cited jails for violating well-being-check requirements.[322]
- In 2017 alone, well-being checks were cited in nine department death reviews.[323] In one death, there was a late well-being check before custody staff discovered an incarcerated person who had died by hanging.
- In a reconsideration request to a conditional-license order, Hennepin County cited rule violations or rule concerns on well-being checks from 45 jails.[324]
- In a December 2024 internal audit, the department found that since 2022, the department had cited 51 jails for well-being-check violations and 31 as in compliance but with concerns.

[321] *Morrison as Trustee for May*, 2022 WL 2442363.
[322] Legislative Auditor, *Mental Health Services in County Jails*, 52.
[323] Take this department observation, for example: "The correctional officers do not look into each cell and do not turn their heads at all towards the cells." And from another death review in the same facility: "The correctional officer doesn't look into each cell and at times is looking down at the floor, doesn't turn his head at all towards the cells . . ." Department of Corrections, "Hennepin County Jail Death Review" (2017, 2018).
[324] Hennepin County Sheriff's Office, *Request for Reconsideration of Conditional License Order* (November 27, 2024).

This frequent failure and pattern of noncompliance occurs despite well-being checks being original to the rule chapter, which in 1978 required one-half-hour interval "security inspection routines."[325] In 1999, the term "well-being check" was added to the chapter along with requirements on the manner and frequency of the checks.[326]

While the department has only had its enhanced sanctioning authority since 2021, the department has issued several correction orders and conditional-license orders, with well-being checks being one of the most-cited violations:

- In an October 31, 2024 conditional-license order, the department found that the Hennepin County jail had a pattern of untimely and noncompliant well-being checks.[327] For all seven deaths referenced in the order, the department found violations:

  > In the past two years, staff have failed to conduct well-being checks within the mandatory 30-minute period, have inaccurately logged that they have completed checks when no checks actually occurred, have completed checks in a manner that would not actually ensure the health and safety of inmates, and have failed to put special-needs-classified inmates on more frequent observation.[328]

  A follow-up notice cited continued noncompliance on well-being checks: "Perhaps most concerningly, Hennepin County ADC, by their own admission, has failed to make substantial progress towards compliance with the well-being check rule."[329]

- In a 2023 conditional-license order, the department detailed its long-standing concerns with Ramsey County jail violations of well-being checks.[330] One well-being-check violation occurred immediately before an incarcerated person suffered a stroke.

- A 2024 correction order issued to Roseau County jail found repeated well-being-check violations.[331]

[325] Corr. 110(A).
[326] Minn. R. 2911.5700, subp. 2 (1999).
[327] Department of Corrections, "Hennepin County Conditional License Order."
[328] *Id.*
[329] Department of Corrections, "Notice of Noncompliance" (March 7, 2025).
[330] Department of Corrections, "Ramsey County Conditional License Order" (February 3, 2023).
[331] Department of Corrections, "Roseau County Correction Order" (July 8, 2024).

- The department has issued many corrective-action plans in its inspection reports that have found jails repeatedly noncompliant with well-being-check requirements. Most notable examples of noncompliance include jails in the following counties: Clearwater (2022), Itasca (2022), Jackson (2022), and Koochiching (2022).

Well-being-check violations fall into three main areas: pace, timing, and observation:

Table 20. Examples of well-being-check violations

Pace	"It was found that four of the rounds were found to be completed at a pace that was too fast to be regarded as a compliant check. Signs of life such as movement, rise and fall of chest and other signs of life would be difficult to determine at such a quick pace." – Clearwater	"During a review of video of well-being checks it was discovered that some well-being checks are being conducted at to[o] quick of a pace to look for signs of life or distress." – Jackson
Timing	"While observing six different rounds it was found that one of the checks was 20 minutes late. It appeared staff became preoccupied and skipped checking on inmate(s)." – Clearwater	"The reoccurring complaint is that checks are being performed at a pace that is too fast or checks exceed 30 minutes with one inspection in 2019 noting a four-hour gap" – Koochiching
Observation	"Policy should be updated to reflect that staff must personally observe inmates as it is required within the rule. It was stated that staff may have completed checks by potentially having viewed the inmates in their cell from outside of the pod in the hallway as staff walk by. It is difficult to determine the inmate's demeanor and verify signs of life at such a distance nor is it good practice." – Clearwater	"The well-being checks being conducted at night of C Pod are being done from the corridor/hallway. With how dark C Pod is and the distance from where the officer is compared to where the inmate is, I find it very unlikely that staff could observe signs of life or distress." – Jackson

Because of jails' ongoing and widespread noncompliance with well-being checks, it's clear that the original reasons for needing rigorous well-being-check requirements remain, as described in the department's 2013 SONAR:

> Finally, amendments are needed in this section to strengthen requirements for checking on inmates by custody staff. Such changes are needed both because of suicide-related litigation in the past and because of the changing nature of the inmate population, which has become more dangerous.[332]

Although the department would now characterize the changing nature of the jail population as having increased health-care needs, rather than labeling the jail population dangerous by default, the sentiment remains: Well-being checks are even more critical today given continued suicides, suicide attempts, and the high levels of incarcerated people with substance-use disorders or mental illnesses.

While these well-being-check violations reflect long-standing problems with many jails, the department also recognizes that other jails perform excellent well-being checks and are responsive to department suggestions and inspection findings. For example, the department highlighted Pennington County jail in an inspection report:

> The Pennington County Jail has demonstrated a high level of compliance with well-being checks. This can most likely be attributed to extensive and thorough training along with a comprehensive audit program.[333]

As the department discusses further, training and auditing are two key components of a jail's comprehensive policy on well-being checks.

[332] Department of Corrections, 2013 SONAR, 16.
[333] https://mn.gov/doc/assets/Pennington%20County%20Jail_tcm1089-594846.pdf

Well-Being Checks and Audits (2911.5010)

1. Subpart 1 (policy and procedure).

Overall, the department doesn't propose dramatic shifts in its amendments on well-being requirements. For example, the department doesn't deviate from its existing requirements on standard 30-minute checks, more-frequent checks, missed checks, and the specifics of conducting checks, all of which exists in current rule:

> A facility shall have a system providing for well-being checks of inmates.
>
> A written policy and procedure shall provide that all inmates are personally observed by a custody staff person at least once every 30 minutes. Thirty-minute checks should be staggered. If a well-being check does not occur due to an emergency, it must be documented in the jail log and have supervisory review and approval.
>
> More frequent observation is required for those inmates of a special need classification who may be harmful to themselves. Examples of inmates of a special need classification include those classified as potentially suicidal, or as mentally ill, or those experiencing withdrawal from drugs or alcohol.[334]

Additionally, both the department's existing and proposed standards are supported by the ACA, the NIC, and other states.[335] For example, the NIC recommends 30-minute checks on an irregular schedule, with more-frequent checks for people who are violent, mentally ill, or under the influence of a substance.[336]

2. Subpart 2 (frequency).

Correctional entities vary in their guidance on the intervals of well-being checks. For example, while the NIC recommends 30-minute checks, the ACA recommends intervals of well-being checks depending on the classification of incarcerated people, and that incarcerated people classified as low security can be personally observed every 60 minutes.[337]

Furthermore, the frequency of well-being checks varies among states: Some states don't prescribe a frequency, other states require checks every 60

[334] Minn. R. 2911.5000, subp. 5.
[335] *Core Jail Standards*, 1-CORE-2A-24. This standard applies to only special-needs inmates.
[336] Martin and Rosazza, *Resource Guide for Jail Administrators*, 112.
[337] *Performance-Based Standards*, 5-ALDF-2A-04.

minutes, and some follow the ACA and prescribe checks depending on classification.

Yet other states require 30-minute checks. For example, Illinois requires 30-minute checks,[338] and North Carolina mandates staff to conduct two checks within a 60-minute period, with four checks within a 60-minute period for people under a substance or on suicide watch, or who are assaultive.[339]

In 2007, a department survey found that most jail administrators preferred 30-minute checks. Then in 2013, the department opted to continue with standard 30-minute well-being checks when recodifying the requirement. Accordingly, the department sees no reasonable need to divert from this 30-minute standard in this rulemaking—rather, the department finds that there is a continued need for 30-minute checks because of the high number of jail violations and the increased number of people admitted into jail who have substance-use disorders or mental illnesses.

3. Subpart 3 (staggered checks).

Jails stagger well-being checks for safety and security reasons, yet existing language only states that well-being checks *should be* staggered. While the use of *should* doesn't meet the definition of a rule, the department's long-standing practice has been to require staggered checks. The department proposes to make this requirement mandatory in rule and clarify that the checks—except for more-frequent checks—be staggered in time and direction.

Staggered in direction means that the order of the well-being checks shifts. For example, if a jail has ten cells, the custody-staff member will conduct checks starting with the first cell. Then for the next round of checks, the custody-staff member will start the checks with the last cell.

Staggering by direction will by operation stagger the timing of the checks. Staggering is important so that incarcerated people don't get accustomed to patterns, as predictable well-being checks provide a greater opportunity for incarcerated people to use or hide contraband or time suicide attempts between checks.

[338] Ill. Admin. Code tit. 20, § 701.130.
[339] 10A N.C. Admin. Code 14J.0601.

The department's proposed requirements aren't different from other states that require well-being checks to be conducted on an irregular basis,[340] and irregular checks are recommended by the NIC and ACA.[341] But because the design of some jails may preclude a staff member's ability to stagger well-being checks, the department qualifies the requirement on the direction of checks in its proposed language by tying the requirement to a jail's physical design.

When the department discussed staggering well-being checks with its advisory committee, some advisory-committee members and jail administrators didn't understand how long they should stagger well-being checks. To account for this concern and variability among jails, the department is requiring that jails stagger well-being checks according to their policy and procedure—this will vary from jail to jail. The department can provide technical assistance on staggering checks and work with jails on their policies and procedures.

4. Subpart 4 (manner).

This subpart prescribes several important standards that custody staff must follow when conducting a well-being check. Specifying the manner in which well-being checks are conducted is needed and reasonable for ensuring the health and safety of incarcerated individuals.

4.1. Direct observation required.

Well-being checks shouldn't be conducted using a camera or similar electronic device, as cameras should be used only as a supplement for a staff member's direct observation.[342] This requirement doesn't prohibit custody staff from using radio-frequency identification to track well-being checks.[343]

[340] *See* Arkansas Department of Corrections, *Minimum Standards for Adult Criminal Detention Facilities*, § 9-1001 (2022); North Dakota Department of Corrections and Rehabilitation, *North Dakota Correctional Facility Standards*, Standard 32 (2025); 10A N.C. Admin. Code 14J.1717.

[341] *Performance-Based Standards*, 5-ALDF-2A-04; Martin and Rosazza, *Resource Guide for Jail Administrators*, 112.

[342] Martin and Rosazza, *Resource Guide for Jail Administrators*, 111.

[343] *See, e.g.*, https://guardianrfid.com/.

Figure 7. Example of Guardian system (from guardianrfid.com)

Because jails don't uniformly have cells or inmate areas with technology or cameras for staff to effectively ensure that an inmate is alive and well, in-person checks are needed so that custody staff can thoroughly confirm that an inmate is not experiencing visible or audible distress. Even with cameras, the cameras do not always capture all cell areas and in most cases don't allow for custody staff to effectively assess whether someone is well. For example, a person could appear on camera to be sleeping normally, but an in-person well-being check could indicate otherwise.

Additionally, while new technology can monitor an incarcerated person's heart rate and blood pressure, the person could be using contraband or making a noose to hang themselves, and this newer technology would never observe that.

The department's proposed changes in this subpart mirror most states, which require direct observation.[344] Illinois specifically prohibits using a monitoring device,[345] and North Carolina states that "if remote electronic monitoring is used to supplement supervision, it shall not be substituted for supervision rounds and direct visual observation."[346]

[344] This includes prisons. For example, Wis. Stat. § 350.18 (2014) states that "a video monitoring system may be used to supplement but not replace personal observations."
[345] Ill. Admin. Code tit. 20, § 701.130.
[346] 10A N.C. Admin. Code 14J.1717.

4.2. Stopping to observe visible or audible distress.

Perhaps no other proposed requirement in this rule has generated as much discussion than requiring custody staff to stop when conducting a well-being check. Both supporters and opponents have made reasonable points on this proposed change.

Opponents believe that a custody staff member doesn't need to stop for incarcerated people in a common area and that this requirement may be difficult for smaller or older jails. They also question how long of a stop is necessary.

Supporters, including the department, believe that stopping is necessary to ensure that someone is alive and well. The department's long-standing interpretation, as evidenced in its inspection reports, has been that custody staff must stop when conducting a well-being check:

> It is recommended that correctional staff stop motion in front of the inmates door and observe the inmate for no less than two seconds. In instances of inmate overdoses, it has been found that the inmate still shows signs of life such as chest rise or head bobbing but they are actively in distress. Additional time to evaluate may lead to better outcomes of accurately determining an inmate's well-being.[347]

Jails such as Ramsey County and Sherburne County that have trained staff on stopping acknowledge that stopping is best practice, safer, and not burdensome.

Stopping at a cell is needed to ensure that someone is alive and well; it might also force custody staff to look into the cell. For example, one department death-review report documented that a custody-staff person didn't turn their head to look into a cell—the incarcerated person was found unresponsive in their cell at the next well-being check.[348]

If someone is out of their cell, that doesn't mean that they are well. The same can be said for individuals in their cells—just because someone is moving in their cell doesn't mean that they are well. In both examples, an individual could be experiencing distress that wouldn't be apparent to custody staff if they didn't stop, such as hallucinating, talking to themselves, or doing something that could harm themselves or others. Additionally, there have been incidents when incarcerated people have fallen while in a dayroom, and

[347] https://mn.gov/doc/assets/Itasca%20County%20Jail_2022_tcm1089-594778.pdf
[348] Department of Corrections, "Scott County Jail Death Review" (2021).

a missed or noncompliant well-being check could jeopardize an incarcerated person's health and safety in these types of incidents.

A custody-staff member must determine the duration of a stop on a case-by-case basis. The department cannot reasonably prescribe a specific duration for how long a custody-staff person must stop, especially when there could be over 48 well-being checks a day per incarcerated person. Each well-being check is different, so the duration of a stop may vary between checks. But all well-being checks should be conducted to ensure an incarcerated person's health and safety.

To provide some flexibility for jails, the department is proposing to allow custody staff to not stop if they can verify that a cell or dayroom is unoccupied. This could occur if an entire unit houses kitchen workers and they aren't in their cells because they are working. In these cases, department inspectors would review video footage and discuss with jail staff why staff didn't stop when conducting their checks.

Overall, if a staff member stops, pauses, and turns, they leave no interpretation. Not only is a staff member checking on an incarcerated person, but they are also looking for other signs to observe that could later cause a health or security risk.

4.3. Covering head and neck.

Inspectors have encountered situations where an incarcerated person has their head and neck covered, which prevents custody staff from effectively checking for visible or audible distress. Because of this safety concern, the department initially wanted custody staff to have an incarcerated person uncover their head and neck, but advisory-committee members were concerned about potential disruptions during sleeping hours.

The department and other advisory-committee members had argued that a person's health and safety needs don't dissipate during sleeping hours and that there are genuine risks of asphyxiation and important visual facial cues for people in distress. But the department also believes that the raised concerns are not unreasonable.

While this requirement doesn't appear in the proposed rules, the department believes that requiring custody staff to stop when conducting a well-being check will help prevent the risk of suicides when an incarcerated person may be covering their head and attempting to use bedsheets or other makeshift nooses.

5. Subpart 5 (documentation).

Existing rule requires custody staff to complete well-being checks and to document those that do not occur due to an emergency. The department proposes to clarify that documentation should take place on all checks and should be documented immediately. Jails may document their checks using a Guardian system, while in jails without this technology, custody staff must immediately document their checks after returning to their security post.

This additional clarification is needed and reasonable because of the associated rule requirements of notifying health-care staff and because of the volume of checks. For example, medium and large jails may have to check upwards of 60 cells, so accurate documentation requires custody staff to document the checks as soon as possible.

6. Subpart 6 (missed well-being checks).

This subpart adds clarifying language to existing requirements on documenting a missed well-being check and states that a missed check doesn't constitute a rule violation if the missed check is documented in compliance with the subpart. The proposed requirements add guidance on when a missed check should be documented and approved.

Reporting and reviewing missed well-being checks are needed so that jails can self-regulate their compliance with well-being-check requirements and for department inspectors to inspect for compliance with well-being checks. When determining how long a supervisor should have to review a missed well-being check, the department believed that one week was too long a gap and that 24 hours was reasonable. On the other hand, some smaller jails don't have supervisors on every shift, so the department proposed 72 hours as a middle ground. The proposed language is also consistent with other 72-hour requirements in rule.[349]

7. Subpart 7 (health-care staff).

The department proposes that a jail's policy and procedure on well-being checks includes guidance on when custody staff must notify and communicate with health-care staff on an incarcerated person's health concerns. This requirement differs from general rule requirements on the health concerns of incarcerated people.[350] The requirement here highlights the importance of robust

[349] *See, e.g.,* proposed Minn. R. 2911.2850, subp. 3b, Minn. R. 2911.3650, subp. 2.
[350] *See, e.g.* Minn. R. 2911.5800, subp. 8.

communication between custody and health-care staff, especially when an incarcerated person is unable to directly communicate their health concerns

With the risk of suicide and previous deaths caused by health concerns (see page 14), this is a needed and reasonable requirement to protect the health and safety of incarcerated people.

> *"Because inmates can be at risk for suicide at any point during confinement, the biggest challenge for those who work in the corrections system is to view the issue as requiring a continuum of comprehensive suicide prevention services . . ."*[351]

8. Subpart 8 (audits).

Auditing is a key component for ensuring a facility's compliance with well-being checks. When department inspectors find well-being-check violations, the inspectors frequently recommend that the cited jail develop an auditing system to ensure compliance and to proactively address violations before the jail's next inspection. A department corrective-action plan requiring an auditing process is generally worded as follows:

> The facility shall create a system of auditing well-being checks for both line staff and supervisory staff who conduct checks. Checks shall be staggered and at a pace sufficient to observe the well-being of the inmate. The facility must complete a minimum of two audits on each staff member (who are charged with performing checks) every month. Documentation shall include well-being check logs, the results of the audit, and any follow up with staff who are not in compliance with the standard.[352]

Out of the 30 jails that the department surveyed in 2024, all but one replied that they reviewed video footage of well-being checks. Responses ranged from six hours per staff member per month to 20 to 25 hours per month. If an audit finds noncompliance, additional training is required, or, at times, progressive discipline may be taken:

- "I regularly pick at random different teams on different shifts and check against the log and also for quality. We also train on it. I would estimate 3-4 hours per month."

[351] Hayes, *National Study of Jail Suicide*, xiii.
[352] https://mn.gov/doc/assets/Clearwater%20County%20Jail_2022_tcm1089-594763.pdf

- "It takes approximately an hour each to complete an assessment and to provide coaching notes if needed. If one-on-one in-person coaching is needed[,] then more time is given to that staff member."
- "Yes. All of my Sergeants (10) review around 4 hours of CCTV per month. Each month we pick different officers to review. It is very time intensive."

Many jails find the auditing process helpful, as demonstrated in the following inspection report:

> The facility began auditing well-being checks after their 2021 inspection, and both administration and supervisors stated that the quality of checks has greatly improved in response to their ongoing auditing efforts.[353]

Most jails already audit for well-being checks or must correct violations under corrective-action plans, so the proposed auditing language should not be a new cost for jails. In fact, the department estimates that many jails already audit more than what the proposed language requires, which the department based off of its long-standing internal processes for auditing a jail's well-being checks, in addition to the survey responses.

Because the department has long required or suggested that jails develop an auditing process, the proposed requirements are needed and reasonable.

[353] https://mn.gov/doc/assets/Wabasha%20County%20Jail_tcm1089-594860.pdf

More-Frequent Well-Being Checks (2911.5015)

Current rule requires more-frequent well-being checks for certain incarcerated people. By its plain language, this requirement could mean 29-minute checks when compared to the baseline requirement of 30-minute checks. This lack of direction is unhelpful for jails and poses a serious safety risk to incarcerated people who need more-frequent checks.

To clarify and correct this vague standard, the department proposes a uniform requirement of 15-minute checks for identified groups of incarcerated people (*see* subpart 2). While the department acknowledges that this uniformity may pose challenges for some jails, the department finds that there are serious health and safety risks when 15-minute checks aren't followed.

1. Subpart 1 (15-minute checks).

In the department's 2024 survey, jails were split on uniform 15-minute checks, with 19 responding that they perform them and 11 saying they don't:

- "We call [them] special checks and we do them at this time."
- "When 'more frequent checks' are needed, we typically do them at 12.5 minutes."
- "Yes, currently do 15s when needed on MH, withdraw, suicide watch."
- "Yes, and we do that for special management inmates including those on suicide watch. No issues with conducting 15-minute checks when needed."
- "We are contemplating the 15 minute checks. Staffing is our biggest challenge as it adds more work to our intake area which is already overwhelming most days in the tasks they have to [perform]."
- "This would be a significant staffing burden that requires additional staffing."
- "Staffing, staff time and location of inmate would all be challenges. Currently in our facility 15 minute checks are done on [suicide] watches only. For us, inmates who are on 'more Frequent checks' are [typically] going through [withdrawals]. They are checked more frequently than 30 minutes as well as being seen [routinely] for MINDS and are getting regular checks by RN's."

Although survey responses showed that staffing was the main concern or barrier to completing 15-minute checks, the department finds that this 15-minute requirement is reasonable for several reasons:

- Many jails—both in Minnesota and other states—already use 15-minute checks for incarcerated people on suicide watch,[354] and jails have a duty to prevent suicides.[355] Courts have also found that failing to prevent jail suicides can be a claim for failing to provide adequate medical treatment.[356]
- The NIC recommends 15-minute checks, as people under the influence may be unstable and unpredictable: "Individuals under the influence of drugs or alcohol should be under heightened and documented observation. Checks should be made at least every 15 minutes, preferably by available medical staff."[357]
- NCCHC recommends 15-minute checks for non-acutely suicidal inmates and constant observation for acutely suicidal inmates.[358]
- Other states such as Maine and North Carolina require 15-minute checks for people on suicide watch or people suffering from withdrawal or a mental illness.[359]
- People undergoing withdrawal are most at risk for the first 72 hours, and the first 72 hours in jail are the most dangerous and when most suicides occur: "Screening for suicide risk regularly throughout the withdrawal process is advised due to the rapidity at which suicidal ideation can evolve."[360]

  Furthermore, people admitted to jail may not be honest about their substance use, so more-frequent and continuous monitoring are critical.
- Jail administrators themselves don't understand the current vague standard, with five administrators in the 2024 survey specifically mentioning more-frequent checks as a rule requirement that they were confused about. The proposed language will establish a clear standard for more-frequent well-being checks.

[354] A 2006 study found that 87% of jails used 15-minute checks for people on suicide watch. Hayes, *National Study of Jail Suicide*, xii.
[355] *Sandborg v. Blue Earth County,* 615 N.W.2d 61, 64 (Minn. 2000).
[356] *Williams v. Kelso,* 201 F.3d 1060, 1065 (8th Cir. 2000); *Bell v. Stigers,* 937 F.2d, 1343 (8th Cir. 1991).
[357] Martin and Rosazza, *Resource Guide for Jail Administrators*, 202.
[358] *Standards for Health Services in Jails*, J-B-05.
[359] 03-201 Me. Code. R. § 2D.3; 10A N.C. Admin. Code 14J.0601.
[360] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 21.

2. Subpart 2 (persons who need more-frequent checks).

Under subpart 2, the identified groups who need more-frequent well-being checks were listed as examples in language that the department is proposing to repeal under part 2911.5000, subpart 5. The department also proposes new language to provide jails flexibility to place incarcerated people on 15-minute checks when directed by health-care staff.

> *"Opioid withdrawal syndrome can be medically complex and, in the absence of appropriate management, life-threatening*."[361]

In addition to monitoring for suicide risk, three important conditions that necessitate 15-minute checks are when an incarcerated person is experiencing a mental-health crisis (also known as a crisis hold), is experiencing acute substance withdrawal, and refuses or is unable to complete the medical screenings. Medical screenings provide critical information for jail staff, so 15-minute checks alleviate the health and safety risks when the screenings cannot be completed (some jails already put incarcerated people who don't complete the screenings on 15-minute checks as a best practice).

Monitoring for signs and symptoms of withdrawal is also a health and safety precaution because generally an individual presents signs of substance withdrawal within 72 hours.[362] Most publications cited in the SONAR mention a dozen or so common indicators of substance withdrawal.[363]

Not adequately monitoring and treating substance withdrawal can be a life-or-death issue:

- Drug/alcohol overdose is the third-leading cause of death in jails, following illness and suicide.[364]
- "There is a significant risk of opioid withdrawal associated with tapering opioids rapidly or discontinuing them suddenly."[365]

[361] *Id.*, 41.
[362] *Id.*, 5; *see also* Federal Bureau of Prisons, *Medically Supervised Withdrawal for Inmates with Substance Use Disorders*, 19.
[363] *See, e.g.,* Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*.
[364] National Commission on Correctional Health Care, *Position Statement: Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths* (NCCHC, October 2021).
[365] Shannon Mace et al., *Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit* (National Council for Mental Wellbeing, n.d.), 61.

- “Forced withdrawal from opioids, including prescribed opioid medications, can be medically hazardous, reduces the likelihood that individuals will participate in substance use disorder treatment or MAT in the future, and poses a serious risk of overdose or death after release from custody if the individual returns to pre-incarceration levels of opioid use.”[366]
- “The frequency of suicide attempts is substantially higher among patients with a substance use disorder, even for those without a pre-existing psychiatric condition. Frequent and thorough patient assessments are indicated during the withdrawal period, with particular attention to thoughts of self-harm.”[367]

This clinical evidence has been borne out in Minnesota. For example, in February 2022, an incarcerated person repeatedly asked for his prescribed medication to treat his opioid withdrawal. Jail staff refused, and he endured sleeplessness, diarrhea, and vomiting.[368]

[366] SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, 66.
[367] Federal Bureau of Prisons, *Medically Supervised Withdrawal for Inmates with Substance Use Disorders*, 5.
[368] Stephen Montemayor, “Suit: Staff at Anoka Jail Withheld Opioid Withdrawal Meds from Inmate Who Collapsed, Was Injured,” *Minnesota Star Tribune*, April 12, 2024.

More-Frequent Well-Being Checks; Evaluation and Care (2911.5020)

1. Subpart 1 (notification).

Subpart 1 requires custody staff to notify health-care staff upon placing an incarcerated person on 15-minute well-being checks; this requirement follows recommendations from the *Guidelines for Managing Substance Withdrawal in Jails*, which emphasizes the importance of a health assessment for someone undergoing substance withdrawal.[369] These guidelines were jointly developed by the federal Bureau of Justice Assistance and the National Institute of Corrections. They were endorsed by jail associations such as the ACA and AJA, which also recommends clinical assessments so that jail staff can determine whether they can address the person's needs or should transfer them to a hospital or another facility to receive a higher level of care.[370]

Because an incarcerated person may be placed on 15-minute checks for various reasons, it's important for custody staff to notify health-care staff of the reason for placement and in case immediate action must be taken. Jail staff can notify health-care staff through an email, a printout, or the jail-management system.

In some instances, health-care staff may decide that an incarcerated person should be placed on 15-minute well-being checks—when this happens, communication should flow to custody staff so they know about the placement and any proper precautions they should take.

2. Subpart 2 (care plan).

As discussed, health-care staff will evaluate an incarcerated person and any care that should be provided to the inmate.

3. Subparts 3 and 4 (continuing well-being checks).

Subparts 3 to 4 are both needed and reasonable to conform with the department's proposed changes on more-frequent well-being checks and for jails to ensure the health and safety of incarcerated people undergoing withdrawal or for other placement reasons such as suicide watch.

[369] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 10-12.

[370] Madyson Bracken, "Managing Substance Withdrawal in Jails," *American Jails*, May/June 2024, https://www.americanjail.org/digital-magazine.

Because an incarcerated person is placed on 15-minute checks for a health or safety reason, health-care staff should determine when the person can transition to standard 30-minute checks. Yet a jail administrator, as the official responsible for managing the jail, can decide to keep an incarcerated person on 15-minute checks.

More-Frequent Well-Being Checks; Documentation (2911.5025)

This part requires documentation for various rule requirements on well-being checks so that department inspectors can ensure compliance. Documentation is a bedrock principle in chapter 2911 and of the department's statutory authority for inspecting and licensing jails.[371] Each jail can decide how it wants to document items and maintain records according to the county's retention schedule.

[371] *See* Minn. Stat. § 241.021, subd. 1: "The commissioner shall have access to the buildings, grounds, books, records, staff, and to persons confined or incarcerated in these facilities. The commissioner may require the officers in charge of these facilities to furnish all information and statistics the commissioner deems necessary, at a time and place designated by the commissioner."

Health Care (2911.5800)

An incarcerated person cannot provide their own medical care, self-treat, or choose their doctor or treatment regimen. They depend entirely on the correctional facility to provide them with health care. And eventually, they will return to the community.

As such, correctional health care is a public health issue and cannot be viewed in isolation. But by no means is correctional health care simple or easy to address. For example, the state's 2007 Correctional Health and Local Public Health Work Group [372] identified how incarcerated people have more-prevalent health issues compared to the general public:

- Acute, long-term diseases
- Mental health and psychiatric conditions
- Dental needs
- Infectious diseases
- Meth (now more so opioids, including fentanyl)[373]

In addition to these elevated health issues, correctional health care is complex. This complexity stems from the flexibility counties and jails have in how to administer health-care services for the incarcerated population.[374] For example, counties have three main options for providing health care in jails:

a) contract with an entity such as a private company or a hospital;

b) directly hire health-care staff; or

c) contract with a local public health department.

Because each jail has a different model for providing correctional health care, the department must mirror this flexibility in rule by prescribing performance-based standards.

[372] State Community Health Services Advisory Committee, Correctional Health and Local Public Health Work Group, *Health Services in County Correctional Settings: The Public Health Role* (November 2007).

[373] Yet meth use has resurged. *See* Jan Hoffman, "As Fentanyl Deaths Slow, Meth Comes for Maine," *New York Times*, April 16, 2025; Sarah Nelson, "Last month's seizure of 900 pounds of meth is no longer an anomaly, federal officials say," *Star Tribune*, July 6, 2025.

[374] Appendix C shows the different ways in which counties—and, by extension— jails can provide health care to the incarcerated population.

1. Right to health care.

Minnesota law provides that an incarcerated person must receive medical care.[375] This right to health care is also well established by state and federal courts. The landmark federal case, *Estelle v. Gamble* (1976), established the standards of deliberate indifference and serious medical needs as they relate to the health-care needs of incarcerated people. Subsequent court rulings have established factors that constitute a serious medical need and the standard of deliberate indifference,[376] with about 13,000 cases citing to *Estelle* between 1985 and 2022.[377]

> *"Inmates must have access to care to meet their serious health needs."*[378]

While convicted persons have the constitutional protections of the 8th Amendment, persons held pretrial are protected under the 14th Amendment.[379] This protection for incarcerated people held pretrial has been affirmed by the 8th Circuit Court of Appeals, which in 2006 ruled that "deliberate indifference is the appropriate standard of culpability for all claims that prison officials failed to provide pretrial detainees with adequate food, clothing, shelter, medical care, and reasonable safety."[380]

As courts have recognized the incarcerated population's 14th Amendment Rights, the ACA has developed about a dozen health-care standards so that incarcerated people "have unimpeded access to a continuum of health care services to ensure that their health care needs, *including prevention and health education*, are met in a timely and efficient manner."[381]

While the overall need—including established constitutional rights— is great for providing adequate health care for incarcerated people, so are the issues jails confront when trying to address these needs. For example, local governments

[375] Minn. Stat. § 641.15, subds. 1, 2.
[376] *Carlson v. Green*, 446 U.S. 14 (1980); *Langford v. Norris*, 614 F.3d 445, 459 (8th Cir. 2010); Palmer, *Constitutional Rights of Prisoners*, 376-378.
[377] Marcella Alsan et al., "Health Care in U.S. Correctional Facilities—A Limited and Threatened Constitutional Right," *New England Journal of Medicine* 388, no. 9 (2023): 848.
[378] *Standards for Health Services in Jails*, 3.
[379] *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239 (1983); *Bell v. Wolfish*, 441 U.S. 520, 535 (1979).
[380] *Butler v. Fletcher*, 465 F.3d 340, 345 (8th Cir. 2006).
[381] *Core Jail Standards*, 1-CORE-4C (emphasis added); *see also Helling v. McKinney*, 509 U.S. 25 (1993).

have for decades expressed concerns about costs and staffing to meets these health-care needs:

> Local health departments expressed deepening concerns related to the escalating costs of correctional health services associated with a rapid increase in the incarcerated jail population, the impact and management of major issues such as a history of methamphetamine use and mental illness in the correctional population, and the numerous requests for additional correctional health services.[382]

These cost concerns have also been echoed as they relate to providing mental-health care or treatment for substance-use disorders. For example, the 2016 OLA audit noted how county officials were concerned about costs for providing mental-health care:

> County officials expressed concern to us that changes in rules could have cost implications for counties. . . . County representatives suggested to us that the Legislature consider financial assistance to counties to help implement better jail-based mental health services, while they acknowledged that the Legislature has not previously provided such assistance for jails. We agree that implementation costs should be one consideration in any update of state rules.[383]

The department recognizes the valid and reasonable cost concerns of elected officials such as sheriffs and county commissioners. To balance their concerns with the high need to adopt standards that protect the health and safety of incarcerated people, the department has looked to its advisory committee, members of the public, other state agencies, and national publications for guidance in crafting the proposed rules.

2. Subpart 1 (availability of resources).

This subpart on health-care services is reorganized into items for structure. Item A requires a jail to have or contract with a health authority, a requirement that has been implicitly required since the rules were first adopted.

Item C clarifies and moves the requirement of a health-care liaison from subpart 5. To protect against litigation and to provide or arrange for health-care access, a jail must always have health-trained custody staff on site when health-care staff are unavailable for 24 consecutive hours. This is needed to ensure that

[382] State Community Health Services Advisory Committee, *Health Services in County Correctional Settings*, 8.
[383] Legislative Auditor, *Mental Health Services in County Jails*, 51.

incarcerated people have access to emergency and nonemergency health care, especially for facilities that don't have 24/7 health-care coverage.

3. Subpart 1a (telehealth).

Telehealth is a vital option for jails (at times, it may be the *only* option) to provide specific health-care services. Jails' use of telehealth reflects how people in the community use it, as recent data on telehealth among the general population found that behavioral health was the most common type of telehealth visit, with over 50% of mental and behavioral-health visits done through telehealth.[384]

> Telehealth can be used in place of in-person visits in many situations, especially for primary care and behavioral health services. Telehealth may also serve as a good way to add additional touchpoints or follow-up for patients managing chronic conditions or with other complex needs.[385]

In addition to increasing access to mental-health care, telehealth can reduce costs of care, better allow jails to manage their resources, and ease the burden of recruiting and retaining on-site health-care providers.[386] Telehealth is also important for coordinating an incarcerated person's discharge and transition to community-based services—that is, telehealth allows for continuity of care.

Like all health-care-related policies and procedures in this chapter, a jail's telehealth services must follow the guidance of the health authority and be reviewed annually.

The proposed minimum standards for telehealth are reasonable requirements that will ensure that the incarcerated population's health-care needs can be met. Because telehealth services can include a variety of health-care services,[387] jails should list and train their staff according to the services that will be provided. It is also important that incarcerated people are trained to use telehealth effectively so they can receive adequate care.

Items D to F conform with related rule requirements documentation and maintaining medical equipment.

[384] Minnesota Department of Health, *Study of Telehealth Expansion and Payment Parity* (St. Paul, September 2024), 8.
[385] *Id.*, 11; *see also* Jeremy Olson, "Telehealth Remains Popular in Minnesota, Does Not Lower Quality of Care: MDH Report," *Minnesota Star Tribune*, October 8, 2024.
[386] Bureau of Justice Assistance, "Using Telehealth for Behavioral Health in the Criminal Justice System."
[387] *See, e.g.,* Minn. Stat. § 256B.0625, subd. 3b.

4. Subpart 2 (responsibility for final clinical judgments).

This subpart states that health-care staff are responsible for clinical judgments, not custody staff or other jail staff. Because jails employ or contract with a variety of health-care staff, the exclusive list of health-care staff is stricken and replaced with a reference to health-care staff.

But while health-care staff are responsible for final clinical judgments, custody staff also play a critical role in ensuring that quality health care is provided to incarcerated people. Whether it's training requirements, more-frequent well-being checks, or health care provided in disciplinary segregation, communication and coordination between health-care staff and custody staff are hallmarks of a well-run jail:

> The delivery of health care in a correctional facility is a joint effort of custody and health staffs and is best achieved through trust and cooperation. . . . The nonmedical considerations needed to carry out such clinical decisions are made in cooperation with custody staff. . . . If this cooperation is lacking . . ., the ability of the health staff to perform their professional and legal responsibilities is impaired and medical autonomy is jeopardized.[388]

The subpart is structured into items, and conforming changes are made.

5. Subpart 2a (health-care policies and procedures).

This subpart requires that all health-care-related policies and procedures are developed under the health authority's direction. Jails already do this, and this is a needed and reasonable requirement to ensure that jails are providing clinically appropriate medical care in a jail. Department inspectors would inspect for this requirement as they currently do (*see* subpart 3) by reviewing documentation such as a health authority's signature indicating they reviewed and approved the policy and procedure.

6. Subpart 3 (policy review).

Plain-language changes are made to this subpart on reviewing health-care policies and procedures, and the department clarifies when these documents should be revised.

7. Subparts 4 and 5 (emergency care; health-care liaison).

Requirements on emergency care are critical because of the differences in health coverage among Minnesota jails and because an incarcerated person, including a

[388] *Standards for Health Services in Jails*, 6-7.

person held pretrial, has a "due process right to be free from deliberately indifferent denials of emergency care."[389]

Subpart 4 makes mostly conforming and technical changes. Item A is moved from the lead-in paragraph and updated to include first aid and CPR, both of which health-trained custody staff must be trained in.

Item E is updated to include mental-health services and strikes vague language on emergency care for when a hospital isn't located in a "nearby community." The department finds that an adjacent county, including a county in a bordering state, is a more enforceable standard and clearer for jails to understand and comply with.

Item F on security procedures strikes "immediate"; while jails will quickly seek to transport an incarcerated person for medical care, jail security regulations may prevent this transfer from being immediate.

Item G ensures that custody staff have a written plan for contacting local emergency medical services and other health-care contacts. This proposed requirement will ensure that when health-care staff aren't on site, custody staff can quickly contact them or emergency medical services.[390]

As stated on page 178, the subpart 5 requirement on health-care liaisons is moved to and clarified under subpart 1.

All requirements under these subparts comply with ACA standards on emergency plans to ensure 24-hour medical coverage.[391]

8. Subparts 6 to 6b (medical screenings).

Well-conducted medical screenings can protect an incarcerated person's health and safety by allowing staff to quickly identify any infectious diseases, substance use, mental illness, prescription medication, or other medical issues that may require immediate medical attention or active monitoring.

A lack of medical screening, or inadequate screening, can significantly hamper a jail's ability to provide health-care services to incarcerated people. For example, a

[389] *Ryan v. Armstrong*, 850 F.3d 419, 427 (8th Cir. 2017); *Stefan v. Olson*, 497 Fed. App'x. 568, 579–80 (6th Cir. 2012).

[390] *See also Core Jail Standards*, 1-CORE-4C-03: "In the event that primary health services are not available, and particularly in emergency situations, back-up facilities or providers should be predetermined. The plan may include the use of an alternative hospital emergency service or a physician on-call service."

[391] *See Performance-Based Standards*, 5-ALDF-4C-08.

survey of jail deaths found that for the "first 24 hours of custody, people in jail were most at risk of drug-related deaths and suicide."[392] And drug and alcohol overdoses constitute the third-leading cause of jail deaths.[393] In Minnesota, deaths have occurred when custody staff didn't document an incarcerated person's suicide risk, intoxication, or withdrawal concerns, or all three.[394]

Case law exists on medical screening for prisons, which may be applicable to jails as well:

> Virtually all of those cases have held that an adequate medical system must include a screening of all incoming inmates within a reasonable period in order to determine if the inmate has any condition that requires treatment and to check for the existence of any contagious disease.[395]

8.1. Subpart 6 (medical screening).

Medical screening, including mental-health screening, is required under part 2911.2525 and required under ACA standards (much of the current rule language stems from these ACA standards).[396] Intake screening is particularly important for preventing suicides:

> Intake screening for all inmates and ongoing assessment of at-risk inmates are critical because research consistently reports that at least two-thirds of suicide victims communicate their intent some time before death, and that an individual with a history of one or more suicide attempts is at a much higher risk for suicide than one who has never made an attempt.[397]

In addition to ACA standards, NCCHC maintains a comprehensive list of health problems in its jail health-care standards that jail staff should screen for, so the department proposes to give jails the option to screen for "other health problems" listed by NCCHC in item A, subitem (1), unit (g).

Item A, subitem (2), unit (c), is stricken because a jail's classification process dictates where to place an incarcerated person—such as in general population—and because other rule requirements under this part govern follow-up care for incarcerated people.

[392] El-Sabawi et al., "Dying Inside: Litigation Patterns for Deaths in Jail Custody."
[393] National Commission on Correctional Health Care, *Naloxone in Correctional Facilities*.
[394] Department of Corrections, "Beltrami County Jail Death Review" (2017).
[395] Palmer, *Constitutional Rights of Prisoners*, 378-79.
[396] *Core Jail Standards*, 1-CORE-2A-14, 1-CORE-4C-09. Some jails supplement this medical screening by using the Columbia Suicide Screen: https://www.cms.gov/files/document/cssrs-screen-version-instrument.pdf.
[397] Hayes, *National Study of Jail Suicide*, 33.

Other changes in item A expand existing screening requirements to better identify an incarcerated person's possible needs relating to pregnancy and postpartum status required under section 241.89, medications, and suicide prevention.

Item B clarifies that medical screenings may be conducted by either health-trained custody staff or health-care staff. This proposed addition reflects current practice and accounts for the 24-hour nature of jails. All mental-health and substance-use-disorder screenings that jails use can be conducted by custody staff. This item also complies with standards from the ACA, NIC, and NCCHC.

8.2. Subpart 6a (mental-health screening).

An incarcerated person should be screened at intake to "ensure that emergent and urgent mental-health needs are met."[398] Most jails will have custody staff perform the initial mental-health screening. The rule than prescribes what happens after the screening: For most jails, custody staff will refer an incarcerated person to see health-care staff, who will talk with the person about the screening results and then determine whether to refer them to see a mental-health professional.

For jails that don't have mental-health coverage, the incarcerated person would still see health-care staff but might not receive a mental-status exam (*see* page 223 on mental-health care).

8.3. Subpart 6b (substance-use screening).

Jails must already screen for drugs and alcohol. Ideally, a jail would use a standardized screening tool, which can significantly improve a jail's ability to identify an incarcerated person's substance use or withdrawal risk:

> Specifically, jails should screen at minimum for recent substance use that is known to lead to high-risk withdrawal syndromes, using standardized screening questionnaires at intake. A lack of substance use screening can also hinder appropriate referral processes for SUD treatments in jails and in the community and have implications for post-release overdose risk. Given their impact on public health, jails may merit support to implement improved screening and intake processes.[399]

[398] *Standards for Mental Health Services in Correctional Facilities*, 75.
[399] Bunting et al., "Characteristics of Substance Use Screening," 7.

Universal screening tools and assessments are recommended by federal agencies, jail publications, and researchers.[400] This is because current jail screening is inadequate and is linked to jail deaths:

- The federal Substance Abuse and Mental Health Services Administration recommends universal screening tools and follow-up assessments for positive screens.[401]
- A 2023 study found that jail screening nationwide is inadequate at identifying substance-use needs.[402] Another study found that only 22% of jails use a standardized screening tool.[403] And a third study reported that "59% of rural jail jurisdictions conducted screenings for opioid use disorder compared to 73% of urban jail jurisdictions."[404]
- A 2022 survey of jail deaths found that a common pattern among deaths was jails failing to properly screen people at intake.[405]
- A 2006 study on jail suicides found that "nearly 47% of inmates who committed suicide were identified during the intake process as having a history of substance abuse."[406]

Even though evidence supports standardized screening for substance use, the department decided to not require jails to use a standardized screening tool—this decision provides jails and their health authorities discretion on how to manage the initial screening and recognizes that requiring screening on substance use—together with effective training and well-being-check requirements—can still protect against deaths from substance withdrawal and conform with evidence-based practices and recommendations from health organizations.

[400] *Jail-Based Medication-Assisted Treatment*, 9; Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*; SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*.
[401] SAMSHA, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders*.
[402] Bunting et al., "Characteristics of Substance Use Screening."
[403] Christy K. Scott et al., "Availability of Best Practices for Opioid Use Disorder in Jails and Related Training and Resource Needs: Findings From a National Interview Study of Jails in Heavily Impacted Counties in the U.S.," *Health & Justice* 10, no. 36 (2022).
[404] Laura M. Maruschak et al., *Opioid Use Disorder Screening and Treatment in Local Jails, 2019* (Office of Justice Programs, April 2023), 6.
[405] Shelly Weizman et al., *Dying Inside: To End Deaths of Despair, Address the Crisis in Local Jails*, (O'Neill Institute at Georgetown Law, December 2022).
[406] Hayes, *National Study of Jail Suicide*, 16.

Depending on the tool used or the jail, health-care staff may conduct the screenings; but in most cases, custody staff will be responsible for the initial screenings.

Current rule requires follow-up care, and this standard should be no different for those who screen positive for a substance-use disorder or for withdrawal management. Both court decisions and medical standards of care demonstrate that follow-up care is both needed and reasonable, and this proposed language is consistent with proposed language in subpart 6a that requires custody staff to notify health-care staff of the screening results.

9. Subpart 7 (health-care follow-up).

Initial medical screening holds little value if there is no health-care follow-up to respond to an incarcerated person's identified health-care needs. That is why both NCCHC and the ACA recommend a health assessment or appraisal within 14 days after a person has been admitted to a jail.[407]

But if clinically indicated, an incarcerated person should receive an assessment sooner than 14 days or if they need emergency care. For example, NCCHC recommends an earlier assessment for someone who is acutely ill or has complex needs.[408] This standard is important because courts have found deliberate indifference when there has been a delay in care or access to treatment.[409]

Identifying health-care needs is incomplete without developing a plan to meet the needs, and the incarcerated person's care should be explained to them, which may help them take ownership of their care.

Critically, an incarcerated person's health-care needs must be shared with custody staff so they can monitor the person—generally, the federal Health Insurance Portability and Accountability Act allows health-care staff to disclose health information to custody staff as necessary to ensure the health and safety of incarcerated people. This is a much-needed requirement because jail deaths—or serious injuries—have occurred when miscommunication between health-care and custody staff has resulted in custody staff not adequately monitoring for health conditions such as withdrawal, suicide, or diabetes.[410]

[407] *Standards for Health Services in Jails*, J-E-04; *Core Jail Standards*, 1-CORE-4C-11.
[408] *Standards for Health Services in Jails*, J-E-04.
[409] *See Blackmore v. Kalamazoo Cty.*, 390 F.3d 890 (6th Cir. 2004); *Hudson v. McHugh*, 148 F.3d 859 (7th Cir. 1998).
[410] For diabetes, *see Phillips v. Roane Cty., Tenn.*, 534 F.3d 531 (6th Cir. 2008).

10. Subpart 8 (health concerns).

This subpart further establishes the responsibilities for jails to meet the health-care needs of incarcerated people and the constitutional right that incarcerated people have to health care (as incarcerated people are entitled to both emergency and nonemergency care, including dental care and mental-health care).[411]

Both the ACA and NCCHC prescribe standards for nonemergency care and care for chronic health conditions.[412] Because of previous jail deaths in Minnesota, communication is emphasized in this subpart so that jail staff can adequately monitor and protect the health of incarcerated people. This is even more important for jails without 24/7 health coverage, and custody staff will need to know when to take vital signs and how to communicate that information to health-care staff.

The health-care needs of people in jail exceeds the needs of those in the community, yet this also presents an opportunity to provide care for this population:

> Interventions in correctional settings provide an opportunity to address a high risk population that is difficult to reach when that population is out in the community setting. This population may also have difficulty accessing the health care system for prevention and case management services.[413]

Item B clarifies that jail staff always have a duty to report neglect according to statutory requirements, which defines neglect, in part, as "the knowing failure or omission to supply a person confined or incarcerated in the facility with care or services."[414]

[411] *See* Palmer, *Constitutional Rights of Prisoners*, 420, 432.
[412] *Core Jail Standards*, 1-CORE-4C-01, 1-CORE-4C-04, 1-CORE-4C-07; *Standards for Health Services in Jails*, J-E-07, J-E-09.
[413] State Community Health Services Advisory Committee, *Health Services in County Correctional Settings*, 11.
[414] *See* Minn. Stat. § 243.52, subd. 3(c)(1).

11. Subpart 8a (health services for pregnant or postpartum incarcerated people).

> *"Although jails operate independently of one another, the stories reveal systemic ignorance, lacking or nonexistent policies, and patterns of violence that call attention to misconceptions about how and why pregnant people become and remain incarcerated at all."*[415]

According to the Prison Policy Initiative, about "80% of women booked into jail are mothers, including over 55,000 women who are pregnant when they are admitted."[416] The initiative also reports that between 2013 and 2023 at least two-thirds of jail births occurred inside a jail cell; in at least one-third of births, the baby was born preterm; and more than half of jail births led to a lawsuit.[417]

Women in custody are often not provided with adequate living conditions or the essential information needed for a healthy pregnancy. Their custodial status itself creates barriers to maintaining meaningful relationships and accessing necessary medical care.[418] While the consensus from most resources is for pregnant and birthing people to not be incarcerated at all, some basic requirements have been acknowledged by lawmakers and incorporated in Minnesota statute § 241.89, such as testing and program offerings.

Subpart 8a is needed to establish the specific care required for incarcerated people who are pregnant, including by cross-referencing to a statutory requirement on care for pregnant women[419] and statutory requirements limiting use of restraints.[420]

While NCCHC standard provides more-detailed guidance,[421] the ACA also has established standards for this population and recommends pregnancy management that includes pregnancy testing, routine and high-risk prenatal

[415] Prison Policy Initiative, "Birth Behind Bars: Ten Years of U.S. Jail Births Covered in the News Highlight Horrific Experiences and Minimal Data Collection," briefings, July 1, 2025, https://www.prisonpolicy.org/blog/2025/07/01/jail_births_media_project/.
[416] Prison Policy Initiative, "New National Data Help Fill 20-Year Data Gap: Offense Data for People in Local Jails," briefings, April 17, 2025, https://www.prisonpolicy.org/blog/2025/04/17/jdi_jail_offenses/.
[417] Prison Policy Initiative, "Birth Behind Bars."
[418] Birth Support Working Group, "Born Inside", October 2025.
[419] Minn. Stat. § 241.89, subd. 2.
[420] Minn. Stat. § 241.88
[421] *Standards for Health Services in Jails*, J-F-05.

care, and postpartum follow-up.[422] The department added a section requiring facility administers to develop a policy and procedure for administering pregnancy tests within 14 days of an individual's incarceration. This requirement, as outlined in Minnesota Statutes 241.89, is both needed and reasonable to ensure compliance with law and to meet the basic care needs of individuals who are pregnant or up to six months of postpartum. The department also adds language requiring prenatal vitamins for incarcerated people who are pregnant; this is a needed and reasonable addition that conforms with the ACA and generally accepted standards of care.[423]

To help prepare for pregnancies, jails should develop a plan for incarcerated people who show signs of active labor or miscarriage, and also determine whether they will stock emergency-delivery kits in their facility.[424] Not all jails will need to stock these kits, depending on how they close they are to a hospital, but this is a reasonable determination that should be made to protect the health of pregnant women.

12. Subpart 8b (quarterly health reviews).

Because of the complex health-care needs of the incarcerated population, it's needed and reasonable for a jail to conduct quarterly health reviews. Some jails already do health reviews as a best practice, as it is an important tool to track health-care needs. These reviews have become even more important given the incarcerated population's mental-health care and substance-use-disorder-treatment needs.

Quarterly reviews are also reasonable because the ACA recommends that the jail administrator meet with the health authority at least quarterly,[425] while NCCHC suggests that statistical reports are made at least monthly.[426] While the proposed rule doesn't require monthly or quarterly meetings between custody staff and health-care staff, the department encourages jails to hold these meetings because they can "give the health staff an opportunity to receive and present current information on all aspects of the facility's health care delivery."[427]

[422] *Performance-Based Standards*, 5-ALDF-4C-13; *Core Jail Standards*, 1-CORE-4C-05.
[423] *Core Jail Standards*, 1-CORE-4C-05.
[424] McKesson, "Emergency O.B. Kit," https://mms.mckesson.com/product/1059396/Hopkins-Medical-Products-610388 (accessed July 22, 2025).
[425] *Core Jail Standards*, 1-CORE-4D-02.
[426] *Standards for Health Services in Jails*, J-A-04.
[427] *Id.*, 8.

Because of the prevalence of incarcerated people with substance-use disorders or mental illnesses, it's reasonable for jails to track data on care that is provided for these two health-care areas. Because some jails don't have mental-health coverage, they will transport an incarcerated person to an emergency room or health clinic to receive mental-health care, when needed.

Tracking the care provided to incarcerated people can help inform public-policy discussions both inside and outside of state government. The department can also use this data to compare health care across all jails and help facilitate solutions to providing and improving this care. The department has worked with jail staff on this subpart and has revised the language to address their concerns about the cost and time for tracking and reporting the data.

Item B is needed so that department inspectors can inspect data for compliance, when needed. Item C accounts for situations when the facility authority or health-care staff cannot provide the data or won't, but most jails should be able to successfully work with their health authority to get the necessary data.

13. Subpart 9 (sick call).

This subpart on sick call makes mostly technical changes, with one clarifying change. Currently, jails are uncertain whether the sick-call requirement applies to a jail's average daily population or to some other capacity standard. The department clarifies this by proposing that a jail's sick-call requirement be tied to its design capacity.

While the department considered using a jail's average daily population, this number can fluctuate, and jails would also have to account for this change in their health-care contracts. Accordingly, tying the sick-call requirements to a facility's design capacity is a reasonable standard and is also consistent with current rule language on a facility's staffing analysis and staffing ratios.[428]

14. Subparts 10 and 11 (infirmary and informed consent).

Both subparts make conforming and technical changes. In subpart 10, *different genders* is used to correspond to current practice and for consistency with other department rules (such as replacing *sex* with *gender*).[429]

[428] Minn. R. 2911.0900, subps. 1, 15.

[429] *See* OAH 22-9051-39958, *In the Matter of the Adopted Exempt Permanent Rules Relating to Restrictive Procedures and Searches in Juvenile Detention Facilities* (October 11, 2024).

"Health staff should support the ethical principle that patients have the right to refuse health interventions."[430]

Subpart 11 governs informed consent. Because the rule chapter has many health-care requirements, it is needed and reasonable to ensure that an incarcerated person's health records are protected under informed-consent requirements.

The department also emphasizes informed consent in its proposed rules on mental health, substance-use-disorder treatment, and medication (for example, requiring staff to explain possible adverse health consequences of prescribed medication).

15. Subpart 12 (ambulance services).

When needed for care or because of an emergency, jails may transport incarcerated people to a local hospital or an emergency room. For example, in Morrison County, the local hospital is three minutes away from the jail, and there is no reasonable need for custody staff to wait for an emergency medical vehicle when there isn't a medical emergency and when they can safely transport the incarcerated person.

16. Subpart 13 (privacy of care).

A jail setting doesn't inherently lend itself to privacy. Yet privacy for clinical encounters is needed and reasonable to address data-practices concerns and to ensure that an incarcerated person can speak freely and confidently with a health-care professional about the incarcerated person's care.

While the rule chapter already provides for privacy on intake procedures,[431] the rule lacks standards on privacy of care for other health-care encounters. The department finds that this omission should be corrected, because "it is essential that in nonemergency situations all protected health information be protected from discovery or access."[432]

There may be times where standard procedures for maintaining privacy is unfeasible, such as when cell-door therapy is being provided or if telehealth is being used. To account for these situations, a facility's policy and procedure

[430] *Standards for Health Services in Jails*, 137.
[431] Minn. R. 2911.2525, subp. 2.
[432] *Standards for Health Services in Jails*, 17.

should detail any precautions that jail staff should take to protect an incarcerated person's privacy of care.

17. Conclusion.

Some criminal-justice groups argue that *Estelle* sets a low bar, remarking that "correctional healthcare systems are designed in such a way that incarcerated people's needs are treated more like a nuisance than their ostensible mission."[433] At the same time, these groups also recognize that "even aspirationally, quality and performance measures should not necessarily mirror community care standards."[434]

The department believes that jails should strive for providing the highest level of care possible within their resources, and the department's proposed rules are one piece within a larger statewide and national conversation on correctional health care. The department's proposed revisions reasonably balance the need for correctional health care to produce positive outcomes while acknowledging the realities and resource constraints that jails face.

[433] Brian Nam-Sonenstein, "Cut-Rate Care: The Systemic Problems Shaping 'Healthcare' Behind Bars," Prison Policy Initiative (February 2025).
[434] *Id.*

Clinical Management of Substance Use Disorders (2911.5810 to 2911.5820)

Compared to 5% of adults in the general population, about 66% of people incarcerated in jails have had a substance-use disorder.[435] Yet despite this large number, treatment for substance-use disorder in jails (such as medication for opioid use disorder, or MOUD[436]) is scarce, with only 24% of jails continuing MOUD for those who are already undergoing treatment.[437] And only 19% of jails initiate MOUD for someone who hasn't started treatment in the community.[438]

Much evidence and research support the benefits that MOUD provides in preventing in-custody deaths, eliminating or minimizing a person's withdrawal symptoms, and reducing overdoses upon a person's reentry into the community. There are three federally recognized forms of MOUD (buprenorphine, methadone, and naltrexone), each with different costs, considerations, and other factors that jails must consider:

[435] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 2; Elizabeth Flanagan Balawajder et al., "Factors Associated with the Availability of Medications for Opioid Use Disorder in US Jails," *JAMA Network Open* 7, no. 9 (2024): 2.

[436] The department emphasizes MOUD because of the statewide and national research on MOUD. MOUD is the clinical term, while jails may refer to medication-assisted treatment, or MAT.

[437] Maruschak et al., *Opioid Use Disorder Screening and Treatment in Local Jails*, 1.

[438] *Id.*

Figure 8. Types of MOUD, from Jail Guidelines for the Medical Treatment of Substance Use Disorders

Maintenance Medications for Addiction Treatment

	Buprenorphine	Methadone	Naltrexone
Mechanism of effect	Partially activates the same areas of the brain as opioids; May block higher risk opioids	Activates the same areas of the brain as opioids but longer lasting to stabilize activity.	Plaques both external (eg, heroin) and internal (eg endorphins) opioids
FDA indications	Opioid use disorder	Opioid use disorder	Opioid use disorder Alcohol use disorder
Route of administration	Sublingual, buccal, subcutaneous extended dash release injection	Oral	Oral, intramuscular extended-release injection
Dosage	≥ 8 mg per day sublingual ≥ 5.7 mg per day buccal 300 and G monthly X 2 months, then 100 mg monthly subcutaneous	Typically 60 to 120 milligrams per day (oral)	50 milligrams per day (oral) 380 milligrams per month (intramuscular)
Pregnancy/ lactation	Widely used during pregnancy and lactation. Neonatal abstinence syndrome is common but treatable and may be less severe than with methadone.	Widely used during pregnancy and lactation. Neonatal abstinence syndrome is frequent treatable.	Controversial, though post induction risk is comparable to buprenorphine and methadone. Induction requires opioid withdrawal during pregnancy. May be used during lactation.
Considerations	Conversion from methadone to buprenorphine should be performed by experienced clinicians to avoid precipitated withdrawal. A patient using fentanyl may require higher doses.	Conversion from buprenorphine to methadone is uncomplicated.	Initiation requires an opioid free period of seven to 10 days before starting long dash acting injectable treatment. Unexpected release to the community may thus interrupt treatment initiation.
Possible adverse effects	Sedation, intoxication, dependence, withdrawal, hepatic impairment, Constipation, edema, dental complications, adrenal insufficiency, respiratory depression, and death (usually when combined with other sedating medications)	Sedation, intoxication, dependence, withdrawal, itching, QT prolongation and cardiac arrhythmia, neonatal opioid withdrawal syndrome, sperm abnormalities, adrenal insufficiency, respiratory depression, and death (especially when combined with other sedating medications	Nausea, hepatic impairment, withdrawal if given around the same time as an opioid, mood changes, suicidality, and pain and bleeding on injection. Higher risk of overdose on opioids after long lasting injectable treatment is discontinued.
Retention in treatment	Medium	Highest	Lowest
Mortality risk	Shown to reduce mortality from opioid use disorder; Shown to reduce suicide.	Shown to reduce mortality from opioid use disorder; Higher risk of mortality during treatment compared to buprenorphine.	Not shown to reduce mortality from opioid use disorder.

It's hard to reconcile this gap between the need for MOUD and the care that is provided considering that "postincarceration overdose deaths could be reduced as much as 31% if jails made all 3 forms of MOUD available to all detainees with OUD."[439]

Additionally, MOUD or, at least, care for substance withdrawal, is recommended by a variety of associations, researchers, and state and federal agencies:

[439] Balawajder et al., "Factors Associated with the Availability of Medications," 9.

- The ACA, AJA, and NCCHC, as outlined in *Guidelines for Managing Substance Withdrawal in Jails*. NCCHC also published a position statement with best-practice recommendations for providing MOUD in correctional settings.[440]
- The National Sheriffs' Association, which in a 2019 resolution stated that the association "supports the use of FDA-approved and evidence-based Medication-Assisted Treatment for Opioid Use Disorder within the confines of a jail or other secure facility . . . ."[441]
- The federal Substance Abuse and Mental Health Services Administration, which recommends that jails use universal screening instruments for substances and conduct follow-up assessments for positive screens, along with individualized treatment plans.[442]
- The Commission on Combating Drug Addiction and the Opioid Crisis, which recommended MOUD for pretrial detainees.[443]
- The American Society of Addiction Medicine, which stated that "access to evidence-based OUD treatment including all FDA-approved medications, either on site or through transport, is the standard of care for all detained or incarcerated people."[444]
- The National Governors Association, which argued for access to MOUD in correctional facilities and upon a person's reentry into the community.[445]
- Hazelden Betty Ford, which stated in a 2024 *MinnPost* article, "We are using evidence-based research and science to determine the best ways of recovery.

[440] National Commission on Correctional Health Care, *Position Statement: Opioid Use Disorder Treatment in Correctional Settings* (March 2021).
[441] National Sheriffs' Association*, National Sheriffs' Association Supports the Use of FDA Approved and Evidence-Based Medication-Assisted Treatment (MAT) for Opioid Use Disorder in County Jails*, Resolution 2019-02 (2019); *see also* Resolution 2022-03 (2022).
[442] SAMSHA, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders*.
[443] Office of National Drug Control Policy, "President's Commission on Opioids," https://trumpwhitehouse.archives.gov/ondcp/the-administrations-approach/presidents-commission-opioids/ (accessed April 25, 2025).
[444] American Society of Addiction Medicine, *Public Policy Statement on Treatment of Opioid Use Disorder in Correctional Settings* (July 2020).
[445] Kelly Murphy et al., *Finding Solutions to the Prescription Opioid and Heroin Crisis: A Road Map for States* (Washington, D.C.: National Governors Association Center for Best Practices, July 2016).

. . . We have determined that MAT is a very helpful tool in the treatment of opioid use disorder and alcohol use disorder."[446]

At the same time, barriers exist that hinder a jail's ability to provide MOUD and other substance-use-disorder treatment for the incarcerated population:

- **Costs and staffing.** The costs of providing MOUD together with ensuring adequate staffing are two main concerns, going back to the state's 2007 Correctional Health and Local Public Health Work Group.[447] Additionally, a jail's health-care structure affects MOUD access:

  > The type of health care model [*sic*] is associated with offering MOUD or any type of treatment for SUDs, and jails reporting services other than direct, contracted, or hybrid health care arrangements (generally, jails with no on-site health care services available) were less likely to offer MOUD than those using their own health care staff. MOUD services require ready access to licensed health care clinicians; these staff present added cost and logistical barriers for many jails.[448]

- **Insurance.** Many people in jail are or will be on Medicaid, the federal health-insurance program for individuals with disabilities or low incomes. State and federal requirements on access to MOUD for incarcerated people restrict insurance coverage for those receiving MOUD in jails.
- **Lack of community partners.** Evidence demonstrates that MOUD use in jails is positively correlated with MOUD access in the surrounding community.[449] Accordingly, jails may hesitate to start MOUD for an incarcerated person if the local community lacks the ability to provide for continued treatment upon a person's discharge.
- **Drug diversion, stigma, and related liability concerns.** Jail administrators may hesitate to allow MOUD because they fear that medication may be diverted (circulated among the general population to those who haven't been prescribed the medication). This fear is a reasonable one rooted in safety and security risks.

[446] Andy Steiner, "A 'More Risky Situation': Abstinence Advocates Say That New Legislation Could Create 'Chaos' in Sober Housing," *MinnPost*, September 24, 2024.
[447] State Community Health Services Advisory Committee, *Health Services in County Correctional Settings*, 25-26.
[448] Balawajder et al., "Factors Associated with the Availability of Medications," 8.
[449] *Id.*

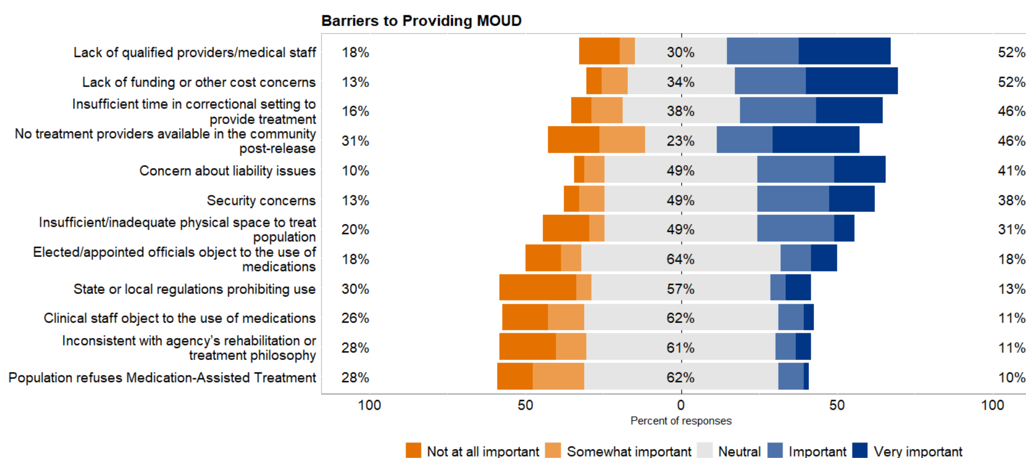
Some jail administrators may be reluctant to offer MOUD, believing that they are providing "a drug to treat a drug."

Additionally, jails employ mostly correctional officers, and these correctional officers aren't licensed health-care professionals. Consequently, jail administrators that don't have 24/7 health-care coverage may worry about the liability of correctional officers providing MOUD.

- **Short lengths of stay.** Jails may be reluctant to start a person on MOUD given that 56% of incarcerated people in Minnesota are pretrial detainees with short lengths of stay. For pretrial detainees, uncertainty around discharge dates can complicate efforts to plan and manage treatment.[450]

All these jail concerns were reflected in a 2021 MMB survey and report.[451]

Figure 9. MMB survey on barriers to providing MOUD



"Comprehensive drug treatment programs in jails are associated with reduced system costs."[452]

While these are all reasonable concerns, the department nevertheless believes that its proposed requirements give jails flexibility in meeting the department's intent and reflect the great need for minimum standards (as also recognized by the legislature). The department also finds that these general concerns have been addressed by other publications and research:

[450] American Society of Addiction Medicine, *Public Policy Statement on Treatment of Opioid Use Disorder*.

[451] Minnesota Management and Budget, *Treating Opioid Use Disorder for Criminal-Justice-Involved Individuals* (October 2021), 5.

[452] *Jail-Based Medication-Assisted Treatment*, 5.

Costs and staffing. In the long term, jails and counties that offer MOUD will see savings and benefits, as a 2016 study found that "methadone and buprenorphine MAT resulted in positive benefit to cost ratios of $2.22 and $1.76. The study estimated that the chance benefits will exceed costs for providing methadone treatment is 89% and 86% for buprenorphine."[453]

Costs will vary according to a jail's health-care provider, and treatment costs depend on the drug being prescribed. For example, methadone treatment costs about $5,000 annually, but the annual cost of confining someone in a prison is about $24,000.[454] Another estimate finds that methadone costs 40 cents a dose, while Suboxone costs $3 for the same amount.[455]

Other possible estimates show this pricing variability:

- A generic tablet version of Suboxone is about $40 for a 30-day supply. A brand-name tablet version is about $150 for a 30-day supply.
- Suboxone strips at 8 mg are about $10 per strip.
- Sublingual (daily) buprenorphine products:
  - Subutex (buprenorphine only) 8 mg tab: $1.60/tab
  - Suboxone (buprenorphine, naloxone) 8 mg/2 mg tab: $0.78/tab
  - Suboxone (buprenorphine, naloxone) 8 mg/2 mg film: $1.60/unit

Overall, costs are hard to estimate because each jail will be different in terms of the medication cost and the time needed for staff to deliver and administer the medication. Yet MOUD may be cheaper for jails because only one drug is being prescribed to manage cravings, whereas multiple drugs may be needed if MOUD isn't provided.

But there are also costs for not providing MOUD, as untreated health-care needs can result in a revolving door of reincarceration, especially among those suffering from a substance-use disorder: "Within 3 months of release from custody, 75 percent of formerly incarcerated individuals with an OUD relapse to opioid use, *and approximately 40 to 50 percent are arrested for a new crime within the first*

[453] Mace et al., *Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons*, 85.

[454] National Institute of Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (April 2014), 27.

[455] Drugabuse.com, "Should We Offer Suboxone in Jails and Prisons?," https://drugabuse.com/blog/should-we-offer-suboxone-in-jails-and-prisons/ (accessed July 25, 2025).

year."[456] Thus, reincarceration costs flow to the county and community if MOUD is neglected.

And there are costs to the individuals themselves: "Prisoners and jail inmates released to the community are between 10 and 40 times more likely to die of an opioid overdose than the general population, especially within the first few weeks after reentering society."[457] There are also costs when treatment isn't provided such as hospitalization, suicide risk, severe dehydration, and seizure.

For staffing concerns and related liability concerns for correctional staff, the department has proposed MOUD-related training requirements. Jails will also need to weigh the litigation costs for failing to provide MOUD.[458] For example, jails could (and have been) sued for in-custody deaths, including under the Americans with Disabilities Act, Civil Rights Act of 1871, Eighth Amendment, Fourteenth Amendment, and Rehabilitation Act of 1973.[459] Furthermore, the US Department of Justice has reaffirmed the legal requirements on caring for individuals with substance-use disorders:

> Recent guidance and enforcement actions from the U.S. Department of Justice have underscored that individuals with substance use disorders can qualify as individuals with a disability under the ADA and that the ADA protects individuals who are engaged in a course of treatment that includes medication for opioid use disorder (MOUD) approved by the Food and Drug Administration (FDA), including in correctional settings.[460]

The department also believes that staff retention could increase if incarcerated people are treated with MOUD, especially those undergoing withdrawal, because meeting the health-care needs of incarcerated people makes for a safer and more secure jail.

[456] SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, 3 (emphasis added).
[457] *Id.*
[458] Bureau of Justice Assistance, *Managing Substance Withdrawal in Jails: A Legal Brief* (February 2022), 4.
[459] Jails have also been sued under the *Estelle* deliberate-indifference standard. *See Foulks v. Cole Cty., Mo.*, 991 F.2d 454, 456-57 (8th Cir. 1993); *Kelley v. County of Wayne*, 325 F. Supp. 2d 788, 791-92 (E.D. Mich. 2004); *Nur v. Olmsted Cty.*, 563 F. Supp.3d 946, 956-70 (D. Minn 2021); *see also* case summaries from the Legal Action Center on discrimination against incarcerated individuals receiving MOUD: *Pesce v. Coppinger*, 355 F. Supp.3d 35 (D. Mass. 2018); *P.G. v. Jefferson Cty.*, No. 5:21-CV-388-DNH-ML (N.D.N.Y. Sept. 7, 2021).
[460] Weizman et al., *Dying Inside*, 3; *see also* U.S. Department of Justice, Civil Rights Division, "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery" (April 5, 2022).

While the department has discussed the challenges jails face when offering MOUD to incarcerated people, experience from other jails and national guidance show how jails can ameliorate these challenges.

- **Insurance.** Best practice, including federal recommendations, is to suspend rather than terminate an incarcerated person's insurance coverage. Like some other states, Minnesota is attempting to use Medicaid waivers to improve access to substance-use-disorder treatment for incarcerated persons: "Recent 1115(b) Medicaid waivers emphasize improved services for persons living with OUDs in carceral settings and improved linkage to services after release."[461]

- **Lack of community partners.** Jail-specific standards on MOUD recommend partnerships between jails and noncorrectional entities such as a methadone treatment provider.[462] These partnerships are necessary because methadone can be prescribed by only licensed opioid treatment programs, and most jails will need to partner with community-based programs.[463]

  But besides methadone, another FDA-approved drug—buprenorphine—can be prescribed by licensed physicians, nurse practitioners, and physician assistants. These medical professionals no longer need to obtain buprenorphine licenses, or "waivers,"[464] under the federal Consolidated Appropriations Act of 2023.[465]

  While some jails may be limited in local community partners, the department and other state agencies can help connect jails to existing state and federal resources such as the federal Comprehensive Opioid, Stimulant, and Substance Use Program.[466] And most jails are already attempting to connect

[461] Balawajder et al., "Factors Associated with the Availability of Medications," 2.
[462] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 48.
[463] There is also the "three-day rule" that allows a physician (or other licensed practitioners) outside of an opioid treatment program to administer, for up to 72 hours, methadone to relieve acute withdrawal symptoms.
[464] *Jail-Based Medication-Assisted Treatment*, 10.
[465] For more on the act, *see* Substance Abuse and Mental Health Services Administration, "Waiver Elimination (MAT Act)," https://www.samhsa.gov/substance-use/treatment/statutes-regulations-guidelines/mat-act (accessed June 5, 2025).
[466] Bureau of Justice Assistance, "Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP)," https://bja.ojp.gov/program/cossup/about (accessed April 25, 2025). This program was created to "provide financial and technical assistance to states, units of local government, and Indian tribal governments to develop, implement, or expand comprehensive efforts to identify, respond to, treat, and support those impacted by illicit opioids, stimulants and other drugs."

with local partners, according to a 2022 study, which found that 72% of jails engage in some form of continuity-of-care activities.[467]

In the absence of community partners, jails could seek to use peer-recovery coaches to provide personal connections and life experiences to those with a substance-use disorder.

- **Drug diversion.** Contrary to common belief, jails that have used MOUD have witnessed decreased incidents of drug diversion.[468] This may be because incarcerated people can get their health-care needs met when they formally receive prescription medications for their substance-use disorders. And depending on the type of drug, diversion may be greatly mitigated. For example, buprenorphine has a low risk of overdose and thus a low health and safety risk if diverted.

  Additionally, current rule requirements on storing medications can mitigate the risks of drug diversion; storage requirements also ensure that medications are used before they expire.

  Other solutions include using pill-call lines, administering medications in a central location, restricting medication access to trained and authorized staff, regular audits, and communicating with incarcerated people about diversion. Additional guidance on combating diversion is offered by the AJA.[469]

- **Short lengths of stay.** The department recognizes the fluid and sudden nature of discharges, but clinical guidelines and other factors—as argued in the SONAR—suggest that MOUD should be available to all incarcerated people, regardless of their length of stay. And a short length of stay doesn't diminish the risk of death. For example, a federal report found that the median length of stay in jail before an incarcerated person died from alcohol or drug intoxication was *one day*.[470]

Last, adopting minimum standards on MOUD can save lives:

> [A] recent simulation study using data from the National Center for Vital Statistics, which estimates that 668 lives out of every 10,000 incarcerated

[467] Scott et al., "Availability of Best Practices for Opioid Use Disorder in Jails": 6.
[468] Mace et al., *Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons*, 39.
[469] Fred Meyer and Claire Wolfe, "Medication-Assisted Treatment: Discharge Planning," *American Jails*, September/October 2023, https://www.americanjail.org/digital-magazine.
[470] Bureau of Justice Assistance, *Managing Substance Withdrawal in Jails*, 1 (emphasis added).

> people nationally would be saved if all incarcerated individuals who had clinical need for MOUD had received it; additionally, 1,609 lives out of every 10,000 incarcerated people would be saved if they had received MOUD both while incarcerated and after release.[471]

Although there is an overwhelming need for jail-based MOUD, this need crashes into the reality that jails face, with each Minnesota jail facing unique challenges. To help manage this clash, the department hopes that jails, county boards, and their health authorities will do their due diligence and analyze their staffing and funding needs, local community resources, and ability to work with other jails that do have the resources to provide MOUD.

[471] Scott et al., "Availability of Best Practices for Opioid Use Disorder in Jails," 11.

Withdrawal Management (2911.5810)

". . . Experiencing opioid withdrawal ('cold turkey') is not therapeutic, and treating withdrawal from the outset is the standard of care."[472]

While not all jails have the resources to provide MOUD, all jails should have policies and procedures to manage substance withdrawal for all incarcerated people. Withdrawal, formerly known as detoxification, requires health-care staff to gradually reduce or taper a person's medications to manage their withdrawal symptoms and reduce their dependence on a substance.

As the department has stated, alcohol and drug withdrawal is the third-leading cause of jail deaths, and there are well-established, evidence-based protocols such as screening and health assessments that can prevent most of these deaths. Additionally, jail associations and accreditation groups all recommend that jails develop policies and procedures on substance withdrawal:

- The NIC suggests that jail develop "protocols for observing and caring for moderately intoxicated arrestees or those undergoing moderate withdrawal."[473] Those suffering acute withdrawal "should be transported to a hospital."[474]
- The ACA has a mandatory requirement on withdrawal management and comments that "medical treatment should include current medications that are indicated to prevent serious withdrawal symptoms, and within the facility include periodic monitoring with documentation of decompensation and/or significant changes . . ."[475]
- NCCHC has an essential standard on medically supervised withdrawal and treatment. This standard is needed because "alcohol and/or drug intoxication is a leading cause of death in jails. It requires urgent if not emergent management to prevent complications including death."[476]

While opioid withdrawal has received much attention—and rightly so—alcohol withdrawal is also deadly, as is withdrawal from benzodiazepines such as

[472] SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, 64.
[473] Martin and Rosazza, *Resource Guide for Jail Administrators*, 202.
[474] *Id.*
[475] *Performance-Based Standards*, 5-ALDF-4C-35.
[476] *Standards for Health Services in Jails*, 119.

Xanax.[477] About 20% of people who take benzodiazepines misuse them, and they are addictive:

> Benzodiazepines such as lorazepam and chlordiazepoxide are notorious for having the potential to be highly addictive. They may also come with difficult—sometimes fatal—withdrawal symptoms.[478]

Even those who don't suffer fatal withdrawal consequences from benzodiazepines can still experience long-term neurological consequences.[479]

1. Subpart 1 (policy and procedure).

This subpart governs the minimum requirements for a facility's policy and procedure on withdrawal management.

If an incarcerated person's initial medical screening indicates that they use or have used substances, health-care staff should screen the incarcerated person's need for withdrawal management.[480] Additionally, the initial screening may not catch everyone who is at risk for withdrawal, so a facility's policy and procedure should allow for other times when staff should screen for withdrawal.

> *"All individuals, regardless of their length of stay in jail, should be screened for risk of withdrawal."*[481]

There are many withdrawal tools that jails can use, and many of these can be done by health-trained custody staff, with health-care staff conducting any clinical evaluations and recommendations:

> The screening tools are simple and easy to use. For many SUD screening tools, jail staff members do not need to be licensed, certified, or credentialed to administer them or score the results. However, medical staff members should be available in cases in which a person being screened could have withdrawal symptoms that require medical attention.[482]

[477] Shalini Ramachandran and Betsy McKay, "Generation Xanax: The Dark Side of America's Wonder Drug," *Wall Street Journal*, March 13, 2025.
[478] Christina Caron, "Don't Underestimate the Risks of Benzodiazepines," *New York Times*, March 12, 2025.
[479] Ramachandran and McKay, "Generation Xanax."
[480] For the importance of screening, *see* Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 7.
[481] *Id.*, 5.
[482] Office of Justice Programs, "Screening for Substance Use Disorders in Jails," https://www.cossup.org/Content/Documents/Articles/AHP_Screening_for_Substance_Use_Disorders_in_Jails.pdf (accessed April 22, 2025).

After conducting the initial screening, custody staff should communicate the screening results to health-care staff, who can then determine any appropriate withdrawal management to provide. If clinically indicated, health-care staff should conduct a clinical assessment. A clinical assessment is important because it allows "tailoring of treatment to a person's withdrawal symptoms."[483] Several publications recommend the following assessment tools:[484]

While the department originally proposed requiring jails to use one of these assessment tools, correctional health-care staff and members of the advisory committee noted that more flexibility was needed. Accordingly, the department decided to offer jails more flexibility by allowing them to choose the screening or assessment tool that works best for them and their health authority; this also prevents the rule from becoming obsolete and limiting if other assessment tools become available.

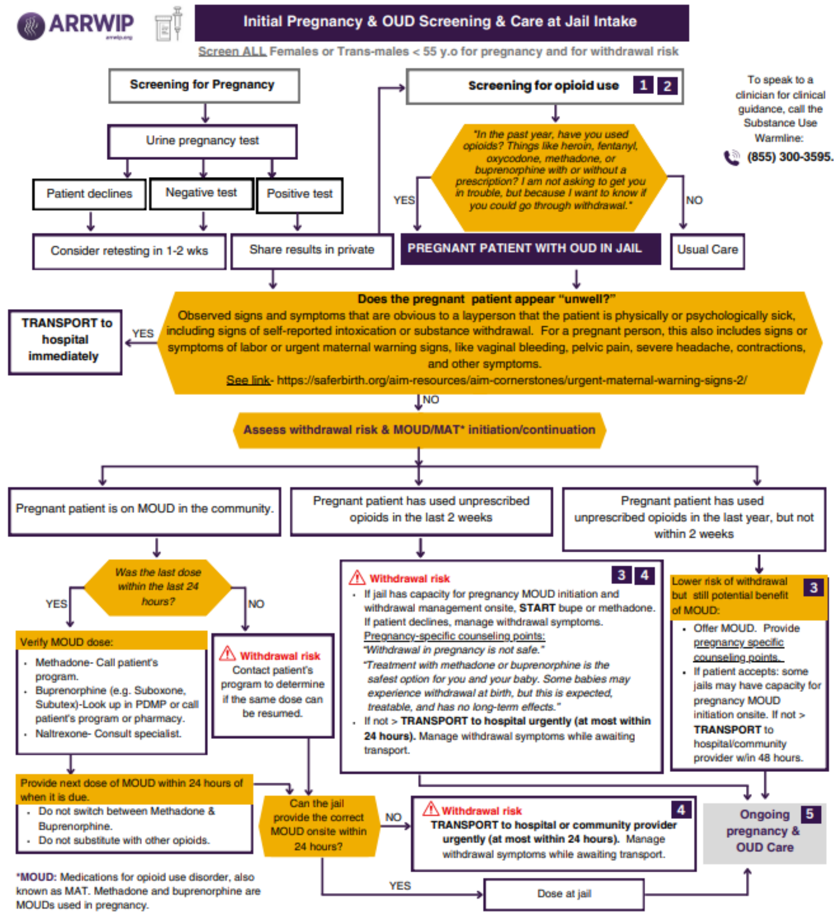
Depending on an incarcerated person's assessment results, a jail will need to provide them withdrawal management. Because "withdrawal from alcohol, sedatives, and opioids can be dangerous and potentially life-threatening,"[485] all incarcerated people should be provided withdrawal management when needed:

[483] *Jail-Based Medication-Assisted Treatment*, 9.
[484] *Id.*; SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, 64; Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*.
[485] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 14.

> A major goal of the initial clinical assessment in a jail setting is to address the need for swift action to avoid critical biomedical or psychiatric issues related to intoxication or withdrawal (e.g., acute withdrawal syndromes, overdose, suicidality, and other acute psychiatric symptoms). Findings of the clinical assessment inform whether the patient's needs can be addressed at the jail or require transfer to a higher level of care.[486]

Jails must also make sure to detail how they will provide withdrawal management to an incarcerated person who is pregnant, given that "opioid withdrawal during pregnancy is associated with miscarriage, premature delivery, and other serious complications."[487]

Figure 9. Figure 9. Advocacy and Research on Reproductive Wellness of Incarcerated People 05/13/2024



486 *Id*, 5.

487 *Jail-Based Medication-Assisted Treatment*, 14. This also applies for alcohol withdrawal: "Pregnant women with alcohol use disorders should receive medically managed withdrawal treatment from alcohol *as soon as possible*." *Id.*, 15 (emphasis added).

Depending on a jail's resources, a jail may sometimes be unable to provide withdrawal management; when this happens, a jail must detail where it will transfer an incarcerated person for appropriate medical care—this will almost always be a hospital emergency room. (A hospital must provide stabilizing treatment for an emergency medical condition under the federal Emergency Medical Treatment and Labor Act.)

As part of informed consent, an incarcerated person should understand the care or treatment they are receiving, including any potential adverse reactions to medication.[488] Education is also important for when a person leaves jail because it can help provide a person with resources for self-care: "Patient education regarding the withdrawal process is a necessary component of treatment."[489]

2. Subpart 2 (coordinating with community-based provider).

If needed to provide withdrawal management, a jail may coordinate with a community-based provider. A provider may include a withdrawal management program under Minnesota Statutes, chapter 245F:

> It is hereby declared to be the public policy of this state that the public interest is best served by providing efficient and effective withdrawal management services to persons in need of appropriate detoxification, assessment, intervention, and referral services.[490]

Nothing requires a jail to partner with a community-based provider, and the final clinical authority still resides with a jail's health authority, except as statutorily prescribed. This provision is needed to provide jails flexibility in providing withdrawal management and in case future legislative initiatives require this type of coordination.

3. Subpart 3 (ongoing monitoring).

"Regularly monitoring patients helps staff detect destabilizing health, enabling providers' timely modification of treatment plans."[491]

The department's proposed training requirements require custody staff to be trained on identifying signs and symptoms of withdrawal; equally important is monitoring incarcerated people during withdrawal, especially when health-care staff are not on site:

[488] *See, e.g., id.*, 9.

[489] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 19.

[490] Minn. Stat. § 245F.01.

[491] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 15.

> Custody staff should not be expected to make decisions about the severity or implications of changes in patient condition. Rather, the patient-specific instructions should describe what should be monitored (e.g., changes in appearance, mental status, behavior, vital signs, score on a validated tool), what changes to look for, and what to do if those changes are noted (e.g., when to contact the on-call qualified health care professional, when to seek emergency medical care).[492]

Ongoing monitoring is a critical component of withdrawal management because inadequate monitoring protocols can lead to serious health outcomes, including death. For example, an incarcerated person in Minnesota died in 2017 from the effects of alcohol withdrawal despite having a reported history of chronic alcoholism and being observed as disoriented and delusional.[493]

While not all jails have a dedicated space—such as a separate housing unit—to provide withdrawal management, "an accurate and current log of all patients being monitored for withdrawal risk and withdrawal management should be maintained including, at a minimum, the substance(s) for which monitoring is being conducted and the frequency of monitoring."[494]

4. Subpart 4 (continuity of care).

> *"The least developed jail-based service is transition planning."*[495]

Continuity of care, especially for those who have received withdrawal management, is critical to preventing incarcerated people from dying upon reentering the community. Because a lack of access to medication is one factor that can produce negative health outcomes, providing an incarcerated person information about their prescription medication can help ensure their continuity of care. For jails that don't have 24/7 coverage, custody staff should tell incarcerated people how to receive this information after they are released—commonly, incarcerated people can get this information at a local clinic or pharmacy.

Everyone who receives withdrawal management should be provided information on community resources given the immediate postrelease risk and associated mortality rate: "Research shows that risk of overdose in the 2 weeks following

[492] *Id.*, 16.
[493] Midwest Medical Examiner's Office, "Medical Examiner's Final Summary" (2017).
[494] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 16.
[495] SAMSHA, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders*, 4.

release from incarceration is extremely high."[496] And because of this overdose risk, incarcerated people should be offered Narcan upon release (see page 212 for more discussion on Narcan).

It is also important that formerly incarcerated people can contact jail staff for any follow-up questions they may have, especially considering that health-care staff may be the only health professionals that incarcerated people interact with.

5. Subpart 5 (documentation).

This subpart establishes the documentation requirements for this part. These documentation requirements are consistent with current and proposed rules and are needed so department inspectors can inspect for compliance and to clearly communicate the expectations for jails.

[496] Bureau of Justice Assistance, *Guidelines for Managing Substance Withdrawal in Jails*, 19.

Substance-Use-Disorder Treatment (2911.5820)

While the department has argued the benefits of providing MOUD in jails, the department still recognizes that not all jails can provide MOUD or substance-use-disorder treatment for other substances such as alcohol and benzodiazepines. Additionally, other state agencies such as the Department of Health, Department of Human Services, and the Office of Addiction and Recovery are working on statewide solutions to increase MOUD access in jails. The department's proposed amendments for this part are crafted for when these solutions become more widespread and accessible for jails.

1. Subpart 1 (policy and procedure).

This subpart provides discretion to jails on whether to provide substance-use-disorder treatment, though recent legislative changes on continuing an incarcerated person's prescription medications may apply (*see* page 240). If a jail chooses to provide treatment, the jail will need to comply with the reasonable evidence-based amendments in this part.

As with the proposed language on substance withdrawal, a facility's policy and procedure should state how health-care staff will assess for substance-use disorders and provide treatment. Ideally, jails would provide treatment for an incarcerated person who is pregnant because the same risks apply as they do for a pregnant person who needs withdrawal management. The department, however, is not mandating this for jails after they expressed concern that stating the requirement in rule might discourage jails from offering substance-use-disorder treatment.

An incarcerated person has the right to determine their health-care needs, and this right extends to substance-use-disorder treatment. If a person decides to discontinue treatment, the facility's policy and procedure should describe how health-care staff will manage any subsequent health risks. While discontinuing treatment will be made on a case-by-case basis, a process for managing this is needed because of the health and safety risks of stopping substance-use-disorder treatment.

As with other proposed health-care requirements, education is essential for informed consent and to help ensure a person's continuity of care after they leave jail.

"Before an individual is enrolled into a jail's MAT program, he or she is educated about the medications offered and the associated choices to be made."[497]

If a person already receiving substance-use-disorder treatment is admitted to a jail, discontinuing their treatment could violate statute and the Americans with Disabilities Act.[498] To ensure compliance with the law, a jail may need to transfer a person to another jail or provide substance-use-disorder treatment if the person has started receiving treatment before admission. Jails also must consider serious health and safety risks:

> Because physiological tolerance to opioids declines during forced abstinence or while taking naltrexone, inmates required to withdraw involuntarily from methadone or buprenorphine face a substantially increased risk of overdose and death if they discontinue treatment upon release and resume illicit opioid use.[499]

2. Subpart 2 (treatment; generally).

With a few exceptions, all incarcerated people have the right to refuse medical care. This principle applies to substance-use-disorder treatment, and the department's proposed language on discontinuing treatment recognizes a person's right to refuse treatment and that "inmates may not be punished for exercising that right."[500] Because substance-use-disorder treatment is a higher level of care than is typically provided in jails, this subpart is needed to specify the rights of incarcerated people for this care and to ensure that any treatment decisions are made to respect an incarcerated person's autonomy.

This part also specifies that jail staff document any case notes for an incarcerated person receiving treatment—this language is consistent with other proposed changes for mental-health care.

In items B and D, the proposed language recognizes that most jail guidelines for MOUD recommend that "medication and other forms of behavioral health treatment should not be used as rewards, nor their withholding as a punishment."[501] If an incarcerated person is diverting medication, the proposed

[497] *Jail-Based Medication-Assisted Treatment*, 20.
[498] U.S. Department of Justice, "The Americans with Disabilities Act and the Opioid Crisis."
[499] SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, 24.
[500] *Standards for Health Services in Jails*, 138; *see also id.*, J-G-05.
[501] *Jail-Based Medication-Assisted Treatment*, 17.

rule allows for exception for health or safety reasons, though "loss of privileges or confinement are more appropriate alternatives."[502]

In item C, the department proposes language that recognizes instances when an incarcerated person's behavior or sanctions for facility rule violations prevent the person from participating in programming such as therapy. This proposed language is consistent with language under parts 2911.3100 on programming and 2911.5830 on mental-health care.

3. Subpart 3 (coordination with community-based provider).

If needed to provide substance-use-disorder treatment, a jail may coordinate with a community-based provider. A provider may include a treatment facility licensed under Minnesota Statutes, chapter 245G. As with the proposed requirements on withdrawal, nothing requires a jail to coordinate with a community-based provider.

4. Subpart 4 (continuity of care).

> *"Because physiological tolerance declines if individuals are not maintained on methadone or buprenorphine while incarcerated, release to the community without follow-up care can lead to higher rates of opioid overdose and mortality if they return to pre-incarceration levels of opioid use."*[503]

For those receiving substance-use-disorder treatment while incarcerated, continuity of care is a life-or-death issue: Upon discharge over a ten-year period (2010 to 2019), "1.5% of all individuals released in Minnesota (548 people) died within one year—*with drug overdose accounting for 33% of these deaths statewide*."[504]

At the same time, discharge planning is resource intensive, and the nature of jails poses challenges for discharges and ensuring continuity of care. Ideally, a jail would follow best practices and provide warm handoffs or wraparound services:

> To help this transition, offer enrollment in wraparound services. Provide referrals to treatment providers and assistance with transportation to those providers prior to release. Identify local support groups as a resource

[502] *Id.*
[503] SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, 27.
[504] Minnesota Management and Budget, "Treating Opioid Use Disorder," 14 (emphasis added).

> for positive social support for individuals returning to the community. Helping incarcerated individuals identify and anticipate barriers to community reintegration, as well as the resources to address them, supports successful reentry.[505]

While prisons are better suited to ensure wraparound services, the department's proposed requirements can still minimally ensure continuity of care, even when jails—at least currently—cannot reasonably meet these best-practice standards of care. And community initiatives, such as long-term recovery supports, are needed as well because of the long-term risks of remission:

> When a person with SUD enters treatment, the situation may be likened to a building on fire, with clinicians implementing critical short-term interventions to extinguish the flames. After the fire is out, however, attention to scaffolding and building materials is necessary for people with SUD to rebuild their lives in a safer and more secure environment that helps prevent the fire from restarting.[506]

Many of the department's proposed requirements on continuity of care mirror the requirements for withdrawal management and mental-health care. But an additional requirement stands out: a long-acting injectable.

As proposed in item E, injectable formulations (Sublocade and Brixadi) for buprenorphine can be a beneficial option to bridge the care gap between discharge and community follow-up, as an injectable shot lasts about a month. Yet the shot is expensive, about $1,200 to $1,700 per dose, and it may need to be supplemented with sublingual Suboxone to protect against fentanyl potency in the community.

Naloxone, on the other hand, is cheaper than long-acting injectables (around $50 for an over-the-counter two pack or as high as $76)[507] and has been proven to reduce overdose deaths.[508]

While not all incarcerated people will need an injectable formulation upon discharge, they should receive naloxone upon discharge as a best health and safety practice.

[505] SAMSHA, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, 57.
[506] John F. Kelly et al., "The Changing Approach to Addiction—From Incarceration to Treatment and Recovery Support," *New England Journal of Medicine* 392, no. 9 (2025): 833.
[507] Eric Tatara et al., "Agent-Based Model of Combined Community- and Jail-Based Take-Home Naloxone Distribution," *JAMA Network Open* 7, no. 12 (2024).
[508] *Id.*

> *"Distribution at jail release is an economical and feasible approach to substantially reducing opioid-related overdose mortality."*[509]

Combined with a bridge prescription,[510] naloxone and education can help reduce the overdose risks upon a person's return to the community. But given the vital importance of discharge planning, the legislature and other stakeholders should continue to strategize how to provide jails the resources to ensure a person's continuum of care.

5. Subpart 5 (documentation).

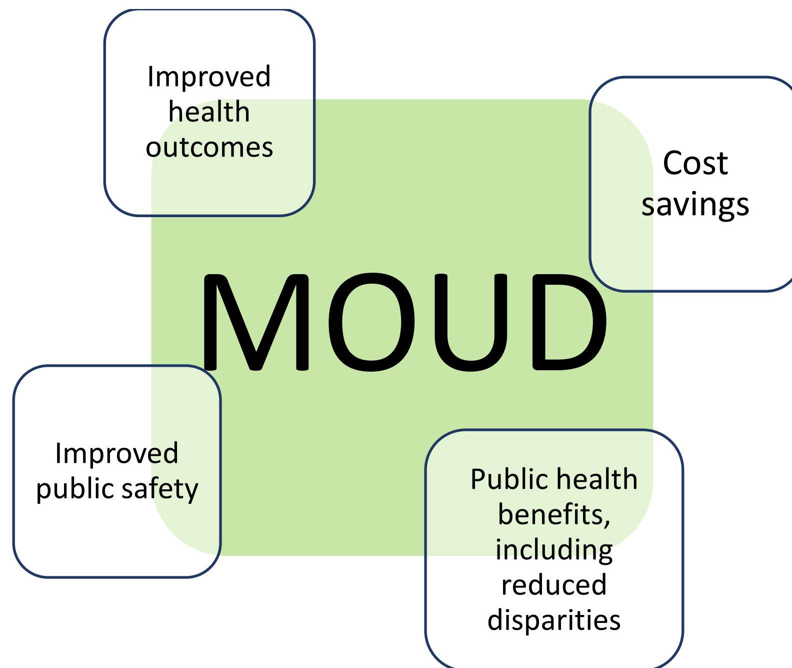
This subpart establishes the documentation requirements under this part. These documentation requirements are consistent with current and proposed rules and allow department inspectors to ensure compliance.

6. Conclusion.

The department alone cannot solve the opioid crisis in jails. Fortunately, two state entities are working on statewide solutions:

- **MOUD in Jails Workgroup.** Composed of corrections officials, medical professionals, community partners, and more, the workgroup seeks to improve statewide access to MOUD for people incarcerated in jail. As the workgroup identified in its 2025 interim report,[511] providing MOUD to incarcerated people is beneficial to incarcerated people, staff, and the community:

[509] *Id.*
[510] *See, e.g.,* Mace et al., *Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons,* 68-69.
[511] Minnesota Office of Addiction and Recovery, MOUD in Jails Workgroup, *Interim Report to the Subcabinet on Opioids, Substance Use, and Addiction* (January 2025).



- **Governor's Advisory Council on Opioids, Substance Use, and Addiction.** This council is a newly established state agency with about 18 members appointed by the governor and consists of Minnesotans who have personal or professional connections to substance-use disorders. As with the MOUD workgroup, one of the council's recommendations is to increase MOUD access for incarcerated people.[512] The council also seeks to support reentry for those leaving jail, increase the capacity of peer-recovery services, and increase community supports and services.

[512] Governor's Advisory Council on Opioids, Substance Use, and Addiction, *Recommendations to the Governor's Subcabinet on Opioids, Substance Use, and Addiction: Year-end Report* (December 2024).

Mental Health Care (2911.5830 to 2911.5850)

"Like it or not, correctional settings have become the de facto psychiatric hospitals of our day."[513]

Many people incarcerated in a jail have a mental illness or other mental-health problem, as illustrated in a 2005 survey:[514]

- 60% had symptoms of a mental-health disorder.
- 54% reported symptoms that met criteria for mania.
- 24% reported symptoms that met criteria for psychotic disorder.
- 76% who had a mental-health problem also met criteria for substance abuse or dependence.
- Incarcerated people with a mental-health problem were twice as likely as those without one to have been charged with violating a facility rule (19% to 9%).

And there's little evidence that these statistics have meaningfully decreased—in fact, they most likely have increased: [515]

- About 2 million times each year, people with a serious mental illness are booked into jails.
- About 2 in 5 people who are incarcerated have a history of mental illness (37% in state and federal prisons and 44% in jails).
- 66% of women in prison reported having a history of mental illness, almost twice the percentage of men.

For decades, mental-health care in jails—and the difficulties providing it—has been the leading concern for jail administrators, county staff, and criminal-justice advocates. For instance, the state's 2007 Correctional Health and Local Public Health Work Group found that mental health was a top concern among correctional health-care staff, in addition to meth and psychotropic

[513] Lorry Schoenly, "4 Tips for Handling Mentally Ill Inmates," *Corrections1*, August 11, 2014.
[514] James and Glaze, "Mental Health Problems of Prison and Jail Inmates."
[515] "Mental Health by the Numbers," National Alliance on Mental Illness, updated April 2023, https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/ (accessed July 22, 2025).

medications.[516] Mental health's importance was spotlighted in the 2016 OLA audit, which spurred a previous department attempt[517] to amend the rule chapter:

> About 99 percent of sheriffs said that, compared with other challenges facing their jails, the issue of inmates with mental illness is of 'high' or 'very high' importance . . . . Among county human services directors, 79 percent said that, compared with other mental health issues affecting their counties, the issue of inmates with mental illness is of 'high' or 'very high' importance.[518]

These concerns haven't diminished, as recently reported by the Minnesota Office of the Ombuds for Corrections. The ombuds reported that "jail administrators and facility staff readily express that jails and correctional staff are often not equipped to handle the complexities of those with high mental health needs."[519] In turn, these concerns affect custody staff and their experience working in a jail, often resulting in a "constant drain on jail staff."[520]

These concerns from jail staff are amplified because courts have ruled that an incarcerated person's right to health care includes mental health care.[521] Furthermore, this constitutional right includes adequate mental-health screening and requires jails to provide timely care. Ultimately, an incarcerated person's broader health is inextricably linked to their mental-health care:

> There can now be no doubt that the requirement that inmates receive needed medical care includes the requirement that they receive needed mental health care. Innumerable class actions have held that psychiatric care is as much an element of a minimally adequate medical care system as any other form of care.[522]

[516] State Community Health Services Advisory Committee, *Health Services in County Correctional Settings*, 22.
[517] OAH 82-9051-36080, *Possible Amendment to Rules Governing Jail Facilities* (May 6, 2019, through July 5, 2019).
[518] Legislative Auditor, *Mental Health Services in County Jails*, 9.
[519] Minnesota Office of the Ombuds for Corrections, *Languishing Behind Bars: The Urgent Need for Mental Health Support in Minnesota Jails* (July 2025), 2.
[520] *Id.*, 10.
[521] *See Partridge v. Two Unknown Police Officers of City of Houston*, 791 F.2d 1182 (5th Cir. 1986); *Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206 (1998) (holding that the Americans with Disabilities Act covers incarcerated people). For rights of pretrial detainees generally, *see Wolfish*, 441 U.S. at 520; *City of Revere,* 463 U.S. at 239; *see also* Legislative Auditor, *Mental Health Services in County Jails*, 16-17.
[522] Palmer, *Constitutional Rights of Prisoners*, 433; *see also A Jailhouse Lawyer's Manual*, Columbia Human Rights Law Review (13th ed. 2024).

Yet while incarcerated people have a right to psychiatric care necessary to maintain their health and safety,[523] the OLA audit highlights how the current rule chapter doesn't align with professional standards for mental-health care, particularly standards from NCCHC, but also from the ACA.

"Overall, the rules provide jails with too much latitude and too little helpful guidance about mental health assessment."[524]

But the OLA audit also reinforced that the same constraints jails face for providing substance-use-disorder treatment also exist for mental-health care:

- Costs, including staffing
- Insufficient availability of community-based mental-health services
- Overall shortage of mental-health professionals in Minnesota

Of course, people in the general population suffer from similar barriers in trying to access mental-health care. For example, as of 2022, more than half of US adults with a mental illness didn't receive treatment, according to Mental Health America. In Minnesota, "there is a severe shortage of mental health providers in Minnesota, with 72% of Minnesota counties federally designated as mental health provider shortage areas."[525] This lack of treatment can be deadly, particularly for people in rural areas,[526] reinforcing how a nationwide shortage of mental-health professionals reverberates through society and, ultimately, jails.[527]

"Jails are not a replacement for mental health hospitals or secure treatment facilities."[528]

An additional concern is the state's shortage of secure inpatient beds for those who need treatment in state-operated treatment programs. This shortage of treatment beds was examined by a 2024 legislative task force. Unsurprisingly, the

[523] *See Hare v. City of Corinth,* 74 F.3d 633, 649 (5th Cir. 1996); *Clark-Murphy v. Foreback*, 439 F.3d 280, 292 (6th Cir. 2006); *Gates v. Cook*, 376 F.3d 323 (5th Cir. 2004).
[524] Legislative Auditor, *Mental Health Services in County Jails*, 55.
[525] Melissa Serafin et al., *Unfinished Business: Examining Barriers to Obtaining Mental Health Licensure Among Minnesota Graduates: Findings and Recommendations* (February 2025).
[526] Taylor Elizabeth Eldridge, "When a Mental Health Emergency Lands You in Jail," *Marshall Project*, September 20, 2017.
[527] *See, e.g.*, Serafin et al., *Unfinished Business*.
[528] Minnesota Department of Human Services, *Task Force on Priority Admissions to State-Operated Treatment Programs* (Vadnais Heights, February 2024), 13.

task force found that the bed shortage strained jails, especially the prolonged wait times for those needing to be transferred to state treatment facilities:

> Counties, county sheriffs in particular, were concerned about the negative impact increasing wait times was having on those living with mental illnesses in their custody and raised concern with advocates and state lawmakers alike. Inmates with untreated mental illnesses, as their conditions worsened behind bars, posed an increased danger to themselves, other inmates, and corrections staff. Jail was not suited for the treatment of many who belonged in a secure psychiatric facility where they could get the timely professional treatment they needed.[529]

Despite these challenges, the task force recommended several ways for jails to meet the mental-health-care needs of their incarcerated populations, one of which centered on administering neuroleptic medications, a topic also studied in the OLA audit (the department discusses its proposed revisions on involuntary medication administration on page 234).[530]

In a follow-up report to the task force's work, another state group recognized the need for jails to provide mental-health care:

> While people are in jail, they have a right to treatment. . . . 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. . . . By providing this level of care we can prevent people from decompensating and needing a higher level of care.[531]

Yet even as correctional associations face this stark reality, they have found solutions:

- **Training.** Increased and more-comprehensive training, such as crisis-intervention training: "Since we can't, in the short term, change the type of inmate arriving at our jails and prisons, we need to prepare to keep both them and staff members physically, legally, and psychologically safe."[532]
- **Education.** Learning how mental illness can affect a person's behavior and how to appropriately respond: "Minor misbehavior, when treated appropriately, is less likely to escalate."[533]

[529] *Id.*, 14.
[530] *Id.*, 26-27.
[531] Minnesota Department of Human Services, *Priority Admissions Review Panel*, 25.
[532] Gary T. Klugiewicz, "Responding to Mentally Ill Inmates," *Corrections1*, October 24, 2011.
[533] Schoenly, "4 Tips for Handling Mentally Ill Inmates."

- **Collaborating with professionals.** Better coordination and communication with mental-health professionals can help correctional staff better respond to and manage the behavior of incarcerated people. Additionally, knowing when to refer people for medical assessments or other care and communicating with health-care staff can help staff spot burgeoning mental-health problems.
- **Specialized housing units.** Some larger jails may be able to use special housing units to provide mental-health care for those with a higher level of need.
- **Regional solutions.** The Northeast Regional Corrections Center[534] provides specialized services for several Minnesota jails. While a recent state study "revealed widespread skepticism toward regional jail concepts,"[535] the study still found support for regional solutions that could improve access to specialized services such as mental-health care and substance-use-disorder treatment.[536]
- **State solutions.** One OLA audit recommendation was to establish a statewide or regional mental-health correctional facility. To meet this recommendation, the legislature, in 2023, created a limited pilot program.[537] This pilot program allowed county or regional jail facilities to place incarcerated people with a serious and persistent mental illness in the department's Mental Health Unit at Oak Park Heights for specialized care.

  While the pilot program struggled with cost concerns and its voluntary nature,[538] the program showed that statewide solutions are needed—and have been considered—to help solve the mental-health crisis in jails.

The mental-health needs of the incarcerated population are summarized in a 2019 *New Yorker* article, which describes the mental-health crisis in jails but also acknowledges the limitations in addressing the crisis:

> Many jails are in rural or poor counties, where administrators complain that they have neither the resources nor the expertise to hire, train, and

[534] The center serves Carlton, St. Louis, Koochiching, and Lake Counties.
[535] *Minnesota Regional/County Jails Consolidation or Merger Study*, 6.
[536] "The ability to provide more comprehensive and diverse programming was seen as a potential benefit of a larger centralized facility." *Id.*, 35.
[537] 2023 Minn. Laws, ch. 52, art. 11, sec. 31.
[538] Minnesota Department of Corrections, *Mental Health Unit Pilot Program Report* (St. Paul, November 2024). In the 2025 legislative session, the legislature amended the pilot program to remove the requirement that incarcerated people agree to placement. *See* 2025 Minn. Laws., ch. 35, art. 7, sec. 25.

> supervise doctors and nurses in the particular demands that their facilities require.[539]

The article proceeds to discuss the challenges in correctional health care but also the consequences of not providing this care:

> Taken as a whole, evidence from cases across the country suggests that four decades of policy failures in both health-care and criminal-justice reforms have left a largely neglected population vulnerable and, at times, at risk . . .[540]

The department believes that its proposed changes reasonably balance the need for mental-health care with the funding, staffing, and other constraints that jails face.

[539] Steve Coll, "The Jail Health-Care Crisis," *The New Yorker*, February 25, 2019.
[540] *Id.*

Mental Status Exam and Mental Health Care (2911.5830)

> *"Responding to inmates in crisis is an ever increasing fact of life for correctional personnel."*[541]

Minimum standards on mental-health care are critical so that jail administrators can orderly maintain the jail's security and to provide for the well-being of the incarcerated population. "Jail staff have shared that the challenge of keeping incarcerated people with severe mental illness safe in a non-therapeutic environment contributes to burnout, particularly of security staff who are not trained mental health professionals."[542] And by meeting an incarcerated person's mental-health needs, jail administrators create a safer and more enjoyable working environment for their staff.

In addition, the Supreme Court has held that the U.S. Constitution guarantees an incarcerated individual's right to adequate medical care, including mental health care. [543] The Court has also recognized that for people held in pretrial status, serious mental health conditions are afforded the same constitutional protection as physical health needs under the Fourteenth Amendment. [544] To state it simply, mental health needs are constitutionally protected medical needs.

1. Subpart 1 (policy and procedure).

All jails must have a policy and procedure on mental-health care to ensure that they can meet the mental-health needs of their incarcerated population. Each jail can tailor its policy and procedure as its resources allow, but the department's proposed minimum requirements are needed and reasonable to ensure that a range of mental-health services are available to all incarcerated people. These

[541] Klugiewicz, "Responding to Mentally Ill Inmates."
[542] Minnesota Office of the Ombuds for Corrections (July 2025). Languishing Behind Bars, The Urgent Need for Mental Health Support in Minnesota Jails.
[543] Estelle v. Gamble, 429 U.S. 97, 97 S.Ct. 285 (1976). The Eighth Amendment's prohibition against cruel and unusual punishment requires the government to provide health care to incarcerated people
[544] *Partridge*, 791 F.2d at 1182; *Brown v. Plata*, 563 U.S. 493 (2011).

resources are needed so that incarcerated people can "maintain their best level of functioning."[545]

Because of the importance of screening, the policy and procedure should include direction on how facility staff will screen for mental illness, as required under part 2911.5800, subpart 6. The policy and procedure should also direct how mental-health care will be provided for incarcerated people in administrative separation and disciplinary segregation—this will ensure continuity with proposed changes in these two areas.

And last, incarcerated people should receive information on the care that they are receiving—this can help them in their self-care and supports their continuity of care when they reenter the community. The importance of continuity of care was frequently discussed in the department's advisory committee meetings, and this requirement is one step toward managing continuity of care.

2. Subpart 2 (mental-status exam).

"Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."[546]

Depending on an incarcerated person's initial mental-health screening, they may be referred to see a mental health professional for a mental-status exam, the functional equivalent to a health-care check-up. Much of what the department had originally proposed in 2019 and 2022 rule drafts would be covered under a mental-status exam: assessing an incarcerated person's mental status, suicide potential, and any needed care.

In an earlier rule draft, the department had proposed requiring a brief or standard diagnostic assessment under the Mental Health Uniform Service Standards Act.[547] But at the advisory committee meetings, correctional health-care staff and jail administrators expressed concerns about the costs of and time needed to conduct these assessments. They also explained how they can still provide appropriate care or referrals without performing diagnostic assessments and how some jails take incarcerated people to a hospital or health clinic.

[545] *Standards for Mental Health Services in Correctional Facilities*, 103.
[546] *Plata*, 563 U.S. at 510.
[547] *See* Minn. Stat. §§ 245I.01-.23.

While diagnostic assessments are a best practice, the department agrees that practical and resource considerations would make almost all jails, even the larger metro-area jails, perpetually out of compliance with the diagnostic-assessment proposal. While correctional mental-health professionals aren't offering a provisional diagnosis, they still can develop appropriate care and referrals to meet an incarcerated person's mental-health needs. Accordingly, the department removed the requirement for a diagnostic assessment and replaced it with the requirement for a mental-status exam.

The department proposes that an incarcerated person is seen within 14 days of their referral so that they can receive timely mental-health care; this proposed language is consistent with the department's proposed rule on health-care follow-ups (part 2911.5800, subpart 7) and both NCCHC and the ACA.[548] But if custody staff observe signs or symptoms that indicate that a person should be seen sooner than 14 days—for example, words or actions that indicate someone is suicidal or psychotic—they must refer the person to a mental-health professional.

Because of the need for mental-health care, jail staff must document why they were unable to conduct a mental-status exam—this may happen if an incarcerated person refuses to see a mental-health professional. If a person isn't seen, other rule requirements such as well-being checks would still help ensure the person's health and safety.

3. Subpart 3 (when mental health care is unavailable).

This subpart is needed to ensure that an incarcerated person is seen by a health-care professional within 14 days of being admitted into jail. While subpart 2 requires a mental-health professional to see an incarcerated person and to conduct a mental-status exam, this subpart is needed in cases where mental-health professionals are unavailable (some jails only contract for a small number of weekly hours) or when jails don't contract for mental-health care.

While ideally all jails would contract for mental-health care or contract for more hours, some jails and counties currently don't have the funding to do so or may be unable to find qualified mental-health professionals, let alone those willing to work in a correctional setting.

[548] *See Standards for Mental Health Services in Correctional Facilities*, MH-E-04; *Performance-Based Standards*, 5-ALDF-4C-29.

Although a health-care professional such as a registered nurse generally cannot conduct a mental-status exam, they can still meet with an incarcerated person to go over the person's medical screenings and to observe signs and symptoms that may warrant a referral to a mental-health professional. For jails that don't contract for mental-health care, this referral will in most cases result in the incarcerated person being taken to a hospital or local health clinic.

4. Subpart 4 (case notes and additional care).

> *"In the correctional setting, as in most other environments, the immediate objective of mental health treatment is to alleviate symptoms of serious mental disorders and prevent relapses to sustain patients' ability to function safely in their environment."*[549]

When conducting a mental-status exam, a mental-health professional will document case notes from the exam such as observations or recommendations for care. The mental-health professional will then discuss with the incarcerated person coping strategies, mental-health resources, medications, or other information to ensure the person's health and safety while incarcerated.

If needed, the mental-health professional will indicate if additional follow-up care is needed or, depending on the qualifications of the person conducting the exam, determine whether to refer the incarcerated person to a licensed mental-health professional or another professional such as a psychiatrist.

As with existing and proposed language on medical sharing (part 2911.6200, subpart 2a), the mental-health professional will recommend to custody staff whether an incarcerated person should be placed on a special-housing status or will communicate additional information about the person's mental health as needed to ensure the person's health and safety. As with other health-care requirements, communication is essential so that custody staff can effectively monitor incarcerated people and know when they should contact health-care staff because of behavioral or emotional changes in an incarcerated person.

5. Subpart 5 (access to mental-health care).

Because incarcerated people have a constitutional right to mental-health care, punitive punishment that includes depriving a person of this right is unlawful and can jeopardize a person's health and safety. Even if a person's behavior threatens the health and safety of jail staff and other incarcerated people, custody staff can

[549] *Standards for Mental Health Services in Correctional Facilities*, 103.

still ensure that the person's mental-health needs are met. While this care may need to be provided at a cell door for a security reason, the incarcerated person must still have access to care.

As with other health-care decisions, an incarcerated person may refuse mental-health care.

6. Subpart 6 (telehealth).

Almost all jails rely on telehealth for mental-health care, particularly rural jails. This subpart clarifies this existing practice and that a jail may use telehealth when offering and providing mental-health care.

7. Subpart 7 (continuity of care).

Ideally, health-care staff would schedule community appointments for an incarcerated person, jails would use social workers for all discharges, and health-care staff would "follow" incarcerated people into the community to ensure their continuity of care. But the practical realities of jails—short lengths of stay, uncertain discharge dates, limited resources—prevent the department from establishing these much-needed standards in rule. Jails would simply be out of compliance, even larger or better-resourced jails. Even for sentenced persons, they may still be detained for a short time or be transferred to a department correctional facility, in which case a discharge plan would be unnecessary.

The department's proposed requirements reflect these realities. While the department hopes that statewide solutions will emerge, the requirements still ensure that an incarcerated person will have access to local mental-health resources and their prescription medication. Even NCCHC recognizes the constraints that jails face by recommending discharge planning for only incarcerated people with serious mental health needs.[550] NCCHC recommends providing resources and arranging for an inmate's prescription medication, both of which the department proposes.

All of these changes are also consistent with parts 2911.5810 and 2911.5820 on withdrawal and substance-use-disorder treatment.

8. Subpart 8 (documentation).

This subpart establishes the documentation requirements for mental-health care; this subpart is needed and reasonable to ensure an incarcerated person's

[550] *Id.*, 93.

mental-health care is documented so mental-health care can be tracked and so that the department can inspect for compliance.

Psychiatric Emergency (2911.5840)

This part on psychiatric emergencies corresponds with the department's proposed changes on involuntary medication administration under part 2911.6700. Standards on psychiatric emergencies and medication administration are needed for when an incarcerated person is dangerous to self or others or when emergency psychotropic medication may be needed to prevent harm.[551]

1. Subpart 1 (definition).

The definition of psychiatric emergency was modeled from a peer-reviewed medical article on psychiatric emergencies,[552] and the definition reflects the legal standards on involuntary medication administration and when immediate intervention is needed to address immediate harm from a person's acute disturbance in mood or behavior.

2. Subpart 2 (policy and procedure).

Given the health and safety risks associated with a psychiatric emergency, a jail needs a policy and procedure to address these potentially harmful and dangerous situations. Because most jails don't have 24/7 health-care coverage, the policy and procedure should state what custody staff should do if health-care staff are unavailable to assess a person's need for emergency medical care. But if health-care staff are available, they should determine medically appropriate care.

Any action taken—whether care or use of force—should be documented.

3. Subpart 3 (emergency medication).

Generally, state laws provide exceptions to informed consent for involuntary medication administration if an incarcerated person is immediately dangerous and less-restrictive measures were attempted. For example, in Minnesota, state law provides a short-term avenue for health-care providers to administer medications without informed consent if an individual lacks capacity to make a medication decision, including in an emergency.[553]

The department's proposed changes are consistent with state law, and health-care staff may administer emergency medication administration if the decision is

[551] *Id.*, 135.
[552] Santina Wheat, Dorothy Dschida, and Mary R. Talen, "Psychiatric Emergencies," *Primary Care* 43, no. 2 (2016): 341-54.
[553] *See* Minn. Stat. §§ 253B.092, 611.47.

consistent with the proposed changes on involuntary medication administration under part 2911.6700. As stated in that part and here, involuntary medication administration should be used only in rare cases. Almost all jails will not administer emergency medication given the ethical and liability risks.

4. Subpart 4 (appropriate follow-up).

In response to an incarcerated person's psychiatric emergency, a jail may transport the person to a hospital for appropriate care. After a hospital medically clears the person to return to jail, health-care staff should conduct any needed follow-up care.

Mental-Health Support; Traumatic Event (2911.5850)

"A suicide or suicide attempt can be a stressful event for staff and other inmates."[554]

While the 2021 legislation required the department to adopt rules on critical-incident debriefing, it's unclear whether this directive is meant to apply to only jail staff or whether it applies to incarcerated people as well. To guard against noncompliance with a legislative directive, the department proposes minimum standards on mental-health support for incarcerated people after a jail death, suicide, assault, or other emergencies and unusual occurrences.

The department believes that its proposed standards are needed and reasonable and are extensions of an incarcerated person's right to mental-health care.

1. Subpart 1 (policy and procedure).

Because this standard will be new for some jails, the department seeks to give them flexibility on their policy and procedure. For example, the department doesn't require a hard timeframe for jails to offer mental-health support (it doesn't either for critical-incident debriefing) and identifies only a couple of possible mental-health services for jails to offer to incarcerated people. At a minimum, mental-health support should be provided by health-care staff and should include individual or group services.

In addition to working with their health authority, jails can also consult the International Critical Incident Stress Foundation, which has resources and training on critical-incident debriefings (they can also do this to help meet the proposed standards under part 2911.3700, subpart 8).

2. Subpart 2 (documentation).

Consistent with other health-care requirements in this chapter, any provided health care should be documented.

A jail cannot force an incarcerated person to receive health care, so this subpart establishes a person's right to refuse offered mental-health support.

[554] *Standards for Health Services in Jails*, 41.

Additional Health Care (2911.6000 to 2911.6800)

These rule parts contain additional health-care standards, all of which are important to ensuring that the health-care needs of the incarcerated population can be met.

1. 2911.6000 (first aid).

Plain-language changes are made to subpart 2.

2. 2911.6200 (medical records).

Jails are responsible for maintaining an incarcerated person's health records in accordance with the Minnesota Government Data Practices Act and the federal Health Insurance Portability and Accountability Act. Additionally, the ACA prescribes standards relating to health records and transferring records.[555]

2.1. Subpart 1a (medical records).

Subpart 1a is organized into items and vertical lists, with conforming and plain-language changes made. Mental health is added for consistency with other proposed changes to the chapter. Under item B, subitem (7), language is added to ensure that an incarcerated person's health records reflect any care received outside the facility. This is needed and reasonable so that jail staff can monitor an incarcerated person's health conditions and respond to them as needed.

Additional changes ensure that an accurate health record is developed for all health care that an incarcerated person receives while detained.

2.2. Subpart 1b (consent forms).

Subpart 1a strikes "release of information" because this is a separate requirement under part 2911.2525.

2.3. Subpart 2 (data practices).

This subpart on an incarcerated person's health record is structured into a vertical list and clarifies how their health record must be maintained or distinguished from their general file that contains information on classification, disciplinary violations, etc.

[555] *Core Jail Standards*, 1-CORE-4D-18.

2.4. Subpart 2a (medical sharing).

> *"Communication between custody and health staff helps make both groups aware of special considerations with inmate movement and decisions regarding special needs patients."*[556]

Subpart 2a is organized into a vertical list and ensures that custody staff are informed of an incarcerated person's health care information as needed to monitor symptoms and help manage the person's care. As the department has argued, medical sharing between custody and health-care staff is vital to protecting the health and safety of incarcerated people. This is because "proper health care and collaborative relationships ultimately reduce liability and foster teamwork. Most importantly, it enhances patient safety, staff safety, facility safety, and community safety."[557]

2.5. Subpart 3 (available information).

Subpart 3 makes conforming changes and removes vague requirements such as "sufficient detail."

2.6. Subpart 6 (transferring records).

Subpart 6 clarifies the requirements for transferring records between jails, between jails and prisons, and between jails and noncorrectional facilities such as local health-care providers. This clarity is important because continuity of care can help reduce recidivism and help an incarcerated person continue to meet their health-care needs.

An incarcerated person may also be referred to see a local provider for mental-health care or other health-care needs, so the word *referral* is added to reflect this care.

Transferring records is important because it's a core component of discharge planning, as required under parts 2911.2560 and 2911.5810 to 2911.5830. Records requirements are found the ACA and NCCHC guidelines.[558] For example, upon an incarcerated person's transfer, a copy of the incarcerated person's health record or a health summary should be sent to the receiving facility.[559] Items B

[556] *Standards for Health Services in Jails*, 44.
[557] Richard Forbus, "Collaborative Leadership in Correctional Healthcare: Improving Operations and Reducing Adverse Medical Events," presentation, Justice Clearinghouse, https://www.justiceclearinghouse.com/resource/collaborative-leadership-in-correctional-healthcare-improving-operations-and-reducing-adverse-medical-events/.
[558] *Core Jail Standards*, 1-CORE-4C-02; *Standards for Health Services in Jails*, J-A-08, J-E-10.
[559] *Standards for Health Services in Jails*, J-A-08.

and C make conforming changes given proposed language in item A on an incarcerated person's possible referral to a noncorrectional facility.

Failing to transfer records can result in serious injury or even death. For example, in 2005 a person was transferred from Hennepin County jail to Sherburne County jail. At the Hennepin County jail, the incarcerated person had been screened for suicide risk, but this information wasn't communicated, nor any records transmitted, to Sherburne County jail upon the person's transfer.[560] The incarcerated person later hung himself.

3. 2911.6400 to 2911.6600 (medication).

Medication has consistently ranked as a top issue for both jail staff and the incarcerated population.[561] For example, the 2016 OLA audit discussed medication and associated needs such as psychiatric medications and medications upon release and discharge (these issues are covered elsewhere in the SONAR).

4. 2911.6400 (medication generally).

This subpart makes technical and conforming changes and adds a cross-reference to 2025 statutory language requiring an incarcerated person to continue receiving their prescription medication upon admission.[562]

5. 2911.6500 (storage).

Conforming and plain-language changes on storing medication are made. The department also clarifies which staff members are responsible for fulfilling or overseeing the rule requirements—these aren't substantive changes with how jails currently operate.

6. 2911.6600 (medication delivery).

> *"Medication errors have been a leading cause of preventable deaths and disabilities in Minnesota hospitals and surgery centers in the 21 years since they started publicly reporting their own adverse events."*[563]

[560] *Heil v. Sherburne Cty.*, No. 08-1419, 2010 WL 11646720 (D. Minn. Apr. 7, 2010).
[561] *See, e.g.,* State Community Health Services Advisory Committee, *Health Services in County Correctional Settings*, 22.
[562] Minn. Stat. § 241.021, subd. 4f (2025 Supp.).
[563] Jeremy Olson, "Minnesota Hospitals Cut Serious Drug Errors After Years of Efforts," *Star Tribune*, June 24, 2025.

Various changes are made in this part on medication topics, including conforming and plain-language changes and changes that clarify vague standards. The department also proposes changes to the following subparts:

- Under subpart 3, the department proposes changing refresher medication training for health-trained custody staff from the current three-year timeline to at least annually. This is a needed and reasonable change given the health risks of inadequate medication delivery and is consistent with annual training requirements under part 2911.1300.
- Subpart 6 on incarcerated people self-administering their medication moves existing requirements from part 2911.6700, subpart 2, on insulin-dependent diabetics and allows incarcerated persons to self-administer additional types of injectables such as weight-loss drugs. As discussed under part 2911.6700, the department doesn't find it reasonable to require direct supervision when incarcerated people are administering topical medications or eye or ear drops.
- Subpart 7 adds needed language to require health-care staff to be consulted on a jail's policy for identifying incarcerated people when their medication is delivered. Many medication errors relate to incorrect medication delivery, especially by custody staff, because incarcerated persons are misidentified.
- Subpart 9 is amended to include medication errors as something that must be reported to health-care staff. This is needed in case there isn't an observable adverse reaction to a medication error.
- Subpart 10 adds a needed documentation requirement on reporting an incarcerated person's refusal to take prescribed medication
- The subpart 11 requirement that prohibits jail staff from depriving medication as punishment is repealed and moved to part 2911.6800.
- Subpart 14 applies a statutory cross-reference to the new statutory language on prescribed medications so that health-care staff can continue an incarcerated person's prescribed medications if the medications are about to expire.
- Subpart 15 clarifies that a facility's health authority is responsible for determining which over-the-counter prescription medication to make available for incarcerated people.

Medication Administration (2911.6700)

The department substantially amends the language in this part on medication administration by repealing subparts, either by combining requirements into other rule parts or by removing unnecessary requirements.

1. Subpart 1 (injection).

This single-sentence subpart states that injection must (or may) be given by a physician or health-care staff. But this requirement is superfluous, as health-care staff, including a physician, must already practice within the scope of their licensure and because injection requirements are governed under a jail's policy and procedure under part 2911.6400 and subpart 1a.

2. Subparts 1a and 1b (voluntary and involuntary administration).

The department proposes to add this part to establish standards for both voluntary and involuntary medication administration.

Almost all existing and proposed rule requirements affect voluntary medication administration. So while this subpart clarifies that a jail must have a policy and procedure on voluntary administration, the department's proposed requirements in this subpart focus on involuntary medication administration.

This focus is needed because of the substantial harms associated with involuntary medication administration such as "extrapyramidal symptoms, sedation, weight gain, in addition to the trauma of being medicated against their will."[564] In addition to these harms, it's challenging to prescribe reasonable standards on involuntary medication administration because of the lack of uniformity among states.

The department must also adopt standards that reflect how involuntary medication is allowed under law in two different scenarios:

- **Jarvis orders.** These are court orders[565] in which a court can authorize emergency administration of medications to a person who lacks the capacity to make decisions on medication administration.[566]

[564] Joana Orta et al., "A Review of Policies on the Involuntary Use of Psychotropic Medications Among Persons Experiencing Incarceration in the United States," *Health & Justice* 11, no. 9 (2023): 2.
[565] *See Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988).
[566] Minn. Stat. § 253B.092, subd. 3.

- **Emergency situations.** The Supreme Court ruled in 1990 that states can involuntarily medicate incarcerated people in emergency situations without a court order.[567] In Minnesota, courts have said that "involuntary administration of neuroleptic medication is an intrusive treatment . . ."[568]

To reflect these different scenarios, subpart 1a is separated into three areas:

a) **Item A**. The proposed language requires a jail's policy and procedure to prescribe when health-care staff can involuntarily administer medication in a medical emergency—this medical emergency is for emergency situations when an incarcerated people lacks decision-making capacity. The department cross-references to the statutory definition of *decision-making capacity* under the statutory chapter on health-care directives.

b) **Item B.** In this item, the department requires jails to detail the lifesaving injectables that health-trained custody staff may administer—this medication isn't psychotropic medication and generally would include naloxone for someone experiencing an overdose or glucose tabs for a diabetic person.

c) **Item C.** This item relates to Jarvis orders and follows the legislature's rulemaking directive requiring jails to ensure that an incarcerated person's Jarvis order will be followed during the person's incarceration.[569]

The department believes that its proposed standards under subpart 1b conform with:

a) state statute;

b) established standards from other states such as Alaska and Massachusetts; and

c) the department's policy for its correctional facilities.[570]

Because a person's constitutional rights are threatened when they are involuntarily medicated, the department realizes that jails are reluctant to administer emergency medication (the proposed requirements do not require jails to do this). But, consistent with the legislature's 2021 directive, a jail must still have a policy and procedure stating its practice on involuntary medication administration.

[567] *Washington v. Harper*, 494 U.S. 210 (1990).
[568] *In re Civil Commitment of Raboin*, 704 N.W.2d 767, 770 (Minn. Ct. App. 2005).
[569] Minn. Stat. § 241.021, subd. 1(a)(2).
[570] DOC Policy 500.321.

An important aspect of a jail's policy and procedure should also include guidance on administering injectables,[571] which cause about two-thirds of medication errors in prisons.[572] In emergency situations, custody staff may need to administer an opiate antagonist such as naloxone, and the facility's policy and procedure should cover this administration.

3. Subpart 1b (involuntary medication in emergency situations).

The proposed requirements on involuntary medication administration in a medical emergency conform with state law and follow NCCHC and ACA guidelines. For example, ACA standards minimally require that any psychotropic medication is authorized by a licensed physician.[573] And depending on the situation, custody staff may need to use force to help health-care staff safely administer the medication (this is one reason why jails don't involuntarily medication incarcerated people).

Because of the safety and legal risks of involuntary medication administration, the department proposes needed and reasonable documentation requirements for a jail if health-care staff administer medication in a medical emergency—this requirement is consistent with NCCHC standards.[574]

Item B then requires 15-minute well-being checks after the medication administration to ensure that an incarcerated person's health is adequately monitored. Most jails do this already for incarcerated people who refuse to take prescribed medications.[575]

Most jails don't have the resources to involuntary administer medications, as the 2016 OLA audit found. As such, the audit recommended that the Minnesota Legislature "amend state law to specify that emergency administration or court-ordered involuntary administration of antipsychotic medications may occur in jails that have the necessary staffing and skills."[576]

Overall, the department recognizes that most jails will not involuntarily medicate incarcerated people. But in keeping with the legislature's directive, the department's proposed requirements are needed and reasonable for jails that may need to.

[571] Most emergency medications are by intramuscular injection.
[572] Orta et al., "A Review of Policies on the Involuntary Use of Psychotropic Medications": 2.
[573] *Core Jail Standards*, 1-CORE-4D-09.
[574] *See Standards for Mental Health Services in Correctional Facilities*, MH-I-02.
[575] Legislative Auditor, *Mental Health Services in County Jails*, 61.
[576] *Id.*, 62.

4. Subpart 2 (injection and insulin).

Subpart 2 is repealed and combined into part 2911.6600, subpart 6, on how an incarcerated person must self-administer their medication, including those who require insulin.

5. Subpart 3 (topical medication).

The department proposes repealing this subpart because this subpart requires an incarcerated person to be monitored when they self-administer eye or ear drops. The department finds that there is minimal to no risk for topicals that would require direct observation, and that this requirement is an unnecessary burden on health-care staff. Other health and safety protections in rule would still apply to topicals, when applicable.

6. Subpart 4 (opiate antagonists).

This new subpart is a conforming amendment to align with statutory changes on opiate antagonists. One of the more common opiate antagonists, naloxone, is widely used in the community, hospitals, and correctional settings because it's a cost-effective and simple tool for saving lives:

> Naloxone is safe, effective, and nonaddictive and has a rapid onset of action. It can be administered as an injection or through the nose (intranasally). Training in its administration is relatively simple. It can be safely used by nonmedical personnel, resulting in more lives saved. . . . Research has shown that opioid overdose education and naloxone distribution programs in prisons and jails reduce mortality."[577]

[577] National Commission on Correctional Health Care, *Naloxone in Correctional Facilities*.

Medication Control (2911.6800)

This part on controlling, verifying, and prescribing medication contains conforming changes, technical changes, plain-language changes, and substantive changes.

> *"Medications are frequently an integral part of mental health treatment, and adherence to the medications prescribed can make the difference between active psychosis and mental stability."*[578]

7. Subpart 1 (records).

Plain-language changes were incorporated.

8. Subpart 1a (definition).

This subpart defines the term "bioequivalent medication" using language modeled on the US Food and Drug Administration's Orange Book, which provides "therapeutic equivalence evaluations for approved multisource prescription drug products."[579] Adding this definition is necessary considering recent amendments to Minn. Stat. § 121.021, subd. 4f, which outline guidance on how medication is verified, continued and discontinued when an individual is admitted to a jail facility.

9. Subpart 2 (verifying prescription medication).

Even though jails already have established practices to verify medications of people admitted into jail (and this is already required by rule), proposed language in this subpart is needed to follow the legislature's directive on guidance for medication verification. Jails may verify medications by calling the dispensing medical provider or a local pharmacy. Sometimes, a jail may look up the medication online through pill-identifier websites; but ultimately, the verification should come from health-care staff or the health authority, as determined by the jail's policy and procedure on medical screening under part 2911.5800, subpart 6.

The department proposes that jail staff attempt to verify an incarcerated person's prescribed medication within 24 hours of admission because it's

[578] *Standards for Mental Health Services in Correctional Facilities*, 50.
[579] Food & Drug Admin., Ctr. for Drug Evaluation & Research, *Approved Drug Products with Therapeutic Equivalence Evaluations: Preface to the Forty-Sixth Edition*, https://www.fda.gov/drugs/development-approval-process-drugs/orange-book-preface

particularly important for jails to verify a person's psychotropic medications as soon as possible:

> Unless psychotropic medications are taken as prescribed, maintaining a therapeutic dose of medications may not be possible, *which may have grave consequences to patient health*. Therefore, inmates being admitted who report taking psychotropic medications currently (with verification) or who bring the medications with them are to continue their medication unless there is a clinical reason to alter or discontinue the medication. When an inmate credibly reports being prescribed psychotropic medications *but verification cannot be completed within 24 hours of admission*, the inmate should be scheduled with a qualified psychiatric provider as soon as possible for an evaluation for need for medication.[580]

Depending on the type and amount of prescription medication an incarcerated person has, verifying prescription medications can take longer than 24 hours. And some rural jails may have difficulty contacting a pharmacy, especially as rural pharmacies in the state dwindle. So if jail staff cannot verify an incarcerated person's medication within 24 hours, they should contact health-care staff, who will alert the health authority. This communication is essential because timely medication verification is needed for constitutional reasons, as courts have recognized an incarcerated person's constitutional right to prescription medication and that withholding a person's prescription medication may constitute deliberate indifference.[581]

While follow-up attempts to verify prescription medication are important, facility policy and procedure should dictate these follow-up attempts because of the difficulty jail staff may have verifying medication when pharmacies are closed or when off-site health-care staff cannot immediately be reached. And delays may also occur if a person refuses to cooperate during the admission process or refuses to authorize their prescriber to release the medication information.

Other proposed changes in this subpart add needed and reasonable documentation requirements, consistent with existing and proposed language.

The problems with inadequate and untimely medication verification were cited in the 2016 OLA audit, which noted that the rules "should establish time limits for the medication verification and review process (perhaps allowing for exceptions, in certain circumstances), to ensure that inmates receive necessary

[580] *Id.*, 63 (emphasis added).

[581] *Dadd v. Anoka Cty.*, 827 F.3d 749, 757 (8th Cir. 2016); *Greason v. Kemp*, 891 F.2d 829, 831–33 (11th Cir. 1990).

medications in a timely manner."[582] The department believes that its proposed rules are reasonable solutions to the problems cited by the OLA and its suggestions to solve problems identified in the audit.

10. Subpart 2a (continuity of care).

After jail staff verify an incarcerated person's medication, the incarcerated person must be allowed to continue taking their prescribed medication—the department establishes this requirement by cross-referencing to the 2025 statutory change that requires an incarcerated person to continue receiving their prescription medication upon admission.

The department recognizes the concern about this statutory requirement, but the department cannot adopt rules that conflict with statute. At the same time, this provision can help an incarcerated person maintain their continuity of care, which is important for a person's health and safety:

> Medications must be taken as prescribed in order to maintain a therapeutic dose; failure to do so may have grave consequences to patient health. Therefore, inmates being admitted who report currently taking medications or who bring the medications with them are to continue their medication unless there is a clinical reason to alter or discontinue it.[583]

11. Subpart 2b (discontinuing medication).

A jail may discontinue a person's medication for several reasons:

- The medication is unavailable at the facility and must be ordered
- A person has been taking medications inappropriately
- A person has been prescribed medications but hasn't been taking them regularly
- A person can't provide jail staff enough details on the prescription medication to allow staff to verify the medication

In these cases, health-care staff will seek to prescribe alternative medication and explain to the incarcerated person why their medication is being discontinued

[582] Legislative Auditor, *Mental Health Services in County Jails*, 59.
[583] *Standards for Health Services in Jails*, 72.

and alternative medication is being prescribed.[584] In other cases, if an incarcerated person has been diverting medication, health-care staff may discontinue the medication and provide the incarcerated person with mental-health care such as coping strategies—this would occur if alternative medication is not clinically indicated.[585]

Health-care staff may also alter an incarcerated person's medication if the incarcerated person risks the health or safety of others. For example, an incarcerated person may abuse their medication or cheek pills and sell them to other incarcerated people. By altering medication, health-care staff can help prevent this diversion while still providing the incarcerated person with their medication.

Because statute now limits stopping or changing an incarcerated person's medications prescribed before admission, this subpart applies to only those incarcerated people who were prescribed medication *after* admission.

12. Subpart 3 (medication upon discharge).

As with an incarcerated person's health-care rights generally, an incarcerated person is entitled to prescription medication, especially upon discharge.[586]

Under subpart 3 on providing an incarcerated person their medication upon discharge, the department proposes to add "if available in the facility" to recognize that once a court has ordered a person released, a jail cannot continue to hold them. Without the amendment, jails would need to order an incarcerated person's prescription medication and continue to hold the person until the medication arrives or release them without their medication and risk a rule violation. This change also reflects how some jails write a prescription for the incarcerated person to then take to a local clinic or pharmacy.

In item B, the department adds a needed and reasonable requirement on prescribing medication for an incarcerated person when they are discharged. Given relevant law and the importance of medication upon discharge, requiring documentation on the health authority's decision is necessary for the department to ensure compliance. This documentation is also important for liability purposes because providing medication upon discharge can help protect

[584] *See, e.g., id.*, 71: "Medications are prescribed only when clinically indicated."
[585] *See, e.g., Standards for Mental Health Services in Correctional Facilities*, 62.
[586] *Wakefield v. Thompson*, 177 F.3d 1160 (9th Cir. 1999); *Griffith v. Hofmann*, 2006 WL 2585074 (D. Vt. 2006).

a jail from deliberate-indifference lawsuits. This documentation should also include whether prescription medication was authorized or unauthorized.

13. Subpart 4 (destroying medication).

In this subpart, the department clarifies the jail staff responsible for destroying medication.

Inmates with Special Needs (2911.7100)

Jails serve a wide range of people, some of whom have physical or mental disabilities or who are otherwise considered an incarcerated person with special needs under the rule. Because inadequate or lack of care for this population can run afoul of the Americans with Disabilities Act and the Rehabilitation Act,[587] each jail should have a policy and procedure for meeting the health-care needs of incarcerated people with special needs.

1. Subpart 1 (postadmission screening).

Conforming and plain-language changes are made on screening and caring for incarcerated people with special needs; obsolete language is stricken to reflect the newly proposed definition of inmates with *special needs* in part 2911.0200.

2. Subpart 2 (inmates with special needs).

With changes to the definition of inmate with special needs, this subpart is superfluous. Furthermore, the list of examples is exclusive and contradicts the existing definition and the proposed changes. Removing this part will make the rule requirements on incarcerated persons with special needs consistent and clear.

3. Subpart 4 (care plan).

Existing rule requires jail staff to conduct a special-needs assessment for an incarcerated person during classification.[588] This assessment requires jail staff to determine “how medical needs, mental health needs, developmental disability, or other behavioral or physical limitations or disabilities”[589] may impact the incarcerated person’s classification. A logical extension of this assessment is requiring a care plan so that the incarcerated person’s health-care needs can be met—if the person’s special-needs assessment indicates that a care plan is necessary. This proposed requirement is a standard clinical practice and supported by NCCHC guidelines.[590]

Additional proposed changes conform with the department’s other rule revisions—discussing the plan with the incarcerated person and documenting the plan, for example. Because the care plan will list the incarcerated person’s

[587] *Yeskey*, 524 U.S. at 206.
[588] Minn. R. 2911.2600, subp. 1(I).
[589] *Id.*
[590] *Standards for Health Services in Jails*, J-F-01.

needs, this plan should be discussed with custody staff, who can ensure that the person's needs are met.

While other rule revisions require care plans, the department still finds that the proposed language is a logical extension of the 2021 statutory requirement on identifying persons with special needs and the existing rule requirement on special-needs assessments.[591] The language is also consistent with proposed changes on care plans for mental-health care. While there may be overlap for people with mental-health needs, the definition of *special needs* is broad and may include people who have a physical disability or are vulnerable in a jail setting.

[591] Minn. R. 2911.2600, subp. 1(I).

Term Changes, Renumbering, and Repealer

The following changes are uncoded changes, with the term changes and renumbering both constituting technical changes. Except for entire rule parts, the need and reasonableness for the repealed rule parts and subparts have been explained in the parts that they are repealed in.

1. Term change.

This instruction states the authority for the revisor's office to editorially change the term *inmate* to *incarcerated person*. Words matter, and *inmate*—like other terms such as *drug addict* or *disabled person*—are now commonly seen as degrading and dehumanizing because they categorize a person on the basis of a single characteristic.[592]

The department recognizes that words matter and strives to refer to people in a less-biased way. The proposed term *incarcerated person* has been found to be preferred by a plurality of people incarcerated in prison.[593]

Because *inmate* appears in the current rule 444 times, it's more efficient to have the revisor's office make this change editorially. The definition of *inmate* under part 2911.0200, subpart 46, will still be accurate as it refers to "an individual, adult, or juvenile, detained or confined in a Class I to Class VI facility."

The department summarizes the other term changes in table 21.

Table 21. Term changes

Existing term	New term	Reason
Custody personnel	Custody Staff	Technical change, as amended in the rule
Data privacy	Data practices	Technical change to better align with the

[592] *See* Melanie Sampson, "Language Is Not Neutral: Writing for Healing, Transformation, and Liberation," *Clarity Journal* 84 (2022): 7-11; *see also* National Institute on Drug Abuse, "Words Matter - Terms to Use and Avoid When Talking About Addiction," https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction (accessed May 8, 2025).
[593] The Marshall Project, "The Language Project," https://www.themarshallproject.org/2021/04/12/the-language-project (accessed May 8, 2025).

Existing term	New term	Reason
		Minnesota Government Data Practices Act
Health care personnel	Health care staff	Technical change to make the staff term consistent with other staff terms
Responsible physician	Responsible practitioner	Technical change, as amended in the rule

2. Renumbering.

- **2911.0200:** subparts are renumbered in alphabetical order.
- **2911.0900:** a subpart is renumbered for a more logical progression of requirements.

3. Repealer.

The following parts and subparts are repealed:

- **2911.0200**:
  - Subp. 7: unnecessary term
  - Subp. 23: replaced with new term
  - Subp. 24: unnecessary term
  - Subp. 52: unnecessary term
  - Subp. 69: unnecessary term
- **2911.0300:**
  - Subp. 5a: replaced with new standards
  - Subp. 6: unnecessary provision
- **2911.0360:** obsolete provision that isn't tied to a substantive rule requirement and that the department no longer inspects for, relying instead on approved capacity or design capacity
- **2911.0370:** duplicative provision that allows a facility to exceed its bed capacity level if the department grants a variance—variance requirements are established under part 2911.0400
- **2911.0600:** unnecessary provision on a jail's staff recruitment and statutory requirements under the Minnesota Human Rights Act—this requirement is governed by county policy and statute

- **2911.0700:** unnecessary provision on an employee's probationary period—this requirement is governed by county policy or collective-bargaining agreements
- **2911.0800:** unnecessary provision on work schedules—this requirement is governed by county policy, collective-bargaining agreements, and state and federal employment law
- **2911.0900:**
  - Subp. 26: duplicative provision
- **2911.1350:** medical training for custody staff that is incorporated into part 2911.1300
- **2911.1800:** unnecessary provision on position descriptions—this requirement is governed by county policy or collective-bargaining agreements
- **2911.2800:**
  - Subp. 6: unnecessary and duplicative provision
- **2911.3600**:
  - Subp. 7: duplicative provision that is incorporated into part 2911.2525, subpart 4
- **2911.3700:**
  - Subp. 3: duplicative provision
- **2911.3900:**
  - Subps. 2, 3, 4, 6, 7, 8: replaced with new standards
- **2911.4100:**
  - Subp. 4: duplicative provision that is moved to part 2911.3900
- **2911.4800:**
  - Subp. 5: duplicative provision
- **2911.5000:**
  - Subp. 5: replaced with new standards
- **2911.5800:**
  - Subp. 5: unnecessary provision replaced with new standards
- **2911.6600:**
  - Subp. 11: moved and incorporated into part 2911.6800
- **2911.6700:**

    - Subp. 1: replaced with new standards
    - Subp. 2: moved and incorporated into part 2911.6600, subpart 6
    - Subp. 3: unnecessary provision
- **2911.7100:**
    - Subp. 2: unnecessary and duplicative provision

References

When drafting the proposed rules and writing the SONAR, the department relied on articles from peer-reviewed journals, news articles, publications from criminal-justice organizations, and other sources. All sources are cited in the footnotes, and almost all the sources are publicly available, on the department's website, or through other means.

In this section, the department highlights the few sources that aren't readily available to the public and the sources that the department most relied on for this rulemaking.

1. American Correctional Association.

"Founded in 1870 as the National Prison Association, ACA is the oldest association developed specifically for practitioners in the correctional profession."[594]

The department relied on two ACA publications:

- *Core Jail Standards*: These jail standards were developed with help from the National Institute of Corrections, American Jail Association, National Sheriffs' Association, and the Federal Bureau of Prisons. These standards are available on the department's 2911 advisory committee web page and can be purchased from the ACA's website.[595]
- *Performance-Based Standards*: The ACA first published performance-based standards in 2000 to "improve the delivery of care to offenders within the correctional environment." These standards can also be purchased from the ACA's website.

2. American Jail Association.

"The AJA is a national, nonprofit organization that supports the professionals who operate our nation's jails. It is the only national association that focuses exclusively on issues specific to the operations of local correctional facilities."[596]

[594] American Correctional Association, "The History of the American Correctional Association," https://aca.org/ACA_Member/ACA/ACA_Member/AboutUs/AboutUs_Home.aspx?hkey=0c9cb058-e3d5-4bb0-ba7c-be29f9b34380 (accessed July 21, 2025).
[595] https://aca.org/ACA/ACA_Member/Marketplace/Standards_Merchandise.aspx.
[596] American Jail Association, "About Us," https://www.americanjail.org/about (accessed July 21, 2025).

- *American Jails magazine*: This magazine and other AJA resources are all publicly available online.[597]

3. National Commission on Correctional Health Care.

NCCHC was formed in the early 1980s and is "the only national organization dedicated solely to improving correctional health care quality."[598] NCCHC offers correctional professionals access to national standards, accreditation, educational programs, and related correctional-health resources.

The department relied on two NCCHC publications, both of which can be purchased online:[599]

- *Standards for Health Services in Jails*: These nationally recognized standards address seven general topics in correctional health care for jails. The department relied on the 2018 edition, not the recently published 2025 edition.
- *Standards for Mental Health Services in Correctional Facilities*: These standards overlap with the *Standards for Health Services in Jails* but are designed for mental-health care, provide more-specific guidance, and are intended for all correctional facilities. The department relied on the 2015 edition.

4. National Institute of Corrections.

The NIC is a federal agency that functions to ensure that "corrections systems operate efficiently, effectively, and with the highest regard for public safety."[600]

The department cites to several NIC publications, all of which are publicly available:

- *Resource Guide for Jail Administrators*
- *Jail Standards and Inspection Programs*
- *Sheriff's Guide to Effective Jail Operations*

[597] https://www.americanjail.org/digital-magazine.
[598] National Commission on Correctional Health Care, "About Us," https://www.ncchc.org/about-us/ (accessed July 21, 2025).
[599] https://www.ncchc.org/online-bookstore/.
[600] National Institute of Corrections, "About the National Institute of Corrections," https://nicic.gov/about-nic (accessed July 21, 2025).

5. Department data.

As the regulatory body responsible for licensing and inspecting jails, the department relied on its inspectors for their subject-matter expertise when drafting the rules and writing the SONAR. This expertise stems from their daily interactions with jail staff but also from complaints; unusual occurrences, including deaths, suicide attempts, and assaults; inspections; licensing actions; corrective-action plans; and death reviews.

Inspection reports, corrective-action plans, and licensing actions are all publicly available online.[601] Data from other documents is generally classified as corrections and detention data under Minnesota Statutes, section 13.85, and also consists of security information, as classified under Minnesota Statutes, section 13.37.

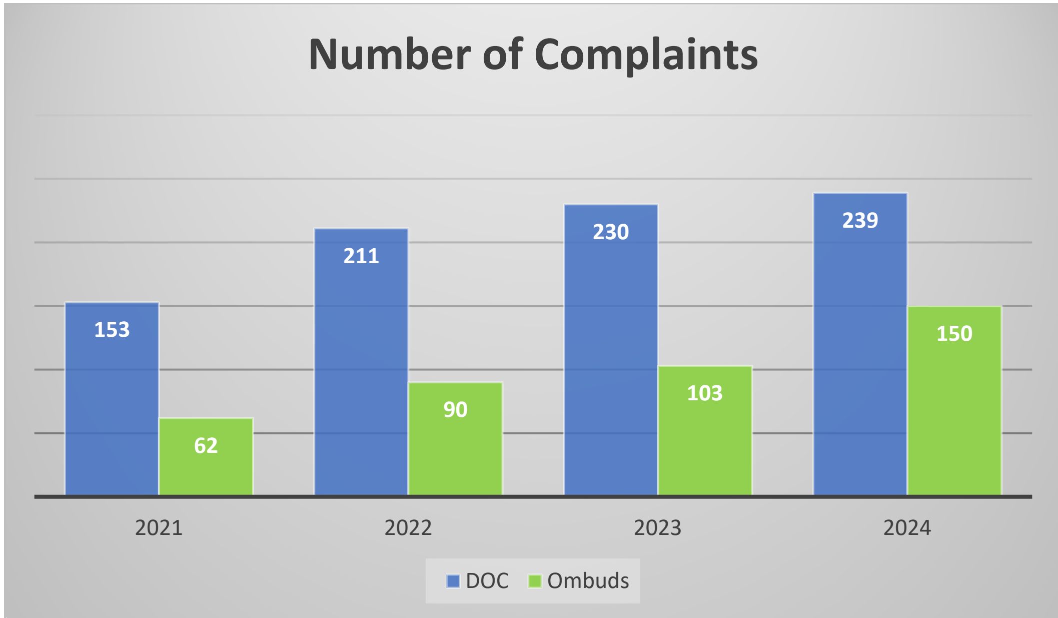
The following data on complaints filed with the department and reported unusual occurrences demonstrate the need for the proposed rules.

Chart 5 shows annual complaints submitted to the department and to the Office of Ombuds for Corrections.[602]

[601] https://mn.gov/doc/about/office-inspector-general/inspection-enforcement-licensing/adult-facilities/adult-facilities-inspection-reports/adultreports.jsp

[602] You can view the office's annual reports, which include the provided data, on the office's website at https://mn.gov/obfc/reports/. The 2024 data includes both jails and other local correctional facilities.

Chart 5. Annual jail complaints filed with the department and ombuds office



In addition to complaints that incarcerated persons and members of the public may file, the department requires its licensed local correctional facilities to report emergencies or unusual occurrences, which include the following categories (subcategories are excluded):

Assault

Attempt Suicide

Death

Escape

Fire

Hospitalization for Suicide Verbalization

Litigation Hold

Other

Pregnant Restraints

Response to Resistance

Riot/Disturbance

Serious Infectious Disease

Serious Resident Illness

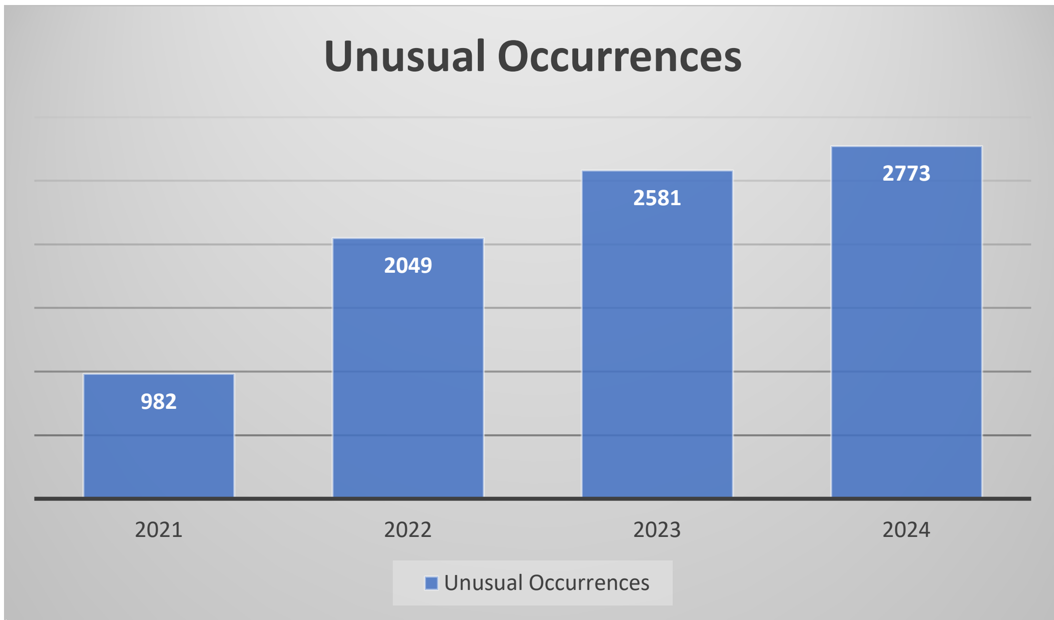
Serious Resident Injury

Sexual Misconduct

Use of Force

Use of Sexual Materials

Chart 6. Annual jail unusual occurrences



Conclusion

In the SONAR, the department has established the need for and the reasonableness of each of the proposed amendments to Minnesota Rules, chapter 2911. The department has provided the necessary notice and complied with all applicable APA rulemaking requirements.

Based on the evidence and information in the SONAR, the proposed amendments are both needed and reasonable. Further, the impetus for the rule remains, as shown by the legislative testimony of Brett Huber Senior on his son's death:

> I'm here for Brett today and for the rest of my family not because any of this can affect his horrific outcome, but because he would want to help ensure that no other human being's or their families find themselves in this same situation . . .
>
> I don't blame any one individual, but I think as a society, we have to do better. As a group of individuals, we have to do better. These are people that are at their lowest point, at their most vulnerable point. I said before, my son was a Christian. He, like I, believe that we were all made in God's image. The time that the people need the help the most is the time that we ought to be there for them. That is not the case. It is proven not to be the case.[603]

Paul Schnell, Commissioner

Department of Corrections

March 23, 2026

[603] Brett Huber, legislative testimony, House File No. 1267, February 26, 2021.