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STATE OF MINNESOTA

EVALUATION REPORT

State-Operated Human Services

FEBRUARY 2013

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STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2013

Members of the Legislative Audit Commission:

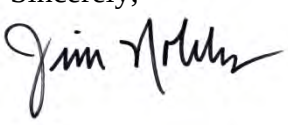
When people qualify for publicly financed human services in Minnesota, the state often purchases those services from private vendors. However, some services are provided through facilities operated directly by the Minnesota Department of Human Services (DHS). These facilities serve individuals with mental illness, developmental disabilities, and chemical dependency, and they include small home-like facilities as well as large institutions with high levels of security.

At your request, we evaluated how well DHS has managed state-operated services and facilities. We found a wide range of significant problems, which we discuss in this report. Of particular concern, we found that the department's approach to managing state-operated services has caused confusion and resulted in inadequate oversight and accountability. Among other recommendations, we call on the Legislature to more clearly define in law the state's role and objectives in directly delivering human services and operating facilities. We also recommend that DHS develop a plan to reduce the number of homes it operates for individuals with developmental disabilities and to foster better placement options for individuals with mental illness who are ready to return to the community.

We also found that the civil commitment process used to place many people in state-operated services needs improvement. We recommend requiring periodic judicial review of individuals committed as mentally ill and dangerous or as developmentally disabled. We also recommend better communication between the courts and DHS when a person is civilly committed to the Commissioner of Human Services.

Our evaluation was conducted by Joel Alter (project manager), David Kirchner, Jo Vos, and Maura Shramko, with assistance from Emi Bennett. The Department of Human Services cooperated fully with our evaluation.

Sincerely,



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Key Facts and Findings:

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- State-run human services facilities today house fewer than 1,300 residents, compared with more than 16,000 in 1960. (p. 4)
- The mission of DHS's state-run services is not clear in state law. (p. 115)
- DHS's governance structure for state-run services has been confusing, and its oversight of these services has, at times, been insufficient. (pp. 27, 30)
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Key Recommendations:

- The Legislature should clarify in law that the mission of state-run facilities is to serve individuals who would not be adequately served by other providers. (p. 118)
- The Department of Human Services should ensure the availability of placement options for individuals ready to leave state-run facilities. (pp. 43, 112)
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- The Legislature should amend state law to ensure periodic court review of civil commitments. (p. 80)
- The Minnesota Security Hospital should develop clear standards regarding psychiatric contacts with patients and the amount of treatment provided. (pp. 107, 109)

Report Summary

The Minnesota Department of Human Services (DHS) directly provides many services to individuals with mental illness, developmental disabilities, and chemical dependency. The department's State-Operated Services (SOS) Division employs more than 3,000 staff to provide inpatient and outpatient services. Expenditures for state-run services totaled about $293 million in fiscal year 2012.

State-run residential facilities range in size from group homes that serve a few individuals to the Minnesota Security Hospital's licensed capacity of 408 patients. All SOS facilities are licensed by DHS, the Department of Health, or both.

Some state-run facilities serve unique functions, while others provide services similar to nonstate providers.

The state's role as a direct provider of human services should be clarified.

State law provides limited guidance on what services DHS should directly provide. Many services provided by state-run facilities are also offered by nonstate providers. Overall, state-run facilities accounted for about 3 percent of the beds in all Minnesota facilities with similar types of state licenses in 2012. The Legislature should clarify in law the role of state-run facilities to serve clients who cannot adequately be served by other providers.

Some state-run facilities serve a unique function and should continue. For example, the Minnesota Security Hospital is the only secure facility licensed to provide residential treatment to adults with mental illness. This enables it to serve dangerous individuals who cannot be housed elsewhere. Also, discharge of Security Hospital residents is determined, according to law, by the DHS commissioner based on recommendations from an independent board, and it is doubtful that nonstate facilities would serve patients for whom they had no direct control over discharge.

In contrast, there are viable alternatives to state-run group homes for certain individuals with developmental disabilities. In 2012, 384 beds were in state-run adult foster homes, a fraction of the 17,000 beds in licensed foster homes statewide. State-run homes should be continued for clients whose needs would not likely be met by other providers, but DHS officials and client advocates believe that reasonable alternatives exist for many individuals in state-run homes.

The department operates seven small community behavioral health hospitals for adults, all of which have opened since 2006. Because these hospitals have no security staff, they sometimes do not admit patients with histories of violence or aggressive behaviors. Such patients often remain in nonstate hospitals, which have struggled to provide appropriate services. To better serve as the provider of last resort, SOS should experiment with adding security staff to some of its hospitals.

Oversight and accountability of state-run services have been weak.

State law authorizes the Commissioner of Human Services to govern state-operated services. But in 2000, the commissioner created a "governing board" for these services, resulting in confusing lines of authority and some violations of state law. In 2012, DHS changed the board's composition so that its

membership now consists entirely of SOS administrators. However, the need for a governing board remains unclear.

Many patients have remained at state-run facilities longer than necessary.

At times, DHS leaders have not given sufficient attention to the internal oversight of state-run services. While it is encouraging that DHS's deputy commissioner provided active oversight of SOS activities in 2012, state-run services will need sustained, effective leadership to succeed.

DHS has provided the Legislature and general public with little information on the performance of state-run services. In biennial budgets covering a 12-year period, DHS provided data on only two performance measures. Also, DHS's public and internal Web sites have provided limited data for evaluating the performance of state-run services. Department management should ensure greater accountability and transparency for SOS activities.

There has been instability in some high-level SOS positions, partly reflecting personnel decisions within the department. For example, two key positions (chief administrator of the Minnesota Security Hospital and SOS chief operating officer) were filled in 2011 and 2012, respectively, but the hired individuals were replaced months later.

Management has not adequately addressed some persistent service delivery problems.

State-run hospitals—especially the Anoka-Metro Regional Treatment Center—have had a history of keeping many patients hospitalized longer than necessary. This has partly reflected limited post-hospital placement options. The 2009 Legislature required DHS to develop a plan for the Anoka facility, but DHS's response offered few specifics, and DHS eventually postponed its proposed action indefinitely. As of September 2012, nearly 40 percent of Anoka's beds were occupied by patients who no longer needed hospital care.

A 1999 U.S. Supreme Court ruling said that undue institutionalization of individuals with mental disabilities is discriminatory. DHS did not begin developing a comprehensive plan for complying with the court's ruling until it was required to do so by a 2011 agreement reached in response to a lawsuit. The department's plan is scheduled to be completed in mid-2013.

The department's start-up of small behavioral health hospitals for adults in recent years facilitated the closure of larger institutions. But some have had problems attracting and retaining psychiatric staff. One repeatedly failed to meet the standards required to bill for federal health care payments, costing the state several million dollars in reimbursements. These small hospitals have the potential to serve an important role, but perhaps they should collaborate more closely with nonstate hospitals. Such collaboration may require financial incentives; DHS's previous effort to establish partnerships was unsuccessful.

State-Operated Services has struggled to contain workplace safety problems at state-run facilities. In 2012, the reported number of physical assaults within SOS grew sharply. Also, many state-run facilities have high workplace injury rates. State-Operated Services recently implemented an improved system for documenting and tracking workplace incidents, but SOS policies on

Addressing workplace safety, providing appropriate treatment, and ensuring an adequate continuum of services remain ongoing challenges.

incident reporting and follow-up remained in need of clarification.

Inappropriate use of patient restraint and seclusion led to the closure of one facility (Minnesota Extended Treatment Options) and a conditional license for another (Minnesota Security Hospital). Since the Security Hospital restricted the use of these practices in 2011, line staff have felt ill-prepared to deal with difficult patients.

The Minnesota Security Hospital has had ongoing management problems for years. For example, there have been unresolved questions about the balance between security and treatment, and staff reporting relationships have sometimes been unclear. The facility's current managers are trying to address many problems, but it remains too soon to determine their success. The Security Hospital has had too few psychiatrists for the past year, and the amount of structured mental health treatment it provides for patients is modest.

Many patients have stayed at the Security Hospital for years, partly reflecting a lack of placement options. DHS should, working with the Legislature if necessary, ensure that services exist for individuals ready to leave the Security Hospital and other state-run facilities—whether these options are run by DHS or other providers.

State law should require periodic court review of civil commitments, and DHS should receive court data on commitments to DHS.

Many individuals enter state-run facilities following an involuntary civil commitment by a district court. During a recent 18-month period, the courts committed nearly 4,000 individuals as mentally ill, chemically dependent, developmentally disabled, or mentally ill and dangerous.

Statewide, courts vary in the extent to which they have civilly committed individuals. Annual commitments per 10,000 population have ranged from less than 6 in some judicial districts to about 16 in another.

The statutory definitions of "mentally ill" and "mentally ill and dangerous" used for purposes of commitment overlap with each other. As a result, different judges may make different commitment decisions when faced with similar individuals who pose public safety risks.

Unlike most states, Minnesota allows some commitments to be indeterminate in length, without prescribing time periods for judicial review of the commitment. The Legislature should require the courts to periodically review the commitments of individuals as mentally ill and dangerous or as developmentally disabled.

DHS should be aware of all individuals for which a court has assigned responsibility to DHS. State courts do not currently provide complete information to DHS on such commitments, but they should. To help DHS conduct background checks of applicants for firearms, current law requires courts to inform DHS about individuals committed to non-DHS facilities; often, however, the courts have not done so. DHS uses multiple information sources to conduct firearms-related background checks, but the process does not appear to be entirely reliable.

Introduction

The Minnesota Department of Human Services (DHS) is Minnesota's largest state agency and plays a leading role in developing and administering the state's human services policies. In addition, DHS is a direct provider of services to many human services clients. In fact, a majority of DHS's employees work in DHS's State-Operated Services (SOS) Division. Many of these employees work for state-run mental health hospitals, group homes for people with developmental disabilities, and a variety of other facilities and nonresidential services.

In March 2012, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate Minnesota's state-operated human services. Our evaluation addressed the following:

- **What residential and inpatient services does DHS directly provide? How do clients enter these programs, how long do they remain, and have there been appropriate, timely discharges to other settings?**

- **To what extent are there viable nonstate alternatives to DHS-run facilities? Should DHS continue directly providing the services it now provides?**

- **Has DHS effectively managed the services it directly provides?**

We examined services provided by SOS. We focused our research primarily on SOS's inpatient and residential services, not its outpatient services. This evaluation did not review the Minnesota Sex Offender Program, which is run by DHS but not by SOS; we evaluated that program in a 2011 report.[1]

We relied on data from multiple sources. We obtained a variety of client, staffing, financial, licensure, and compliance data from DHS. Where appropriate, we also reviewed licensure and compliance data from the Department of Health, and we obtained information on facility accreditation from the Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations). Because many individuals enter state-operated services as a result of a civil commitment, we obtained statewide data on petitions for commitments since 2007 and the resulting court judgments. We conducted surveys of (1) county human services directors and (2) a sample of Minnesota's private hospital officials.[2] We visited several state-operated

[1] Office of the Legislative Auditor, *Civil Commitment of Sex Offenders* (St. Paul, 2011).

[2] We sent surveys to all human services directors of counties or multicounty organizations. We received responses from 91 percent of the 80 directors. We also sent surveys to 38 nonstate hospitals, including (1) all 31 hospitals with behavioral health units and (2) representatives of 7 hospitals without behavioral health units that referred at least 100 patients to SOS between December 2008 and June 2012. Altogether, we received responses from representatives of 23 hospitals (61 percent).

facilities, and we interviewed DHS staff, disability advocates, legal experts, and others. In addition, we reviewed a variety of documents, such as SOS policies and procedures, compliance reports prepared by DHS Licensing staff, and summaries of SOS governing body and leadership meetings. We did not systematically evaluate the effectiveness of treatment provided by SOS facilities, although we reviewed some treatment records and solicited opinions about treatment in our surveys. We also examined DHS information on the performance of SOS programs.

Some of the terms DHS uses to describe its services are not very descriptive to a general audience. Thus, our report often avoids DHS program names that we think might be confusing. For example, we use the name "Minnesota Security Hospital" (rather than "forensic services") to refer to the secure and nonsecure services for individuals committed as mentally ill and dangerous in St. Peter.[3] Also, we have limited our references to SOS's Minnesota State-Operated Community Services program because this name does not clearly describe the facilities in this program (which are mostly group homes for persons with developmental disabilities).[4] In addition, SOS has five facilities it describes as "Minnesota specialty health systems;" our report characterizes these facilities based on the type of program license they have.

[3] There are several SOS programs at the St. Peter campus. DHS often refers to just one of these—the residential treatment program in the most secure buildings—as the "Minnesota Security Hospital." However, the secure and nonsecure residential treatment programs, as well as a Competency Restoration Program described in Chapter 5, are all covered by a single treatment facility license from DHS.

[4] We often refer to these facilities as group homes or intermediate care facilities that serve individuals with developmental disabilities—even though a small share of their clients are not developmentally disabled.

1 Background

Minnesota has a long history of providing human services to individuals at state-run facilities. This chapter briefly describes the Department of Human Services' (DHS) history as a service provider. We then present an overview of current DHS facilities and discuss the funding arrangements and staffing levels for state-run services.

HISTORY

Minnesota began establishing state-operated human services institutions shortly after statehood.

Minnesota's Legislature began establishing state institutions for individuals with physical or mental disabilities shortly after statehood. In 1863, the Legislature appropriated funds for the instruction of blind and deaf children at a residential facility in Faribault.[1] In 1866, the Legislature authorized the establishment of the first state-operated hospital.[2] A temporary hospital opened in St. Peter in 1866, and the first wing of the permanent hospital opened in 1873. In subsequent years, the Legislature authorized additional state hospitals (or institutions that later became state hospitals) for individuals with mental illness, developmental disabilities, or chemical dependency at Rochester (1875), Faribault (1881), Fergus Falls (1887), Anoka (1899), Hastings (1899), Willmar (1907), Cambridge (1919), Moose Lake (1935), Sandstone (1951), and Brainerd (1957). As one report said:

> These hospitals were the result of a national social reform movement which linked the therapeutic concept of asylum with the good of society. Social reformers advocated isolating mentally ill and mentally retarded people from the rest of society, preferably in peaceful rural settings. There, they could receive treatment and shelter from abuse and exploitation, while, at the same time, society would be protected from them.[3]

The populations of Minnesota's state hospitals grew rapidly through the first half of the twentieth century. By 1960, there were 16,355 patients in state hospitals.[4] In addition, the Legislature had established several other state-run human services institutions, including nursing homes at Walker and Oak Terrace, and children's institutions at Owatonna, St. Paul, and Shoreview. However,

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[1] *Laws of Minnesota* 1863, chapter 9.

[2] *Laws of Minnesota* 1866, chapter 6. Initially, this facility was called the Hospital for the Insane of the State of Minnesota. Prior to 1866, state law authorized the Governor to place certain individuals into the custody of a similar institution in Iowa.

[3] Office of the Legislative Auditor, *Deinstitutionalization of Mentally Ill People* (St. Paul, 1986), 3.

[4] Minnesota State Planning Agency, *Minnesota's State Hospitals* (St. Paul, 1985), 6.

- **The populations at Minnesota's state-operated institutions for human services clients have declined dramatically since 1960.**

Advocates for persons with mental illness and developmental disabilities preferred to see many of these individuals in less restrictive settings than large state institutions. New federal and state laws encouraged development of community services and reductions in state hospital populations. The development of new psychotropic medications helped to hasten the movement of many individuals to community-based settings.

From a population of more than 16,000 in 1960, the state's inpatient and residential facilities now have fewer than 1,300 residents on any given day.

Over time, most of Minnesota's state hospitals—whose names were changed to "regional treatment centers" in 1985—were closed by the Legislature. The regional treatment center at Anoka and the Minnesota Security Hospital in St. Peter continue to serve individuals with mental illness from throughout the state. As other regional treatment centers closed, DHS created small hospitals—known as "community behavioral health hospitals"—around the state. However, the total number of individuals now served in state-run hospitals, the Anoka-Metro Regional Treatment Center, and the Minnesota Security Hospital is less than 600 on any given day.

The Department of Human Services also created other types of smaller residential facilities, such as chemical dependency treatment facilities and group homes for individuals with developmental disabilities. These are discussed more in the next section. In total, fewer than 1,300 individuals are now served in state-operated inpatient or residential facilities on a given day.

Minnesota hospitalizes fewer people per capita in state-run facilities than the national average. According to 2009 national data, there were 17 state hospital patients in the U.S. per 100,000 residents.[5] Minnesota has more state-run mental health hospitals (ten) than most states, but most of Minnesota's hospitals are small.[6] Thus, Minnesota—with 10.4 patients in state-run hospitals per 100,000 residents—has a relatively low rate of hospitalization.

OVERVIEW OF RESIDENTIAL SERVICES

State-Operated Services (SOS), a division of the Department of Human Services, delivers publicly funded behavioral health care and support services to persons with complex and sometimes interrelated conditions, including chemical dependency, developmental disabilities, mental illness, and traumatic brain injuries. With a staff of over 3,500 full- and part-time employees, SOS provides services in a variety of outpatient, inpatient, and residential settings statewide.

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[5] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Funding and Characteristics of State Mental Health Agencies, 2009* (Rockville, MD, 2011), 67.

[6] For purposes of comparison with the national rate, Minnesota's state-run psychiatric hospitals are defined to include the state's seven community behavioral health hospitals for adults, the Anoka-Metro Regional Treatment Center, the Minnesota Security Hospital, and a hospital that serves children and adolescents.

Some state-run facilities mainly serve individuals placed there under court order.

Many of the people SOS serves represent a danger to themselves or others, resulting in court rulings that they must be sent to treatment facilities, with or without their consent. Court actions may be short term, such as judicial "holds" that last only a few days, or long term, such as involuntary civil commitments that last for years. Some SOS facilities, such as the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital, almost exclusively serve individuals that are at the facilities under court order. Other facilities, such as chemical dependency treatment centers, serve a mix of voluntary and involuntary clients. Chapter 4 discusses the civil commitment process in more detail.

This section examines the different types of inpatient or residential facilities run by SOS, including their licensure status and compliance with facility licensing standards. We compare the number and type of SOS residential facilities with similarly licensed facilities run by other entities. State-Operated Services also provides a variety of nonresidential services that are not described in detail here. These include five dental clinics, outpatient evaluations of individuals' mental competence to stand trial in criminal courts, and outpatient chemical dependency services. Also, nine teams of professional staff provide community support services throughout the state, such as client assessment, consultations with service providers on client services and medications, and staff training on therapeutic interventions.

Types of Facilities

Using its own employees, SOS runs a diverse array of residential and inpatient facilities that range from small group homes and hospitals to large institutions. All SOS facilities are licensed by the departments of Human Services or Health (or both). Exhibit 1.1 shows:

- **In 2012, State-Operated Services ran more than 130 residential or inpatient facilities for adults, adolescents, and children with chemical dependency, developmental disabilities, mental illness, and traumatic brain injuries.**

Overall, 85 percent of SOS's 136 facilities primarily serve people with developmental disabilities.[7] Because most of these facilities are adult foster homes housing five or fewer residents, they accounted for only 29 percent of SOS's licensed beds in calendar year 2012. As of December 2012, these facilities served 461 residents, which was about 94 percent of their combined licensed capacity.

In contrast, 10 percent of SOS facilities, including the Minnesota Security Hospital, Anoka-Metro Regional Treatment Center, eight community behavioral health hospitals, and four residential treatment facilities, were designed primarily

[7] The total of 136 facilities noted here does not include "intensive therapeutic homes" (commonly referred to as MITHs) for children and adolescents with severe emotional disturbances. These homes provide foster care, and SOS employees provide supplemental treatment whenever a resident's individual care plan calls for it. For accounting purposes, DHS treats MITHs as SOS facilities on those occasions when one or more residents receive such treatment from SOS staff.

Exhibit 1.1: Licensed Residential Facilities Run by State-Operated Services, 2012

Type of Residential Facility	Description	Number of Facilities	Number of Licensed Beds
Facilities for People with Mental Illness			
Minnesota Security Hospital	Secure treatment facility primarily for (1) individuals civilly committed as mentally ill and dangerous and (2) adults undergoing pre-trial evaluations	1	408
Anoka-Metro Regional Treatment Center	Psychiatric hospital providing acute care to adults with mental illness	1	175
Community Behavioral Health Hospitals	16-bed hospitals providing short-term, acute psychiatric services to adults with a mental illness	7	112
Child and Adolescent Behavioral Health Hospital	Psychiatric hospital serving children and adolescents with serious emotional disturbances	1	70
Residential Treatment[a]	Community-based facilities that provide residential treatment to five or more adults with mental illness	4	64
Facilities Primarily Serving People with Developmental Disabilities			
Adult Foster Care	Group homes providing foster care, including food, lodging, protection, supervision, and household services, to five or fewer adults	99	384
Intermediate Care	Residential facilities certified by the federal government to provide health or rehabilitative services to five or more people	15	90
Residential Services	Community-based residential facility providing developmental or rehabilitative services to five or more adults	1	16
Facilities for Other Populations			
Chemical Dependency Treatment	Facilities providing chemical dependency treatment services to adults and adolescents	6	313
Forensic Nursing Home	Psychiatric nursing home for adults committed to the departments of Human Services or Corrections	1	48
Total		136	1,680

NOTES: Besides the facilities shown here, SOS also supports a number of "intensive therapeutic homes" (commonly referred to as MITHs) for children and adolescents with severe emotional disturbances. These homes provide foster care that SOS employees supplement with intensive treatment whenever a resident's individual care plan calls for it. For accounting purposes, MITHs are considered SOS facilities when one or more residents receive such treatment from SOS staff. When this occurs, staff in MITHs are likewise considered SOS employees.

[a] State-Operated Services refers to these facilities as "Minnesota specialty health systems" as well as "intensive residential treatment services" (IRTS).

SOURCE: Office of the Legislative Auditor, analysis of data from the Minnesota Department of Human Services, August 2012.

to treat persons with mental illness or traumatic brain injuries.[8] These facilities accounted for 49 percent of SOS's licensed beds in 2012. In December 2012, these facilities served 617 residents, about 74 percent of their licensed capacities.

[8] State-Operated Services refers to its facilities that provide community-based residential treatment to people with mental illness as "Minnesota specialty health systems" or "intensive residential treatment services" (IRTS). We refer to these facilities by the type of program license they hold—Residential Treatment for Adults with Mental Illness.

Some state facilities have populations well below their licensed capacities.

The remaining 5 percent of SOS facilities included six residential chemical dependency treatment centers (comprising 19 percent of SOS's licensed beds)[9] and the Forensic Nursing Home (with about 3 percent of SOS's beds).[10] As of December 2012, SOS's chemical dependency treatment facilities and nursing home served 169 and 28 residents, respectively, or 54 percent and 58 percent of their respective licensed capacities.

The number of licensed beds in a facility does not necessarily correspond to the actual number of beds available for use. Licensed facilities may operate at less than their licensed capacities for a variety of reasons. For example, although the Anoka-Metro Regional Treatment Center had a licensed capacity of 175 beds in 2012, the facility was funded and staffed to handle only 110 residents at a time, according to DHS. Similarly, the Child and Adolescent Behavioral Health Hospital in Willmar had a licensed capacity of 70 beds in 2012. But, according to DHS, the facility could provide treatment for only 14 children or adolescents at a time given its funding level. The SOS chemical dependency treatment facilities had a licensed capacity of 313 in 2012 but were staffed to serve up to 177 residents at a time.

We provide brief descriptions of selected SOS facilities below.

Minnesota Security Hospital

Despite its name, the Minnesota Security Hospital is not licensed as a hospital. Rather, it is Minnesota's only facility that provides extended residential treatment for mental illness in a secure setting.[11] Most of the Security Hospital's patients have been civilly committed by a court as "mentally ill and dangerous to the public."[12] Chapter 4 discusses the civil commitment process in more detail. Typically, individuals committed to the Security Hospital remain there for years; Chapter 5 provides additional background on the Security Hospital and its patients.

Anoka-Metro Regional Treatment Center

The Anoka-Metro Regional Treatment Center is the state's only remaining regional treatment center, and it serves a dual purpose. First, it is a state-run behavioral health hospital for the seven-county Twin Cities region, providing acute psychiatric services that supplement those offered in the region by nonstate providers. (Acute care has traditionally been defined as short-term inpatient and emergency care.) Second, this facility serves patients from around the state whose needs for psychiatric acute care cannot be met by other facilities. In 2011,

[9] State-Operated Services refers to its chemical dependency treatment program as "community addiction recovery enterprise" or "CARE." This program provides inpatient as well as outpatient services; our evaluation did not review the nature of the outpatient services.

[10] Although the Forensic Nursing Home, which opened in late 2010, is located on the campus of the Minnesota Security Hospital in St. Peter, it is licensed separately from the Security Hospital.

[11] A portion of this facility—called "Transition Services"—provides treatment in a nonsecure setting for patients who have demonstrated an ability to live outside the facility's secure areas.

[12] *Minnesota Statutes* 2012, 253B, subd. 18.

31 percent of the Anoka-Metro Regional Treatment Center's admissions were from outside the Twin Cities region, up from 15 percent in 2008. Nearly all individuals admitted to the Anoka facility have been placed there involuntarily, usually through civil commitment for mental illness.

Community Behavioral Health Hospitals

As the Department of Human Services (DHS) closed four large institutions in recent years, it opened several small behavioral health hospitals.

Between 2006 and 2008, Minnesota closed four large regional treatment centers—in St. Peter, Fergus Falls, Brainerd, and Willmar. In their place, ten state-run "community behavioral health hospitals" opened during these years, all outside the Twin Cities metropolitan area.[13] According to DHS, community behavioral health hospitals "were designed to serve adults who required short-term in-patient psychiatric hospitalization until they could be discharged home or to a less intensive service in their community that would better serve their needs."[14] As originally designed, each hospital was to provide acute care and have a 16-bed capacity, making each eligible for federal Medicaid funds for which larger facilities cannot qualify.[15] One of these hospitals (Cold Spring) closed in 2009 due to staffing problems and its duplication of other services in the St. Cloud area. Two others (at Willmar and Wadena) were converted in 2011 into state-run residential treatment programs for people with mental illness.[16] State-Operated Services' original vision for community behavioral health hospitals was for them to partner with private hospitals—perhaps even operating as units within private hospitals. In practice, however, all of the SOS community behavioral health hospitals have operated as "stand-alone" facilities.

Individuals are usually referred to one of SOS's community behavioral health hospitals by another public or private hospital or by a county human services caseworker. The referral typically occurs after the individual has been seen in an emergency room or received inpatient services from another hospital. Fifty percent of the patients admitted to SOS's community behavioral health hospitals between December 2008 and June 2012 came from hospitals that had inpatient mental health units; 35 percent came from hospitals that offered no inpatient mental health services.[17]

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[13] The ten hospitals were located at Alexandria, Annandale, Baxter, Bemidji, Cold Spring, Fergus Falls, Rochester, St. Peter, Wadena, and Willmar.

[14] Minnesota Department of Human Services, *Report on the Utilization of the Community Behavioral Health Hospitals* (St. Paul, March 30, 2012), 7.

[15] Mental health facilities with more than 16 beds are defined in federal regulations as "institutions for mental diseases," and Medicaid does not pay for services in such facilities except for patients under age 22 or age 65 and over. See 42 *CFR* 435.1009 (2006). As discussed in Chapter 3, one community behavioral health hospital (in Rochester) was not approved by the federal government to receive federal Medicaid payments until early 2013.

[16] "Residential" treatment programs are not licensed or accredited as hospitals and typically have longer client stays than hospitals that provide acute care.

[17] These percentages are based on an Office of the Legislative Auditor analysis of individual admissions to community behavioral health hospitals using DHS preadmissions data. In the remaining 15 percent of referrals, patients either came from nonhospital locations or the patient's prior location was not indicated in the data. As of 2012, 31 Minnesota hospitals not operated by the state had behavioral health units.

About 95 percent of the patients admitted to DHS's community behavioral health hospitals were from counties outside the seven-county Twin Cities metropolitan area.[18] Some parts of the state—notably northeast Minnesota—do not have a state-run hospital nearby, so people in these areas are often served by nonstate hospitals. Individuals from the Twin Cities region who require hospitalization are typically referred to nonstate hospitals in the region or the Anoka-Metro Regional Treatment Center.

Group Homes for Individuals with Developmental Disabilities

Group homes for individuals with developmental disabilities represent the largest number of DHS's facilities.

About 30 years ago, DHS started to establish "group homes" in parts of Minnesota near residential treatment centers. The department added more sites over the years, partly in response to requests from counties or family members of developmentally disabled individuals. As of mid-2012, SOS ran 99 facilities licensed as adult foster homes and 15 licensed as intermediate care facilities. About 90 percent of the residents of these facilities had primary diagnoses of developmental disabilities, ranging from mild to profound; most other residents had primary diagnoses of mental illnesses or traumatic brain injuries. Most SOS facilities for people with developmental disabilities provide long-term care, not treatment.[19] State-Operated Services also provides nonresidential vocational services, such as job training and supported employment, at about 20 locations for group home residents.

Chemical Dependency Treatment Programs

State-Operated Services runs six residential chemical dependency treatment facilities in Anoka, Brainerd, Carlton, Fergus Falls, St. Peter, and Willmar. These facilities have developed specializations that affect the types of client referrals they receive. The Anoka and St. Peter programs focus on clients with dual diagnoses of chemical dependency and mental illness. The Willmar program serves heroin and cocaine users, the Brainerd program focuses on Native American clients, and all of Carlton's clients are women. Two facilities—Anoka and Fergus Falls—provide treatment in a locked setting.

External Oversight of Facilities

The State of Minnesota uses various methods to ensure that state-run facilities and other human services meet minimum standards related to health, safety, and services. Overall, we found that:

[18] This figure is based on our analysis of referrals to SOS's central preadmissions unit from December 2008 through June 2012.

[19] Most state-run facilities serving individuals with developmental disabilities are part of SOS's Minnesota State-Operated Community Services (MSOCS) program. MSOCS facilities licensed as "adult foster care homes" provide food, lodging, protection, supervision, and household services to adults on a 24-hour per day basis; these homes generally provide no treatment. MSOCS facilities licensed as "intermediate care facilities" provide on-site health or rehabilitative services and are certified by the federal government, which allows facilities to receive Medicare and Medicaid reimbursement for qualified residents. Apart from the MSOCS program, SOS operates one other facility for adults with developmental disabilities. This facility, which is licensed as a "residential services" facility, provides residential care plus counseling, developmental habilitation, or rehabilitation services.

- **All facilities run by State-Operated Services must be licensed by at least one state agency, and some voluntarily seek accreditation or federal "certification."**

As described below, some SOS facilities are required to be licensed by more than one state agency. Also, some voluntarily seek "certification" (to be eligible for federal health care payments) or accreditation from private organizations. Overall, as of October 2012, 26 percent of SOS facilities maintained multiple licenses, accreditations, or certifications.

Facility Licensure

The departments of Human Services and Health license state-operated human services facilities.

As shown in Exhibit 1.2, all SOS facilities are licensed by DHS or the Minnesota Department of Health (MDH).[20] The DHS Licensing Division, in addition to issuing licenses, monitors facilities' ongoing compliance with licensing rules, conducts background checks of people holding licenses or having direct contact with children or vulnerable adults in licensed facilities, and investigates complaints of alleged maltreatment.[21] This division—which is *not* part of SOS—issues licenses to facilities required to have a DHS license, whether state-run or not. It assesses state-run facilities using the same criteria that apply to all other similar facilities it licenses. Any facility whose license has been revoked, including state-operated facilities, cannot operate.

Facilities often need a license from both DHS and MDH to operate; consequently, both agencies are responsible for facility monitoring.[22] In these instances, DHS licenses generally set forth broad program and administrative requirements for specific populations (for example, facilities for people with mental illness must meet different program standards or rules than facilities for people with chemical dependency or developmental disabilities). Human services rules typically require that facilities employ (or contract with) certain types of staff and maintain certain types of policies, procedures, plans, resident and staff files, documentation, and reports. All DHS-licensed facilities designed to serve more than five residents must also obtain an MDH-issued supervised living facility license.[23] These licenses establish specific health and physical plant requirements such as food handling protocols and the size and location of windows. When MDH is the primary licensing authority (as it is for hospitals and nursing homes), its rules cover not only physical plant requirements, but also program and administrative requirements.

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[20] For the facilities we examined, DHS issues facility licenses pursuant to *Minnesota Statutes* 2012, 245A, while MDH issues licenses pursuant to *Minnesota Statutes* 2012, 144.50.

[21] The Department of Human Services delegates some of these responsibilities to county human services agencies.

[22] Some licenses, especially initial licenses, may also require building and fire/life safety code inspections before being issued.

[23] *Minnesota Statutes* 2012, 144.50, subd. 6, also authorizes MDH to license intermediate care facilities for at least four persons with developmental disabilities as supervised living facilities.

Exhibit 1.2: Licensure, Accreditation, and Certification of Facilities Run by State-Operated Services, 2012

Type of Residential Facility	Licensed by Minnesota Department of Human Services	Licensed by Minnesota Department of Health	Accredited by the Joint Commission[a]	Certified to Receive Federal Health Care Payments[b]
Facilities for People with Mental Illness				
Minnesota Security Hospital	X	X	X	
Anoka-Metro Regional Treatment Center		X	X	X
Community Behavioral Health Hospitals		X	X	X[c]
Child and Adolescent Behavioral Health Hospital		X	X	X
Residential Treatment	X	X	X	X
Facilities Primarily Serving People with Developmental Disabilities				
Adult Foster Care	X			
Intermediate Care	X	X		X
Residential Services	X	X		
Facilities for Other Populations				
Chemical Dependency Treatment	X	X	X	
Forensic Nursing Home		X		

[a] Accreditation by the Joint Commission is voluntary on the part of health care organizations. The Minnesota Department of Health accepts accreditation by the Joint Commission as proof that a facility complies with MDH regulations necessary to obtain state licensure as a hospital.

[b] The U.S. Centers for Medicare and Medicaid Services (CMS) may accept accreditation by the Joint Commission as proof that a facility complies with CMS requirements necessary for federal reimbursement. Certified hospitals qualify for Medicare and Medicaid payments. Other facilities qualify only for Medicaid (as a result of federal certification or as provided in Minnesota's federally approved Medicaid state plan). Anoka-Metro Regional Treatment Center qualifies for Medicaid payments only for individuals under age 21 and over age 64.

[c] As we discuss in Chapter 3, all of SOS's community behavioral health hospitals are now certified to receive federal health care payments, although the Rochester facility only became certified in early 2013.

SOURCES: Office of the Legislative Auditor, analysis of data from the Minnesota departments of Health and Human Services and the Joint Commission.

Facility Accreditation

In addition to licensure, facilities can voluntarily seek accreditation from a national organization, reflecting compliance with professional standards. The main health care accreditation body is the Joint Commission (formerly called the Joint Commission on Accreditation of Healthcare Organizations). We found that:

- **Twenty of State-Operated Services' hospital or treatment facilities for people with mental illness or chemical dependency were accredited by the Joint Commission in 2012.**

Partly to avoid duplication of effort, MDH and DHS can "deem" that certain types of facilities accredited by approved outside entities—such as the Joint

Commission—also meet state licensing rules.[24] For example, rather than requiring Joint Commission-accredited hospitals to go through another inspection process by state licensing staff, MDH generally accepts accreditation by the Joint Commission as proof that a facility also meets state licensing requirements. The Joint Commission is also responsible for routinely monitoring hospitals' continuing compliance with accreditation (and therefore state licensing) standards as well as investigating complaints it receives.[25] For the most part, the Joint Commission's standards reflect state licensing standards, setting forth administrative, staffing, program, and physical plant requirements that facilities must meet.

Facility Certification for Federal Health Care Payments

Many state-run facilities can bill the federal government for health care they provide.

Separate from licensing and accreditation, hospitals run by SOS must be certified by the U.S. Centers for Medicare and Medicaid Services (CMS) if they are to receive federal health care payments for qualified residents. Some other SOS facilities qualify for federal payments under Minnesota's federally approved Medicaid state plan. We found that:

- **Twenty-seven of State-Operated Services' hospital or residential facilities were certified to receive Medicare or Medicaid payments in 2012.**

Certified facilities included 8 behavioral health hospitals for people with mental illness, 4 residential facilities for people with mental illness, and 15 intermediate care facilities for people with developmental disabilities. In Chapter 3, we discuss one SOS hospital that finally received certification in 2013 following several failed attempts.

For the most part, the standards used for federal certification as a psychiatric hospital are the same as those used for hospital accreditation, and CMS has used the results from accreditation surveys in lieu of conducting its own certification inspections. Federal certification as a psychiatric hospital, however, requires that facilities comply with additional standards related to psychiatric hospital staffing and recordkeeping.[26]

Unlike CMS's certification of hospitals, MDH licensing staff conduct certification inspections for CMS in intermediate care facilities for people with

[24] *Minnesota Statutes* 2012, 144.55, subd. 4, allows MDH to recognize some inspections conducted by accrediting bodies as a substitute for state inspections. *Minnesota Statutes* 2012, 254B.05, subd. 2, allows DHS to accept compliance with accreditation standards as equivalent to partial compliance with state licensing rules for chemical dependency programs.

[25] As with state licensing visits, Joint Commission accreditation visits are unannounced. Joint Commission accreditation is generally good for a maximum of 36 months.

[26] CMS requires that psychiatric hospitals (1) maintain individualized patient records that indicate the degree and intensity of services provided and (2) have adequate numbers of qualified staff to evaluate patients, develop treatment plans, provide active treatment, and take part in discharge planning. See 42 *CFR* (2007) 482.61-482.62. Until 2011, CMS conducted inspections to ensure compliance with these two requirements; it now allows the Joint Commission to inspect facilities for these components (see *Federal Register*, vol. 76, no. 38, February 25, 2011, 10,598-10,600).

developmental disabilities. Federal guidelines direct MDH to conduct recertification inspections about once a year.[27]

Similarly Licensed Facilities Run by Other Entities

As part of our evaluation, we looked at the number and capacity of SOS facilities relative to similar types of facilities run by other entities, including private companies, nonprofit organizations, and other levels of government. We judged facilities operated by other entities to be "similar" if they held the same types of licenses from the departments of Human Services or Health. Overall, we found that:

- **In 2012, State-Operated Services' facilities accounted for a very small share of all similarly licensed facilities for people with chemical dependency, developmental disabilities, or mental illness.**

The DHS facilities for people with developmental disabilities represent 2 percent of similarly licensed facilities statewide.

As shown in Exhibit 1.3, DHS and MDH licensed nearly 5,600 inpatient or residential facilities for people with chemical dependency, developmental disabilities, and mental illness in 2012, for a maximum capacity of nearly 56,000 licensed beds statewide. Facilities operated by SOS comprised just 2 percent of all facilities holding like licenses, and they accounted for only 3 percent of all licensed beds.

Data in Exhibit 1.3 also show that:

- **In 2012, State-Operated Services' facilities comprised a larger share of similarly licensed facilities and beds for people with mental illness than they did for people with developmental disabilities.**

Facilities operated by SOS that primarily served persons with developmental disabilities accounted for about 2 percent of all similarly licensed facilities and 3 percent of similarly licensed beds in 2012. In contrast, SOS facilities primarily for persons with a mental illness accounted for 16 percent of all similar facilities and 32 percent of similar beds statewide. Chemical dependency treatment facilities run by SOS accounted for 7 percent of similarly licensed facilities and 10 percent of beds.

[27] U.S. Centers for Medicare and Medicaid Services, *State Operations Manual*, "Chapter 2-The Certification Process," 2138G, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf, accessed December 21, 2012. Facilities licensed as intermediate care facilities must also obtain a supervised living facility license from MDH. According to health department officials, staff generally conduct licensing inspections every other year and recertification inspections every year. Intermediate care facilities also hold a DHS-issued license, and DHS staff review facilities' "self-surveys" rather than conducting on-site licensing inspections.

Exhibit 1.3: Number of Licensed Residential Facilities and Beds in Minnesota by Type of Facility License, 2012

Facility by Type of License[a]	Number of: All Licensed Facilities	Number of: SOS Facilities	Percentage of All Facilities Run by SOS	Number of Beds in: All Licensed Facilities	Number of Beds in: SOS Facilities	Percentage of All Beds Run by SOS
Facilities for People with Mental Illness						
Residential Treatment[b]	50	5	10%	1,239	472	38%
Behavioral Health Hospitals[c]	40	9	23	1,331	357	27
Subtotal	90	14	16	2,570	829	32
Facilities Primarily Serving People with Developmental Disabilities						
Adult Foster Care	4,786	99	2	17,327	384	2
Intermediate Care	211	15	7	1,835	90	5
Residential Services	17	1	6	110	16	15
Subtotal	5,014	115	2	19,272	490	3
Facilities for Other Populations						
Chemical Dependency Treatment	91	6	7	2,999	313	10
Forensic Nursing Home	376	1	<1	30,856	48	<1
Subtotal	467	7	1	33,855	361	1
Total	5,571	136	2%	55,697	1,680	3%

[a] "Type of license" refers to the primary license issued by either the Minnesota Department of Human Services or Department of Health.

[b] "Residential treatment" consists of the Minnesota Security Hospital and four "intensive residential treatment services" facilities.

[c] "Behavioral health hospitals" consist of the following SOS facilities: Anoka-Metro Regional Treatment Center, seven community behavioral health hospitals, and the Child and Adolescent Community Behavioral Health Hospital. The 31 non-SOS facilities in this category are behavioral health units that are part of larger hospitals.

SOURCES: Office of the Legislative Auditor, analysis of data from the Minnesota departments of Health and Human Services, August 2012, and the Minnesota Hospital Association, July 2012.

Compliance

We looked at licensing inspection records and complaint investigations for all SOS facilities as well as the general track record of similarly licensed facilities. Both DHS and MDH issue their licenses on a yearly basis, with licenses running from January through December. Although facilities must undergo inspections before receiving their initial licenses, annual inspections are generally not required for subsequent renewals.[28] Currently, DHS Licensing staff told us that they try to conduct routine site visits at least once every two years, although this is not always possible. While MDH tries to inspect most supervised living facilities once every two years, the department tries to inspect SOS supervised

[28] The Department of Human Services has delegated certain licensing functions for adult foster care facilities to counties, including processing license applications, conducting routine inspections, and monitoring compliance.

living facilities yearly.[29] The health department does not usually monitor or inspect the accredited hospitals that it licenses, relying largely on the Joint Commission to conduct routine inspections, monitor compliance, and investigate complaints filed with the Joint Commission. However, at the direction of CMS, MDH staff conduct on-site inspections in a small number of accredited hospitals each year to ensure compliance with state and federal standards.

Both DHS and MDH can issue correction orders when facilities do not meet license requirements; this usually occurs as a result of a routine licensing inspection or complaint investigation. When violations warrant it (for example, when residents' health, safety, or rights are adversely affected), staff may also revoke or suspend a license, issue a conditional license, or impose a fine.[30]

We looked at various compliance-related measures imposed by DHS from January 2007 through October 2012, as well as the number of substantiated complaints regarding licensing violations or resident maltreatment lodged against each facility.[31] We found that:

- **With two exceptions, the overall compliance records of SOS facilities have generally been comparable to those of similarly licensed facilities run by nonstate entities.**

As shown in Exhibit 1.4, SOS facilities accounted for 8 percent of all substantiated complaints, 3 percent of conditional licenses, 8 percent of all fines, and 9 percent of the total dollar amount of fines issued by DHS Licensing staff from January 2007 through October 2012.[32] During this period, SOS facilities comprised about 2 percent of all facilities examined. However, two SOS facilities—the Minnesota Security Hospital and Minnesota Extended Treatment Options—had disproportionately larger shares of compliance problems than did other similarly licensed facilities. The Security Hospital is the only SOS facility operating under a conditional license, and nine of the ten complaints substantiated against SOS's residential treatment facilities for people with mental

[29] Staff at MDH told us that they try to inspect state-run facilities annually because they generally house a more vulnerable population than facilities run by other entities.

[30] *Minnesota Statutes* 2012, 245A.07, subd. 3, sets forth the various amounts of fines that DHS may impose. *Minnesota Statutes* 2012, 144.55 and 144.653, give MDH the authority to fine facilities up to $1,000 per uncorrected deficiency, while *Minnesota Statutes* 2012, 144A.53, authorizes the issuance of fines resulting from complaint investigations.

[31] We did not examine the number and type of correction orders issued to facilities. State agencies do not distinguish between correction orders issued for minor rule violations, such as filing reports a day late or with missing signatures, versus major violations, such as neglecting residents or not providing appropriate medical care.

[32] These data exclude SOS hospitals because they are licensed by MDH rather than DHS. We examined complaints investigated by MDH's Office of Health Facility Complaints and found few substantiated complaints regarding SOS facilities. We also found only one fine assessed against SOS residential treatment facilities by MDH Licensing staff over the last few years.

Exhibit 1.4: Department of Human Services' Complaint Investigations and Sanctions in Residential Facilities, January 2007 through October 2012

	Number of Complaints		Number of Sanctions Imposed			
Type of Facility	Investigated	Substantiated	Suspensions and Revocations	Conditional Licenses	Fines	Total Amount of Fines
Residential Treatment-Mental Illness (*N*=50)	200	41	0	3	26	$26,000
SOS (*N*=5)	68	10	0	1	6	9,200
Percentage for SOS	34%	24%	0	33%	23%	35%
Chemical Dependency Treatment (*N*=91)	238	78	1	3	33	31,200
SOS (*N*=6)	43	9	0	0	2	4,800
Percentage for SOS	18%	12%	0	0%	6%	15%
Intermediate Care (*N*=211)	115	12	0	0	24	15,400
SOS (*N*=15)	8	1	0	0	3	1,600
Percentage for SOS	7%	8%	0	0%	13%	10%
Residential Services-Developmentally Disabled (*N*=17)	33	9	0	0	3	1,400
SOS (*N*=1)	15	6	0	0	2	1,200
Percentage for SOS	45%	67%	0	0%	67%	86%
Adult Foster Care (*N*=4,786)	3,961	388	116	31	201	119,050
SOS (*N*=99)	153	18	0	0	2	600
Percentage for SOS	4%	5%	0	0%	1%	1%
Total (*N*=5,155)	4,547	528	117	37	287	193,050
SOS (*N*=126)	287	44	0	1	15	17,400
Percentage for SOS	6%	8%	0	3%	5%	9%

NOTES: Complaint investigations address possible licensing violations or resident maltreatment. Facility counts reflect numbers as of October 2012. Facility counts may have varied over the time period we examined as some facilities opened while others closed.

SOURCE: Office of the Legislative Auditor, analysis of data from the Minnesota Department of Human Services.

illness involved the Security Hospital.[33] It also accounted for three of the six fines levied against this type of SOS facility and $4,400 of the $9,200 paid in fines.[34]

A second SOS facility that encountered significant compliance problems over the last several years was the Minnesota Extended Treatment Options facility. The Department of Human Services closed it in 2011 to help settle a lawsuit brought against the State of Minnesota for resident abuse. Since 2007, this facility

[33] The other substantiated complaint involved a residential mental heath treatment facility in St. Paul.

[34] Two other SOS facilities for adults with mental illness had fines during the time period examined. A residential mental health treatment facility in St. Paul was fined $3,800, and a facility in Wadena was fined $1,000.

accounted for five of the nine complaints substantiated in all residential services facilities in Minnesota for people with developmental disabilities and 86 percent of the total fine amounts for such facilities.[35] In Chapter 3, we discuss this facility's problematic restraint and seclusion practices as well as similar problems at the Minnesota Security Hospital.

FINANCES

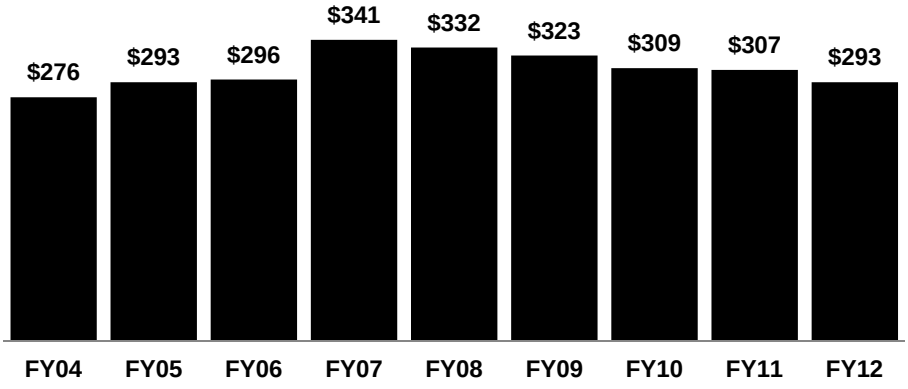
Expenditures

State-Operated Services' annual expenditures are larger than those of some entire state agencies. Exhibit 1.5 shows SOS's total expenditures since fiscal year 2004, unadjusted for inflation. These expenditures include all SOS costs, including residential, inpatient, and nonresidential services, as well as direct administrative expenses. The exhibit shows that:

- **State-Operated Services expenditures totaled $293 million in fiscal year 2012, down from a peak in fiscal year 2007 of $341 million.**

In fiscal year 2007, SOS had started operating a number of small behavioral health hospitals around the state, and it was still operating several large state-run

Exhibit 1.5: State-Operated Services Total Expenditures (in Millions), Fiscal Years 2004-2012



NOTE: Expenditures for the Minnesota Sex Offender Program, which was part of State-Operated Services until 2008, are excluded from all applicable years. Expenditures include transfers SOS made to other parts of DHS.

SOURCE: Minnesota Department of Human Services.

[35] Of the other four substantiated complaints, one was at a state-run facility. It involved the residential facility for individuals with developmental disabilities in Cambridge that opened in 2011 following closure of the Minnesota Extended Treatment Options facility at that location.

facilities that were in the process of closing. For example, in fiscal year 2007, SOS spent $33.3 million for the following facilities that have since closed: Ah-Gwah-Ching Nursing Home in Walker, Fergus Falls Regional Treatment Center, Brainerd Regional Treatment Center, Minnesota Extended Treatment Options in Cambridge, and Minnesota Neuro-Rehabilitation Services in Brainerd.[36] In addition, SOS incurred an unusually large amount of expenditures ($36.2 million) categorized as "systemwide" in fiscal year 2007—nearly $14 million more than the amount spent for this category in any other year. "Systemwide" expenditures include (1) SOS-wide administrative services, such as information technology, human resources, fiscal services, and staff development; (2) expenditures from central reserve accounts (such as for tort claims, building repairs or betterments, workers compensation, or capital equipment); and (3) other expenditures having a systemwide purpose or impact. Among SOS's largest systemwide expenditures in fiscal year 2007 were for "mothballing" SOS campuses that were closing ($5.8 million); a one-time transfer to DHS's Adult Mental Health Division ($5 million); disposing of the Fergus Falls Regional Treatment Center property ($2.5 million); an agencywide information technology project ($1.4 million); capital equipment at newly opened facilities ($1.3 million); and increases to the SOS dental clinics' cash flow ($1 million).

Revenue Sources

State-operated services are funded in one of three primary ways. We found that:

- **A majority of State-Operated Services expenditures are "appropriated services"—that is, they are paid for with direct appropriations to the Department of Human Services from the state's General Fund.**

In recent years, the Minnesota Security Hospital has seen large growth in its resident population and expenditures.

Exhibit 1.6 shows SOS expenditures in the three main categories of funding. In fiscal year 2012, appropriated services accounted for $178.1 million, or 61 percent of total SOS expenditures.[37] These services were funded by the Legislature's direct appropriation to DHS of $187.0 million for SOS.[38]

Exhibit 1.6 shows that the largest expenditure in the appropriated services category was for the Minnesota Security Hospital, which spent $67.6 million in fiscal year 2012. Unadjusted for inflation, the Security Hospital's fiscal year 2012 expenditures increased 107 percent from the fiscal year 2004 amount—the largest increase during that period among SOS's programs and services. One reason is that the Security Hospital's population increased by about 58 percent

[36] Minnesota Extended Treatment Options closed on June 30, 2011, but SOS continued to incur some costs in fiscal year 2012 for this facility.

[37] In fiscal year 2010, DHS used $83.5 million from the American Recovery and Reinvestment Act of 2009 to pay for services that in other years were entirely funded by the state's General Fund.

[38] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 10, sec. 3, subd. 5.

during this period, including the establishment of a secure nursing home on the Security Hospital campus.[39]

Exhibit 1.6: State-Operated Services Expenditures by Type of Revenue, Fiscal Year 2012

Revenue Type/Program	FY 2012 Expenditures	Percentage Change in Spending, FY 2004-2012[a]
Appropriated Services		
Minnesota Security Hospital	$ 67,573,456	+107%
Anoka-Metro Regional Treatment Center	33,228,153	+34
Community behavioral health hospitals	30,032,928	NA
Systemwide	16,958,553	-1.4
Intensive residential treatment facilities	11,412,725	NA
Child and adolescent behavioral health services	5,338,075	NA
Transfer to other parts of DHS	5,335,000	NA
Community support services	4,602,831	NA
Adult mental health community services	2,077,334	-46
Minnesota Extended Treatment Options	985,430	-89
Closed campuses	543,286	NA
Subtotal	$178,087,771	+9%
Enterprise Services		
Minnesota State-Operated Community Services	$ 82,241,549	+23%
Chemical dependency treatment	18,043,301	-1
Intensive treatment homes for children and adolescents	1,703,224	-86
Subtotal	$101,988,074	+1%
Dedicated Revenue		
Community Partnership Network	$ 9,395,551	NA
Dental clinics	1,699,359	+59
Other	608,101	-93
Subtotal	$ 11,703,011	+26%
Other Funding Sources	$ 1,435,611	-46%
Total	$293,214,467	+6%

NOTES: The calculation of percentage changes between fiscal years 2004 and 2012 did not adjust for inflation. Expenditures for the Minnesota Sex Offender Program, which was part of SOS until 2008, were excluded from data used to compute percentage changes. The 2012 state-appropriated expenditures category called "transfers to other parts of DHS" is mainly for certain administrative services provided to SOS.

[a] "NA" indicates programs or services that did not exist in fiscal year 2004.

SOURCE: Minnesota Department of Human Services.

[39] We calculated this increase based on the maximum daily census count for the fourth quarters of 2003 and 2011 for the St. Peter campus, excluding the Minnesota Sex Offender Program.

A second category of services shown in Exhibit 1.6—"enterprise activities"—was established by legislation passed in 1999.[40] Statutes for SOS define enterprise activities as:

> …the range of services, which are delivered by state employees, needed by people with disabilities and are fully funded by public or private third-party health insurance or other revenue sources available to clients that provide reimbursement for the services provided.[41]

Some state-run services are operated as "enterprise activities," which rely on funding sources other than state appropriations.

In other words, enterprise activities must rely on funding sources other than state appropriations designated specifically for state-operated services. Enterprise activities are required by law to retain any revenues they receive and keep them in an interest-bearing account.[42] In fiscal year 2012, enterprise activities accounted for 35 percent of total SOS expenditures. The largest enterprise activity—and the SOS program with the highest expenditures—was Minnesota State-Operated Community Services. This program primarily serves individuals with developmental disabilities, with services mostly paid for by Medicaid waivers. In fiscal year 2012, expenditures for serving these individuals totaled $82.2 million. State-Operated Services' other large enterprise activity is chemical dependency treatment. These services are primarily paid for with money from Minnesota's Consolidated Chemical Dependency Treatment Fund.[43] This fund is comprised of a combination of state-appropriated money and federal funds, but its state appropriations are not specifically earmarked for state-run services.

About 4 percent of SOS expenditures are funded by "dedicated revenues"—that is, revenues dedicated in accordance with law to a particular purpose. Minnesota law authorizes DHS to enter into agreements with other governmental or nongovernmental units to participate in shared service agreements, and the SOS program that provides the service may retain "all receipts."[44] The largest SOS program funded in this manner is the Community Partnership Network (with expenditures of more than $9 million in fiscal year 2012). It provides nonresidential mental health professional services through contracts with counties and other entities. Network staff are considered state employees, although they do not work under direct state supervision.

Billing for Services

We noted earlier that enterprise programs are allowed to keep any revenues they collect. In contrast,

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[40] *Laws of Minnesota* 1999, chapter 245, art. 5, sec. 9.

[41] *Minnesota Statutes* 2012, 246.0136, subd. 1. This law authorizes DHS to initiate enterprise activities for adult mental health or adolescent services or to establish a "public group practice." The department must obtain legislative approval to initiate any other enterprise activities.

[42] *Minnesota Statutes* 2012, 246.18, subd. 6.

[43] *Minnesota Statutes* 2012, 254B.02, subd. 1.

[44] *Minnesota Statutes* 2012, 246.57, subd. 1.

- **For state-operated services funded through state appropriations, revenues collected from third-party payers or other sources must, for the most part, be deposited in the state's General Fund.**

When allowed by federal and state regulations, SOS bills parties for its state-appropriated services and tries to collect payments. The parties charged may include public insurers (mainly the state's Medicaid program, called "Medical Assistance," and the federal Medicare program), private insurers, counties, and the clients themselves.[45] The ability to charge for services depends on various factors. For example, federal regulations disqualify large mental health institutions (such as the Anoka-Metro Regional Treatment Center) from Medicaid payments for individuals between ages 22 and 64.[46] Also, public and private health insurance do not cover costs of care at the Minnesota Security Hospital because it is a "forensic" treatment facility.[47]

DHS is authorized to bill counties and clients for some services.

State-Operated Services bills counties for certain state-appropriated services, and these payments go to the General Fund.[48] For example, state law requires the home county to pay 10 percent of a patient's cost of care at the Minnesota Security Hospital.[49] For clients admitted to Anoka-Metro Regional Treatment Center, home counties pay nothing for the first 30 days, 20 percent of the cost of care for days 31 to 60, and, for clients deemed appropriate for discharge, 50 percent for days 61 and greater.[50]

Statutes also specify circumstances in which clients or their relatives may be charged for services, and these payments also go to the General Fund. Using the examples of the Minnesota Security Hospital and Anoka-Metro Regional Treatment Center, DHS determines what portion of the cost of care the client is able to pay, based on state rules.[51] The client's spouse or parents may also be liable for care costs not covered by the client. If the client dies and has unpaid liabilities for SOS care, the Commissioner of Human Services is required by law to file a claim against the client's estate.[52]

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[45] Expenditures from the Medical Assistance program are funded half by the federal government and half by the state. The Department of Human Services administers Medical Assistance, but Medical Assistance expenditures come out of the department's budget for publicly funded health care programs rather than SOS's budget.

[46] 42 *CFR* 435.1009 (2006).

[47] As a "forensic" facility, the Security Hospital largely serves individuals who pose a public safety risk and have been civilly committed by the courts for treatment of a mental illness, often instead of (or in addition to) criminal sentencing.

[48] The county of financial responsibility is generally the client's county of residence before entering a facility.

[49] *Minnesota Statutes* 2012, 246.54, subd. 2.

[50] *Ibid.*, subd. 1. The law says that if the state receives payments from other sources for the Minnesota Security Hospital or Anoka-Metro Regional Treatment Center clients that exceed a specified level, the county is only obligated to pay the remaining share.

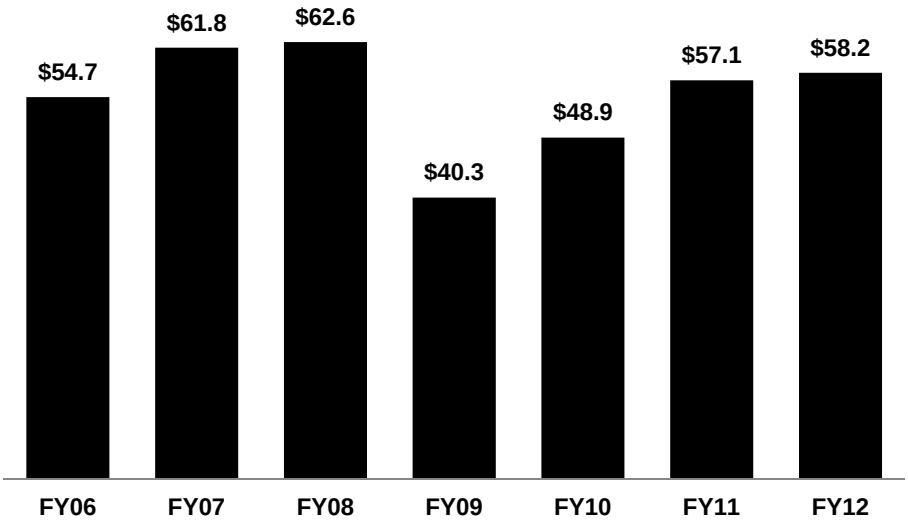
[51] *Minnesota Rules* 2012, 9515.1000-9515.2600.

[52] *Minnesota Statutes* 2012, 246.53.

Thus, revenues for services funded through state appropriations generally do not affect SOS's financial bottom line.[53] Exhibit 1.7 shows total collections for SOS services that went to the General Fund in recent years.

In fiscal year 2012, the state obtained nearly $60 million in revenues by charging for certain services initially funded by state appropriations.

Exhibit 1.7: Dollars (in Millions) Collected by State-Operated Services for the State's General Fund, Fiscal Years 2006-2012



SOURCE: Minnesota Department of Management and Budget, annual *Economic Update* reports.

Cost of Care

State-Operated Services bases the amount it bills to responsible parties on facilities' "cost of care." As defined in statute, the cost of care at an SOS facility is the Commissioner of Human Services' charge for services provided to any person admitted.[54] Department of Human Services staff determine the cost of care for state-run facilities, using information on those facilities' direct and indirect costs. Exhibit 1.8 shows a four-year history of selected facilities' cost per day. In fiscal year 2013, the cost at these facilities ranged from $388 per patient-day to more than $1,000 per patient-day.

Some SOS facilities are not shown in Exhibit 1.8 because their daily rates vary by client. For group homes primarily serving people with developmental

[53] *Minnesota Statutes* 2012, 246.18, subd. 4. The law identifies some exceptions. Notably, subdivision 8 says that revenues generated by certain new services must be deposited in a special revenue fund.

[54] *Minnesota Statutes* 2012, 246.50, subd. 5. In response to this statute, DHS has defined the cost of care as the cost of services, treatment, maintenance, bonds issued for capital improvements, depreciation of buildings and equipment, and indirect costs related to facility operation.

disabilities, SOS negotiates client-specific rates with each client's county of financial responsibility. As of mid-2012, the daily rates charged for these clients ranged from $176 to $1,553, with a median of $305. In addition, the rates paid for SOS's residential chemical dependency treatment programs are based on a statewide rate structure that applies to both publicly and privately operated programs. This rate structure was developed by DHS's Alcohol and Drug Abuse Division, not by SOS. Chemical dependency treatment rates vary, depending on the intensity of the treatment provided and whether the facility is providing specialized services. In fiscal year 2013, the rates charged for SOS's chemical dependency clients varied from $141 to $206 per day.

Exhibit 1.8: Cost of Care per Patient-Day, Selected State-Operated Facilities, Fiscal Years 2010-2013

Some state-operated facilities cost more than $1,000 a day per patient.

	Cost per Day			
Facility or Program	FY 2010	FY 2011	FY 2012	FY 2013
Facilities Licensed as Hospitals				
Anoka-Metro Regional Treatment Center	$ 785	$ 982	$1,038	$1,020
Community behavioral health hospitals	1,411	1,121	1,162	1,153
Child and adolescent behavioral health	1,650	1,484	1,514	1,678
Minnesota Security Hospital				
Secure portion	543	518	561	553
Transition services (nonsecure)	446	425	416	419
Forensic nursing home	623	675	675	594
Competency restoration program	509	614	520	523
Intensive Residential Treatment Facilities				
Brainerd	NA	942	589	589
St. Paul	337	311	339	388
Wadena	NA	825	563	563
Willmar	NA	825	580	580

NOTES: Rates reflect the cost of services, treatment, facility maintenance, bonds issued for capital improvements, and depreciation of buildings and equipment, as well as indirect costs related to the operation of facilities. Costs were divided by the anticipated number of client days in that year to arrive at per diem rates. "NA" means not applicable; facility was not operating in that year.

SOURCE: Minnesota Department of Human Services.

The cost per day at SOS facilities is substantial and often more than at other facilities with similar licenses. These cost differences may reflect differences in the services provided by these facilities or the types of clients served; it is hard to know for sure. Nationally, the average cost per day of a patient's stay in a community hospital for mental health reasons in 2008 was $710; as shown in Exhibit 1.8, the cost per patient-day at an SOS community behavioral health hospital exceeded $1,100 in recent years.[55] Among Minnesota facilities licensed

[55] Elizabeth Stranges, Katharine Levit, Carol Stocks, and Pat Santora, *State Variation in Inpatient Hospitalizations for Mental Health and Substance Abuse Conditions, 2002-2008*, Healthcare Cost and Utilization Project Statistical Brief #117 (Rockville, MD: Agency for Healthcare Research and Quality, June 2011), 2.

as "intensive residential treatment services" for adults with mental illness, SOS's four facilities had higher rates in calendar year 2012 than the other 34 comparably licensed facilities that were not state-run.[56] The only nursing home operated by SOS had a daily cost per patient in fiscal year 2013 ($594) that was several times the average cost statewide for a nursing facility ($165 per patient in 2010).[57] Finally, it is worth noting that the Minnesota Sex Offender Program, which is run by DHS (but not by SOS) at secure facilities in Moose Lake and St. Peter, costs $326 per day per resident in fiscal year 2013,[58] compared with $553 for residents in the secure portion of the Minnesota Security Hospital.

STAFFING

A majority of DHS's employees work for State-Operated Services.

Although the policy divisions of DHS are perhaps the most prominent part of the agency's work, DHS actually employs more individuals in SOS than in all of its other programs combined. The vast majority of SOS employees are care providers that work directly with the populations served by various SOS facilities and programs. In addition, the large size of SOS requires many other employees—for example, data for 2012 showed that SOS employed more than 70 full-time employees in fields related to building, construction, and maintenance.

Because SOS employees are scattered around the state in various facilities, coordination among employees can be difficult. For example, dozens of small SOS adult foster care homes have fewer than 10 employees, many of whom work part time. If SOS administrators want to provide a particular training module to all foster care home staff, they must solve substantial logistical challenges.

In reviewing SOS employment records, we found that:

- **In October 2012, State-Operated Services employed 3,558 full-time and part-time employees, down from 3,841 in fiscal year 2008.**

Exhibit 1.9 shows the overall number of full- and part-time SOS employees since 2002. There was a sharp drop in the number of employees associated with the 2008 separation of the Minnesota Sex Offender Program from SOS. Since then, the number of full-time employees has declined further. Between October 2009 and October 2012, the number of full-time employees dropped by 16 percent, from 2,060 to 1,739.

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[56] To compare rates, we used the calendar year 2012 rates approved by DHS's Chemical and Mental Health Division. For state-run facilities, the daily rates per patient were $589 (Brainerd), $580 (Willmar), $563 (Wadena), and $388 (St. Paul). Among nonstate facilities in this license category, the median rate was $260.

[57] Nursing home rates vary by their "case mix" levels, which reflect differences in resident care needs and allowable facility costs. The SOS Forensic Nursing Home provides its services in a secure setting, which undoubtedly contributes to the facility's higher costs compared with nonsecure facilities.

[58] Minnesota Department of Human Services, *Bulletin: Minnesota Sex Offender Program Establishes Cost of Care Rate as of August 1, 2012* (St. Paul, July 31, 2012).

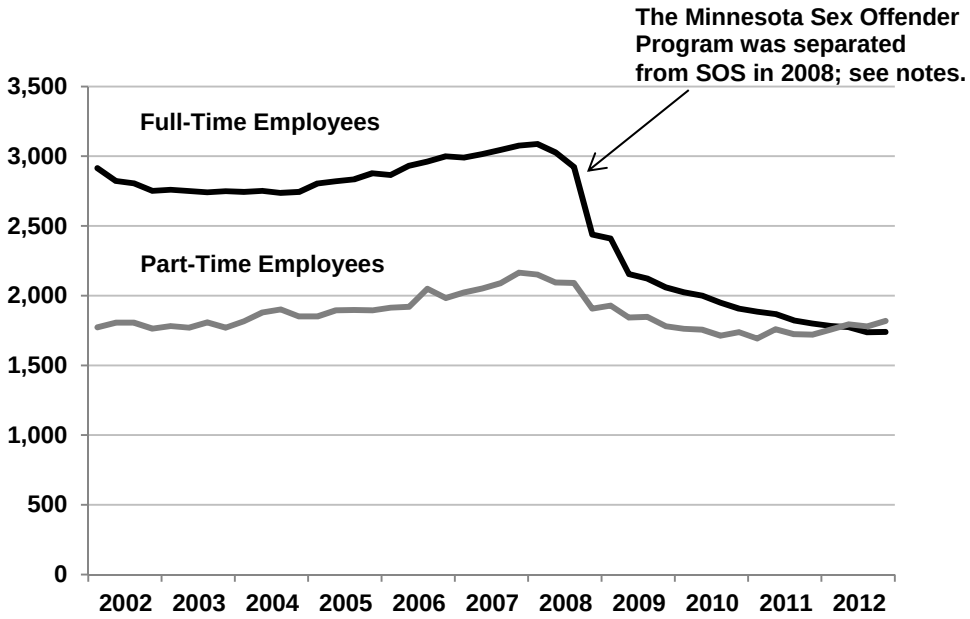
We also found that:

- **State-Operated Services relies heavily on part-time employees to provide care to the populations it serves.**

As shown in Exhibit 1.9, more than half of SOS employees are classified as part-time or intermittent employees. SOS has increased its use of part-time employees in the past two years; the number of SOS part-time employees rose 7 percent from January 2011 to October 2012 while the number of full-time employees continued to decline. Part-time employees are used throughout SOS, but some programs rely especially heavily on them. For example, Exhibit 1.10 shows that 76 percent of the employees in programs serving individuals with developmental disabilities worked part time; in contrast, 30 percent of Minnesota Security Hospital employees were employed in part-time positions.

Part-time employees now comprise a slight majority of the State-Operated Services workforce.

Exhibit 1.9: Number of State-Operated Services Employees, 2002-2012



NOTES: Part time includes workers classified as "intermittent." The Minnesota Sex Offender Program was part of State-Operated Services until 2008. Payroll data do not fully exclude all Sex Offender Program employees until July 2009.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services payroll data.

Exhibit 1.10: Percentage of Full-Time and Part-Time Employees in Selected State-Operated Services Facilities, 2012

	Full Time	Part Time
Minnesota Security Hospital	70%	30%
Minnesota Security Hospital		
Forensic Nursing Home		
Court-ordered psychiatric evaluations		
Other Facilities Serving Persons with Mental Illness	60	40
Anoka-Metro Regional Treatment Center		
Behavioral health hospitals		
Residential treatment		
Outpatient programs		
Facilities Serving Persons with Chemical Dependency	51	49
Chemical dependency treatment centers		
Outpatient programs		
Facilities Serving Persons with Developmental Disabilities	24	76
Adult foster care		
Intermediate care		
Residential services		
Day programs (nonresidential)		

NOTES: The categories above also include smaller programs that have far fewer employees than the major programs listed. For example, employees working with Community Support Services, a program assisting clinically complex individuals to build support networks and live in community settings, are classified together with Minnesota Security Hospital employees. Similarly, employees working in state-run dental clinics that serve patients with disabilities are classified in the category "Other facilities serving people with mental illness."

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services payroll data.

2 Governance, Leadership, and Performance Measurement

Facilities operated by Department of Human Services (DHS) employees serve a wide array of individuals in settings ranging from group homes to large institutions. It is important for DHS to ensure that its State-Operated Services (SOS) Division has clear, effective leadership and is accountable for results. This chapter examines broad issues related to management of this large, complex division of DHS.

GOVERNANCE

In 2000, the DHS Commissioner created a State-Operated Services "Governing Board."

State law gives the DHS Commissioner "the exclusive power of administration and management of…state hospitals for persons with developmental disabilities, mental illness, or chemical dependency."[1] It authorizes the commissioner to determine all matters related to developing these institutions and any other institutions that are "vested in the commissioner."[2] In addition, the law says: "The commissioner of human services may establish policies and procedures which govern the operation of the services and programs under the direct administrative authority of the commissioner."[3] However,

- **Past human services commissioners created and maintained a governance structure that muddled accountability and was contrary to state laws.**

Statutes do not specifically authorize other entities to govern State-Operated Services. In 2000, the DHS commissioner created a "governing board" for SOS. The board was created in accordance with *Minnesota Statutes* 1999, 15.014, subd. 2, which authorized state agency commissioners to create "advisory task forces" for a period of up to two years.[4] According to SOS Governing Board

[1] *Minnesota Statutes* 2012, 246.01.

[2] *Ibid.*

[3] *Minnesota Statutes* 2012, 246.014(d).

[4] The two-year expiration date applied to advisory task forces for which enabling legislation (if the task force was statutorily mandated) did not specify an expiration date.

bylaws, the commissioner appointed board members "from all geographic regions of the state" to "represent a variety of professional backgrounds."[5]

While many of the SOS Governing Board's stated duties were advisory in nature, others were not. For example, SOS policy stated that the board provided "an organized means to *direct* or review the programmatic or administrative operations" of SOS (emphasis added).[6] Also, SOS Governing Board bylaws said the board would "ratify" all appointments, credentials, and privileges for SOS medical staff.[7] In fact, SOS's bylaws for medical staff state that medical staff must accept and discharge responsibilities for the quality of patient care "as determined by the authority of the [SOS] Governing Board."[8]

The functions and authority assigned to the board created confusion and violated some state laws.

The relationship of the SOS Governing Board to top SOS administrative leaders was complex and sometimes unclear. The term "governing board" suggested that the board had authority to govern all or parts of SOS, even though state law granted no such authority to the board.[9] As originally created, the board was staffed by a DHS assistant commissioner and other SOS officials, who—according to board bylaws—were to "carry out the Board's directives."[10] Some current and former DHS officials told us the existence of the board weakened the accountability of SOS to top DHS leadership. In addition, we were told that SOS Governing Board members were confused about whether the board had real authority.

Policies regarding the SOS Governing Board violated state law in several ways. First, although the law limits advisory task forces to two years, the SOS Governing Board remained in continuous existence from 2000 to 2012, with no evidence that the commissioner recreated it every two years. In fact, since 2005, the length of board members' terms (three years) exceeded the statutory two-year limit on the duration of a task force. Second, as noted above, calling this advisory body a "governing board" indicated that it had authority that was not granted by law. Third, SOS's bylaws for the board said its members might be provided with "not-public data that is reasonably necessary to carry out its

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[5] These requirements regarding board composition were a part of various versions of the bylaws in effect from 2000 until 2012. Throughout this period, the bylaws required the board to have 12 to 15 members.

[6] State-Operated Services, Policy 2010, *Governing Board Bylaws*, effective December 1, 2009. This policy remained in effect until 2012.

[7] This provision was in effect in various versions of the board's bylaws from 2000 until 2012.

[8] State-Operated Services, Policy 2100, *Medical Staff Bylaws*, effective September 30, 2011, Preamble. According to Article XVI, these bylaws—which set forth extensive policies and procedures governing the actions of SOS medical staff—take effect if approved by two-thirds of the "full members" of the SOS medical staff and by the SOS Governing Board.

[9] State law contains brief references to the SOS Governing Board, although the law does not define the board or its composition. *Minnesota Statutes* 2012, 246.018, subd. 3, requires the SOS medical director to consult with the commissioner, community mental health center directors, and "the state-operated services governing body" when developing treatment standards. In addition, *Minnesota Statutes* 2012, 246.125, subd. 3, requires a 2010 task force to include one representative appointed by the chair of "the state-operated services governing board."

[10] State-Operated Services, *Governing Board Bylaws*, Article 7.1, effective May 2000.

work."[11] However, disclosing such data to this body was not explicitly authorized by state law.

The department disbanded the SOS Governing Board in early 2012, although SOS's policies relating to its operation remained in place until May 2012. In July 2012, the commissioner established a new SOS Governing Board and related policies. This board is "the primary decision-making body of SOS, exceeded only by the Commissioner's authority."[12]

DHS reconstituted the SOS Governing Board in 2012, but we think the board is unnecessary.

Unlike the previous governing board, which was comprised of citizen members appointed by the commissioner, the current board consists of five DHS administrators: the deputy commissioner, the medical director, the chief compliance officer, SOS's chief executive officer, and SOS's chief financial officer.[13] Thus, the authority of this board derives from DHS's existing administrative authority, not from the statute that authorizes advisory task forces. Still,

- **There does not seem to be a compelling reason for the Department of Human Services to retain a State-Operated Services "Governing Board."**

We asked DHS officials why it is necessary to have such a board, given that the board now consists entirely of DHS administrative officials. They told us that entities that accredit or regulate SOS facilities expect these facilities to be overseen by a board. However, our review of accreditation standards and federal regulations suggests a need for clear, accountable administrative authority, not necessarily a governing board. For example, the body that accredits SOS's hospitals defines "governance," for its purposes, as:

> The individual(s), group, or agency that has ultimate authority and responsibility for establishing policy; maintaining quality of care, treatment, or services; and providing for organization management and planning.[14]

Similarly, the federal government—which certifies hospitals to enable them to qualify for federal funds—has the following regulation:

> There must be an effective governing body legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for

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[11] State-Operated Services, Policy 2010, *Governing Board Bylaws*, Article 10.2, effective December 1, 2009. This policy remained in effect until 2012.

[12] State-Operated Services, Policy 2010, *Governing Board Team Charter*, effective July 27, 2012.

[13] Several SOS administrators were *ex officio* members of the previous SOS Governing Board and could cast votes. They included the SOS chief executive officer, the DHS assistant commissioner for chemical and mental health, the DHS chief operating officer, the DHS chief compliance officer, the SOS chief medical officer, and an elected representative of the SOS medical staff.

[14] The Joint Commission, *E-dition*, "Accreditation Process Info: Glossary," accessed January 16, 2013. (This document is not available at a publicly accessible Web site.)

> the conduct of the hospital must carry out the functions specified in [this regulation] that pertain to the governing body.[15]

For purposes of accreditation or federal certification, the provisions cited above allow responsible individuals or agencies—not just governing boards—to be held accountable for an institution's governance.

At a minimum, the term "governing board" invites confusion and should be dropped.

In addition, the board's name is still confusing. Though called a board, the SOS Governing Board was not statutorily created as a "board" as defined in *Minnesota Statutes* 2012, 15.012. Furthermore, calling this body a "governing board" sounds contrary to the statement in the board's charter (cited earlier) that the board's authority is exceeded by the commissioner's. Although the commissioner can delegate certain decision-making authority to others, there is no record on file with the Minnesota Secretary of State of a formal delegation of authority to the SOS Governing Board.[16]

RECOMMENDATION

The Commissioner of Human Services should eliminate the State-Operated Services Governing Board, relying instead on the commissioner's statutory governance authority and any appropriate delegations of that authority.

The current members of the SOS Governing Board—in their roles as high-level administrators within DHS and State-Operated Services—may choose to meet periodically to address SOS issues or solicit public input. This group may even wish to operate with a degree of formality—for example, making decisions based on votes of the members and posting a record of its actions at a public Web site. But, in our view, describing this group as a "governing board" invites confusion, given its lack of statutory or delegated authority.

DEPARTMENT ATTENTION TO STATE-OPERATED SERVICES

State-Operated Services is a single division of Minnesota's largest state agency, but it is larger than many individual state agencies. In addition, the provision of direct services to clients presents special challenges that require appropriate oversight from DHS's executive leadership. We found that:

- **Until recently, top Department of Human Services officials have not always given sufficient attention to State-Operated Services and its complex network of facilities.**

[15] 42 *CFR* 482.12 (2012).

[16] *Minnesota Statutes* 2012, 15.06, subd. 6(1), requires state agencies to file information with the Secretary of State regarding delegation of the commissioner's powers or duties to subordinate employees. The Office of the Secretary of State has no record of specific delegations to the State-Operated Services Governing Board.

Until recently, State-Operated Services sometimes received insufficient attention from DHS leaders.

The Department of Human Services is currently led by a commissioner, one deputy commissioner, and five assistant commissioners. For most recent years, SOS's chief executive officer reported to the assistant commissioner for chemical and mental health services. This assistant commissioner was responsible for statewide policy development in chemical and mental health services, as well as overseeing state-run services in these areas. Some people thought this dual oversight of policy and operations created potential conflicts of interest—for example, on occasions when the assistant commissioner approved provider payment rates that applied to state-run facilities. In addition, this assistant commissioner's responsibility for both policy and operations created a very broad span of control.

According to current and former SOS officials we interviewed, many top DHS executives have had limited understanding of SOS before assuming their positions or have lacked experience with the provision of direct services. One observed that commissioners and their top assistants have been primarily attracted to DHS leadership jobs by important policy challenges and less by the challenges of overseeing the direct operation of services. Frequent turnover among top DHS executives, such as assistant commissioners, has required SOS officials to provide ongoing education about SOS to new leaders. Some SOS officials expressed concern that past DHS leaders did not give sufficient attention to gaps in services that remained when regional treatment centers closed during the past decade. They also expressed concern about some changes initiated by past DHS managers that, in their view, did not fully consider impacts on state-run operations. For example, one SOS official told us that changes made by a DHS assistant commissioner regarding SOS medical staff reporting relationships were made "out of the blue" and caused significant confusion.

However,

- **In 2012, the Commissioner of Human Services elevated oversight of State-Operated Services, assigning this responsibility to a deputy commissioner who closely scrutinized SOS operations.**

This change placed SOS under the direct oversight of the second-highest official in DHS, one level above its previous level of oversight. Because the deputy commissioner supervises state-run services but does not directly oversee policy development in chemical and mental health, this change also reduced the potential for conflicts of interest. Furthermore, the current deputy gave significant attention to SOS issues during 2012. She made frequent visits to the Minnesota Security Hospital, which had been given a conditional license by DHS's Licensing Division in December 2011 and experienced a leadership change in March 2012. Security Hospital leaders expressed appreciation for this support and attention. The deputy commissioner also raised questions in 2012 about DHS's role as a direct provider of human services and worked with other parts of DHS on SOS-related issues.

While DHS leaders have provided active oversight of SOS in recent months, SOS still competes with many other issues for the time of the deputy commissioner (and the commissioner). It will remain an ongoing challenge for DHS's top leaders to devote the attention required by a system of direct care

facilities. Organizational changes—for example, devoting a DHS deputy commissioner position solely to the oversight of state-run services, or even making State-Operated Services an agency separate from DHS—might simplify oversight and accountability. But such organizational changes are not a panacea; proper oversight and direction for SOS will depend on what leaders do, not on what titles they hold. We offer no recommendations for structural changes.

LEADERSHIP TURNOVER

The Commissioner of Human Services is ultimately accountable for staffing within DHS and sometimes has participated directly in the selection of top SOS officials. However, much work leading up to recruitment and retention decisions for high-level SOS positions is performed by other top DHS officials and executives within the State-Operated Services Division. We found that:

- **State-Operated Services has had instability in several key leadership positions in recent years.**

Exhibit 2.1 shows SOS's high-level administrative officials and their reporting relationships. Several of these positions have undergone changes—sometimes more than once—in the past 18 months.

Two top State-Operated Services leaders were hired but then replaced a short while later.

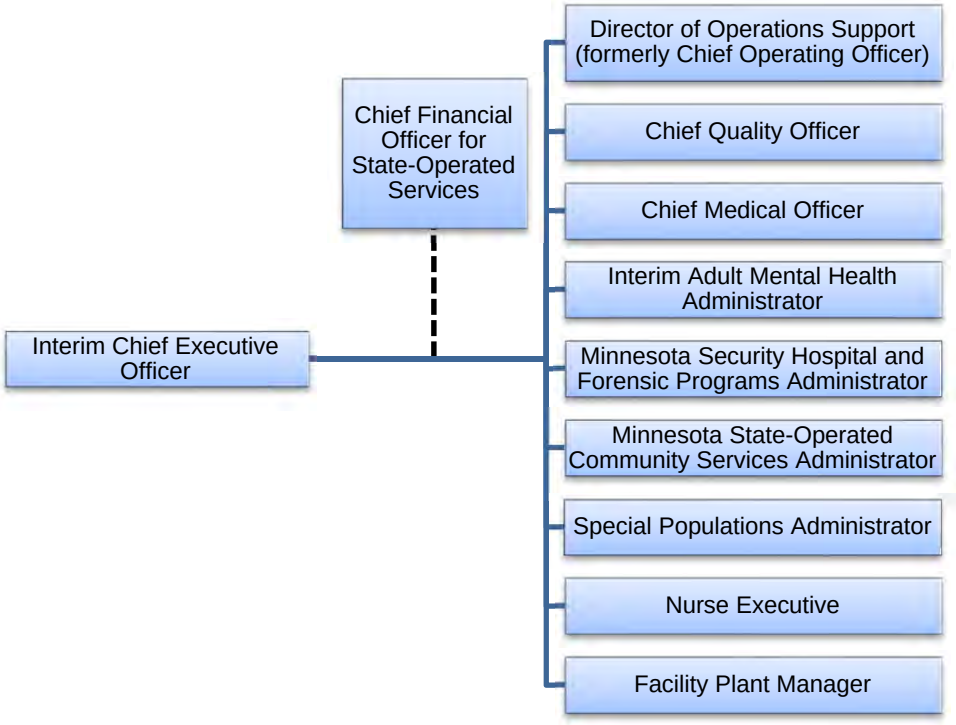
In two cases, key leaders were hired but then replaced a short while later. One of these instances involved SOS's chief operating officer position, which was unsettled during most of 2012. This position oversaw administrative and support functions throughout SOS. With the incumbent chief operating officer scheduled to retire in June 2012, SOS hired a new chief operating officer in January 2012. The six-month overlap in the tenures of the previous and new chief operating officers was intended to allow for a smooth transition. However, the new chief operating officer found a lack of clear responsibilities and direction during the transition period, and SOS leaders reassigned him to a different position before he could take sole possession of the position for which he had been hired. State-Operated Services subsequently retitled and reclassified the chief operating officer position.[17]

Another instance of a hiring decision that was subsequently reconsidered involved the top administrative position at the Minnesota Security Hospital, which is SOS's largest facility. The administrator hired for this position in August 2011 was replaced in March 2012 after a turbulent tenure. The process leading up to the 2011 hiring decision was protracted and deliberate. However, due to miscommunication or misunderstanding at the end of this process, department officials hired the Security Hospital administrator without first consulting with any of his prior supervisors.[18] It is unclear whether discussions with supervisory references would have changed the hiring decision, but DHS leaders decided several months later that the administrator they had hired was the wrong person for the job.

[17] The position is now titled "Director of Operations Support," and it was filled in November 2012.

[18] Department officials obtained information from several of this applicant's references, but not from the applicant's prior supervisors.

Exhibit 2.1: State-Operated Services Executive Staff and Key Reporting Relationships, January 2013



NOTES: The exhibit shows executive-level positions with direct reporting relationships to the State-Operated Services CEO. The chief financial officer and chief medical officer also report to non-SOS officials within DHS. The "Special Populations Administrator" oversees several specialized SOS programs, such as chemical dependency services, community-based residential treatment facilities for individuals with mental illness, and a behavioral health hospital for children and adolescents.

SOURCE: Minnesota Department of Human Services.

State-Operated Services' highest ranking position has been filled by an interim administrator since late 2011.

In addition, some key positions shown in Exhibit 2.1 have been filled on an interim basis in recent months. The current SOS chief executive officer has held that position on an interim basis since November 2011. She came out of retirement to accept the top SOS administrative position, expecting to remain in the job for at least a year. From our observations, she has approached the job with seriousness and vigor. Still, we question why such a high-level position has had interim status for such a long period.

Also, SOS's director of adult mental health (who was simultaneously serving as the head of the Anoka-Metro Regional Treatment Center) was appointed in late 2012 to a high-level DHS position outside of the State-Operated Services Division. Thus, going into 2013, an interim director of adult mental health headed SOS's oversight of its mental health hospitals.

One other position that has had an unsettled history is the SOS chief quality officer. State-Operated Services filled this position in mid-2012, but the position

The chief quality officer position was vacant for nearly five years.

had been vacant for nearly five years. According to the job description for this position,

> The [chief quality officer] is responsible for development and implementation of strategies to effectively support this healthcare network in its goal of providing quality services to the people we serve. The [officer] oversees the critical areas of risk management and compliance in SOS and communicates with the DHS Chief Compliance Officer on issues of broad impact.[19]

The responsibilities of this position were mostly handled during the past five years by SOS's chief operating officer. The person who held that position expressed concern to us and SOS leaders about her ability to adequately absorb these duties. She told us the position was not filled by SOS leadership due to budget constraints, but she thought the impact of not filling the position adversely affected patient care. She also told SOS leadership that it lacked adequate management reports on SOS operations, due to lack of resources for the office that the chief quality officer was supposed to oversee.

State-Operated Services leaders expressed concern to us that further turnover is likely in coming months and years, as a number of top SOS executives near eligibility for retirement. In addition, DHS and SOS officials said it has been difficult to recruit highly qualified candidates for top SOS management positions, partly due to salary limitations for state government positions.

PERFORMANCE MEASUREMENT

We examined the extent to which SOS collects and reports information on its performance. Such information can help policy makers evaluate whether services they have funded are delivering value for the money, and it can help the managers of these services make adjustments where needed.

We began by looking at information reported to the Legislature through the biennial budget process. Since the mid-1970s, Minnesota state agencies have been encouraged by the state's executive branch budget agency to present information on performance in their biennial budget proposals. Given the size of the state's expenditures for state-operated services, it seems reasonable to expect budget proposals to provide information on the effectiveness or efficiency of these services. We found that:

- **The Department of Human Services' biennial budgets have provided the Legislature with little concrete information on the performance of state-operated services.**

We examined DHS's presentation of SOS performance information in the six most recent biennial budgets, covering budgets submitted from 2001 through 2011. In biennial budgets we reviewed, DHS suggested 18 performance

[19] Department of Human Services, *Position Description, SOS Chief Quality Officer*, "Position Purpose," effective April 30, 2012.

DHS has provided little meaningful information on the performance of state-run services to the Legislature and public.

measures for SOS, but the budgets presented actual data for only 2 of them. For example, five biennial budgets identified length-of-stay in SOS facilities as an important performance measure, but only one budget included any data on average length-of-stay.[20] In three consecutive biennial budgets, DHS suggested measuring the percentage of Minnesota Security Hospital patients who both qualify for community-based treatment and supervision and are receiving it. DHS repeatedly said these services and the performance measure were under development but subsequently never presented any data on the indicator. In addition, DHS three times suggested measuring SOS hospital readmissions as a performance measure, but the budgets never provided data on this measure. Given the importance of SOS programs and the size of their budgets, the lack of meaningful performance information is unacceptable.

Another opportunity DHS has had to present information on SOS performance is the Web sites it has developed for the benefit of the general public and its own employees. We found:

- **The Department of Human Services' public and internal Web sites have provided only limited data for evaluating the performance of state-operated services.**

The department's "dashboard" of performance information on its public Web site presents information that citizens can use to "know what they're getting from the programs they pay for."[21] The department manages a wide range of human services programs, so it is a challenge to succinctly convey information about program performance on a public Web site. Of the 20 measures at this site, only one is specifically related to the performance of SOS programs. That measure—the average number of nonacute bed-days per patient that adults with mental illness spend in state hospitals for inpatient psychiatric care—is an important one. It is worth noting, however, that this measure relates to only one type of SOS facility (acute care hospitals), and the Web site's explanation of the measure's meaning is minimal. For example, the Web site does not explain what a "nonacute" bed-day is. In addition, the site says that nonacute bed-days increase costs to the state, but it does not explain why.

The department's internal Web site—available for use only by its own employees—has a wider range of performance measures than the agency's public Web site. The department created this site "so every DHS employee can see how successful we are in meeting our mission and vision."[22] Unlike the public site, the internal Web site has a separate SOS section. The SOS page has information on ten measures, as listed in Exhibit 2.2.

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[20] In the fiscal year 2008-2009 budget, DHS said the average length-of-stay in acute care or intensive residential settings was 20.5 days in 2005. However, providing a single year of information on a measure that combined length-of-stay data for two significantly different types of care (acute care and intensive residential treatment) was not very helpful.

[21] Department of Human Services, "Dashboard Home Page," http://dashboard.dhs.state.mn.us/default.aspx, accessed November 9, 2012.

[22] DHS, "Internal Dashboard Home Page," accessed November 9, 2012. This site is not available to the general public.

DHS's online "dashboard" offers little insight into the overall effectiveness or efficiency of the department's direct services.

Exhibit 2.2: State-Operated Services Performance Indicators on the Department of Human Services' Internal "Dashboard," 2012

- Percentage of persons receiving services from SOS who have been screened for body mass index
- Percentage of persons served by SOS intensive residential treatment facilities who have been screened for hypertension
- Employee injury rates, as measured using days away from the job, on restricted duty, or transferred to other jobs
- Workers compensation cases filed
- Percentage of clients admitted to chemical dependency treatment who complete it
- Percentage of eligible patients at the Minnesota Security Hospital who are engaged in therapeutic work activities
- Average annual earnings by clients in day treatment and habilitation programs
- Percentage of bed-days by patients at acute care hospitals that are for nonacute care
- Percentage of patients hospitalized for mental health issues who, at the time of discharge, have a follow-up appointment scheduled for some time in the following 30 days
- Average number of psychotropic medications prescribed at discharge to patients at the SOS child and adolescent behavioral health hospital

SOURCE: Minnesota Department of Human Services, "Internal Dashboard Home Page," accessed November 9, 2012. This Web site is not available to the general public.

The measures in Exhibit 2.2 are potentially valuable, but they provide limited insight into the overall effectiveness or efficiency of SOS programs. For example, a primary goal of SOS is to improve the mental health of patients at its psychiatric hospitals, yet Exhibit 2.2 includes no measures for this. Measures that indicate the extent to which clients have been screened for physical problems, such as body mass and hypertension, cannot substitute for measures of clients' mental well-being, readmissions to treatment, or satisfaction with services. Two measures of *employee* injuries shown in Exhibit 2.2 are useful ones to track, but SOS's internal dashboard shows no measures of adverse *patient* events—such as patient injuries or deaths, or the extent to which patients have been placed in seclusion or restraint. The measure of how many eligible Minnesota Security Hospital patients participate in work activities has some value, but we do not view it as the most important measure of that facility's performance. Finally, the explanation of these measures at this site is also inadequate. For example, the site uses a number of undefined acronyms (such as "MSHS") and provides minimal descriptions of several measures.

Aside from information posted at these public and internal Web sites, individual SOS programs have been developing a wider array of program-specific performance information. This information is not posted publicly, but it is used for management purposes. For example, there has been almost no performance information on the Minnesota Security Hospital in past DHS budgets or on DHS's public and internal Web sites, but the facility has developed its own "dashboard" of measures. Its indicators range from compliance with fire drills and kitchenette cleaning schedules to hours of patient seclusion and restraint.

The adequacy of these program-specific dashboards is uneven across SOS. Some parts of SOS—notably adult mental health services—started developing dashboards several years ago, while other parts started quite recently. But, like the broader SOS dashboards discussed earlier, the program-specific dashboards developed so far lack sufficient information on SOS's ultimate goals—such as reductions in clients' mental health symptoms, minimizing clients' instances of relapse following discharge, and ensuring client safety in SOS treatment and residential settings.[23]

State-Operated Services needs to be more accountable.

RECOMMENDATION

State-Operated Services should develop performance measures, strategic plans with measurable objectives, and performance-oriented action plans that relate directly to the organization's most fundamental goals.

State-Operated Services needs to be more accountable. One way to achieve this is by continuing to develop better measures of performance. A 2003 publication by the U.S. Department of Health and Human Services discusses the results of a federal initiative to develop information on a uniform set of mental health performance measures.[24] Although this report is now ten years old, it would be a useful resource as SOS strives to implement appropriate measures of service quality and outcomes.

In addition, SOS should develop strategic plans with measurable performance objectives. State-Operated Services' most recent strategic plan—developed in 2011—has a series of broad goals, but it lacks specific performance targets.[25] One of that plan's goals is to "establish metrics to evaluate person-centered outcomes and satisfaction"—a reasonable goal, but one that a large human services organization arguably should have established and implemented years ago.[26]

In mid-2012, SOS hired a chief quality officer, filling a long-vacant position. A key responsibility of this official is to "direct activities to monitor, audit, analyze, and report program performance against established standards."[27] Hiring this individual was an important step for SOS, but SOS will achieve accountability only when it develops performance-oriented plans, sets specific and comprehensive targets for performance, and communicates its actual performance clearly to policy makers, the public, and employees.

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[23] For some facilities, such as community behavioral health hospitals, SOS has tracked the extent of new patient hospitalizations following discharge. However, the measures were for short follow-up periods (within 30 to 90 days of discharge) and focused only on readmissions to state-run hospitals.

[24] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Sixteen State Study on Mental Health Performance Measures* (Rockville, MD, 2003).

[25] State-Operated Services, *Strategic Plan: Goals and Objectives, 2011* (St. Paul, undated).

[26] *Ibid.*, 1.

[27] Department of Human Services, *Position Description, SOS Chief Quality Officer*, "Position Purpose," effective April 30, 2012.

POLICIES

We also looked at the overall extent to which SOS policies have been kept up-to-date. According to SOS policy, all of the organization's policies and procedures should be reviewed at least every two years.[28] We found that:

- **Some State-Operated Services policies are out of date, and some SOS officials have been frustrated by the inability to get clear policy direction in a timely manner.**

We examined all SOS policies and procedures as of mid-2012 and determined that about 19 percent had not been reviewed within the previous two years, contrary to SOS policy. For example, an SOS-wide policy specifying medical records that must be kept by residential facilities has not been revised since 2001.[29] In addition, we determined that 71 percent of policies and procedures for one SOS program—Minnesota State-Operated Community Services—had not been reviewed in at least two years.

Some State-Operated Services policies have not been updated in a timely way.

The absence of up-to-date policies has sometimes frustrated staff and may have contributed to elevated levels of risk within SOS. Minnesota Security Hospital staff provided us with documents regarding that facility's past requests for various SOS policy changes and legal guidance. Some of the requests were made repeatedly in past years without timely resolution, according to Security Hospital staff.[30]

When SOS developed a new online system in 2012 for staff to report "incidents" (discussed in Chapter 3), SOS should have had policies in place that reflected the new procedures rather than old ones. The SOS incident reporting policy was due to be updated in September 2012, right before the new incident reporting system took effect in October 2012. However, as of early 2013, SOS still did not have an updated incident reporting policy posted on its internal Web site.

In some cases, it has taken a long time to develop initial policies on certain topics. For example, there is no SOS-wide policy that addresses methods for transporting clients.[31] One SOS official told us the lack of timely action to develop this policy reflected "decision paralysis" among SOS leadership. In the meantime, there have been various transportation-related incidents that placed the safety of staff or patients at risk.

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[28] State-Operated Services, Policy 2000, *Policy and Procedure Development and Implementation*, effective December 21, 2011.

[29] State-Operated Services, Policy 6160, *Medical Records*, effective September 7, 2001.

[30] Staff said delays in implementing policies significantly affected the facility's ability to manage certain risks or operate its programs. For example, they said it took years to update policies regarding SOS's obligation to warn victims who requested notification of the release of certain clients and policies for warning individuals who were the subject of client threats.

[31] Some individual SOS programs have developed their own transportation-related procedures. Also, SOS leadership is scheduled to consider a draft of a proposed SOS-wide policy in early 2013.

RECOMMENDATION

State-Operated Services managers should ensure that the organization's policies and procedures are updated or developed in a timely manner.

State-Operated Services has a Policy Oversight Committee, comprised of staff from throughout the organization and appointed to the committee by top SOS leaders. This committee examines existing policies, identifies ones due for review, and helps oversee the development of new policies as needed. Typically, however, this committee relies considerably on staff of SOS programs to draft updates of existing policies. The chair of this committee told us this process usually works well but acknowledged that some policies have gotten bogged down. We suggest that SOS executives play a more active role in ensuring progress on policy development, especially for policies with large-scale implications.

3 Service Development, Delivery, and Management

The previous chapter examined broad issues related to State-Operated Services' (SOS) management, focusing on governance, leadership, and accountability. But, when managing a direct services organization like State-Operated Services, it is also important for the Department of Human Services (DHS) and SOS administrators to address ongoing issues that are more directly related to day-to-day service delivery. This chapter focuses on issues that relate to client services and facility operations.

APPROPRIATENESS OF PATIENT HOSPITALIZATIONS

"Acute care" in a hospital setting has traditionally referred to short-term inpatient services (usually 30 or fewer days) and emergency care.[1] The Department of Human Services operates eight "acute care" psychiatric hospitals for adults: the Anoka-Metro Regional Treatment Center and seven community behavioral health hospitals. We found that:

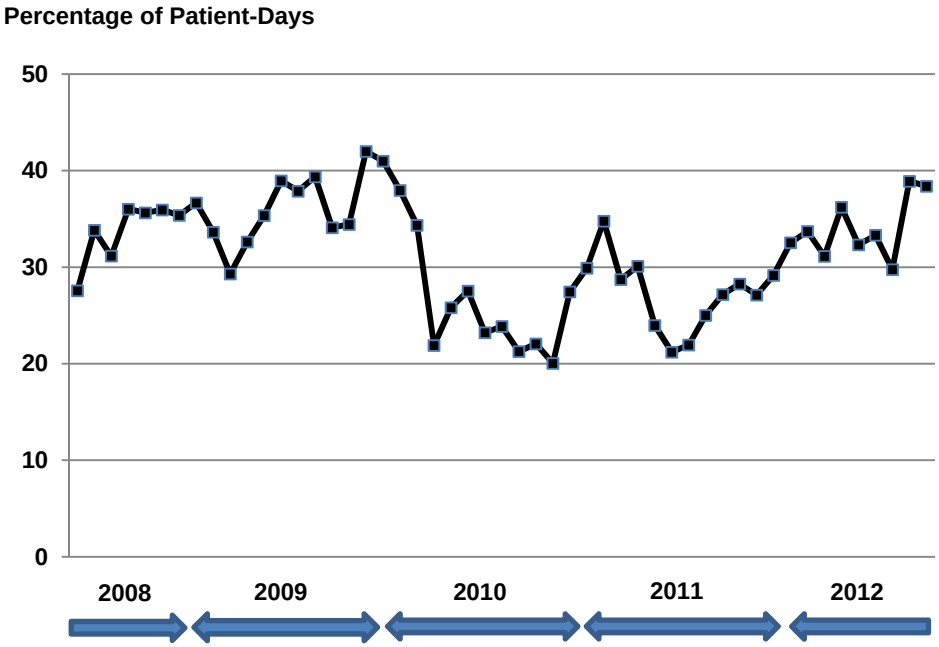
- **Patients in State-Operated Services' acute care hospitals have frequently stayed longer than necessary, resulting in significant fiscal and patient care implications.**

We examined data from July 2008 to September 2012 for SOS acute care hospitals. During this period, 25 percent of all patient-days in SOS acute care hospitals were for patients who did not need acute care. The percentage was even higher at Anoka-Metro Regional Treatment Center, as shown in Exhibit 3.1. In some months, around 40 percent of Anoka's patient-days were used by patients not requiring acute care, and Anoka's percentage consistently exceeded 20 percent during this period. Over the time period we examined, the Anoka facility accounted for 75 percent of SOS's acute care patient-days by patients who did not need this level of care.

Providing acute care for patients who do not need it has several important implications. First, from a legal perspective, it is inappropriate for a patient to remain in a hospital longer than necessary. We address this issue more in the

[1] This definition is from President's New Freedom Commission on Mental Health, *Subcommittee on Acute Care: Background Paper* (Rockville, MD, 2004), 1.

Exhibit 3.1: Anoka-Metro Regional Treatment Center Nonacute Patient-Days as a Percentage of All Patient-Days, July 2008 through September 2012



SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

A significant share of the Anoka-Metro Regional Treatment Center's beds have been filled by patients who no longer needed hospital care.

next section, where we discuss DHS's response to the U.S. Supreme Court's 1999 *Olmstead v. L.C.* decision. In short, however, states have an obligation to provide care for individuals with disabilities in the most "integrated" setting appropriate to their needs.[2]

Second, when patients remain in hospital care longer than necessary, hospital beds are unavailable to individuals who really do need hospital-level care. Later in this chapter, we note that many individuals have been placed on lengthy waiting lists for the Anoka-Metro Regional Treatment Center because beds at the facility were not available.

Third, providing hospital care for patients who no longer need it has adverse fiscal implications for the state. The federal Medicaid and Medicare programs (as well as private insurers) will not pay for acute care once hospital patients are deemed to no longer need this level of care.[3] In such cases, hospital beds are

[2] Olmstead v. L.C., 527 U.S. 581 (1999) and 28 *CFR* 35.130(d).

[3] As described later in this chapter, federal regulations classify the Anoka facility as an "institution for mental diseases." As such, it does not qualify for Medicaid payments for individuals between ages 22 and 64. If the Anoka facility keeps patients longer than necessary, it becomes ineligible for (1) Medicaid payments for individuals under age 22 or older than 64; and (2) Medicare payments. In addition, community behavioral health hospitals are typically eligible for Medicaid and Medicare payments, but they lose eligibility for patients that stay too long.

occupied by individuals for whom DHS cannot collect reimbursements on behalf of the state's General Fund while individuals needing hospitalization (and who qualify for federal reimbursements) may wait for care.

Fourth, treating patients longer than necessary has important financial implications for the patients. Because insurers will not pay for this care, SOS bills the patient—and only the patient—for this care. At a cost per day of more than $1,000, debts can accumulate quickly. In certain situations, state law authorizes the Commissioner of Human Services to waive patient (or relative) payments, based on ability to pay.[4] However, debts that are not waived show up on patients' credit reports, and the state is authorized to pursue recoveries from estates after the individuals die.[5] State-Operated Services' chief financial officer told us this is a significant concern among patients.

Hospitalizing patients longer than necessary can result in costs being shifted to patients and the state.

There may be various reasons why patients who no longer need hospital care remain in SOS hospitals. Some people suggested to us that more "step-down" options in the community—such as residential treatment programs or foster homes—are needed for individuals ready to leave hospitals. Some people also suggested that there should be better discharge planning by SOS hospitals and the patients' home counties. Also, patients sometimes lose their housing or community services when they remain hospitalized for a long time, which makes it harder to arrange for discharge.

RECOMMENDATION

The Department of Human Services should evaluate the impact of previous efforts to improve placement options for individuals ready for discharge from the Anoka-Metro Regional Treatment Center and other state-run facilities. It should develop or foster additional placement options as needed.

The 2011 Legislature appropriated $1.5 million to DHS for fiscal years 2012 and 2013 "for housing and other supports for persons with mental illness and other complex conditions."[6] The department entered into an interagency agreement with the Minnesota Housing Finance Agency for a grant program to expand discharge options at Anoka-Metro Regional Treatment Center. Grants awarded in 2012 are now providing funding to 77 households around the state, primarily in the form of rent subsidies. The department should evaluate what impact these grants are having on discharges at the Anoka facility. For the Anoka facility and other state-run facilities, DHS should consider the need for continued or

[4] *Minnesota Statutes* 2012, 246.51, subd. 1a, authorizes waiver of the payments that exceed the responsible party's ability to pay for care in community behavioral health hospitals, but not at the Anoka-Metro Regional Treatment Center.

[5] *Minnesota Statutes* 2012, 246.53.

[6] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 10, sec. 3, subd. 5. The Legislature also specified that, for the fiscal year 2014-2015 biennium, "base level funding for this activity is $1,000,000 each year from the general fund."

expanded rent subsidies, as well as alternative strategies (such as development of adult foster homes or community-based treatment programs).

Another option that has been discussed as a way to encourage timely discharge of patients at Anoka and other state-run facilities is to increase the county share of patient costs. When an individual is placed at Anoka, the home county pays no cost for the first 30 days of treatment, 20 percent of the cost for days 31 to 60, and 50 percent for days over 60.[7] Some SOS officials suggested that requiring counties to pay more of the costs for patients who no longer need acute care might increase counties' efforts to help find appropriate placements. We did not examine case records related to the discharge of individual patients, and we do not have direct evidence that counties have been unresponsive to DHS's requests for assistance. Thus, we offer no recommendation on this suggestion. However, the extent to which the state and counties share the costs at Anoka and other state facilities is an important policy choice that merits legislative attention.

According to the U.S. Supreme Court, keeping disabled people involuntarily in institutions when they do not require that level of care is unconstitutional discrimination.

COMPLIANCE WITH *OLMSTEAD* REQUIREMENTS

In a 1999 ruling (*Olmstead v. L.C.*), the U.S. Supreme Court said that undue institutionalization of individuals with disabilities—including mental illnesses or developmental disabilities—constitutes discrimination. In that case, the court referenced regulations for implementing the Americans with Disabilities Act that require public agencies to reasonably accommodate individuals with disabilities to live in the "most integrated setting" appropriate to the individuals' needs.[8]

The ruling suggested—but did not require—that states demonstrate compliance with the Americans with Disabilities Act by implementing plans for increasing the integration of people with mental impairments into community settings.[9] The federal government initially encouraged states to establish planning processes for implementing the *Olmstead* decision but allowed states to determine the form of their plans. As of late 2012, 26 states had developed "*Olmstead* plans."[10] A recent Minnesota report said that it would be difficult for a state to demonstrate compliance with the *Olmstead* ruling without preparing a plan.[11] However,

[7] *Minnesota Statutes* 2012, 246.54. The county share may be smaller, depending on amounts billed to insurance or the client. The increase to 50 percent is imposed when the facility determines that it is clinically appropriate for the client to be discharged.

[8] Olmstead v. L.C., 527 U.S. 581 (1999), 592 and 602.

[9] The court ruling said: "If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the [federal regulation requiring public agencies to make 'reasonable modifications' to avoid discrimination based on disability] would be met" (p. 584).

[10] Terence Ng, Alice Wong, and Charlene Harrington, Olmstead Plans and Related State Activity (Center for Personal Assistance Services, December 2012), http://www.pascenter.org/olmstead/olmsteadplans.php, accessed January 4, 2013.

[11] Minnesota Olmstead Planning Committee, *The Promise of* Olmstead*: Recommendations of the* Olmstead *Planning Committee* (St. Paul, October 23, 2012), 7.

- **It has taken a long time for the Department of Human Services to develop comprehensive steps for complying with the 1999 *Olmstead* ruling, although a plan is now due in mid-2013.**

In 2011, DHS entered into an agreement to settle a lawsuit related to restraint and seclusion practices at the state-operated Minnesota Extended Treatment Options facility (discussed later in this chapter). As part of that agreement, DHS agreed to develop a comprehensive *Olmstead* plan by June 2013 that sets measurable goals for increasing the number of people with disabilities receiving services.

Addressing improper placements in state facilities will require improvements in the availability of community-based services.

An *Olmstead* plan has implications for a variety of services. For example, recent federal guidance said:

> [An *Olmstead* plan] should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs.[12]

In our view, there are special challenges for ensuring compliance with *Olmstead* by state-run services. Legislators, client advocates, and DHS have had longstanding concerns about the timeliness of client discharges from the state-operated Minnesota Security Hospital, Anoka-Metro Regional Treatment Center, and community behavioral health hospitals, as we discuss later in this and other chapters. For example, one client advocate expressed concern to us that individuals with mental illness who are not placed in less restrictive settings when they are ready for such placements may experience deterioration in their mental health. Inadequate planning to ensure appropriate discharges from SOS facilities may have placed the state at legal risk, and DHS should have addressed these problems before it was required to do so by a settlement agreement.

Resolving inappropriate placements in state-run facilities will require improvements in the availability of community-based services, and we offer recommendations elsewhere in this report. Until Minnesota's *Olmstead* plan is completed in mid-2013, it may be unclear whether DHS can make these changes on its own or whether legislative action or funding will be required. Recent federal guidance said:

> Any [*Olmstead*] plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in *Olmstead*, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.[13]

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[12] U.S. Department of Justice, *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and* Olmstead v. L.C. (Washington, DC, June 22, 2011), 7.

[13] *Ibid.*

ANOKA-METRO REGIONAL TREATMENT CENTER

The Anoka-Metro Regional Treatment Center (hereafter called "Anoka") provides mental health treatment to court-committed individuals from throughout the state. There have been questions about what role this facility—the state's last remaining regional treatment center—should continue to play. These questions arise partly from several significant management challenges. First,

- **The Anoka-Metro Regional Treatment Center has a long waiting list for admission.**

On average, individuals are not admitted to the Anoka-Metro Regional Treatment Center until nearly three weeks after referral.

We examined data on individuals referred to SOS's centralized preadmissions center between December 2008 and June 2012.[14] During this time, it took an average of 19.4 days from the date a client was referred to the preadmissions center until he or she was admitted to Anoka. The majority of referrals to Anoka during this time were "deferred," meaning that the referred client was eventually placed somewhere other than Anoka; deferred clients were on the Anoka waiting list for an average of about 22 days.[15] About three-fourths of the nearly 4,400 individuals referred to Anoka during this time period were, at the time of the referral, in a hospital with a behavioral health unit. In these cases, staff at the referring hospital presumably felt unable to adequately serve the patient, yet the patient typically remained in that hospital's care for nearly another three weeks prior to admission at Anoka or removal from the Anoka waiting list.

Many county human services directors and private hospital officials expressed concerns about Anoka's waiting lists in surveys we conducted. For instance, on the county survey, 67 percent of respondents disagreed with the following statement: "Individuals who need immediate care at Anoka-Metro RTC receive it without waiting." Comments from county human services staff and private hospital officials included the following:

> [Anoka] does a good job with the clients they serve. However, the waiting list is unacceptable. When there are behavioral clients under commitment, they need a placement NOW, not weeks later.
>
> Private hospitals are forced to care for challenging patients for very long periods of time...due to [Anoka's] extensive waiting list…. Private hospitals are for acute crisis with the goal to stabilize and discharge to ongoing treatment. This mismatch

[14] State-operated facilities used to individually receive client referrals and make their own admissions decisions. Since 2006, SOS has had a centralized preadmissions unit that receives referrals around the clock, collects necessary information from physicians, nurses, case managers, and others, identifies which SOS facilities may have openings, and provides relevant information to SOS physicians so they can make admission determinations. The preadmission unit primarily works with SOS's mental health facilities; it plays no role, for example, in admissions to adult foster care facilities for the developmentally disabled.

[15] During the time that deferred clients were on the waiting list, they may have remained in the referring facility or been admitted to another facility.

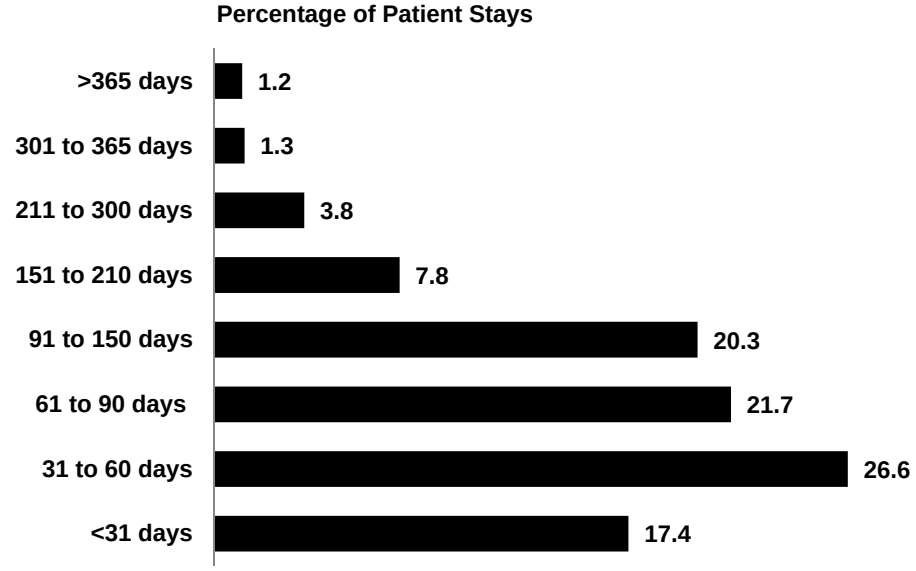
> creates a huge burden for private hospitals who do not have the programs and staff needed to serve a long-term population, resulting in suboptimal care for [seriously and persistently mentally ill] patients. In addition, our acute beds are overtaxed and patients seeking care in our [emergency department] are often transferred to other facilities outside their community….
>
> [Our hospital] ends up keeping patients way past what we should because the waiting list is so long for [Anoka]. We do not have the resources—we end up turning away acute patients because patients waiting for [Anoka] are here so long.

A second management challenge, as shown in Exhibit 3.2, is:

- **Many patients have long stays at Anoka-Metro Regional Treatment Center.**

Among patients served from January 2007 through July 2012, the median length of a patient stay was 67 days. As we discussed earlier in this chapter, many patients remained at Anoka well past the time when staff determined the patients no longer needed hospital-level care.

Exhibit 3.2: Lengths of Patient Stays at Anoka-Metro Regional Treatment Center, January 2007 through June 2012



NOTES: We excluded patients still at the Anoka facility June 30, 2012. We also excluded patients assigned to (1) the Competency Restoration Program at Anoka and (2) a transitional program in St. Paul that was formerly associated with the Anoka facility. We included patients assigned to the Cronin Program, a transitional program on the Anoka-Metro Regional Treatment Center campus.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

Third,

- **Because of its large size, the Anoka-Metro Regional Treatment Center qualifies for only limited federal health care funding.**

Anoka is classified under federal regulations as an "institution for mental diseases." This is defined as a hospital, nursing facility, or other institution of more than 16 beds that provides diagnoses, treatment, or care of persons with mental diseases.[16] Because of this classification, Anoka cannot bill the federal Medicaid program for patients of ages 22 to 64. This has an adverse impact on the State of Minnesota because the state's General Fund does not receive the federal payments for Anoka that it receives for smaller state-run hospitals that are not classified as institutions for mental diseases. When the state closed regional treatment centers in outstate Minnesota, it created 16-bed state-run community behavioral health hospitals so that patients would qualify for Medicaid funding. This has not occurred in the Twin Cities metropolitan area.

The 2009 Legislature required DHS to prepare a plan to "transform" the Anoka facility, but DHS offered little helpful advice.

Recognizing these problems, the 2009 Legislature required DHS to "develop an array of community-based services to transform the current services now provided to patients at the Anoka-Metro Regional Treatment Center."[17] The Legislature directed DHS to complete its planning for this transformation by October 1, 2009. However,

- **The Department of Human Services' plans for retooling the Anoka-Metro Regional Treatment Center were not completed by the Legislature's 2009 deadline, and the department eventually postponed the plans indefinitely.**

After the October 1, 2009, legislative deadline to complete planning on Anoka had passed, SOS held a series of meetings with counties and other stakeholders. One topic discussed was the future of the Anoka-Metro Regional Treatment Center. But these meetings—and the resulting recommendations from SOS—addressed a broad array of SOS issues, not just the Anoka facility. When SOS finally issued a report to the Legislature in March 2010, it suggested a variety of possible changes to chemical and mental health services throughout the state.[18] The report made a single recommendation for Anoka, suggesting that SOS replace one treatment unit at Anoka with a new, small psychiatric nursing facility in St. Peter, and that the remaining Anoka units "be operated in partnership" with existing behavioral health units in Twin Cities hospitals.[19] The report provided no rationale for this proposal, nor did it suggest necessary steps to accomplish this change.

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[16] 42 *U.S. Code, sec.* 1396d(i); 42 *CFR* chapter IV, 435.1009.

[17] *Laws of Minnesota* 2009, chapter 79, art. 3, sec. 18. The legislation said these community-based services "may be provided in facilities with 16 or fewer beds, and must provide the appropriate level of care" for the admitted patients.

[18] Department of Human Services, *Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience & Recovery of the People We Serve* (St. Paul, March 2010).

[19] *Ibid.*, 7.

The Legislature subsequently established a task force to advise DHS on transforming its current facilities, including Anoka, with a report due in December 2010.[20] In October 2010, SOS began soliciting input from counties on possible changes to Anoka, and SOS said it intended to issue a formal "request for proposals" in March 2011 for collaborative arrangements for psychiatric care in the Twin Cities involving SOS and other providers.[21] After the November 2010 election, DHS leadership changed, and the department never issued the request for proposals. Through the end of 2012, DHS offered no specific plan for changes at Anoka. In Chapter 6, we offer a recommendation regarding Anoka's future role.

Development of several state-run behavioral health hospitals in 2006 helped DHS close larger institutions.

COMMUNITY BEHAVIORAL HEALTH HOSPITALS

The seven state-run community behavioral health hospitals for adults have a much shorter history than the Anoka-Metro Regional Treatment Center. Development of these 16-bed hospitals since 2006 helped make possible the closure of several larger state institutions. However,

- **Since 2006, community behavioral health hospitals have had a variety of problems related to staffing, admissions, and discharge planning.**

A majority of county human services directors responding to our survey said that, in their opinion, SOS's community behavioral health hospitals provide high quality treatment to patients.[22] But problems with facility staffing and patient admissions and discharges have caused concerns, as we discuss below. This section offers no recommendations. However, recommendations elsewhere in this report address the need to improve the ability of state-run hospitals to admit patients with challenging behaviors, the need to explore collaboration between state-run hospitals and their private counterparts, and the need for improved placement options for patients discharged from SOS facilities.

[20] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 19, sec. 4.

[21] The December 2011 report from the legislatively commissioned task force was vague on the solution to Anoka's problems, recommending the development of "at least one pilot initiative in the metro region that will provide an array of services as an alternative to hospitalization at Anoka Metro Regional Treatment Center." See Chemical and Mental Health Services Transformation Advisory Task Force, *Recommendations on the Continuum of Services* (St. Paul, December 2010), 5.

[22] Fifty-five percent of county human services directors responding to our survey said the community behavioral health hospital they use the most "provides high quality mental health services to its patients;" 7 percent disagreed, and the rest offered no opinion.

Staffing

The beds in community behavioral health hospitals were barely half filled through fiscal year 2009, partly due to their limited staffing.[23] One of the hospitals opened without a psychiatrist on staff. Some others opened without a nurse practitioner, resulting in SOS having to place caps on the number of available beds. According to SOS officials, the hospitals continue to struggle to attract and retain psychiatrists, licensed social workers, and registered nurses with a psychiatric background. While psychiatric hospitals throughout the country have faced shortages of specialized staff, one SOS official told us the staffing problems at state-run facilities have also reflected a lack of planning by SOS.

DHS has had difficulty recruiting and retaining staff for its small behavioral health hospitals.

Because the new SOS hospitals were small and not part of larger hospitals, SOS also struggled to arrange for "on call" staffing when doctors were not at the facility. On-call doctors approve admissions, evaluate patients, prescribe medications, develop initial treatment plans, authorize the use of restraint or seclusion, coordinate transfers or discharges, and advise facility staff. They receive compensation for on-call hours equal to one-fourth of their regular hourly compensation. State-Operated Services has spent about $1 million to $2 million annually in recent years for on-call services by medical specialists, with the largest share of these expenditures for community behavioral health hospitals. Some individual doctors have logged large amounts of on-call time. At times, individuals have been paid for on-call time totaling three times the number of regular hours worked in a two-week pay period—a staffing arrangement that resulted in unusually high compensation for some individual state employees.[24] For example, a regional medical director for SOS serving several community behavioral health hospitals worked 6,134 hours of on-call time in 2009 (for $161,094 in addition to his regular salary) and 5,466 hours of on-call time in 2010 (for another $143,551). As we discuss in Chapter 6, on-call coverage might be arranged differently if small, state-run hospitals were allied with community hospitals run by other entities.

We did not examine in detail SOS's efforts to recruit professionals for positions at the community behavioral health hospitals or other facilities. However, DHS officials said it has proven difficult to recruit and retain some types of health care specialists at state compensation levels—particularly to serve a client population with challenging behaviors at facilities located outside a major metropolitan area. DHS would like to explore creative recruitment approaches, perhaps including some that would require legislative authorization.

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[23] Also, it appears that too many SOS hospitals were built initially. Between fiscal years 2008 and 2012, the total number of patient-days at SOS's community behavioral health hospitals increased by a small amount (6 percent). Closing three community behavioral health hospitals since 2009 has enabled the remaining hospitals to operate more efficiently. By fiscal year 2012, community behavioral health hospitals filled 89 percent of their available beds.

[24] State-Operated Services does not track the number of times doctors are contacted while on call or the amount of time they spend responding to on-call queries.

Admissions

Counties, private hospitals, and mental health advocates have expressed frustration about difficulties getting individuals admitted to community behavioral health hospitals.[25] In our survey of county human services directors, 18 percent of respondents said individuals who need immediate care at a community behavioral health hospital receive it without waiting, while 48 percent disagreed.[26] Counties expressed particular concern about their inability to get certain types of clients admitted, as noted in the following comments:

Community behavioral health hospitals have often been unable to serve patients with histories of aggression or violence.

> [Community behavioral health hospitals] have no access to medical treatment which is a barrier and sometimes limits the kinds of patients they can accept.

> In some cases, the [community behavioral health hospital] is not able to take challenging clients, creating service gaps for some very needy patients.

> [W]e find it difficult to place individuals in the [community behavioral health hospitals], even when they are "committed" for six months. I do not think that the current SOS system is serving our most needy clients…. I realize that there were growing pains initially in the Central Admissions Process, but the system is still too complex and not responsive to our requests for admission.

Community behavioral health hospitals do not have security staff, so they have often been unable to serve individuals with histories of aggressive or violent behavior. Consequently, some individuals referred to SOS with serious psychiatric symptoms remain "stuck" in other settings, such as hospital emergency rooms, hospitals without psychiatric services, or jails. As one private hospital official told us:

> [The nearest SOS community behavioral health hospital] is not willing to accept patients who have any indication of potential for violence, or [have] other challenging behaviors. Out of necessity we end up admitting these patients if we have a bed, despite the fact that the care needs exceed our capacity to manage such behaviors.

In a 2012 report, DHS said the number of aggressive or violent patients is small, but the report said the inability of SOS community behavioral health hospitals to effectively serve this population represents "a significant gap in Minnesota's continuum of care."[27]

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[25] In 2006, a centralized preadmissions unit was created to ensure greater consistency in admissions decisions at state-run hospitals. If a referred client needs hospital care and the nearest community behavioral health hospital is full, the preadmissions unit considers other options in reasonable proximity, including private hospitals or other state-run hospitals.

[26] The remaining respondents offered no opinion.

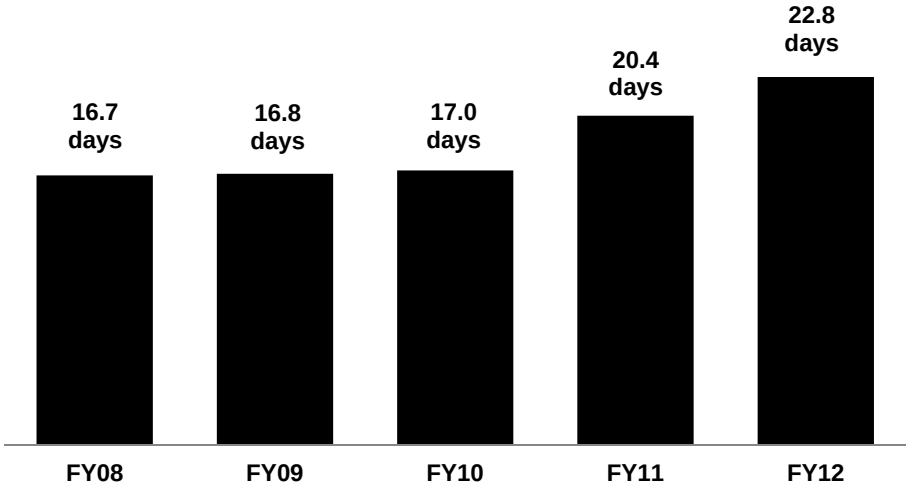
[27] DHS, *Report on the Utilization of the Community Behavioral Health Hospitals*, 23.

Discharges

County officials expressed mixed views about the adequacy of the hospitals' plans for discharge of patients following treatment.[28] As shown in Exhibit 3.3, the average length of patient stays in community behavioral health hospitals increased in recent years. Earlier in this chapter, we noted that patients sometimes remain in these hospitals longer than necessary. Some county staff also expressed concern that other patients are discharged from these hospitals before they are ready, and many voiced concerns about discharge planning. Typical of these comments were the following:

The average length of stay in community behavioral health hospitals has increased.

Exhibit 3.3: Average Length of Patient Stays in State-Run Community Behavioral Health Hospitals, Fiscal Years 2008-2012



NOTE: Patient stay is defined as the number of days from admission to discharge.

SOURCE: Minnesota Department of Human Services, State-Operated Services "key indicators" reports on community behavioral health hospitals.

> Discharge plans are often done without coordinating with [county] case managers, which can result in unsuccessful aftercare.
>
> The emphasis seems to be on moving clients out of treatment rather than treating them to the point of stability prior to returning to the community.

[28] Forty-one percent of county human services directors responding to our survey agreed with a survey statement that the community behavioral health hospital they use the most "makes reasonable plans for the discharge of its patients;" 30 percent disagreed with the statement, and the rest expressed no opinion.

> Over the past few years, we have been told that we are being uncooperative when we oppose discharges to locations that clearly do not have the capacity to meet a client's needs.

INCIDENT REPORTING AND INVESTIGATION

State-Operated Services defines an "incident" as "any situation or occurrence that adversely affects the safety or well-being of clients, visitors or the operation of the program."[29] Such incidents can have a significant effect on staff morale and the treatment environment. They may also be indicators of problems that need to be addressed.

We analyzed data from SOS on the number of reported incidents in recent years. The analysis does not include data from one large residential program, which records incidents in a separate database, using different categories.[30] Also, the 2012 numbers are estimates of full-year totals, based on incident reports from the first nine months of 2012. We observed that:

Reports of physical assaults at state-operated facilities increased in 2012.

- **Systemwide, the estimated annual number of incident reports grew in 2012, with a particularly large increase in reports of physical assaults.**

Exhibit 3.4 shows incident reporting trends since 2007. Based on our estimates, SOS was on pace to have the largest number of incidents in 2012 it has seen in recent years. For example, we estimate that the total number of incident reports increased 32 percent from 2011 to 2012. In addition, the estimated number of physical assault reports in 2012 was nearly double the numbers reported in previous years. It is possible that part or all of the increase resulted from more complete reporting rather than growth in the number of incidents, but there is no way to determine this.

We also found that:

- **State-Operated Services has had significant workplace safety issues.**

The federal government computes a workplace safety measure based on days that employees were away from work, had restricted work activity, or were transferred due to injury or illness. This is commonly referred to as a "DART"

[29] State-Operated Services, Policy 2020, *Incident Reports*, effective September 30, 2010.

[30] Adult foster homes and intermediate care facilities that serve individuals with developmental disabilities do not have access to the electronic recordkeeping system (called "Avatar") that other SOS facilities use. However, since October 2012, these facilities have reported incidents using the SOS online system described later in this chapter.

Exhibit 3.4: Types of Incidents Reported at State-Operated Facilities, 2007-2012

Type of Incident	2007	2008	2009	2010	2011	2012 (est.)[a]
Physical assault	1,037	1,071	1,073	1,037	1,155	1,969
Self-injurious behavior	758	721	791	621	538	693
Fall or slip	743	783	586	573	596	653
Threat	419	477	378	403	498	827
Property damage or loss	317	309	362	305	318	401
Medical	316	331	235	238	377	436
Contraband	275	206	196	147	199	197
Injury from activities of daily living	304	212	165	174	155	184
Unauthorized attempt to leave facility	190	231	174	160	176	184
Found on floor or ground	127	121	91	71	125	232
Sexual	116	92	68	70	78	128
Injury from behavioral intervention	112	88	59	63	52	40
Drug/alcohol use	74	52	66	73	59	64
Injury from equipment	86	61	46	41	45	84
Ingested foreign object	38	71	60	47	38	48
Unexplained injury	85	57	38	35	36	39
Suicide attempt	54	49	43	30	31	40
Burn	59	36	24	21	22	25
Choking	46	29	31	27	21	36
Death	12	7	5	6	10	11
Motor vehicle related	11	14	1	2	4	9
Fire	9	9	4	2	6	7
Other or no type reported	987	957	791	887	981	1,164
Total incident reports	5,383	5,221	4,567	4,312	4,627	6,088

NOTES: In the reporting system used by State-Operated Services, an incident may have more than one type—for example, an incident might be reported both as a physical assault and as property damage. Thus, the total number of incident types in each year is greater than the total number of incident reports. For example, in 2011 there were 5,520 incident types associated with the 4,627 incident reports. Additionally, staff filed separate incident reports for each client involved in an incident, so the total number of unique incidents is smaller than the number of incident reports shown above. Incidents in state-run outpatient or nonresidential programs are included. However, incidents in state-run adult foster homes or intermediate care facilities for individuals with developmental disabilities are not included because those facilities had different reporting procedures.

[a] Estimates for 2012 were extrapolated based on actual data from January through September 2012.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

rate.[31] Nationally, the DART rate for psychiatric and substance abuse hospitals in 2011 was 3.9, meaning there were 3.9 "recordable" cases (for federal reporting

[31] The Days Away, Restrictions, and Transfers (DART) rate is calculated using the formula (N/EH) x 200,000, where N is an organization's number of cases involving days away, job transfers, or restricted work activities due to work-related injuries or illnesses, and EH is the number of hours worked by all employees during the calendar year. By multiplying by 200,000, the rate provides an indication of the annual number of cases involving lost time per 100 full-time employees (i.e., per 200,000 work hours per year).

Many state-run facilities have had high rates of workplace injuries.

purposes) involving workplace-related injuries or illnesses per 100 full-time employees.[32] In 2011, SOS's program-specific DART rates often exceeded the national average, reflecting a higher level of work-related injuries or illnesses.[33] For example, rates were 7.8 for the Minnesota Security Hospital, 7.2 for Anoka-Metro Regional Treatment Center, 8.1 for Minnesota State-Operated Community Services (primarily group homes), and 27.0 for Children and Adolescent Behavioral Health Services. Four of the seven SOS community behavioral health hospitals had rates over 8.0. In addition, we observed that data on these rates for 2009 and 2010 are missing in DHS records for a large SOS program (Minnesota State-Operated Community Services). A DHS safety official told us this program never submitted the required safety reports for those years, and the administrator for the Minnesota State-Operated Community Services program told us he does not have this information.

Workplace injuries and illnesses in SOS have resulted in costs to the state. In fiscal year 2012, SOS's total workers compensation costs exceeded $6.3 million. In each recent year, the largest share of SOS's workers compensation costs was in programs serving individuals with developmental disabilities. Exhibit 3.5 shows workers compensation costs in selected SOS programs or facilities in recent years. The state sometimes bears responsibility for individuals' workers compensation costs for many years; in fiscal year 2012, the state made about $1.3 million in workers compensation payments for injuries sustained in past years at now-closed state-operated facilities.

A top DHS safety official told us there has been "indifference and disregard" to safety issues by officials in State-Operated Services over a period of years. This official said that SOS administrators and facility-based safety committees have given insufficient attention to federal Occupational Health and Safety Administration requirements and disregarded advice from DHS's central office safety staff.

We found that:

- **State-Operated Services implemented overdue improvements to its incident reporting process in 2012, but weaknesses remained in its written policies for incident reporting and investigation.**

When incidents occur, it is important that information be reported promptly and consistently, with appropriate notifications to supervisors. Various SOS and DHS officials expressed concern to us about past instances in which incidents at SOS facilities—including deaths—were not reported to management adequately or in a timely manner. Staff told us that, while policies on reporting incidents existed, in practice incidents were reported informally and inconsistently. In

[32] U.S. Bureau of Labor Statistics, "Table 1: Incidence Rates of Nonfatal Occupational Injuries and Illnesses by Industry and Case Types, 2011," http://www.bls.gov/iif/oshwc/osh/os/ostb3191.pdf, accessed November 13, 2012.

[33] Using the average DART rate for psychiatric and substance abuse hospitals is not necessarily an ideal benchmark for all types of SOS facilities, and SOS officials told us they are in the process of looking for other safety benchmarks.

Exhibit 3.5: Workers Compensation Payments for Selected State-Operated Facilities or Programs, Fiscal Years 2009-2012

Facility or Program	FY 2009	FY 2010	FY 2011	FY 2012
Programs Primarily Serving People with Developmental Disabilities				
Minnesota State-Operated Community Services	$1,789,180	$1,580,131	$2,322,667	$2,105,159
Minnesota Extended Treatment Options	313,279	504,418	274,458	210,838
Programs Serving People with Mental Illness				
Anoka-Metro Regional Treatment Center	661,820	399,734	424,930	569,339
Minnesota Security Hospital[a]	386,246	640,721	686,470	960,148
Community Behavioral Health Hospitals	145,781	164,915	272,037	357,893
Child and Adolescent Behavioral Health Services	65,954	160,809	173,988	236,133
Other				
Community Partnership Network	87,454	280,876	180,740	487,364

[a] Includes other "forensic services" at the St. Peter campus.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

State-Operated Services implemented a new online system in late 2012 for its staff to report incidents affecting safety or program operations.

2011, an internal review of the SOS incident reporting process concluded that: "The current process...took too much time, involved too many staff, was handled inconsistently and used a form that provided little value."[34] The team offered recommendations for changes, and a new online incident reporting process was introduced in October 2012.

State-Operated Services staff cited several advantages to the new reporting system. They said the online system eliminates opportunities for incident reports to get lost on the desks of data entry staff or supervisors. Also, the new system automatically generates e-mail notifications for key staff when significant incidents are reported. In addition, while staff used to complete more than one form for an incident involving multiple clients, the new system uses a single form and eliminates entry of duplicate information in such cases.

The development of a new online reporting system in 2012 was an important achievement, but SOS policies regarding incident reporting remained inadequate. First, revisions to incident reporting policies were still pending in early 2013, well after the new incident reporting system started in October 2012. The policy

[34] Department of Administration, *e-Lean update* (December 2011), 2, http://www.lean.state.mn.us/LEAN_NL_December2011.pdf, accessed November 13, 2012.

in place in October 2012 referenced sections of an incident reporting form that was no longer used, and it did not mention the online reporting system.[35] Also, this general incident reporting policy did not apply to SOS's largest program serving developmentally disabled individuals—which, as we noted, has SOS's largest share of workers compensation costs. The incident reporting policy for that program was last updated in March 2009. State-Operated Services requires that each of its policies be reviewed for necessary updates at least every two years, but the incident reporting policies in place at the beginning of 2013 had not been updated to reflect changes in practice.[36]

However, SOS did not update its incident reporting policies before the new reporting system started.

Second, many individual SOS programs have adopted their own procedures for incident reporting, and some have been inconsistent with each other and with SOS's general policy. For example, the general SOS policy in place at the beginning of 2013 said that "significant incidents" must be reported to the SOS chief operating officer, who must provide for their review. But the definition of a significant incident varied within SOS. The procedures for some SOS facilities defined "client-to-client sexual contact" as a "critical incident;" for some other facilities, sexual contact was defined as significant only if it involved "force or coercion" or allegations of abuse. Some programs defined verbal aggression as a significant incident, while others did not. The SOS general policy on incident reporting defined "seclusion or restraint" and client "neglect" as examples of incidents that should be considered significant, but the new online reporting form provided no option to record these as such.[37]

Third, SOS's general incident reporting policy has not been sufficiently clear about which incidents require further internal review and how this should occur. Within SOS programs and facilities, certain individuals have been designated as "administrative reviewers" of incidents. The SOS policy in place at the beginning of 2013 stated that the administrative reviewer shall examine each incident report for accuracy and completeness, and determine whether there is a need for further internal review of the incident. The policy said the administrative reviewer should look for "questionable incidents, injuries, or data suggesting further investigation."[38] It instructed the administrative reviewer to initiate "internal program reviews" or "administrative reviews" if necessary, but the policy provided limited guidance about the different types of reviews and which might be appropriate for particular circumstances."[39]

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[35] State-Operated Services, Policy 2020, *Incident Reports*, effective September 30, 2010.

[36] State-Operated Services, Policy 2000, *Policy and Procedure Development and Implementation*, effective December 21, 2011. The general SOS incident reporting policy was last updated in September 2010.

[37] The SOS policy in place at the beginning of 2013 authorized the facility administrator to identify, at his or her discretion, other incidents as significant (citing examples such as security incidents, thefts, break-ins, drugs, alcohol, or contraband), but the new form provided no option for this.

[38] State-Operated Services, Policy 2020, *Incident Reports*, effective September 30, 2010.

[39] According to SOS records, administrative reviews have been the most common type of incident review conducted in SOS—in recent years, the total number conducted ranged from 82 in 2009 to 427 in 2007.

State-Operated Services has made limited use of a special investigations office within DHS.

Fourth, SOS policies have not indicated circumstances in which it may be appropriate for staff to involve DHS's Office of Special Investigations in internal reviews. The department created this office within SOS about seven years ago. This office's duties include investigating criminal activity by patients, staff, or facility visitors; assessing security threats to facilities; monitoring patients on provisional discharge in the community; and apprehending patients who have left a facility without authorization. When DHS moved the Minnesota Sex Offender Program (MSOP) out of State-Operated Services' purview in 2008, the Office of Special Investigations was placed under the direction of MSOP's director. The services of the Office of Special Investigations are still available for use by SOS, upon request. However, SOS's use of the Office of Special Investigations has declined—from 148 cases in 2009 to an average of about 30 cases per year since then. The general SOS policy on incident reporting does not mention the Office of Special Investigations or discuss when it should be consulted. Nearly all of the Office of Special Investigation's work for SOS has been at the Minnesota Security Hospital, and the Security Hospital has a policy specifying circumstances in which the Office of Special Investigations should be used—such as cases involving possible criminal misconduct.[40] However, the Minnesota Security Hospital's use of this office has declined sharply since 2009, even as its number of assaults has increased.

RECOMMENDATIONS

State-Operated Services should:

- ***Establish objectives and strategies for reducing rates of workplace injuries;***
- ***Amend SOS incident reporting policies to ensure that they are consistent, up-to-date, and sufficiently explanatory; and***
- ***Clarify in its policies the circumstances in which the Office of Special Investigations should be involved in incident reviews or investigations.***

Workplace safety issues and workers compensation costs need additional attention from SOS management. The activities recommended above can now be overseen by SOS's chief quality officer, a position that was not filled for several years prior to 2012. In addition to the actions recommended above, it would be helpful for SOS leaders to forge a stronger working relationship with DHS's agencywide safety officials. State-Operated Services managers should use input from DHS safety staff to identify and help resolve workplace safety issues at individual facilities.

[40] State-Operated Services, Procedure 10001, *Administrative: Office of Special Investigations, Forensic Utilization of,* effective May 25, 2011.

USE OF SECLUSION AND RESTRAINT

According to state law, individuals over age 18 who reside in a State-Operated Services facility are "vulnerable adults."[41] State law prohibits use of any "aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons," except when this occurs for therapeutic reasons or by accident, as defined in statute.[42] Similar protections are in law for minors.[43]

A key challenge for SOS is finding ways to appropriately manage residents' behaviors.

Individuals served in state-run facilities sometimes pose dangers to themselves or others. Thus, a key challenge for SOS is to manage the behaviors of facility residents without using techniques that would constitute abuse or neglect. This section focuses on two methods that have occasionally been used to manage individuals: (1) the temporary separation of individual clients from others—a practice referred to as "seclusion;" and (2) the use of restraints to control an individual's movements. Minnesota rules define a restraint as "any physical device that limits the free and normal movement of body and limbs."[44]

We found that:

- **No single policy on the use of restraint and seclusion applies to all state-operated facilities, partly because different types of facilities are subject to different state rules and accreditation standards.**

For example, the rules governing all licensed chemical dependency programs in Minnesota—state-run or other—prohibit the use of restraint and seclusion for any behavior-related emergencies.[45] In contrast, state rules governing licensed facilities for individuals with developmental disabilities authorize the use of certain types of restraint and seclusion in emergencies.[46]

In some cases, state rules for one type of facility are different from the accreditation standards for another type. State-run facilities that primarily serve individuals with developmental disabilities require that individuals in mechanical restraints—such as restraint chairs or straps—be checked by staff at least every 30 minutes; this SOS policy reflects the requirements of a Minnesota rule.[47] In contrast, SOS policies for mental health hospitals require that individuals in such a restraint be checked every 15 minutes; this reflects the standard of a national accreditation organization.[48]

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[41] *Minnesota Statutes* 2012, 626.5572, subd. 21.

[42] *Ibid.*, subds. 2, 3, 17, and 20.

[43] *Minnesota Statutes* 2012, 626.556.

[44] *Minnesota Rules* 2012, 9520.0510, subp. 25.

[45] *Minnesota Rules* 2012, 9530.6475.

[46] *Minnesota Rules* 2012, 9525.2770.

[47] *Minnesota Rules* 2012, 9525.2750.

[48] The Joint Commission, Provision of Care, Treatment, and Services Standard 03.03.23 (2010).

In other cases, differences in facilities' restraint and seclusion practices appear to only reflect differences in SOS policies, not differences in overarching rules or accreditation standards. For instance, SOS adult and children's mental health hospitals are required by SOS policy to have "debriefing interviews" with the patient and the patient's family or guardian soon after a restraint or seclusion incident; this is not a requirement of accreditation standards or state rules.[49] We saw no similar requirement for debriefing patients or family members in SOS policies on restraint and seclusion for individuals with developmental disabilities.

We found that:

- **State-operated facilities differ in the extent and types of restraint and seclusion they use.**

Exhibit 3.6 shows the use of restraint and seclusion by several types of SOS facilities over an 18-month period.[50] The exhibit shows that one small facility—the Children's and Adolescent Behavioral Health Hospital in Willmar—reported

Exhibit 3.6: Number of Times the Use of Restraint or Seclusion Was Reported in Selected State-Operated Facilities, January 2011 through June 2012

Facility	Number of Budgeted Beds (December 2012)	Seclusion	Physical Hold	Ambulatory Restraint	Non-Ambulatory Restraint	Total Instances of Restraint or Seclusion
Anoka-Metro Regional Treatment Center	110	69	32	0	489	590
Children's and Adolescent Behavioral Health Hospital	14	197	375	180	206	958
Community Behavioral Health Hospitals	98	81	182	33	52	348
Minnesota Security Hospital[a]	350	369	235	152	20	776

NOTES: State-Operated Services reports "budgeted beds" to reflect typical occupancy levels. "Seclusion" involves the physical separation of a patient from other patients and staff. A "physical hold" is a form of restraint in which staff restrict patient movements through the use of physical force. An "ambulatory restraint" involves mechanical devices, such as handcuffs, that restrict arm and leg movements. "Non-ambulatory restraints" involve greater restriction of movement than ambulatory restraints, for example, using a restraint chair.

[a] In December 2011, the Department of Human Services Licensing Division cited the Minnesota Security Hospital for not accurately reporting its use of restraints.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data.

[49] State-Operated Services, Procedures 16673 (*Adult Mental Health: Seclusion or Restraint,* effective August 26, 2012) and 13309 (*Child & Adolescent Behavioral Health Services: Client Care: Seclusion and Restraint,* effective April 26, 2010).

[50] We also obtained data on restraint and seclusion from the Minnesota State-Operated Community Services program, but it is recorded in a somewhat different manner in a separate database. The administrator of this program told us that this program no longer uses seclusion or "time-out rooms" for its residents.

the most frequent use of these procedures. This facility's most common type of restraint or seclusion was a physical hold by staff on a patient. Most of the Anoka-Metro Regional Treatment Center's restraints were classified as "nonambulatory" restraints. This might include, for example, a restraint chair. The Minnesota Security Hospital made more use of patient seclusion than the other facilities shown.

The completeness of the reporting by facilities is unclear. For example, prior to 2011, certain Minnesota Security Hospital procedures which restrained individuals (including mesh wraps and some uses of handcuffs) were not recorded by staff as an instance of restraint—making it difficult to assess in retrospect how widespread such practices were.

The use of restraint and seclusion has had particularly strong repercussions on two state-operated facilities, as we discuss next. In both cases,

- **The failure of State-Operated Services management to develop sound policies and practices regarding the use of restraint and seclusion had negative effects on patients and entire facilities.**

The use of restraint and seclusion merit closer scrutiny by State-Operated Services management.

In both of the cases discussed below, changes in restraint and seclusion occurred after entities outside of SOS raised concerns. In our view, these issues should have been identified and addressed sooner by SOS.

RECOMMENDATION

State-Operated Services should designate a senior administrator to monitor and oversee restraint and seclusion practices throughout the organization.

We did not look at specific circumstances involving the use of restraint and seclusion at SOS facilities. But the far-reaching problems with these practices at two facilities suggest that the oversight of restraint and seclusion should not be left entirely to individual facilities. State-Operated Services should designate a top official to help ensure compliance with appropriate standards at all SOS facilities.

Minnesota Extended Treatment Options and New Cambridge Facility

State-Operated Services opened the Minnesota Extended Treatment Options (METO) facility in 1997 on the campus of the former Cambridge Regional Treatment Center. This state-run facility served persons with developmental disabilities who posed a public safety risk, and it was licensed to house up to 48 people. However,

- **Inappropriate use of restraints led to the 2011 closure of Minnesota Extended Treatment Options and an agreement for compensating METO's former residents.**

Inappropriate use of restraints led to the 2011 closure of a 48-bed facility in Cambridge and state payments to its former residents.

A 2008 report by the state Ombudsman for Mental Health and Developmental Disabilities found METO staff using restraints "as a routine treatment modality in far too many cases."[51] The report expressed concern about METO's widespread use of restraints, the type of restraints used (for example, metal handcuffs and leg hobbles), the reasons it used restraints, and the total amount of time people were restrained. In July 2009, a class action lawsuit was filed in federal court alleging that METO residents were being unlawfully and unconstitutionally secluded and restrained.[52] The state and defendants reached an agreement in June 2011 that required DHS, in part, to (1) close METO by June 30, 2011; (2) adopt new policies prohibiting seclusion and limiting the use of restraints to emergency situations in SOS facilities for people with developmental disabilities and severe behavioral problems; (3) increase nonresidential services staffing; (4) implement new and increased training requirements; and (5) put in place an oversight process to ensure that new restraint policies were followed.[53] The agreement also required the state to establish a class action settlement fund of $3 million for METO residents who had been unlawfully restrained, with $2.8 million coming from the state and $200,000 coming from two insurance companies.

In July 2011, SOS replaced METO with another facility known as Minnesota Specialty Health Systems–Cambridge. This 16-bed facility is licensed under DHS's residential services rule for persons with developmental disabilities. Facilities with this type of DHS license are not federally certified to receive federal reimbursement for services provided to eligible residents.

DHS's Licensing Division determined that the new Cambridge facility also had problems with use of restraints in emergency situations. In February 2012, DHS conducted its first licensing review and issued a correction order because the facility did not adhere to its policy that required reporting the use of restraints within 24 hours. In July 2012, the department issued two more correction orders within a week of each other for similar violations. In October 2012, licensing staff cited the facility for using restraints in inappropriate circumstances. A day later, licensing staff issued another correction order—the facility's fourth since mid-February for not adhering to facility policy regarding the review and reporting of the use of restraints.

In September 2012, the state Ombudsman for Mental Health and Developmental Disabilities made an unannounced visit to the facility. The ombudsman's report documented various concerns related to the facility's treatment activities, inappropriate medication of residents as a form of "chemical restraints," lack of

[51] Ombudsman for Mental Health and Developmental Disabilities, *Just Plain Wrong* (St. Paul, 2008), iii.

[52] U.S. District Court, District of Minnesota, James and Lori Jensen, et al. v. Minnesota Department of Human Services, et al., Court File No. 09-CV-1775 (DWF/FLN), July10, 2009.

[53] U.S. District Court, District of Minnesota, *Settlement Agreement re James and Lori Jensen, et al. v. Minnesota Department of Human Services, et al.,* June 23, 2011.

vocational and rehabilitative programming, and use of the local medical center when a resident's behavior is out of control.[54]

Minnesota Security Hospital

Another SOS facility that faced strong repercussions due to its use of restraint and seclusion is the Minnesota Security Hospital. Specifically,

- **In December 2011, the Department of Human Services placed the Minnesota Security Hospital on a "conditional" license for two years and levied a $2,200 fine—in large part, for problems related to use of restraint and seclusion.**

In 2011, DHS licensing staff placed the Minnesota Security Hospital on "probation" for two years.

In effect, the Security Hospital was placed on "probation" for a two-year period. This was partly based on 21 violations stemming from a May 2011 licensing inspection, of which 8 violations were related to seclusion or restraint policies or practices. In some cases, licensing staff documented instances of maltreatment by the facility itself, individual staff persons, or both. In other cases, licensors found inadequacies in maltreatment-related policies, training, and reporting practices.

DHS licensing staff identified five Security Hospital policies, procedures, and protocols related to the use of seclusion and restraint. The licensing review determined that these regulations were inconsistent with each other and were not implemented consistently. The review also said the Security Hospital violated state rules that prohibited the use of restraint or seclusion (1) as a form of punishment or (2) for the convenience of staff.

Several licensing violations related to the Security Hospital's use of a practice called "protective isolation." For many years, the Security Hospital distinguished between two types of situations in which patients were locked in rooms apart from other patients, sometimes for extended periods. First, patients could be secluded for conduct that was an extension of a patient's mental illness, which was sometimes called "programmatic seclusion." Second, patients could be placed in seclusion for conduct that was not an extension of the patient's mental illness, which was called "protective isolation."[55] Separate Security Hospital policies and procedures existed for each type of seclusion, with protective isolation subject to the requirements of a 1984 consent decree.[56] However, DHS licensing staff said in 2011 that distinctions between these categories of seclusion "eroded over time," and that protective isolation had been increasingly used for

[54] Ombudsman for Mental Health and Developmental Disabilities, *Review of MSHS–Cambridge* (St. Paul, September 26, 2012). A chemical restraint is the administration of a drug or medication which is not the standard treatment or dosage for an individual's condition for the purpose of managing an individual's behavior or restricting freedom of movement.

[55] Protective isolation was also called "protective seclusion." It was defined as placing a patient in a room from which he or she was not allowed to exit in order to protect the patient or other persons from the unreasonable risk of imminent serious physical harm or to prevent imminent serious property damage.

[56] Reome v. Gottlieb, et al., No. 835507, Minnesota Fourth Judicial District, February 17, 1984 (order governing protective seclusion).

both types of cases.[57] The licensing review said Security Hospital staff tended to place patients in protective isolation because "there were fewer supervision and documentation requirements for protective isolation as compared with [programmatic] seclusion."[58] The review also said the Security Hospital's requirements regarding protective isolation "did not provide sufficient direction for consistent implementation."[59]

The use of a questionable practice called "protective isolation" continued at the Security Hospital for many years despite widespread concerns.

Concerns about the use of protective isolation at the Minnesota Security Hospital were not new at the time of the 2011 DHS Licensing sanctions. In 2002, the Joint Commission (a body that accredits health care organizations) said the Security Hospital's use of protective isolation was "not always based on a clinical decision."[60] In 2010, national consultants told Security Hospital officials that its use of protective isolation "is inconsistent with the national and international trends" and urgently advised the facility to change its practices.[61] An internal DHS review in 2010 recommended a re-examination of the Security Hospital's training and practices regarding protective isolation.[62] In a 2011 review, accreditation officials found the Security Hospital's practices "resulted in patients being in seclusion or restraint for many hours without an order by the appropriate licensed independent practitioner and other appropriate protective processes."[63] A Security Hospital official told us there had been significant staff concern about the facility's use of protective isolation over the past decade.

Nevertheless, the facility continued to use protective isolation until Security Hospital officials prohibited its use in May 2011. In fact, the Security Hospital sometimes used protective isolation for lengthy periods. For example, one individual was in protective isolation from February 4, 2011, until May 11, 2011, with the exception of a three-day period in March. Another individual was in protective isolation from January 23, 2011, until March 14, 2011, with the exception of a three-day period in February.[64] The DHS Licensing order in December 2011 highlighted one particularly troubling incident where a patient was not only placed in protective isolation for months, but was forced to sleep on a concrete slab without a mattress for 25 days. Determining that maltreatment had occurred, the order stated:

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[57] Maura McNellis-Kubat, Supervisor, Department of Human Services, Division of Licensing, order to David Proffitt, Minnesota Security Hospital, *Determination of Maltreatment: Order to Pay a Fine and Order of Conditional License*, December 22, 2011, 8.

[58] *Ibid.*

[59] *Ibid.*

[60] Joint Commission on Accreditation of Healthcare Organizations, *Official Accreditation Decision Report: Minnesota Security Hospital* (April 11, 2002, as revised in August 2002), 7.

[61] Raul Almazar and Marty Martin-Forman, *National Association of State Mental Health Program Directors, Site Visit Consultation Report* (undated, based on October 13-14, 2010, site visit), 9.

[62] Department of Human Services, *State Operated Forensic Services Program Review: Report to Commissioner Cal Ludeman* (St. Paul, December 16, 2010), 5.

[63] The Joint Commission, *Official Accreditation Decision Report: Minnesota Security Hospital* (April 8, 2011), 4-5.

[64] During extended periods of protective isolation, there were sometimes limited periods during the day when the individual was allowed to interact with other patients.

> The release criteria for protective isolation, in this case, was dependent solely on the resident refraining from numerous target behaviors for periods of time in order to be released from protective isolation. The target behaviors required for the resident to be released from protective isolation were not reasonably achievable.[65]

After the Security Hospital's placement on "probation" by DHS Licensing in December 2011, the facility incurred an additional penalty. In May 2012, DHS fined the Security Hospital an additional $1,000 for an incident of patient maltreatment that occurred prior to December 2011.[66] In this instance, staff had placed a resident in seclusion without a mattress for more than two hours and without any clothing for about an hour.[67]

State-Operated Services has taken steps at the Security Hospital in recent months to respond to various concerns raised by licensing officials.

In December 2012, SOS addressed to DHS Licensing's satisfaction the last remaining issues cited in the correction orders attached to the Security Hospital's conditional license. However, its conditional license will remain in effect until the end of 2013.

Overall, restraint and seclusions practices at the Security Hospital were problematic over a period of many years. DHS Licensing staff regularly conducted investigations at the Security Hospital in response to individual complaints. But, prior to 2011, Licensing had not done a full inspection of the Security Hospital since 2000.[68] Although greater scrutiny by DHS's Licensing Division might have brought problems at the Security Hospital to light sooner, primary responsibility for the ongoing problems with restraint and seclusion at the Minnesota Security Hospital rested with SOS management. For years, there was internal concern about restraint and seclusion practices, and several external reviews identified problems well before DHS Licensing placed the Security Hospital on a conditional license.

FAILURE TO OBTAIN NECESSARY APPROVALS BEFORE OPENING A FACILITY

As we were reviewing the licensure status of state-run facilities, we found that:

- **State-Operated Services opened a residential facility in Cambridge in 2011 without first obtaining the necessary approvals from the Minnesota Department of Health or the State Fire Marshal.**

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[65] *Determination Of Maltreatment, Order To Pay A Fine And Order Of Conditional License,* December 22, 2011, 8-9.

[66] Maura McNellis-Kubat, Supervisor, Department of Human Services, Division of Licensing, order to Carol Olsen, *Minnesota Security Hospital, Determination of Maltreatment and Order to Pay a Fine*, May 24, 2012, 1.

[67] *Ibid.*, 1-2.

[68] Licensing staff conducted "modified reviews" of the Security Hospital in 2003 and 2006, which were more limited in scope than a full inspection.

In mid-2011, SOS closed a 48-bed facility (Minnesota Extended Treatment Options) in Cambridge and replaced it with a new 16-bed facility in the same location. The new facility is licensed under DHS's residential services rule for persons with developmental disabilities and is the only SOS facility of this particular type.[69]

A DHS facility operated for about ten months before it obtained a necessary license from the Department of Health.

To ensure compliance with health and safety requirements, state law requires that license applicants (including SOS) document compliance with applicable fire and life safety codes, as well as health rules, when opening a new facility.[70] But SOS failed to notify MDH or obtain the department's approval before opening SOS's new facility on July 1, 2011. Likewise, SOS did not notify MDH that it was closing Minnesota Extended Treatment Options on June 30, 2011. Staff at MDH told us they contacted DHS in Fall 2011 about renewing the license for Minnesota Extended Treatment Options. State-Operated Services staff did not respond until January 2012, when they submitted an incomplete application for the MDH license. It was not until February 2012 that MDH learned that one SOS facility had closed and a new one had opened—slightly more than seven months after the fact.

Minnesota Department of Health officials told us they do not approve any supervised living facility license until both engineering and licensing staff at MDH as well as the State Fire Marshal have determined that a building is fit for occupancy. Health Department staff began obtaining the necessary licensing information and approvals from SOS and the State Fire Marshal, issuing the Cambridge facility its first supervised living facility license in April 2012—almost ten months after the first residents had moved in.

FINANCIAL ISSUES

Our evaluation of State-Operated Services did not include a financial audit of SOS activities. However, while reviewing SOS operations, we became aware of several management issues with important financial implications, which we discuss below.

Delays in Obtaining Federal Certification for the Rochester Community Behavioral Health Hospital

The federal government requires that health care facilities be "certified" if they wish to receive Medicare and Medicaid reimbursement for services provided to qualified individuals. When a facility is not certified, the responsible payer is the patient. Certification is granted by the Centers for Medicare and Medicaid Services, an agency that is part of the U.S. Department of Health and Human

[69] There are a total of 17 Minnesota facilities licensed to provide residential services for persons with developmental disabilities. As noted earlier, facilities with other types of DHS licenses may also serve people with developmental disabilities.

[70] *Minnesota Statutes* 2012, 245A.04, subd. 2a.

Services. As described in Chapter 1, certification is similar to the accreditation process that many health care facilities voluntarily undergo.

Since opening in 2006, SOS's community behavioral health hospital in Rochester failed to obtain federal certification on three separate occasions. Based on the experience of SOS's other community behavioral health hospitals in collecting federal reimbursement, officials from DHS estimated that:

- **Over a recent four-year period, the Rochester hospital's lack of federal certification resulted in a loss of about $7.5 million in federal reimbursements.**

Lacking federal certification, a state-run behavioral health hospital in Rochester has been unable to charge the federal government for services provided to Medicaid and Medicare clients.

In the facility's first attempt at certification (November 2007), the federal government refused to certify the Rochester facility in part because patient treatment plans were inadequate and active treatment was not always provided. This resulted in some patients

> …sleeping in their room[s], sitting idly in the dayroom or walking the halls. This failure potentially prevented them from making progress toward their goals and may have delayed their discharge.[71]

The federal review also found that the hospital failed to provide adequate clinical leadership in the medical, nursing, and social work areas, which resulted in patients receiving inadequate care. Facility staff developed a plan to correct the deficiencies, but federal investigators again refused to certify the facility when they returned in January 2008, citing many of the same problems. Federal investigators visited the facility again in October 2010 and once more withheld certification. The reviewers noted problems with the facility's administration of medications.[72] In December 2012, the Rochester hospital underwent its fourth certification inspection. This time, the review was conducted by the Joint Commission (an accreditation body) rather than federal inspectors; the federal government now authorizes this accreditation body to conduct certification reviews on its behalf. In February 2013, SOS learned that the Rochester hospital passed its most recent certification review.

The state-run facility in Rochester is the only SOS community behavioral health hospital that has experienced delays in obtaining federal certification.[73] Some people told us the facility's certification difficulties may have been due, in part,

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[71] Jacqueline Lewis, Program Representative, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Non-Long Term Care Certification and Enforcement Branch, letter to Mike Tessneer, *Statement of Deficiencies and Plan of Correction*, November 13, 2007, 2.

[72] *Ibid*., 6-7. Investigators said physician orders for one patient's antipsychotic medications were vague, which required nursing staff to make decisions outside their areas of expertise. The review noted that a patient continued to receive a strong antipsychotic medication although the patient's medical records and psychiatrist said the patient showed no evidence of psychosis. The nursing director said the patient received these doses of medication because the patient kept asking for it.

[73] The other six SOS community behavioral health hospitals were certified between 2007 (St. Peter) and 2010 (Baxter).

to staffing problems. According to DHS, this hospital "has struggled to attract and retain adequate numbers of licensed independent psychiatric providers and health care staff, due in part to competition from other hospitals in the region."[74] Whatever the causes, however, the inability of the Rochester facility to obtain certification over a multiyear period prevented the State of Minnesota from collecting federal reimbursements it would otherwise have received. In addition, the findings of the earlier certification reviews suggested that the Rochester facility did not provide acceptable care to its patients. We offer no recommendations, given the certification of the Rochester facility in early 2013.

Overtime Use

When state employees qualify for overtime, they are paid at rates prescribed by law or the applicable labor contract. Sometimes overtime is paid at the employee's regular salary; in other cases, it is paid at 1.5 times the employee's regular hourly salary. Because of the potential fiscal impact, it is preferable for management to have sufficient numbers of employees and schedule them in a manner that minimizes the need to use overtime. We found that:

- **In recent years, State-Operated Services' use of overtime has exceeded the amount targeted by management.**

Staff use of overtime within State-Operated Services grew over the past four years.

State-Operated Services aims to limit overtime to 2.5 percent of the total hours worked by direct care staff and to avoid the use of overtime by administrative and support staff. However, actual overtime use has consistently exceeded these targets. In Exhibit 3.7, we show the overall overtime percentages for selected program categories, with SOS's benchmarks calculated for all employees combined. In the first half of fiscal year 2013, the Security Hospital's overtime was 4.7 percent of total work hours, well above the 2.1 percent benchmark derived from combining SOS targets for different staff categories. Furthermore, in each of the areas shown in Exhibit 3.7, the use of overtime grew between fiscal years 2010 and 2013. State-Operated Services administrators expressed concern about the levels of overtime. One facility administrator described recent overtime as "over the top;" another described it as "horrendously over target."

We did not try to determine what factors have contributed to high levels of overtime, and there is disagreement within SOS on this issue. State-Operated Services officials mentioned various possibilities, such as facility scheduling practices, work rules (for example, rules governing employees' use of vacation), staffing levels for certain positions, and treatment practices (such as the extent to which doctors require intensive supervision of certain patients).

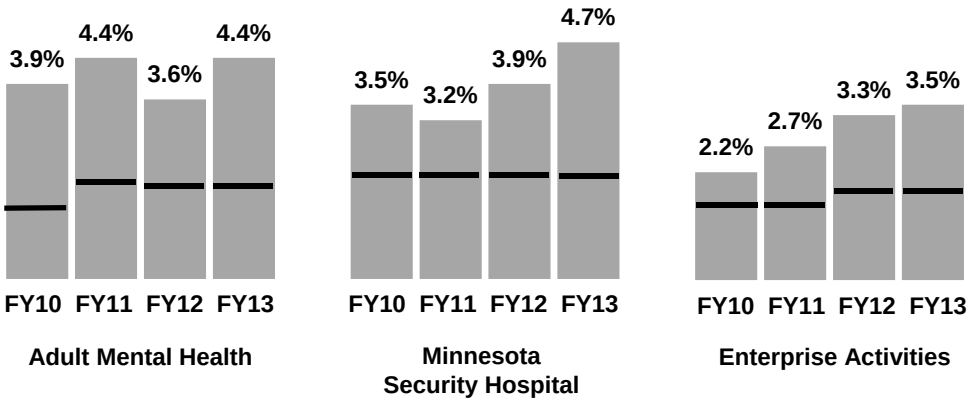
[74] Department of Human Services, Chemical and Mental Health Division, *Report on the Utilization of the Community Behavioral Health Hospitals* (St. Paul, March 30, 2012), 22.

RECOMMENDATION

State-Operated Services should seek ways to limit overtime use to a reasonable level through administrative actions or negotiations with affected bargaining units.

We offer no recommendation on what specific course of action SOS should pursue to limit overtime. But, given the cost implications of overtime, SOS should elevate the use and visibility of performance measures and objectives related to overtime use so that the goal of reducing overtime to a reasonable level becomes central to SOS operations.

Exhibit 3.7: Overtime as a Percentage of Total Work Hours, Selected Programs, Fiscal Years 2010-2013



NOTES: Fiscal Year 2013 data are through the pay period ending December 18, 2012. The black lines show SOS benchmarks for each program area in each year. SOS has a systemwide overtime benchmark of 2.5 percent of total work hours for direct care employees and 0 percent for other employees; program benchmarks varied based on the proportion of employees involved in direct care.

SOURCE: Minnesota Department of Human Services, State-Operated Services overtime benchmark summaries.

Financial Shortfalls of State-Operated Chemical Dependency Treatment Facilities

By law, SOS "enterprise activities" must be financed without direct state appropriations. Specifically, the law says these activities must be "fully funded by public or private third-party health insurance or other revenue sources available to clients that provide reimbursement for the services provided."[75] Placements of lower income individuals in Minnesota's public or private chemical dependency treatment facilities are typically funded from the state's

[75] *Minnesota Statutes* 2012, 246.0136, subd. 1.

Consolidated Chemical Dependency Treatment Fund, which is comprised of state appropriations and federal revenues. However, the Legislature does not appropriate funds directly to state-run chemical dependency treatment facilities, and these facilities compete with nonstate facilities to serve clients eligible for services paid from the Consolidated Chemical Dependency Treatment Fund.

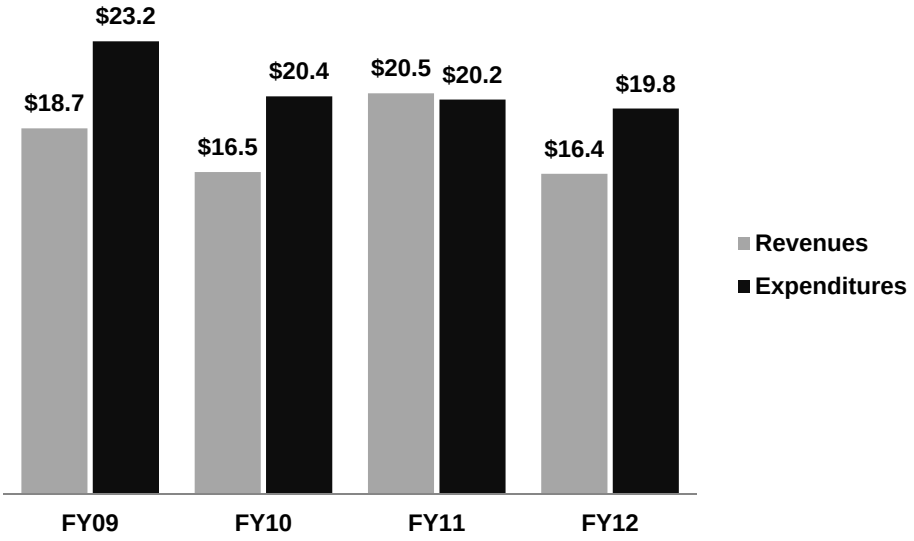
As shown in Exhibit 3.8,

- **In recent years, state-run chemical dependency services have usually not been self-supporting.**

Finance officials from SOS told us that the inability of state-run services to cover their expenses in fiscal years 2009 and 2010 reflected reimbursement changes that adversely affected many state-run and nonstate chemical dependency treatment programs in Minnesota.[76] In fiscal year 2011, the SOS chemical dependency services showed a small surplus. In part, this occurred because the SOS facilities had reduced their staffing levels and received revenues due to them from previous fiscal years.

State-operated chemical dependency programs have had difficulty generating sufficient revenues since DHS implemented a new method of paying treatment providers in 2011.

Exhibit 3.8: Revenues and Expenditures in State-Operated Chemical Dependency Services, Fiscal Years 2009-2012



NOTE: Revenues and expenditures amounts are in millions of dollars.

SOURCE: Minnesota Department of Human Services.

[76] Around that time, DHS started contracting with insurance companies to function as managed care organizations for part of the state's Consolidated Chemical Dependency Treatment Fund. The insurers had technical and contractual problems that limited their ability to make timely payments from the fund to providers.

State-run chemical dependency facilities again encountered financial problems after DHS implemented a uniform rate structure for making payments to providers from the state's Consolidated Chemical Dependency Treatment Fund. Before July 2011, facilities negotiated agreements with the "host county" in which the facility was located that determined the rates that would be charged for the facility's services. Under the new structure, geographic rate variations were eliminated. Any variation in rates around the state was intended to reflect differences in services provided. For example, facilities that provided more intensive treatment or served certain subgroups of clients were eligible for higher payment rates than facilities that did not. In fiscal year 2012, revenues for SOS chemical dependency services were $3.3 million short of expenditures. In response to the shortfall, SOS stopped requiring the state-run chemical dependency programs to pay for a share of SOS-wide overhead costs. Also, SOS offset part of the shortfall with revenues collected in fiscal year 2013 for services provided in fiscal year 2012.

State-Operated Services is projecting another budget shortfall in fiscal year 2013 for state-run chemical dependency programs. Staff in DHS's Alcohol and Drug Abuse Treatment Division (which is not part of SOS) acknowledged that the new rate structure might not adequately reflect the cost of certain types of higher-cost clients. However, any changes by the Alcohol and Drug Abuse Division to the rate structure would probably not occur before 2014. We offer no recommendations for changes until this division can fully evaluate the current rate structure. However, it is important for the Legislature to be aware that the state-run chemical dependency treatment programs are not fully self-supporting at this time.

4 Civil Commitment

Many individuals in state-operated facilities have been civilly committed by a court.

Civil commitment is the legal process by which a court places an individual involuntarily in a setting to receive treatment or services. Minnesota law specifies procedures for voluntary admission to treatment, and it states that "voluntary admission is preferred over involuntary commitment and treatment."[1] But the law also empowers courts to place individuals with mental illness, developmental disabilities, or chemical dependency in treatment against their will. Courts sometimes civilly commit individuals who have been previously accused or convicted of criminal wrongdoing, but the civil commitment process does not attempt to determine guilt in criminal matters.

Many individuals served in state-run human services facilities have been civilly committed by Minnesota courts. In particular, a majority of individuals entering the state-run facilities for people with mental illness do so following a court order or an "emergency hold" that requires a court order to continue. This chapter examines statutory provisions related to the civil commitment process and discusses how often Minnesota courts have made such commitments. We did not examine civil commitments of individuals as a "sexual psychopathic personality" or a "sexually dangerous person," which are two other types of civil commitments authorized in Minnesota law."[2]

COMMITMENT PROCESS

The processes to civilly commit individuals as mentally ill, chemically dependent, or developmentally disabled are similar to each other. Exhibit 4.1 shows the statutory definitions of individuals committed in these categories. There are somewhat different statutory provisions for civilly committing an individual as "mentally ill and dangerous," and we discuss these differences in the next section ("Statutory Issues").

The civil commitment process often begins after an individual's behavior indicates possible danger to self or others. Sometimes this behavior leads to an

[1] *Minnesota Statutes* 2012, 253B.04, subd. 1(a).

[2] The commitment process for these individuals is addressed in a separate section of *Minnesota Statutes* 2012, chapter 253B. We evaluated these commitments in: Office of the Legislative Auditor, *Civil Commitment of Sex Offenders* (St. Paul, 2011).

Exhibit 4.1: Definitions of "Mentally Ill," "Chemically Dependent," and "Developmentally Disabled" in Minnesota's Civil Commitment Law, 2012

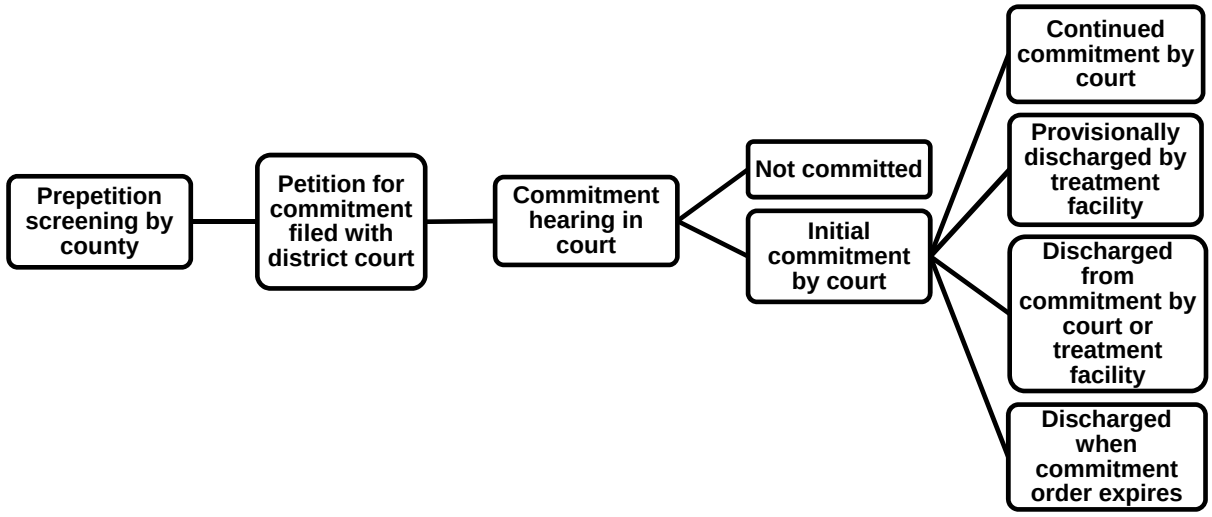
Category	Definition
Mentally Ill	A person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which is manifested by instances of grossly disturbed behavior or faulty perceptions and poses a substantial likelihood of physical harm to self or others as demonstrated by: • a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment; • an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided; • a recent attempt or threat to physically harm self or others; or • recent and volitional conduct involving significant damage to substantial property.
Chemically Dependent	A person: (1) who is determined to be incapable of self-management or management of personal affairs by reason of the habitual and excessive use of alcohol, drugs, or other mind-altering substances; and (2) whose recent conduct as a result of habitual and excessive use of alcohol, drugs, or other mind-altering substances poses a substantial likelihood of physical harm to self or others as demonstrated by: (a) a recent attempt or threat to physically harm self or others, (b) evidence of recent serious physical problems, or (c) a failure to obtain necessary food, clothing, shelter, or medical care. Also, a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following substances or their derivatives: opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine, tetrahydrocannabinol, or alcohol.
Developmentally Disabled	A person: (1) who has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior and who manifests these conditions prior to the person's 22nd birthday; and (2) whose recent conduct is a result of a developmental disability and poses a substantial likelihood of physical harm to self or others in that there has been: (a) a recent attempt or threat to physically harm self or others, or (b) a failure and inability to obtain necessary food, clothing, shelter, safety, or medical care.

SOURCE: *Minnesota Statutes* 2012, 253B.02, subds. 2, 13, and 14.

"emergency hold," in which the individual may be kept for a short period in a secure setting.[3] As shown in Exhibit 4.2, the civil commitment process begins in earnest with a "**prepetition screening**," a preliminary investigation by a county human services agency to determine if an individual meets commitment requirements. This screening may be requested by a family member or other "interested person."[4]

After prepetition screening, an interested person can file a **petition for commitment** in district court.[5] Once a petition has been filed, the court may issue a judicial hold, ordering the patient to be held in a treatment facility while awaiting completion of the commitment proceedings.

Exhibit 4.2: Process for Committing Individuals as Mentally Ill, Chemically Dependent, or Developmentally Disabled, 2012



NOTE: This represents a simplified depiction of the sequence of steps outlined in statutes for civil commitments, from the initiation of the petition for commitment to discharge of the commitment.

SOURCE: Office of the Legislative Auditor, analysis of *Minnesota Statutes* 2012, 253B.

[3] The head of a treatment facility may authorize an emergency hold for up to 72 hours, based on a trained examiner's statement that a person is mentally ill, chemically dependent, or developmentally disabled and in danger of injuring self or others. A person may not be held for more than 72 hours without a court order; a treatment facility may not issue consecutive emergency holds. See *Minnesota Statutes* 2012, 253B.02, subd. 7, and 253B.05, subds. 1-3.

[4] An "interested person" may include a public official, legal guardian, spouse, parent, legal counsel, adult child, next of kin, or other person designated by the client, according to *Minnesota Statutes* 2012, 253B.02, subd. 10.

[5] According to *Minnesota Statutes* 2012, 253B.07, the petition must include descriptions of the patient's recent behaviors and a statement supporting commitment by a physician or other professional specified in statute who recently examined the patient. The head of a treatment facility must file a petition for commitment if he or she believes that commitment is required and no petition has been filed.

The court then holds a **commitment hearing.**[6] If the court finds by clear and convincing evidence that an individual is mentally ill, chemically dependent, or developmentally disabled, and there is no suitable alternative to judicial commitment, it must commit the patient to the least restrictive treatment program or alternative program that can meet the patient's treatment needs.[7] According to state law,[8]

- **Courts may make commitments to a range of treatment programs, including state-run facilities, acute care hospitals, community residential treatment, or community-based nonresidential treatment.**

If a court wishes to commit an individual to a state-run facility, the court must commit the person to the Commissioner of Human Services; the law says the commissioner shall then designate where the individual will be placed.[9] The initial commitment begins on the date of the court order, and it cannot exceed six months.[10]

By law, the courts must commit individuals as mentally ill or chemically dependent for limited periods, although these periods may be extended by subsequent court actions.

Upon petition, the court can later **continue a commitment** if it finds by clear and convincing evidence that: (1) the person continues to be mentally ill, chemically dependent, or developmentally disabled; (2) involuntary commitment is necessary for the protection of the patient or others; and (3) there is no alternative to involuntary commitment.[11] The court can continue a commitment for a person who is mentally ill or chemically dependent for up to 12 months at a time. For a person with developmental disabilities, continued commitment is for an indeterminate amount of time, meaning there is no scheduled time frame for judicial review of the commitment.

The head of a treatment facility can "**provisionally discharge**" a patient committed as mentally ill, chemically dependent, or developmentally disabled.[12] This means that the individual is released but remains under court commitment. State law authorizes county human services agencies to revoke an individual's provisional discharge under certain circumstances, resulting in a return to the treatment facility. Each patient released on provisional discharge must have a written aftercare plan.

"**Discharge**" refers to the end of a civil commitment, without provisions. Discharge of an individual committed as mentally ill or chemically dependent occurs: (1) when the court, in response to a petition, determines that the individual is no longer in need of care and treatment (or is no longer mentally ill or chemically dependent); (2) when the treatment facility head certifies that the

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[6] *Minnesota Statutes* 2012, 253B.08, subd 1(a).

[7] *Minnesota Statutes* 2012, 253B.09, subd. 1(a). The court can also stay an order for commitment for up to 6 months and can then continue the order for a maximum of an additional 12 months.

[8] *Ibid.*, subd. 1(b).

[9] *Ibid.*, subd. 1(c).

[10] *Ibid.*, subd. 5.

[11] *Minnesota Statutes* 2012, 253B.12, subd. 4.

[12] *Minnesota Statutes* 2012, 253B.15, subd. 1.

patient no longer needs care and treatment; or (3) at the conclusion of the commitment order. Discharge of an individual committed as developmentally disabled occurs: (1) when the court, in response to a petition, determines that the individual is no longer in need of care and treatment; or (2) when the individual's statutorily designated screening team determines that the individual's needs can be met by community services and has a plan to place the person in available services.[13]

STATUTORY ISSUES

Beyond the definition of mental illness shown in Exhibit 4.1, state law has a separate definition of a person who is "mentally ill and dangerous to the public," which is described in Exhibit 4.3. However,

- **In Minnesota law, the definitions of "mentally ill" and "mentally ill and dangerous" used in civil commitment overlap one another.**

By the statutory definition, a person with mental illness "poses a substantial likelihood of physical harm to self or others."[14] The law says this can be demonstrated by "a recent attempt or threat to physically harm self or others."[15] In comparison, the statutory definition of a mentally ill and dangerous person is a person who "presents a clear danger to the safety of others," as demonstrated by a previous attempt to cause "serious physical harm" and the "substantial likelihood" of such attempts in the future.[16] A person who poses a threat to

Exhibit 4.3: Definition of "Mentally Ill and Dangerous" in Minnesota's Civil Commitment Law, 2012

Category	Definition
Mentally Ill and Dangerous	A person who: (1) is mentally ill; and (2) as a result of that mental illness presents a clear danger to the safety of others as demonstrated by the facts that: (a) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and (b) there is a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.

SOURCE: *Minnesota Statutes* 2012, 253B.02, subd. 17.

[13] *Minnesota Statutes* 2012, 253B.16, subd. 1, and 253B.17. These provisions do not apply to individuals committed as mentally ill and dangerous. The "screening team" specified for individuals with developmental disabilities is described in *Minnesota Statutes* 2012, 256B.092, subd. 7. A court's order that a person no longer needs care or treatment, or is not mentally ill, chemically dependent, or developmentally disabled, is referred to in statute as a "release" rather than a "discharge."

[14] *Minnesota Statutes* 2012, 253B.02, subd. 13.

[15] *Ibid.*

[16] *Ibid.*, subd. 17.

others could be civilly committed under either definition.[17] The definition of a mentally ill and dangerous person mentions *serious* physical harm, not just physical harm, although the difference is open to interpretation. Legal experts we spoke with said the statutory definitions leave considerable discretion to the court.

The overlapping definitions are important because:

- **Commitments of individuals as mentally ill and dangerous are substantively different than commitments for persons with mental illness.**

The commitment of an individual as mentally ill and dangerous lasts for an undefined period of time, and the affected individual cannot petition the original court to review the commitment.

The procedure leading up to an individual's commitment as mentally ill and dangerous is similar to the process we described above for other types of commitments. However, the nature of the commitment and the process after commitment are quite different.

First, mentally ill and dangerous persons must be committed to a secure treatment facility "unless the patient establishes by clear and convincing evidence that a less restrictive treatment program is available that is consistent with the patient's treatment needs and the requirements of public safety."[18] In contrast, courts have latitude to commit persons as mentally ill to a variety of state or community-based programs, with few restrictions.

Second, individuals committed as mentally ill and dangerous are committed for an indefinite time period. At the end of a 60-day initial commitment period, if the court chooses to continue the commitment as mentally ill and dangerous, the law provides no option for a time-limited commitment.[19] Individuals remain committed as mentally ill and dangerous for the rest of their lives unless they are discharged under a special process (described below). In contrast, individuals committed as mentally ill but not dangerous must have their commitments reviewed by a court at least every 12 months.

Third, unlike other types of commitments, persons committed as mentally ill and dangerous cannot petition the original court to review the commitment. Instead, the law authorizes the Commissioner of Human Services to establish a "special review board" to consider requests for transfers to less secure facilities or discharges from commitment.[20] The special review board hears each petition for

[17] According to *Minnesota Statutes* 2012, 253B.18, subd. 1, when an individual is found not guilty of a crime against another person by reason of mental illness, this verdict "constitutes evidence that the proposed patient is a person who is mentally ill and dangerous."

[18] *Ibid.* As defined in *Minnesota Statutes* 2012, 253B.02, subd. 18a, a secure treatment facility means the secure portions of the Minnesota Security Hospital and the Minnesota Sex Offender Program.

[19] *Minnesota Statutes* 2012, 253B.18, subd. 3.

[20] *Ibid.*, subd. 4c. A patient or the Minnesota Security Hospital medical director can file a petition for a reduction of custody or revocation of provisional discharge with the commissioner. The patient cannot file a petition for six months after he or she is committed indeterminately, but the medical director can file a petition at any time. By law, the special review board consists of three members experienced in the field of mental illness and must include a psychiatrist and an attorney.

transfer or discharge and makes a recommendation to the commissioner. We reviewed the cases of eight individuals who remained at the Minnesota Security Hospital for more than 30 years. According to SOS records, four never petitioned the special review board for a hearing during their decades in the Security Hospital, and the others had from two to five petitions each.

State law establishes an administrative process to determine whether individuals committed as mentally ill and dangerous should be discharged.

Individuals committed as mentally ill and dangerous may be transferred or discharged only if the special review board recommends in favor of the requested action and the commissioner agrees.[21] A person cannot be discharged unless it appears to the commissioner, after a favorable recommendation by the special review board, "that the person is capable of making an acceptable adjustment to open society, is no longer dangerous to the public, and is no longer in need of inpatient treatment and supervision."[22] State law authorizes individuals to appeal decisions by the commissioner to a three-judge appeal panel.[23] Unlike other types of commitments discussed earlier, however, judicial review of a person committed as mentally ill and dangerous occurs at the initiation of the individual or others rather than at intervals specified in law.

We also found that:

- **Minnesota laws that provide for indefinite commitment of certain individuals are unusual and open to legal challenges.**

In a 1975 decision (*O'Connor v. Donaldson*), the U.S. Supreme Court held that confinement under an involuntary commitment cannot continue after the basis for the commitment no longer exists.[24] In that case, a jury determined that a long-institutionalized patient was not dangerous, and the Supreme Court said there was "no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."[25] A subsequent decision by the Connecticut Supreme Court held that civilly committed individuals must be granted periodic judicial review of their continued confinement—initiated by the state, not by the individual.[26] Starting decades ago, there was a "virtual demise" nationally of indeterminate involuntary institutionalization, according to a review published by the American Bar Foundation.[27] More recently, a published summary of civil commitment law said the right of clients to periodic judicial

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[21] *Ibid.*, subds. 6, 7, and 15.

[22] *Ibid.*, subd. 15. Subdivisions 7 through 10 allow for *provisional* discharge of a patient, in which case the county social service agency must develop, implement, and monitor a provisional discharge plan.

[23] *Minnesota Statutes* 2012, 253B.19. The law also authorizes the county attorney of the county that committed the individual, or the county attorney of the individual's county of financial responsibility, to appeal a decision by the commissioner.

[24] O'Connor v. Donaldson, 422 U.S. 575 (1975).

[25] *Ibid.*

[26] Fasulo v. Arafeh, 173 Conn. 483, 378 A.2d (1977).

[27] Samuel Jan Brakel, John Parry, and Barbara A. Weiner, *The Mentally Disabled and the Law*, 3rd ed. (Chicago: American Bar Foundation, 1985), 72.

review is "firmly entrenched" in the law, and the author told us that indefinite civil commitment without such review is, in his opinion, unconstitutional.[28]

RECOMMENDATION

The Legislature should amend Minnesota statutes to give district courts continuing jurisdiction over all individuals civilly committed as mentally ill and dangerous or as developmentally disabled, and provide for periodic judicial review of their need for continued commitment.

It would be preferable for commitments to be reviewed on a regular schedule, rather than relying on committed individuals to initiate the review process.

This recommendation would affect two types of commitments.[29] For individuals committed as mentally ill and dangerous, once a district court makes a final determination and commits the individual for an indeterminate period, its jurisdiction ends. This is different from cases in which individuals are committed as mentally ill; for those cases, the court periodically reconsiders whether the commitment is appropriate. Although statutes provide for a patient-initiated administrative process to review ongoing commitments, we question whether relying on a patient-initiated process provides sufficient protections. As the Connecticut Supreme Court ruled in a significant case,

> The burden should not be placed on the civilly committed patient to justify his right to liberty…. The burden must be placed on the state to prove the necessity of stripping the citizen of one of his most fundamental rights…. [The state's argument for a patient-initiated procedure] ignores the practical difficulties of requiring a mental patient to overcome the effects of his confinement, his closed environment, his possible incompetence and the debilitating effects of drugs or other treatment on his ability to make a decision which may amount to the waiver of his constitutional right to a review of his status.[30]

In our view, it would be more legally defensible to have the committing court follow a regular schedule for reviewing whether a committed individual is still mentally ill and dangerous.

Our recommendation also would affect certain commitments of individuals as developmentally disabled. The law authorizes such commitments to be made for an indefinite period of time. The statutes have provisions under which these individuals may petition for their discharge from commitment, but we again question why discharges should depend on the initiative of the committed person.

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[28] Michael L. Perlin, *Mental Disability Law: Civil and Criminal*, 2nd ed. (Charlottesville, VA, 1998), 462, and e-mail from Professor Michael Perlin, New York Law School, to Joel Alter, Office of the Legislative Auditor, September 24, 2012.

[29] Individuals committed as sex offenders are also committed indefinitely. Because SOS does not serve persons with such commitments, we did not examine and offer no recommendations on the commitment process for sex offenders. However, the legal issues we raise in this chapter call into question any use of commitments without ongoing judicial review.

[30] Fasulo v. Arafeh, 173 Conn. 480-482, 378 A.2d (1977).

If the Legislature adopts our recommendation for periodic judicial review, it may also wish to consider giving the courts additional commitment options. For example, legal experts suggested that it might be helpful for statutes to provide the courts with the ability to amend prior commitment orders.[31]

COMMITMENT PRACTICES

In addition to looking at civil commitment laws, we examined the extent to which individuals have been committed as well as the variation in commitments throughout the state. We used statewide data from the State Court Administrator's Office regarding court judgments on civil commitments and petitions for such judgments. Due to limited data for earlier years, we focused on civil commitment decisions that occurred between January 2011 and June 2012.

Individuals Committed

We found that:

- **Commitment of individuals as mentally ill is by far the most common type of civil commitment.**

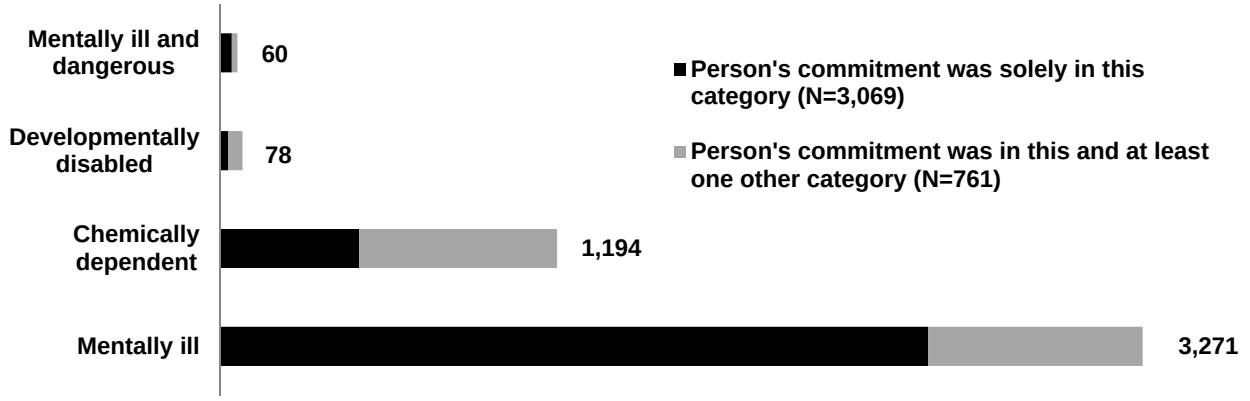
Commitments of individuals as developmentally disabled or mentally ill and dangerous are relatively uncommon.

Exhibit 4.4 shows the number of persons civilly committed by a court from January 2011 through June 2012. Some were committed in more than one category; in such cases, we counted individuals in each category for which they were committed. Of the 3,830 individuals committed during this period, 3,271 individuals (85 percent) were committed as mentally ill, with 2,510 committed solely as mentally ill. In contrast, of 1,194 individuals who were committed as chemically dependent, a majority were also committed in one of the other categories during the 18-month period.

Substantially fewer individuals were committed as developmentally disabled or mentally ill and dangerous during this period. Sixty individuals were committed by a court as mentally ill and dangerous during this period, including 20 who had a mentally ill and dangerous commitment as well as another type of commitment. Seventy-eight individuals were committed as developmentally disabled, including 51 who had this commitment combined with another type of commitment.

[31] For commitments now subject to judicial review, courts can continue the original commitment order or release the individual from commitment. The Legislature may wish to consider additional options—such as allowing courts to "stay" (that is, suspend) a portion of the original commitment that no longer applies to the individual while continuing other parts. For example, a court could be allowed to determine that a person committed as mentally ill and dangerous no longer poses a clear danger to the safety of others (and thus suspend the "dangerous" part of the commitment) while continuing the commitment order to ensure that the individual receives ongoing mental health treatment.

Exhibit 4.4: Number of Persons Civilly Committed in Various Categories, January 2011 through June 2012



NOTES: The data are based on an analysis of commitment decisions made during an 18-month period. The light gray portion of the bars includes individuals committed in more than one of the categories shown—either as part of a single commitment (for example, being committed by the court as mentally ill and chemically dependent on the same date) or in more than one commitment (for example, a commitment as mentally ill on one date and a separate commitment of chemically dependent several months later). Within a given category of commitment (such as mentally ill), an individual is counted only once, even if the person had more than one commitment. Individuals with commitments in different categories are represented more than once. Data on 3,830 unique individuals are shown.

SOURCE: Office of the Legislative Auditor, analysis of data from Minnesota State Court Administrator's Office.

Variation in Commitments Around Minnesota

Some people involved in the commitment process expressed concerns to us that courts around the state have been inconsistent in their commitment practices. We found that:

- **Courts throughout Minnesota have varied in their rates of civil commitment.**

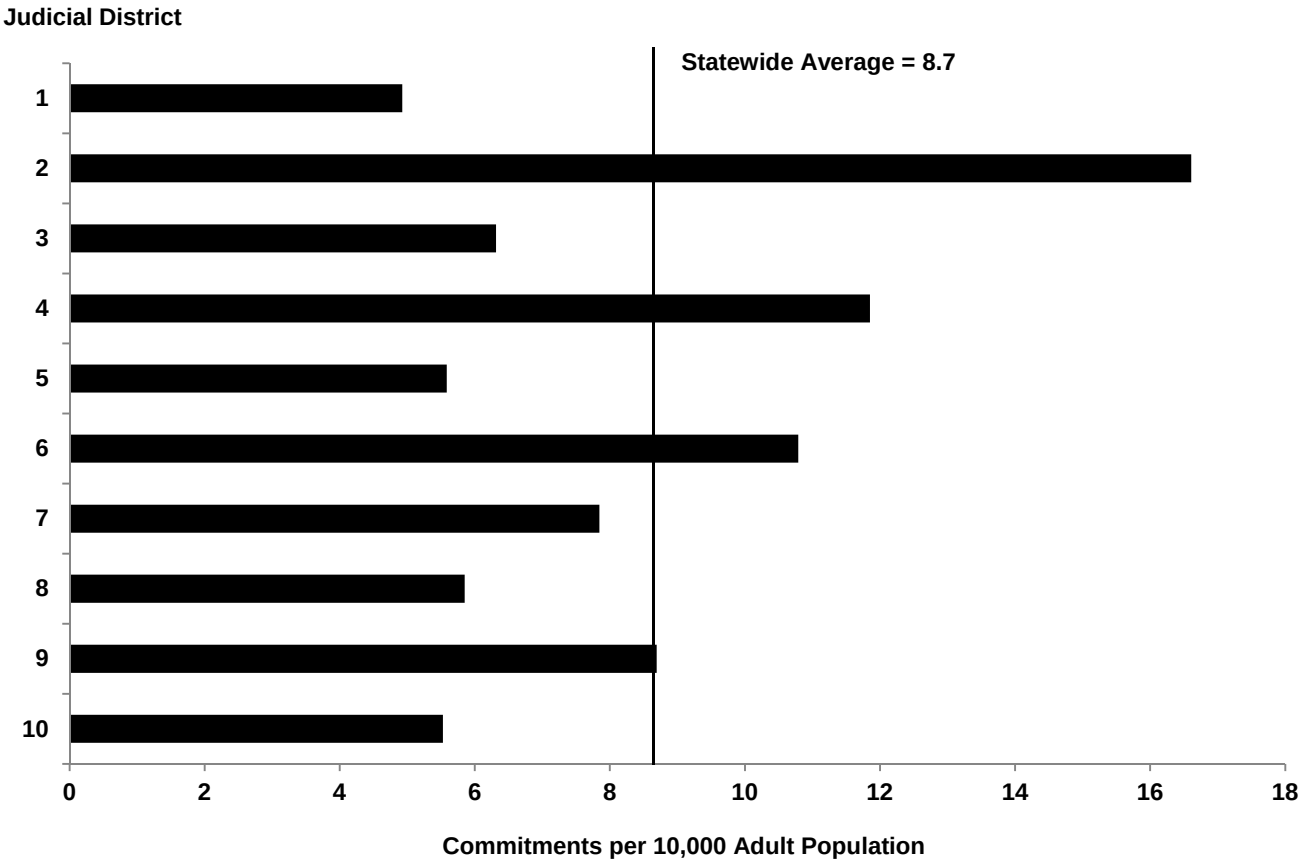
Statewide, there were 8.7 commitments annually for every 10,000 adult residents. Exhibit 4.5 shows the variation in annual commitment rates among the state's ten judicial districts.[32] Judicial districts 2 and 4 (Ramsey and Hennepin counties, respectively) had higher than average commitment rates, with 16.6 and 11.9 commitments per 10,000 adults, respectively. District 6 in northeastern Minnesota also had an above average rate of commitments, with 10.8 commitments per 10,000 adults. On the other hand, the judicial districts with the lowest rates were District 1 (in areas mostly south and west of Hennepin and Ramsey counties), District 5 (in southwestern Minnesota), and District 10 (in

[32] We examined *commitments* per 10,000 adult population in each district rather than the unique number of *individuals* committed. A commitment is a court judgment to commit a person as mentally ill, chemically dependent, developmentally disabled, or mentally ill and dangerous. For this analysis, one judgment resulting in two different commitment types (for example, an individual committed as mentally ill and chemically dependent at the same judgment) was considered one commitment. We annualized rates by dividing commitments during an 18-month period by 1.5.

areas mostly north and east of Hennepin and Ramsey counties), all of which had fewer than 6 commitments per 10,000 adult residents.

There was a wide range of annual commitment rates in individual counties. Exhibit 4.6 shows the variation among counties with populations over 50,000. As noted earlier, Ramsey and Hennepin counties had rates well above the statewide average. In addition, St. Louis County had a commitment rate of 11.1 commitments per 10,000 adults. But several high-population counties had commitment rates well below the state average. Wright and Washington counties

Exhibit 4.5: Average Annual Commitments per 10,000 Adult Population by Judicial District, January 2011 through June 2012



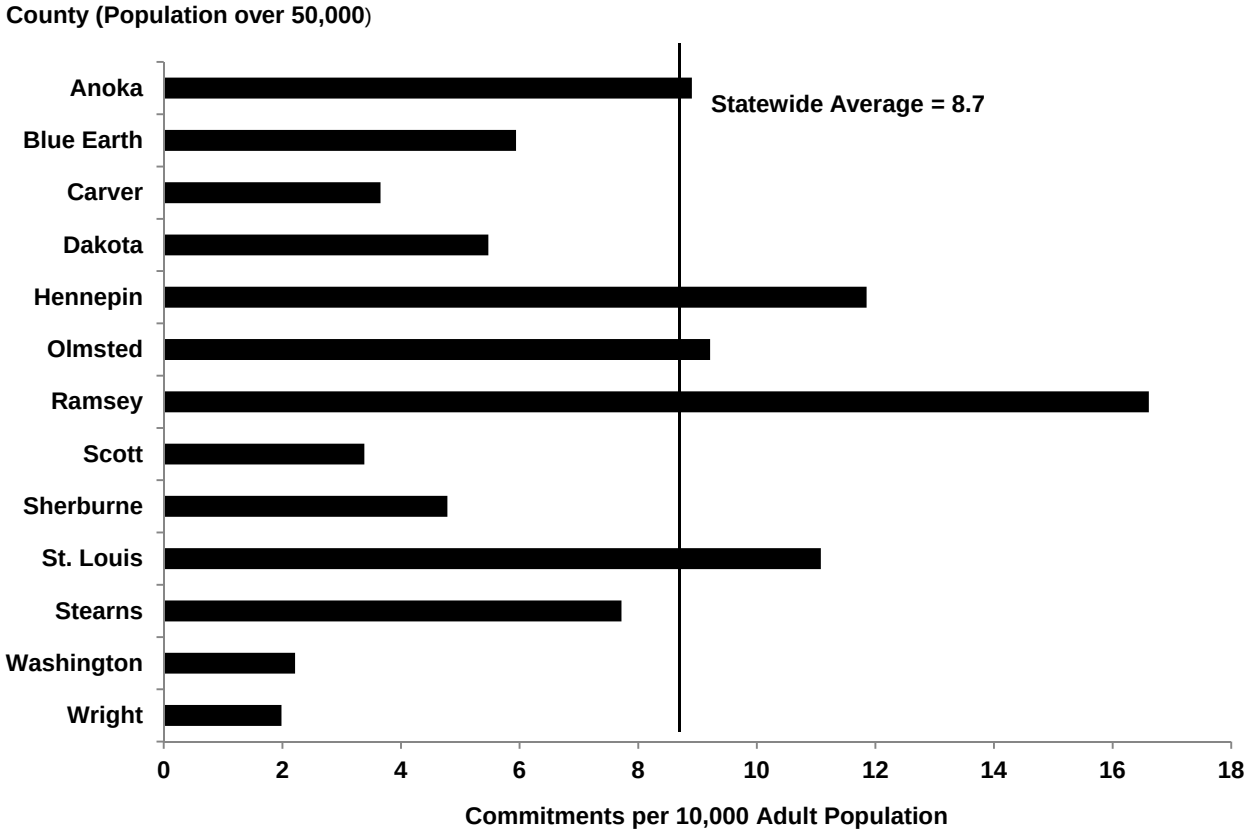
NOTES: A commitment is any judgment by a court to civilly commit a person as mentally ill, chemically dependent, developmentally disabled, or mentally ill and dangerous. A single judgment resulting in two different commitment types (for example, an individual committed as mentally ill and chemically dependent at the same judgment) was considered one commitment for the purpose of this analysis. We computed annual averages by dividing the total number of commitments over the period by 1.5.

SOURCES: Office of the Legislative Auditor, analysis of data from Minnesota State Court Administrator's Office and 2010 U.S. Census data.

had rates of close to 2 commitments per 10,000 adults, and Scott and Carver counties had rates of about 4 commitments per 10,000.[33]

There are a number of possible explanations for the variation in commitment rates around the state. For example, there may be underlying differences in the characteristics of the populations of various regions and individual counties. Locations with higher poverty rates or a greater concentration of social services might have more individuals who have debilitating conditions. In addition, differences in commitment rates might be influenced by the extent to which

Exhibit 4.6: Average Annual Commitments per 10,000 Adult Population by County, January 2011 through June 2012



NOTES: A commitment is any judgment by a court to civilly commit a person as mentally ill, chemically dependent, developmentally disabled, or mentally ill and dangerous. A single judgment resulting in two different commitment types (for example, an individual committed as mentally ill and chemically dependent at the same judgment) was considered one commitment for the purpose of this analysis. We computed annual averages by dividing the total number of commitments by 1.5.

SOURCES: Office of the Legislative Auditor, analysis of data from Minnesota State Court Administrator's Office and 2010 U.S. Census data.

[33] A long-standing agreement between Washington and Ramsey counties helps to explain Washington's relatively low rate. The Second District (Ramsey County) handles cases from Washington County (in the Tenth District) involving petitions for (1) commitments of individuals as mentally ill or (2) dual commitments of individuals as mentally ill and chemically dependent.

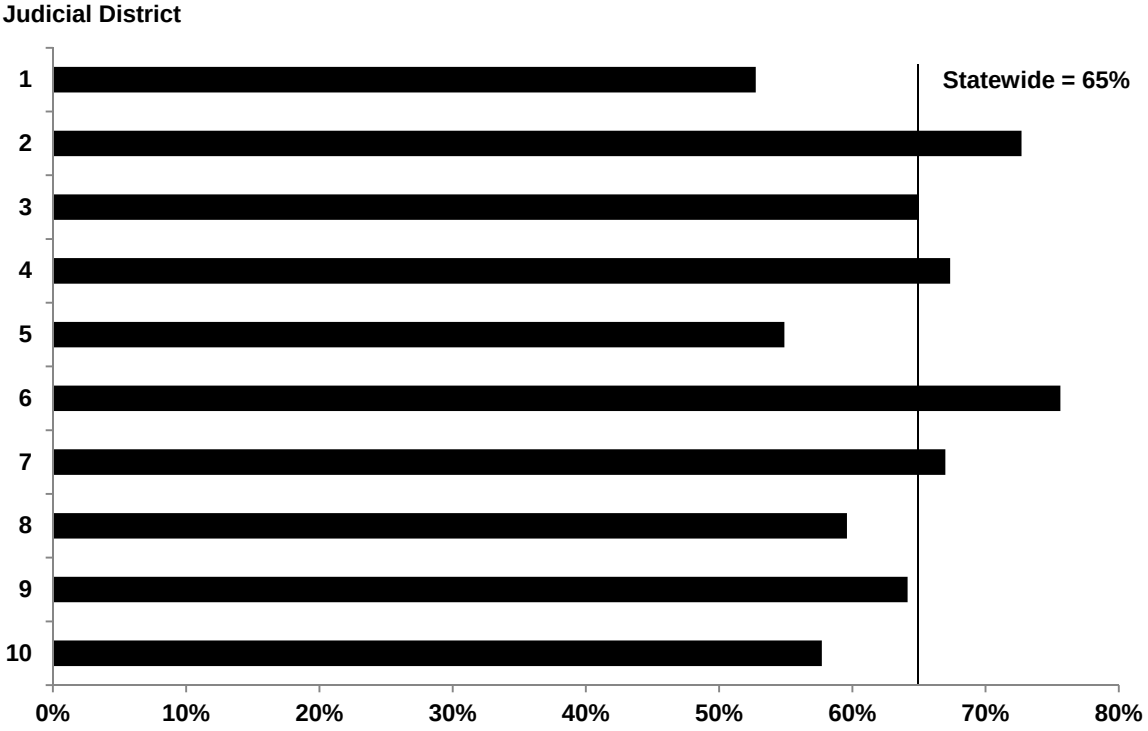
individual counties or other entities go to court to petition for civil commitments, as well as the extent to which individual judges decide to commit individuals for whom petitions have been offered.

One factor that can affect commitment rates is the proportion of petitions for commitment that result in court decisions to commit. Thus, in addition to looking at variation in commitment rates, we also examined variation in petitions as a percentage of commitments. We found:

- **There were limited differences among judicial districts in the percentage of petitions resulting in commitments.**

Statewide, 65 percent of petitions filed in 2011 resulted in commitments. As can be seen from Exhibit 4.7, most individual judicial districts differed by no more than ten percentage points from the statewide average. Overall, there was a strong relationship between judicial districts' percentage of petitions resulting in

Exhibit 4.7: Percentage of Petitions Resulting in Commitments by Judicial District, 2011



NOTES: A petition is a request to a court for a commitment. A commitment is any judgment by a court to civilly commit a person as mentally ill, chemically dependent, developmentally disabled, mentally ill and dangerous, or as a combination of one or more categories. A single petition may result in more than one commitment. The chart above shows 3,982 petitions, including 13 petitions still pending without a judgment as of June 30, 2012. We excluded 80 petitions filed that were closed with no judgment.

SOURCE: Office of the Legislative Auditor, analysis of data from Minnesota State Court Administrator's Office.

commitment and their commitment rates per 10,000 residents.[34] District 6 had the highest percentage of petitions resulting in commitments (75 percent); it also had a high number of commitments per 10,000 residents. The lowest percentages were in districts 1 and 5, with 53 percent and 55 percent, respectively; both districts also had low rates of commitment per 10,000 residents.

DATA ISSUES

Commitments to the Commissioner of Human Services

Courts commit individuals to the Commissioner of Human Services, a specific facility, or both.

For persons committed as mentally ill, chemically dependent, or developmentally disabled, Minnesota law requires courts to commit the individual to the least restrictive treatment program or alternative program that can meet the individual's needs.[35] A court may commit an individual to the Commissioner of Human Services or to a specific facility or program; sometimes it does both.[36] (A court that makes a commitment to a specific facility might, as a back-up, also make the commitment to the commissioner in case the facility is not able to admit the individual.) Based on our review of court commitments over a recent 18-month period, we found that:

- **Seventy-four percent of all commitment orders assigned the committed person to the custody of the Commissioner of Human Services.**

The commitments to the Commissioner of Human Services were about evenly split between those assigned solely to the commissioner and those assigned to the commissioner in combination with a specific state or nonstate facility, as shown in Exhibit 4.8. Approximately half of the commitments specified an individual treatment facility—state-operated or nonstate—for the individual. In the data we obtained from the Office of the State Court Administrator, 10 percent of all commitments had no information on where the individual was committed.[37]

For individuals committed by the courts to both the Commissioner of Human Services and a nonstate facility, state law does not specify exactly what the commissioner's legal responsibilities may be. In fact, the law does not make any provision for "dual commitments." The law says that courts may not commit individuals to facilities or programs "not capable of meeting the patient's

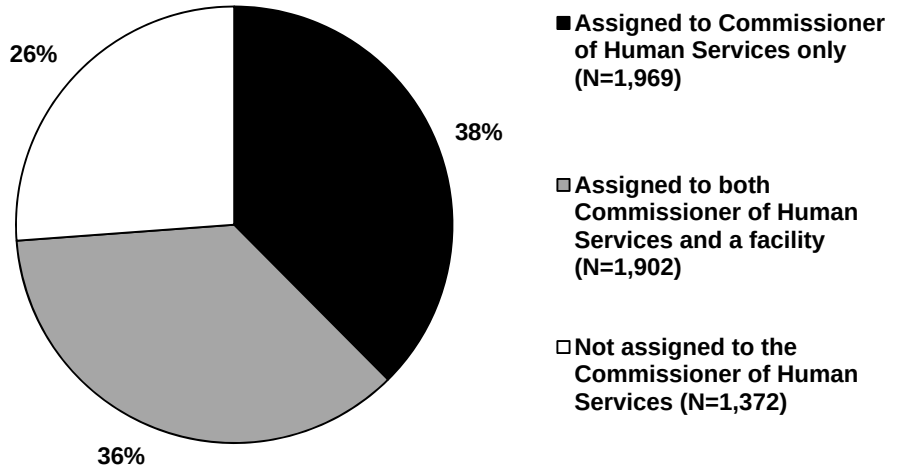
[34] Among judicial districts, there was a strong positive association ($r = +0.81$) between the commitment rates discussed previously and the percentages of petitions that resulted in commitments.

[35] *Minnesota Statutes* 2012, 253B.09, subd. 1(a).

[36] *Ibid.*, subd. 1. If a court wishes to commit an individual to a state-operated facility, the court is supposed to make the commitment to the commissioner, allowing the commissioner to designate the specific facility to which the individual will be assigned. In practice, courts sometimes commit individuals to specific SOS facilities.

[37] It is not clear if the commitment orders did not list a commitment location or if this information was not transmitted to the Office of the State Court Administrator.

Exhibit 4.8: Total Commitments by the Court's Assignment of Responsibility, January 2011 through June 2012



NOTES: A commitment is a judgment by a court to civilly commit a person as mentally ill, chemically dependent, developmentally disabled, or mentally ill and dangerous. A single judgment resulting in two different commitment types (for example, an individual committed as mentally ill and chemically dependent at the same judgment) was considered one commitment for the purpose of this analysis.

SOURCE: Office of the Legislative Auditor, analysis of data from Minnesota State Court Administrator's Office.

When a person is committed to both a nonstate facility and the Commissioner of Human Services, the commissioner's responsibility is unclear.

needs."[38] It is an open question whether the commissioner bears legal responsibility to ensure that individuals' needs are met when they are placed in a nonstate facility following a commitment that simultaneously assigns them to the commissioner's custody.

While DHS has information on individuals placed in state-run facilities, it appears that:

- **Minnesota courts often do not inform the Department of Human Services when committing individuals to both nonstate facilities and the Commissioner of Human Services.**

According to Minnesota law, when a court commits an individual to a non-SOS program or facility, the court must report the commitment to DHS.[39] In fact, the state judicial branch has developed a form for this purpose. However, the judicial branch's form for reporting individuals committed to nonstate facilities

[38] *Minnesota Statutes* 2012, 253B.09, subd. 1(b). This section pertains to individuals committed as mentally ill, chemically dependent, or developmentally disabled.

[39] *Ibid.*, subd. 3a. The law says that this requirement is "for purposes of [DHS] providing commitment information [to law enforcement agencies] for firearm background checks." We discuss these background checks later in the chapter.

DHS does not have complete information on individuals committed to the commissioner.

does not indicate whether the commitment was also made to the Commissioner of Human Services. Further, DHS staff told us they generally receive this form from only a few of the state's counties. Thus, DHS has incomplete information on individuals committed to nonstate facilities, and it does not know which of these cases involve dual commitments to the commissioner.

We provided DHS with names and birthdates for a sample of 96 individuals who had been committed to both non-SOS facilities and the Commissioner of Human Services. When DHS staff searched the department's records—including information submitted to DHS by the courts—for information related to this sample, they found records for only 22 percent of these individuals.

RECOMMENDATION

The Legislature should amend state law to require the Office of the State Court Administrator to periodically provide the Department of Human Services with information on all individuals committed to the Commissioner of Human Services.

Even if DHS is not currently providing services to an individual committed to the commissioner, DHS should be aware of all such commitments. The Legislature could require each court to report information to DHS each time it committed someone to the Commissioner of Human Services. However, the individual courts have often not provided the commitment information to DHS that they are currently required to provide. We think it would be more efficient and effective for DHS to obtain information on commitments to the commissioner from a central source—the Office of the State Court Administrator, which maintains statewide data on court actions. We recommend that the Legislature amend state law to require this judicial office to periodically provide information to DHS on all commitments to the Commissioner of Human Services, including the type of commitment, the time period of the commitment, and all entities to whom the individual was committed. Going forward, this would provide DHS with information on all commitments to the commissioner.

Firearms-Related Background Checks

Another reason for DHS to have information on commitments is to conduct background checks required by state law. The law says:

> [T]he commissioner of human services shall provide commitment information to local law enforcement agencies on an individual request basis…for the sole purpose of facilitating a firearms background check…or an explosives background check…. The information to be provided is limited to whether the person has been committed under chapter 253B and, if so, the type of commitment.[40]

[40] *Minnesota Statutes* 2012, 245.041.

DHS is statutorily required to help law enforcement agencies determine whether individuals applying for firearm permits have been civilly committed.

State law prohibits individuals who have been committed as mentally ill, developmentally disabled, chemically dependent, or mentally ill and dangerous from possessing a firearm, except in specified circumstances.[41] Local law enforcement authorities are required by law to obtain commitment information from DHS (or from another state "if the information is reasonably available") before granting permits to individuals to carry or possess firearms.[42]

Using data from the State Court Administrator's Office, we provided DHS with identifying information on samples of individuals who had been civilly committed by a Minnesota court in recent years. We then asked DHS staff to search the databases to which they had access to determine whether those databases indicated that the individual had any history of a court commitment. In effect, we asked DHS staff to conduct searches comparable to the firearms background checks they regularly conduct at the request of law enforcement agencies. We found that:

- **Searches conducted by Department of Human Services staff identified most—but not all—instances in which the individuals should be denied access to firearms based on their commitment history.**

We provided DHS with names and birthdates of 191 individuals we knew had been civilly committed, and DHS conducted background searches of these individuals.[43] The department reviewed its own databases of individuals previously or currently served in state-operated services, which often include information on any civil commitments involving these individuals. In addition, DHS used its access to a statewide court database to search for commitment information on these individuals.

For 98 percent of the individuals reviewed, DHS found evidence of a commitment that would disqualify the individual from firearm access; for the other 2 percent, it did not.[44] It is unclear why DHS's searches did not reveal

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[41] *Minnesota Statutes* 2012, 624.713, subd. 1. This law establishes a procedure by which courts may restore an individual's right to possess a firearm. Also, individuals committed as chemically dependent may, under this law, have their rights restored if they complete treatment.

[42] *Minnesota Statutes* 2012, 624.714, subd. 4. Because this statute requires local law enforcement to obtain commitment information from DHS or from another state, there may be instances in which Minnesota law enforcement officials only request information from another state, not from DHS. In addition, *Minnesota Statutes* 2012, 624.7131, subd. 2, and 624.7132, subd. 2, require law enforcement agencies to obtain commitment information from DHS when the possession of certain types of firearms is proposed for "transfer" to individuals.

[43] We selected (1) a random sample of 100 individuals committed between January 2007 and June 2012, and (2) a sample of 116 individuals committed to both the Commissioner of Human Services and a non-DHS facility during this same period. Some individuals in the samples did not have birthdate information in the data provided to us by the State Court Administrator's Office; DHS staff told us they would be unable to conduct reliable searches for these 25 individuals, and we excluded them from the searches. In total, DHS searched its databases for information on 95 individuals from our random sample and 96 individuals from our nonrandom sample.

[44] Although DHS found no evidence of commitment for some previously committed individuals, this does not necessarily mean that such individuals would have been inappropriately granted a firearm permit. Law enforcement looks at other sources of information during the permitting process, in addition to DHS's background checks.

For a sample of cases we identified, DHS's background checks usually—but not always—detected individuals with prior commitments.

certain individuals' prior commitments. Department staff searched for exact matches of the names and birthdates we provided with those in their databases, so any deviation between the identifying information entered by DHS and the information it searched could have resulted in failure to identify prior commitments. It is worth noting that DHS has access to only a portion of the statewide court database, and the depth of information DHS can access directly on these individuals and their commitment history is limited.[45]

RECOMMENDATION

The Department of Human Services should periodically test the accuracy of its firearms-related background checks and explore ways to mitigate possible errors.

Given that one of the information systems DHS searched in its background checks was the same system from which we drew our sample of committed individuals, it seems odd that DHS did not find matches for all of the cases. This could indicate inconsistencies in the way identifying information was recorded within the court information system, or it could reflect problems in the way DHS conducted some searches. DHS, working with the State Court Administrator's Office, should more closely review the cases from our sample for which DHS could not find evidence of commitments. Periodically, DHS—working with this court office—should test the accuracy of DHS background searches, focusing on individuals who had been committed to non-SOS facilities.[46]

Department of Human Services officials suggested to us that other entities—such as the court system or the Bureau of Criminal Apprehension—might be better suited to conduct searches for court commitments as a part of firearms-related background checks. The department noted that the judicial branch maintains the statewide database on court commitments. Although DHS searches the judicial branch's records when it conducts background checks, DHS has access to a limited portion of the data. Furthermore, even when DHS obtains public data from the courts on commitments, the data become classified as health care records and must be protected from public disclosure unless the subject of the data consents. Thus, for background checks conducted by DHS, law enforcement officials must obtain a form from the person seeking a firearm permit that authorizes DHS to release any commitment information to law enforcement authorities. Such authorizations are not required if law enforcement or the courts obtain information directly from the court database.

[45] An agreement between DHS and the court system has provided DHS with direct online access to an abbreviated version of the court system's full database.

[46] DHS usually has information in its own databases regarding commitments of individuals to state-run facilities. As discussed earlier, DHS is less likely to have information in its own databases on individuals who were committed to nonstate facilities.

5 Minnesota Security Hospital

For over a century, the Minnesota Security Hospital has served as the state's most secure facility for the mentally ill. Currently, it primarily treats mentally ill individuals who have committed crimes as a result of their illness or who have the potential to commit crimes while ill. It is the largest facility that State-Operated Services (SOS) runs, with a licensed capacity of 408 beds.[1]

BACKGROUND

The Minnesota Security Hospital is located on a large campus in St. Peter that once housed both the Security Hospital and a regional treatment center for individuals with mental illness and developmental disabilities. The Security Hospital consists of several buildings, the largest being a high-security building constructed in 1982 and further expanded in 1996. Despite its name, the Minnesota Security Hospital is not licensed as a hospital, but rather as a residential treatment facility and supervised living facility.[2] The Department of Human Services (DHS) has proposed renovations to the secure building and construction of new nonsecure buildings to improve safety and create a more therapeutic environment.[3]

Programs at the Minnesota Security Hospital Campus

Although the Minnesota Security Hospital is frequently thought of as a single, large facility, its campus in St. Peter actually houses four separate SOS

[1] The actual capacity depends not only on the number of beds, but also on the number of staff. When we visited the Security Hospital in September 2012, administrators told us that they had a high number of very disruptive patients at that time. Disproportionate staff resources were used to manage these patients, meaning that the facility could not accommodate as many patients as the total number of beds.

[2] The name "Minnesota Security Hospital" was chosen by patients in the 1950s to replace the previous name, the "Asylum for the Dangerously Insane." The Legislature adopted the new name in *Laws of Minnesota* 1957, chapter 196, sec. 1.

[3] *Minnesota Laws* 2012, chapter 293, sec. 18, subd. 4, provided funding for initial planning and design for the new construction.

programs.[4] All of these programs are "forensic" programs—that is, they provide evaluation, treatment, or care for mentally ill individuals involved with the criminal justice system.

The campus of the Minnesota Security Hospital has four State-Operated Services programs.

The secure residential units of the Minnesota Security Hospital provide long-term care and treatment for patients that are civilly committed as mentally ill and dangerous. Additionally, some individuals are sent to the secure units for court-ordered mental health evaluations. Patients live on locked wards with 24-hour monitoring by security staff. Programming and treatment are designed to improve mental health so that patients can transfer to less restrictive settings. On July 1, 2012, there were 247 patients housed in the secure units.

Transition Services is a less restrictive environment for former residents of the secure residential units who have improved to the point that they can more safely interact with each other, staff, and the community. Patient activities are monitored, but there are no security staff in Transition Services residential units, and patients have greater flexibility to choose their activities. Programming is designed to teach skills patients will need to live long term in less restrictive settings.[5] On July 1, 2012, there were 84 patients in Transition Services.

The Competency Restoration Program is a short-term program for individuals deemed incompetent to stand trial—that is, a court has determined that their mental illnesses have impaired their ability to understand court proceedings. Individuals in this program are assisted to understand basic legal concepts—such as what a judge is or what it means to be charged with a crime—so that they can participate in a trial. Of the 131 participants that exited the program between April 2010 and December 2012, 80 percent were deemed competent, 11 percent were deemed "not restorable," and 8 percent had their charges dropped before completing the program.[6] The average length of stay in the program was about 5.5 months. The Competency Restoration Program is housed within the Security Hospital's secure building and operates under the same license, but it serves a fundamentally different purpose than the treatment programs serving other patients at the Security Hospital. On July 1, 2012, there were 29 persons enrolled in the Competency Restoration Program.

The Forensic Nursing Home—which operates under a separate license from the rest of the Minnesota Security Hospital complex—is a facility for residents who are potentially a danger to themselves or others and who need higher levels of

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[4] The DHS-run Minnesota Sex Offender Program also has facilities on the St. Peter campus, but it was physically and administratively separated from SOS in 2008. Its buildings are contained within a separate high-security perimeter; other than a few shared functions like mail and food service, it shares no staff with the Minnesota Security Hospital or other SOS programs. We evaluated the Minnesota Sex Offender Program in 2011. See Office of the Legislative Auditor, *Civil Commitment of Sex Offenders* (St. Paul, 2011).

[5] As discussed in Chapter 4 and also later in this chapter, individuals committed as mentally ill and dangerous may not be transferred to less restrictive settings without the approval of a "special review board" appointed by the Commissioner of Human Services.

[6] Counties must decide where to send individuals deemed not restorable and thus unable to stand trial; nearly all were sent to some type of care facility. Three participants (2 percent) were transferred out of the Competency Restoration Program to other Security Hospital units. Percentages do not add to 100 due to rounding.

medical care for physical illnesses or disabilities. Patients primarily come from the Minnesota Security Hospital, the state-run Minnesota Sex Offender Program, or state prisons. Many of the patients have chronic medical issues that require long-term or permanent nursing care. Others are receiving end-of-life care; just over one-third of the individuals that exited the Forensic Nursing Home between its opening in 2010 and June 2012 were discharged due to death. On July 1, 2012, there were 28 patients housed at the Forensic Nursing Home.

Security Environment

The Security Hospital campus has a combination of secure and nonsecure residential units.

Patients are housed in three different buildings at the Security Hospital.[7] The largest building is entirely secure, and contains eight patient residential units as well as the Competency Restoration Unit. A second building houses only Transition Services patients and is nonsecure. A third building is shared by three secure residential units and one less secure unit for Transition Services patients.

In the secure residential units, each unit is separately secured. Patients with similar mental illnesses are housed together, and each unit provides differentiated programming directed toward its patients' particular needs. Bedrooms in the largest secure building are small and spartan, consisting of little more than two concrete platforms for mattresses and bedding and a few shelves to keep clothing and other personal possessions. There is very little floor space in the rooms; four people cannot easily stand in a two-person patient room at the same time. The bedrooms open onto common hallways and community areas, where patients may interact with each other and with staff. Each unit also has rooms where patients can be restrained or held in seclusion when necessary. The secure residential units in the smaller building shared with Transition Services are arranged similarly, but patients have somewhat more personal space.

In most instances, patients in secure residential units may leave their units only when accompanied by staff.[8] Entrances and exits between areas of the building are secured, and outside access is carefully controlled. Nursing stations and other unit-based offices are separated from patient common areas by secure doors, windows, and other barriers. Security is tight enough that when incarcerated individuals are sent to the Minnesota Security Hospital from state prisons, no additional measures need to be taken to ensure their confinement.

By contrast, in the residential units for Transition Services, patients have relatively unrestricted access to building amenities and staff work areas. The unit in the shared building is locked from the inside so that patients can only leave the premises when permitted by a staff member; however, it is open from the outside so that patients can return at will. The other building has no physical barrier to entrances or exits. Patients in either setting are routinely permitted to leave the buildings and walk around the campus. The majority can earn passes which allow them to have unsupervised access to the community.

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[7] The Forensic Nursing Home makes up a fourth building and is secure.

[8] Patients preparing to transfer to Transition Services are given greater freedoms, including, in some instances, permission to leave units without staff accompaniment.

Patients newly arriving at the Security Hospital are placed in a secure residential unit with the most dangerous and aggressive residents. They remain in this unit until Security Hospital staff evaluate their condition and determine an appropriate long-term placement. Security Hospital administrators acknowledged that this arrangement is not preferable, but said that there is not space to create an area devoted solely to new arrivals.[9]

LONG-TERM PROBLEMS

In chapters 2 and 3, we discussed the unclear mission and organizational challenges facing SOS as a whole. System-wide weaknesses have also existed at the Minnesota Security Hospital. Overall, we found that:

- **State-Operated Services leadership allowed systemic problems at the Minnesota Security Hospital to persist for years.**

It is too soon to judge the effects of recent changes in structure and leadership at the Security Hospital.

The Minnesota Security Hospital has lacked cohesion in recent years, reflecting confusion about mission, changes in leadership and organization, turnover of key medical staff, shifting rules regarding patient treatment, ongoing concerns about staff injuries, labor-management disagreements, and a difficult relationship between the Security Hospital and SOS leadership. We describe these issues in more detail below.

We offer no recommendations regarding the following issues for two reasons. First, as we describe below, DHS has recently made substantial changes to Security Hospital structure and leadership. It is too soon to evaluate the effects of those changes. Second, our ability to review Security Hospital operations was limited by our charge to examine SOS as a whole.

Unclear Mission

The dual responsibilities of the Security Hospital's mission are embodied in its name. It has high security areas intended to keep patients, staff, and the wider community safe from patients whose behavior may hurt others. But it is also a treatment facility, in which patients are evaluated and treated for the mental illnesses that cause their dangerous behavior.

Administrators and staff with whom we spoke recognized the tensions inherent in the Security Hospital's dual missions. They acknowledged that:

- **The Security Hospital's balance between security and treatment shifted towards security during the 2000s, when Security Hospital patients were intermingled with patients from the Minnesota Sex Offender Program.**

[9] In 2011, administrators planned to create a separate admissions unit as part of a larger facility reorganization, but eventually concluded a separate unit was not feasible at that time. The current DHS proposal to expand the facilities at the Security Hospital would create a separate admissions unit.

Remnants of a punitive treatment environment remain at the Security Hospital, reflecting the facility's past ties with a state-run sex offender program.

Although individuals committed to the Minnesota Sex Offender Program had previously been treated at the Minnesota Security Hospital, the number of sex offender commitments rose dramatically in the 2000s. Staff told us that individuals committed as sex offenders have somewhat different characteristics and treatment approaches from those committed as mentally ill and dangerous. For example, we were told that most individuals committed as sex offenders have spent time in prison or jails for criminal convictions, in contrast to most Security Hospital patients. Also, sex offenders may be less likely to be prescribed psychotropic medications than individuals committed as mentally ill and dangerous. Treatment for both categories of individuals may involve the use of cognitive behavioral therapy, but treatment of committed sex offenders is focused specifically on changing thinking patterns and behaviors that led to criminal offenses. Additionally, the sex offender population has many individuals who are talented at appearing good while behaving badly.[10]

Despite these differences, the two groups were treated as a uniform population even as the proportion of Sex Offender Program participants grew rapidly. As a result, evaluations of all patients, not just those in the Sex Offender Program, began to focus primarily on their behavior and not on their level of illness. Patients who were cooperative and easy to manage were sometimes more likely to progress toward release, regardless of their level of mental impairment. Patients that were uncooperative or aggressive were punished with loss of privileges. While these approaches made it easier for staff to manage patients, they did not necessarily contribute to improving patients' mental health.

Despite the separation of Sex Offender Program patients from Security Hospital patients in 2008, the culture fostered by the Sex Offender Program's presence has been slow to change. National consultants who visited the Security Hospital two years after the separation of the two programs recommended:

> [T]he facility needs to evaluate practices within its program that are remnants of correctional practices and that are inconsistent with a treatment environment, and the antithesis of a recovery oriented, person-centered, trauma-informed program.[11]

Security Hospital administrators we spoke with emphasized the importance of patient-centered care and of treating disruptive outbursts as symptoms of psychiatric illness needing treatment, not as inappropriate behaviors that should lead to punishment. Yet many of these administrators also described difficulties in persuading staff members to fully embrace this change in practice.

Frequent Organizational Changes

In the past few years, the Security Hospital has implemented important changes to programmatic leadership, patient care, staff reporting relationships, and staff

[10] For a discussion of sex offender treatment, see Office of the Legislative Auditor, *Civil Commitment of Sex Offenders*, Chapter 3.

[11] Raul Almazar and Marty Martin-Forman, *National Association of State Mental Health Program Directors, Site Visit Consultation Report* (undated, based on October 13-14, 2010, site visit), 9.

roles. Regardless of the merits of each individual change, their cumulative impact has been to create a climate of uncertainty. We found that:

- **Adjusting to many organizational changes in a short period of time has been challenging for administrators and staff.**

The Security Hospital has experienced turnover in many key leadership positions since 2010. SOS leadership chose to replace the Security Hospital's chief administrator in 2011, seeking someone who could more effectively address long-term problems at the facility. However, the new chief administrator lasted only about six months before being relieved of his duties. In addition, the program director of the secure units at the Security Hospital has changed three times since 2008. The clinical director of the secure units changed in 2011, but then the new clinical director resigned in 2012 and the position was discontinued. Lastly, the long-term medical director of the Security Hospital left in early 2012.

Turnover in facility leadership and a 2009 reorganization contributed to a climate of uncertainty.

A further change in top-level leadership was instituted by the commissioner of DHS in early 2012. Wanting a more hands-on approach to SOS, she directed the deputy commissioner to assume direct oversight of SOS, with particular attention to the Security Hospital. The deputy commissioner was at the Security Hospital on a weekly basis for several months following the removal of the chief executive officer in March 2012. Though that level of oversight has since diminished, the deputy commissioner continues to closely follow events at the Security Hospital, giving the program higher visibility within the department than existed previously.

In addition to these leadership changes, administrators implemented a major restructuring of patient units at the secure portion of the Security Hospital in 2009, grouping patients together into new units based on similarities among patients. At the same time, the decision-making authority of residential unit supervisors was reduced and more authority was placed with clinical directors (for example, the directors of social work, psychology, and nursing). This restructuring was poorly received by many line staff. The 2010 consultants' report offered a blunt assessment of the changes' impact:

> The program restructuring that occurred in September of 2009 caused significant hard feelings and mistrust within the organization…. It appears that the changes made in September of 2009 were made in the absence of a vision/mission clarification so that the staff experienced the changes as arbitrary and unnecessary.[12]

Similarly, a December 2010 DHS program review of the Minnesota Security Hospital suggested that these changes had "resulted in overall systemic

[12] Almazar and Martin-Forman, *Site Visit Consultation Report*, 4.

dysfunction."[13] Nonetheless, the changes remain in place. Additionally, several programs were physically moved into new quarters in late 2011.

Lines of authority and staff roles have also been a problem. The 2010 program review of the Security Hospital criticized conflicting lines of authority within the facility and found that some staff reported to multiple people while others could not readily identify one specific person who oversaw their position.[14] Some of those issues have since been resolved, but tensions continue to exist within residential units due to overlapping lines of authority.

Overlapping lines of authority have caused some tensions.

Each unit is managed by a treatment team leader who guides the work of a multidisciplinary team of psychiatrists, psychologists, nurses, therapists, counselors, social workers, and other direct care staff. It is important that staff members on the same unit work together, back one another up, and pool their knowledge about patient progress. But most of these staff also report directly to supervisors within each specialty—otherwise, a treatment team leader trained as a recreational therapist, for example, would be placed in the difficult position of evaluating the professional skills of a psychiatrist or psychologist or registered nurse. Instead, such evaluations are conducted by supervisors with appropriate expertise. Further, the directors of the various specialties are responsible for allocating staff across the Security Hospital's residential units to ensure that coverage is maintained during staff absences and position vacancies.

Security Hospital administrators contend that both lines of authority are necessary. Nonetheless, administrators acknowledged that this bifurcated reporting structure has caused difficulties in some residential units.

Another difficulty described by Security Hospital staff was the changing role of security staff. Many security staff did not have human services backgrounds when they came to the Security Hospital, and many worked for years in the security-focused environment that characterized the facility in the 2000s. The recent emphasis on reducing the "correctional" atmosphere of the facility has changed how security staff are asked to do their jobs and how their performance is assessed. Administrators expressed frustration with the resistance of security staff to changes designed to improve patient care. Security staff, on the other hand, have been unhappy that they have not received clear guidance on how their duties should change and that there have been many revisions to job descriptions in a short period of time.

Psychiatric Staffing Problems

The Security Hospital has confronted obstacles to providing effective, reliable psychiatric care to its patients. We found that:

[13] Minnesota Department of Human Services, *State Operated Forensic Services Program Review* (St. Paul, December 2010), 3.

[14] *Ibid.*, 4.

- **Prior to 2012, Security Hospital administrators allowed psychiatrists to work irregular or unpredictable schedules that impeded collaboration and communication with other staff.**

According to several administrators we spoke with, the Security Hospital had ongoing difficulties holding some of its psychiatrists accountable for fulfilling their professional responsibilities. Most notably, some psychiatrists would not show up to conduct patient visits with other treatment team members and sometimes did not visit residential units for long periods. These work habits made it difficult for other therapeutic staff to interact with psychiatrists and collaborate with them regarding patient care. For example, minutes from a Security Hospital Leadership Team meeting in May 2011 noted:

> Treatment teams have expressed that they would like the medical practitioner to be present when the patient comes out of seclusion. *There is a broad concern that the medical practitioners don't want to come in*, and there have been situations when patients have been released too soon when the decision to let the patient out has been without a face-to-face interaction.[15] (Emphasis added.)

For more than a year, the Security Hospital has not had enough psychiatrists.

Shortly after arriving at the Security Hospital in August 2011, the former chief administrator of the Security Hospital initiated a review of psychiatrists' work schedules. He found that most psychiatrists were spending less than 40 hours per week on campus, and some spent less than 32 hours per week. All of the psychiatrists that worked for the Security Hospital in 2011 have since left, but the shortage of psychiatrists has led to other communication and coordination problems.

As of December 2012, the Minnesota Security Hospital had only two full-time psychiatrists and a part-time psychiatric nurse practitioner on its permanent staff.[16] We found that:

- **The Security Hospital has been critically understaffed with licensed psychiatrists since January 2012.**

Until late 2011, the Security Hospital had eight psychiatrists (one of whom was the facility's medical director). Several psychiatrists clashed with the Security Hospital chief administrator who was hired in August 2011 and later dismissed. Starting at the end of 2011, all of these psychiatrists, including the facility's medical director, left their positions within a two-month period, leaving the facility dangerously short-staffed with psychiatric care starting in January 2012.[17] Although DHS vigorously sought new psychiatrists for the Security Hospital,

[15] State Operated Forensic Services Leadership Team Meeting, May 24, 2011, 1.

[16] In addition, one former Security Hospital psychiatrist worked on a part-time basis (0.2 FTE) preparing documentation that required review and approval by a licensed psychiatrist. This psychiatrist did not work on site and did not see patients. An additional full-time psychiatric nurse practitioner was scheduled to start work in January 2013.

[17] The resignation of the medical director had been announced two months previously and was apparently not for the same reasons as the departure of the other psychiatrists.

administrators said that an overall shortage of psychiatrists in the marketplace, the facility's location outside the Twin Cities metropolitan area, average or below-average salaries, and negative news coverage surrounding the Security Hospital made it difficult to fill the open positions. As a result, the facility has had to rely on a patched-together workforce of part-time and temporary psychiatrists.

Security Hospital administrators and staff with whom we spoke said that the lack of psychiatric care had created significant workload, therapeutic, and safety concerns. The new medical director spent so much time providing direct care to patients that he was unable to carry out other aspects of his job. Doctoral-level psychologists have taken on additional duties that were once performed by psychiatrists. Patients with complex mental health conditions were treated by temporary psychiatrists who were unfamiliar with patient histories and Security Hospital practices. Some administrators suggested to us that the shortage of psychiatrists was one of the major factors contributing to the increase in incidents and injuries reported by Security Hospital staff during the first half of 2012. One administrator referred to the situation as a "psychiatric crisis" and another called it "dire."

Shifting Rules Regarding Patient Treatment

As we described in Chapter 3, the Security Hospital was forced to change its procedures regarding seclusion and restraint in 2011 because its operating license was made conditional on the implementation of such changes.[18] It abruptly stopped using "protective isolation" in May 2011 and amended its procedures regarding physical restraints.[19] However, these sudden changes led to other problems. We found that:

Sudden changes in facility practices left staff unsure how to deal with disruptive patients.

- **Because the Security Hospital had relied for years on the use of improper seclusion and restraint techniques, it was unprepared when required to change its methods of managing difficult patient behaviors.**

Despite many internal discussions about reducing the use of seclusion and restraint, Security Hospital reports show no sustained decrease over time in the use of seclusion and restraint prior to late 2010. The total amount of time spent by patients in protective isolation averaged over 1,800 hours per month in the four months before administrators discontinued the practice.

When the changes were introduced, staff on residential units were suddenly deprived of some of their standard methods of managing disruptive patients. According to line staff, these changes occurred with limited training or guidance in how to act differently. Although restraint and seclusion were still permitted in certain situations, staff felt considerable pressure to avoid using these techniques

[18] The Security Hospital began changing its procedures shortly after the site visit by licensing staff, though it did not receive official notice of the conditional license for several months.

[19] We describe protective isolation, a form of solitary confinement used to curb undesirable patient behaviors, more fully in Chapter 3.

altogether. Pressure on staff increased after a psychiatrist and nurse were fired in late 2011 for authorizing abusive treatment of a patient.[20]

As a result, many Security Hospital staff felt that they were no longer empowered to take action to defuse situations before they grew out of control. When we visited the Security Hospital, administrators were actively working to strike the right balance so that staff would not hesitate to use seclusion and restraints when appropriate, but would use the minimum amount of force and duration necessary.

Staff Injuries

We found that:

- **The number of injuries to Security Hospital staff increased sharply in 2012.**

As shown in Exhibit 5.1, patient assaults led to 32 staff injuries in 2011 that required medical treatment beyond simple first aid. In 2012, that number doubled while the number of patients stayed roughly constant. As of December 9, 2012, Security Hospital staff had sustained 63 injuries as a result of patient assaults. Security Hospital staff and administrators have expressed great concern over the increasing number of staff injuries. A DHS internal review completed in 2010 reported:

The Security Hospital's number of staff injuries requiring medical attention doubled in 2012.

> The issue of staff and patient safety was the most pressing concern for direct care staff. Significant distress was expressed by all with whom the review team spoke about the reported increase in staff and patient injuries in recent years.[21]

Security Hospital administrators suggested that the recent increase in injuries was due primarily to lack of clarity regarding when to use restraints and seclusion and inconsistent psychiatric care. The effort to reduce seclusion and restraint led some staff to avoid ever using these techniques preventively, using them instead only after a violent (and possibly injurious) outburst had occurred. The Security Hospital's reliance on many temporary psychiatric staff led to frequent changes in patient care, as each new provider would make independent diagnostic and treatment judgments. Union leadership agreed that the reduction of seclusion and restraint and sudden changes in clinical staffing—including both a significant turnover in psychological staff in 2009-2010 and the shortage of psychiatrists in 2012—had created conditions more conducive to injuries.

It is difficult to draw conclusions about the causes of injuries without examining the circumstances of each individual event, which we did not do. However, as is shown in Exhibit 5.1, the number of reported injuries did not increase immediately after changes to restraint and seclusion practices in May 2011, but did increase immediately after the turnover in psychiatric staff in January 2012.

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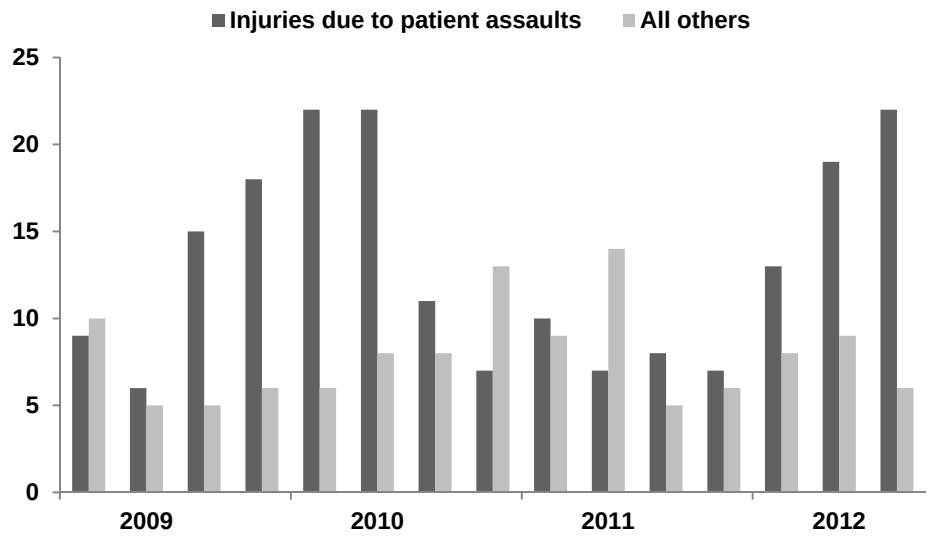
[20] The nurse was reinstated approximately a year later after successfully challenging her dismissal through an arbitration process.

[21] Department of Human Services, *State Operated Forensic Services Program Review*, 5.

Exhibit 5.1: Staff Injuries at the Minnesota Security Hospital by Quarter, 2009-2012



NOTES: Injuries shown above are those that must be recorded under federal law. Employers only record injuries that are work-related and that result in lost work time, restricted work activity, medical treatment beyond first aid, loss of consciousness, hearing loss, or potential infection (such as being cut with an object contaminated with another's blood).

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Labor-Management Disagreements

The long-term challenges facing the Security Hospital are daunting and addressing them will require extensive teamwork by the facility's staff. However, we found that:

- **A tense relationship exists between Security Hospital administrators and the labor union affiliate representing security staff.**

Over one-third of all Security Hospital employees are security staff represented by the American Federation of State, County, and Municipal Employees (AFSCME).[22] Many administrative staff have viewed the union as resistant to needed changes and quick to fight decisions it does not like by appealing to senior DHS leadership or political allies. Union leaders, on the other hand, believe that administrators have implemented changes without understanding the implications for staff safety and working conditions. For example, they criticized the 2009 reorganization that placed patients with similar psychiatric problems in the same units, contending that placing similarly aggressive and disruptive patients together led to more conflicts. Similarly, union leaders felt that the sudden decision to discontinue the use of protective isolation and to reduce the

[22] AFSCME also represents licensed practical nurses and work therapy assistants.

use of seclusion and restraints in May 2011 had not been preceded by adequate planning or training; security staff were abruptly forbidden to use techniques they had used in the past to deal with disruptive patients, but were not given effective alternatives.

A more recent dispute between management and labor has revolved around how employees' work shifts are scheduled. In an effort to reduce overtime and to limit the impact of the least experienced staff being concentrated at the least desirable shift times, administrators proposed shifting all direct care staff to a new work schedule where employees would work six days followed by two days off.[23] Such a schedule could have meant that long-term staff who had spent years accumulating enough seniority to have their off-days coincide with weekends would lose that status—every employee would work some weekends and get some weekends free. This proposal was opposed by the union representing security staff due to the lack of scheduling consistency from week to week for union members and their families.

Difficult Relationship with State-Operated Services Administration

A 2010 internal DHS report presented options for removing the Security Hospital from SOS, at least until some of its problems could be addressed.

While other state-operated programs underwent major transformations over the past three decades in conjunction with deinstitutionalization, the Security Hospital has not experienced these types of large-scale changes. The Security Hospital's clientele, programming, and needs are unlike those of other SOS programs. But there has been a perception among SOS (and DHS) managers that Security Hospital management has been dysfunctional, contributing to unresolved problems. Senior SOS administrators have also perceived the Security Hospital to be somewhat disconnected from the rest of SOS and resistant to some necessary changes. Additionally, the Security Hospital's location in St. Peter has geographically isolated it from the central office in St. Paul; most of the other SOS programs have had their senior management based in the Twin Cities metropolitan area.[24]

In 2010, an internal DHS program review argued that "significant change [at the Security Hospital] cannot occur within the current [DHS organizational] structure."[25] The report offered three options for the Security Hospital's placement within DHS, each of which would remove the Security Hospital from SOS altogether, either temporarily or permanently. Implicitly, the report suggested that the situation at the Security Hospital was analogous to the situation the Minnesota Sex Offender Program faced in 2008. At that time, the Minnesota Sex Offender Program was removed from SOS after its leaders successfully made the case that it would be too difficult to make significant

[23] Employees would occasionally receive additional days off so that they would end up working the same amount of days in a year as with a traditional schedule of five days on and two days off. This work schedule is used for most employees at the Minnesota Sex Offender Program.

[24] The administrator for "Special Populations" is based in Fergus Falls. Also, as of this writing, the interim head of SOS Adult Mental Health is based in Fergus Falls, but previous individuals holding that position were based in the metropolitan area.

[25] Department of Human Services, *State Operated Forensic Services Program Review*, 8-9.

operational changes while "embedded" within the larger SOS management structure. Although the restructuring options presented in the 2010 report were not implemented, each option would also have created a more direct reporting line from the commissioner to the Security Hospital—a change that has occurred recently through the active oversight of the deputy commissioner.

PATIENTS

Unlike many private facilities that treat the mentally ill, the Minnesota Security Hospital does not specialize in treating patients with particular conditions. By law, any patient found mentally ill and dangerous must be committed to a "secure treatment facility"—usually this is the Minnesota Security Hospital—unless the patient can establish that a less restrictive program can meet the patient's needs while protecting public safety.[26] The Security Hospital must admit and treat any patient committed to it by a court, regardless of diagnosis. We found that:

- **It is unclear whether the Minnesota Security Hospital is the most suitable program for some patients committed there.**

Some Security Hospital patients have been diagnosed with disorders that are not very amenable to treatment.

The finding that an individual is mentally ill and dangerous is a legal decision, not a medical one. A small percentage of patients (about 4 percent of those treated between January 2007 and June 2012) have a primary diagnosis of antisocial personality disorder or some other type of personality disorder. Antisocial personality disorders are "notoriously difficult to treat," according to the Mayo Clinic, and are more accurately thought of as "essentially a way of being, rather than a curable condition."[27] A leading medical encyclopedia notes that the most promising treatments of antisocial personality disorder appear to be those that "reward appropriate behavior and have negative consequences for illegal behavior"—perhaps more like a correctional setting than a medical one.[28]

Senior Security Hospital clinical staff expressed concern about individuals with personality disorders, whom they described as "criminalistic" and not very amenable to treatment. These opinions appear consistent with prevailing views in the field. In a national survey of psychiatrists published in 2007, respondents were asked which mental disorders ought to be defined as mental illnesses in laws providing for civil commitment. Only 11 percent thought that antisocial personality disorder should be included in such definitions; only 17 percent thought that other personality disorders should be included.[29]

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[26] *Minnesota Statutes* 2012, 253B.18, subd. 1. The law also defines "secure treatment facility" to include the Minnesota Sex Offender Program, but this program specializes in serving individuals committed as sexually dangerous or as having sexual psychopathic personalities.

[27] Mayo Foundation for Medical Education and Research, "Antisocial Personality Disorder: Treatments and Drugs" (October 8, 2010), http://www.mayoclinic.com/health/antisocial-personality-disorder/DS00829, accessed January 10, 2013.

[28] A.D.A.M. Medical Encyclopedia, "Antisocial Personality Disorder" (November 10, 2012), http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001919/, accessed February 11, 2013.

[29] Robert A. Brooks, "Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey," *Journal of the American Academy of Psychiatry and the Law*, 35, no. 2 (June 2007): 219-228.

The Security Hospital has also consistently served a small number of individuals that are committed as developmentally disabled. As shown in Exhibit 5.2, 34 patients committed by a court as developmentally disabled or as both mentally ill and developmentally disabled were treated at the Security Hospital between January 1, 2007, and June 30, 2012. Further, our analysis of patient data showed that at least 81 Security Hospital patients during that time period were diagnosed with a developmental disability by Security Hospital psychiatrists in at least half of their total diagnosis records.[30]

Exhibit 5.2: Civil Commitment Status of Patients at the Minnesota Security Hospital, January 2007 through June 2012

Commitment Status	Over Entire Period	On June 30, 2012
Mentally ill and dangerous (initial or final)	457	305
Mentally ill	76	6
Evaluations or judicial holds[a]	60	3
Sex offender[b]	48	0
Developmentally disabled/mentally ill and developmentally disabled	34	12
Mentally ill and chemically dependent	8	0
More than one commitment status	26	5
Total	709	331

[a] Patients who entered on a judicial hold or for an evaluation but were then committed to the Security Hospital are counted under their commitments. If they were not committed or moved to less restrictive facilities after commitment, they are counted as evaluations or holds.

[b] Nearly all patients committed as sex offenders were transferred out of the Security Hospital when the Minnesota Sex Offender Program separated from State-Operated Services in 2008.

NOTES: Individuals not committed as mentally ill and dangerous generally have shorter stays at the Security Hospital. Thus, combining all admissions over the entire period counts more of these short-term patients. The second column, which shows the status of patients on June 30, 2012, better represents the proportions on any given day since 2008. Patients with more than one stay appear more than once in the first column; there are 655 patients represented in the 709 records. Data exclude individuals in the Competency Restoration Program and the Forensic Nursing Home.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Some client advocates question the placement of individuals with developmental disabilities at the Security Hospital.

Advocates for persons with developmental disabilities have questioned whether the Security Hospital is an appropriate setting for these individuals. Because the Security Hospital is licensed as a residential facility serving clients with mental illness, advocates suggest that its focus is on treating illness rather than serving individuals with permanent cognitive deficits. They worried that individuals with both mental illnesses and developmental disabilities could struggle if their cognitive impairments were not taken into account. Further, programming in the

[30] In the data we examined, nearly all patients were diagnosed at admission. Most patients received updated diagnoses from time to time, so many patients had multiple diagnosis records. Of the patients in the Security Hospital on June 30, 2012, the average time since each patient's most recent diagnosis was about 4.5 months. Analyses in the paragraph above and this footnote do not include patients in the Competency Restoration Program or the Forensic Nursing Home.

Security Hospital seeks to develop skills that patients will need to successfully integrate into less restrictive settings when their stay at the Security Hospital ends. Developmentally disabled patients, say advocates, are likely to be discharged to very different environments than other Security Hospital patients and need different coping skills.

Security Hospital administrators said that the facility has sufficient resources and expertise to provide differentiated services for individuals with developmental disabilities. Additionally, they noted that most developmentally disabled individuals at the Security Hospital are there because they present a danger to others and must be kept in a secure facility. For now, they said, there are not better alternative placements.

RECOMMENDATION

The Department of Human Services should publicly clarify what types of disorders are best treated at the Minnesota Security Hospital.

The department cannot deny admission to patients sent by courts to the Security Hospital. As the state's designated secure treatment facility, it must accept all patients that are civilly committed as mentally ill and dangerous. However, DHS could offer general guidance to courts and prosecutors regarding the treatment that is available at the Security Hospital and the types of individuals for whom treatment is likely to prove effective. Additionally, if the Legislature addresses our recommendations in Chapter 4 and revises the Civil Commitment Act, DHS may wish to ask the Legislature to reexamine whether the definition of mental illness for the purposes of commitment should include persons primarily suffering from personality disorders.

We did not evaluate whether developmentally disabled patients at the Security Hospital are truly in the most integrated setting appropriate to their needs, as required by federal rule.[31] However, lawsuits in other states (including *Olmstead v. L.C.*, which we described in Chapter 3) have compelled states to move developmentally disabled patients out of institutional settings. In our view, the Security Hospital and SOS should examine whether current services for developmentally disabled patients—especially those committed as developmentally disabled but not mentally ill and dangerous—are able to withstand a court challenge.

State law and rules provide little guidance about the nature of the treatment provided at the Security Hospital.

TREATMENT

State law declares that the Minnesota Security Hospital shall function as a "secure treatment facility."[32] This law does not further specify the nature of treatment, but it says the DHS commissioner shall manage and supervise the

[31] 28 *CFR* 35.130(d).

[32] *Minnesota Statutes* 2012, 253.20.

Security Hospital "the same as in the case of other state hospitals."[33] For those other hospitals (later amended in law to be called "regional treatment centers"), the law says the commissioner shall ensure that they "provide active treatment" and "meet contemporary professional standards for staffing levels and for quality of program, staffing, and physical environment."[34]

The Security Hospital is licensed by DHS as a residential facility for adults with mental illness. The rules require the following services to be made available to residents of a program with this license: case management services, crisis services, independent living skills training, mental health therapy, motivation and remotivation services, recreation and leisure time services, socialization services, support group services, social services, vocational services, and other services deemed necessary by facility assessments.[35] The rules do not specify which of these activities constitute "treatment," although any of these activities may have therapeutic effects. Furthermore, the rules do not specify how much of these services—individually or together—must be provided by a licensed facility. We are not aware of national standards regarding the amount of time per week that a patient in a residential mental health treatment facility should spend in therapy specifically focused on mental health symptoms.

In our view, the amount and type of treatment provided at the Minnesota Security Hospital is important, especially given the lengthy stays at this facility that many patients experience, their court commitments of indeterminate length, and the severity of their illnesses (leading the courts to designate many of the facility's patients as "dangerous"). Furthermore, at costs of about $500 per day per patient at the Security Hospital, it is reasonable to have high expectations for the services provided.

On average, patients have about 16 hours of scheduled activities a week, and most are not directly related to the patients' mental illnesses.

Each Security Hospital patient is required by state rules to have an individualized program plan that identifies goals and objectives, and strategies for accomplishing them.[36] We did not systematically review patient treatment plans or staff notes on patients' progress. But, to better assess the nature of patient activities, we examined the weekly schedules of a sample of 150 Security Hospital patients for Fall 2012.[37] We found that:

- **Many Security Hospital patients receive a modest amount of mental health therapy.**

We began by looking at all scheduled group activities (excluding meals) and scheduled activities that were specific to an individual patient. On average, patients had 16 hours of scheduled activities per week. Among the 13 residential units we examined, this average ranged from 11 hours to 20 hours.

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[33] *Ibid.*

[34] *Minnesota Statutes* 2012, 245.490.

[35] *Minnesota Rules* 2012, 9520.0620.

[36] *Minnesota Rules* 2012, 9520.0640.

[37] We systematically selected samples from 13 secure and nonsecure residential living units at the Minnesota Security Hospital, representing about half of the residents in those units. Security Hospital staff provided us with the schedules for the patients in our sample.

The amount of time devoted to counseling and psychoeducational activities was quite limited. The majority of patients' scheduled hours were consumed by employment, wood shop, physical fitness and recreation, library visits, hobby-related courses, and social activities. Not counting these activities, we found that the average patient had just over one hour per day of scheduled therapeutic activities. This small amount included mental health treatment-related meetings or groups, educational courses (such as math, reading, English as a Second Language, and driver's education), and "community meetings" that most residential units held on weekdays.

As a point of contrast, state rules governing sex offender treatment programs in Minnesota require an average of at least 12 hours of sex offender treatment per week during the primary phases of treatment, with an average of at least 2 hours of treatment per week in the "transitional" and "reentry" phases of treatment.[38] In a 2011 report, our office found that DHS's state-operated Minnesota Sex Offender Program provided six to eight hours per week of group therapy and psychoeducational programming specifically related to sex offenses.[39] This is more than the average amount of therapy and programming at the Security Hospital specifically focused on mental health issues. We recommended that the Minnesota Sex Offender Program provide additional treatment hours, and DHS agreed.

RECOMMENDATION

The Minnesota Security Hospital should adopt policies regarding the hours of counseling, therapy, and other treatment offered per week to help patients address their underlying mental health issues.

It is important for the Minnesota Security Hospital to provide a balanced array of therapeutic activities for clients, including activities related to vocational preparation, fitness, hobbies, and social skills. Patients may need different types of activities at different times, depending on the course of their mental illness. However, for patients committed to the most secure of Minnesota's residential treatment programs for mental illness, it is essential for the Security Hospital's activities to, first and foremost, address patients' mental health needs. Mental health treatment consists partly of staff's careful management of patient medications, but we think the Security Hospital should also define a minimum amount of daily activities that would be intended to help patients recognize and manage their mental health symptoms. It would also be helpful for facility administrators to monitor the total amount of such treatment provided; currently, management does not receive reports on patients' hours of scheduled activities.

A key component of mental health treatment is periodic patient meetings with psychiatrists. Earlier, we discussed recent instability in the Security Hospital's psychiatric staff. In addition, we examined policies related to the frequency of

[38] *Minnesota Rules* 2012, 2965.0150, subp. 1.

[39] Office of the Legislative Auditor, *Civil Commitment of Sex Offenders*, 62.

psychiatrist contacts with patients, and we reviewed patient records regarding such contacts. We found that:

- **State-Operated Services has inconsistent standards that specify how often patients should be seen by psychiatrists, and a majority of patients have been seen less than monthly.**

A number of SOS policies address the frequency of psychiatrist contacts with patients. These policies typically address the frequency of contact by indicating how often the psychiatrist is required to make "progress notes" on a patient. Exhibit 5.3 shows excerpts of some of these policies. Depending on the policy, the requirements call for monthly, quarterly, or even semi-annual contacts with

Exhibit 5.3: Inconsistencies in Minnesota Security Hospital Policies Regarding the Frequency of Psychiatric Meetings with Patients, 2012

- State-Operated Services' "Medical Staff Bylaws" state that medical staff should record progress notes on patients **quarterly**.[a]
- A Security Hospital policy titled "Psychiatric Assessment—Forensic Services" says: "Psychiatric Progress Notes are completed weekly for the four (4) weeks after admission and then **monthly** thereafter (unless the patient meets [the] criteria…below) or more frequently if warranted by patient condition…. Patients may be seen on a **semi-annual** basis after the first four (4) weeks if the attending practitioner determines the patient (a) is clinically stable, (b) has no significant acute medical or psychiatric issues, (c) has no recent medication changes, (d) has no significant legal, security or programmatic changes."[b]
- A Security Hospital policy titled "Assessments for Planning Treatment" says: "The patient's response to hospitalization and initial treatment are assessed and documented by the psychiatrist, nurse, and social worker at least weekly during the first four weeks after admission…. After the first 4 weeks, progress notes regarding the patient's response to treatment must be completed **monthly** by the psychiatrist, nurse, and social worker."[c]
- A policy for the Transition Services program says that psychiatric consultation (or "assessment") "will occur at least **quarterly** for all patients…. Criteria used to determine if less than monthly assessment is indicated include (1) no significant medication change in at least 3 months, (2) clinical stability with symptoms in reasonable remission, (3) team support for the Special Review Board and/or reduction in structure."[d]

NOTE: For the portions of these policies that apply to patients who have been at the Security Hospital at least four weeks, we used boldface type to highlight words that convey the frequency of the expected contacts.

[a] State-Operated Services, *Medical Staff Bylaws* (September 30, 2011), Article 4.4.4.3.

[b] State-Operated Forensic Services Procedure 10005/50613, *Psychiatric Assessment, Forensic Services*, effective February 10, 2012.

[c] State-Operated Forensic Services Procedure 10101/C302, *Assessments for Treatment Planning*, effective October 18, 2011.

[d] State-Operated Forensic Services Transition Services Protocol FTS.C-14, *Psychiatric Consultation*, effective February 2012.

SOURCE: Office of the Legislative Auditor, review of State-Operated Services policies.

patients. We brought these inconsistencies to the attention of the Security Hospital's medical director, who acknowledged that this was a problem.

In the past, the Security Hospital has been cautioned about having standards that did not require sufficiently frequent psychiatrist-patient interaction. Specifically, in 2010, national mental health consultants told SOS they were unaware of comparable programs in the nation with standards that allowed, as did the Security Hospital, for psychiatrist contacts as infrequently as every three months.[40] The consultants said most programs require at least monthly contacts.

We reviewed Security Hospital records for September 2012 for 321 patients to determine the frequency of patient-psychiatrist contacts.[41] We found that 45 percent of patients had been seen by a psychiatrist in the previous 30 days. Another 34 percent had been seen most recently one to two months before, 17 percent had been seen two to three months before, and 4 percent had been seen more than three months before.[42] The Security Hospital medical director told us that patients were not being seen by a psychiatrist every three months when he assumed his position in January 2012. He said most of the facility's patients are psychiatrically stable and probably do not need to see a psychiatrist more than once every three months. He initiated—for clinical and management purposes—regular tracking of the frequency of psychiatric visits. He said the frequency of psychiatric visits appears to have increased during 2012 from previous levels, although this was not tracked systematically before 2012. He noted that a small number of patients are seen by a psychiatrist very frequently—sometimes daily—due to acute symptoms.

The Security Hospital needs clearer policies regarding how often patients should be seen by a psychiatrist.

RECOMMENDATION

State-Operated Services should develop clear, consistent standards that address how often Minnesota Security Hospital patients should be seen by a psychiatrist, and it should monitor compliance with these standards.

As a starting point, SOS should address inconsistencies in existing policies so there is a common understanding of the minimum frequency with which psychiatrists should see Security Hospital patients. The tracking of psychiatric contacts with patients that started in 2012 was a positive development, although it would be useful for Security Hospital managers to relate this information to whatever standards SOS adopts. It might also be useful to develop reports that relate the frequency of psychiatric contacts to expectations set forth in individualized patient treatment plans.

[40] Almazar and Martin-Forman, *Site Visit Consultation Report*, 6.

[41] Our review included records from both the secure and nonsecure parts of the Security Hospital.

[42] In a 2012 report by the DHS Division of Licensing, the Minnesota Security Hospital was found to have violated its own policy regarding the frequency with which psychiatrists saw patients. The report said that, of 38 files reviewed, 18 were "out of compliance" with a Security Hospital policy requiring monthly progress notes following a patient's first four weeks at the facility. As indicated above, this Security Hospital policy is inconsistent with some others that address the frequency of client progress notes. See DHS, Division of Licensing, *Public Summary Regarding Possible Licensing Violations, Minnesota Security Hospital*, Report 20114749, March 15, 2012.

DISCHARGES

As the state's most secure residential treatment facility for the mentally ill and as the statutorily designated commitment location for the mentally ill and dangerous, the Minnesota Security Hospital receives a slow but steady stream of new patients every year. To make room for these patients, the Security Hospital needs to regularly discharge patients that no longer need the level of care required there. However, progress toward discharge for Security Hospital patients is often very slow. We found that:

About one-fourth of the Security Hospital's patients have been at the facility for at least ten years.

- **Some patients have remained at the Minnesota Security Hospital for many years.**

Exhibit 5.4 shows that, of the 331 patients at the Security Hospital on July 1, 2012, 64 (about 19 percent) had been there for more than ten years.[43] Thirteen had been at the Security Hospital for over 20 years, and a handful had been there since the 1970s. Although some long-term patients do finally progress to discharge, in any given year the number of long-term patients discharged is a small fraction of the number remaining at the facility.

Nearly all of the longer-term patients were civilly committed by a court as mentally ill and dangerous, while patients who spend a relatively short time at the Security Hospital frequently have some other legal status. Of the 174 patients at the Minnesota Security Hospital on June 30, 2012, who had been there for five years or more, all but 9 were committed as mentally ill and dangerous.

Exhibit 5.4: Lengths of Stay at the Minnesota Security Hospital for Patients Treated During January 2007 through June 2012

Length of Stay	Patients Discharged January 2007 through June 2012	Patients Still at Security Hospital on June 30, 2012
Less than 1 year	178	44
1-5 years	119	136
6-10 years	51	87
11-15 years	12	32
16-20 years	6	19
21-30 years	8	9
Over 30 years	4	4

NOTES: Discharges include both discharges into community settings and transfers of patients to other state-run facilities (such as the Forensic Nursing Home or state prisons). Discharges also include deaths. Patients with more than one stay appear more than once; there are 655 patients represented in the 709 patient records above. Data exclude individuals in the Competency Restoration Program and the Forensic Nursing Home.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

[43] Figures in this section exclude the Competency Restoration Program and the Forensic Nursing Home.

Conversely, only 25 of the 178 patients discharged between January 2007 and June 2012 after a stay of less than a year had been committed as mentally ill and dangerous.

We did not review individual patient records to independently examine whether all Security Hospital patients continue to need the level of care provided there. However,

- **According to Security Hospital administrators, many patients could be discharged from the Security Hospital to less restrictive settings, but there is nowhere to send them.**

Some observers, pointing to recent difficulties in admitting new patients because of lack of space, have suggested that the state needs to increase the number of beds at state psychiatric facilities. The Security Hospital's lack of available beds, however, does not appear to be due to lack of resources. Instead, it is primarily due to the fact that the Security Hospital has great difficulty finding placements for patients who are ready to be discharged. According to Security Hospital administrators, there are several patients in the Security Hospital's Transition Services program at any given time that staff have deemed ready to move to community settings but for whom such settings cannot be found. Similarly, there are usually several patients in secure residential units ready to move to a nonsecure unit in Transition Services once space opens up.

Security Hospital and SOS administrators told us that there are likely dozens of patients at the Security Hospital who do not need to be there. One administrator noted that many patients currently at the Security Hospital probably would not meet the criteria for admission if they were referred as new patients. Despite such statements, Security Hospital and SOS administrators were unable to state or estimate exactly how many patients fall into this category.

Problems finding placements for patients ready to be discharged sometimes make it difficult for the Security Hospital to admit new patients.

Once patients are at the Security Hospital, it has proven very difficult to find less restrictive treatment settings that will accept these patients after their acute psychiatric symptoms have abated. Patients who have been treated at the Security Hospital frequently have histories of criminal—even violent—behavior while under the influence of their mental illness. Privately run facilities for the mentally ill may be reluctant to accept such patients because of the substantial risk of liability. State-run facilities are better able to handle liability issues, but few state-run facilities provide an appropriate level of care for long periods of time. For example, facilities licensed as "intensive residential treatment facilities" for people with mental illness generally have a 90-day limit on resident stays, although this limit can be extended. Also, Security Hospital staff told us it is sometimes challenging for counties or the state to find ways to pay for the ongoing services needed by individuals leaving long-term institutionalized settings.

County human services directors that we surveyed recognized this problem. About 70 percent of the directors responding to our survey said that there are insufficient community-based resources for individuals awaiting discharge from the Security Hospital. One director wrote that "the lack of community based services makes discharge challenging." Another commented, "SOS needs to

develop a more comprehensive continuum of step-down placements in partnership with counties."

The legal process surrounding the discharge of persons committed as mentally ill and dangerous creates further obstacles. As we described in Chapter 4, a statutorily mandated special review board composed of three non-DHS employees must hear all requests for provisional discharge.[44] In practice, the special review board will usually not approve provisional discharges unless the county fiscally responsible for the patient supports the request. Generally, such support is contingent on the county finding not only an acceptable residential setting for the patient, but also funding for that placement. The default is the status quo—if there is no placement ready to accept the patient, the special review board will generally not approve a provisional discharge regardless of the patient's mental health. Further, the approval for a discharge is time limited—if the new placement is not ready to receive the patient within six months of the special review board's decision, a new petition for discharge must be filed and a new hearing held.

In reviewing records of discharges from the Security Hospital, we found that:

- **The annual number of provisional discharges is very small, but it increased somewhat in 2012.**

From 2007 to 2011, the annual number of provisional discharges granted by the special review board ranged from 14 to 17.[45] In the first eight months of 2012, there were 18 provisional discharges approved. In total, there are about 150 individuals on provisional discharge from the Security Hospital. Full discharges—that is, discharges that release the individual from their civil commitment—are rare.

RECOMMENDATION

The Department of Human Services should foster or develop new placement options for individuals ready to be discharged from the Minnesota Security Hospital.

The lack of available placements has caused a backup of patients within the Security Hospital who are waiting to get out. This backup has a number of negative effects. First, patients may be confined in an institutional setting longer than necessary, potentially contributing to deterioration in their conditions.

[44] *Minnesota Statutes* 2012, 253B.18, subds. 4c and 7. A "provisional discharge" means that the discharged individual is still under the commitment order of the court. If the individual's mental health worsens, the discharge can be unilaterally revoked by the Security Hospital and the individual must return to the facility under the original commitment order. Because a commitment as mentally ill and dangerous continues indefinitely, individuals that have received such a commitment may remain on "provisional" discharge for the rest of their lives even if they never return to the Security Hospital.

[45] We refer here to new provisional discharges, not changes to the terms of an existing provisional discharge (which may also require special review board approval).

If necessary, State-Operated Services should directly provide additional services to help more Security Hospital residents safely and successfully return to the community.

Second, the inability of the Security Hospital to discharge patients has limited its ability to accept new patients. The Security Hospital's intake coordinator told us that at times the facility has had difficulty meeting its statutory obligation to promptly admit patients committed as mentally ill and dangerous. The Security Hospital has been unable to accept some patients for whom admission has been sought but whose commitment status does not automatically enable admission.

Third, state costs are higher than they might otherwise be. The state pays for nearly all of the cost of care of patients at the Security Hospital.[46] It is likely that at least some of these patients could be served in community-based facilities where costs would be lower and where services would be eligible for federal reimbursements. If so, the overall cost to the state of caring for these individuals could decrease.

To address our recommendation, DHS could consider providing these services itself, by repurposing existing SOS facilities or building new ones. Alternatively, DHS could propose increasing incentives or creating new ones so that nonstate providers might be more willing to serve individuals ready to leave the Security Hospital. We do not make a recommendation between these two options; we think SOS is better suited to examine alternatives and make a case for either or both. Similarly, we make no recommendations regarding funding, because the approach DHS chooses and its decisions about facilities currently used by other SOS programs would influence whether additional legislative funding is required.

The Department of Human Services has proposed new construction at the Security Hospital campus. Whatever the merits of that proposal, we think creating placement options for patients ready to leave the Security Hospital deserves immediate attention. Among other reasons, it is difficult to estimate the number of patients the Security Hospital should be renovated to serve if the question of placements for discharged patients remains unresolved.

[46] Counties pay 10 percent of patient care costs at the Security Hospital; the state pays the remaining 90 percent. *Minnesota Statutes* 2012, 246.54, subd. 2(a).

6 State's Role in Operating Services

As described in Chapter 1, the Department of Human Services (DHS) has a long history as a direct service provider. Since shortly after Minnesota became a state, the department (or its predecessors) has operated institutions for people with mental illnesses, developmental disabilities, and substance abuse problems. Most of the large DHS facilities have been closed, but many other state-run facilities have been created in recent years to help serve similar types of clients. Questions remain about what role DHS should play as a service provider. In fact, DHS officials encouraged our office to critique its service delivery role as part of this evaluation of the State-Operated Services (SOS) Division.

In this chapter, we discuss the mission of SOS and examine the rationale for a direct state role in various service areas. We focused on selected residential and inpatient services, not outpatient services.[1] Overall, we think there is a need to sharpen the focus of SOS's mission. The Department of Human Services should maintain an array of state-run facilities, but its involvement in some types of direct services should be reduced.

Also, as recommended elsewhere in this report, the department should play a stronger role in ensuring a continuum of care for individuals with mental illness, developmental disabilities, and chemical dependency. This may require DHS to foster more community-based service options (run by SOS or other providers) or collaborate more with nonstate service providers.

MISSION OF STATE-OPERATED SERVICES

Services to individuals with mental illness, developmental disabilities, or chemical dependency may be provided by a variety of providers, public and private. We reviewed Minnesota statutes to determine whether the law identifies particular circumstances that call for delivery of such services by state employees. We found that:

- **State law does not clearly establish the underlying purpose of the Department of Human Services' direct provision of services to individuals.**

[1] This chapter does not discuss all existing state-run facilities. We did not closely examine a 16-bed facility in Cambridge for individuals with developmental disabilities who have histories of legal problems or pose safety risks, nor did we examine the state-run Child and Adolescent Behavioral Health Hospital in Willmar. Also, our review of four SOS "intensive residential treatment" facilities for individuals with mental illness was limited.

Minnesota law sets forth the scope of state-operated services as follows:

> State-operated services shall include regional treatment centers, specialized inpatient or outpatient treatment programs, enterprise services, community-based services and programs, community preparation services, consultative services, and other services consistent with the mission of the Department of Human Services. These services shall include crisis beds, waivered homes, intermediate care facilities, and day training and habilitation facilities…. The state-operated services staff may deliver services at any location throughout the state…. The commissioner of human services shall create and maintain forensic services programs. Forensic services shall be provided in coordination with counties and other vendors. Forensic services shall include specialized inpatient programs at secure treatment facilities…, consultative services, aftercare services, community-based services and programs, transition services, or other services consistent with the mission of the Department of Human Services.[2]

For the most part, the law does not specify a distinct role for State-Operated Services.

For the most part, the law does not specify the reasons state employees rather than other providers should deliver certain services. For one subgroup of services—enterprise activities—the law establishes a "safety net" role for DHS. The law says: "Enterprise activities within state-operated services shall specialize in caring for vulnerable people *for whom no other providers are available* or for whom state-operated services may be the provider selected by the payer"[3] (emphasis added). A "safety net" role is not explicitly specified in statute for state-operated services funded by appropriations, which comprise a majority of the direct services DHS provides.

Other state laws refer to the mission of SOS, but they do not articulate a unique role for these services. For instance, the law says: "The primary mission of the regional treatment centers for persons with major mental illness is to provide inpatient psychiatric hospital services."[4] This statement describes the setting in which the service is provided rather than specifying a desired outcome or a rationale for the state's role. In addition, the law requires the commissioner to provide state-operated services in a manner consistent with the statutory missions of the adult and children's mental health systems.[5] However, these statutory missions encompass all mental health services in Minnesota, state-operated or not. The law also says the commissioner shall provide care and treatment of

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[2] *Minnesota Statutes* 2012, 246.014(a) and (b). In addition, *Minnesota Statutes* 2012, 253.015, subd. 1, says the state's facilities located at Anoka, Brainerd, Fergus Falls, St. Peter, and Willmar "shall constitute the state-operated services facilities for persons with mental illness." This section of statutes is outdated; state-run mental health facilities have been added at several additional locations over the past decade.

[3] *Minnesota Statutes* 2012, 246.0136, subd. 1. As noted in Chapter 1, enterprise activities are intended to be self-supporting, primarily relying on revenues generated from billing third parties.

[4] *Minnesota Statutes* 2012, 253.016.

[5] *Minnesota Statutes* 2012, 246.014(a).

persons with mental illness "as speedily as is possible."[6] Finally, the law says that the role of SOS in providing community-based programs "must be defined within the context of a comprehensive system of services for persons with mental illness," but it does not offer a clear definition of this role.[7]

In addition, we observed that:

- **The vision and mission statements adopted by State-Operated Services do not delineate a unique role or purpose for the services it provides.**

Exhibit 6.1 shows SOS's most recent vision and mission statements. These broadly worded statements do not clearly differentiate state-operated services from the services of other providers, nor do they indicate the underlying rationale for state-operated services.[8] Some former SOS officials told us that the mission of state-operated services has long needed clarification, noting confusion about which clients SOS should be serving and toward what ends. They said turnover among high-level DHS leaders over the years has contributed to ongoing shifts in SOS priorities.

For the most part, county representatives, client advocates, and private service providers we surveyed and interviewed supported a continued state role for DHS in direct service delivery.[9] However, many expressed concerns that the role they see as most appropriate for SOS has not been adequately provided. Specifically, they suggested a need for SOS to offer services that other providers do not—the

Exhibit 6.1: State-Operated Services' Vision and Mission Statements, 2011

Vision Statement

Inclusive communities across Minnesota that are vibrant, sustainable, healthy and support people in effectively addressing their behavioral health needs allowing them to achieve their life goals.

Mission Statement

Partnering with others, we provide and support innovative and responsive specialty services to people with complex behavioral health needs and challenges.

SOURCE: Minnesota Department of Human Services, State-Operated Services, *Vision/Mission/Values, 2011*, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5444A-ENG, accessed November 7, 2012.

[6] *Minnesota Statutes* 2012, 246.013.

[7] *Minnesota Statutes* 2012, 253.28, subd. 1.

[8] We also reviewed SOS's most recent strategic plan. That plan offers a more detailed set of goals than the vision and mission statements, but it does not differentiate SOS's role from that of other providers.

[9] As described in the Introduction, we conducted statewide surveys of county human services directors and representatives of non-SOS hospitals. We also interviewed some of these officials as well as representatives of various advocacy groups.

"safety net" role referenced earlier. The following comments from county officials exemplify these sentiments:

> [State-Operated Services is] our only "Safety Net" even though it's not adequately meeting our needs for the most difficult to serve population.
>
> [T]he state is not providing the fail-safe programs needed for these high need, high risk, high behavioral, aggressive and/or autism/Aspergers clients that constantly rotate through [public and private facilities] with no long term stability.
>
> [I]t seems to me that the State might be better positioned than private partners in two areas: risk/liability for the high risk population and pilot programs as a way to fill service gaps in areas where no service exists.

The Legislature should clarify in law a "safety net" role for facilities operated by DHS.

As we discussed in Chapter 3, we heard concerns that SOS's community behavioral health hospitals have not been willing to admit certain individuals with violent or aggressive histories. In addition, we heard concerns about the sufficiency of services (SOS or other) available for individuals ready to be discharged from SOS inpatient facilities.

RECOMMENDATION

The Legislature should clarify in state law the role of State-Operated Services' residential and inpatient facilities, stating a mission of serving individuals who cannot be adequately served by other providers.

If DHS is to be a direct provider of human services, state law should set forth a clearer direction about DHS's role. In our view, it is appropriate for DHS to play a safety net role by providing high-quality services to address gaps in the service system. In the next section, we discuss the extent to which specific DHS services have fulfilled such a mission.

APPROPRIATENESS OF STATE'S ROLE IN SPECIFIC SERVICES

We considered whether DHS should continue its role as a direct provider of services. For this purpose, we mainly focused on selected inpatient or residential facilities operated by SOS, as discussed in the sections below. We reviewed the way these services operate, collected information on other providers of these services, and solicited input from county officials, nonstate service providers, mental health and disability advocates, and others.[10] Overall, in our view,

[10] We did not attempt to estimate the number of beds needed to address client needs, through state-operated or other services.

- **Some services now provided directly by the Department of Human Services could be offered by nonstate providers or through stronger collaboration between state and nonstate providers.**

- **The department has not always served the most challenging clients, so it seems likely there has been some overlap between the clients served by the department and those served by other providers.**

DHS should focus on providing services that do not duplicate those of other capable providers.

As noted earlier, state law does not clearly specify the circumstances in which DHS should directly provide services to clients. But, as we suggested in our recommendation above, we think DHS should focus on providing services that do not duplicate those of other capable providers. For example, if there are insufficient numbers of nonstate service providers that are willing or able to offer services that meet clients' needs, it is reasonable for the state to directly provide (or arrange for) these services. On the other hand, alternatives to state-operated services should be considered if there are nonstate providers that are willing to serve the types of clients now served directly by DHS and that could do so cost-effectively and capably.

Some people we interviewed suggested additional reasons that DHS might consider "shedding" some services it now provides directly. For example, we heard some concern that the wide breadth of services now provided directly by DHS makes it challenging for the department to define a clear mission for itself, hire leaders for these specific purposes, and focus on critical areas needing improvement. Others suggested to us that clients might be better served if funds now used by DHS to administer and operate its own facilities were redirected—for example, to create funding streams for appropriate client services, without tying this funding to services that are state-operated.

Minnesota Security Hospital

According to Minnesota law, the Minnesota Security Hospital in St. Peter is a "secure treatment facility" for persons (1) committed to that facility by the courts, (2) transferred to that facility by the Commissioner of Human Services, (3) found to be mentally ill while in a correctional facility, or (4) found to be mentally ill and dangerous.[11] Because this facility serves persons with specific types of commitments or custodial arrangements, we determined that:

- **The Minnesota Security Hospital serves a unique population that has traditionally not been served by private providers, and it should continue this role.**

At a given point in time, about 90 percent of the Security Hospital's patients have been committed by a court as "mentally ill and dangerous to the public."[12] By law, such individuals must be sent to a secure treatment facility or a facility

[11] *Minnesota Statutes* 2012, 253.20.

[12] This term is defined in *Minnesota Statutes* 253B.02, subd. 17, as someone who (1) is mentally ill and (2) as a result of that mental illness presents a clear danger to the safety of others.

willing to accept the patient.[13] The Security Hospital is Minnesota's only facility licensed as a residential treatment facility for adults with mental illness that offers treatment in a secure setting.[14] This enables it to serve individuals with behaviors or risks that similar facilities serving individuals with mental illness for extended periods of time generally cannot accommodate.

The state should continue to operate a secure treatment facility for mentally ill individuals who pose a danger to others.

In addition, nearly all Minnesota Security Hospital patients are the legal responsibility of either the departments of Human Services or Corrections. Some have been specifically committed by the courts to the Security Hospital. Some have been sentenced to a prison term, and placing them in a nonstate facility in a nonsecure setting to receive treatment would not be a viable option.

Also, it is doubtful that nonstate mental health treatment facilities would be willing to serve clients for whom they had no authority to make transfer or discharge decisions. Nonstate mental health treatment facilities generally make the discharge decisions about the clients they serve.[15] In contrast, patients committed as mentally ill and dangerous cannot be transferred to less secure settings or discharged without receiving approval from a "special review board."[16] Thus, while some nonstate providers may be capable of providing the treatment that clients now receive in the nonsecure part of the Minnesota Security Hospital, the lack of provider control over admission and discharge decisions might impede efforts to rely on nonstate providers for these services.[17] Furthermore, the Commissioner of Human Services may, understandably, prefer to retain direct responsibility for providing services to individuals legally committed as "dangerous."

Overall, we think the state should continue to provide a secure treatment facility for mentally ill individuals who pose a danger to others. Ensuring public safety is an important state responsibility, and it is appropriate for DHS to directly provide services to individuals committed to the department for public safety reasons. As recommended in Chapter 5, it is possible that some Security Hospital residents could be served in less restrictive settings (or settings in which they are more "integrated" with the general public) if there were improvements in services available for discharged residents.

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[13] *Minnesota Statutes* 2012, 253B.18, subd. 1.

[14] As noted in Chapter 5, a portion of this facility (Transition Services) provides treatment in a nonsecure setting for patients who have demonstrated an ability to live outside the facility's secure building. While some public and private hospitals in Minnesota have locked units for persons with mental illness, the Security Hospital, despite its name, is not licensed as a hospital.

[15] *Minnesota Rules* 2012, 9520.0610, requires mental health residential programs to develop policies outlining the circumstances in which their clients will be discharged.

[16] *Minnesota Statutes* 2012, 253B.18, subds. 6 and 7.

[17] Transition Services could be provided at a location other than the Minnesota Security Hospital campus. The secure and nonsecure parts of the Security Hospital have developed their own treatment regimes fairly independently, and there is not a clear sequence of treatment that patients continue when they move between the two. On the other hand, there may be advantages to having all parts of the Minnesota Security Hospital on a single campus—for example, this may enable patients to see the same psychiatrist when they move from a secure to a nonsecure setting or vice versa.

Anoka-Metro Regional Treatment Center

The Anoka-Metro Regional Treatment Center has played an important role, but some important challenges need attention.

In Chapter 3, we found that the Anoka facility faces some significant operating challenges. Most notably, it has long waiting lists for admission, keeps many patients longer than their symptoms require, and is ineligible for Medicaid payments for many patients. The 2009 Legislature required DHS to prepare a plan on this facility's future, but DHS never provided a detailed proposal.

Our survey of county human services directors indicated that the Anoka facility has served an important niche in the state's mental health system. More than three-fourths of the county officials responding to our survey said the Anoka-Metro Regional Treatment Center serves patients that non-SOS hospitals do not have the resources to serve, and that Anoka's patients are, on average, more challenging to serve than patients in nonstate hospitals.[18] Also, although many county respondents did not have opinions about the quality of Anoka's care, few county human services directors expressed concern about Anoka's service quality.[19]

Some people have suggested that opening more beds at Anoka-Metro Regional Treatment Center would address the facility's problem with long waiting lists. But a former administrator of the facility told us that when Anoka did reduce its waiting lists several years ago, non-SOS hospitals increased their referrals to Anoka and did not try as hard to find acceptable alternatives to Anoka.

Funding additional beds at Anoka is an option that should remain under consideration. But this option would not address the state's inability to get federal Medicaid reimbursement for most patients' care at Anoka, due to the facility having more than 16 beds. It also would not address the need for collaboration among Anoka and nonstate hospitals that DHS recommended in a 2010 report.[20] In our view, any consideration of adding beds to the Anoka facility must be part of a broader discussion regarding that facility's future.

RECOMMENDATION

The Department of Human Services should provide the 2014 Legislature with a substantive plan for the Anoka-Metro Regional Treatment Center.

[18] In response to a statement that read, "Anoka-Metro RTC serves behavioral health patients that private hospitals do not have the resources to serve," 78 percent of responding county human services directors agreed, 1 percent disagreed, 4 percent neither agreed nor disagreed, and 17 percent expressed no opinion. In response to a statement that read, "On average, Anoka-Metro RTC serves more challenging patients than those served by private hospitals' behavioral health units," 79 percent of respondents agreed, 3 percent disagreed, 3 percent neither agreed nor disagreed, and 15 percent expressed no opinion.

[19] In response to a statement that read, "Anoka-Metro RTC provides high-quality mental health services to its patients," 45 percent of county human services directors agreed, 4 percent disagreed, and the remainder neither agreed nor disagreed or offered no opinion.

[20] Department of Human Services, *Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience & Recovery of the People We Serve* (St. Paul, March 2010), 7.

DHS should develop or foster additional placement options for patients at the Anoka facility.

Anoka has played an important role in the state's continuum of care. At times, it has been the acute care hospital of last resort that serves patients that other public and private hospitals cannot. In Chapter 3, we recommended that DHS (1) evaluate the impact of past legislative efforts to improve placement options for patients when they leave the Anoka facility and (2) develop or foster additional placement options for Anoka patients, as needed. Such actions should commence as soon as possible, but the department's 2014 plan should address whether additional legislative action is necessary to improve placement options. Also, DHS said in 2010 that the Anoka-Metro Regional Treatment Center's units should operate in partnership with other Twin Cities hospitals.[21] In the 2014 plan, the department should determine whether this is still a desirable goal—and, if so, what steps would be needed to accomplish it.

Community Behavioral Health Hospitals

Since SOS's community behavioral hospitals began opening in 2006, they have had a variety of management issues, as discussed in Chapter 3. They initially had difficulty filling their beds; after three hospitals were closed, the occupancy rates of the remaining hospitals have been higher. Some of the hospitals have had difficulty hiring and retaining specialized staff. Because the state-run hospitals are small and not connected with other health care facilities, there have been significant expenditures for on-call services by medical professionals. At times, the state-run hospitals have been unable to admit patients with a history of violence or aggression, which has frustrated county officials and referring hospitals. Also, some counties have had concerns about the adequacy of the hospitals' discharge planning.

In addition, some mental health advocates have expressed doubts about whether SOS's community behavioral health hospitals have been a good state investment. At more than $1,100 per patient per day, some advocates have questioned whether these small facilities are providing the best expenditure of scarce state dollars.

One option for addressing such concerns would be for the State of Minnesota to rely more on non-SOS hospitals in Minnesota to serve clients now served by state-run hospitals. As of mid-2012, 31 non-SOS Minnesota hospitals had behavioral health units. According to data from the Minnesota Hospital Association, these units have more than 900 beds for patients with mental health needs. The Department of Human Services already contracts with 17 of these hospitals to help ensure the availability of beds for individuals who are insured by public health care programs or have no insurance.[22] But,

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[21] *Ibid.*

[22] The Department of Human Services established a contract bed program in response to the restructuring and closure of its regional treatment centers. Hospitals receive funding through Medical Assistance grants (on a per-patient basis) or state "operating subsidy" grants (on a lump-sum basis). We did not evaluate the contract bed program, which is administered by DHS's Chemical and Mental Health Division, not SOS. According to DHS mental health staff, paying nonstate hospitals to serve individuals needing inpatient care has likely diverted some individuals who would otherwise have been referred to SOS facilities.

- **While there are many nonstate hospitals in Minnesota that provide mental health services, it is unclear whether those hospitals could meet the demand for inpatient services if state-run hospitals no longer existed.**

We are not aware of any definitive studies on the need for inpatient psychiatric beds in Minnesota. A recent national report said "there is little consensus on the minimum number of psychiatric inpatient beds communities should have available" because the answer depends on what other services are available.[23]

Nonstate hospitals provide behavioral health services to many individuals, but it is unclear that they could fully meet the demand for such care if state-operated hospitals closed.

In our surveys of county officials and administrators at non-SOS hospitals, we asked about the ability of non-SOS hospitals to serve clients now served at state hospitals. Exhibit 6.2 shows responses to several questions. Many respondents said that the state-run hospitals do not serve patients who are, on average, more challenging than those served by nonstate hospitals. But, if community behavioral health hospitals no longer existed, most respondents thought non-SOS hospitals would not have sufficient resources (without changes in funding or staffing) to serve the state-run hospitals' patients. A top State-Operated Services official with previous experience in a private health care company told us that behavioral health services have not been very profitable for non-SOS hospitals. Furthermore, some SOS and county staff questioned whether non-SOS hospitals would be willing to admit patients with histories of violence or those committed by a court to the Commissioner of Human Services for a mental illness.

Some people we spoke with advocated a second option: using a portion of funds now used for SOS community behavioral health hospitals to create a mental health funding source not tied to specific facilities. This approach, according to its advocates, would fund client-responsive community-based services in a flexible way that reduces the need for future hospitalizations. Proponents of this approach acknowledged to us that, if this approach was implemented, there would continue to be individuals who would require hospital-level or other types of intensive services. In fact, some public officials have expressed concern that Minnesota lacks enough hospital beds for individuals with serious mental illness.[24] Thus, before taking action to close relatively new SOS hospitals or divert their funding to other purposes, policy makers should carefully consider the adequacy of Minnesota's existing inpatient and other services for people with mental illness.

Another option would be to improve the integration of SOS's community behavioral health hospitals with other community resources. State-Operated Services officials told us that nonstate hospitals were not willing to partner with SOS at the time state-run behavioral health hospitals were created. However, some people think the original plan to have state-run hospitals partner with other

[23] National Alliance for Mental Illness, *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness* (Arlington, VA, 2009), 33.

[24] For example, the Hennepin County sheriff recently lamented the lack of psychiatric hospital beds for jail inmates. See Rich Stanek, "A Jail is No Place for the Mentally Ill," *Star Tribune*, November 25, 2012, p. 3OP.

Exhibit 6.2: Selected Survey Responses Regarding Community Behavioral Health Hospitals, 2012

Statement on Survey	Percentage of County Human Services Directors			Percentage of Outstate Private Hospital Representatives		
	Agree	Disagree	Neither/ Don't Know	Agree	Disagree	Neither/ Don't Know
The community behavioral health hospital serves patients that private hospitals in my area lack the resources to serve.	42%	41%	16%	47%	47%	7%
On average, the community behavioral health hospital serves more challenging patients than those served by behavioral health units in my region's private hospitals.	35	43	22	13	67	20
If the community behavioral health hospital did not exist, private hospitals in the region would have sufficient resources to serve the patients it now serves.	14	74	12	0	73	27
Community behavioral health hospitals should be co-located at private hospitals, private clinics, or mental health centers, rather than being stand-alone facilities.	29	30	41	44	50	6

NOTES: For the questions above, the number of respondents on the county survey was 72 or 73. The number of private hospital respondents was 15 or 16, depending on the question. We did not ask these questions of hospital representatives from the Twin Cities area because they used community behavioral health hospitals infrequently. Totals may not add to 100 percent due to rounding.

SOURCES: Office of the Legislative Auditor, surveys of county human services directors and nonstate hospital representatives, August to November 2012.

community hospitals remains a goal worth pursuing. For example, co-location would enable patients of state-run behavioral health hospitals to more readily receive services for physical health issues in addition to mental health issues—addressing a concern about disjointed services we heard from some people. Also, if a small, state-run hospital was allied with a larger hospital in the community, perhaps on-call duties could be spread among a larger number of physicians. It is even possible that this type of arrangement might result in reduced on-call hours, if the larger hospital's physicians provided consultations that did not have to be purchased at an hourly rate. Exhibit 6.2 showed mixed opinions regarding whether state-run community behavioral health hospitals should be co-located with hospitals, clinics, or mental health centers run by other entities.

Without better information on the need for inpatient mental health services, we think policy makers should make improvements in community behavioral health hospitals at this time rather than abandoning them. The improvements we suggest are (1) integrating certain services between state-run and private providers and (2) enhancing the ability of some state-run hospitals to handle aggressive patients.

RECOMMENDATION

As a pilot program, the Department of Human Services should develop a plan that enables at least one community behavioral health hospital to integrate its services more fully with at least one nonstate hospital—through co-location or other collaborative arrangements.

State-operated hospitals should be better integrated with other health care resources in the community.

Non-SOS community hospitals are already serving many challenging patients—due to restrictive admission practices at state-run facilities and by participating in DHS's "contract bed" program. A collaborative relationship between at least one state-run hospital and one nearby non-SOS hospital would allow DHS to explore service efficiencies and better ways to meet patient needs. All of SOS's state-run hospitals are in regions of the state that have at least one non-SOS hospital with a psychiatric unit.[25] The department tried previously to foster collaboration with nonstate hospitals and did not succeed. Making this type of pilot project attractive to a non-SOS provider might require financial incentives that were not offered in DHS's previous attempt to forge partnerships. Depending on the outcome of this pilot, the Legislature and DHS could consider whether to pursue this option at other locations.

RECOMMENDATION

The Department of Human Services should add security arrangements to at least two community behavioral health hospitals that would enable them to admit individuals with the most challenging behaviors.

Some state-run hospitals should have enhanced ability to serve patients with difficult behaviors.

Earlier in this chapter, we recommended clarifying SOS's mission to emphasize serving the clients least able to be served by other providers. We recognize that it is challenging for any hospital to serve clients who are aggressive or have a history of violence, and community behavioral health hospitals have not been equipped to do so effectively. Serving such a population may require changes to a facility's staffing levels and perhaps its physical configuration. State-Operated Services contends that the population of violent or aggressive clients is small, so we think it may be impractical to ensure that every state-run hospital in Minnesota has resources to serve these patients. However, having this capacity at two or more outstate locations seems consistent with the role that SOS should be expected to play.

Group Homes for Adults with Developmental Disabilities

The largest single SOS program from a budget perspective is called Minnesota State-Operated Community Services (MSOCS). In fiscal year 2012,

[25] We examined the location of state-run and other hospitals in the state's 11 economic development regions as defined by the Minnesota Department of Employment and Economic Development.

expenditures for this program totaled more than $82 million. For this program, SOS operates 99 facilities licensed as adult foster homes and 15 licensed as intermediate care facilities. The primary diagnosis of about 90 percent of MSOCS residents is some form of developmental disability, ranging from mild to profound. Most of the remaining residents have a primary diagnosis of a mental illness or traumatic brain injury. Most MSOCS residences provide long-term care rather than treatment. State-Operated Services also provides vocational services, such as job training and supported employment, for group home residents at 19 locations throughout the state.

We found that:

- **The Department of Human Services is one of many Minnesota providers offering similar types of group residential services to individuals with developmental disabilities, and a reduced state role in this area would be reasonable.**

Nonstate providers operate most of the foster homes and intermediate care facilities in Minnesota.

Exhibit 6.3 shows that the number of state-run group homes represents a small fraction of similarly licensed facilities statewide. As of mid-2012, nearly 4,700 adult foster homes were licensed by the state but not operated by DHS. Each of these homes provided residential accommodations for one to five persons. In addition, there were about 200 intermediate care facilities for individuals with developmental disabilities in Minnesota, each serving 4 to 64 people. The existence of thousands of licensed group homes around Minnesota shows the viability of this industry. Most regions of the state have significant numbers of group homes, as Exhibit 6.4 shows.

Many residents of MSOCS could probably be served by nonstate facilities. Staff in DHS's Disability Services Division—which oversees policy for Minnesota's publicly funded programs for people with disabilities but does not operate any facilities—told us that state-operated and other group homes serve overlapping client populations. They said nonstate providers could capably serve existing MSOCS residents, but estimated that these providers might be unwilling to serve 20 to 60 residents whose services present special challenges. State-Operated

Exhibit 6.3: Number of Adult Foster Care and Intermediate Care Facilities in Minnesota, 2012

	Statewide Number of:				
Type of Facility	All Licensed Facilities	SOS Facilities	Beds in All Licensed Facilities	Beds in SOS Facilities	Percentage of All Beds in SOS Facilities
Adult Foster Care	4,786	99	17,327	384	2%
Intermediate Care-Developmental Disabilities	211	15	1,835	90	5
Statewide	4,997	114	19,162	474	2%

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data, July 2012.

Exhibit 6.4: Distribution of Licensed Adult Foster Care Homes in Minnesota, 2012

Region	Adult Population	Number of: All Licensed Facilities	Number of: Beds in All Licensed Facilities	Number of: SOS Facilities	Number of: Beds in SOS Facilities	Percentage of All Beds in SOS Facilities
1-Northwest	65,272	76	270	2	6	2.2%
2-North-central	62,881	105	366	6	24	6.6
3-Northeast	259,828	548	2,035	5	20	1.0
4-West-central	171,599	356	1,242	8	29	2.3
5-Central	124,727	182	680	12	48	7.1
6-Southwest-central	123,901	240	887	5	20	2.3
7-East-central	417,781	624	2,265	9	36	1.6
8-Southwest	90,131	116	445	2	6	1.4
9-South-central	179,723	286	1,066	0	0	0.0
10-Southeast	375,412	544	1,980	20	79	4.0
11-Twin Cites area	2,148,607	1,709	6,091	30	116	1.9
Statewide	4,019,862	4,786	17,327	99	384	2.2%

NOTE: The regions shown here correspond to the economic development regions used by the Minnesota Department of Employment and Economic Development.

SOURCES: Office of the Legislative Auditor, analysis of Minnesota Department of Human Services data, July 2012, and U.S. Census Bureau.

Services staff agreed that there is potential for significantly reducing the number of state-operated group homes. By their estimates, around half of the current residents of state-run homes for people with developmental disabilities could be reasonably served by licensed facilities other than those run by DHS.

Department of Human Services officials said that certain types of individuals might be best suited to remain in state-operated homes. For example, some individuals require high levels of security and staff supervision or the use of specialized assistive technology. DHS staff said that state-run homes have access to consulting services and back-up staff who can be mobilized to serve difficult clients. DHS told us that private providers serve some very challenging individuals but may be reluctant to serve clients with self-injurious or violent behaviors.

RECOMMENDATION

The Department of Human Services should develop a plan for the 2014 Legislature for reducing the number of state-run group homes for individuals with developmental disabilities.

The department should present the 2014 Legislature with a plan, based on a detailed analysis of individual facilities and residents. The plan would provide a more precise estimate of the potential for reducing the number of state-run facilities and suggest a timeframe in which this would occur.

DHS officials and client advocates think that some residents of state-operated homes could be served effectively in other settings.

Decisions to close any state-run homes would change the living arrangements of current residents, and these actions should be considered carefully. In surveys conducted by MSOCS, most responding residents of state-run facilities expressed satisfaction with their residences, and family members also expressed generally favorable opinions. On the other hand, representatives of groups who advocate on behalf of individuals with developmental disabilities told us that many group home residents could probably live more independently than they do now. They expressed concern that group homes offer a somewhat sheltered existence, providing residents with limited interaction with nondisabled people. Advocates acknowledged that some individuals need intensive, around-the-clock care, but they said some group homes have fostered dependence on services that residents may not need. In addition, some client advocates and DHS officials said that private facilities have lower costs per day than state-run facilities serving similar clients, and relying more on private facilities might enable limited public dollars for clients with disabilities to go further.[26] Our review of facility compliance showed that, in aggregate, SOS adult foster care facilities have had more investigated and substantiated complaints per facility than nonstate facilities, but have been less likely to receive license suspensions or revocations, conditional licenses, or fines.

As we discuss elsewhere in this report, state-run inpatient facilities for individuals with mental illness—such as the Minnesota Security Hospital and Anoka-Metro Regional Treatment Center—need better options for serving patients ready for discharge. Small group homes have been used to a limited extent for these individuals, and perhaps they should be used more. The DHS plan recommended above should consider the need to retain or add state-run group homes for this purpose.

Chemical Dependency Treatment Facilities

Statewide, there are 91 DHS-licensed chemical dependency residential treatment facilities in Minnesota. As of mid-2012, the six state-run chemical dependency facilities were licensed for 313 beds, or about 10 percent of the total licensed capacity in Minnesota's licensed chemical dependency facilities.[27] Based on our review,

- **State-operated residential chemical dependency programs play an important role in Minnesota, although some of their clients could probably be served by privately operated programs.**

To help us compare the state-run programs and the large number of other residential programs, we examined certain characteristics of clients admitted to SOS and non-SOS programs, as shown in Exhibit 6.5. A larger percentage of persons admitted to state-run facilities in 2011 were committed or ordered to treatment by a court (37 percent compared with 18 percent for nonstate

[26] We are not aware of recent analyses that have definitively compared the cost per day of state-run and nonstate facilities serving individuals with comparable levels of disability.

[27] The state-run facilities are not staffed to support all the beds for which they are licensed. As of mid-2012, DHS facilities had staffing for 177 beds.

programs). In aggregate, SOS clients tended to have more prior arrests than non-SOS clients upon admission to treatment and more prior placements in treatment. Treatment facilities also rate their new clients on several more subjective dimensions. As summarized on these ratings in Exhibit 6.5, persons entering SOS treatment in 2011 had more serious problems than their non-SOS counterparts on some measures (for example, their readiness to change), while on some measures they had fewer problems (for example, their biomedical conditions). Overall, a majority of the measures shown in Exhibit 6.5 suggest that SOS clients had, in aggregate, more challenging characteristics than non-SOS clients had, although the differences were not always large.

Exhibit 6.5: Comparison of Clients Admitted to Residential Chemical Dependency Treatment Programs, 2011

Clients in state-operated chemical dependency facilities were more likely to have been committed by a court than clients in nonstate facilities.

Client characteristic at time of admission to chemical dependency treatment in 2011	SOS Clients	Non-SOS Clients
Percentage with a court commitment or court order	37%	18%
Median number of arrests in lifetime	4	2
Median number of detox facility admissions in lifetime	1	1
Median number of admissions to a chemical dependency treatment program	3	2
Percentage with a revoked driver's license due to a drunk driving violation	31%	22%
Percentage rated as having "serious" or "extreme" potential for acute intoxification or withdrawal[a]	3%	12%
Percentage rated as having "serious" or "extreme" biomedical conditions[a]	6%	10%
Percentage rated as having "serious" or "extreme" emotional, behavioral, or cognitive conditions[a]	31%	26%
Percentage rated as having "serious" or "extreme" problems with readiness to change[a]	55%	43%
Percentage rated as having "serious" or "extreme" potential for relapse or continued substance use[a]	85%	91%
Percentage rated as having "serious" or "extreme" problems with their recovery environment[a]	84%	85%

[a] Based on a rating by the treatment provider at the time of admission. Other measures in the exhibit are based largely on client self-reports to the treatment provider.

SOURCE: Minnesota Department of Human Services, Alcohol and Drug Abuse Division.

County officials generally believe that state-operated chemical dependency facilities serve an important role. In our survey of county human services directors, 11 percent of respondents said that nonstate facilities could adequately

serve the clients now served by state-run facilities, while 64 percent said they could not.[28] Examples of comments we heard included the following:

> Some clients need the security of the locked facility and understanding of the commitment order that the [state-operated] programs can uniquely provide.

> For anyone with medical issues beyond diabetes, it's nearly impossible to find treatment. Without state-operated services, we may not be able to find places with or without a Court order because private facilities turn them away due to complex issues.

State-operated chemical dependency programs often serve challenging clients, although they are not necessarily unique among providers in this regard.

The department's Alcohol and Drug Abuse Division has authorized SOS facilities to serve some especially challenging populations, although they are not necessarily unique in this regard. For example, some of Minnesota's public and private residential treatment providers have been specifically authorized by DHS to provide "high intensity" chemical dependency treatment combined with medical services and services for co-occurring mental illnesses. From July 2011 through November 2012, SOS facilities accounted for 23 percent of the $7 million paid from Minnesota's Consolidated Chemical Dependency Treatment Fund for this purpose.[29] In contrast, the only treatment facility that received payments ($196,915) during this period for "high intensity" treatment combined with medical services and medication-assisted treatment for opioid addiction was the state-operated Willmar facility, suggesting that the facility was fulfilling a unique niche in the service system.

We talked with a group of directors of private chemical dependency treatment programs. Most thought the state-run programs should continue to exist, but perhaps focusing to a greater extent on clients who need longer or more intensive treatment. They said that the state-run programs today more closely resemble private programs than they used to—for example, in program length. Using statewide data, we confirmed that the average length of stay for clients in state programs is approximately the same as that of clients in nonstate programs, in aggregate.[30]

Some county and state officials expressed concern to us about the quality of state-run chemical dependency programs. A top official with DHS's Alcohol and Drug Abuse Division told us that state-run programs may not have the resources necessary to adequately serve the more complex clients referred to them. He also suggested that the statewide rate structure that is used to determine payments from the Consolidated Chemical Dependency Treatment Fund might not adequately reflect the cost of serving some of the challenging clients the SOS facilities serve. However, in our statewide survey, 58 percent of county human

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[28] Respondents were asked whether they agreed with the following statement: "If state-operated substance abuse programs did not exist, private facilities would adequately serve the clients now served by the state-run facilities." The remaining 25 percent of respondents neither agreed nor disagreed, or they responded "don't know."

[29] Nonstate providers at 27 different locations provided this type of service during this period.

[30] The average length of stay for individuals discharged from residential treatment programs during 2011 was 40 days for both state-run and nonstate facilities.

services directors said that SOS chemical dependency programs provide high-quality treatment, while 7 percent disagreed.[31] We did not independently analyze the effectiveness of SOS chemical dependency treatment programs or the adequacy of their staffing levels.

Overall, there is probably some overlap in the populations served by state-run and nonstate chemical dependency facilities, but state-run facilities serve some difficult clients and offer specialized programs to do so. For the most part, the SOS programs are valued by key stakeholders. As we discussed in Chapter 3, however, it is unclear whether state-run chemical dependency treatment services are financially sustainable. If the state-run programs continue to exist, it is important that they maintain an ability to provide high quality, intensive treatment to the state's most challenging clients. We offer no recommendations for changes in DHS's role at this time.

Community Partnership Network

Our evaluation focused on SOS services in inpatient or residential settings. However, in the course of our evaluation, we also reviewed some information on the Community Partnership Network, a program of nonresidential services that SOS funds throughout the state. We found that:

- **The state bears liability for some SOS employees it does not supervise, and the workers compensation costs for these employees have grown.**

Through a network of nonresidential services funded by DHS, the state bears financial responsibility for some risks over which it has little control.

Several years ago, the Legislature authorized "adult mental health initiatives" around Minnesota in conjunction with plans to close regional treatment centers.[32] In 2008, the state appropriation for these initiatives was moved from SOS to DHS's Adult Mental Health Division. At that time, counties were given the option of hiring the state staff that worked in the initiatives or contracting with SOS to provide staff to continue working in their regions. Many counties chose to contract for staff with SOS. These staff are considered state employees, but they are supervised by counties rather than SOS. This was the beginning of SOS's Community Partnership Network.

In fiscal year 2012, the state paid $487,364 in workers compensation costs for employees in the Community Partnership Network. This was a large increase from previous years. For example, the workers compensation costs for this program totaled about $181,000 in fiscal year 2011 and $281,000 in fiscal year 2010. Department of Human Services finance and human resources officials expressed concern to us that the state is financially responsible for risks over which it has little control.

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[31] Many county officials indicated some difficulties in getting clients into state-run chemical dependency programs in a timely manner. While 32 percent of county human services directors said that clients who need immediate chemical dependency treatment receive it at state-run facilities, 44 percent said they do not.

[32] *Laws of Minnesota* 1999, chapter 245, art. 5, sec. 21.

RECOMMENDATION

The Department of Human Services should discontinue employing staff in the Community Partnership Network it does not directly supervise.

There is no statutory requirement for DHS to operate the Community Partnership Network. The department could continue it in some form, perhaps as a grant program. However, it does not make sense for the state to retain liability for staff supervised by others.

PRACTICAL CONSIDERATIONS

In this chapter, we have discussed the option of closing some facilities now operated by the Department of Human Services. These discussions focused on whether there is a strong rationale for continued operation of these services by DHS, and whether nonstate providers could capably operate these services. In addition to these considerations, it is important for the Legislature and DHS to consider some additional issues. First,

- **The state's ability to phase out services now provided with its own employees is limited by restrictions in state law and labor contracts.**

Statutory provisions and labor contracts place some limits on DHS's ability to restructure its existing services.

Statutory language passed by the 2009 Legislature prohibited DHS from laying off staff at Minnesota Extended Treatment Options (METO) in Cambridge as a result of program "restructuring."[33] When DHS closed the facility in 2011, it faced the challenge of how to accommodate METO's 140 employees without laying them off. The department first negotiated memoranda of understanding that gave METO employees priority for job openings at other SOS facilities. It then negotiated memoranda of understanding that offered "enhanced separation benefits" to METO employees from two bargaining units.[34] Twenty-two employees chose the latter option, at a total state cost of about $400,000.

Another provision passed by the 2009 Legislature—as a rider to an appropriations bill—prohibits DHS from laying off staff if it "restructures" the Anoka-Metro Regional Treatment Center.[35] While there is room for interpretation about whether such riders remain in effect beyond the period of the appropriation, DHS has treated the provision as one that remains in effect today. State-negotiated memoranda of understanding with certain bargaining units also restrict DHS's ability to lay off staff at Anoka.[36]

[33] *Laws of Minnesota* 2009, chapter 79, art. 3, sec. 17, as codified in *Minnesota Statutes* 2012, 252.025, subd. 7.

[34] The bargaining units were the American Federation of State, County, and Municipal Employees and the Minnesota Association of Professional Employees.

[35] *Laws of Minnesota* 2009, chapter 79, art. 3, sec. 18.

[36] The bargaining units whose layoffs are restricted are the American Federation of State, County, and Municipal Employees, the Minnesota Nurses Association, and the Middle Management Association.

In addition, DHS does not have unfettered authority to close the programs funded by state appropriations that it operates. The 2010 Legislature passed language that said:

> If the closure of a state-operated facility is proposed, and the department and respective bargaining units fail to arrive at a mutually agreed upon solution to transfer affected state employees to other state jobs, the closure of the facility requires legislative approval.[37]

Because this provision is relatively new, no facility closures have yet required legislative approval.

In addition to these statutory restrictions,

- **Program changes involving state employee layoffs can have significant short-term costs.**

Layoffs of employees from state-operated facilities would have fiscal implications that policy makers should consider.

In 2011, legislation was drafted that would have privatized several SOS programs, and DHS prepared "fiscal notes" that estimated the cost of these proposals.[38] The department assumed that the average cost per laid-off employee would be $30,000—to cover the cost of unemployment benefits and payoffs of unused vacation and sick leave severance pay. Such costs could be greater if the bargaining unit's contract has special layoff provisions. The department estimated that the cost of laying off all employees of the Minnesota State-Operated Community Services program would be $34 million.[39] It also estimated that the cost of laying off all employees at the state-run community behavioral health hospitals, Anoka-Metro Regional Treatment Center, and Minnesota Security Hospital would be about $61 million.

These fiscal notes may have overstated the net fiscal impact of these actions on the state. They did not consider possible cost savings if private facilities' operating costs per diem would have been less than those of state-operated facilities' costs. Nevertheless, the short-term cost implications of layoffs are real and potentially large.

We offer no recommendations regarding statutory provisions that may limit DHS's ability to restructure its state-run services. However, as policy makers consider the department's future role in directly providing human services with its own employees, these provisions and the cost of possible layoffs are important factors to keep in mind.

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[37] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 19, sec. 6, as codified in *Minnesota Statutes* 2012, 246.129. This provision does not apply to SOS enterprise services.

[38] Fiscal notes prepared for S.F. 9785, 2011 Leg., 87th Sess. (MN); and S.F. 9787, 2011 Leg., 87th Sess. (MN).

[39] The fiscal note estimated the cost of eliminating residential facilities that primarily serve individuals with developmental disabilities as well as eliminating nonresidential day training and habilitation programs for these individuals.

List of Recommendations

- The Commissioner of Human Services should eliminate the State-Operated Services Governing Board, relying instead on the commissioner's statutory governance authority and any appropriate delegations of that authority. (p. 30)

- State-Operated Services should develop performance measures, strategic plans with measurable objectives, and performance-oriented action plans that relate directly to the organization's most fundamental goals. (p. 37)

- State-Operated Services managers should ensure that the organization's policies and procedures are updated or developed in a timely manner. (p. 39)

- The Department of Human Services should evaluate the impact of previous efforts to improve placement options for individuals ready for discharge from the Anoka-Metro Regional Treatment Center and other state-run facilities. It should develop or foster additional placement options as needed. (p. 43)

- State-Operated Services should:

  - Establish objectives and strategies for reducing rates of workplace injuries;

  - Amend SOS incident reporting policies to ensure that they are consistent, up-to-date, and sufficiently explanatory; and

  - Clarify in its policies the circumstances in which the Office of Special Investigations should be involved in incident reviews or investigations. (p. 58)

- State-Operated Services should designate a senior administrator to monitor and oversee restraint and seclusion practices throughout the organization. (p. 61)

- State-Operated Services should seek ways to limit overtime use to a reasonable level through administrative actions or negotiations with affected bargaining units. (p. 69)

- The Legislature should amend Minnesota statutes to give district courts continuing jurisdiction over all individuals civilly committed as mentally ill and dangerous or as developmentally disabled, and provide for periodic judicial review of their need for continued commitment. (p. 80)

- The Legislature should amend state law to require the Office of the State Court Administrator to periodically provide the Department of Human Services with information on all individuals committed to the Commissioner of Human Services. (p. 88)

- The Department of Human Services should periodically test the accuracy of its firearms-related background checks and explore ways to mitigate possible errors. (p. 90)

- The Department of Human Services should publicly clarify what types of disorders are best treated at the Minnesota Security Hospital. (p. 105)

- The Minnesota Security Hospital should adopt policies regarding the hours of counseling, therapy, and other treatment offered per week to help patients address their underlying mental health issues. (p. 107)

- State-Operated Services should develop clear, consistent standards that address how often Minnesota Security Hospital patients should be seen by a psychiatrist, and it should monitor compliance with these standards. (p. 109)

- The Department of Human Services should foster or develop new placement options for individuals ready to be discharged from the Minnesota Security Hospital. (p. 112)

- The Legislature should clarify in state law the role of State-Operated Services' residential and inpatient facilities, stating a mission of serving individuals who cannot be adequately served by other providers. (p. 118)

- The Department of Human Services should provide the 2014 Legislature with a substantive plan for the Anoka-Metro Regional Treatment Center. (p. 121)

- As a pilot program, the Department of Human Services should develop a plan that enables at least one community behavioral health hospital to integrate its services more fully with at least one nonstate hospital—through co-location or other collaborative arrangements. (p. 125)

- The Department of Human Services should add security arrangements to at least two community behavioral health hospitals that would enable them to admit individuals with the most challenging behaviors. (p. 125)

- The Department of Human Services should develop a plan for the 2014 Legislature for reducing the number of state-run group homes for individuals with developmental disabilities. (p. 127)

- The Department of Human Services should discontinue employing staff in the Community Partnership Network it does not directly supervise. (p. 132)

Minnesota Department of **Human Services**

February 8, 2013

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the recommendations included in the draft audit report titled "State-Operated Human Services." The Department of Human Services (department) appreciates the time and effort of the Legislative Auditor in reviewing State Operated Services. This report clearly and accurately identifies the issues facing the department as we work to provide a safe and caring environment for our clients and employees.

The department supports the key recommendations of the report, which are largely consistent with our own assessments and ongoing efforts to address areas needing improvement. We will work with the counties and care providers to develop more and better placement opportunities for those clients ready to be discharged from our facilities or who could be better served in the community. Further, we will work in collaboration with counties and other stakeholders to develop plans to bring to the legislature for repurposing state-run group homes, setting a clear direction for Anoka-Metro Regional Treatment Center, and clarifying the role of State Operated Services in the future.

Internally, the department will work hard to develop additional performance measures, strategic plans, and performance-oriented action plans that help us achieve our goals. We will continue our work to safely reduce the use of restraints, and will focus on providing timely and relevant training to employees that we believe will help reduce the rates of workplace injuries, and provide the best care possible for our clients.

Thank you again for the work of your office in conducting this evaluation and addressing fairly the important issues facing State Operated Services and the clients we serve.

Sincerely,

Lucinda E. Jesson

Lucinda E. Jesson
Commissioner
Enclosure

Department of Human Services
Response to the Legislative Audit Report titled
State-Operated Human Services

Audit Recommendation #1

The Commissioner of Human Services should eliminate the State-Operated Services Governing Board, relying instead on the commissioner's statutory governance authority and any appropriate delegations of that authority.

Agency Response to Recommendation #1

The Department supports the recommendation and has eliminated the appointed governing board. The commissioner has delegated the responsibilities to an oversight group consisting of Deputy Commissioner, Director of Compliance, SOS Medical Director, SOS Chief Executive Officer and SOS Chief Finance Officer.

Person Responsible: Patricia Carlson, SOS CEO
Estimated Completion Date: Completed

Audit Recommendation #2

State-Operated Services should develop performance measures, strategic plans with measurable objectives, and performance-oriented action plans that relate directly to the organization's most fundamental goals.

Agency Response to Recommendation #2

SOS management recognizes the critical nature of this recommendation and is beginning the process to expand performance measures as well as to develop the action plans and measurable objects. The hiring in 2012 of the Chief Quality Officer was important to future efforts.

Person Responsible: Donna Budde, Chief Quality Officer and Geoff Barnes, Director of Strategic Initiatives
Estimated Completion Date: Summer 2013 for program level, public and internal DHS dashboard revisions and expansion and action plans
Date: August 2013 for Strategic Plan measures and action plans

Audit Recommendation #3

State-Operated Services managers should ensure that the organization's policies and procedures are updated or developed in a timely manner.

Agency Response to Recommendation #3

The Agency agrees with this recommendation and SOS will review current status of SOS policies and procedures to ensure they reflect consistency throughout SOS.

Person Responsible: Thomas Ruter, Director of Support Operations and Service line administrators
Estimated Completion Date: December 31, 2013

Department of Human Services
Response to the Legislative Audit Report titled
State-Operated Human Services

Audit Recommendation #4

The Department of Human Services should evaluate the impact of previous efforts to improve placement options for individuals ready for discharge from the Anoka-Metro Regional Treatment Center and other state-run facilities. It should develop or foster additional placement options as needed.

Agency Response to Recommendation #4

The agency agrees with this recommendation and will work with CMHSA and Long Term Care Divisions to identify individuals and report accurately those ready for discharge; identify known barriers and promote the development of additional placement options as needed. It is a system wide issue and effort that will be expanded across SOS as work progresses.

Person Responsible:	Derrick Jones, Interim Adult Mental Health Administrator; Nancy Webster Smith, Hospital Administrator, AMRTC; Dave Hartford, CMHSA Interim Assistant Commissioner
Estimated Completion Date:	June 30, 2014

Audit Recommendation #5

State-Operated Services should:

- *Establish objectives and strategies for reducing rates of workplace injuries;*
- *Amend SOS incident reporting policies to ensure that they are consistent, up-to-date, and sufficiently explanatory; and*
- *Clarify in its policies the circumstances in which the Office of Special Investigations should be involved in incident reviews or investigations.*

Agency Response to Recommendation #5

The Agency agrees with the recommendation and will pursue appropriate mechanisms to address workplace injuries. We have expanded our training efforts, are hiring additional staff to address injury prevention and wellness and evaluating injuries that occur and conducting safety audits.

SOS incident reporting policy will be reviewed to ensure the procedures reflect consistency throughout SOS and that they are self–explanatory and current. SOS will also clarify policies around incident reviews and clarify the role of the Office of Special Investigations.

Person Responsible:	Donna Budde, Chief Quality Officer; Thomas Ruter, Director of Support Operations
Estimated Completion Date:	July 1, 2013

Audit Recommendation #6

State-Operated Services should designate a senior administrator to monitor and oversee restraint and seclusion practices throughout the organization.

Department of Human Services
Response to the Legislative Audit Report titled
State-Operated Human Services

Agency Response to Recommendation #6

The Agency agrees with the recommendation and has identified a senior staff member responsible for this oversight. The Quality Management Officer working with the Quality Improvement Risk Management Group will perform the oversight function.

Person Responsible: Donna Budde, Quality Management Officer
Estimated Completion Date: June 30, 2013

Audit Recommendation #7

State-Operated Services should seek ways to limit overtime use to a reasonable level through administrative actions or negotiations with affected bargaining units.

Agency Response to Recommendation #7

The agency agrees with this recommendation and will convene operational managers and Human Resources representatives to identify key issues that should be addressed in developing options for solutions through administrative action or negotiations with bargaining units.

Person Responsible: SOS Administrative Committee
Estimated Completion Date: June 30, 2013

Audit Recommendation #8

The legislature should amend Minnesota Statutes to give district courts continuing jurisdiction over all individuals civilly committed as mentally ill and dangerous or as developmentally disabled, and provide for periodic judicial review of their need for continued commitment.

Agency Response to Recommendation #8

The Department agrees with and supports this recommendation.

Person Responsible: Anne Barry, Deputy Commissioner
Estimated Completion Date: N/A

Audit Recommendation #9

The Legislature should amend state law to require the Office of the State Court Administrator to periodically provide the Department of Human Services with information on all individuals committed to the Commissioner of Human Services.

Agency Response to Recommendation #9

The Department agrees with and supports this recommendation. The Department will put together a plan for the 2014 Legislature to consider.

Person Responsible: Anne Barry, Deputy Commissioner
Estimated Completion Date: December 31, 2013

Department of Human Services
Response to the Legislative Audit Report titled
State-Operated Human Services

Audit Recommendation #10

The Department of Human Services should periodically test the accuracy of its firearms-related background checks and explore ways to mitigate possible errors.

Agency Response to Recommendation #10

The agency agrees with this recommendation. Random audits will be completed quarterly to verify accuracy of results specific to information released for firearms-related background checks.

Person Responsible: Sondra Johnson, SOS HIMS Director
Estimated Completion Date: March 31, 2013

Audit Recommendation #11

DHS should publicly clarify what types of disorders are best treated at the Security Hospital.

Agency Response to Recommendation #11

The agency agrees with this recommendation. SOS will clarify disorders best treated at the Security Hospital. The impact of this recommendation shall be evaluated around current SOS capacity to best service individuals committed to the Commissioner as well as how and where to best serve these persons.

Person Responsible: Patricia Carlson, CEO, SOS; Dave Hartford, Interim CMSHD Assistant Commissioner; Alan Radke, Chief Medical Officer, SOS; Senior Administrators, MSH.
Estimated Completion Date: July 1, 2013

Audit Recommendation #12

The Minnesota Security Hospital should adopt policies regarding the hours of counseling, therapy, and other treatment offered per week to help patients address their underlying mental health issues.

Agency Response to Recommendation #12

The Agency agrees with this recommendation. The department will review best practices regarding hours per week of treatment offered, and adopt best practices policies that meet the mental health needs of the individuals served.

Person Responsible: Alan Radke, CMO; Steve Pratt, MSH Medical Director; Carol Olson, Hospital Administrator
Estimated Completion Date: July 1, 2013

Department of Human Services
Response to the Legislative Audit Report titled
State-Operated Human Services

Audit Recommendation #13

State-Operated Services should develop clear, consistent standards that address how often Minnesota Security Hospital patients should be seen by a psychiatrist, and it should monitor compliance with these standards.

Agency Response to Recommendation #13

The agency agrees with this recommendation and will develop such standards of practice.

Person Responsible: Alan Radke, MD, Chief Medical Officer, SOS; Steve Pratt, MD, Medical Director, MSH
Estimated Completion Date: May 1, 2013

Audit Recommendation #14

The Department of Human Services should foster or develop new placement options for individuals ready to be discharged from the Minnesota Security Hospital.

Agency Response to Recommendation #14

The Department agrees with this recommendation. The department will explore options, collaborate with stakeholders, and develop plans that best meet the needs of our clients.

Person Responsible: Anne Barry, Deputy Commissioner
Estimated Completion Date: March 31, 2014

Audit Recommendation #15

The Legislature should clarify in state law the role of State-Operated Services' residential and inpatient facilities, stating a mission of serving individuals who cannot be adequately served by other providers.

Agency Response to Recommendation #15

The agency agrees with this recommendation. A recommendation from SOS will be developed for the Commissioner of Human Services' review with the plan to bring to the 2014 legislative session.

Person Responsible: Thomas Ruter, Director of Support Services; Patricia Carlson, CEO
Estimated Completion Date: June 1, 2013

Audit Recommendation #16

The Department of Human Services should provide the 2014 Legislature with a substantive plan for the Anoka-Metro Regional Treatment Center.

Agency Response to Recommendation #16

The agency agrees with this recommendation but recognizes that this effort is one that must include a number of other divisions within DHS and within SOS. A work group will be convened to develop a proposal to present to the 2014 Legislature.

Department of Human Services
Response to the Legislative Audit Report titled
State-Operated Human Services

Person Responsible: Derrick Jones, Interim Adult Mental Health Administrator; Nancy Webster-Smith, AMRTC Hospital Administrator
Estimated Completion Date: November, 2013

Audit Recommendation #17

As a pilot program, the Department of Human Services should develop a plan that enables at least one community behavioral health hospital to integrate its services more fully with at least one nonstate hospital – through co-location or other collaborative arrangements.

Agency Response to Recommendation #17

The agency agrees with this recommendation and will pursue establishing a stronger working relationship with a local medical resource.

Person Responsible: Patricia Carlson, CEO; Derrick Jones, Interim Adult Mental Health Administrator
Estimated Completion Date: July 1, 2014

Audit Recommendation #18

The Department of Human Services should add security arrangements to at least two community behavioral health hospitals that would enable them to admit individuals with the most challenging behaviors.

Agency Response to Recommendation #18

The agency agrees with the need for additional measures to assure safety of staff and patients. SOS will seek best practices and develop a plan to implement such efforts.

Person Responsible: Derrick Jones, Interim Adult Mental Health Administrator
Estimated Completion Date: May 1, 2013

Audit Recommendation #19

The Department of Human Services should develop a plan for the 2014 Legislature for reducing the number of state-run group homes for individuals with developmental disabilities.

Agency Response to Recommendation #19

The agency agrees with the recommendation and believes that it will be most useful if we are able to plan with our labor partners, the counties who use these services and the divisions within DHS who provide funding for the community placements and most importantly, representatives for those we serve. This is in the SOS 2013 Strategic Initiatives Plan.

Person Responsible: Roger Deneen, MSOCS Administrator; Geoffrey Barnes, Director of Strategic Initiatives: Patricia Carlson, CEO, SOS.
Estimated Completion Date: December 30, 2013

Department of Human Services
Response to the Legislative Audit Report titled
State-Operated Human Services

Audit Recommendation #20

The Department of Human Services should discontinue employing staff in the Community Partnership Network it does not directly supervise.

Agency Response to Recommendation #20

The agency agrees that this is a difficult arrangement that would be more efficient if we were not the responsible employer. However, counties acknowledge the value of this program in providing expanded community service and most have not been in a position to add employees to their staff to replace such a loss of availability. The agency will investigate alternatives to the present model which would result in the elimination of this program.

Person Responsible: Derrick Jones, Interim Adult Mental Health Administrator;
Estimated Completion Date: July, 2015

Forthcoming Evaluations

Medical Assistance Payment Rates for Dental Services, March 2013
Special Education, March 2013

Recent Evaluations

Agriculture
"Green Acres" and Agricultural Land Preservation Programs, February 2008
Pesticide Regulation, March 2006

Criminal Justice
Law Enforcement's Use of State Databases, February 2013
Public Defender System, February 2010
MINNCOR Industries, February 2009
Substance Abuse Treatment, February 2006
Community Supervision of Sex Offenders, January 2005
CriMNet, March 2004

Education, K-12, and Preschool
K-12 Online Learning, September 2011
Alternative Education Programs, February 2010
Q Comp: Quality Compensation for Teachers, February 2009
Charter Schools, June 2008
School District Student Transportation, January 2008

Education, Postsecondary
Preventive Maintenance for University of Minnesota Buildings, June 2012
MnSCU System Office, February 2010
MnSCU Occupational Programs, March 2009
Compensation at the University of Minnesota, February 2004

Energy
Renewable Energy Development Fund, October 2010
Biofuel Policies and Programs, April 2009
Energy Conservation Improvement Program, January 2005

Environment and Natural Resources
Conservation Easements, February 2013
Environmental Review and Permitting, March 2011
Natural Resource Land, March 2010
Watershed Management, January 2007

Financial Institutions, Insurance, and Regulated Industries
Liquor Regulation, March 2006
Directory of Regulated Occupations in Minnesota, February 1999
Occupational Regulation, February 1999

Government Operations
Helping Communities Recover from Natural Disasters, March 2012
Fiscal Notes, February 2012
Capitol Complex Security, May 2009
County Veterans Service Offices, January 2008
Pensions for Volunteer Firefighters, January 2007
Postemployment Benefits for Public Employees, January 2007

Health
Financial Management of Health Care Programs, February 2008
Nursing Home Inspections, February 2005
MinnesotaCare, January 2003

Human Services
State-Operated Human Services, February 2013
Child Protection Screening, February 2012
Civil Commitment of Sex Offenders, March 2011
Medical Nonemergency Transportation, February 2011
Personal Care Assistance, January 2009
Human Services Administration, January 2007
Public Health Care Eligibility Determination for Noncitizens, April 2006

Housing and Local Government
Consolidation of Local Governments, April 2012
Preserving Housing: A Best Practices Review, April 2003
Managing Local Government Computer Systems: A Best Practices Review, April 2002
Local E-Government: A Best Practices Review, April 2002
Affordable Housing, January 2001

Jobs, Training, and Labor
Workforce Programs, February 2010
E-Verify, June 2009
Oversight of Workers' Compensation, February 2009
JOBZ Program, February 2008
Misclassification of Employees as Independent Contractors, November 2007
Prevailing Wages, February 2007

Miscellaneous
The Legacy Amendment, November 2011
Public Libraries, March 2010
Economic Impact of Immigrants, May 2006
Gambling Regulation and Oversight, January 2005
Minnesota State Lottery, February 2004

Transportation
Governance of Transit in the Twin Cities Region, January 2011
State Highways and Bridges, February 2008
Metropolitan Airports Commission, January 2003

Evaluation reports can be obtained free of charge from the Legislative Auditor's Office, Program Evaluation Division, Room 140 Centennial Building, 658 Cedar Street, Saint Paul, Minnesota 55155, 651-296-4708. Full text versions of recent reports are also available at the OLA Web site: http://www.auditor.leg.state.mn.us