MINNESOTA DIRECT CARE AND TREATMENT ADVISORY COMMITTEE MEETING MINUTES

Meeting Information

- **Date and Time:** Wednesday, August 26, 2026, from 9:30-11:30 am CT
- **Location:** In-person location at Forensic Mental Health Program, St. Peter (100 Freeman Drive, St. Peter, Minnesota 56082) for Advisory Committee members and a virtual meeting available via Zoom for other attendees
- **Direct Care and Treatment (DCT) Advisory Committee Attendees:**
    - In-person attendees: Chair Dave Baker; Vice Chair Bianca Virnig; Commissioner Tara Jebens-Singh; Marcus Schmit; Jessica Langhorst; and Jim Postier
    - Excused attendees: Sen. John Hoffman and Sen. Paul Utke
    - Absent attendees: James Carlson
- **DCT Advisory Committee Facilitators:** Jill Kemper and Danielle Swanson, Health Management Associates (HMA)
- **Speakers:** Dan Storkamp, Executive Director, External Relations, DCT; Dale Klitzke, Chief General Counsel, DCT ; Carol Olson, DCT Executive Board Chair; Mitch Arvidson, Legislative Affairs Coordinator, DCT; Breanna Drummer, Executive Assistant, Forensic Services; Soniya Hirachan, MD, Executive Director & Medical Director for Forensics; Scott Melby, Chief Operations Officer, Forensic Services

Meeting Summary

- **Welcome**
    - Chair Dave Baker welcomed members to the August MN DCT Advisory Committee meeting at the St. Peter facility before turning the time over to Soniya Hirachan, MD, Executive Director & Medical Director for Forensics, to present on the Forensics Program.
- **Presentation: Quality and Compliance**
    - Dr. Hirachan provided an overview of Forensic Services, its patient population, treatment programs, and current operational challenges, followed by a discussion with Committee members about community reintegration, discharge barriers, public safety, waitlists, and opportunities for system improvement. (*Note: information found on slides is not repeated in the minutes below - see slides 3-27 below for those details*.) A summary of the discussion is provided below.

- A substantial portion of the discussion focused on Community Integrated Services (CIS), which supports approximately individuals living in community settings under provisional discharge. Dr. Hirachan described CIS as a critical bridge between secure treatment and long-term community living. Individuals remain subject to conditions such as medication compliance, engagement with case management, and other supervision requirements, while a team of clinicians works closely with counties to intervene when concerns arise.
- Committee members asked whether the program was producing the outcomes it was designed to achieve and whether individuals were frequently returning to the hospital after discharge. Dr. Hirachan reported that fewer than ten percent of individuals supervised through CIS return in any given year, and that typically only one or two people return in an average month. She noted that Minnesota's return rate compares favorably to other forensic programs nationally and stated that, overall, the program appears to be working as intended. At the same time, she stressed that any return represents an opportunity to improve earlier intervention and community support. Dr. Hirachan explained that substance use is by far the most common factor for return. In many cases, individuals lose housing or become unstable after resuming substance use, ultimately requiring a return to the hospital. Far fewer returns are attributable to medication noncompliance. She explained that these returns place pressure on limited secure-bed capacity and therefore remain a significant area of focus for the program.
- Committee members also explored questions related to public safety and community concerns. Dr. Hirachan acknowledged that the forensic population includes individuals with histories of violence and noted that risk management is an ongoing consideration throughout treatment and discharge planning. While serious incidents are relatively uncommon, they do occur. She described a recent attempted elopement in which facility staff, local law enforcement, and the county sheriff worked together to locate and return a patient within approximately thirty minutes. Dr. Hirachan emphasized that significant incidents are followed by formal root-cause analyses and that Forensic Services maintains strong relationships with local law enforcement agencies. These partnerships include quarterly meetings with law enforcement, county officials, and community stakeholders.
- Committee members asked how patients are monitored when they begin participating in community activities. Dr. Hirachan explained that community passes serve a therapeutic purpose and help individuals develop skills needed for independent living after years in institutional settings. Passes may involve activities such as visiting a library, shopping for groceries, or completing other community-based tasks. Staff verify participation and community members occasionally contact the facility if they observe concerning behavior. Those reports are reviewed by treatment teams and incorporated into ongoing treatment planning.

- The Committee also explored how patients feel about transitioning from secure treatment into less restrictive environments. Dr. Hirachan indicated that experiences vary considerably depending on where patients are in the treatment continuum. Individuals in the secure perimeter are often motivated to gain privileges and progress to the next level of treatment. However, some individuals in non-secure settings become reluctant to leave because they have grown comfortable with the structure, predictability, and support available within the system. In those situations, treatment teams sometimes struggle to identify ways to encourage further progression. Dr. Hirachan noted that patient satisfaction surveys conducted throughout the year generally indicate patients feel supported by their treatment teams and do not believe they are being inappropriately delayed in their progression.
- Committee members asked whether counties have sufficient capacity to receive individuals who are clinically ready for transition. Dr. Hirachan explained that discharge planning begins immediately upon admission and that county case managers are actively involved throughout the process. While relationships with counties are generally strong, she acknowledged that many communities lack the resources necessary to support some of the most complex patients. Dr. Hirachan stated that the most difficult cases involve people who do not need the intensity of the secure setting but cannot safely navigate the community without substantial ongoing support. She explained that the typical pathway is from secure treatment to a non-secure program, then to adult foster care, and eventually to more independent living. For people who cannot follow that pathway, DCT has partnered with Community-Based Services to develop customized one-, two-, or four-bed living arrangements. Dr. Hirachan estimated that this population is approximately 15 to 20 individuals that are committed as mentally ill plus roughly 10 additional individuals have significant cognitive and impulsivity-related support needs. She stressed that there are capacity constraints associated with these discharges both within DCT and in the community/county.
    - The discussion then turned toward potential solutions. Dr. Hirachan highlighted current success of one local residential setting developed in partnership with Community-Based Services which has helped divert individuals from returning to secure treatment over the past two years. Because of its success, DCT is developing a second, ADA-accessible home. Committee members asked whether expanding state-operated community homes could address some of the discharge barriers currently facing the system. Dr. Hirachan responded that additional community-based housing continues to be explored, but noted that expansion requires not only funding, but also workforce capacity (noting challenges with turnover among county case managers which affects transitions), community support, and local willingness to host such facilities. Executive Board Chair Carol Olson also added that a recent legislative change extended the period during which a person may return voluntarily without

automatic revocation of provisional discharge. Dr. Hirachan explained that the prior limit was 60 days; it is now 90 days for psychiatric reasons and up to six months for medical reasons. The change can prevent patients from having to restart the Special Review Board process and from losing housing while that process is pending (see more on the Special Review Board below).

- Committee members inquired about the costs associated with secure treatment and community care. Dr. Hirachan explained that secure treatment currently costs approximately $350,000 per patient annually. She clarified how costs are shared between the state and counties during different stages of the process (the state bears 90 percent of the cost and the county 10 percent in the secure perimeter; the split changes to 50-50 only after the individual moves to the non-secure program) and noted that while financial considerations certainly influence decision-making, concerns related to public safety, staffing, housing availability, and community acceptance are more commonly cited barriers to discharge than cost alone.
    - Given substantial costs, Committee members inquired why some individuals with persistent cognitive limitations or static risk factors are moved toward community integration even when substantial risk and cost concerns remain. Dr. Hirachan explained that the Olmstead framework requires consideration of the most integrated setting appropriate to each person. Some patients have received the maximum benefit available from secure treatment, consistently take medication, and participate in programming, but may never achieve the same level of functioning as others because of cognitive limitations or impulsivity. Continued institutionalization may not be the most appropriate setting for those individuals. DCT staff clarified that the most-integrated-setting requirement stems from federal disability law and that Minnesota has adopted additional person-centered requirements in state law. In response to inquiries about whether Minnesota legislation should be adjusted, DCT staff said unusual cases and potential legislative changes are reviewed annually to determine whether a broader change is warranted or the issue is limited to an individual case.
- The Committee and Dr. Hirachan then spent time discussing the Jail Consultation Services, which provide education and support to county correctional facilities on best practices. Committee members asked how patients respond to involuntary medication under Jarvis orders. Dr. Hirachan said approximately half of patients in the secure perimeter are subject to an active Jarvis order. A small number actively resist medication, but she said there have not been many related injuries and most patients are adherent. Dr. Hirachan said post-training surveys and meetings with counties show demand for additional support, including consultation on specific cases, medication administration practices, and transitions when individuals leave jail. She said feedback has generally been positive and that interest from additional counties is growing. In

response to questions about tools and measurement, Dr. Hirachan said the team is tracking issues such as contemplated Jarvis petitions, administration of involuntary medication, and requests for case-specific consultation. Committee members also asked where responsibility lies when county jails use outside medical providers and DCT provides consultation. Dr. Hirachan said the jail and county retain responsibility for the individual, while DCT's role is consultative. She said DCT has met with contracted medical providers to clarify respective responsibilities. Committee members suggested that a future follow-up examine which medical service models produce the best behavioral-health outcomes across counties. DCT staff reminded members that Jail Consultation Services is a pilot supported by one-time legislative funding that expires June 30, 2027; continuing or expanding the service would require additional funding or another sustainable approach.

- Committee members then inquired about referrals and wait time, including questions about why referrals from some counties appear significantly higher and whether wait times are comparable among other states. Dr. Hirachan said most priority referrals wait in jail, with a small number in community hospitals. She also stated no per-capita referral analysis had been completed. Committee members and DCT staff suggested examining whether referral patterns are driven by local practices or by the statewide concentration of specialized services in urban areas. Dr. Hirachan also noted that direct wait time comparison is difficult because Minnesota's civil-commitment structure differs from the competency-to-stand-trial systems that commonly drive forensic waitlists elsewhere, although she expected waitlist challenges may be comparable.
    - Committee members also asked how the Special Review Board process differs across commitment types and whether transfers could be made more efficient. Dr. Hirachan described a potential proposal to eliminate Special Review Board review for transfers from secure to non-secure treatment within the campus. She said Forensic Services' recommendations have concurred with Special Review Board opinions approximately 92 to 99 percent of the time during the six-year period she reviewed, leaving very few cases of disagreement. Removing that step could reduce delay while preserving the facility's clinical and forensic review process. Dr. Hirachan also provided background on the Special Review Board, which was put in place prior to the creation of the Forensic Review Panel.
- Committee members discussed whether the current system is structured to achieve the best outcomes for individuals, communities, and taxpayers. Several members observed that significant resources are spent maintaining individuals in restrictive settings and questioned whether earlier intervention, additional community capacity, and stronger transition support could produce better outcomes at lower long-term cost. Dr. Hirachan agreed that these questions deserve continued attention and cautioned

against viewing additional secure beds as the primary solution to wait times and system pressures. Drawing on experiences from other states, she noted that jurisdictions that have expanded bed capacity often find themselves facing the same challenges only a few years later. Instead, she emphasized the importance of strengthening the entire continuum of care, including community placement options, transition supports, treatment pathways, and partnerships with counties and providers, to improve patient outcomes while maintaining public safety.

- **DCT Executive Board Update**
    - Carol Olson, DCT Executive Board Chair, reported that Dr. Paul Goering stepped down as Vice Chair of the Executive Board and Mary Maertens is serving as the new Vice Chair. Olson also noted that one member, Dr. Prachi Striker, whose term is expiring has requested reappointment. Olson noted that continuity is valuable as the Board completes its first year of operation. Following Commissioner Shireen Gandhi's retirement, Assistant Commissioner Teresa Steinmetz is being oriented to serve as the Commissioner's designee on the Board.
    - Olson described the Board's Finance and Quality and Compliance workgroups, which include Board members working directly with DCT leaders to understand financial, quality, compliance, and operational issues. Olson noted that the Board has participated in review of legislative proposals and received updates on the Mentally Ill and Dangerous Task Force and the Priority Admissions Review Panel. The Board has also accepted public comment during recent meetings, primarily related to MSOP. The Board is also moving to an every-other-month meeting cadence, while workgroups will continue to meet monthly and additional meetings may be called as needed.
    - Olson said orientation and direct engagement with DCT service lines have been important because of the system's complexity. With regard to interactions between the Board and the Advisory Committee, Olson said quarterly meetings with Committee leadership and participation in Advisory Committee meetings have been helpful. Participants agreed that the cadence and relationship are still developing and should continue to be refined during the Committee's remaining term.
- **DCT Advisory Committee Business**
    - Chair Baker led a discussion of attendance expectations after recent consecutive absences and unsuccessful attempts to reach one Committee member. Members agreed that virtual attendance should continue to be permitted and that occasional absences are understandable when members notify the Chair or meeting staff prior to the meeting. The Committee supported distinguishing excused from unexcused absences in the minutes and emphasized that communication is the key indicator of continued engagement.
    - **Committee Member Attendance:** DCT staff, Committee members, and Committee staff reviewed prior outreach to James Carlson, including multiple emails, phone calls, and two letters. Because the prior correspondence did not explicitly state that another

missed meeting could lead to removal as stated in the Committee removal legislation, the Committee agreed that the next notice should clearly describe the consequence and be sent by certified mail. Committee members also agreed to initiate contact with the Governor's Office about opening the position for applications so potential candidates could be identified if a vacancy occurs.

- **Moose Lake Site Visit Debrief:** The Committee debriefed its June site visit to the Moose Lake MSOP facility. Members valued speaking directly with clients and said future visits should allow more time for those conversations. Several members identified a sense of hopelessness among some clients and discussed how indefinite timelines, institutionalization, long lengths of stay, and limited understanding of how to progress may affect treatment engagement and staff well-being. Members suggested potential areas for further exploration, including a plain-language guide that explains the steps through the MSOP treatment and release process; earlier and more frequent peer mentoring by individuals who have progressed to Community Preparation Services; video messages or other first-person accounts from individuals who have advanced through treatment; and additional ways to involve and support families. Members noted that some peer visits already occur and discussed whether those opportunities could be expanded or introduced earlier. The Committee also expressed interest in comparing MSOP and Forensic Services treatment progression and lengths of stay, understanding why the experiences differ, and examining approaches and outcomes in other states. Members stressed that any future discussion must consider public safety, victims' rights, treatment effectiveness, client outcomes, staff well-being, community acceptance, and the political challenges associated with proposed changes. Committee members supported placing a deeper discussion of these issues on a future agenda.
- **Upcoming Meetings:** Chair Baker suggested that the next meeting of the Advisory Committee occur at the Anoka facility on October 7, 2026, and that the Committee does not meet in September. Committee members agreed and DCT staff were instructed to begin processes for preparing for the October 7th visit to Anoka.

- **Open Public Comment**
  - Chair Baker introduced the public comment segment of the agenda and shared that the individual who had signed up for public comment notified Advisory Committee staff that they were unable to attend. No other individuals had signed up for public comment. Chair Baker transitioned to the meeting close.
- **Wrap Up and Next Steps**
  - Chair Baker closed the meeting by noting that more information on the Advisory Committee and upcoming meetings is available on the DCT Advisory Committee webpage. The next meeting will take place on October 7, 2026, at the Anoka facility.

Minnesota Direct Care and Treatment:
Advisory Committee Meeting

AUGUST 26, 2026

ST. PETER, 100 FREEMAN DRIVE, ST. PETER, MINNESOTA 56082

Today's Agenda

1. Welcome
2. Presentation: Forensics Program
3. DCT Executive Board Updates
4. DCT Advisory Committee Business
5. Open Public Comment
6. Wrap Up and Next Steps

DIRECT CARE AND TREATMENT

Forensic Services

Soniya Hirachan, MD| Executive Director & Medical Director

Forensic Services Programs & Service Lines

Forensic Services consists of

- Forensic Mental Health Program
- Forensic Nursing Home
- Community Integrated Services
- Competency Attainment Services
- Jail Consultation Services
- Forensic Network

Forensic Services Residential Programs

- Residential treatment programs providing services in secure and nonsecure settings.
- Located in St. Peter: 3 locations
- Serve individuals civilly committed as mentally ill, mentally ill and dangerous, developmentally disabled, and or chemically dependent.
- Joint commission accredited Behavioral Health Care facility.

- Employees: 1,221.53 budgeted FTEs
- Budget: $166,679,453 (FY27)
- Budgeted beds: 407 (FY27)
- Annual admissions: 73 (FY24)
- Average daily census: 378 (FY27)
- Bed occupancy: 92.88% (FY27)
- Average length of stay: 5.44 years (FY24)

Forensic Nursing Home

- The only secure, licensed nursing home in the state of Minnesota.
- Most patients have been civilly committed or are on a medical release from the Department of Corrections.
- Care that is provided includes assistance with daily living activities, rehabilitation services, and end of life care.

- Employees: 85.15 FTE's (FY27 budget)
- Budget: $9,784,839 (FY25)
- Budgeted beds: 30
- Annual admissions: 23 (FY24)
- Average daily census: 28 (FYTD27)
- Bed occupancy: 83% (FY27)
- Average length of stay: 1.39 yrs. (FY24)

Community Integrated Services

- New program added to Forensic Services in 2022.
- CIS is a mobile team comprised of trained and experienced staff located in community-based offices throughout the state.
- Assist clinically complex individuals who are civilly committed as MI&D to remain in their communities whenever safely possible.

- Employees: 13 FTE's (FY26 budget)
- Budget: $1,799,748 (FY26)
- Budgeted beds: N/A
- Annual referrals: 77
- Average PD census: 260
- Bed occupancy: N/A
- Average length of stay: N/A

Competency Attainment Services

- CAS provided to patients under Chapter 611
- AMRTC is the first DCT site to be certified as a Competency Attainment provider within DCT.
- Future expansion anticipated within DCT

Jail Consultation Services

- Provide education and support to county correctional facilities on best practices
- As of 08/19/26, contracts are in place with 11 counties, with 3-4 pending further collaboration
- Tools and trainings are being developed for each individual jail based on their specific needs
- Currently, most focus has been on Commitment and Jarvis petition processes, understanding mental illness, documentation training, etc.

Forensic Network

- Prepare a variety of mandated, and court ordered evaluations for the Courts.
- Evaluations include competency to proceed evaluations, criminal responsibility evaluations, MI&D final treatment reports and a variety of other evaluations for the Courts.
- Approximately 10% growth in referrals each year.

- Employees: 28.60 FTEs budgeted
- Budget: $4,155,983 (FY25)

Challenges and Opportunities

Challenges

- Admission waitlists
- Difficulty discharging patients due to a lack of placement options in the community
- Staff safety

Opportunities

- Explore technology options that will enhance patient treatment.
- Baldridge Journey.
- Partner with community providers on transitions in care for our patient population.
- Explore technology that will aid in operational efficiency and time management for staff.

Expansion and Renovation Project

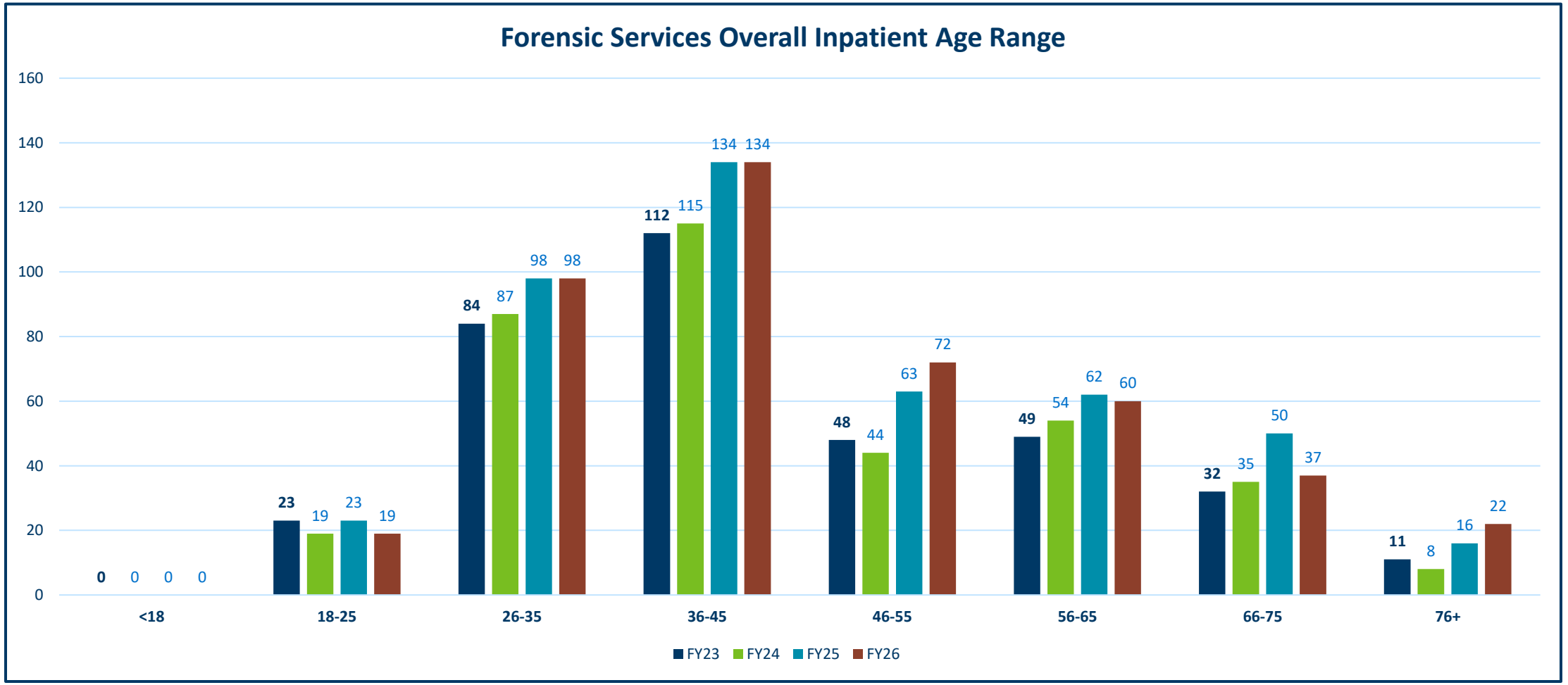
Total Investment: $123 million

2012 predesign:	$3 million
2015 Phase I:	$50 million (occupied 2017)
2017 Phase II:	$70 million (occupied 2020)

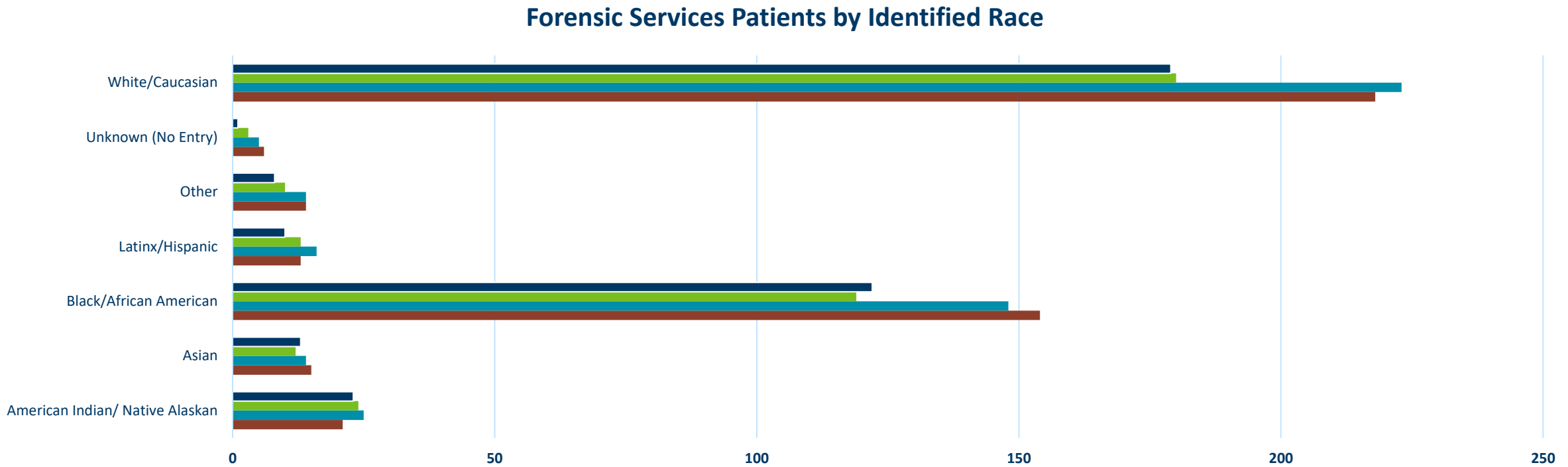
Patient Demographics

Some quick snapshots of our patients by age, race, county of commitment, and discharge status.

Patient Age Range

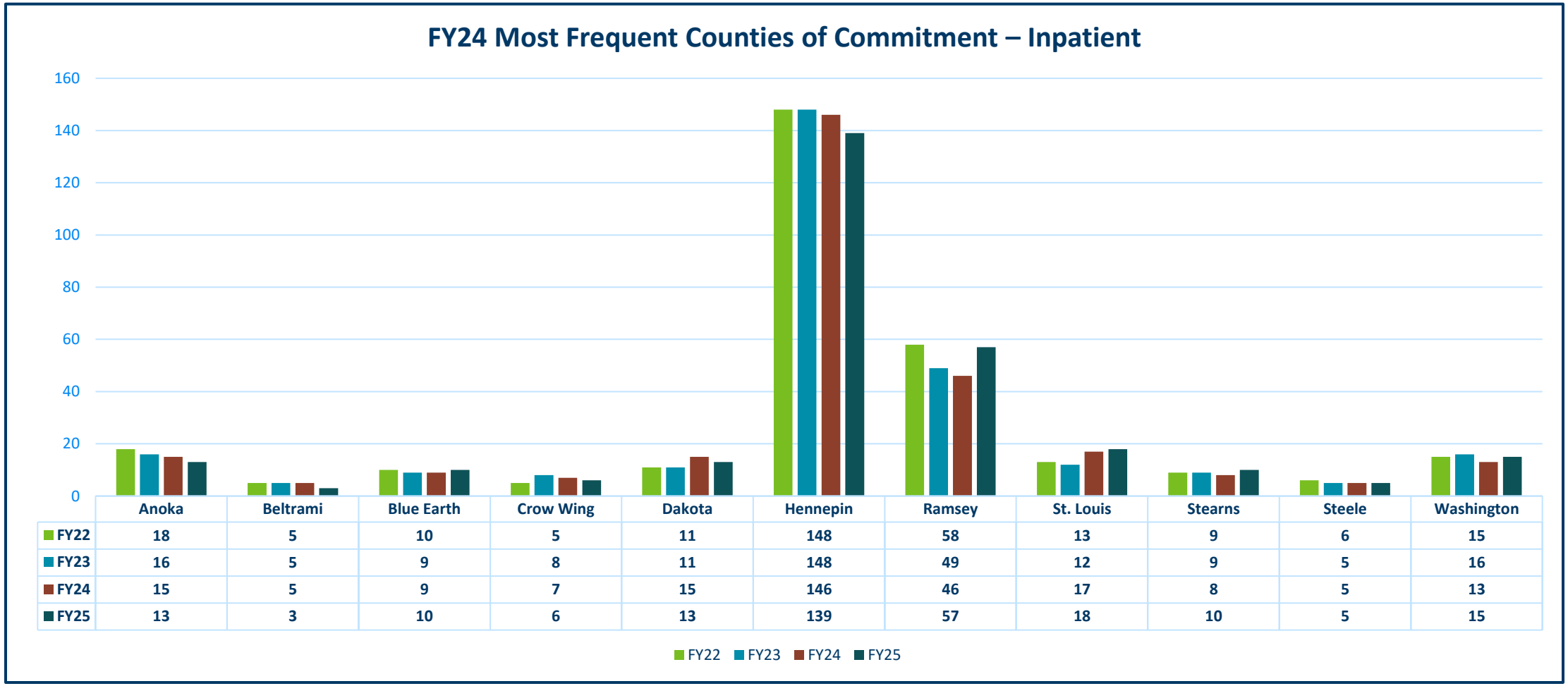


Patients by Race



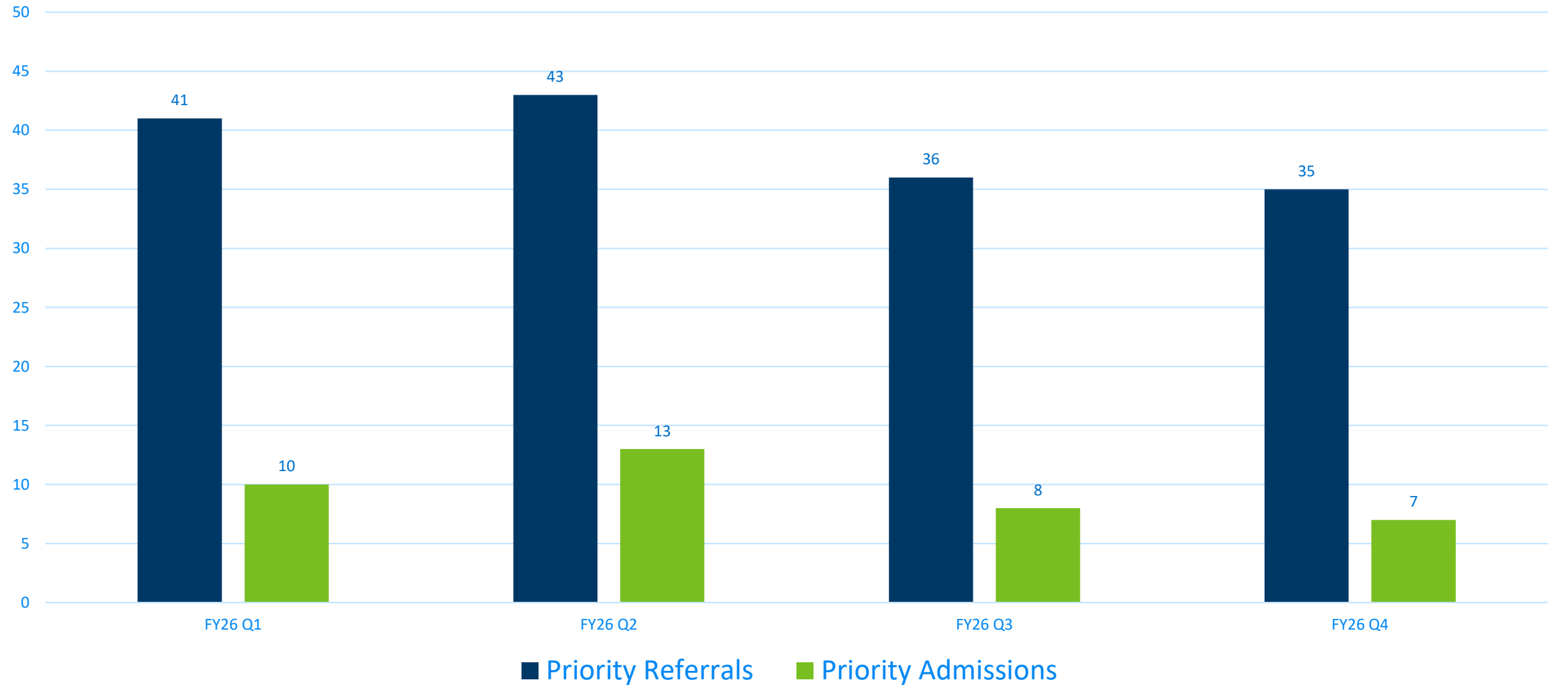
	American Indian/ Native Alaskan	Asian	Black/African American	Latinx/Hispanic	Other	Unknown (No Entry)	White/Caucasian
FY23	23	13	122	10	8	1	179
FY24	24	12	119	13	10	3	180
FY25	25	14	148	16	14	5	223
FY26	21	15	154	13	14	6	218

Patients by County of Commitment

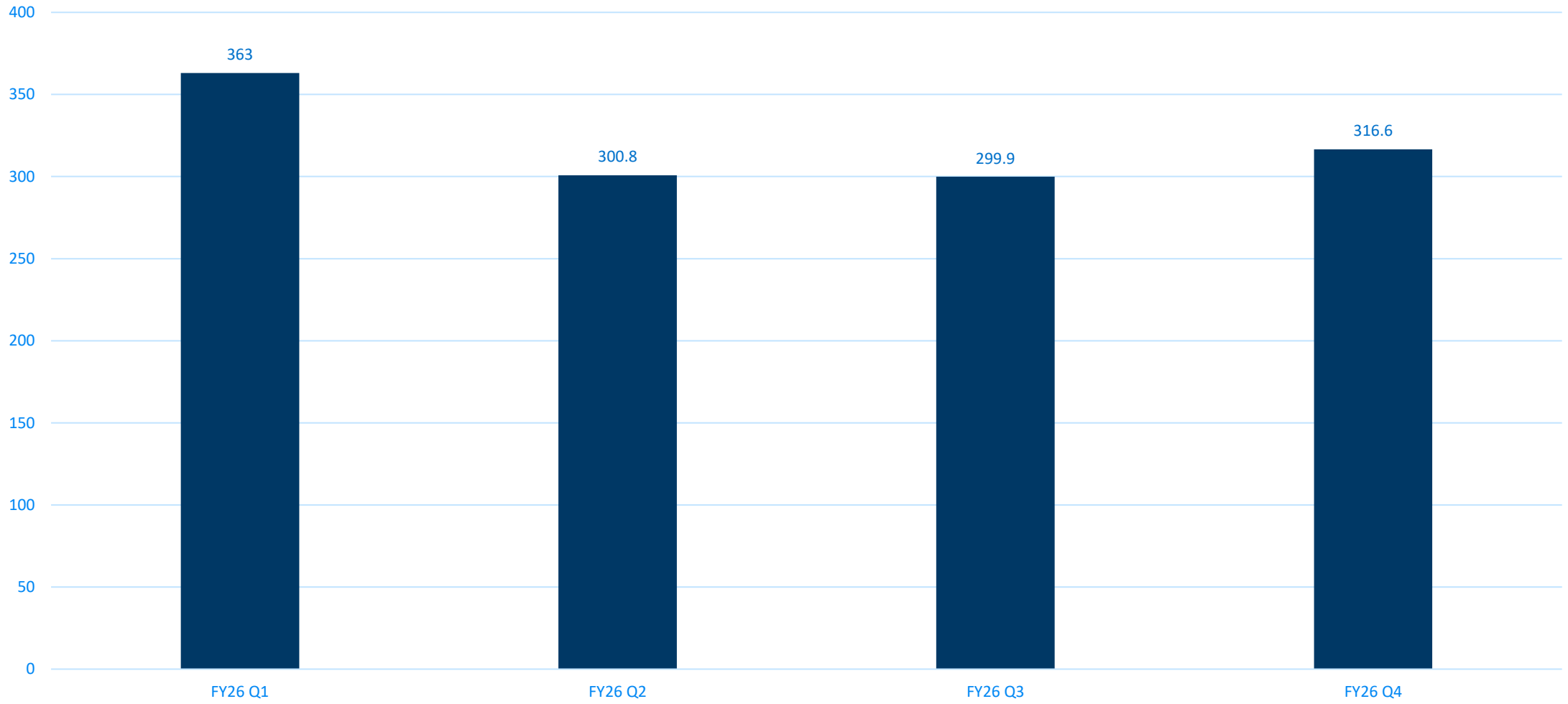


	Anoka	Beltrami	Blue Earth	Crow Wing	Dakota	Hennepin	Ramsey	St. Louis	Stearns	Steele	Washington
FY22	18	5	10	5	11	148	58	13	9	6	15
FY23	16	5	9	8	11	148	49	12	9	5	16
FY24	15	5	9	7	15	146	46	17	8	5	13
FY25	13	3	10	6	13	139	57	18	10	5	15

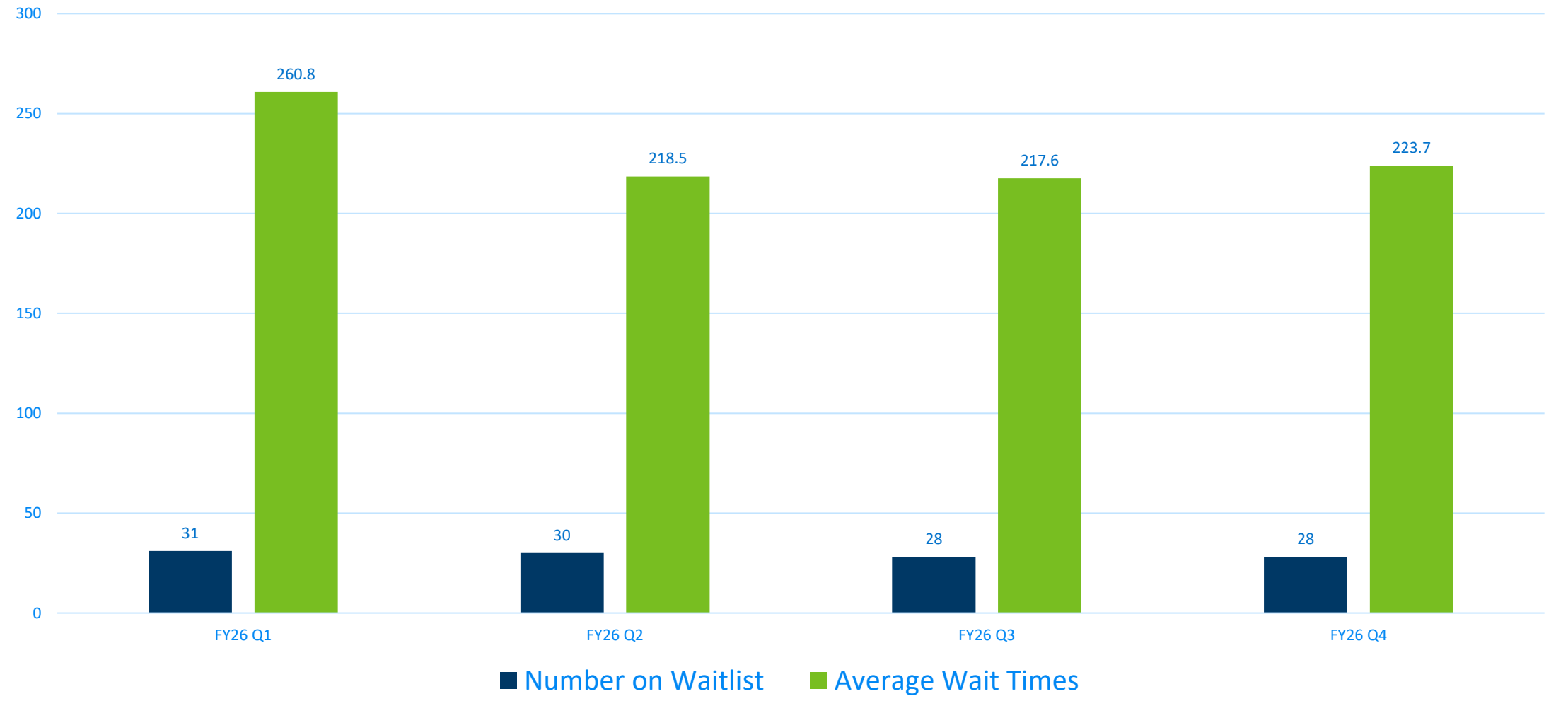
Priority Referrals and Admissions



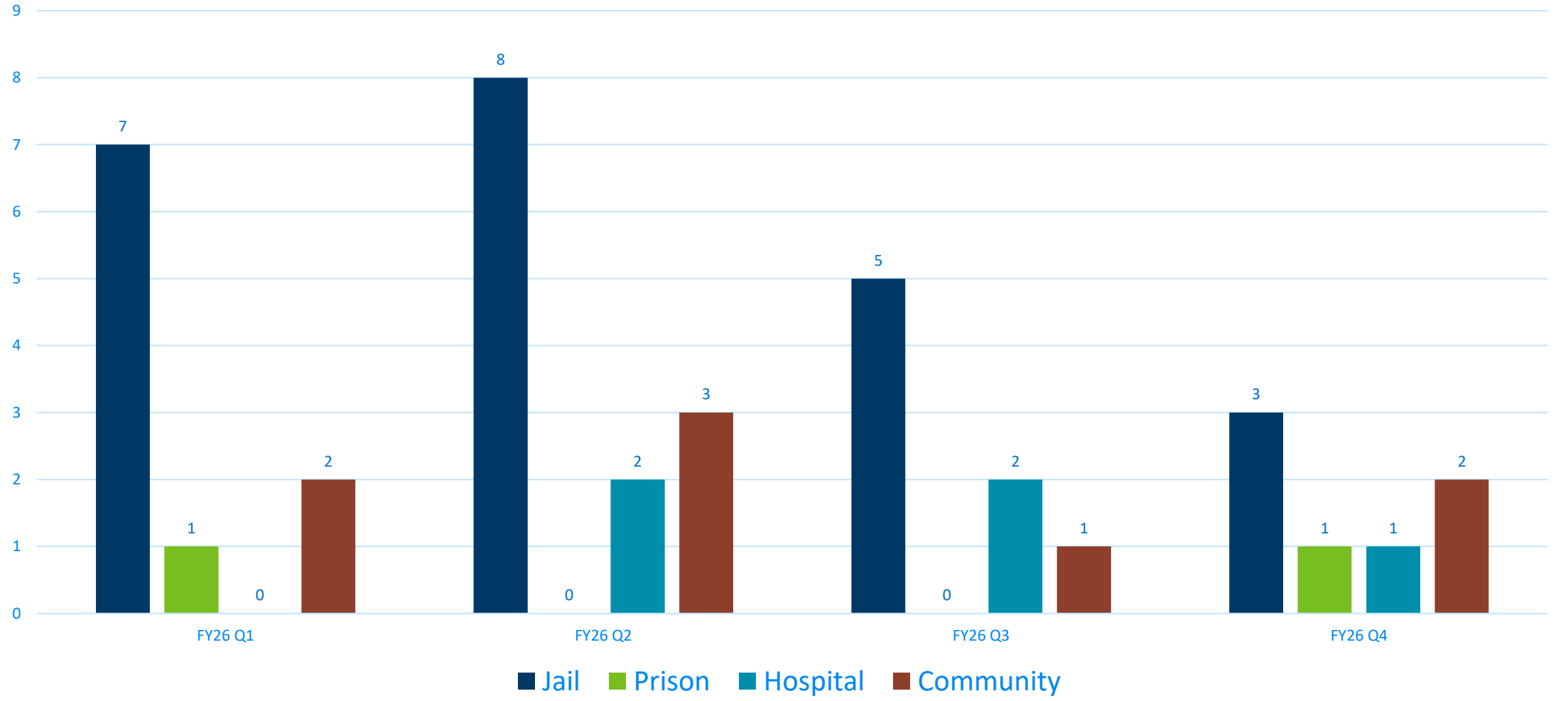
Wait-Times for Priority Admissions



Number on Waitlist and Average Wait Times



Priority Admissions - Sources



Treatment Progression

A look at the typical steps patients take as they progress in treatment and work toward eventual provisional discharge

Admission to the Secure Perimeter

- Initial focus on
  - Stabilization
  - Assessment
  - Treatment
- Initial unit placement
- Treatment planning
  - Treatment team
  - Abuse protection plan
  - Admission treatment plan
  - Individual treatment plan

Residential Treatment

- Housed in secure units with patients who have similar mental illnesses
- Programming directed toward patient's individual needs
- Services include:
  - Mental health therapy, support groups
  - Case management, crisis intervention
  - Independent living skills, recreation
  - Vocation, Education

Non-Secure Treatment Setting

- Supervised residential units
- Primary Focus
  - Independent management
  - Community integration and community supports
  - Provisional discharge planning
- Services offered
  - Psychosocial rehabilitation
  - Skill enhancement
  - Collaboration with community partners
  - Crisis consultation and intervention

Provisional Discharge

- Conditional discharge without termination of civil commitment.
- Patients on provisional discharge live in community settings and are supported by Community Integrated Services and county social services.

Full Discharge

- Final discharge with termination of civil commitment.

DIRECT CARE AND TREATMENT

Thank You!

DCT Executive Board Updates

Carol Olson, DCT Executive Board Chair

DCT Advisory Committee Business

MN DCT Advisory Committee Business

Advisory Committee to review and discuss the following items:

- Committee membership
- Site visit debrief
- Upcoming meeting cadence and agenda planning
- Additional Advisory Committee business

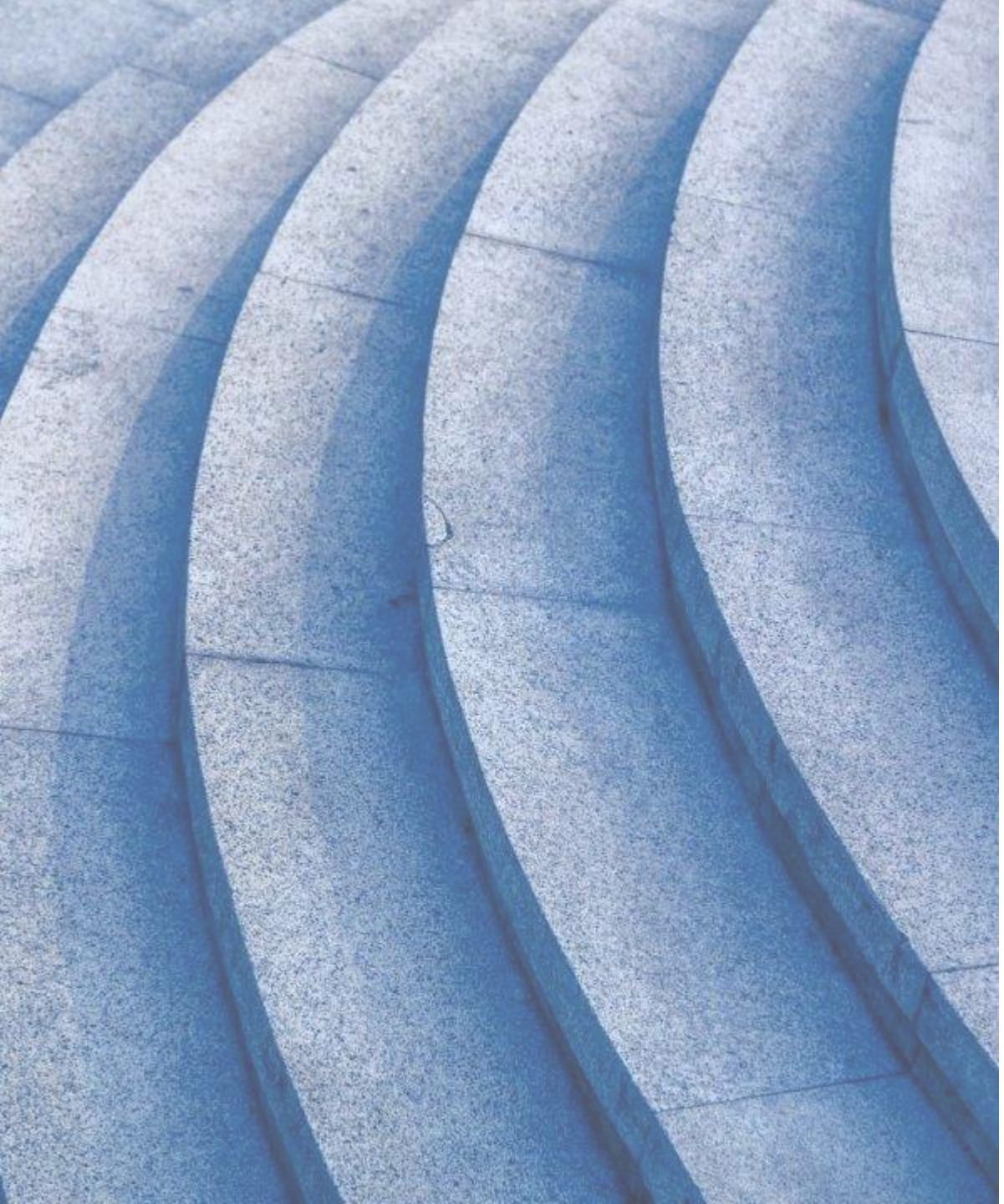
Open Comment Period

MN DCT Advisory Committee Meeting Open Comment

The Committee is dedicated to creating a consistent, fair and transparent method for members of the public to provide comments during meetings. The last 15 minutes of each meeting will be dedicated open comment.

- Members of the public who would like to comment must submit the form on the MN DCT Advisory Committee webpage.
- Comments are limited to topics within the DCT Advisory Committee's scope.
- Each speaker is allotted about three minutes to provide their comment.
- Public comment rules and expectations include:
  - Commenters must adhere to the amount of time allotted.
  - Commenters must address the committee respectfully. Personal attacks, profanity, or disruptive behavior are not permitted.
  - Presentations or materials are not allowed.
  - Comments must not contain any personal health information (PHI) or personally identifiable information (PII) about individuals who are associated with or have received care at DCT facilities.
- The Committee Chair or meeting staff may issue a warning or end a speaker's comment if rules are violated.
- During the public comment, the Advisory Committee will listen to comments and will not engage in discussion or provide responses.

Wrap Up and Next Steps



Wrap Up and Next Steps

- **Upcoming Meetings**
  - To be determined
  - Information on the Advisory Committee and upcoming meetings available on the DCT Advisory webpage
- **Questions or concerns:** Reach out to Dani or Jill (email addresses in chat)