



# REPORT ON THE RAMSEY COUNTY MENTAL HEALTH INITIATIVE PROJECT

## Rule 20 Clients: Barriers, Interventions, and Recommendations

2023–2025 Grant Cycles

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*December 2024*

# Contents

|                                                |    |
|------------------------------------------------|----|
| Executive Summary .....                        | 3  |
| Introduction and Background.....               | 4  |
| Stakeholder Inquiry and Initial Findings ..... | 5  |
| Training Design, Delivery, and Outcomes .....  | 6  |
| Bed-Hold Design and Early Implementation.....  | 7  |
| Systemic Barriers Identified.....              | 8  |
| Practical Tools and Processes Developed .....  | 9  |
| Recommendations and Implementation Plan .....  | 10 |
| Notes on Data and Limitations .....            | 10 |
| References .....                               | 11 |

## Executive Summary

This report analyzes multi-year efforts under successive Mental Health Innovation grants to reduce the cost and duration of locked-facility stays for individuals found incompetent to stand trial under Minnesota Rule 20. The work began with the hypothesis that provider stigma was the primary barrier to community placement. Structured inquiry with case managers, housing providers, probation officers, and court personnel, combined with direct experience implementing bed-hold agreements, showed that hypothesis to be incomplete. Systemic process failures—fragmented communication, prolonged and opaque benefits determinations, licensing constraints, and weak post-placement coordination—emerged as the dominant, addressable obstacles. The interviews, focus groups, training design and delivery, and process development described here were conducted as a solo project, with activities and materials approved by Ramsey County Mental Health.

The analysis produced both diagnostic clarity and practical artifacts: a multi-step care-coordination pathway, a weekly bed-availability newsletter, structured provider selection criteria, and interactive training formats focused on real operational problems such as elopement and incomplete discharge planning. These elements demonstrate the translation of stakeholder evidence into reusable processes. Recommendations for the 2025–2026 cycle emphasize process mapping, targeted expediting capacity, and continued collaborative problem-solving rather than additional didactic training alone.

## Introduction and Background

In 2020 Ramsey County spent approximately \$8.2 million on individuals who remained in hospitals after they no longer met criteria for inpatient care. A large share of these costs involved people found incompetent to stand trial under Minnesota Rule 20. Once stabilized, insurance stops paying the daily rate; for indigent clients the county of residence becomes the payor. The county was also paying up to \$300 per day to hold some Rule 20 clients in correctional facilities solely because housing was a condition of release and no placement could be found.<sup>12</sup>

Clients remained in locked settings for weeks or months after they were ready for discharge because housing providers and case managers struggled to locate appropriate community beds. The resulting cycle of delayed discharge, rehospitalization, or reincarceration generated both human and fiscal costs. By the end of 2024 related locked-facility expenditures had risen to \$12.4 million, a roughly 33 percent increase over four years.<sup>3</sup>

Ramsey County received a Mental Health Innovation grant in 2021 to identify barriers to community transition for this population. The 2021–2022 phase concluded that stigma and bias among housing providers and case managers were the primary obstacles. A second grant for 2023–2024 funded training and education intended to dispel those perceptions, plus limited bed-hold contracts to accelerate placement. The interviews, focus groups, training sessions, and bed-hold support work under that grant were carried out as a solo project, with proposed activities and materials reviewed and approved by Ramsey County Mental Health. Direct experience revealed that the original diagnosis was an oversimplification: while residual bias existed, internal county and state procedures created the more persistent barriers. A third grant for 2025–2026 was awarded to address those systemic issues.<sup>45</sup>

Under Minnesota law a defendant is incompetent to stand trial if mental illness or cognitive impairment prevents rational consultation with counsel, understanding of the proceedings, or participation in the defense. Criminal proceedings are suspended; civil commitment may be pursued. For many felonies, charges can ultimately be dismissed if competency is not restored within statutory periods, reducing incentive for engagement in restoration. The designation itself does not create a distinct clinical or housing category; front-line workers repeatedly noted that they already served clients with comparable or greater risk profiles.

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<sup>1</sup>Minnesota Rules of Criminal Procedure, Rule 20.01 (competency to stand trial). See also Minn. Stat. §§ 611.40–611.59 (Competency Proceedings).

<sup>2</sup>Internal financial figures (including the \$8.2 million and \$12.4 million locked-facility cost estimates and any bed-hold savings placeholders) are drawn from the source report and are estimates that require independent verification against Ramsey County fiscal and utilization records.

<sup>4</sup>Minnesota Department of Human Services. Mental Health Innovation Grant Program. <https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/mh-innovation-grant-program/>

<sup>5</sup>Ramsey County received Mental Health Innovation Grant funding for 2023–2024 and again for 2025–2026 periods.

## Stakeholder Inquiry and Initial Findings

Focus groups with case managers and housing providers, which I conducted both in person and remotely and separated by role, quickly challenged the premise that provider bias was the central problem. Participants described routine work with clients who had serious criminal histories, including violent offenses and sexual offenses, and stated that a Rule 20 finding at one moment in court did not itself create additional housing or care needs. One housing provider recounted approaching a shelter resident who already possessed an approved CADL waiver and SSI income; after multiple contacts with the case-management agency, the client remained unhoused for more than a month despite available beds. Case managers similarly described fighting for a year or longer to secure a waiver only to have the county later contest the rate, leaving beds empty.

Both groups identified the same process failures. MNChoice, SMRT, and waiver applications were characterized as needlessly complex, with rejections that arrived without explanation and forced trial-and-error resubmissions. Timelines that participants estimated at roughly six months in 2023 had stretched toward fourteen months by the 2024 focus groups. Exception requests under licensing moratoria were routinely denied; review of actual denial letters showed that many simply restated the underlying restriction (for example, rejecting an age exception for a client under 55 by noting that the client was under 55). Ramsey County's lack of flexible room-and-board funds for indigent clients under age 55 forced placements outside the county. High turnover meant clients often did not know their current case manager, and housing providers reported unanswered calls and emails. A recent post-discharge incident that resulted in civil litigation had made front-line workers more cautious about personal liability for violent offenders.

Probation and parole officers described a parallel communication failure. They explained that early notice of non-compliance could be used to meet with the client and leverage conditions of release before problems reached the point of revocation. In practice they were contacted only after the situation had already escalated, or not at all until the client was rearrested. Court personnel highlighted the absence of any reliable restoration pathway and the lack of a shared mechanism for updating both criminal and civil courts once a Rule 20 finding moved a case between them. These accounts supplied the concrete topics that later shaped training and the design of structured communication protocols.

### COMMUNICATION SILOS IN THE MENTAL HEALTH SYSTEM

Disconnected Services. Fragmented Care.

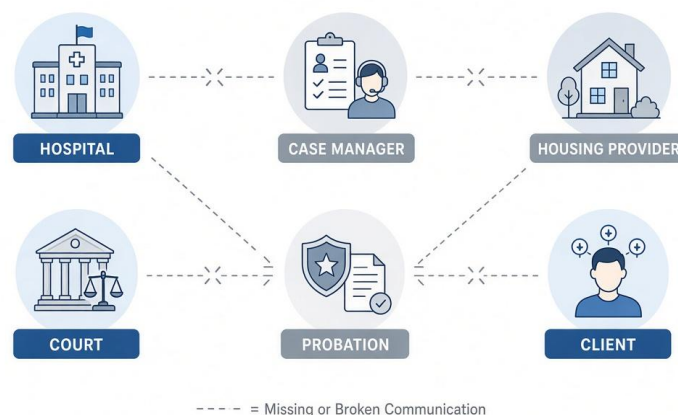


Figure 1. Communication silos identified across stakeholder groups.

## Training Design, Delivery, and Outcomes

Topics drawn from the focus groups were consolidated from more than 150 discrete items into a ten-week series of fourteen sessions. I designed and delivered the series, balancing the county's continuing emphasis on stigma reduction with the front-line request for practical navigation tools. Live Thursday-afternoon sessions covered Rule 20 overview, interviewing techniques, placement keys (including 245D licensing and 6790 billing forms for housing providers, CADl waivers and housing types for case managers), and community resources. Remote sessions presented clinical material on prenatal trauma, executive dysfunction, social cognition, alexithymia, and food insecurity. Notebooks, meals, and certificates with social-work continuing-education credit were provided to encourage attendance.

Sixty-one individuals attended at least one session, averaging twenty-seven participants, with a range of seventeen to thirty-six. Eighty-five percent identified as case managers, parole officers, or jail-based mental health staff; only fifteen percent were housing providers. Post-training surveys, returned by roughly forty-five percent of attendees, showed that eighty-three percent reported increased confidence in working with Rule 20 clients. Knowledge gains were strongest on executive functioning and substance-use topics. Housing-provider attendance in the formal series remained low—only nine staff from seven providers out of more than four hundred invited—yet those who attended were highly engaged and later formed the core of bed-hold relationships. Monthly collaborative meetings proved more successful at drawing housing providers, particularly sessions on practical billing forms.

Case managers reported concrete practice changes: more deliberate silence and active listening in interviews, earlier outreach to probation, assessment for alexithymia, and greater attention to food insecurity. Supervisors noted improved knowledge and cross-agency connections even when meeting frequency with Rule 20 clients did not immediately rise, attributing the latter to systemic barriers such as homelessness rather than individual skill. No county-wide cost reduction could be tied directly to the training series; participants continued to identify process delays as the binding constraint. The monthly meetings themselves evolved: after an unplanned two-hour open discussion was judged the most valuable session of the year, the format shifted toward networking first and shorter educational segments second. From those discussions came the request for a weekly open-bed newsletter, which was launched and distributed to case managers.



## Bed-Hold Design and Early Implementation

The bed-hold agreement was designed to secure a bed and begin structured support while remaining paperwork was completed, ending the period in which a client who no longer met locked-facility criteria continued to generate county cost. Providers willing to accept clients directly from hospitals or jails received a modest daily rate to hold the bed until move-in; that rate ended on the day of placement. I developed the process steps and supporting materials, which were reviewed and approved by Ramsey County Mental Health before use.

The process begins with a referral and client-signed releases of information. The referral is distributed to contracted providers; once a provider identifies a bed, at least one pre-placement interview is required so the client understands rules and expectations. Records are reviewed by a consultant who prepares a client-specific plan covering diagnosis, motivational factors, medication adherence, and elopement risk. A stakeholder meeting then aligns the housing provider, case manager, consultant, and county team. Move-in occurs only after MNChoice, SMRT, and waiver status are confirmed, the rate sheet is approved, a payor is identified, and pharmacy arrangements are complete. Post-placement contact starts weekly and steps down to monthly if the placement stabilizes.

Contracting delays limited implementation to mid-2024 and to a single active provider. One early placement at Olu's Home was completed in eight weeks rather than the typical five-month process, demonstrating the effect of hand-carrying paperwork. Three additional placements in October ended in elopement; two of those clients were reincarcerated and later returned. Common features of the unsuccessful cases included the absence of a pre-placement interview, client unfamiliarity with structured housing rules, and substance-related absences. These patterns produced tighter requirements for pre-placement contact and discussion tools focused on harm reduction and reintegration after elopement. Client interviews conducted later in the year illustrated the human side of the same barriers: one woman described twelve case workers over five years of shelter stays and repeated assaults; a registered sex offender described five years of homelessness after release with no identification or transitional supports until a single case worker finally assembled his documents.

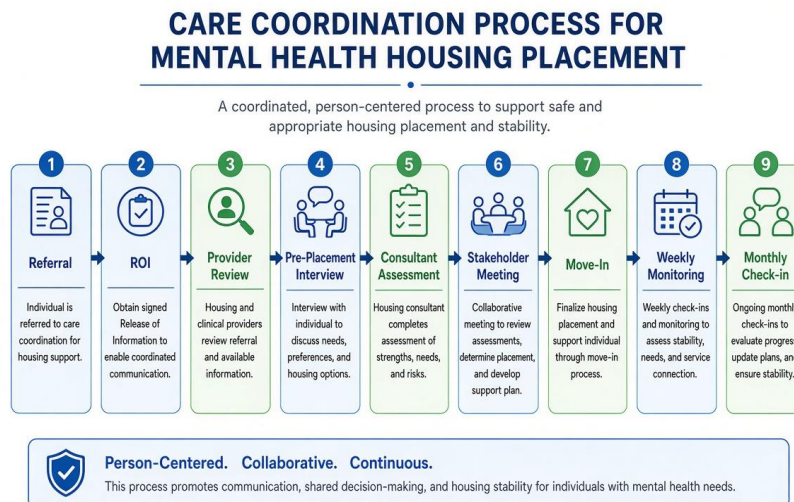


Figure 3. Care coordination process developed for bed-hold placements.

## Systemic Barriers Identified

Across focus groups, training feedback, monthly meetings, and direct bed-hold experience, structural barriers proved more persistent than residual stigma. Communication among the parties who touch a discharge—hospital or corrections staff, housing provider, case manager and supervisor, county waiver unit, criminal court, civil court, probation or parole, and the client—is fragmented. No shared checklist assigns responsibility for each required document, so files stall while professionals assume someone else is handling the next step. After placement the same parties rarely maintain contact, allowing small problems to escalate until housing and benefits are lost. One housing provider described contacting a shelter, being refused entry because staff could not distinguish a housing provider from housing support, then locating a qualified client only to discover that the assigned case manager initially denied the person was on their caseload.

Information about available beds is similarly scattered. Multiple directories exist, including a state site later identified as HB101.org, yet many case managers do not know about them and default to familiar providers. Print resources such as the Book of the Streets are widely possessed and rarely consulted. Formal training on MNChoice, SMRT, and waiver applications is limited, producing high rates of incomplete submissions and a reliance on private consultants. Statewide licensing moratoria on adult foster care and related settings restrict new capacity; exception criteria are not transparent, and denials frequently restate the restriction itself.<sup>6</sup>

Benefits determination is a sequential three-part process whose clocks are not coordinated. An MNChoice assessment is valid for only sixty days and can expire while the client waits for a State Medical Review Team disability determination; the subsequent waiver can then be rejected at the county level on cost grounds, restarting the sequence. Participants described timelines of eight to fourteen months. Staffing shortages at both county and state levels exacerbate the delays. For clients without income, Ramsey County's 2020 moratorium on Housing Assistance (formerly Group Residential Housing) funds, with exceptions limited to clients over age 55 or grandfathered providers, further restricts options inside the county.<sup>7</sup>

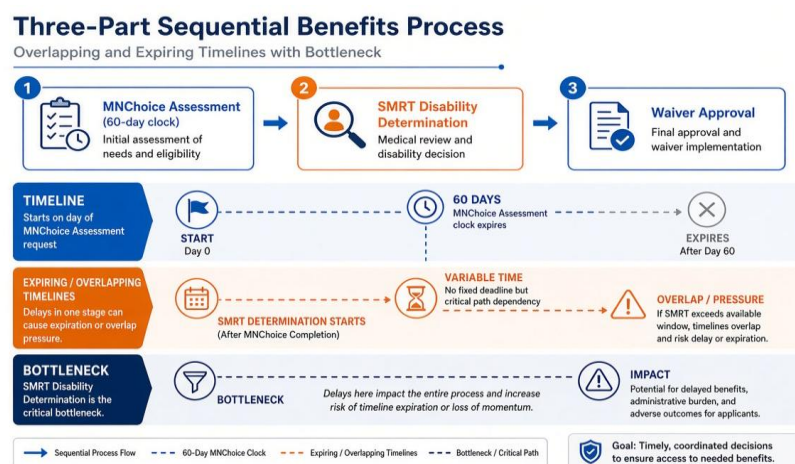


Figure 4. Sequential benefits process and timeline constraints.

<sup>6</sup>Minn. Stat. § 245A.03 (licensing moratorium on adult foster care and related settings). Exceptions exist for certain age-based or facility transition cases.

<sup>7</sup>Disability Hub MN and Arc Minnesota guides to MnCHOICES and SMRT processes; typical timelines range from several months to over a year depending on staffing and documentation.

## Practical Tools and Processes Developed

The inquiry and implementation work generated several reusable tools. I created a weekly newsletter format to list open beds by housing type, license status, and contact information, responding directly to the request that emerged from monthly meetings. Provider selection for bed-hold agreements was structured around scored interviews covering staffing, activities, substance-use monitoring, person-centered practice, Rule 20 experience, and communication with case managers; corresponding training tracks were designed for any identified gaps and offered at symposiums. All materials were submitted for Ramsey County Mental Health approval prior to use.

A multi-step care-coordination pathway was documented, moving from referral and release of information through provider review, consultant assessment, stakeholder meeting, confirmed move-in, and stepped monitoring. Symposium and concurrent-session designs shifted emphasis toward interactive problem-solving—role-based exercises that surface communication silos, workshops that produce discharge checklists, and facilitated discussions on substance use and elopement—rather than extended lectures. These artifacts show how stakeholder evidence was converted into operational processes that can be refined and scaled.



Figure 5. Sample weekly bed availability newsletter format.

## Recommendations and Implementation Plan

The findings support a shift from primarily educational interventions toward coordinated process improvement. A one-page, multilingual flowchart of the benefits and placement sequence, distributed through shelters and other entry points, would give clients and providers a shared map. A searchable online repository of providers, open beds, and support resources would address the information gap that the weekly newsletter only partially fills.

Quarterly symposiums and open-forum meetings focused on role clarification and real-time barrier resolution are likely to be more effective than multi-week didactic series. Bed-hold contracts should be refined with mandatory pre-placement interviews, explicit elopement-prevention protocols, and routine tracking of time-to-placement and cost differentials so that savings can be demonstrated. Targeted expedited-review capacity inside county financial and waiver units for high-cost Rule 20 files would address the staffing bottleneck without requiring a full system redesign. A structured readiness-for-discharge assessment and a post-placement monitoring pathway that includes all key stakeholders would reduce the preventable disruptions observed in early placements.

These steps are incremental and compatible with existing statutory frameworks. Their purpose is to shorten the interval between the determination that a client no longer requires locked care and the start of stable community housing, thereby reducing repeated institutional stays and associated county expenditures while improving continuity of support.

## Notes on Data and Limitations

Internal financial figures are estimates drawn from the source materials and require verification against Ramsey County fiscal and utilization records. Client narratives are presented as reported during focus groups and interviews. Public citations support the legal and process frameworks; they do not replace internal evaluation data. The analysis prioritizes patterns that appeared consistently across multiple stakeholder groups and direct implementation experience.

## References

*Minnesota Rules of Criminal Procedure, Rule 20.01.* Competency to stand trial. Office of the Revisor of Statutes. [https://www.revisor.mn.gov/court\\_rules/rule/cr-20](https://www.revisor.mn.gov/court_rules/rule/cr-20)

*Minnesota Statutes, Chapter 611.* Competency Proceedings (§§ 611.40–611.59). <https://www.revisor.mn.gov/statutes/cite/611>

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*Minnesota Statutes § 245A.03.* Licensing moratorium provisions for adult foster care and community residential settings.

*Disability Hub MN.* Guides to MnCHOICES assessment and State Medical Review Team (SMRT) process. <https://disabilityhubmn.org>

*The Arc Minnesota.* Arc Guide to State Medical Review Team (SMRT) and MnCHOICES. <https://arcminnesota.org>

*Ramsey County.* Mental Health Innovation Grant awards documented in DHS grantee lists for 2023–2024 and 2025–2026 cycles.

*University of Minnesota Conservancy.* Rule 20 Assessment Ramsey County (capstone paper, 2023). <https://hdl.handle.net/11299/254701>