MINNESOTA SUPREME COURT

ADVISORY TASK FORCE ON THE CIVIL COMMITMENT SYSTEM

FINAL REPORT

January 17, 1996

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PART ONE

I. ACKNOWLEDGEMENTS

This report would not have been possible without the support and cooperation from public and private agencies and organizations that are part of the Civil Commitment system; and a wide range of concerned practitioners. Everyone contacted by the Task Force was more than willing to give of their time and expertise to further the work of the Task Force, and for that the Task Force is truly grateful.

Many professionals, staff members, and members of the public contributed by attending the Focus Group meetings and the Public Hearings. The Task Force wishes to give special thanks to the staff of programs that hosted Site Visits and provided logistical support for the Public Hearings.

II. MEMBERSHIP OF ADVISORY TASK FORCE

Chair:	Honorable Sandra S. Gardebring, Associate Justice, Minnesota Supreme Court
Vice-Chair:	Beverly Jones Heydinger, Deputy Attorney General
Committee Chairs:	
Judicial Process Committee:	Honorable Dennis Murphy, District Court Judge, Ninth Judicial District
Treatment Committee:	Cecelia M. Taylor, Ph.D., R.N., Chair, Department of Nursing, The College of St. Scholastica
Funding and Systems Committee:	Janice Allen, Assistant Anoka County Attorney
Advocacy and Patients' Rights Committee:	Kathleen Kelso, Executive Director, Mental Health Association of Minnesota

Members:

Lisa Anderson-Reed, Social Worker, Carlton County Social Services
Lois Bendix, Public Member, Grand Rapids
Senator Don Betzold, Minnesota State Senate
Mary Davies, Executive Director, Linden Center for Psychological Health
Donna Draves, Public Member, Minneapolis
Representative Matt Entenza, Minnesota House of Representatives
Dr. Dallas Erdmann, Department of Psychiatry, Hennepin County Medical Center
Honorable James F. Finley, District Court Referee, Second Judicial District
Honorable James D. Gibbs, District Court Judge, Tenth Judicial District
Professor Eric S. Janus, William Mitchell College of Law
Honorable Margaret Shaw Johnson, District Court Judge, Third Judicial District
Senator Sheila Kiscaden, Minnesota State Senate
Chief Bradley Kollmann, St. Peter Police Department
Bonnie Lee, Residential Program Management Division, Department of Human Services
Evelyn Lund, Court Manager, Fourth Judicial District
Representative Carlos Mariani, Minnesota House of Representatives
Honorable Harlan L. Nelson, District Court Judge, Seventh Judicial District
Valerie Nelson, Social Worker, Fergus Falls Regional Treatment Center
Sheriff Lawrence W. Podany, Anoka County Sheriff
Dr. Alan Radke, Medical Director, Willmar Regional Treatment Center

James R. Redman, Public Member, St. Paul
Representative Jim Rhodes, Minnesota House of Representatives
Norma Schleppegrell, Public Member, Hibbing (resigned)
Gerald Schmidt, Mental Health Program Manager, Blue Earth County Human Services
Roger Schwab, Client Advocate, Office of Ombudsman for Mental Health and Mental Retardation
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Pat Siebert, Managing Attorney, Minnesota Mental Health Law Project
Marc Paul Smith, Mental Health Unit, Ramsey County Human Services
Dr. Thomas Stapleton, Psychiatrist, St. Peter
Tim Tinglestad, Assistant Beltrami County Attorney
John Whalen, Executive Director, Alliance for the Mentally Ill of Minnesota
Carolyn Wheeler, Director of H.O.P.E., South Central Human Relations Center
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Dr. Steven Zuckerman, Aspen Clinic

Ex Officio Members:

John Zakelj, Mental Health Division, Department of Human Services
Kaye Zarn, Admissions Officer, St. Peter Regional Treatment Center

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III. CHARGE OF THE ADVISORY TASK FORCE

The Advisory Task Force on the Civil Commitment System was convened in August, 1994 and charged by the Legislature to conduct a study of the civil commitment system and make recommendations concerning the following:

1) hearings and procedures governing administration of neuroleptic medications;

2) provisional discharges;

3) monitoring of medication;

4) mental health treatment advance declarations;

5) relationship between the commitment act and the psychopathic personality statute;

6) criteria for commitments and 72-hour holds;

7) time lines and length of commitment;

8) impact of available resources and service delivery systems on commitments and implementation of least restrictive alternatives;

9) training and expertise of professionals involved in the commitment process;

10) separation of functions and conflicts of interest and related due process issues in the commitment system;

11) rights of patients;

12) variations in implementation and interpretation of commitment laws around the state.

13) vulnerable adult reporting and mental competency issues; and

14) any other commitment, legal, and treatment issues identified by the task force.

The Task Force, chaired by Justice Gardebring, is comprised of forty members, and two Ex Officio members. The membership included private citizens; community leaders and advocates; judges; attorneys; legislators; a law professor; service providers; law enforcement officers; and staff of state and county agencies. The Task Force also sought broad based input through focus group meetings, site visits, public hearings, and expert presentations. [1]

[1] See infra Appendix A.

IV. EXECUTIVE SUMMARY

A. OVERVIEW

The Advisory Task Force on the Civil Commitment System was established by order of the Supreme Court on August 4, 1994, at the request of the Minnesota Legislature. This eighteen month study was initiated in response to the concern about the custody and welfare of persons with mental illness involved in the Civil Commitment process.[2] The report is a comprehensive look at several significant procedural and policy aspects of Minnesota's Civil Commitment system. The Task Force's legislative mandate was limited to consideration of persons involved in the Civil Commitment system due to the effects of mental illness. The Task Force did not address the Civil Commitment of persons as psychopathic personalities, sexually dangerous persons, mentally ill and dangerous, chemically dependent, or mentally retarded.

The first meeting of the Task Force was held on August 25, 1994. Forty Task Force members, and two ex officio members, all with expertise in the area of mental health, comprised the Task Force. Focus group meetings and public hearings were held to ensure that issues and concerns pertaining to the judicial process of Civil Commitment and treatment of persons with mental illness were not overlooked.[3] The Task Force was organized into committees that focused on four areas: Judicial Process, Treatment, Funding and Systems, and Advocacy and Patients' Rights.

The goal of the Task Force was not to develop a broad visionary plan for the future but, rather, to recommend specific changes to the Civil Commitment system to improve the service provided to persons with mental illness and provide for more effective management of the Civil Commitment cases appearing before the courts. However, in addition, the Task Force developed guiding principles and two models for the delivery of mental health care should the Legislature decide to consider more sweeping reform.

The Task Force has been studying procedural and policy changes that, if enacted, will enhance the Civil Commitment system's ability to respond more appropriately to persons with mental illness and their families. However, it must be recognized that the solution to the humane treatment of persons with mental illness lies in public education, training of professionals in the system, incorporating families and communities in the solution, and providing additional community-based services in order reduce the reliance on the court system.

Community-based services are generally less expensive to provide than inpatient services, however it is difficult to shift resources from institutional services to less restrictive community-based services. As a result, extensive reliance on the state-operated Regional Treatment Centers for services impacts the state's ability to develop a full array of services within the adult mental health system. The lack of available community-based programming

[2]The Minnesota Civil Commitment Act is found at Minn. Stat. § 253B (1994).

[3]See infra Appendix B.

also effects the release of persons from the Regional Treatment Centers to their communities.

While the Civil Commitment Act does not create these problems, the current allocation of resources impedes the Civil Commitment Act from working as it was intended. Less restrictive alternatives and community commitment can not be utilized as dispositions by the court, if the community-based treatment services are not available. In addition, geographic and demographic characteristics of the state have created the need to divert persons from placement at their designated Regional Treatment Centers. These diversions create delays in hearings, added court costs, and excessive transporting of patients.

The Civil Commitment Act can not work as intended without a full array of treatment services available. The Department of Human Services and many counties around the state have strived to improve the community-based services and decrease reliance on commitments. However, local coordination and the delivery of community-based services remains inconsistent statewide.

The Task Force expressed concern that persons with mental illness may lack support networks or personal resources to deal with mental health problems. The Task Force expressed their commitment to the view that all people must be treated with dignity and respect when the court becomes involved in their lives. Further, constitutional protections and the assurance of due process must not differ according to one's mental health or socio-economic status.

The Task Force is committed to the public policy that the mental health service system should provide a continuum of levels of supervision and appropriate programming to meet the needs of persons with mental illness, provided in the least restrictive environment that is consistent with the person's safety and treatment needs; and the public's safety. The recommendations made by the Task Force are designed to be consistent with this public policy.

Involuntary commitment is an area that involves not only a medical but a social judgement; liberty is our most precious civil right. The determination of when and under what circumstances the liberty of an unwilling citizen should be taken away can be most difficult. The views of the Task Force incorporate several key assumptions based on expert testimony, information from site visits to residential and day treatment facilities, information from other states, and public testimony:

- Community based mental health treatment, including hospitalization close to home, is preferable to the involuntary hospitalization of persons far away from their homes, and would decrease commitments.

- Minnesotans wish to preserve the civil rights of persons with mental illness, while facilitating access to mental health treatment and services.

- There is a need to provide early intervention for persons who are clearly decompensating due to mental illness, but do not yet meet the strict criteria required for civil commitment.

- Due process should not unnecessarily delay prompt access to needed treatment.

- Supervision of persons on provisional discharge in the community should be strengthened to increase the likelihood of successful maintenance in the community.

As the Task Force listened to the Focus Group participants and the testimony at the Public Hearings, the members recognized that the Civil Commitment process, in practice, did not provide the variety of dispositional options necessary to respond to individual situations. An improved system response was needed for persons decompensating but not yet meeting the criteria for commitment; for individuals who are incapacitated and objecting to neuroleptic medication; and for persons on provisional discharge who need to be returned to a more restrictive setting. The Task Force sought to design a series of recommendations that would work together to produce improvements in how persons within the Civil Commitment system are treated.

When addressing the complex issue of involuntary interventions, there are numerous policy positions that reflect powerful feelings or beliefs, and represent fundamental social values. The Task Force acknowledged that consensus would need to be reached among the persons and organizations involved representing a variety of policy positions if improvements in the Civil Commitment system were to occur. As a result, all the recommendations are the product of a high degree of compromise and a desire to reach consensus by the members of the Task Force.

The results of the Task Force's study will present many challenges for policy makers and practitioners. The passage of Legislation would be a significant achievement. However, translating the law into altered systems of services and better outcomes for people with mental illness, will present an even greater challenge. The combination of leadership, commitment, talent, and experience of the people who served on the Task Force has ensured that the changes being recommended were carefully and thoughtfully considered.

The following are the Task Force's recommendations. Further information on each area of recommendation can be found in Part Two of this report.

B. TASK FORCE RECOMMENDATIONS

Court Ordered Early Intervention:

The Legislature should provide for a new standard of early intervention that allows for a variety of dispositions that are less intrusive than involuntary long-term inpatient hospitalization; and a process to petition for early intervention to provide treatment for a person who:

1. has a mental illness; and

2. refuses to accept mental health treatment or hospitalization; and

3. whose mental illness is manifested by instances of grossly disturbed behavior or faulty

perceptions that:

a. significantly interfere with the person's ability to care for self, and there is clear and convincing evidence of what the person would have chosen to do in the situation when having the capacity to make a reasoned decision;

or

b. due to such mental illness, the person:

i. within the previous three years has twice received court ordered inpatient treatment; and

ii. is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the involuntary inpatient treatments; and

iii. unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate to the point of meeting the criteria for civil commitment.

The new process should be as follows:

1. Prior to filing a petition for early intervention, an interested person shall apply to the designated agency in the county of the person's residence or presence for conduct of a preliminary investigation, pursuant to section 253B.07, subdivision 1.

2. Upon the petition by the county attorney for early intervention summons and notice of hearing and examination shall be issued, the early intervention hearing shall be scheduled, and the person shall be examined. The court shall give five days' notice that the hearing will be held and at least two days' notice of the time and date of the hearing.

3. If the person fails to appear for the scheduled examination the court may:

a. reorder the examination; or

b. proceed with the hearing and consider the failure to appear as a waiver of the person's right to an examination; and

c. consider the failure to appear for the examination in determining the merits of the case.

4. A hearing on the petition for early intervention shall be held within 14 days from the date of the filing of the petition at which the court will determine if the person meets the criteria for early intervention, and whether court ordered intervention is necessary. If the person fails to appear for the hearing pursuant to the summons, the court may

direct a health officer, peace officer, or other person to take the person into custody and transport the person to the hearing.

5. If the criteria for early intervention are met, and intervention is determined to be necessary, the court may order a variety of interventions including but not limited to: day treatment, medication compliance monitoring, and short-term hospitalization not to exceed 10 days.

6. If short-term hospitalization is necessary, the court shall determine whether a substitute decision maker will be needed to make decisions for the person regarding the administration of neuroleptic medications. The person should not be hospitalized until the process regarding the administration of neuroleptic medication is complete.

7. If it is determined that short-term hospitalization is necessary and the person will not go voluntarily, the court may direct a health officer, peace officer, or other person to take the person into custody and transport the person to the hospital.

8. The order for early intervention shall not exceed 90 days.

9. Any party may request a court hearing to modify the order for early intervention.

Change in Definition of Mental Illness:

The Legislature should revise the definition of mental illness as it appears in the definition section of the Civil Commitment Act to be consistent with the language in the Comprehensive Mental Health Act, and remove the criteria for civil commitment from the definition section, relocating the criteria in the judicial commitment section. It should be made clear that the dangerousness criteria are the criteria for civil commitment and not the criteria for the diagnosis of mental illness or qualifications for the receipt of mental health treatment and services.

Access to Mental Health Treatment for Incompetent Consenters:

The Legislature should provide for streamlined access to mental health treatment for those persons who agree to accept mental health treatment or hospitalization, but for whom there is some question as to their legal capacity to give informed consent to treatment, as follows:

1. The local mental health authority or its designee may give informed consent on behalf of the person;

2. The person, or an interested person acting on his or her behalf, may seek expedited review by the District Court on the issue of the voluntariness of the person's agreement to accept treatment or hospitalization;

3. The local mental health authority shall provide the person with notice of the right to

seek expedited review by the District Court, and the right to refuse treatment or hospitalization.

New Process for the Administration of Neuroleptic Medications:

The Legislature should revise the statutory process for the administration of neuroleptic medication to persons under a court order for mental health treatment or hold to provide that unless the person already has a guardian or conservator with the authority to make medical decisions for the person, and where treatment with neuroleptic medication is anticipated, the court shall make a finding whether the person does or does not have the capacity to make an informed decision regarding the administration of neuroleptic medication.

1. The petition and the physician's statement must address the question of capacity.

2. The pre-petition screening report shall include the information and facts the pre-petition screening team has which could assist the court in assessing capacity and determining the existence of a guardian, conservator, or proxy. If a guardian, conservator, or proxy is identified, he or she shall receive notice of the proceedings. If it appears that treatment with neuroleptic medications will be considered, the pre-petition screening report should include any information the team may have regarding whether the person is likely to consent or refuse neuroleptic medication.

3. If the petitioner questions the person's capacity to give informed consent, at the Preliminary Hearing the court shall make a preliminary finding based on a showing of probable cause whether or not the person lacks capacity to give informed consent. If lack of capacity is found, a substitute decision maker shall be appointed with the authorization to give or withhold consent to the administration of neuroleptic medication, subject to the person's acquiescence.

4. The substitute decision maker shall be an individual or a multi-disciplinary panel, community or institutional, designated by the local mental health authority. The authority of the substitute decision maker shall last for the duration of the court order or until the person is found to have capacity to give informed consent, whichever is earlier.

5. If both the substitute decision maker and the person consent to treatment with neuroleptic medications, treatment is authorized and may begin immediately. If either the substitute decision maker or the person refuses consent, the matter shall be considered at the Civil Commitment or Early Intervention Hearing.

6. If a preliminary finding as to capacity was made, the court shall review that determination at the Civil Commitment Hearing or Early Intervention Hearing, and make a finding of fact, based on a preponderance of the evidence presented, either affirming or reversing the preliminary finding. If there is no preliminary finding, the court may address the issue of capacity at the Civil Commitment or Early Intervention Hearing.

7. When a substitute decision maker was appointed at the Preliminary Hearing, at the Civil Commitment or at the Early Intervention Hearing:

   a. If the substitute decision maker has consented to neuroleptic medications, and the person is not refusing, the court shall make a finding that consent has been given and treatment is authorized.

   b. If either the substitute decision maker or person refuses to consent to neuroleptic medications, the court shall review the decision and issue an order either approving or denying authorization to administer neuroleptic medications.

8. If no substitute decision maker was appointed at the Preliminary Hearing, and the person is found to lack capacity at the Civil Commitment or Early Intervention Hearing, the court shall then appoint a substitute decision maker.

9. There is a legal presumption of capacity to make decisions regarding administration of neuroleptic medications. The burden is on the petitioner to prove incapacity by a preponderance of the evidence. The judge shall weigh the following factors in determining the person's capacity to make decisions about the use of neuroleptic medications. When appropriately presented with information:

   a. Does the person demonstrate an awareness of the nature of his or her situation, including reasons for hospitalization, and the possible consequences of refusing treatment with neuroleptic medications?

   b. Does the person demonstrate a factual understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives? Factual understanding does not have to be scientific.

   c. Does the person communicate a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on delusion, even though it may not necessarily be what is in the person's best interest? Communication of the choice may be verbal or non-verbal. Disagreement with the doctor's recommendation is not per se evidence of an unreasonable decision.

10. If an order for Civil Commitment or Early Intervention does not grant authority to administer neuroleptic medication, the treatment facility can file a motion with the court to initiate the process for administration of neuroleptic medications.

    The matter shall proceed in the same manner as if the request were made at the Preliminary Hearing prior to Civil Commitment or Early Intervention.

11. If the court finds that the person has the capacity to make an informed decision with regard to the administration of neuroleptic medication, the person's informed consent or informed refusal must be followed.

12. If the court determines the person does not have the capacity to make an informed

decision regarding neuroleptic medication, the court must designate a substitute decision maker, within 24 hours or less, to make decisions with regard to neuroleptic medication on the person's behalf.

13. If the person's treating physician recommends treatment with neuroleptic medication, the substitute decision maker shall review the recommendation, discuss it with the patient, and give or withhold consent. If the substitute decision maker gives consent to treatment with neuroleptic medications, and the person does not refuse, the person may be treated and the court so notified.

14. If the substitute decision maker refuses consent or the person refuses, the person may not be treated without a court order. The court shall review the reasonableness of the substitute decision maker's decision based on the standards for substitute decision makers, and enter an order either granting or denying authority to administer neuroleptic medication, within 7 days of the Preliminary Hearing.

15. If at any time after treatment with neuroleptic medication begins, the substitute decision maker withdraws consent, the person may not be treated without a court order to continue medications based on a review of the substitute decision maker's decision.

16. If at any time after the medications have begun to be administered, pursuant to consent by the substitute decision maker, and the patient changes his or her mind and decides to refuse the neuroleptic medication, a motion must be filed with the court for an order to continue medication and a hearing must be held within 7 days, to review the substitute decision maker's decision. Treatment with neuroleptic medication can continue pending the outcome of the hearing.

17. A second, independent medical opinion may be obtained by the court or any party objecting to the medication. A request for a second examiner must be made at the Preliminary Hearing. The second opinion must be rendered by a medical doctor who is knowledgeable, trained, and practicing in the diagnosis and treatment of mental illness.

18. When the person lacks the capacity to make decisions regarding the administration of neuroleptic medication, the substitute decision maker and the court shall use the following standards in making a decision regarding administration of neuroleptic medications:

    a. If the person has clearly stated what he or she would have chosen to do in this situation when having the capacity to make a reasoned decision, the person's wishes shall be followed using substituted judgment. This evidence includes written instruments, including health care powers of attorney and advance mental health directives.

    b. If evidence of the person's wishes regarding the administration of neuroleptic medications is conflicting or lacking, the decision shall be based on what a reasonable person would do taking into consideration the following:

i. the person's family, community, moral, religious, and social values;

ii. the medical risks, benefits, and alternatives to the proposed treatment;

iii. past efficacy and any extenuating circumstances of past use; and

iv. any other relevant factors.

19. The informed consent of a substitute decision maker or a court order for authority to administer neuroleptic medication, is enforceable until the person is discharged from Civil Commitment or an Early Intervention Order, or until the person is determined by the court to have the capacity to give informed consent, whichever is earlier.

20. If physical force is required to administer the neuroleptic medication, such force shall only take place in a treatment facility or therapeutic setting where the person's condition can be reassessed and appropriate medical staff are available.

21. A substitute decision maker who consents to treatment is not civilly or criminally liable for the performance of or the manner of performing the treatment. A person is not liable for performing treatment without consent if the substitute decision maker has given proper written, informed consent. This provision does not affect any other liability that may result from the manner in which the treatment is performed.

22. This new process for administration of neuroleptic medication is not intended to effect the provisions for emergency situations in current law.

23. A hearing may be requested pursuant to Minn. Stat. § 253B.17 (1994) if the patient or any interested person believes that circumstances have changed and the court's order concerning capacity or treatment with neuroleptic medications is no longer just or equitable.

Strengthening the Provisional Discharge Process:

1. The Legislature should provide that supervision of persons on provisional discharge in the community be strengthened, when necessary to the continued success of the person in maintaining community placement, by modifying the statute to provide that:

   a. The court may extend the commitment of a person through the recommitment process; or utilize the Early Intervention process, to extend the court's supervision of a person who is receiving services in the community.

   b. A copy of the aftercare plan developed for a person released on provisional discharge shall be given to the person's attorney.

   c. When a person is on provisional discharge in the community and needs continued commitment, the county case managers shall be responsible for

providing recommitment reports to the court.

2. The Legislature should revise the statutory process for revocation of provisional discharge to provide that:

   a. The designated agency, not the head of the treatment facility, is responsible for the revocation of provisional discharges.

   b. The designated agency may revoke a provisional discharge if:

      i. The person has violated material conditions of the provisional discharge, and the violation creates the need to return the person to a more restrictive setting;

      or

      ii. There exists a serious likelihood that the safety of the person or others will be jeopardized, in that either the person's need for food, clothing, shelter, or medical care is not being met, or will not be met in the near future, or the person has attempted or threatened to seriously physically harm self or others.

   The designated agency must demonstrate that every effort has been made to avoid revocation, and that revocation of provisional discharge is the least restrictive alternative available.

   c. Only one process be used for revocation of provisional discharges, whether the revocation occurs within the first 60 days of the provisional discharge or after the first 60 days. The process for revocation of a provisional discharge, should also provide for hospitalization of the person, without a prior hearing.

      i. The designated agency shall commence the revocation process by notifying the person, the person's attorney, and the treatment facility of the planned revocation. This notice shall set forth the grounds upon which the planned revocation is based, and shall inform the person of his or her rights under this chapter.

      ii. The designated agency shall provide the court, within 48 hours of the notice, a copy of the notice and a report reciting the recent actions of the person and the reasons for the planned revocation.

      iii. The report should be in sufficient detail to enable the court to make a finding as to whether revocation of the provisional discharge is necessary, and shall include specific efforts made to avoid revocation.

      iv. A copy of the report should be provided to the person, his or her attorney, and the treatment facility within the same 48 hour period.

v. The person may challenge the basis for the planned revocation of the provisional discharge by filing an affidavit with the court specifying the reasons for contesting revocation. The burden of proof shall be upon the party seeking revocation. If no affidavit contesting the revocation is filed by the person or his or her attorney within five days of receiving the notice, the revocation of provisional discharge becomes final.

vi. If an affidavit contesting the revocation is filed, the court should then make a threshold determination of whether there exists a genuine issue as to the propriety of the revocation.

vii. If the court finds no genuine issue, the revocation of the provisional discharge becomes final.

viii. If a preliminary showing of a valid challenge to the propriety of the revocation is made, the court may take steps necessary under the circumstances, including setting the matter for a hearing on the merits. This hearing shall be held within three days of the filing of the affidavit, unless continued for an additional five days for good cause shown. After a hearing on the merits, if the court does not find factual basis for revocation, the person retains provisional discharge status, if the court finds factual basis for revocation, the revocation becomes final.

ix. If it is necessary to hospitalize a person, prior to a hearing:

a) The person may be hospitalized, without a prior hearing, upon notice of the planned revocation, if the provisional discharge is being revoked because there exists a serious likelihood that the safety of the person or others will be jeopardized, in that either the person's need for food, clothing, shelter, or medical care is not being met, or will not be met in the near future, or the person has attempted or threatened to seriously physically harm self or others.

b) If the person is hospitalized the above procedures are followed, however, the affidavit contesting the planned revocation must be filed within 48 hours of receipt of the notice. If the affidavit is not filed within 48 hours, the revocation of provisional discharge becomes final. The filing of the notice and report; the filing of the affidavit contesting; a threshold determination by the court; and if needed, a hearing on the merits shall be completed within five days of notice of planned revocation.

c) The person may be returned to the treatment facility from which he or she was discharged, or to another treatment facility that agrees to accept the person.

e. When a person's provisional discharge is revoked, the person's voluntary return to a more restrictive setting does not discharge the person's civil commitment.

3. The Legislature should provide that the new process for revocation of provisional discharge be applicable to persons committed as chemically dependent, and those committed as mentally retarded as well as those committed as mentally ill.

Equitable Delivery of Services:

1. Revising The Rules of Court: The Minnesota Supreme Court Advisory Committee on Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act should provide that:

   a. During recommitment hearings the court may base its decision on relevant and admissible evidence, including the testimony of a treating physician or other qualified physician, a member of the patient's treatment team, a court appointed examiner, witness testimony, or the patient's medical records.

   b. While in person testimony is preferred, judges should have discretion to admit telephone testimony and testimony by interactive television at commitment hearings for persons with mental illness, and the Supreme Court Advisory Committee on Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act should set standards for the use of such testimony, taking the best interest of the person into consideration.

2. Developing Transportation Alternatives: The Department of Human Services should educate and assist counties in the development of a transportation plan that provides alternatives to the exclusive use of sheriffs for transport of persons in the commitment process, including persons on emergency holds and released from holds. The Department should work locally with counties with input from law enforcement, county human services, local mental health authorities, local mental health advisory councils and other appropriate individuals and organizations to develop and implement a transportation plan. The transport plan should provide for:

   a. training of persons providing the transportation in mental health issues, and

   b. provision of security with respect to the person being transported, and

   c. reduction of stigma for persons who are being transported which is created by the use of handcuffs, law enforcement uniforms, and marked vehicles.

3. Reallocation of Resources: The Legislature should support the ongoing efforts of the Department of Human Services to reallocate the Department's mental health resources to more closely match the location and type of mental health service needs.

Mental Health Care Coverage and Reform:

1. The Legislature should consider the following principles as they undertake overall reform of mental health care and human services:

   a. The goal of a managed care system should be effective, coordinated, ongoing access to quality services, based on the recipient's mental health needs and designed to enable continued community living.

   b. Funding mechanisms should be structured to:

      i. encourage utilization and development of less restrictive alternatives, where appropriate; and

      ii. provide incentives for the state, counties, health plans, and health care providers to provide treatment in the setting most appropriate to the person's needs; and

      iii. allow sufficient flexibility for the development of individualized community-based plans. Effective community-based plans should integrate mental health treatment with housing; vocational services; social and economic support; physical health care; and transportation to access services.

   c. It is generally preferable that people receive mental health treatment in or near the communities in which they live.

   d. Persons with special mental health treatment needs should have access to specialized treatment programs irrespective of their county of residence. Additional specialized treatment programs, for special needs such as multiple personality disorders, dual diagnoses, and dissociative disorders, should be developed.

   e. A person's legal status under the Civil Commitment Act should not be a basis for determining access to treatment programs.

2. The Legislature should provide that for all health care coverage provided or regulated by the state:

   a. a person's legal status, under the Civil Commitment Act, can not be a basis for denying payment for mental health treatment and services; and

   b. health plans should support the local mental health authority by acting as primary payor or provider for mental health services within the coverage required by law or contract.

3. The Legislature should provide that the county, during its Pre-petition Screening

investigation, make reasonable efforts to include the person's health care payor, if any, when considering alternatives for the person's placement.

4. The Legislature should consider the following models when determining how the principles may best be implemented:

a. Model I - Integrated Funding for Mental Health Services

i. Funding for mental health services should be integrated at the state level, with the state serving as the payor. The local mental health authority, which is the county board under current state law, should administer the funds, based on minimum state-wide standards of care, and ensure the provision of services through a variety of vendors, including supportive services and housing necessary to maintain the person in the community.

ii. Persons should be committed by the court to a local mental health authority, and:

a) the local mental health authority should have the authority to place the person in the least restrictive treatment alternative that is appropriate and available.

b) during the commitment period the local mental health authority should have the authority to transfer the person between resources as dictated by the person's needs.

c) the local mental health authority should be required to notify the court of any transfers, but such transfers do not require prior court authorization, except that for persons under the jurisdiction of the criminal court, the court must pre-authorize the transfer.

d) the person should have the right to request a court review hearing to contest a placement.

iii. Incentives should be provided for local mental health authorities to create cooperative agreements and regional services in order improve services to people.

iv. This model should be developed and evaluated through the use of pilot projects.

b. Model II - Linking Health Plans, Regional Treatment Centers, and Counties If Separate Funding is Retained for Health Care, Regional Treatment Centers, and Social Services.

i. State health care programs that purchase care from a managed care entity, should include a provision in the contract specifying the managed

care entity's fiscal responsibility for court ordered mental health services, including hold orders and placement at a Regional Treatment Center. The value of the covered services should be worded to encourage the most appropriate treatment for the person's needs.

ii. This responsibility would not be subject to the managed care entity's normal pre-approval authority and would not reduce the benefits that the person would otherwise receive under the contract.

iii. The provision should be part of all contracts for publicly funded managed health care, including disabled and non-disabled persons.

iv. The actuarial value of this provision should be part of the capitation received by the managed care entity.

v. The managed care entity, or its contracted mental health provider, will need to coordinate with the county in the development of the treatment plan that is submitted to the court. This should lead to development of creative non-commitment alternatives provided and funded jointly by the county and the managed care entity.

vi. The model should be designed such that there are no financial incentives to retain a person in an inpatient treatment program when the person is ready to be discharged to the community.

Updating of the Civil Commitment Act:

The Legislature should revise the language and organization of the Civil Commitment Act to:

1. rename the Act to more appropriately reflect its scope;

2. eliminate archaic language within the Act;

3. provide additional clarification where needed;

4. reorganize the Act for ease of use; and

5. clarify to whom the Act applies.

Creation of a Training and Resource Center:

The Legislature should provide for the establishment of a statewide Civil Commitment Training and Resource Center that would provide:

1. an organized system for providing ongoing, interdisciplinary training to be conducted

at least quarterly in various locations in the state;

2. information dissemination; and

3. legal consultation primarily for persons with mental illness and their representatives.

The Office of the Ombudsman for Mental Health and Mental Retardation should issue a Request for Proposals to administer and manage the Center; develop and provide the training; disseminate information; and provide consultation services. The administration and management of the Civil Commitment Training and Resource Center should not be provided by a mental health service provider, including the Department of Human Services.

Medical and Court Records:

1. The Legislature should provide that when:

   a. a person with mental illness is under an order for mental health treatment by the court; and

   b. the person transfers between mental health treatment facilities or programs; and

   c. the person does not have the capacity or is unwilling to consent to the release of relevant medical records;

   the person's treating physician who is making medical decisions regarding the prescription and administration of medications to treat mental illness, may have access to the portions of the person's prior medical records relevant to the administration of medications used to treat mental illness and the person's response to those medications without consent of the person.

2. Under current law a notice of the proceedings, notice of filing of the petition, a copy of the petition, the examiner's supporting statement and order for examination, and the Pre-petition Screening report are sent to "any interested person". The Legislature should provide that the above documents are sent to the respondent, the attorneys, the petitioner, the treatment facility, the court, the examiners, persons designated by the court, and persons designated by the respondent. The notice of the proceedings, and notice of filing of the petition should be sent to the above parties plus any interested person.

Increased Programming:

1. The Legislature should provide financial incentives for communities to develop treatment programs for persons with dual diagnoses, and institutions of higher education to develop and implement programs designed to prepare professionals to treat persons with a dual diagnoses.

2. The Legislature should provide that if a person is under a court order for treatment that includes medications, and the person is unable to pay for the medications and there is no other source of payment, then the county must be responsible to ensure medications are available to the person. The Legislature should provide additional funding for this purpose, with the exception of persons on Medical Assistance, General Assistance Medical Care, or MinnesotaCare, since these programs already cover medications.

Persons with Mental Illness in the Correction System:

The Advisory Task Force on the Civil Commitment Process strongly endorses the recommendations put forth by the Minnesota Department of Correction's Mental Health Services Review Committee in the report, "Mental Health Services for Adult Inmates in Minnesota Correctional Facilities" dated September 14, 1995, and recommends that the Legislature ensure that resources are available for the implementation of the recommendations. The Advisory Task Force suggests the following recommendations be given emphasis:

1. The delivery of mental health services for the department should be coordinated by a psychiatrist, and all correctional facilities should have a psychological services staff person available for consultation 24 hours a day.

2. Security staff and case managers should receive ongoing training on topics related to mental health.

3. Record-keeping for mental health services should be standardized and computerized to facilitate the provision of mental health services. A complete Diagnostic and Statistical Manual - IV diagnosis should be recorded in psychological services records if it is determined that the inmate has an Axis I disorder.

4. Inmates involved in chemical dependency programs should be evaluated to determine whether they have a dual diagnosis, and if mental health services are needed they should be addressed in the treatment setting.

5. Psychological services staff should identify inmates who are unable to understand disciplinary procedures, and if there is a question as to whether an inmate can understand the discipline rules and procedures, discipline prosecutors should be required to request a psychological services evaluation.

6. A more comprehensive discharge planning process should be developed and there should be increased coordination when inmates are transferred back into the general population from the Mental Health Unit.

Other Recommendations for Improvement:

Advance Declarations

The Legislature should provide a universal, state wide advance psychiatric directive form. The form should be user friendly, not require admission of mental illness, include criteria to revoke or rescind a directive, and allow the person to state his or her mental health problem in lay terms.

Timing

1. The Legislature should provide that a petition for civil commitment must be filed with the court within the emergency hold period, but that the court administrators have an additional 24 hours within the subsequent 14 day period to schedule the hearing, assign defense counsel, schedule the examination, etc.

2. The Legislature should provide that the period of civil commitment begins on the date the warrant of commitment is issued, and that the warrant shall include a statement that the criteria for civil commitment have been met.

Rules of Court - The Request to Appeal

The Supreme Court Advisory Committee on Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act should clarify the effect of Rule 4.06 if a respondent requests an appeal of a Civil Commitment case that the attorney believes is frivolous.

PART TWO
TASK FORCE RECOMMENDATIONS

I. INTRODUCTION

The purpose of the Civil Commitment process is to allow the state, or caregivers, to intervene in a person's life and require the individual to accept mental health treatment when, as a result of the mental illness, that person is unable to understand or appreciate the effect of the mental illness and the need for mental health treatment. The Civil Commitment process is basically civil in nature and procedure, even though loss of liberty is often a result.

Depriving a citizen of his or her liberty through a civil proceeding is a serious matter. A constant dilemma is how to best honor the values for personal choice, self-determination and independence of persons with mental illness, and simultaneously meet the responsibility to protect vulnerable people and the public from harm. The judiciary, attorneys, family members, physicians, and mental health professionals struggle daily with this dilemma which is inherent in every Civil Commitment proceeding.

The Civil Commitment process transfers the physical custody and control of a person to the head of a treatment facility. Persons may be Civilly Committed if they are determined to be mentally ill and either present a danger of physical harm to themselves or others, or are mentally ill and are in need of care or custody because they are unable to provide basic care for themselves.[4] The person can be required to accept mental health treatment based on the assumption that the person's delusional thought process prevents him or her from recognizing that treatment would have a beneficial effect.[5] For persons committed as mentally ill, the initial commitment can not exceed six months.[6] At the conclusion of the initial commitment, if the criteria for continued commitment are satisfied, the commitment can be continued for up to twelve months.[7]

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[4]The current statutory definition of a "mentally ill person" contains the criteria for Civil Commitment as follows:

> "Mentally ill person" means any 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
>
> (a) is manifested by instances of grossly disturbed behavior or faulty perceptions; and
>
> (b) poses a substantial likelihood of physical harm to self or others as demonstrated by:
>
> (i) a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment, or
>
> (ii) a recent attempt or threat to physically harm self or others. This impairment excludes (a) epilepsy, (b) mental retardation, (c) brief periods of intoxication caused by alcohol or drugs, or (d) dependence upon or addiction to any alcohol or drugs.

Minn. Stat. §253B.02, subd. 13 (1994).

[5]Mental health treatments that are considered intrusive must have additional court approval. Id. § 253B.03, subd. 6c (1995).

[6]Id. § 253B.09, subd. 5 (1994).

[7]Id. § 253B.13, subd. 1 (1994).

A. STATISTICAL OVERVIEW

In Minnesota, two to three percent of adults experience severe mental disorders in a one year period, and twenty-two percent experience mental illness.[8] Research has verified that mental illness can be successfully treated. In addition, appropriate mental health treatment can result in reduced utilization of general medical care. The cost of mental health treatment is manageable and comparable to the cost of other illnesses with similar prevalence such as diabetes.[9]

Although the precise number of Minnesota adults with serious mental illness in need of services from the public sector is not known, data suggests that there are approximately 24,000 adults in need of public sector mental health services.[10] In 1993, there were 22,970 adults with serious mental illness served by the mental health system. Of those adults, 3,180 were served by the state operated regional treatment centers, and 4,360 were served through community inpatient treatment services. The remaining 15,430 adults were served through outpatient treatment or community-based mental health programs.[11]

The number of Civil Commitment filings has increased slowly and steadily over the last ten years. In 1984, there were 1,976 filings, and in 1994 there were 3,345 filings.[12] In 1994, the Second Judicial District, Ramsey County, accounted for 21% of the filings, and the Fourth Judicial District, Hennepin County, accounted for 28% of the filings.[13]

B. THE MENTAL HEALTH SERVICE SYSTEM

Although there is a broad array of federal programs which affect mental health care, the primary responsibility for mental health care for people with serious mental illness rests with state government. The state government's role is complicated by the need for both private and public mental health service sectors, as well as by a complex system of categorical state and federal funding.

The public mental health system in Minnesota is composed of three basic types of

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[8]Mental Health Division, Department of Human Services, Outline for Mental Health Presentation to DHS Health Care Integration Planning "Phase II" Work Group, p. 1 (Dec. 30, 1993)[hereinafter Work Group]. Figures are based on national studies, and are adapted to Minnesota definitions of mental illness.

[9]Id.

[10]Mental Health Division, Minnesota Department of Human Services, Mental Health Report to the Legislature 12-13 (1994)[hereinafter Report to Legislature].

[11]Id. at 22.

[12]Sharon Krmpotich, Office of Research & Planning, Minnesota Supreme Court, Commitment Filings by Year 1982-1994 (Dec. 1994)(on file with the Minnesota Supreme Court).

[13]Id.

organizations: the state mental health authority, which is part of the Department of Human Services; the local mental health authority, which is under each county's board of commissioners and its administrative agency; and the various mental health service providers with whom the counties contract to provide direct services to clients. In addition to these organizations, clients and their families, advocates, local and state advisory councils, and the state legislature play key roles in shaping the system, as do recently formed state and local coordinating bodies.[14]

The state mental health authority in Minnesota is the Community Mental Health and State Operated Services Administration of the Minnesota Department of Human Services. This agency is responsible for developing policy and monitoring compliance; coordinating system plans; developing new or reorganized service delivery; evaluating performance; developing standards for service programs; providing technical assistance; and allocating funds. In addition, the Department of Human Services operates six multi-disability regional treatment centers, a forensic hospital, and a nursing home that provide direct service to persons with mental illness.[15]

Administration of local community mental health systems is the responsibility of the county boards of commissioners. Each county board is responsible for system planning, for implementing and coordinating programs of service delivery among local providers, for coordinating client care through case management, for deciding how to allocate and expend public mental health resources, and for reporting data and information requested by the Department of Human Services. Most public mental health services in the state are purchased by counties from contract provider organizations, although some counties are also providers of services.[16]

Outpatient services are typically provided by contracted community mental health centers or the outpatient clinics of community hospitals. Residential treatment for county clients is generally provided by private residential facilities, most under sixteen beds. There are twenty-six community mental health centers, and seventy-four adult residential treatment facilities in the state. Counties also contract with community support service providers, and provide most of the case management for the county's clients. Inpatient treatment is contracted from community hospitals or is provided by the regional treatment centers.[17]

A state advisory council and local advisory councils in each county participate in the system. Membership on these councils includes consumers and families, advocates, providers, government staff, and others.

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[14]Report to the Legislature, supra note 10, at 2.

[15]Id. at 2-3.

[16]Id.

[17]Id. at 3-4.

C. AN OVERVIEW OF THE CIVIL COMMITMENT PROCESS

Minnesota's Civil Commitment process is similar to most other states. Some states have a jury trial available, or operate under different time lines, but are basically the same adversarial process.

The first step in the Civil Commitment process is usually referral for a preliminary investigation.[18] Proposed patients are generally referred to the county for a preliminary investigation by family members, individuals concerned about the person, and hospitals. Other sources of referral include social service providers, medical personnel, and law enforcement. Each county has an inter-disciplinary, pre-petition screening team that decides if a petition for civil commitment is an appropriate response to the individual's situation. The team can also identify less restrictive alternatives that are appropriate to the situation.

If the pre-petition screening team recommends civil commitment, the county attorney will usually draft and present the petition to the court, although the county attorney retains the right to refuse to file a petition. If the pre-petition screening team does not recommend commitment, the request for a petition, by a concerned person, can be made directly to the county attorney. The petition must contain a detailed statement of why Civil Commitment is necessary.[19]

As soon as the petition is filed, the court appoints an attorney for the proposed patient, and if necessary, an apprehend and hold order can be issued by the court. The proposed patient may retain a private attorney at his or her own expense, but few do. The proposed patient may also proceed *pro se* if the court can be persuaded the proposed patient is competent to waive the right to counsel. The role of the proposed patient's attorney is to advocate for the client's wishes. If the client's wishes cannot be known, the attorney must advocate for the least restrictive alternative.[20]

Most of the representation of proposed patients is done by private attorneys on contract with the county to provide defense services. The Task Force heard testimony that sometimes proposed patients have problems accessing their attorneys, and that it is likely that the proposed patient may not see the attorney in person before the first court hearing. The Task Force also heard testimony that there are problems related to the time defense attorneys have to prepare in advance. Defense counsel also reported having difficulty in seeking out and recommending placement alternatives.

Intervention can also take place through an emergency response. If there is danger of immediate harm to the person or others, the person may be taken into custody, transported to

[18]Minn. Stat. §253B.07, subd. 1 (1994).

[19]Id. at subd. 2 (1994).

[20]Minnesota Special Rules of Procedure for Commitment, Rule 4, Comment (1982).

a treatment facility, and involuntarily held.[21] The authority to detain rests with police or health officers who must deliver the person to the nearest hospital or treatment facility which handles such problems. Once at the hospital or treatment facility the person may be admitted, voluntarily or under an emergency hold, for emergency care and treatment with the consent of the head of the treatment facility.

If a person has been deprived of liberty through an emergency or peace or health officer hold, he or she has a constitutional right either to have a judicial hearing within a reasonable time or be released. Emergency and peace or health officer holds require a medical examination, and a 72 hour time limit on the hold unless a hearing is held and probable cause is found to continue to hold the person.[22] If the hearing is not held within 72 hours the person must be released. The issue at the hearing is whether the proposed patient poses an imminent threat of physical harm to self or others. The burden of proof is on the party seeking the court hold, by a preponderance of the evidence.

At the preliminary hearing the parties may be willing to settle the case with alternatives to Civil Commitment. The parties may be willing to consider various placement options such as a halfway house, or a continuance of trial on condition of voluntary treatment, or a release before commitment subject to conditions. If settlement is not possible, the matter must be continued for trial. Examiners are appointed by the court, an examination of the proposed patient takes place, and reports are issued.

Before Civil Commitment is ordered by the court, there must be a full adversarial hearing before the court, in which testimony is taken and evidence presented by both the petitioner and the proposed patient. It is usual for the court to appoint an examiner to examine the proposed patient and file a report with the court prior to the hearing.

An examiner is a person who is knowledgeable, trained, and practicing in the diagnosis and treatment of mental illness and is also a licensed physician or licensed psychologist.[23] Prior to the hearing, the court must inform the person of the right to a second independent examiner of the person's choosing to be paid for by the county.[24]

At the completion of the hearing, the court makes its findings of fact and conclusions of law, on the record, justifying the Civil Commitment under the statute, or dismissing the petition. If the order is for Civil Commitment, the court makes the disposition order. The order states the duration of the commitment, and which treatment program is to get custody of the person.

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[21]Id. § 253B.05, subd. 1, 2 (1994).

[22]Minn. Stat. § 253B.05, subd. 3, 5 (1994); Id. at § 253B.06, subd. 3 (1994); Id. at § 253B.07, subd. 7 (1994).

[23]To be an examiner, a licensed psychologist must have a doctoral degree in psychology or have become licensed as a licensed consulting psychologist before July 2, 1975. Id. § 253B.02, subd. 7 (1994).

[24]Id. § 253B.07, subd. 3 (1994). The Task Force heard testimony requesting that additional categories of mental health professionals, such as Licensed Independent Social Workers and Psychiatric Nurses, be allowed to serve as examiners. The Task Force discussed this issue but was not able to reach consensus.

The disposition by the court of the person can be to a public or private facility; to community based treatment; or there can be supervised release before commitment. Although the duration of commitment can vary, persons with mental illness are generally committed for an initial six months. If a hearing at the end of six months shows that the criteria for continued treatment are met, the court can commit for the probable length of commitment necessary or twelve months whichever is less. After twelve months the petition is reviewed. If the commitment is to be continued, a new petition must be filed, after which the commitment is reviewed every twelve months.[25]

During commitment there are periodic reviews done by the treatment program that are submitted to the court.[26] In addition, any person committed as mentally ill can petition to have the commitment reviewed by the court.[27]

While the person is under Civil Commitment, treatment with neuroleptic medications may become necessary. Neuroleptic medications are considered intrusive mental health treatment and have special requirements for administration. Neuroleptic medications can not be administered unless the person is competent and gives informed consent; there is a court order granting authority to administer the medications; or there is an emergency situation.

D. THE NEEDS AND THE RESPONSE

The right of persons with mental illness to be treated in the least restrictive setting that is consistent with their treatment needs has received nearly universal acceptance. Virtually every state, including Minnesota, has incorporated the concept of the least restrictive alternative into the language of its mental health laws and policies.[28] In order to implement this policy, mental health treatment and support services must be accessible in the community in order to reduce the need for involuntary commitment and to allow those persons involuntarily committed to be released to the community after their commitment.

The Task Force heard testimony that indicated emergency holds and commitment are used as ways to gain access to mental health services. There are persons who are committed because the community-based service system is under funded or fragmented. Sometimes commitment and placement in state regional treatment centers is used in order to gain access to mental health services when a person's financial resources have been depleted since the state operated regional treatment centers provide inpatient services at the lowest cost to the county.

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[25]Id. § 253B.12 (1994); Id. at §253B.13, subd. 1 (1994).

[26]Id. § 253B.09, subd. 5 (1994).

[27]Id. § 253.B.17 (1994).

[28]M. Muentz & J. Geller, The Least Restrictive Alternative in the Postinstitutional Era, 40 Hospital and Community Psychiatry (Oct. 1993).

In addition, there are persons who are in need of mental health services and who do not meet the dangerousness criteria for Civil Commitment. The Task Force heard testimony that indicates that persons with mental illness who seek services voluntarily may be turned away from services because they do not meet the statutory criteria for commitment. The Task Force also heard testimony about persons who are not willing to seek treatment voluntarily, and who must decompensate to the point of dangerousness before there can be intervention under the Civil Commitment Act.

The language of the current Civil Commitment Act contemplates a wide variety of possible interventions, however in reality the court has limited choices. The court can either commit, commit and stay the commitment, or dismiss the case. Although there is an option of voluntary or informal admission, the testimony indicated that this is a relatively little used option. Individuals vary greatly in their treatment needs, treatment history, and situation. Many of the Task Force's recommendations are aimed a giving the county and court adequate options for intervention, and the court more dispositional options once intervention has occurred.

In developing the recommendations the Task Force sought to achieve a balance between the intrusion on the civil rights of the person and the extent of the intrusion. The Task Force was ever mindful of the person's due process and privacy rights, and reflected this concern in the procedural protections built into the recommendations.

There were many areas of concern raised that the Task Force was not able to address and go well beyond the commitment process itself such as: the social bias against persons with mental illness; the demeaning process of commitment; the powerlessness of the committed person; and the overwhelming caseloads of county case workers. These are all serious issues which effect the commitment statute, its use and effectiveness, but are not included in this report because of the limited resources of this Task Force, although they could form the basis for further studies.

The judicial process was a major focus of the Task Force's effort. The Task Force considered how new intervention and dispositional options could be created, and how the current judicial procedures could be modified to make the Civil Commitment process more effective, and less dehumanizing.

II. COURT ORDERED EARLY INTERVENTION

Minnesota's Commitment Act contemplates that commitment will be imposed for a variety of services such as community-based nonresidential treatment, community residential treatment, partial hospitalization, acute care hospitalization, and outpatient services. However, the current criteria for commitment, which requires that the person pose a substantial likelihood of physical harm to self or others[29], in most cases will require the person to decompensate to the point

[29]Minn. Stat. § 253B.02, subd. 13 (1994).

at which only involuntary inpatient care is appropriate. This apparent confusion of purpose caused by the juxtaposition of the criteria and the dispositional options may well explain why the community based commitment option provided in the statute is so little used.[30]

A. CURRENT CRITERIA FOR CIVIL COMMITMENT

Typically, jurisdictions limit involuntary civil commitment to persons with (1) severe, significant, gross, or substantial mental illnesses who because of their mental illnesses (2) pose a danger to self or others, or are gravely disabled, and for whom (3) inpatient hospitalization is the least restrictive viable alternative.[31] Minnesota's current statutory commitment scheme is typical and consists of two major components: statutorily defined categories of mental condition that permit commitment, such as mental illness, mental retardation, and chemical dependency; and the criteria for commitment that link the mental condition to specific justifications for requiring involuntary commitment.

In Minnesota, the criteria for commitment has a predictive component. There must be a showing that if the state does not intervene there will be some future harm. Specifically, the person must pose a substantial likelihood of physical harm to self or others as demonstrated by either: a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment, or a recent attempt or threat to physically harm self or others.[32]

The statute also requires that the person be placed in the least restrictive alternative for treatment.[33] This requirement is based on the concept that when the state intervenes, it should not intervene in a way that is more restrictive than necessary. In addition, the court cannot commit a person to a facility that cannot provide treatment to the person.[34]

B. NEW CRITERIA FOR COURT ORDERED EARLY INTERVENTION

The Task Force repeatedly heard testimony that expressed the need for a new form of court ordered intervention. Due to the stringent criteria for commitment, commitment is usually followed by long-term placement in a regional treatment center. Early intervention, with new criteria, may give the court a broader range of appropriate less restrictive services and decrease long-term hospitalization.

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[30]Id. § 253B.093 (1994).

[31]J. Parry, Involuntary Civil Commitment in the 90's: A Constitutional Perspective, 18 Mental & Physical Disability Law Reporter 320, 323 (May-June 1994).

[32]Minn. Stat. § 253B.02, subd. 13 (1994).

[33]Id. § 253B.09, subd. 1 (1994).

[34]Id.

Clearly, commitment should not be used to involuntarily confine non-dangerous persons who, either on their own or with the assistance of others and the state, can reside in the community safely. However, the Task Force found that there are persons with a history of mental illness who routinely reject the care and treatment offered to them on a voluntary basis and as a result decompensate to the point of requiring repeated commitment and long-term psychiatric hospitalization.

The Task Force also heard testimony regarding persons whose mental illness significantly interferes with their ability to care for self and who demonstrates a marked change in behavior. Without court ordered care and treatment, these persons would also predictably deteriorate to the point of commitment and long-term psychiatric hospitalization.

The Task Force was well aware how easily civil rights may be subverted when people are attempting to act in the best interest of others. Therefore, the criteria for the new form of intervention needed to be narrowly drawn in order to target two groups of persons who were highly likely to be committed in the near future if there was no early intervention.

First, the Task Force determined that there are persons with serious and chronic mental illness who revolve through the system, and for whom intervention in the early stages of decompensation can shorten treatment time. Persons who have been repeatedly committed will often exhibit symptoms or behavior substantially similar to those that proceeded and led to one or more of the previous involuntary inpatient treatments. Court Ordered Early Intervention is intended to provide a less intrusive method of court and service intervention before the person decompensates to the point of near tragedy.

Second, the Task Force recognized a group of persons for whom the onset of mental illness may create a marked change in their ability to care for themselves. If there is clear and convincing evidence of what the person would have chosen to do in the situation when having the capacity to make a reasoned decision, the Task Force determined that this group should also be targeted for Court Ordered Early Intervention.

C. FLOW CHART OF THE RECOMMENDED EARLY INTERVENTION PROCESS

The Court Ordered Early Intervention process would require the same due process protections as the Civil Commitment process. Pre-petition Screening would submit a report, a petition would be filed, defense counsel would be appointed, examinations would be ordered, and a hearing would be held within 14 days of the filing of the petition.

The flow chart on page 37 includes the recommended process for Early Intervention.

D. INTENDED EFFECT OF COURT ORDERED EARLY INTERVENTION

The new Court Ordered Early Intervention process is intended to intervene before expensive long-term hospitalization is necessary. Medical professionals testified that if a person can receive treatment in an expeditious manner the chances of recovery are greater, and the length

of hospitalization, if necessary, is shorter. Therefore, the new process is intended to reduce the stigma associated with civil commitment, and the costs associated with long-term hospitalization.

The policy of the least restrictive alternative demands that where special protective or restrictive measures are shown to be necessary because of a person's mental illness, the measures should be as limited in scope and duration as is possible consistent with the needs of the person and society. In keeping with this concept, The Task Force restricted the type of intervention allowed under the Early Intervention process.

If the criteria for early intervention are met, the court may order a variety of interventions including but not limited to day treatment, visits to mental health professionals, medication compliance, and short-term hospitalization not to exceed ten days. The court can not order long-term involuntary hospitalization under an Order for Early Intervention. The Order for Early Intervention is also limited to 90 days in duration.

The criteria were specifically targeted to persons who if left alone would predictably deteriorate to the point of needing commitment. It is intended that the Court Ordered Early Intervention process will not necessarily add to the number of persons in the civil commitment system, but will reach and treat those in need sooner with less expensive treatment options.

E. DEFINITION OF MENTALLY ILL

The current definition of a mentally ill person in the definition section of the Civil Commitment Act both defines mental illness and states the criteria that must be met for Civil Commitment. As a result, a person by statutory definition can not be mentally ill unless they are also dangerous to self or others. This definition will need to be changed since one of the criteria for Court Ordered Early Intervention is that the person is mentally ill. Since Early Intervention is specifically targeted to reach persons before they become dangerous, the current statutory definition of a mentally ill person becomes inappropriate.

The Task Force recommends that the definition of mental illness in the Civil Commitment Act be revised to be consistent with the definition of mental illness in the Comprehensive Mental Health Act. This would allow the criteria for Civil Commitment, and the criteria for Court Ordered Early Intervention to be located in the appropriate sections of the statute. In addition, the change would clarify that the dangerousness criteria is intended to be used to determine the person's eligibility for Civil Commitment, and is not the criteria to be used when diagnosing mental illness or determining if a person is eligible for mental health treatment or services.

RECOMMENDATION:

The Legislature should provide for a new standard of early intervention that allows for a variety of dispositions that are less intrusive than involuntary long-term inpatient hospitalization; and a process to petition for early intervention to provide treatment for a person who:

1. has a mental illness; and

2. refuses to accept mental health treatment or hospitalization; and

3. whose mental illness is manifested by instances of grossly disturbed behavior or faulty perceptions that:

   a. significantly interfere with the person's ability to care for self, and there is clear and convincing evidence of what the person would have chosen to do in the situation when having the capacity to make a reasoned decision;

   or

   b. due to such mental illness, the person:

      i. within the previous three years has twice received court ordered inpatient treatment; and

      ii. is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the involuntary inpatient treatments; and

      iii. unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate to the point of meeting the criteria for civil commitment.

The new process should be as follows:

1. Prior to filing a petition for early intervention, an interested person shall apply to the designated agency in the county of the person's residence or presence for conduct of a preliminary investigation, pursuant to section 253B.07, subdivision 1.

2. Upon the petition by the county attorney for early intervention summons and notice of hearing and examination shall be issued, the early intervention hearing shall be scheduled, and the person shall be examined. The court shall give five days' notice that the hearing will be held and at least two days' notice of the time and date of the hearing.

3. If the person fails to appear for the scheduled examination the court may:

   a. reorder the examination; or

   b. proceed with the hearing and consider the failure to appear as a waiver of the person's right to an examination; and

   c. consider the failure to appear for the examination in determining the merits of the case.

4. A hearing on the petition for early intervention shall be held within 14 days from the date of the filing of the petition at which the court will determine if the person meets the criteria for early intervention, and whether court ordered intervention is necessary. If the person fails to appear for the hearing pursuant to the summons, the court may direct a health officer, peace officer, or other person to take the person into custody and transport the person to the hearing.

5. If the criteria for early intervention are met, and intervention is determined to be necessary, the court may order a variety of interventions including but not limited to: day treatment, medication compliance monitoring, and short-term hospitalization not to exceed 10 days.

6. If short-term hospitalization is necessary, the court shall determine whether a substitute decision maker will be needed to make decisions for the person regarding the administration of neuroleptic medications. The person should not be hospitalized until the process regarding the administration of neuroleptic medication is complete.

7. If it is determined that short-term hospitalization is necessary and the person will not go voluntarily, the court may direct a health officer, peace officer, or other person to take the person into custody and transport the person to the hospital.

8. The order for early intervention shall not exceed 90 days.

9. Any party may request a court hearing to modify the order for early intervention.

Change in Definition of Mental Illness

The Legislature should revise the definition of mental illness as it appears in the definition section of the Civil Commitment Act to be consistent with the language in the Comprehensive Mental Health Act, and remove the criteria for civil commitment from the definition section, relocating the criteria in the judicial commitment section. It should be made clear that the dangerousness criteria are the criteria for civil commitment and not the criteria for the diagnosis of mental illness or qualifications for the receipt of mental health treatment and services.

III. ACCESS TO MENTAL HEALTH TREATMENT FOR INCOMPETENT CONSENTERS

A. CURRENT PROCESS

Under Minnesota's statutory scheme, a person may receive mental health treatment in a variety of ways. One is through informal admission as a voluntary patient. Currently, any person 16 years of age or older may request to be admitted to a treatment facility as an informal, or

voluntary, patient for observation, evaluation, diagnosis care and treatment.[35] The statute expresses a preference for informal admission by consent over involuntary commitment.[36] If a person is to be admitted for treatment through informal admission by consent, it is necessary to determine if he or she has the capacity to give informed consent.

In general, informed consent is consent voluntarily given after explanation and disclosure of information sufficient for the person to make a knowing and willful decision without any element of force, duress or any other form of coercion. If a facility knows or should know that the person is incapable of making an informed decision about his or her admission, the facility can not admit the person as a voluntary patient.[37] As a result, a person who is incompetent to give informed consent, even though he or she is willing to be admitted for treatment, must have the procedures for Civil Commitment initiated.

B. A NEW STREAMLINED PROCESS

The Task Force heard testimony that the commitment process is dehumanizing and difficult for proposed patients and families. However, it is especially difficult to suffer the stigma of Civil Commitment when the person, although incompetent, is not resisting the proposed treatment. Testimony suggested that this is particularly true for elderly persons who do not wish to be committed, but for whom due to incapacity there is no other option. Although a guardian or conservator may admit a ward or conservatee to a regional treatment center, the statute limits the duration of the admission to less than 90 days.[38]

The Task Force determined that a new option, other than Civil Commitment, should be available for persons who are in need of mental health treatment, not resisting treatment, but are incompetent to give informed consent to treatment or admission. The Task Force recommends that the local mental health authority, or its designee, have the authority to give informed consent on behalf of a person agreeing to mental health treatment. If the local mental health authority gives informed consent on behalf of the person, and the person does not refuse treatment, the treatment is allowed. This process is not intended to affect the court process that is required for mental health treatment with neuroleptic medication. Intrusive treatment, including treatment with neuroleptic medications, would still be subject to the separate court processes required for administration of such medications.

The treatment allowed would be subject to the right to expedited review by the District Court,

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[35]Minn. Stat. § 253B.04, subd. 1 (1994).

[36]Id.

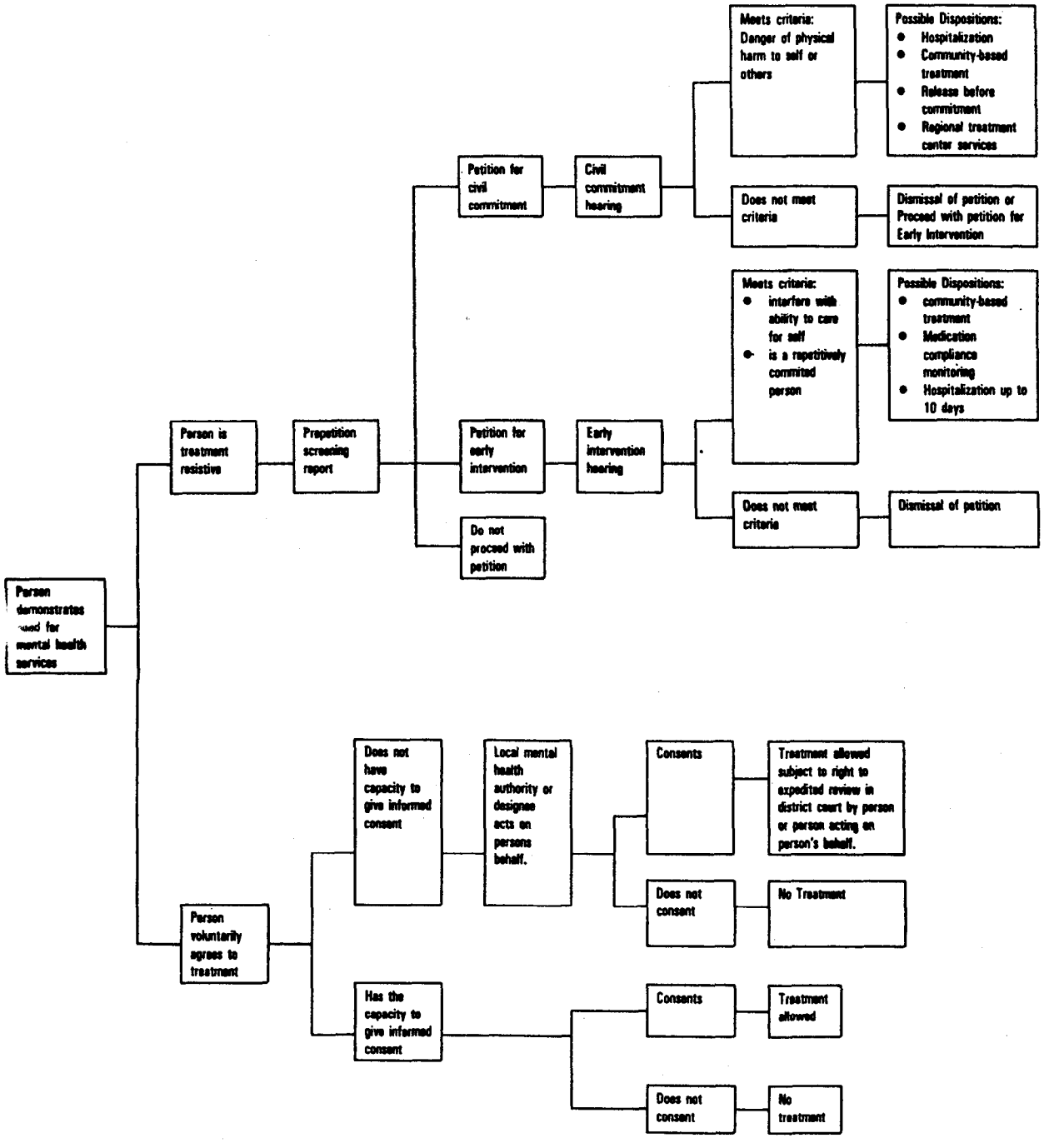
[37]In 1990, the United States Supreme Court found that a patient's complaint was sufficient to state a claim for violation of his procedural due process rights when a Florida state hospital admitted him as a voluntary patient for treatment of mental illness when he was incompetent to give informed consent to his admission. The patient contended that the hospital should have afforded him the procedural safeguards that are required for the involuntary hospitalization of a person with mental illness. Zinermon v. Burch, 110 S.Ct. 975, 977, 990 (1990).

[38]Minn. Stat. § 525.56, subd. 3 (1) (1994).

if the person or a person acting on the person's behalf so requests. If the person decides to refuse treatment, treatment would not be allowed and an involuntary treatment process, if needed, would be initiated.

The flow chart on page 37 includes the recommended process for Access to Mental Health Treatment for Incompetent Consenters.

Proposed Access to Mental Health Treatment



NOTE: This chart does not affect the process required for treatment with neuroleptic medications.

RECOMMENDATION:

The Legislature should provide for streamlined access to mental health treatment for those persons who agree to accept mental health treatment or hospitalization, but for whom there is some question as to their legal capacity to give informed consent to treatment, as follows:

1. The local mental health authority or its designee may give informed consent on behalf of the person;

2. The person, or an interested person acting on his or her behalf, may seek expedited review by the District Court on the issue of the voluntariness of the person's agreement to accept treatment or hospitalization;

3. The local mental health authority shall provide the person with notice of the right to seek expedited review by the District Court, and the right to refuse treatment or hospitalization.

IV. NEW PROCESS FOR THE ADMINISTRATION OF NEUROLEPTIC MEDICATIONS

Forced treatment of patients who will not consent to treatment is a complex and controversial issue. In American society, individuals are generally recognized as having a fundamental right to make important decisions about their own health and mental health treatment. However, the Task Force agreed that it is important to recognize that severe mental illness may hamper an individual's ability to make these critical treatment decisions.

Regarding general health and medical care, the commitment order does not take away the person's civil rights. A competent person, even though committed, can give or withhold consent to general medical care. If the person is incompetent, a surrogate decision maker can give consent to general medical care. If there is no surrogate decision maker the treatment facility can request approval from the court to treat the person. If a person is under a court order for mental health treatment, the person's consent is not required to impose non-intrusive treatment for mental illness.

It is the administration of intrusive mental health treatment, and specifically treatment with neuroleptic medications, which has been highly controversial and extensively litigated. The Task Force heard testimony highlighting problems with the current process for the administration of neuroleptic medications. In response, the Task Force spent a considerable amount of its time discussing this process and making recommendations for change.

A. CURRENT LAW REGARDING ADMINISTRATION OF NEUROLEPTIC MEDICATIONS

Patients Who Are Competent

If the patient is competent, written and informed consent of the patient is needed in order to treat with intrusive mental health care.[39] Intrusive mental health care includes administration of neuroleptic drugs. The purpose of informed consent is to provide information to the person in order for him or her to make a knowledgeable decision about the use of medication as part of his or her treatment. It is intended to educate, share information, and negotiate a solution.

A person is presumed competent unless the petitioner can prove the person lacks:

1. An awareness of having a mental disorder;
2. Sufficient knowledge about the mental disorder and the neuroleptic medication; and,
3. The refusal to take neuroleptic medication is not based upon delusional beliefs.[40]

In addition, policies of the Department of Human Services require that the person has, through evaluation by a physician, all of the following:

1. The ability to comprehend relevant facts about the medication, including both the expected benefits and possible risks of the treatment.
2. An appreciation or rational understanding of his or her mental disorder.
3. Acceptance or refusal of the proposed medication is not based on delusional beliefs.[41]

A competent patient has the option of giving written consent for the use of medication or refusing to give his or her consent. If there is no question regarding the person's competency, the decision to refuse intrusive mental health care can not be overridden except in case of an emergency. An emergency is a situation requiring intervention to prevent or respond to serious immediate physical harm by a person to self or others.

Patients Who Are Incompetent and Not Refusing

When intrusive mental health treatment is recommended and the person is considered incompetent to consent, the medications can be administered if:

1. The patient does not object or refuse the medication;
2. A court-appointed guardian ad litem gives written informed consent; and

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[39]Minn. Stat. § 253B.03, subd. 6c (1994).

[40]In re Peterson, 446 N.W.2d 669 (Minn. Ct. App.), rev. denied (Minn. 1989).

[41]Department of Human Services, Residential Program Management Division, Residential Facilities Manual, Policy Number 6601 (July 1990).

3. A treatment review panel has given written approval.[42]

Patients Who are Incompetent and Refusing

When treatment with neuroleptic medication is recommended and the person is refusing treatment, the process used to decide whether or not the incompetent patient's refusal should be overridden becomes critical. Most jurisdictions require judicial authorization for forced intrusive mental health care. A second opinion of another psychiatrist or the approval of a multidisciplinary panel are generally deemed insufficient to override the person's refusal.[43]

Currently, in Minnesota if the patient is considered incompetent to give written informed consent, the facility cannot administer intrusive treatment over the objections of the patient without a court order, except in emergency situations. The court order to administer neuroleptic medications is obtained through what is commonly referred to as a Jarvis hearing.[44] In Jarvis, the Minnesota Supreme Court held that neuroleptic medications are an intrusive form of treatment and that absent an emergency, a medical director seeking to administer neuroleptic medication to a mentally ill committed patient who objects, must obtain pre-treatment judicial approval. The medical director petitions the committing court for a hearing concerning the administration of neuroleptic medication. The hearing must be held within 14 days from the date of filing the petition, or up to an additional 15 days for good cause shown.

At the Jarvis hearing, the court is to consider six factors in determining the necessity and reasonableness of the treatment:

1. The extent and duration of changes in the patient's behavior patterns and mental activity affected by the treatment;
2. The risks and adverse side effects to the patient;
3. The experimental nature of the treatment;
4. The acceptance of the proposed treatment by the medical community of Minnesota;
5. The extent of intrusion into the patient's body and the pain connected with the treatment; and,
6. The patient's ability to competently determine whether the treatment is desirable.[45]

The Task Force heard testimony that generally 95% of the motions for court ordered treatment with neuroleptic medications are granted by the courts.

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[42]Minn. Stat. § 253B.03, subd. 6c(d) (1994).

[43]National Council of Juvenile and Family Court Judges, Civil Commitment, 38 Juv. & Fam. Ct. J. 41 (1987).

[44]Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988).

[45]Price v. Sheppard, 307 Minn. 250, 239 N.W.2d 905 (1976).

B. NEW PROCESS FOR THE ADMINISTRATION OF NEUROLEPTIC MEDICATIONS

The Task Force heard a significant amount of testimony that the process for requesting a court order for neuroleptic medication was unnecessarily delaying treatment. Mental health professionals testified to the delays in treatment and the feeling that patients were spending too much time waiting in hospitals before treatment could begin. The physicians also testified that the chance of a successful outcome for the patient was reduced if the illness was allowed to continue untreated. The Task Force sought to create a new process for the administration of neuroleptic medications that would adequately protect the civil rights of the patients and yet provide needed treatment in a more timely manner.

It was suggested that the new process be designed so that it could be initiated early in the patient's hospitalization, rather than waiting until the commitment was complete and then filing a petition for a Jarvis hearing. It was also considered desirable if the process could be utilized with the Early Intervention process. It is expected that allowing the treatment of the mental illness early in the intervention process may allow the person to stabilize and avoid commitment altogether.

C. THE FIRST STEP: THE COURT DETERMINES CAPACITY

The Task Force recommends that the court should make a finding regarding the capacity of a person to consent to neuroleptic medications at the earliest possible point in the intervention process, unless the patient already has a court appointed guardian or conservator with the authority to consent to medical treatment. Absent a prior appointment of a guardian or conservator, the person's capacity would be presumed, and the burden of proving lack of capacity would be on the petitioner. The judge shall weigh three factors in determining the person's capacity to make decisions about the use of neuroleptic medications. These factors are generally, the person's awareness, understanding, and communication of a reasoned decision, not based on delusion.

Whenever possible, at the Preliminary Hearing, the court shall make a preliminary finding based on a showing of probable cause whether or not the person lacks capacity to give informed consent. At a Civil Commitment Hearing or Early Intervention Hearing, the court shall make a finding of fact, concerning capacity, based on a preponderance of the evidence. If a preliminary finding as to capacity was made at a prior hearing, the court shall review that determination and, based on a preponderance of the evidence presented, either affirm or reverse the earlier court finding.

D. APPOINTMENT OF A SUBSTITUTE DECISION MAKER

If the court finds that the person has the capacity to make an informed decision with regard to the administration of neuroleptic medication, the person's informed consent or informed refusal must be followed.

If the court determines the person does not have the capacity to make an informed decision regarding neuroleptic medication, the court must designate a substitute decision maker to make decisions with regard to neuroleptic medication on the person's behalf. The Task Force heard significant testimony from patients regarding the desire to have their opinions regarding medications more fully considered by the medical personnel. They testified as to feeling left out of the process. The substitute decision maker should be able to assist both the patient and the medical personnel in this process.

The substitute decision maker could be a proxy in a health care power of attorney or advance mental health directive. If no previously appointed substitute decision maker exists, or if a guardian, conservator, or proxy refuses or is not available to serve, the court shall appoint a substitute decision maker. The Task Force intended there to be flexibility in the court's selection of a substitute decision maker if no designated one is available. The substitute decision maker appointed by the court can be an individual such as a friend or family member. In addition, the local mental health authority can establish a multi-disciplinary panel, which can be community based or institutional based, to serve as the substitute decision maker. The substitute decision maker should be appointed immediately, or within 24 hours. Whenever possible this appointment should be made at the time of the Preliminary Hearing.

E. THE DECISION TO CONSENT OR REFUSE

If the person's treating physician recommends treatment with neuroleptic medication, the substitute decision maker will need to talk with the patient to determine his or her wishes, and also discuss with the physician the reasons for selecting the course of treatment and the particular medications. The substitute decision maker shall then review the recommendation and give or withhold consent. If the substitute decision maker gives consent, and the person does not refuse, the person may be treated with neuroleptic medications and the court shall be so informed. If either the substitute decision maker or the person refuses treatment, the person may not be treated without a court order. In most instances, the refusal will be considered by the court at the Civil Commitment or Early Intervention Hearing.

If either the substitute decision maker or the person refuses to consent, then at the hearing the court shall review the reasonableness of the substitute decision maker's decision based on the criteria and the person's reasons for refusing, if any, and enter an order either granting or denying the authority to administer the neuroleptic medication.

F. STANDARDS FOR MAKING A SUBSTITUTE DECISION

If the person has clearly stated what he or she would have chosen to do in this situation when having the capacity to make a reasoned decision, the person's wishes shall be followed using substituted judgment. This evidence includes written instruments, including health care powers of attorney and advance mental health directives.

If evidence of the person's wishes regarding the administration of neuroleptic medications is conflicting or lacking, the decision shall be based on what a reasonable person would do,

taking into consideration the person's values; the medical risks, benefits, and alternatives; success of past treatments; and any other relevant factors.

G. CHANGES DURING THE DURATION OF A CIVIL COMMITMENT OR EARLY INTERVENTION ORDER

Withdrawal of Consent

If at any time after treatment with neuroleptic medication begins, the substitute decision maker withdraws consent, and the court has not previously entered an order granting the authority to administer the neuroleptic medications, the person may not be treated without a court order to continue medications based on a review of the substitute decision maker's decision.

If at any time after treatment with neuroleptic medication begins, the patient changes his or her mind and decides to refuse the neuroleptic medication, and the court has not previously entered an order granting authority to administer the neuroleptic medications, a motion must be filed with the court for an order to continue medication and a hearing held, to review the substitute decision maker's decision. Treatment with neuroleptic medication can continue pending the outcome of the hearing.

Change in Capacity

Following the entry of a Civil Commitment or Early Intervention Order, any party may file a motion with the court, either to restore a person to capacity, or to initiate the process for approval to administer neuroleptic medications.

H. ENFORCEMENT OF THE CONSENT OR ORDER

Absent the changes set forth in "G" above, the informed consent of a substitute decision maker or a court order for authority to administer neuroleptic medication, is enforceable until the person is discharged from Civil Commitment or an Early Intervention Order.

Testimony indicated that currently community-based services are reluctant to enforce Jarvis orders. The Task Force discussed at length whether or not this new process could be used in non-hospital settings. The Task Force's concern centered on the need for the use of physical force to administer the medications involuntarily. The use of physical force was determined to effect both the intrusiveness of the treatment and the safety of the patient. The Task Force decided that if physical force is required to administer the neuroleptic medication, precautions must be taken to ensure humane treatment of the patient. The Task Force decided to limit the use of physical force to treatment facilities or therapeutic settings where the person's condition and need for neuroleptic medications can be reassessed and appropriate medical staff are available to administer the medication.

I. STREAMLINING THE PROCESS

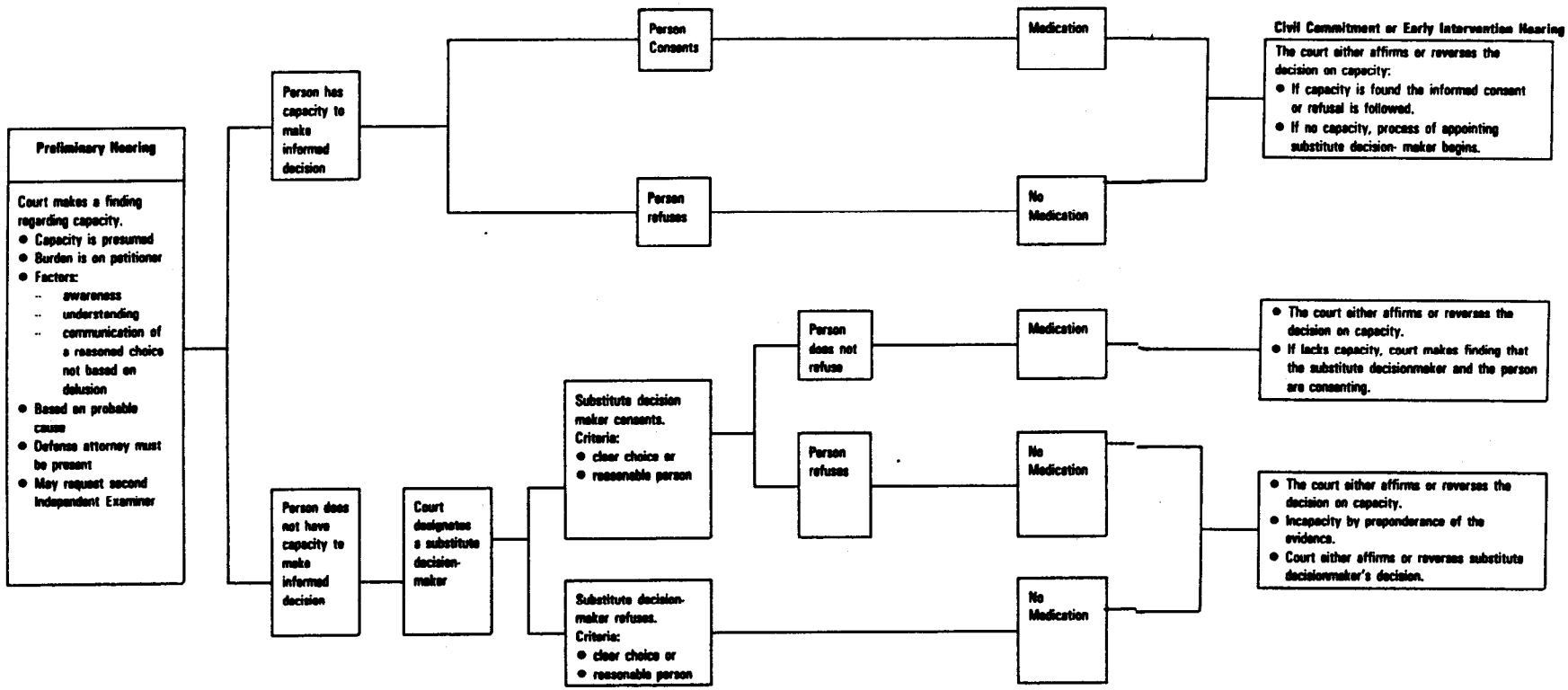
Currently, the process to secure a Jarvis medication order can often take up to 32 days. The Task Force anticipates that the new process would ordinarily take fourteen days, and in many cases may take less. Whenever possible, the new process will begin at the Preliminary Hearing and conclude with the Civil Commitment or Early Intervention Hearing. Therefore, the new process will provide treatment in a more timely manner to patients. The process can be used with the Early Intervention process, making orders for neuroleptic medication possible in non-hospital settings.

It is also expected that the number of persons requiring hearings on the substitute decision maker's decisions will be less than the current number of Jarvis hearings conducted. For incompetent consenting patients, the process should be much more efficient.

For the incompetent refusing patient, the insertion of a substitute decision maker will provide the opportunity for a third party to enter the discussion with the mental health professionals and the patient. It is expected that many patients will not refuse treatment if a substitute decision maker has been involved in the process.

For those patients who refuse to consent, they will receive a full court hearing before the medication is administered. The flow chart on page 45 outlines the Proposed Process for Administration of Neuroleptic Medication.

Proposed Process for the Administration of Neuroleptic Medication



RECOMMENDATION:

The Legislature should revise the statutory process for the administration of neuroleptic medication to persons under a court order for mental health treatment or hold to provide that unless the person already has a guardian or conservator with the authority to make medical decisions for the person, and where treatment with neuroleptic medication is anticipated, the court shall make a finding whether the person does or does not have the capacity to make an informed decision regarding the administration of neuroleptic medication.

1. The petition and the physician's statement must address the question of capacity.

2. The pre-petition screening report shall include the information and facts the pre-petition screening team has which could assist the court in assessing capacity and determining the existence of a guardian, conservator, or proxy. If a guardian, conservator, or proxy is identified, he or she shall receive notice of the proceedings. If it appears that treatment with neuroleptic medications will be considered, the pre-petition screening report should include any information the team may have regarding whether the person is likely to consent or refuse neuroleptic medication.

3. If the petitioner questions the person's capacity to give informed consent, at the Preliminary Hearing the court shall make a preliminary finding based on a showing of probable cause whether or not the person lacks capacity to give informed consent. If lack of capacity is found, a substitute decision maker shall be appointed with the authorization to give or withhold consent to the administration of neuroleptic medication, subject to the person's acquiescence.

4. The substitute decision maker shall be an individual or a multi-disciplinary panel, community or institutional, designated by the local mental health authority. The authority of the substitute decision maker shall last for the duration of the court order or until the person is found to have capacity to give informed consent, whichever is earlier.

5. If both the substitute decision maker and the person consent to treatment with neuroleptic medications, treatment is authorized and may begin immediately. If either the substitute decision maker or the person refuses consent, the matter shall be considered at the Civil Commitment or Early Intervention Hearing.

6. If a preliminary finding as to capacity was made, the court shall review that determination at the Civil Commitment Hearing or Early Intervention Hearing, and make a finding of fact, based on a preponderance of the evidence presented, either affirming or reversing the preliminary finding. If there is no preliminary finding, the court may address the issue of capacity at the Civil Commitment or Early Intervention Hearing.

7. When a substitute decision maker was appointed at the Preliminary Hearing, at the Civil Commitment or at the Early Intervention Hearing:

a. If the substitute decision maker has consented to neuroleptic medications, and the person is not refusing, the court shall simply make a finding that consent has been given and treatment is authorized.

b. If either the substitute decision maker or person refuses to consent to neuroleptic medications, the Court shall review the decision and issue an order either approving or denying authorization to administer neuroleptic medications.

8. If no substitute decision maker was appointed at the Preliminary Hearing, and the person is found to lack capacity at the Civil Commitment or Early Intervention Hearing, the court shall then appoint a substitute decision maker.

9. There is a legal presumption of capacity to make decisions regarding administration of neuroleptic medications. The burden is on the petitioner to prove incapacity by a preponderance of the evidence. The judge shall weigh the following factors in determining the person's capacity to make decisions about the use of neuroleptic medications. When appropriately presented with information:

a. Does the person demonstrate an awareness of the nature of his or her situation, including reasons for hospitalization, and the possible consequences of refusing treatment with neuroleptic medications?

b. Does the person demonstrate a factual understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives? Factual understanding does not have to be scientific.

c. Does the person communicate a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on delusion, even though it may not necessarily be what is in the person's best interest? Communication of the choice may be verbal or non-verbal. Disagreement with the doctor's recommendation is not per se evidence of an unreasonable decision.

10. If an order for Civil Commitment or Early Intervention does not grant authority to administer neuroleptic medication, the treatment facility can file a motion with the court to initiate the process for administration of neuroleptic medications.

The matter shall proceed in the same manner as if the request were made at the Preliminary Hearing prior to Civil Commitment or Early Intervention.

11. If the court finds that the person has the capacity to make an informed decision with regard to the administration of neuroleptic medication, the person's informed consent or informed refusal must be followed.

12. If the court determines the person does not have the capacity to make an informed decision regarding neuroleptic medication, the court must designate a substitute decision maker, within 24 hours or less, to make decisions with regard to neuroleptic medication on the person's behalf.

13. If the person's treating physician recommends treatment with neuroleptic medication, the substitute decision maker shall review the recommendation, discuss it with the patient, and give or withhold consent. If the substitute decision maker gives consent to treatment with neuroleptic medications, and the person does not refuse, the person may be treated and the court so notified.

14. If the substitute decision maker refuses consent or the person refuses, the person may not be treated without a court order. The court shall review the reasonableness of the substitute decision maker's decision based on the standards for substitute decision makers, and enter an order upholding the decision, or reversing the decision and granting authority to administer neuroleptic medication, within 7 days of the Preliminary Hearing.

15. If at any time after treatment with neuroleptic medication begins, the substitute decision maker withdraws consent, the person may not be treated without a court order to continue medications based on a review of the substitute decision maker's decision.

16. If at any time after the medications have begun to be administered, pursuant to consent by the substitute decision maker, and the patient changes his or her mind and decides to refuse the neuroleptic medication, a motion must be filed with the court for an order to continue medication and a hearing must be held within 7 days, to review the substitute decision maker's decision. Treatment with neuroleptic medication can continue pending the outcome of the hearing.

17. A second, independent medical opinion may be obtained by the court or any party objecting to the medication. A request for a second examiner must be made at the Preliminary Hearing. The second opinion must be rendered by a medical doctor who is knowledgeable, trained, and practicing in the diagnosis and treatment of mental illness.

18. When the person lacks the capacity to make decisions regarding the administration of neuroleptic medication, the substitute decision maker and the court shall use the following standards in making a decision regarding administration of neuroleptic medications:

    a. If the person has clearly stated what he or she would have chosen to do in this situation when having the capacity to make a reasoned decision, the person's wishes shall be followed using substituted judgment. This evidence includes written instruments, including health care powers of attorney and advance mental health directives.

    b. If evidence of the person's wishes regarding the administration of neuroleptic medications is conflicting or lacking, the decision shall be based on what a reasonable person would do taking into consideration the following:

        i. the person's family, community, moral, religious, and social values;

ii. the medical risks, benefits, and alternatives to the proposed treatment;

iii. past efficacy and any extenuating circumstances of past use; and

iv. any other relevant factors.

19. The informed consent of a substitute decision maker or a court order for authority to administer neuroleptic medication, is enforceable until the person is discharged from Civil Commitment or an Early Intervention Order, or until the person is determined by the court to have the capacity to give informed consent, whichever is earlier.

20. If physical force is required to administer the neuroleptic medication, such force shall only take place in a treatment facility or therapeutic setting where the person's condition can be reassessed and appropriate medical staff are available.

21. A substitute decision maker who consents to treatment is not civilly or criminally liable for the performance of or the manner of performing the treatment. A person is not liable for performing treatment without consent if the substitute decision maker has given proper written, informed consent. This provision does not affect any other liability that may result from the manner in which the treatment is performed.

22. This new process for administration of neuroleptic medication is not intended to effect the provisions for emergency situations in current law.

23. A hearing may be requested pursuant to Minn. Stat. § 253B.17 (1994) if the patient or any interested person believes that circumstances have changed and the court's order concerning capacity or treatment with neuroleptic medications is no longer just or equitable.

V. STRENGTHENING THE PROVISIONAL DISCHARGE PROCESS

Eventually, persons committed as mentally ill will be released to the community since they have a determinate disposition. Only a few will continually meet the criteria for recommitment. A full discharge from commitment removes all legal control over the person. In general, it is the head of the treatment facility who decides when the patient should be fully discharged. The court can also review the commitment and discharge the patient, or the discharge can occur simply as a result of the commitment period ending. When treatment is completed or the jurisdictional time expires, the patient must be discharged. Petitions for recommitment may be filed prior to the expiration of the previous petition.

For most patients who have been committed, the first step back into the community is a Provisional Discharge. Provisional Discharges essentially release patients from the physical control of the facility, but not from the commitment order. A Provisional Discharge may not exceed the length of the court ordered commitment. In general, the head of the treatment facility makes the decision of when and to where the patient should be Provisionally

Discharged.[46] Before a Provisional Discharge is granted, patients must be assigned a case manager at the county level, and must have an aftercare treatment program plan. The aftercare plan is monitored by the case manager and can be altered during the Provisional Discharge.

The aftercare plan specifies the services and treatment to be provided, the financial resources available, the expected length of the Provisional Discharge, the requirements for granting full discharge, and conditions or restrictions on the patient during the provisional discharge. The aftercare plan is reviewed on a quarterly basis by the patient, designated agency and other appropriate persons. The aftercare plan must contain the grounds upon which the Provisional Discharge may be revoked.[47]

A. CURRENT LAW REGARDING REVOCATION OF PROVISIONAL DISCHARGES

The court's function does not end with the commitment order. Jurisdiction of the court is kept open for enforcement and review procedures. When necessary, a Provisional Discharge can be revoked if certain due process protections are followed. The criteria for revocation require that the person has either violated material conditions of the Provisional Discharge, creating a need to return to the facility; or that there is a serious likelihood that the safety of the patient or others will be jeopardized.[48] Currently, it is the head of the treatment facility that may revoke a Provisional Discharge. The designated agency, or any interested person may request the revocation of the person's Provisional Discharge.[49]

Revocation is commenced by a notice of intent to revoke Provisional Discharge, which is served upon the patient, the patient's attorney, and the designated agency. If a review of the intended revocation is requested, by the patient or any interested person, the head of the treatment facility files with the committing court a petition for review, and a hearing on the petition must be held within 14 days. If no review is requested within 14 days, the revocation is final and the court, without a hearing, may order the patient returned to the facility.[50]

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[46]Minn. Stat. § 253B.15, subd. 1 (1994).

[47]Id.

[48]Revocation of provisional discharge. The head of the treatment facility may revoke a provisional discharge if:

(i) The patient has violated material conditions of the provisional discharge, and the violation creates the need to return the patient to the facility; or,

(ii) There exists a serious likelihood that the safety of the patient or others will be jeopardized, in that either the patent's need for food, clothing, shelter, or medical care are not being met, or will not be met in the near future, or the patient has attempted or threatened to seriously physically harm self or others.

Id.

[49]Id.

[50]Id. at subd. 3, 4 (1994).

B. THE TWO EXCEPTIONS

Currently, the standard revocation process, which may take 28 days or more to implement a return to the facility, has two exceptions. First, the case manager may apply to the committing court for an order returning the person immediately to the facility if it can be shown that it is necessary to avoid serious, imminent harm to the patient or others.[51] This is commonly referred to as the emergency revocation.

Second, during the first 60 days of Provisional Discharge, the case manager, upon finding that either of the criteria for revocation are met, may revoke the Provisional Discharge, without being subject to the due process requirements set forth in the standard revocation process.[52] In 1984, the Minnesota Supreme Court, in the Peterson case, limited the ability of case managers to revoke Provisional Discharges within in the first 60 days of Provisional Discharge by determining that the head of the facility does not have absolute and final discretion to revoke a Provisional Discharge within the 60 day period.[53]

The Court decided that within the first 60 days of Provisional Discharge a brief rehospitalization, without a prior hearing is authorized, provided that within 48 hours of rehospitalization the court, patient, and patient's counsel is provided with an affidavit detailing the patient's recent actions and the reasons for the rehospitalization. If the patient challenges the revocation he or she may file an affidavit with the court contesting the revocation and the court must then make a threshold determination of whether there exists a genuine issue as to the propriety of the revocation.[54] The court may then either affirm the revocation, or set the matter for hearing. These proceedings must be completed within five days of the rehospitalization.[55]

The Task Force reviewed the current process for revocation, the exceptions, and the Peterson case. The Task Force noted that the due process requirements of the Peterson case have not been incorporated into the current statute.

C. CREATION OF ONE PROCESS FOR REVOCATION

The Task Force heard testimony indicating that it is unnecessary to have one type of revocation for less than 60 days, and another type of revocation for over 60 days. The testimony indicated that the lengthy process required for revocations over 60 days is so

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[51] Id. at subd. 5 (1994).

[52] Id. at subd. 6 (1994).

[53] In Re Peterson, 360 N.W.2d 333, 335 (Minn. 1984).

[54] Id. at 335-36.

[55] Id. at 336.

burdensome, and similar to a full commitment hearing, that the process is rarely used. As a result, patients over 60 days into their Provisional Discharges are most likely left to decompensate in the community until either an emergency occurs or recommitment procedures can be initiated.

To make revocation a more viable option for all patients, the Task Force recommends that the designated agency, not the head of the treatment facility, be responsible for revocations. The Task Force noted that it is the designated agency that has the responsibility to monitor the person's aftercare plan and success in the community. The designated agency is the party most aware when situations arise that indicate revocation should be considered. The designated agency would need to demonstrate that every effort has been made to avoid revocation and that revocation is the least restrictive alternative under the circumstances. The designated agency would need to coordinate the revocation, with the appropriate treatment facilities to ensure proper placement is available.

The Task Force also recommends that only one process be used for revocation of Provisional Discharges. The recommended process is similar to the current process required for revocations of less than 60 days. The timeline would be shortened to allow five days for a person, or his or her counsel, to contest the planned revocation rather than the current 14 days. If the revocation is contested the hearing must be held within three days of the filing of the affidavit, unless extended for five days upon good cause shown, rather than the current 14 days. This will make revocation a more viable alternative for persons who have been on Provisional Discharge for more than 60 days.

This new single process also allows for hospitalization upon notice of the planned revocation, without a prior hearing, if the provisional discharge is being revoked because there exists a serious likelihood that the safety of the person or others will be jeopardized, in that either the person's need for food, clothing, shelter, or medical care is not being met, or will not be met in the near future, or the person has attempted or threatened to seriously physically harm self or others.

The Task Force recommends that if the person is hospitalized without a prior hearing, all of the revocation procedures must be followed and completed within five days of the notice of planned revocation. However, the timeline for filing the affidavit contesting the planned revocation is shortened to within 48 hours after receipt of the notice. If the affidavit is not filed within 48 hours, the revocation of provisional discharge becomes final. This process allows for immediate hospitalization, and complies with the due process mandates of the Peterson case. Since a person can be hospitalized without a prior hearing, there should be no need to use the emergency revocation procedure currently provided in the statute. In order to provide the most appropriate, and least restrictive treatment, the designated agency can arrange for the person to be returned to the treatment facility from which he or she was discharged, or to another treatment facility that agrees to accept the person.

D. OTHER IMPROVEMENTS

The Task Force considered ways to improve supervision of persons on provisional discharge in the community. Testimony indicated that although contemplated in the language of the statute, some courts will not extend the commitment of a person through the recommitment process when the intent of the designated agency is to continue the person on Provisional Discharge status. When it is necessary for the continued success of the person in maintaining community placement, the Task Force recommends clarifying that if the person meets the criteria, the court can extend commitment though the recommitment process or by utilizing the new Early Intervention process.

There was testimony to indicate that the person's attorney was not always aware when the person is given a Provisional Discharge and may not be informed until the need for revocation becomes apparent. Therefore, it was suggested that a copy of the aftercare plan developed for a person released on Provisional Discharge be given to the person's attorney.

Currently, it is the head of the treatment facility that writes the recommitment reports.[56] The Task Force noted that when a person is on Provisional Discharge in the community and needs continued commitment, it is the designated agency that would have the most up to date information on the person and his or her need to have continued commitment. Therefore, the Task Force recommends that when a person is on Provisional Discharge in the community, the county case managers shall be responsible for providing recommitment reports to the court.

RECOMMENDATIONS:

1. The Legislature should provide that supervision of persons on provisional discharge in the community be strengthened, when necessary to the continued success of the person in maintaining community placement, by modifying the statute to provide that:

   a. The court may extend the commitment of a person through the recommitment process; or utilize the Early Intervention process, to extend the court's supervision of a person who is receiving services in the community.

   b. A copy of the aftercare plan developed for a person released on provisional discharge shall be given to the person's attorney.

   c. When a person is on provisional discharge in the community and needs continued commitment, the county case managers shall be responsible for providing recommitment reports to the court.

2. The Legislature should revise the statutory process for revocation of provisional discharge to provide that:

[56]Minn. Stat. § 253B.12, subd. 1 (1994).

a. The designated agency, not the head of the treatment facility, is responsible for the revocation of provisional discharges.

b. The designated agency may revoke a provisional discharge if:

i. The person has violated material conditions of the provisional discharge, and the violation creates the need to return the person to a more restrictive setting;

or

ii. There exists a serious likelihood that the safety of the person or others will be jeopardized, in that either the person's need for food, clothing, shelter, or medical care is not being met, or will not be met in the near future, or the person has attempted or threatened to seriously physically harm self or others.

The designated agency must demonstrate that every effort has been made to avoid revocation, and that revocation of provisional discharge is the least restrictive alternative available.

c. Only one process be used for revocation of provisional discharges, whether the revocation occurs within the first 60 days of the provisional discharge or after the first 60 days. The process for revocation of a provisional discharge should also provide for hospitalization of the person, without a prior hearing.

i. The designated agency shall commence the revocation process by notifying the person, the person's attorney, and the treatment facility of the planned revocation. This notice shall set forth the grounds upon which the planned revocation is based, and shall inform the person of his or her rights under this chapter.

ii. The designated agency shall provide the court, within 48 hours of the notice, a copy of the notice and a report reciting the recent actions of the person and the reasons for the planned revocation.

iii. The report should be in sufficient detail to enable the court to make a finding as to whether revocation of the provisional discharge is necessary, and shall include specific efforts made to avoid revocation.

iv. A copy of the report should be provided to the person, his or her attorney, and the treatment facility within the same 48 hour period.

v. The person may challenge the basis for the planned revocation of the provisional discharge by filing an affidavit with the court specifying the reasons for contesting revocation. The burden of proof shall be upon the party seeking revocation. If no affidavit contesting the revocation is filed

by the person or his or her attorney within five days of receiving the notice, the revocation of provisional discharge becomes final.

vi. If an affidavit contesting the revocation is filed, the court should then make a threshold determination of whether there exists a genuine issue as to the propriety of the revocation.

vii. If the court finds no genuine issue, the revocation of the provisional discharge becomes final.

viii. If a preliminary showing of a valid challenge to the propriety of the revocation is made, the court may take steps necessary under the circumstances, including setting the matter for a hearing on the merits. This hearing shall be held within three days of the filing of the affidavit, unless continued for an additional five days for good cause shown. After a hearing on the merits, if the court does not find factual basis for revocation, the person retains provisional discharge status, if the court finds factual basis for revocation, the revocation becomes final.

ix. If it is necessary to hospitalize a person, prior to a hearing:

a) The person may be hospitalized, without a prior hearing, upon notice of the planned revocation, if the provisional discharge is being revoked because there exists a serious likelihood that the safety of the person or others will be jeopardized, in that either the person's need for food, clothing, shelter, or medical care is not being met, or will not be met in the near future, or the person has attempted or threatened to seriously physically harm self or others.

b) If the person is hospitalized the above procedures are followed, however, the affidavit contesting the planned revocation must be filed within 48 hours of receipt of the notice. If the affidavit is not filed within 48 hours, the revocation of provisional discharge becomes final. The filing of the notice and report; the filing of the affidavit contesting; a threshold determination by the court; and if needed, a hearing on the merits shall be completed within five days of notice of planned revocation.

c) The person may be returned to the treatment facility from which he or she was discharged, or to another treatment facility that agrees to accept the person.

e. When a person's provisional discharge is revoked, the person's voluntary return to a more restrictive setting does not discharge the person's civil commitment.

f. The new process for revocation of provisional discharge should be applicable to

persons committed as chemically dependent, and those committed as mentally retarded as well as those committed as mentally ill.

3. The Legislature should provide that the new process for revocation of provisional discharge be applicable to persons committed as chemically dependent, and those committed as mentally retarded as well as those committed as mentally ill.

VI. EQUITABLE DELIVERY OF SERVICES

Long-term inpatient mental health services are provided to adults with mental illness through five state-operated Regional Treatment Centers located throughout the state. In 1994, there were 1,370 inpatient beds available for adults in the Regional Treatment Centers.

Each Regional Treatment Center has a specified geographic or catchment area that it serves. The catchment areas are quite large, which means persons in need of services must be transported from their county of residence to the Regional Treatment Center servicing their catchment area. The Anoka-Metro Regional Treatment Center serves the entire metropolitan area which includes nearly half the population of the state. The number of committed persons in the Anoka-Metro Regional Treatment Center's catchment area generally exceeds the Center's capacity. This necessitates the diversion of patients to Regional Treatment Centers in other parts of the state. The Department of Human Services is currently purchasing beds in community hospitals to serve the needs of some committed patients, and to decrease diversions. However, this alone has not eliminated the problem.

The Task Force heard testimony that the geographic and demographic characteristics of the state, and the diversion of patients out of their catchment areas, creates delays in hearings, added court costs, and excessive transporting of patients. This means that some patients are transported long distances, while others are not. Some patients have their hearings delayed, while others do not. The situation, in general, creates an inequity in the way patients experience the Civil Commitment process. The Task Force considered various strategies that could be used to improve the situation.

A. REVISING THE RULES OF COURT

The Task Force considered how changes to the rules of court could alleviate some of the problems created by the patient receiving services in one county, and having the court process take place in his or her county of residence.

Use of Medical Records at Recommitment Hearings

Prior to the termination of the initial commitment order or final discharge of the patient, the head of the treating facility files a written report with the court stating whether or not the

patient needs to continue to be committed.[57] Before the committing court makes a final determination on the need to continue commitment, a hearing must be held.[58]

An extensive medical record is usually accumulated during the period of commitment. This medical record is generally utilized by the court in making its determination as to the need for continued commitment. Currently, the medical record is entered into evidence by calling a witness from the treatment facility.

The calling of this witness to present the medical record creates additional scheduling concerns and travel demands. The Task Force recommends giving the court the discretion of making the decision of whether or not to recommit a person based on the testimony of other witnesses and copies of the medical record without requiring a person from the treatment facility to present the medical record. This recommendation parallels the language change in the statute made last session regarding the administration of neuroleptic medication.[59]

Use of Telephone Testimony at Commitment Hearings

When a committed patient is placed in a treatment program that is located some distance from his or her county of commitment, any type of hearing may require travel by witnesses, attorneys, the patient, or human services staff. The Task Force discussed holding hearings at the location of the patient. This option would save travel of the patient, and treatment facility staff, but then the patient's friends, family, defense counsel, and county human services staff would have to travel to attend the hearing at the facility.

After lengthy discussion the Task Force continued to support having the hearings held in the county of commitment. In order to relieve some of the travel burden, the Task Force recommends that both testimony by telephone, and interactive video be admissible at the discretion of the court for commitment hearings for persons with mental illness.

The Task Force heard testimony that some courts are already successfully admitting telephone testimony by psychiatrists. Admission of telephone testimony would make the psychiatrists more accessible to the court and expedite scheduling of the hearing. The Task Force determined that if this method of testimony appeared to be detrimental to the patient, the court would have discretion as to whether or not to allow testimony by telephone.

Use of Interactive Audio-Video Testimony at Commitment Hearings

Use of interactive audio-video communications is intended to save time, court costs, and transportation costs. The Minnesota Supreme Court has approved two pilot projects in which testimony will be admitted through the use of interactive audio-video technology in Civil

[57]Minn. Stat. § 253B.12, subd. 1 (1994).

[58]Id. at subd. 4 (1994).

[59]Id. at 253B.03, subd. 6c (k) (1994).

Commitment hearings.[60] The two projects are virtually identical. In general, the court would receive the testimony of the patient, the physician, or other witnesses physically located at the treatment facilities, through interactive audio-video communications. The judge, county attorney, and other court personnel would be located at the courthouse in the county of commitment. Other witnesses could be at either location as appropriate.

The transmission path of the audio-video communications must be secured against electronic eaves-dropping. No persons will be allowed to attend the hearing at either location who would not be permitted to attend the hearing had it been conducted entirely in the courtroom.

The defense counsel, on behalf of the patient, has the right to object to the use of interactive audio-video testimony if it appears not to be in the patient's best interest. The patient should be given information in writing regarding the right to object to the use of interactive audio-video testimony.

RECOMMENDATION:

The Minnesota Supreme Court Advisory Committee on Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act should provide that:

1. During recommitment hearings the court may base its decision on relevant and admissible evidence, including the testimony of a treating physician or other qualified physician, a member of the patient's treatment team, a court appointed examiner, witness testimony, or the patient's medical records.

2. While in person testimony is preferred, judges should have discretion to admit telephone testimony and testimony by interactive television at commitment hearings for persons with mental illness, and the Supreme Court Advisory Committee on Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act should set standards for the use of such testimony, taking the best interest of the person into consideration.

B. DEVELOPING TRANSPORTATION ALTERNATIVES

During the course of a person's involvement with the Civil Commitment system there are numerous occasions which will necessitate the transport of the person. The agencies which are financially responsible for the various types of transport are identified in the statute. Diversions to a distant Regional Treatment Center place significant burdens on the patients, their families, county staff, and the sheriff's department.

[60]The First Judicial District requested approval for a pilot project in February of 1995. The Second Judicial District requested approval for a pilot project in September of 1995. On March 22, 1990, the Fourth Judicial District filed a final report with the Supreme Court on its successful "Interactive Audio Video Demonstration Project". This project utilized interactive television for Jarvis and Price hearings.

The State's Responsibility

The statute places most of the cost of transport on the counties. The Department of Human Services is authorized, by statute, to either pay or reimburse for transportation costs in limited situations. These situations are as follows:

a. Transportation to and from hearings petitioned by a patient or an interested person to review the need for continued commitment, the status of the mental health of the person, and other relief as the court deems just and equitable.[61]

b. Transportation to a treatment facility when a patient is returned from an unauthorized absence.[62]

c. Transportation to a treatment facility when a patient's Provisional Discharge is revoked.[63]

d. Transportation from a treatment facility to the patient's home upon discharge.[64]

The County's Responsibility

The county is responsible for the other types of transport incurred in the Civil Commitment process. For each proceeding under the Civil Commitment Act, the court orders the county to pay the persons conveying the patient to the place of detention.[65] A proceeding is defined as every hearing where the patient has a right to counsel, such as continued commitment hearings, and involuntary treatment, or Jarvis hearings.[66]

The Task Force heard testimony that indicated that sheriff departments are almost exclusively used by the courts for transport. The sheriffs testified that the increase in transport for mental health cases has been significant,[67] and that they have been finding it increasingly difficult

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[61]Minn. Stat. § 253B.17, subd. 1 (1994).

[62]Id. § 253B.23, subd.1 (a) (1994).

[63]Id. § 253B.15, subd. 5 (1994).

[64]Id. § 253B.20, subd. 2 (1994).

[65]Id. § 253B.23, subd. 1 (a) (1994).

[66]In Re Hefler, 378 N.W.2d 808 (Minn. Ct. App. 1985).

[67]Between 1991 and 1994 the Ramsey County Sheriff's Department experienced a 69% increase in the number of persons transported for Civil Commitment purposes. In addition, there was a 74% increase in the transportation demand for transport of mental health patients from out of the metropolitan area. Ramsey County Sheriff Department Staff Study, Courts Division, Issue of Probate Transportation (Jan. 1995)(on file with the Minnesota Supreme Court).

to both meet the needs of the court in transporting patients to their hearings, and to provide other necessary law enforcement. Diversion of patients to distant Regional Treatment Centers increased staff time and expense.

The sheriffs identified a number of other significant problems occurring in the transportation area. They are as follows:

a. Sheriffs' staffing and resources can not meet the demands placed upon them to carry out mental health court orders.

b. Sheriffs' staff lack the necessary training to deal with mental health patients. Training is particularly important when the transports are lengthy.

c. Lengthy transports sometimes result in patients not receiving medications in a timely fashion, or missing the medication.

d. The increased mental health transport demands reduce the sheriff staff available for law enforcement. This is particularly true in rural areas where there may be only one or two sheriffs or deputies available to serve all the needs of the county.

Development of Local Transportation Plans

The Task Force discussed various strategies for reducing the problems associated with transportation of patients. Redistributing services closer to the persons needing treatment would be preferable. Until that occurs, other creative approaches should be considered. The Task Force noted that although the county is fiscally responsible for most of the transportation, the statute does not require the exclusive use of the sheriff's department for transport. The Task Force noted that some counties are developing shared service agreements with the Regional Treatment Centers to provide transportation.[68]

The Task Force agrees that use of law enforcement personnel is not always necessary, cost-effective, or the most humane way of dealing with the need to transport patients. The Task Force determined that, consistent with the concept of encouraging community-based services, alternative transportation plans were best determined locally. The county, judges, representatives from the Department of Human Services, and others are in the best position to create a solution to meet that area's needs. These needs will be unique to the area because of differences in the number of transports, the size of the sheriff's department, the distances to needed services, the size of the catchment area, and what other alternatives are or could be

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In the last five years, the Hennepin County Sheriff's Department has experienced a 58% increase in the number of persons transported by Sheriff's plainclothes transportation units. The number of overtime hours needed to complete court ordered mental health transports has increased 110% over the last five years. Hennepin County Sheriff's Department Staff Study (June 1994)(on file with the Minnesota Supreme Court).

[68]Willmar Regional Treatment Center has a shared services agreement with six surrounding counties to have the Center provide transportation.

made available.

RECOMMENDATION:

The Department of Human Services should educate and assist counties in the development of a transportation plan that provides alternatives to the exclusive use of sheriffs for transport of persons in the commitment process, including persons on emergency holds and released from holds. The Department should work locally with counties with input from law enforcement, county human services, local mental health authorities, local mental health advisory councils and other appropriate individuals and organizations to develop and implement a transportation plan. The transport plan should provide for:

a. training of persons providing the transportation in mental health issues, and

b. provision of security with respect to the person being transported, and

c. reduction of stigma for persons who are being transported which is created by the use of handcuffs, law enforcement uniforms, and marked vehicles.

C. REALLOCATION OF RESOURCES

The 1987 Comprehensive Adult Mental Health Act established a state policy that adults with serious and persistent mental illness should be served in the least restrictive, most appropriate setting. The Comprehensive Adult Mental Health Act also mandates a comprehensive array of services to be provided which range from inpatient hospitalization to community support and prevention. The mandated services anticipate a diversity of mental health service needs within the target population of adults with serious and persistent mental illness.[69]

One problem impacting the continued development of the array of services within the adult system is extensive reliance on the state-operated Regional Treatment Centers. While the thrust of the Comprehensive Adult Mental Health Act is to reduce reliance on the more costly and restrictive inpatient or residential treatment, the use of the Regional Treatment Centers has not fallen as dramatically as hoped. This is due, in part, to resistance from the local communities where the Regional Treatment Centers are located to playing a reduced role in the system; to strong labor unions representing Regional Treatment Center employees; and to the shortage of funds available for the full development of alternative community-based services.[70]

The Regional Treatment Centers consume a relatively large proportion of total mental health

[69]Report to the Legislature, supra note 10, at 15.

[70]Id. at 19.

funds.[71] The state continues to spend over $150 million per year for placement of adults with serious and persistent mental illness in Regional Treatment Centers, community residential facilities, and acute care hospitals.[72]

Based on an assessment of client needs done by the Department of Human Services, residential and inpatient services appear to be over-utilized.[73] The Task Force heard testimony that some commitments could be avoided if there was adequate funding for development of community-based services.

Community-based services are generally less expensive to provide than inpatient services, however resources are very difficult to shift from institutional services to less restrictive settings. In addition, placement in the Regional Treatment Centers is the low cost residential or hospitalization option for the counties as the state covers most of the cost and the counties pay only a small percentage of the cost of treatment.

The Task Force also heard testimony indicating that the lack of available community-based programming impedes the release of persons from the Regional Treatment Centers to their communities. The Task Force heard that there is a back-log of patients ready to be released on Provisional Discharge for whom there is no appropriate placement available. Upon discharge, the patients often need special services to reduce the chances of rehospitalization and to maintain an acceptable quality of life in the community. Without appropriate services the patient may be held in the Regional Treatment Center and sometimes recommitted while waiting for a community-based placement.

The Task Force supports the ongoing efforts of the Department of Human Services to comply with the spirit of the Comprehensive Adult Mental Health Act. The Task Force encourages the continued development of community-based mental health services and the reallocation of the available resources in order to more closely match the geographic location of the persons in need of mental health services.

RECOMMENDATION:

The Legislature should support the ongoing efforts of the Department of Human Services to reallocate the Department's mental health resources to more closely match the location and type of mental health service needs.

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[71] Id. at 15.

[72] Id. at 85.

[73] Work Group, supra note 8, at 1-2.

VII. MENTAL HEALTH CARE COVERAGE AND REFORM

A. INTRODUCTION

Public mental health services are funded by federal, state, and local levels of government. In some cases, two or more government levels contribute to a particular fund. Medical Assistance, for instance, is composed of a federal share (54%) and a state share (46%). State grants to counties sometimes require a county match, such as 10% or 50% of the state grant amount. Some of the state funds are categorical, intended for a particular service or for use with a particular population, and some take the form of block grants that offer a higher degree of county control and flexibility.[74]

In Minnesota, adult mental health services are funded predominately by the state. In state fiscal year 1993, public mental health funding for adults amounted to approximately $300,000,000. About 63% was state money, most from appropriations for the Regional Treatment Centers and the state's share of Medicaid (Medical Assistance). Federal funds accounted for about 20% of the total; county funds for about 17% of the total.[75]

The Department of Human Service's mental health funding flows through various service providers and the counties. The capped appropriations, with the exception of Regional Treatment Center funds, flow through the counties. Most of the entitlement funding, which is primarily Medical Assistance, flows directly to the providers of the services.[76] Inpatient treatment in the Regional Treatment Centers accounted for about 39% of the total public expenditures for adult mental health, inpatient treatment in community hospitals for 19%, community residential treatment for 11%, and outpatient treatment for 11.5%. Community support services, day treatment, and case management together accounted for about 15%.[77]

The Task Force discussed the impact of the current service delivery systems and funding structure on the Civil Commitment process. Even the best treatment facility is of no value if there are no funds available to pay for the person's care. The Task Force heard testimony indicating that currently the funding drives the system of care. Too often where the person is placed for treatment is based more on availability of funding than the person's treatment needs. The Task Force heard testimony indicating that the current constraints placed on funding for services result in poor utilization of the funds or inappropriate placements.

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[74]Report to the Legislature, supra note 10, at 29.

[75]Mental Health Division, Minnesota Department of Human Services, Recommendations for Improving the Adult Mental Health System 4 (Feb. 1995)[hereinafter Recommendations for Improving].

[76]Work Group, supra note 8, at 2.

[77]Recommendations for Improving, supra note 75, at 4-5.

B. THE NEED FOR REFORM

The Task Force heard testimony indicating that funding of the service delivery system is in need of reform. This issue was raised continually at the public hearings, focus groups, and the Task Force's own discussions. In the end, the findings of the Task Force regarding the need for reform were very similar to the findings of the Local Mental Health Task Forces that were organized in 35 counties during 1994. The findings of these Local Mental Health Task Forces, in summary, were:

- Community services, particularly crisis services, case management, employability, transportation, housing, psychiatric services, services for dually diagnosed persons, and community support services are often inadequate, not appropriate to the needs of the clients, or simply unavailable.

- Categorical funding streams that support most mental health services often result in a service system that is driven by funding rather than addressing the needs of clients. The current system funds programs, not people.

- There is a need for a more effective, comprehensive, integrated local mental health authority. Current funding flows directly from the state to the various components of the service system, making it difficult for the county to effectively implement its statutory role.

- In many areas, there has been a heavy reliance on institutional models of care which are not well integrated with community care and do not address individual client need.

- The overall health care system is undergoing rapid and profound change. Mental health needs must be appropriately addressed within these broader system changes.

- Current statutory responsibilities often overlap across health plans, counties and Regional Treatment Centers. In this confusion of responsibility, clients are passed from one system to another, some clients fall through the cracks, private costs are shifted to the taxpayer, and available funding is not used as effectively as it could be.

- Many adults from cultural and ethnic minorities fail to seek needed mental health services because they see the available services as inadequate, inappropriate, inaccessible or unresponsive to their needs.

- In order to assure effective, quality services, a consumer-driven, recovery-oriented focus needs to be incorporated into every aspect of the mental health system.

- The broader system problems described above have resulted in frequent, inappropriate utilization of the commitment process. If appropriate services were available at the right time, many people who are now committed would choose voluntary treatment. The number of commitments could be reduced. When commitments are truly

necessary, the length of commitment could be shortened.[78]

C. THE EFFECT OF HEALTH CARE COVERAGE ON THE USE OF THE CIVIL COMMITMENT PROCESS

The Task Force heard considerable testimony regarding the effect of a person's legal status under the Civil Commitment Act. In some cases, hospitals transfer the cost of care to the county when the person is placed on a 72 hour hold. This cost-shifting will often result in the person's health care provider not being held responsible for the cost of care. Testimony also indicated that 72 hour holds may be placed on a person in order to shift the cost of care to the county.

For persons on Medical Assistance, current law prohibits hospitals from billing counties for medically necessary hold orders and Civil Commitments.[79] In other words, Medical Assistance should be billed first. However, hospitals often find it easier to bill the counties, and there are varying interpretations of the term "medical necessity." Also, there are not similar provisions in the current law indicating who should be the primary payor if the person is not covered by Medical Assistance. When a person is on a hold order in a Regional Treatment Center, current law appears to require the Department of Human Services to bill counties for the full cost of care, regardless of the availability of other funds.[80]

The cost-shifting may continue through the Civil Commitment process itself if the person does not have funding to remain in a private, or community facility. The county pays only 10% of the cost of care, with the exception of hold orders, at a Regional Treatment Center. Thus the Regional Treatment Centers are a low cost placement option for the counties. The Task Force heard some testimony indicating that this may result in a person being committed in order to secure funding for his or her treatment.

The Task Force also heard testimony indicating that persons seeking treatment on a voluntary basis may be turned away for services if they do not meet the criteria for Civil Commitment. As a result persons willing to seek voluntary treatment must be committed in order to secure services. The Task Force recommends that mechanisms be put in place to eliminate misuse of the Civil Commitment process.

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[78]Memo from John Zakelj, Planner, Mental Health/ State Operated Services Division, Department of Human Services, to the Civil Commitment Task Force (Dec. 22, 1995)(on file with the Minnesota Supreme Court); See generally Recommendations for Improving, supra note 75.

[79]Minn. Stat. § 256.969, subd. 21 (1994).

[80]Id. § 253B.11, subd. 2 (1994).

D. TWO PROPOSED MODELS

The Funding and Systems Committee of the Task Force discussed extensively various models of service delivery that could potentially reduce the misuse of the Civil Commitment process. The Task Force considered the Civil Commitment process in the states of Ohio, Kansas, and Wisconsin. The Task Force held an interactive video teleconference with representatives of the Civil Commitment system in Ohio, with the assistance of the Minnesota Department of Human Services.

Due to time constraints, the Task Force was not able to produce a recommended model for reform. However, the Task Force developed principles for the Legislature to consider as they undertake overall reform of mental health care and human services, and two models for consideration.

Model I: Integrated Funding for Mental Health Services

This model would integrate all funding for adult mental health services at the state level. The state would develop minimum state-wide standards of care, but the local mental health authority would administer the funds. The local mental health authority would contract with vendors, which could include the state, to provide a full array of community based mental health services.

The court would commit the person, not to a treatment facility as is done currently, but to the local mental health authority. The local mental health authority would then place the person in the least restrictive treatment alternative that is appropriate and available. Under this model, the local mental health authority would have the funding and the authority to provide for the person's treatment.

Model II: Linking Health Plans, Regional Treatment Centers and Counties

This model retains separate funding for the Regional Treatment Centers, health care, and social services. However, the Task Force recommends that clear linkages be developed in order to minimize cost shifting. For example, if the state health care programs, such as Medical Assistance, General Assistance Medical Care, and MinnesotaCare, purchase care from a managed care entity, the contract should state that the managed care entity has responsibility to pay for court ordered mental health services. The contract would need to clarify that this responsibility would not be subject to the managed care entity's normal approval authority and would not reduce the benefits the person would otherwise receive under the contract.

This provision should be part of all contracts for publicly funded managed health care, including disabled and non-disabled populations. The person's managed care entity would also need to be a part of the pre-petition screening process, including recommendations for treatment to the court. This partnership should lead to development of creative, non-commitment alternatives provided and funded jointly by the county and the managed care

entity.[81]

RECOMMENDATIONS:

1. The Legislature should consider the following principles as they undertake overall reform of mental health care and human services:

   a. The goal of a managed care system should be effective, coordinated, ongoing access to quality services, based on the recipient's mental health needs and designed to enable continued community living.

   b. Funding mechanisms should be structured to:

      i. encourage utilization and development of less restrictive alternatives, where appropriate; and

      ii. provide incentives for the state, counties, health plans, and health care providers to provide treatment in the setting most appropriate to the person's needs; and

      iii. allow sufficient flexibility for the development of individualized community-based plans. Effective community-based plans should integrate mental health treatment with housing; vocational services; social and economic support; physical health care; and transportation to access services.

   c. It is generally preferable that people receive mental health treatment in or near the communities in which they live.

   d. Persons with special mental health treatment needs should have access to specialized treatment programs irrespective of their county of residence. Additional specialized treatment programs, for special needs such as multiple personality disorders, dual diagnoses, and dissociative disorders, should be developed.

   e. A person's legal status under the Civil Commitment Act should not be a basis for determining access to treatment programs.

2. The Legislature should provide that for all health care coverage provided or regulated by the state:

   a. a person's legal status, under the Civil Commitment Act, can not be a basis for

[81]Memo from John Zakelj, Planner, Mental Health Division/ State Operated Services, Department of Human Services, to the Civil Commitment Task Force (Oct. 17, 1995)(on file with the Minnesota Supreme Court).

denying payment for mental health treatment and services; and

b. health plans should support the local mental health authority by acting as primary payor or provider for mental health services within the coverage required by law or contract.

3. The Legislature should provide that the county, during its Pre-petition Screening investigation, make reasonable efforts to include the person's health care payor, if any, when considering alternatives for the person's placement.

4. The Legislature should consider the following models when determining how the principles may best be implemented:

a. Model I - Integrated Funding for Mental Health Services

i. Funding for mental health services should be integrated at the state level, with the state serving as the payor. The local mental health authority, which is the county board under current state law, should administer the funds, based on minimum state-wide standards of care, and ensure the provision of services through a variety of vendors, including supportive services and housing necessary to maintain the person in the community.

ii. Persons should be committed by the court to a local mental health authority, and:

a) the local mental health authority should have the authority to place the person in the least restrictive treatment alternative that is appropriate and available.

b) during the commitment period the local mental health authority should have the authority to transfer the person between resources as dictated by the person's needs.

c) the local mental health authority should be required to notify the court of any transfers, but such transfers should not require prior court authorization, except for persons under the jurisdiction of the criminal court.

d) the person should have the right to request a court review hearing to contest a placement.

iii. Incentives should be provided for local mental health authorities to create cooperative agreements and regional services in order improve services to people.

iv. This model should be developed and evaluated through the use of pilot projects.

b. Model II - Linking Health Plans, Regional Treatment Centers, and Counties If Separate Funding is Retained for Health Care, Regional Treatment Centers, and Social Services.

i. State health care programs that purchase care from a managed care entity, should include a provision in the contract specifying the managed care entity's fiscal responsibility for court ordered mental health services, including hold orders and placement at a Regional Treatment Center. The value of the covered services should be worded to encourage the most appropriate treatment for the person's needs.

ii. This responsibility would not be subject to the managed care entity's normal pre-approval authority and would not reduce the benefits that the person would otherwise receive under the contract.

iii. The provision should be part of all contracts for publicly funded managed health care, including disabled and non-disabled persons.

iv. The actuarial value of this provision should be part of the capitation received by the managed care entity.

v. The managed care entity, or its contracted mental health care provider, will need to coordinate with the county in the development of the treatment plan that is submitted to the court. This should lead to development of creative non-commitment alternatives provided and funded jointly by the county and the managed care entity.

vi. The model should be designed such that there are no financial incentives to retain a person in an inpatient treatment program when the person is ready to be discharged to the community.

VIII. UPDATING THE CIVIL COMMITMENT ACT

The language and organization of the Civil Commitment Act were reviewed by both the Advocacy and Patients' Rights and Judicial Process Committees of the Task Force. The Committees agreed that some of the language of the Act is archaic and needs modernization. For example the word "institutionalization" is used throughout the Act and should be updated.[82] Some of the language of the Act is unclear or used inconsistently within the statute, including such terms as interested person, medical welfare, partial hospitalization, and partial institutionalization. The Committees determined that some definitions need to be updated to reflect the broader purpose of the Act, such as informal admission, treatment facility, and patient.

[82]Another example is that the term psychiatric social worker is no longer a recognized category of social worker.

In addition to language revision, the Committees discussed the need to include a preface to the Act indicating to whom the Act applies. The Committees expressed concern that patients' rights in private settings need the protection provided by the Act. Also discussed was the need to restructure the Act for ease of use. Currently, the Act applies to commitments based on mental illness, chemical dependency, and developmental disability. It also has a section covering the mentally ill and dangerous person. The Committee determined that the Act would be easier to use if each type of commitment had its own section, and the sections were re-titled to more accurately reflect their content.

The Task Force discussed the Committees' recommendations, but due to time constraints was not able to detail all the needed revisions. Therefore, the Task Force recommends that a separate process be utilized to update and revise the Act.

RECOMMENDATION:

The Legislature should revise the language and organization of the Civil Commitment Act to:

1. rename the Act to more appropriately reflect its scope;

2. eliminate archaic language within the Act;

3. provide additional clarification where needed;

4. reorganize the Act for ease of use; and

5. clarify to whom the Act applies.

IX. CREATION OF A TRAINING AND RESOURCE CENTER

Throughout its deliberations, the Task Force identified a need for a state wide training program that would provide inter-disciplinary instruction on Civil Commitment laws and process, and other topics pertinent to the mental health law of Minnesota. Training was identified as particularly important to a system of quality defense representation for persons with mental illness. Training is needed to ensure equitable treatment of all Minnesota citizens affected by the Civil Commitment process. The Task Force also considered that without sufficient resources for the judiciary, attorneys, and other professionals involved with the Civil Commitment process to receive training, the practical effect of the changes being proposed by the Task Force would be reduced.

The Task Force reviewed materials from the Mental Health Law Training and Research Center at the University of Virginia.[83] The Center is under contract to the Virginia Department of Mental Health to provide a variety of training programs and support. The Task Force is

[83]Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22908.

recommending that a Training and Resource Center be established in Minnesota.

RECOMMENDATION:

The Legislature should provide for the establishment of a statewide Civil Commitment Training and Resource Center that would provide:

1. an organized system for providing ongoing, interdisciplinary training to be conducted at least quarterly in various locations in the state;

2. information dissemination; and

3. legal consultation primarily for persons with mental illness and their representatives.

The Office of the Ombudsman for Mental Health and Mental Retardation should issue a Request for Proposals to administer and manage the Center; develop and provide the training; disseminate information; and provide consultation services. The administration and management of the Civil Commitment Training and Resource Center should not be provided by a mental health service provider, including the Department of Human Services.

X. MEDICAL AND COURT RECORDS

A. MEDICAL RECORDS

The Task Force heard testimony, at Focus Group Meetings, Site Visits, and Public Hearings, that committed patients could be transferred between treating facilities without their medical records being released to the new facility. In these cases, the new treating physician lacks important information about the patient's current medications, past medication therapy, and the patient's reaction to previously prescribed medications.

It was noted that this situation was often due to either the patient not consenting to the release of his or her medical records, or the patient's lack of capacity to consent to the release. The Task Force was concerned that the patient's unwillingness to consent to release may be a result of the mental illness and, if the patient lacks capacity to consent, the records can not be obtained. As a result, the patient's medication routine may be disrupted or the new treating physician will lack important information regarding previously tried medications. In these cases, the physician will not have available information regarding the patient's reactions to medications either positive or adverse.

In general, a person who has the capacity to authorize the release of medical data should retain that right.[84] However, after extensive discussion, the Task Force determined that under very narrowly drawn circumstances, the portions of the patient's medical records dealing with the

[84]Minn. Stat. § 144.335 (1994).

medications prescribed for treatment of the mental illness should be transferred with the committed patient to the new treating facility, even though the patient may not consent.

Last year, the Legislature revised the statute regarding administration of neuroleptic medications to permit access to the physician's order section of a patient's past records dealing with administration of neuroleptic medications, if the patient lacks capacity to authorize the release of the records.[85] The Task Force is recommending that this concept be extended to cover all of the medications which are prescribed for the treatment of mental illness, and to cover situations where there is a lack of consent as well as incapacity to consent. The Task Force is not recommending that all portions of the medical records be released, only those portions dealing with drugs prescribed for the treatment of mental illness, and the patient's reactions to those drugs.

B. COURT RECORDS

The pre-petition screening report generally forms the basis for the court's intervention in the person's life. The report is an assemblage of vital data, behavior, background, previous treatment, diagnoses, and recommendations for the current situation. It can summarize hospital reports, police reports, treatment progress reports, and discuss the appropriateness of various treatment options. It is often the basis for drafting the petition for commitment, and is source of witnesses for both parties. The pre-petition screening report can be of great assistance to the court.

The information collected in connection with the preparation of the pre-petition screening report is considered private data on individuals.[86] However, the Civil Commitment Act states that the pre-petition screening report, as well as the examiner's supporting statement, and a copy of the petition, is to be given to "any interested person".[87] An interested person is

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[85] A treating physician who makes medical decisions under this subdivision regarding the prescription and administration of neuroleptic medication may have access to the physician's order section of a patient's records on past administration of neuroleptic medication at any treatment facility, if the patient lacks the capacity to authorize the release of records. Upon request of a treating physician under this subdivision, a treatment facility shall supply complete information relating to the past records on administration of neuroleptic medication of a patient subject to this subdivision. A patient who has the capacity to authorize the release of data retains the right to make decisions regarding access to medical records as provided by section 144.335.
Id. § 253B.03, subd. 6c (1995).

[86] In Re Morton, 386 N.W.2d 832 (Minn. Ct. App. 1986).

[87] A plain language notice of the proceedings and notice of the filing of the petition, a copy of the petition, a copy of the examiner's supporting statement, and the order for examination and a copy of the pre-petition screening report shall be given to the proposed patient, patient's counsel, the petitioner, any interested person and any other persons as the court directs.
Minn. Stat. § 253B.07, subd. 4 (1994).

defined in the Act to include spouses, parents, adult children, and next of kin.[88]

The Task Force heard testimony from consumers of the Civil Commitment System who testified that they had been extremely upset by this personal information being sent to various family members, some of whom they had not seen or heard from in years. Other consumers testified that they, as adults, did not feel it was appropriate for this type of information to be routinely given to their parents, or to their adult children.

The Task Force is recommending that the plain language notice of the proceedings and notice of the filing of the petition continue to be given to interested persons. However, due to the sensitive nature of the information contained in the petition, the examiner's supporting statement, and the pre-petition screening report, that the distribution of these documents should be limited to the proposed patient, the attorneys involved in the case, the petitioner, the treatment facility holding the person, the court, the examiners, other persons designated by the court, and persons specifically designated by the proposed patient.

The Task Force also discussed the fact that the court documents in a Civil Commitment case file are open to the public. As a result, incorporation of the pre-petition screening report into the petition itself or by reference renders the report accessible to the public. The entire Commitment case file can be sealed by court order,[89] but according to testimony received by the Task Force; this is not routinely done. The Task Force determined that in most cases, the pre-petition screening reports and medical reports introduced at trial should be sealed and not be accessible to the public.

The Task Force heard testimony indicating that the district courts handle sensitive material in the Civil Commitment file differently. The Task Force determined that the existing methods for protecting the material in the court file are adequate, and suggests that the district courts closely monitor access to the pre-petition screening reports, and other sensitive material in the court file.

RECOMMENDATIONS:

1. The Legislature should provide that when:

   a. a person with mental illness is under an order for mental health treatment by the court; and

   b. the person transfers between mental health treatment facilities or programs; and

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[88] "Interested person" means an adult, including but not limited to, a public official, including a local welfare agency acting under section 626.5561, and the legal guardian, spouse, parent, legal counsel, adult child, next of kin, or other person designated by the proposed patient.
Id. § 253B.02, subd. 10 (1994).

[89] Id. § 253B.23, subd. 9 (1994).

c. the person does not have the capacity or is unwilling to consent to the release of relevant medical records;

the person's treating physician who is making medical decisions regarding the prescription and administration of medications to treat mental illness, may have access to the portions of the person's prior medical records relevant to the administration of medications used to treat mental illness and the person's response to those medications without consent of the person.

2. Under current law a notice of the proceedings, notice of filing of the petition, a copy of the petition, the examiner's supporting statement and order for examination, and the Pre-petition Screening report are sent to "any interested person". The Legislature should provide that the above documents are sent to the respondent, the attorneys, the petitioner, the treatment facility, the court, the examiners, persons designated by the court, and persons designated by the respondent. The notice of the proceedings, and notice of filing of the petition should be sent to the above parties plus any interested person.

XI. INCREASED PROGRAMMING

A. PROGRAMMING FOR PERSONS WITH DUAL DIAGNOSES

A person with mental illness is considered to have a dual diagnosis if they have received a chemical dependency or developmentally disabled diagnosis concomitant with a diagnosis of mental illness. According to the diagnoses submitted with the billings for Medicaid reimbursement in Minnesota, it appears that 3.3% of persons who receive mental health services have dual diagnoses.[90]

Both service providers and advocates in the state feel that the true percentage of persons with dual diagnoses is much higher, perhaps as high as 30%.[91] In the survey conducted by the Task Force, 60% of county human services directors indicated that treatment programs for persons who are dually diagnosed as mentally ill and chemically dependent are not adequately available.[92]

The Task Force heard testimony indicating that finding treatment programs for persons with dual diagnoses is difficult and can delay treatment. There are few specialized services developed for this special population.[93] Physicians testified that there is a lack of proven

[90]Report to the Legislature, supra note 10, at 13.

[91]Id.

[92]Research and Planning Office, State Court Administration, Minnesota Supreme Court, Graphical Summary of Commitment Survey Results 6 (1995)(on file with the Minnesota Supreme Court)[hereinafter Graphical Summary].

[93]Report to the Legislature, supra note 10, at 13.

therapeutic models for dealing with dual diagnoses. In general, persons are treated for the chemical dependency first, and then treated for the mental illness. The Task Force also heard testimony that suggested that the number of persons with the dual diagnosis of mental illness and chemical dependency is definitely on the rise.

The Task Force noted that there is a lack of funding for the development of treatment programs designed to treat persons with dual diagnoses. In addition, there is a lack of professionals that are trained to treat persons with dual diagnoses. The Task Force recommends that services be developed for this special population.

B. PAYMENT FOR MEDICATIONS

The Task Force heard testimony that indicated one of the reasons persons with mental illness do not continue to comply with the recommended medication regimen once they have returned to community living is an inability to pay for the medications. In the survey conducted by the Task Force, county human services directors were asked how often funding of medications is a problem for persons with various types of medical funding.

Funding for medications was always or often a problem for 35% of the persons presented for pre-petition screening with no medical coverage.[94] Funding for medications was a problem for 23% of the persons on Medical Assistance with a spend-down; and 22% of persons on Medicare without Medical Assistance.[95] Eleven percent (11%) of persons with private insurance still have trouble with payment for necessary medications.[96]

In a study done by the Mental Health Division of Hennepin County Adult Services Department, the county screeners indicated that six percent of the sampled clients were not taking prescribed medications because they could not afford them.[97] The Task Force heard testimony that due to low income, persons with mental illness are required to chose between paying for their medications or other necessary living expenses such as food or shelter.

The Hennepin County study identified the consistent use of neuroleptic medications as playing a significant role in relapse prevention.[98] The Task Force heard testimony that several counties have already established small emergency medication funds to assist clients in paying for medications. The Task Force expressed concern that there may be persons under a court order to comply with treatment, including medication compliance, that have no way to pay for

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[94]Graphical Summary, supra note 92, at 6.

[95]Id.

[96]Id.

[97]Mental Health Division, Hennepin County Adult Services Division, Factors Related to Commitment for Mental Illness 46 (Sept. 1995).

[98]Id. at 47.

such medications. Therefore, the Task Force is recommending that when a person is under a court order for treatment, that the county ensure the medications that the person is being ordered to take are available to him or her.

RECOMMENDATIONS:

1. The Legislature should provide financial incentives for communities to develop treatment programs for persons with dual diagnoses, and institutions of higher education to develop and implement programs designed to prepare professionals to treat persons with a dual diagnoses.

2. The Legislature should provide that if a person is under a court order for treatment that includes medications, and the person is unable to pay for the medications and there is no other source of payment, then the county must be responsible to ensure medications are available to the person. The Legislature should provide additional funding for this purpose, with the exception of persons on Medical Assistance, General Assistance Medical Care, or MinnesotaCare, since these programs already cover medications.

XII. PERSONS WITH MENTAL ILLNESS IN THE CORRECTION SYSTEM

Several factors increase the likelihood that an individual's unusual or deviant behavior will be dealt with by the criminal justice system rather than the mental health system. They include the very high standard and strict criteria for Civil Commitment; the lack of adequate support systems for the mentally ill in the community; the unavailability of long-term hospitalization in a state regional treatment center for persons with chronic mental illness; and expectations that police deal with deviant behavior more quickly and efficiently than the mental health system.[99]

As a result, persons with moderate to severe mental illness are incarcerated in Minnesota's prisons. The Department of Corrections is required to provide appropriate mental health programs within the prison system.[100] In addition, the Department is required to operate an inpatient mental health unit.[101] This twenty-two bed unit is located at Minnesota Correctional Facility at Oak Park Heights. In September of 1995, the Department of Corrections issued a report which was developed through a multi-disciplinary, multi-agency group of professionals who agreed to assist the Department of Corrections with a comprehensive review of the

[99]R. Jemelka, E. Trupin & J. Chiles, The Mentally Ill in Prisons: A Review, 40 Hospital and Community Psychiatry (May 1989).

[100]Minn. Stat. § 244.03 (1994).

[101]Id. § 241.69 (1994).

services it provides to inmates with mental illness.[102] This Task Force reviewed the report and endorses the recommendations for improvement of mental health services proposed in the report.

RECOMMENDATION:

The Advisory Task Force on the Civil Commitment Process strongly endorses the recommendations put forth by the Minnesota Department of Correction's Mental Health Services Review Committee in the report, "Mental Health Services for Adult Inmates in Minnesota Correctional Facilities" dated September 14, 1995, and recommends that the Legislature ensure that resources are available for the implementation of the recommendations. The Advisory Task Force suggests the following recommendations be given emphasis:

1. The delivery of mental health services for the department should be coordinated by a psychiatrist, and all correctional facilities should have a psychological services staff person available for consultation 24 hours a day.

2. Security staff and case managers should receive ongoing training on topics related to mental health.

3. Record-keeping for mental health services should be standardized and computerized to facilitate the provision of mental health services. A complete Diagnostic and Statistical Manual - IV diagnosis should be recorded in psychological services records if it is determined that the inmate has an Axis I disorder.

4. Inmates involved in chemical dependency programs should be evaluated to determine whether they have a dual diagnosis, and if mental health services are needed they should be addressed in the treatment setting.

5. Psychological services staff should identify inmates who are unable to understand disciplinary procedures, and if there is a question as to whether an inmate can understand the discipline rules and procedures, discipline prosecutors should be required to request a psychological services evaluation.

6. A more comprehensive discharge planning process should be developed and there should be increased coordination when inmates are transferred back into the general population from the Mental Health Unit.

[102]Mental Health Services Review Committee, Minnesota Department of Corrections, Mental Health Services for Adult Inmates in Minnesota Correctional Facilities, Report to the Commissioner of Corrections (Sept. 14, 1995).

XIII. OTHER RECOMMENDATIONS FOR IMPROVEMENT

A. ADVANCE PSYCHIATRIC DIRECTIVES

In Minnesota there are four legal mechanisms by which a person can state their wishes regarding their health and mental health care should they loose their capacity to give informed consent.[103] Although a person can include mental health treatment in a Durable Power of Attorney for Health Care, the Mental Health Treatment Declaration, or as is it commonly known Advance Psychiatric Directive, is also available to allow a competent adult to make a specific declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include the consent or refusal of intrusive treatments.[104]

In an Advance Psychiatric Directive, the person may designate a proxy to make decisions about the person's mental health treatment. Such a directive is only effective if it is signed by the person and two witnesses, both of whom have stated that they believe the person understands the nature and significance of the directive.[105] The statute states that such a directive can be revoked in whole or in part at any time and in any manner by the person, if he or she is competent at the time of revocation.[106]

The Task Force expressed concern that although the Advance Psychiatric Directive is helpful in allowing the person to direct his or her treatment, the lack of a consistent format, and the ease with which directives can be revoked has created problems in the practical use of the directives. The Task Force heard testimony indicating that treatment facilities are unlikely to rely on an Advance Psychiatric Directive if the person is resisting treatment. This is due, in part, to the lack of a definition of competency to revoke a directive, and in part, due to the ease with which the statute allows revocation.

The Task Force recommends that in order to encourage use of the Advance Psychiatric Directive, one statewide form be developed. This form should include the criteria to be used in determining whether a person is competent to revoke or rescind a directive. When considering the criteria to be used, the Task Force recommends that the person not be required to state that he or she is mentally ill to create a directive.

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[103]The four mechanisms are: the Living Will, Minn. Stat. § 145B; the Durable Power of Attorney for Health Care, Minn. Stat. § 145C; the Nomination of Guardian or Conservator, Minn. Stat. § 525.544; the Mental Health Treatment Declaration, Minn. Stat. § 253B.03.

[104]Minn. Stat. § 253B.03, subd. 6d (1994).

[105]Id. at subd. 6d (b)(c) (1994).

[106]Id. at subd. 6c (e) (1994).

RECOMMENDATION:

The Legislature should provide a universal, state wide advance psychiatric directive form. The form should be user friendly, not require admission of mental illness, include criteria to revoke or rescind a directive, and allow the person to state his or her mental health problem in lay terms.

B. TIMING

Court Administration

The Task Force surveyed court administrators regarding the Civil Commitment process. A major problem identified by a significant number of court administrators is the recurring rush to complete the court hold and order for hearing before the expiration of the 72 hour hold. The court administrators stated that most of the 72 hours is utilized for the preparation of the pre-petition screening report, the physician's supporting statement, and the petition itself.[107]

The court administrators reported that they often receive the petition near the expiration of the 72 hours. As a result, they have very little time to call and schedule court examiners, set court dates, appoint defense counsel, locate a judge to sign the hold order, and have the papers served by the sheriff.[108]

The Task Force reaffirms that the petition should to be filed within the 72 hour time limit, but that the court administrators be allowed to use the next 24 hours of the 14 day period to schedule the examiners, set court dates, and appoint defense counsel. This recommendation is not intended to lengthen the time that the person is held in the facility. It is intended to ensure the court administrators a definite block of time that can be used by them for the scheduling process once the decision has been made to hold the person and proceed with a Civil Commitment petition.

Date Commitment Begins

The Task Force heard testimony indicating that the statute is unclear as to when the period of Civil Commitment actually begins. After discussion of various options, the Task Force recommends that the date the warrant of commitment is signed be the date the period of Civil Commitment begins. The warrant of commitment will need to include a statement by the judge that the statutory criteria for Civil Commitment have been met. The order, setting forth the findings of fact and conclusions of law, should be issued promptly.

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[107]Research and Planning Office, State Court Administration, Minnesota Supreme Court, Administrative Issues Questionnaire, Open-Ended Responses (Aug. 1995)(on file with the Minnesota Supreme Court).

[108]Id.

RECOMMENDATIONS:

1. The Legislature should provide that a petition for civil commitment must be filed with the court within the emergency hold period, but that the court administrators have an additional 24 hours within the subsequent 14 day period to schedule the hearing, assign defense counsel, schedule the examination, etc.

2. The Legislature should provide that the period of civil commitment begins on the date the warrant of commitment is issued, and that the warrant shall include a statement that the criteria for civil commitment have been met.

C. RULES OF COURT - THE REQUEST TO APPEAL

According to Rule 4.06 of the Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act, a defense attorney is required to follow a respondent's instructions as to what ultimate disposition to seek in the case.[109] Defense attorneys expressed concern that this Rule may require an appeal even where there is no basis for an appeal and the client's mental illness may be affecting his or her understanding of the merits of an appeal. The Task Force did not have time to fully consider this issue and recommends that the Supreme Court Advisory Committee address the defense attorneys' concerns.

RECOMMENDATION:

The Supreme Court Advisory Committee on Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act should clarify the effect of Rule 4.06 if a respondent requests an appeal of a Civil Commitment case that the attorney believes is frivolous.

[109]To the extent that respondent articulates instructions in the following areas, they are binding on counsel:
(a) what ultimate disposition to seek and which dispositions to oppose;. . .
Minn. R. Civ. Commitment 4.06 (a).

APPENDIX A

Information on the focus groups, public hearings, and site visits. Commentary from the focus groups are on file with the Minnesota Supreme Court.

Public Hearings

Public hearings were held in the following cities in Minnesota:

February 15, 1995	Minnesota Judicial Center, St. Paul
March 2, 1995	Steele County Courthouse, Owatonna
March 23, 1995	Kandiyohi County Courthouse, Willmar
April 5, 1995	St. Louis County Courthouse, Duluth
April 26, 1995	Pennington County Courthouse, Thief River Falls

Focus Groups

Focus groups were held with the following:

October 13, 1994	County Attorneys and Attorney General
October 20, 1994	Defense Attorneys
October 21, 1994	Mental Health Advocates
October 27, 1994	Psychiatrists, Psychologists, Nurses
November 3, 1994	State and County Mental Health Agencies
November 10, 1994	Parents and Family of Consumers
November 17, 1994	Consumers
November 18, 1994	Judges
December 8, 1994	Law Enforcement
December 9, 1994	Caseworkers, Social Workers, Pre-petition Screeners

Program Site Visits

Program site visits were made to the following programs:

February 15, 1995	Anoka Metro Regional Treatment Center
March 2, 1995	Owatonna Hospital Mental Health Unit, and South Central Human Relations Center, Owatonna
March 23, 1995	Willmar Regional Treatment Center, Willmar
April 5, 1995	Miller-Dwan Medical Center, In-Patient and Out-Patient Mental Health Units, Duluth
April 26, 1995	Mental Health Division, Northwest Medical Center, and Northern Lights Book Store, Thief River Falls
May 12, 1995	Familystyle of St. Paul, Inc., St. Paul

APPENDIX B

Key Issues Identified by the Focus Groups

1. Persons going through the Civil Commitment process deserve adequate representation. Defense attorneys need sufficient time to prepare a commitment defense, and to provide follow through after commitment. The proposed patient and his or her family receive little information or assistance during the commitment process. Second examinations are sometimes not used at all, or are ineffective due to lack of preparation time for the second examiner.

2. The commitment process is dehumanizing and difficult for proposed patients and families. However, it is especially difficult for the elderly. Sometimes the commitment law is being used inappropriately to commit elderly persons in order to provide needed assistance. There should be a mechanism to provide services to the elderly in need of immediate assistance without using the commitment process.

3. There needs to be a process by which persons placed on 72 hour holds can receive medications without delay. This would help stabilize the person prior to the hearing and would prevent some commitments.

4. Persons with mental illness must decompensate to the point of near tragedy before intervention is allowed. A new type of emergency or temporary hold should be created that has a different threshold of dangerousness, and allows all facts, circumstances, and the history of the person to be considered by the police and the admitting facility when making the decision to hold the person.

5. Persons with serious and persistent mental illness who revolve through the system, can not be treated in a time limited manner. There should be a different standard or criteria for commitment, and a longer commitment period coupled with sufficient due process protections, for those persons who have been repeatedly committed.

6. The Jarvis process needs to be made more efficient, less expensive, and still protect the rights of patients. As currently interpreted, Jarvis creates delay in the treatment of patients, and a tremendous burden on the system.

7. There is a lack of community based resources for persons with mental illness across the state. There needs to be a broader range of services for persons with mental illness, and specialized programs such as programs for those persons with dual diagnosis, crisis intervention, low income subsidized housing, culturally sensitive programming, etc. Services should include long range planning as to how a person with mental illness can be maintained in the community at a lower cost than institutionalization. There are no financial incentives for counties, or anyone, to develop these community based services.

8. A new form of community commitment or protective placement is needed as a less restrictive alternative to commitment and placement in the regional treatment centers. This would allow more appropriate placement for some patients who could benefit from less intensive services with medication monitoring.

9. The current process of outpatient medication monitoring is very poor. There needs to be adequate monitoring and support for the patient in the community to ensure that they continue their treatment program.

10. Provisional discharges are difficult to revoke, and the length of the provisional discharge is dependant on the amount of time remaining in the commitment period upon release. Consideration should be given to making provisional discharges a standardized length of time after release. This would create a consistent period of time for planning the person's return to the community.

11. The funding of mental health services is fragmented. A coordinated system of funding services for persons with mental illness needs to be established allowing clients to access mental health services and support services throughout the state. The funding should follow the client. The number of commitments continues to increase, and people are being committed and placed in regional treatment centers in order to access funding for services.

12. A person with mental illness willing to accept assistance voluntarily generally finds access to services difficult if not impossible.

13. The Civil Commitment System can appear inconsistent due to variations in case dispositions. Often the quantity and quality of community resources available for treatment, and the funding for which the person qualifies, effects the decision as to who will be committed as well as the placement of the person.

14. There are few mechanisms to enforce existing patients' rights. There is little recourse for a patient with mental illness whose rights have been violated.

15. Additional training is necessary for district court judges, court personnel, case workers, county personnel, law enforcement officers, and prison guards and officials.