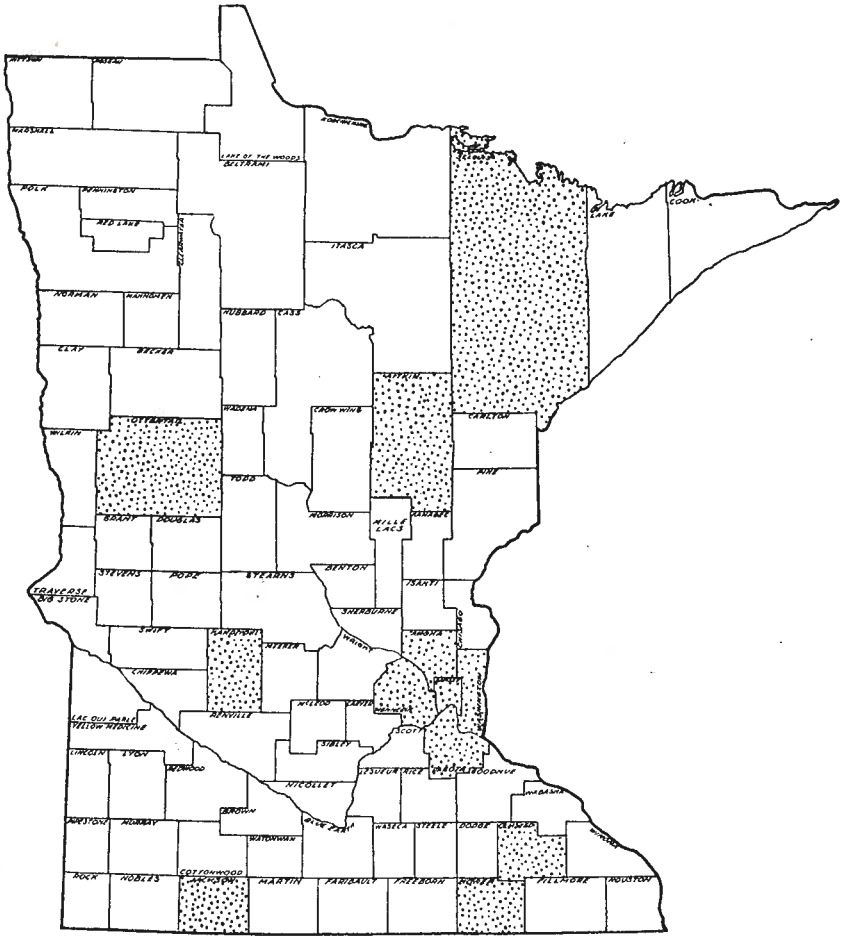
CIVIL COMMITMENT

IN MINNESOTA



FINAL REPORT

of the

SUPREME COURT STUDY COMMISSION

on the

MENTALLY DISABLED & THE COURTS

HAMLINE UNIVERSITY SCHOOL OF LAW
ST. PAUL, MINNESOTA 55104

Office of the Dean

(612) 641-2345

July 20, 1979

Hon. Robert J. Sheran
Chief Justice
Minnesota Supreme Court
Minnesota State Capitol
St. Paul, Minnesota 55101

Dear Mr. Chief Justice:

Enclosed is the final report of the Supreme Court Study Commission on the Mentally Disabled and the Courts. The members of the Commission--a group of distinguished and dedicated men and women--have contributed much time and effort to planning the research effort, analyzing the data obtained, and formulating their recommendations. They and our excellent staff are to be commended highly.

All of us are hopeful that these efforts will result in fairer and more helpful contacts of the mentally disabled and their families with the courts of Minnesota.

Most sincerely,

Richard C. Allen
Dean
Chairman, Supreme Court Study
Commission on the Mentally Disabled
and the Courts

RCA:cp

Enclosure

FOREWORD

Richard C. Allen, Chairman
Supreme Court Study Commission on the
Mentally Disabled and the Courts

The Study

The Study of the Mentally Disabled and the Courts had its genesis in the concerns of the Chief Justice of Minnesota and others as to whether the courts and other institutions of the state are adequately meeting the needs of the mentally disabled and their families, and as to whether present court procedures are fair, appropriate and uniform around the state. Funding was obtained from the National Law Enforcement Assistance Administration through the Crime Control Board and Judicial Planning Commission of the State of Minnesota.

Dr. Gerald Ronning (Vice Chairman of the Commission), Justice Rosalie Wahl (appointed by the Chief Justice to serve as liaison to the Supreme Court), and I met a number of times, beginning in late 1977, to consider the makeup of the Commission. Each of the members we proposed was further considered and approved by the Supreme Court of Minnesota. Obviously many more people were qualified to serve than it was possible to name to the Commission. However, the group finally decided upon could hardly have been improved upon in terms of background, experience and dedication to the tasks set out for them.

The Commission and Staff

The Commission reflects a wealth of knowledge and experience, and represents a wide range of disciplinary, institutional and geographic perspectives. Among its members are: six psychiatrists and 14 attorneys (including five sitting judges); several institutional officials (including the director of a large state hospital); representatives of a number of concerned organizations, including the President's Commission on Mental Health, the Mental Health Association of Minnesota, and the National Institute of Mental Health; public officials, including state legislators from both the Senate and House of Representatives; advocates, both lay and professional; psychologists; a journalist; and a psychiatric nurse. The Commission includes persons experienced in dealing with the problems of the developmentally disabled as well as others whose professional concerns are primarily for the mentally ill; and represents geographically virtually every part of the state.

The first task of the Commission was appointment of a research director. We were fortunate in obtaining the services of Ms Lisbeth J. Nudell to fill that role. Ms Nudell was serving at the time of her appointment as an attorney with Legal Assistance of Ramsey County, is experienced in representing proposed patients in hospitalization proceedings, and has taught courses in mental health law at both William Mitchell College of Law and the University of Minnesota's Mental Health Administration Program. Associated with her on the staff of the project have been: Norman Hoffmann, Ph.D., of the St. Paul-Ramsey Community Mental Health Center; an attorney, Randy Victor; and a law student, Margaret Westin. Connie Galt served as the secretary for the staff.

If this final project report proves to be of value, it will have been largely due to the excellence of the project staff and to the interest and experience of the members of the Commission. All of the latter group contributed their time, and did so generously. Indeed, I believe that one of the most important, albeit intangible, results of the project is the interaction and learning process which occurred through the many meetings which were held by the Commission to discuss the data and their recommendations.

Scope of Research

In any research effort there is great temptation to study the world, and great need to exercise research parsimony. Perhaps especially is this true of studies of the mentally disabled and the courts.

> No. I think that's a problem. To predict dangerousness, I think you'd best have to have some evidence that they'd once done something, and that now they are building up to it, and that their grasp on their conduct or their grasp of logic is so impaired that you can no longer rely on the ordinary restraints that the ordinary citizen has.

The mother of a young man committed three times complained about the pain and embarrassment of his having been transported from the hospital to the courthouse in a police car by a uniformed officer.

The director of a chemical dependency program claimed that the success rate of the program was the same whether the patient was committed or voluntary. In response to further questioning he admitted that this was so because: "The person who comes in 'voluntarily' . . . they're forced in by some fashion anyway."

An attorney with a legal services agency spoke of the legal problems of patients occasioned by the fact of hospitalization; and about discriminations practiced against former mental patients in employment, housing, etc. He urged most eloquently that there be in-house legal services available to hospitalized patients.

An advocate complained that patients – especially those on "provisional discharge" – are not sufficiently informed of their status and rights. Another advocate observed that effective representation of patients is impaired by the advocate's lack of training and the fact that they are employees and under the direction of the hospital.

An attorney noted:

> I think that one of the problems that people have with their attorneys . . . is that the attorney acts as a facilitator of the commitment process, and not as an advocate for the person.

A county social services director concurred:

> There's a lot of talk about the need for counsel. I just restate there is a need for counsel to act as advocate. Again, what . . . it should be considered an adversary proceeding, so that by the time the patient gets to the hospital, if they have any ability to understand at all, they will at least feel that they got a fair shake, and may be more willing to be accepting of the fact that they need help.

The Commission Recommendations

Chapter 4 in the text to follow, contains 24 Recommendations by the Commission. Some are implementable by court rule, some may require legislative action or the development of new administrative procedures. Some require simply closer adherence to the principles set forth in existing law. Few of them represented the unanimous opinion of Commission members. Yet most were the product of a high degree of consensus – remarkable in itself considering the diverse backgrounds of the Commissioners.

Throughout the list of Recommendations there was basic underlying agreement on the part of most of the members of the Commission on the applicability of the concepts of "normalization" and "least restrictive alternative." "Normalization" is the principle that all persons – including those who receive mental health care – should be dealt with in as close to normal fashion as is possible. Unnecessarily demeaning or paternalistic measures should not be used, even if they are more "convenient" for the staff. "Least restrictive alternative" is a new and growing concept in law, which says, essentially, that where special protective or restrictive measures are shown to be necessary because of one's mental impairment, they should be as limited in scope and duration as is possible consistent with the needs of the patient

and society. Thus, if community care can be rendered, hospitalization should not be ordered. If sedation and restraints can be avoided, they should be. If an open ward and freedom to come and go are possible, they must be permitted.

Among the most vigorous discussions of the proposed Recommendations were those pertaining to the role of counsel and the courts. We have, therefore, included excerpts from the transcript of our discussions so that the various points of view presented can be seen and evaluated.

The Criteria for Involuntary Hospitalization

The Commission was unable to reach agreement with respect to several proposals offered for changes in the criteria for involuntary hospitalization. A quarter of a century or so ago, several states adopted the recommended language of what was called the Draft Act, promulgated by the National Association for Mental Health and the National Institute of Mental Health. Under the language of that Act, one might be involuntarily hospitalized if because of his illness he was found to be either: (1) likely to injure himself or others if allowed to remain at liberty; or (2) in need of custody, care or treatment in a mental hospital, but because of his illness lacking sufficient insight or capacity to make responsible decisions with respect to his hospitalization. In the middle sixties, sparked by hearings before the Subcommittee on Constitutional Rights of the Mentally Ill of the United States Senate Judiciary Committee – out of which came the Ervin Act for the District of Columbia – the concept of dangerousness to self or others became the sole criterion of commitment in Washington, D.C., and in a number of states. More recently, efforts have been made in several states to abolish involuntary hospitalization or to substitute for "likely to injure" or "dangerousness" commission of an act which absent a finding of mental illness would have been a sufficient basis for incarceration by a criminal court.

The Minnesota Statute (Section 253A.07, subd. 17) defines four categories of persons who may be involuntarily hospitalized by judicial order. In addition to "inebriate person" (for whom the period of confinement is strictly limited) and "mentally deficient person" (which contains essentially the same evidentiary requirements as "mentally ill person"), the statute lists two other categories: "mentally ill person" and "mentally ill person who is dangerous to the public." While it would appear at first glance that this is essentially the Draft Act dichotomy, in actuality the evidentiary requirements for involuntary hospitalization of mentally ill persons are more rigorous than a mere finding of need for hospitalization and "lack of insight." The Minnesota statute requires that there be evidence of conduct clearly showing an attempted or threatened suicide, or an attempt to seriously physically injure himself or others, or failure to care for his own needs for food, clothing, shelter, safety, or medical care, or failure to protect himself from exploitation from others, together with evidence that there has been careful consideration of reasonable alternative dispositions and that no suitable alternative to involuntary hospitalization exists. As will be seen in the project report to follow, inconsistencies were found in the application of these statutory criteria.

The Supreme Court of the United States observed in **O'Connor v. Donaldson**, 422 U.S. 563 (1975):

> Mental illness alone cannot justify . . . locking a person up against his will and keeping him indefinitely . . . There is . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.

Several state statutes, which were essentially in the Draft Act mold, have recently been found unconstitutional (Wisconsin, Pennsylvania, Hawaii, Nebraska, Iowa, Michigan, and most recently Utah). Some of the new laws enacted in response to judicial decisions now require evidence of recent threats or attempts, or a finding of imminence of serious harm, and most use language like "physical harm to self or others" or "dangerousness." The Illinois statute, recently enacted following a multidisciplinary, three-year study, requires that there either have been "a significant threat that supports a reasonable expectation that he will inflict a serious physical harm upon himself or another in the near future," or a clear demonstration of inability to provide for his basic physical needs "by engaging in behavior which poses a serious threat to his life or physical health."

Opinion was strongly divided among the Commission members. Some felt that involuntary hospitalization should be as simple as possible, and largely dependent upon the doctor's judgment. Others felt that strong behavioral evidence of imminent danger should be required – perhaps amounting to an actual homicidal or suicidal attempt. Some felt that the language of the Minnesota statute was ambiguous and redundant, and left little room for discrimination between "mentally ill" and "mentally ill and dangerous." And several expressed concern about the person who, because of senility, mental retardation, or acute mental illness, is unable to provide for himself the necessities of life and is thus in danger of harm – not because of self-destructive tendencies – but because of self-neglect.

My own preference would be for language similar to that of the Illinois statute. It seems to me that more should be required for involuntary hospitalization than the opinion of a physician that the proposed patient would be benefited by in-patient care. We are dealing, after all, with an area that involves not only a medical but a social judgment; liberty is our most precious civil right. And, it seems to me that the evidence should be more than prospective. If it is only prospective or speculative, then we have created a system of preventive detention. On the other hand, I don't think society should be required to wait until there is a serious suicide attempt or an actual attempt on the life of another. Because to wait that long might be to wait too long.

However, it is perhaps not of crucial importance that the Commission was unable to agree on a new formulation of words. The determination of when and under what circumstances the liberty of an unwilling citizen should be taken away can be most difficult. Nor is there much guidance in the alternative language of competing state statutes (*e.g.*, compulsive check-writing was once held to be "dangerous behavior" under the Ervin Act in the District of Columbia). It is, I believe, far more important that the Commission was able largely to agree on the importance of fair and effective representation by counsel, and on determinate rather than indeterminate hospitalization, with review no less frequently than once a year. In any event, because the criteria for involuntary hospitalization are so much a matter of debate around the country currently, it seemed to me that reference should be made to the Commission's inability to come up with a final resolution of the problem.

Conclusion

As Chairman of the Supreme Court Study Commission on the Mentally Disabled and the Courts, I would like to express – for myself and for the people of Minnesota – profound gratitude to the staff and members of the Commission, who gave of themselves so selflessly to this research effort. I hope and believe that that effort has produced a document that will provide significant benefits for the mentally disabled and their families, and that will help to bring about fairer and more effective court action in protecting their rights.

This project was supported by grants #3312021176 and #33120021178 awarded to the Minnesota Supreme Court by the State of Minnesota Crime Control Planning Board. Points of view and opinions stated in this report are those of the Supreme Court Study Commission on the Mentally Disabled and the Courts and do not necessarily represent the official position or policies of the Crime Control Planning Board or the Minnesota Supreme Court.

PREFATORY REMARKS

Dr. Gerald F. Ronning, Vice-Chairman
Supreme Court Study Commission on the Mentally Disabled and the Courts

The recommendations of the Study Commission are based on extensive data gathered during the course of the study and are the result of an open and candid debate by a diverse group of individuals. These data were derived from a variety of sources including the experiences of the commission members, the participation by the members in the public hearings, and empirical data collected by skilled research staff. The manner in which the commission and staff collaborated reflects an explicit acknowledgment that no one group, interest, or professional discipline has the best or the final answer to the complexities documented in the study.

The problems which the courts are asked to consider in commitment hearings represent complex, biological, social and psychological processes and any proceedings which attempt to reduce this complexity to a formality or to a perfunctory ritual does an injustice to all parties. The data gathered in the study suggests that proceedings are often brief and often depend almost entirely on the opinion of the medical expert and that theprocedures which are so crucial in the lives of many people are experienced by many of the participants including physicians and family as indifferent, often dehumanizing and of doubtful efficacy in accomplishing the intended goals. Mental illness is a symptom of isolation and lack of alternatives and procedures or practices which mirror these characteristics perpetuate the problems. Medical psychiatric expertise which is valid in the clinical setting is of dubious validity when applied as the sole criterion for commitment in the court setting.

While there was not unanimous agreement amongst the commission members on any one of the recommendations which appear in the final report, the discussions demonstrated the complexities involved and the need to avoid undue reliance on any single perspective. The final recommendations are informed by the principle of openness and the belief that properly conducted proceedings in which the competence of all parties is encouraged and in which the dignity of the participants is assured will be the most likely to result in the employment of the least restrictive alternatives.

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CHAPTER 1

INTRODUCTION

THE COMMISSION

In 1976, Chief Justice Robert J. Sheran, along with several other Minnesotans, attended the First National Conference on the Legal Rights of the Mentally Disabled in Topeka, Kansas, sponsored by the Menninger Foundation and the Kansas Bar Association. The issues raised and discussed at this conference added to the concerns of the Chief Justice regarding the status and enforcement of the legal rights of the mentally disabled in Minnesota. At the same time, more and more cases, both in Minnesota and elsewhere, were being presented to the courts, which addressed issues of legal rights of mentally disabled persons.

Chief Justice Sheran directed the Crime Control Planning Board staff to develop a grant proposal to fund a study of the status of legal rights of mentally disabled persons in Minnesota. This proposal was submitted, funding was granted, and the Chief Justice, in late 1977, began appointing Commission members.

Knowing of ASSOCIATE JUSTICE ROSALIE E. WAHL's interest and concern for problems of mentally disabled persons, Chief Justice Sheran designated her the Court's liaison to the Commission.

The Chief Justice appointed DEAN RICHARD C. ALLEN, Dean of Hamline Law School, formerly Legal Consultant to the President's Committee on Mental Retardation, and author of several books on forensic psychiatry, as the Commission Chairman. Appointed as Vice-Chairman was DR. GERALD F. RONNING, psychiatrist and Medical Director of the Crisis Intervention Center at Bethesda Lutheran Hospital.

The following persons were appointed by the Chief Justice, on the recommendation of Dean Allen and Dr. Ronning, to serve as Commission members:

ROSEMARY ANNEXSTAD, Admissions Unit Director, Security Hospital, Saint Peter
DR. DAVID AURAN, Psychiatrist, Private Practice, Saint Paul
ELIZABETH A. BUCKLEY, Deputy Commissioner of Corrections (resigned 1979), St. Paul
PROFESSOR DAVID COBIN, Esq., Hamline University Law School, St. Paul
VIRGINIA DAYTON, President's Commission on Mental Health, Long Lake
GEORGE ELWELL, Esq., Chief of Mental Health Division, Assistant Hennepin County Attorney, Minneapolis
JAMES F. FINLEY, Esq., Ramsey County Court Commissioner, St. Paul
JOSEPH S. FRIEDBERG, Esq., Private Practice, Minneapolis
HONORABLE ROBERT GRAFF, Judge of County Court, Aitkin
*LUTHER GRANQUIST, Esq., Executive Director, Central Minnesota Legal Services, Minneapolis
THERESA HALLORAN, Director of Mental Health, Hennepin County; formerly with the Mental Health Division, Dept. of Public Welfare, Minneapolis
**GERI JOSEPH, Contributing Editor, Minneapolis Star & Tribune, Minneapolis
***ERIC JANUS, Esq., Managing Attorney, Developmental Disabilities Advocacy Project, Central Minnesota Legal Services, Minneapolis
HONORABLE THADDEUS JUDE, Esq., Minnesota House of Representatives, Mound

*Luther Granquist resigned upon accepting a position with Alaska Legal Services.
**Geri Joseph resigned upon her appointment as United States Ambassador to the Netherlands.
***Eric Janus was appointed to replace Luther Granquist.

DR. JOHN KELLY, Psychiatrist, Department of Family Practice, University of Minnesota, Minneapolis
MIRIAM KARLINS, Consultant, National Institute of Mental Health, Minneapolis
DR. JOHN C. KLUZNIK, Psychiatrist, Private Practice, Golden Valley
REBECCA KNITTLE, Esq., Managing Attorney, Southern Minnesota Regional Legal Services, St. Paul
DR. CARL P. MALMQUIST, Psychiatrist, Department of Criminal Justice, University of Minnesota, Minneapolis
PAUL MESSPLAY, Executive Director, Mental Health Association of Minnesota, Minneapolis
HONORABLE DONALD M. MOE, Minnesota House of Representatives, St. Paul
DR. R. OWEN NELSEN, Chief Court Psychologist, Hennepin County Court Services, Minneapolis
HONORABLE ALLEN L. OLEISKY, Judge of District Court, Minneapolis
DOLORES C. OREY, Esq., Private Practice, Security Hospital Review Board, St. Paul
HONORABLE GEORGE F. PERPICH, Minnesota State Senate, Chisholm
*DR. EDWARD POSEY, Psychiatrist, Veterans' Administration Hospital, Minneapolis
HONORABLE GERARD RING, Judge of County Court, Rochester
NATALIE ROSEN, R.N., C. Certified Psychiatric Practitioner, St. Paul
HONORABLE NOAH S. ROSENBLOOM, Judge of District Court, New Ulm
DR. CLARENCE ROWE, Psychiatrist, Private Practice, St. Paul
DR. MARGARET SILBERBERG, Psychologist, Family Health Program, Minneapolis
DR. FRANCIS TYCE, Medical Director, Rochester State Hospital, Rochester
PAUL ZERBY, Esq., Assistant Attorney General, Department of Public Welfare, St. Paul

The Commission was staffed by a Director, Lisbeth J. Nudell, Esq., who was hired in November, 1977. Working with her, beginning in March, 1978, was Randy Victor, Esq., who remained with the staff through November, 1978. Since that time, Margaret Westin, currently a student at William Mitchell College of Law, has been employed full-time, though she has been with the project since July, 1978. Connie Galt has worked as the staff's secretary since May, 1978. The staff designed, implemented and analyzed the research project in consultation with Dr. Norman Hoffmann, Ph.D., Researcher and Clinician, Saint Paul-Ramsey Medical Center, Department of Psychiatry. Data were collected for the most part during the summer, 1978, by six law students who worked full-time during that summer, and who traveled to the various counties in the state to gather the necessary data. These students, some of whom have continued to work with the Commission staff are:

Margaret Westin, William Mitchell College of Law
Elizabeth Zerby, Hamline University Law School (graduated May, 1979)
Gregory Bulinski, University of Minnesota Law School (graduated June, 1979)
Kit Hadley, University of Minnesota Law School
Dan Altwegg, Hamline University Law School
David Girard, Hamline University Law School

The Commission first met in November, 1977. At that meeting, Chief Justice Sheran spoke to the Commission and presented the Commission with its charge. The Commission, at that meeting and at other meetings, raised several issues which have not been included in this Commission's study only because of the limited resources of the Commission. The issues which were raised and may form the bases for further studies are:

- The use of Mental Illness as a defense in criminal trials.
- What standards are there, if any, to determine who is sent to a corrections facility and who is sent to Security Hospital (or, in the case of females, to Anoka State Hospital's secure unit)?
- Do transfer procedures for the transfer of persons between corrections and welfare institutions protect the rights of persons subject to their use?
- Why has there been a substantial increase in the number of commitments of persons as "mentally ill and inebriate" in 1978? (In Hennepin County, there was a 35% increase over the previous year.)

*Dr. Posey resigned in April, 1979.

- Are we adequately insuring that persons in need of treatment are being cared for under our existing delivery systems?

- The availability of treatment for persons within corrections facilities.

- A review of the impact of popular opinion and understanding of mental illness and its impact on treatment.

- The need to define who should be committed as "mentally ill and dangerous to the public".

The Commission, having recognized the overwhelming possibilities for study of the rights of mentally disabled persons in Minnesota, agreed upon a study of the rights of mentally disabled persons in civil commitment proceedings.

Under the direction of the Commission, the staff proceeded to develop and implement a study designed to gather empirical data on civil commitment in Minnesota. Following the gathering of data, the Commission convened on several occasions, including a two-day session at Spring Hill Conference Center, to discuss proposed staff recommendations, develop other recommendations, and further pursue the ends of the study.

As part of the study included the holding of Public Hearings, the Commission determined that issues raised by interested persons testifying at these Hearings would perhaps serve the Commission by pointing out areas in need of further study beyond the terms or life of the current Commission. These additional areas of study can be found in the Public Hearing summaries in this report.

The Commission respectfully submits the following report and appendices in fulfillment of the charge placed upon it.

MINNESOTA CIVIL COMMITMENT STUDY[1]

To determine whether legal rights of mentally disabled persons in Minnesota are adequate, and are enforced, required a look at whether or not practices in the 87 counties in Minnesota are uniform and with clearly defined standards. Early in the study it became clear that the practices and procedures implemented among the many counties in the state are not uniform. It was also clear that there was, in several aspects of the commitment process, a lack of specified standards, which could be a factor in the apparent lack of uniformity.

The study design, had as its primary purpose the determination of how the Minnesota Hospitalization and Commitment Act has been implemented, including the uniformity or lack of uniformity of such implementation. The design was also to test whether or not there is a need to promote uniformity and develop standards in various aspects of the civil commitment process.

With the technical assistance of Norman Hoffmann, Ph.D., research psychologist, the staff developed a study design which included a blanket-survey of all judges and county attorneys who are participants in the commitment process; the design further included an in-depth study of selected counties in which records of commitment proceedings were reviewed, field observations of commitment hearings, and examinations by court-appointed examiners were recorded, and informal interviews were held with key personnel in the commitment process.

[1]For the record review, data gathered were from the calendar year 1977: Observation data were from proceedings during June through September, 1978.

Public Hearings were held by the Commission to solicit information from all members of the public wishing to be heard. Testimony was received from many persons, including: consumers of mental health care services, relatives of consumers, psychiatrists, psychologists, nurses, other mental health care professionals, lay advocates, lawyers and other concerned citizens.

BLANKET-SURVEY AND IN-DEPTH STUDY

A two-tier study was designed to provide data on a statewide basis and on a selected county basis.

A blanket-survey of all counties was accomplished through questionnaire responses. An in-depth study was done through a review of court records and through field observations, when feasible, in a limited number of counties. Finally, informal interviews were held with key participants in the commitment process, particularly in counties in which the staff research included field observations and interviews.

Comments and other information were received by the staff from additional sources with special knowledge and information of the commitment process as it is practiced in the 87 counties of the state.

The purpose of the study was not statistically to determine the implementation of the Minnesota Hospitalization and Commitment Act throughout Minnesota. Rather, the purpose was to:

a. determine the implementation of the Minnesota Hospitalization and Commitment Act; and
b. determine the uniformity of implementation; and
c. determine model practices as adopted in one or more counties; and
d. determine the need for change in the implementation of the Minnesota Hospitalization and Commitment Act; and
e. provide a forum for individuals and groups to express concerns and comments.

The objectives of the study (together with all other work of the Commission and its staff during the tenure of the Commission) were as follows:

a. to provide the Commission with information upon which they could make statements/recommendations; and
b. to gather for the Commission statistics on the number of commitment petitions filed and the dispositions of those petitions; and
c. to determine whether practices and procedures are standard throughout the state; and, if not, in what respects the practices are not standardized; and, if necessary, how standardization might be achieved; and
d. to discover and/or design model practices which could form the basis for recommendations for the promulgation of court rules; and
e. to determine whether legal rights of mentally disabled persons in Minnesota are being protected; and
f. to provide information necessary for further study of a judicial process which had heretofore not been subject to statewide study.

The blanket-survey consisted of two questionnaires which were designed to be answered by the county court/probate court judges (in many instances with the assistance of the Clerk of Court's staff), and by county attorneys or assistant county attorneys who are involved in the implementation of the MHCA. The questionnaire to judges included a request for information regarding the number of petitions, the frequency of types of petitions, and the dispositions of those petitions.

It was also determined that, with the responses from the two questionnaires, and the data from the record review (in-depth study) and the Public Hearing testimony, together with all other data and information received, there is sufficient data to conclude the study as proposed by the staff and approved by the Commission.

The in-depth study was accomplished through a review of all 1977 court records pertaining to MHCA proceedings which were on the calendar of the courts in the selected counties in the calendar year 1977. The method of data collection and other information is more fully detailed in the section containing the description and analysis of data collected through this portion of the study.

PUBLIC HEARINGS

Six Public Hearings were held between May and December, 1978. Hearings were held in each quarter of the state (Fergus Falls, Rochester, Duluth and Willmar) as well as in Saint Paul and in Minneapolis. All Public Hearings were tape recorded and each hearing record has been transcribed and the transcripts are appended to this report.[2]

To insure public participation in the work of the Commission, each hearing was advertised as broadly as possible to reach all interested persons and organizations. Press releases were sent to all area newspapers. Individuals and organizations which could be identified were notified by letter of the Public Hearing in their area. Because of the cooperation of a contact person in each geographical area (exclusive of Saint Paul and Minneapolis),[3] we were able to identify and personally contact a diverse group of persons who presented testimony to the Commission at the Public Hearings as well as presented written information to the staff.

Three or more Commission members represented the Commission at each Public Hearing. At each Hearing, the Commission members represented the multidiscipline character of the Commission in that a doctor (medical or Ph.D. psychologist), a lawyer and another Commission member representing neither of these professions was present at each Public Hearing.

Testimony was presented by consumers, former consumers, treatment professionals, lawyers, a judge and others interested in legal problems of the mentally disabled in Minnesota. Though some of the information goes beyond the scope of this study (and beyond the jurisdiction of the courts), persons were encouraged to testify as to all matters of concern so as not unduly to restrict information which may prove useful and informative.

Testimony from Public Hearings was for the purpose of reinforcing other findings of the staff, and for the purpose of showing problems and concerns in areas not otherwise empirically studied. It is recognized that the concerns of an individual testifying at a Public Hearing are not necessarily a sound foundation upon which any conclusions may be premised, but the value of some testimony is that this information could not be quantified in any other manner through our current study, and the information should be noted as part of the study.

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[2]Appendix D: Transcript from Fergus Falls Public Hearing.
Appendix E: Transcript from St. Paul Public Hearing.
Appendix F: Transcript from Minneapolis Public Hearing.
Appendix G: Transcript from Rochester Public Hearing.
Appendix H: Transcript from Duluth Public Hearing.
Appendix I: Transcript from Willmar Public Hearing.

[3]Persons who assisted the staff to insure the success of the Public Hearings are:
Bill Johnson, Advocate, Fergus Falls State Hospital.
Sandy Butturff, Advocate, Rochester State Hospital.
Trudy Dunham, Mental Health Coordinator, Northeast Area Board, Duluth.
Brian Relay, Advocate, Willmar State Hospital.

MONOGRAPHS

There were areas of concern which could not be included in the study given the limited resources and expertise available. Therefore, the staff contracted with three individuals, each with a special area of mental health law expertise, for three monographs which would supplement the work and findings of the Commission. These monographs are appended to this report,[4] and there are references contained in the body of the report to the contents of these monographs.

The first of these monographs discusses alternatives available in Minnesota to in-patient hospitalization which the courts may consider, as they are required to do under the Minnesota Hospitalization and Commitment Act. This paper, by Kathleen O'Connor, former director of the Exodus Program, a non-residential treatment program, points out the serious lack of community or other resources available to persons in Minnesota who are in need of treatment and who may be subjects of involuntary commitment. This monograph discusses the needs, lack of facilities and the problems of allocation of limited resources for the treatment of the mentally disabled population.

The second monograph is written by Alan W. Weinblatt, Esq., a Saint Paul attorney experienced in mental health law most notably as the plaintiff's attorney in Price v. Sheppard. This monograph was written by Mr. Weinblatt together with Carolyn Sachs, a recent law school graduate. The subject of this monograph is the issue of informed consent and the implications of informed consent on issues of mental health treatment. This paper explores the elements of informed consent, recent case law, and suggested requisites of informed consent for mental health treatment. Also included are suggested forms for use in implementing a system whereby their notions of informed consent may be insured.

The third monograph includes guidelines for defense counsel representation in civil commitment cases. This paper was written by Richard E. Leonard, a Saint Paul attorney who is one of the court-appointed panel of attorneys, and represents all proposed patients in commitment proceedings in Ramsey County every seventh week.

OTHER STUDY COMPONENTS

To broaden the input into the study, a number of materials were obtained by the staff, including statements and comments in lieu of or to supplement Public Hearing testimony, printed materials and program descriptions. Summaries of the written statements are included in this report.

Printed materials submitted to or collected by the staff include scholarly writings, reports of relevant studies, newspaper and magazine articles, and other printed materials.

Program descriptions were also submitted as part of the study. Included are written descriptions of treatment programs, advocacy programs, court procedural rules, codified county welfare department practices, and other data of concern to this study.

All of these materials will be retained by the Supreme Court Administration, including computerized data, raw data (questionnaire responses and data collection forms) and may be available for use as researchers or other interested persons may wish to make of them.

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[4] Appendix A: "Alternatives to Civil Commitment in Minnesota", by K. O'Connor.
Appendix B: "Informed Consent", by A.W. Weinblatt, Esq., and C.C. Sachs.
Appendix C: "Defense Counsel's Role in the Commitment Process, by R.E. Leonard, Esq.

CHAPTER 2

JUDGES' QUESTIONNAIRE

INTRODUCTION TO JUDGES' QUESTIONNAIRE

Questionnaires were sent to the judge, referee, or other judicial officer identified in each county as being responsible for presiding over commitment proceedings, or who presides over most of that county's commitment proceedings. In counties in which no single person was identifiable, the questionnaire was sent to all judicial personnel in the county.

This questionnaire (as well as the questionnaire sent to county attorneys) was designed by the staff in consultation with Dr. Norman Hoffmann, Ph.D., the staff's research consultant, who is both a research and clinical psychologist at Saint Paul-Ramsey Community Mental Health Center.

The first page of the questionnaire requested data on numbers of petitions filed in 1977 and the disposition of those petitions. Pages two, three and four elicited information regarding procedures practiced by the counties in commitment proceedings. A follow-up letter was then sent to each judge or judicial officer asking for any comments or suggestions which may be of interest to the Commission.

Seventy counties, representing 88% of the state's population, responded to pages 1 through 4 (the entire questionnaire), and thus provided the Commission with responses to inquiries about pre-petition procedures, attorneys' roles, hearing procedures and other matters.

Eighty-two counties representing an estimated 97.5% of the state's population responded to page 1.[1] Based on these responses using 1974 population estimates,[2] the following numbers represent an estimate of 100% of the population as well as the exact numbers reported by the 82 responding counties. The counties which did not respond are: Carlton, Grant, Kanabec, Martin and Stevens.

RESPONSES AND ANALYSES

1. NUMBER OF PETITIONS FILED UNDER THE MINNESOTA HOSPITALIZATION AND COMMITMENT ACT IN 1977.

PETITIONS FILED ALLEGING:

	97.5%	estimated 100%[3]
Mental Illness	1576	1666
Inebriacy	1670	1713
Mentally Ill and Inebriacy	340	349
Mentally Ill and Dangerous	106	109
Mentally Deficient and in Need of Hospitalization	89	91
TOTAL PROCEEDINGS UNDER MINNESOTA STATUTE CHAPTER 253A	3781	3873

[1]The population figures are 1974 estimated population figures which are recorded by the Minnesota State Demographer in the *Minnesota Pocket Data Book*, 1975, rev. 1976.

[2]*Ibid.*

[3]*Ibid.*

In 1977, there was approximately one petition filed under the Minnesota Hospitalization and Commitment Act (which hereinafter may be referred to as the MHCA) for each 1028 residents of the state.

Hennepin County, with 23.6% of the state's population, had a total of 1355 petitions filed, or an average of 26 petitions filed per week. 35.5% of all Minnesota Hospitalization and Commitment Act petitions and 59% of all petitions alleging "mentally ill and dangerous" were filed in Hennepin County.

Ramsey County, with 12% of the state's population, had a total of 320 petitions filed, or an average of 6.2 petitions filed per week. 8.47% of all Minnesota Hospitalization and Commitment Act petitions and 1.9% of all petitions alleging "mentally ill and dangerous" were filed in Ramsey County.

Saint Louis County, with 5.5% of the state's population, had a total of 128 petitions filed, or an average of 2.5 petitions filed per week. 3.4% of all Minnesota Hospitalization and Commitment Act petitions and 3.7% of all petitions alleging "mentally ill and dangerous" were filed in Saint Louis County.

2. HOLD ORDERS

Upon the filing of a petition under the Minnesota Hospitalization and Commitment Act, the court may order a person to be confined until such time as a hearing is held. The statute further authorizes the court to order that, if the person is not already in the hospital, the proposed patient may be picked-up and brought to the place of confinement. There are no standards or guidelines which indicate when or under what conditions these orders may be issued.

> Minn. Stat. §253A.07, subd. 3: The court may direct a health or peace officer or any other person to take the proposed patient into custody and transport him to a public hospital, private hospital consenting to receive him, public health facility, or other institution, for observation, evaluation, diagnosis, emergency treatment and, if necessary, confinement.
>
> Minn. Stat. §253A.04, subd. 3: Upon the filing of a petition, the court may order the detention of the person until determination of the matter. [This subdivision applies to confinement orders for persons currently under confinement.]

INQUIRY: IN APPROXIMATELY WHAT PERCENT OF CASES ARE ORDERS FOR CONFINEMENT ISSUED?

RESPONSE: Upon the filing of a petition, proposed patients are confined prior to a hearing in:

28 counties	in 100% of all cases
20 counties	in 90-99% of all cases
10 counties	in 70-80% of all cases
2 counties	in 60-69% of all cases
8 counties	in 50% of all cases
2 counties	in less than 50% of all cases
70 counties	**TOTAL NUMBER RESPONDING**

INQUIRY: WHAT RATIONALE UNDERLIES YOUR ISSUANCE OF CONFINEMENT ORDERS? (MORE THAN ONE REASON UNDERLIES ORDERS IN MOST COUNTIES.)

RESPONSE:

Standard Operating Procedure	29 counties
To Insure Court Appearance	20 counties
To Have Proposed Patient Examined	34 counties
Petitioner Requested the Pick-up	19 counties
Factual Allegations of Dangerousness to Self	22 counties
Factual Allegations of Dangerousness to Others	22 counties
Current Threats of Dangerousness	22 counties

COMMENTS: *Fifteen counties report the issuance of orders confining a person upon the mere filing of a petition,* **without** *factual allegations of dangerousness to self or others* **and** *without any threat of dangerous behavior.*

Courts in nine counties issue "hold orders" 100% of the time as their standard operating procedure, and for no other reason.

Courts in many counties responded that the petitioner's request for pre-hearing confinement of the proposed patient is a factor in the decision to apprehend and confine. (Eighteen indicate this to be their primary consideration.)

Another consideration of judges in the decision to issue "hold orders" was the ease with which pre-hearing medical/psychiatric examinations can be performed if the proposed patient is hospitalized.

Responses from only six counties indicated that the considerations for issuance of apprehend and confine orders were solely factual allegations of dangerous or threatening behavior. (Clearwater, Morrison, Mower, Norman, Polk and Wabasha Counties.)

3. GENERAL HEARING PROCEDURES

The statutory provisions which address the question of who has a right to attend commitment hearings, and who may be excluded from these proceedings, are set forth below:

> Minn. Stat. §253A.07, subd. 10: The proposed patient, the petitioner and all other persons to whom notice has been given pursuant to subdivision 9 may attend the hearing and, except for the patient's legal counsel, may testify. The court shall notify such persons of their right to attend the hearing and to testify.
>
> Minn. Stat. §253A.07, subd. 12: Subject to the proposed patient's right to attend the hearing, the court in its discretion may permit the proposed patient to be absent from the hearing if the person conducting the hearing shall have observed and consulted with the proposed patient prior to the hearing. The court may exclude from the hearing any person not necessary for the conduct of the proceedings except those persons to whom notice was given pursuant to subdivision 9 and any other persons requested to be present by the proposed patient . . .

INQUIRY: IN WHAT PERCENT OF CASES IS THE PETITIONER PRESENT AT THE COMMITMENT HEARING?

RESPONSE:

Petitioners attend:	100% in	60 counties
	99% in	1 county
	95% in	4 counties
	90% in	2 counties

INQUIRY: IN WHAT PERCENT OF CASES IS THE PROPOSED PATIENT PRESENT AT THE COMMITMENT HEARING?

100% in	52 counties
99% in	2 counties
95% in	10 counties
85% in	2 counties
75% in	1 county
TOTAL RESPONDING	**67 counties**

INQUIRY: IS THE PETITIONER NECESSARY TO PROVE UP THE PETITION?

RESPONSE:

Yes	49 counties
No	18 counties
TOTAL RESPONDING	**67 counties**

4. ROLE OF COUNSEL

The Minnesota Hospitalization and Commitment Act specifically provides for the appointment of counsel to represent the proposed patient:

> Minn. Stat. §253A.07, subd. 15: . . . The proposed patient shall be afforded an opportunity to be represented by counsel, and if neither the proposed patient nor others provide counsel, the court at the time the examiners or licensed physicians are appointed shall appoint counsel to represent the proposed patient. Counsel shall consult with the proposed patient prior to the hearing and shall be given adequate time to prepare therefor. Counsel shall have the full right of subpoena.

Other provisions of the Minnesota Hospitalization and Commitment Act which refer to the role of counsel include requirements that counsel be served notice of orders, be given five days notice prior to the holding of a hearing and be given a copy of any written reports of examiners which are prepared prior to the hearing. (See Minn. Stat. §253A.07, subd. 2, 9, 10.)

The statute makes no reference to compensation of counsel in the event that counsel is court-appointed or otherwise provided by the county, except as follows:

> Minn. Stat. §253A.20, subd. 1: . . . and to patient's counsel, when appointed by the court, a reasonable sum for travel and for each day or portion thereof actually employed in court or actually consumed in preparing for the hearing . . .

INQUIRY: WHAT COMPENSATION DO COURT-APPOINTED COUNSEL RECEIVE?

RESPONSE:

Hourly rate	56 counties
Per client	10 counties
Per hearing	1 county
Monthly retainer	3 counties[4]
TOTAL RESPONDING	**70 counties**

[4]One county has recently changed from a monthly retainer to an hourly rate, thereby leaving only two counties which continue to compensate through a monthly retainer.

Hourly compensation (6 counties did not provide data on the hourly rate)

Rate	NUMBER OF COUNTIES In-Court-time	Out-of-Court-time
$20/hr	0	2
$25/hr	6	6
$30/hr	20	18
$35/hr	17	15
$37.50/hr	1	1
$40/hr	34	1
$50/hr	2	0
Total Counties	**50**	**43**

Some counties compensate at different rates for in-court time and out-of-court time; the number of responses varies probably because rate of compensation for in-court = rate of out-of-court.

Average compensation of counsel compensated on an hourly basis varies greatly from $25 (one hour/client at $25/hr) to $200 (5½ hours at $35/hr).

Most counties responded that counsel's compensation is for approximately 2-4 hours per client.

Per Client

	Number of Counties
$40/client	4
$50/client	4
$100/client	2
Total Counties	**10**

Per Hearing . . . . . $150.00 in one county

Monthly Retainers . . . . . No information was provided on the rate of compensation in two counties which use this method of compensation; counsel in those two counties are retained as Public Defenders under the same retainer agreement.

The third county, which in 1977, averaged 6 petitions per month, paid a monthly retainer of $600/month. This county now compensates counsel at an hourly rate.

COMMENTS: *Compensation varies widely among counties with similar economic bases. For example, Hennepin County compensates counsel on a "per client" basis; Ramsey County at an hourly rate; and St. Louis County includes these matters under juvenile/mental health public defender retainers.*

Compensation may range from $35.00 for a case in one county to $435.00 which was paid for one case in 1977, in another county.

The number of attorney hours compensated ranges from an average of only 1 hour per client in only one county to an average of 2½-4 hours in most counties.

The average cost to the county for counsel's fees ranges within $100-$150 per petition.

INQUIRY: HOW FREQUENTLY ARE PROPOSED PATIENTS REPRESENTED BY COURT-APPOINTED COUNSEL?

RESPONSE: Of responses from 70 counties, 25 indicated that 100% of all proposed patients are represented by court-appointed counsel. In 27 counties, 95-99% of all proposed patients have court-appointed counsel.

In 10 counties, 90% of all proposed patients have court-appointed counsel. In only 6 out of 70 counties do proposed patients retain their own counsel in more than 10% of the cases. (Therefore, the rate of compensation for "court-appointed counsel" bears on most proceedings under the MHCA.)

INQUIRY: WHEN DO THE DUTIES OF COURT-APPOINTED COUNSEL TERMINATE?

RESPONSE: Based upon responses from 64 counties:

At the end of the hearing	26
Upon issuance of the 60-Day Warrant of Commitment	12
Upon issuance of Indeterminate Commitment Order .	8
Upon complete discharge of proceedings	23[5]
At the attorney's discretion	1
TOTAL	70[6]

COMMENTS: *The staff find these responses inconsistent with their field observation regarding the extent and length of patients' counsel's involvement.*

Though eight counties responded that counsel's responsibilities terminate at the issuance of the Indeterminate Commitment Order, this response may merely reflect that a copy of the 60-Day Report (sent by the confining institution to the court) is sent to the "patient's counsel" (Minn. Stat. §253A.07, subd. 23). There does not appear to be any contact between counsel and patient at any time following a Warrant of Commitment, except in very few counties.

It is worth noting that counsel's duties terminate at the end of the hearing in 26 counties or in 41% of all counties. This strongly suggests that the right to appeal may, in many counties, be a vacuous right.

Further, and perhaps more important, there is no counsel provided or no opportunity for counsel at the most crucial stage — at the time a decision to indeterminately commit is made. Counsel, therefore, in many counties, is provided only for proceedings to determine 60-Day commitments; but, no such safeguards are provided for patients who face commitment for what could be years.

[5]This response is inconsistent with field observations of staff and is contrary to information received from advocates at several Minnesota State Hospitals. According to several State Hospital Advocates, rarely does the court-appointed counsel (or any other attorney) advise or represent a patient after the initial commitment hearing or after the initial order for the 60-Day Commitment.

[6]Responses from six counties indicated two answers.

5. ROLE OF GUARDIANS AD LITEM

The Minnesota Hospitalization and Commitment Act makes only one reference to the appointment of guardians *ad litem* in commitment proceedings. A guardian *ad litem* is "a guardian appointed by a court of justice to prosecute or defend for an infant in any suit to which he may be a party."[7]

> Minn. Stat. §253A.07, subd. 6: . . . If the court has reason to believe that notice (of the filing of the petition and the order for examination) would be likely to be injurious to the proposed patient, notice to the proposed patient may be omitted if a guardian ad litem is appointed by the probate court for receipt of such notice. Such guardian shall represent the proposed patient throughout the action of the petition.

INQUIRY: IS A GUARDIAN AD LITEM APPOINTED IN MOST CASES?

RESPONSE:
Yes 57
No 11

(The person appointed a guardian *ad litem* is always the same person who is appointed to serve as patient's counsel.)

COMMENTS: *Counties which appointed guardians* ad litem *do so usually as a matter of course. This is encouraged by the form used in most counties which includes a printed provision ordering the appointment to the dual role of both counsel and guardian* ad litem. *Using the form, this appointment as both guardian* ad litem *and counsel is made unless part of the form is crossed out.*

The other rule governing guardians ad litem *is found in Rule 17 of the Minnesota Rules of Civil Procedure. This rule defines the formal requisites for the appointment of a guardian* ad litem.

The Minnesota Court has never had an opportunity to address the question of whether the appointment of a guardian ad litem*/counsel can fulfill the constitutional right to counsel. The role of counsel, whether or not the same individual also is appointed guardian* ad litem, *has not been litigated in Minnesota.*

The majority of the Minnesota Bar Association's Human Rights Committee issued the following resolution in 1976:

> *Resolved, it shall be improper for a lawyer to serve as both the attorney and guardian ad litem for a proposed patient in civil commitment proceedings.*[8]

The minority opinion of the Committee acknowledged the potential for conflict, but resolved that the appointed attorney make the determination on a case by case basis — the attorney decides in each case whether or not this dual role presents a conflict.

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[7] *Black's Law Dictionary,* Revised 4th Edition, 1968, p. 834.

[8] *Bench and Bar of Minnesota,* Vol. 32, No. 11, pp. 79-80.

6. ROLE OF EXAMINERS

INQUIRY: DO YOU ENCOUNTER DIFFICULTIES IN SEEKING EXAMINERS TO ACCEPT APPOINTMENTS AS COURT-APPOINTED EXAMINERS FOR COMMITMENT PROCEEDINGS?

RESPONSE:

Yes	51
No	16
Total Responding	**67**

INQUIRY: WHEN ARE COURT-APPOINTED EXAMINERS USUALLY GIVEN THE PROPOSED PATIENT'S MEDICAL RECORDS?

RESPONSE: Medical records are available:

	Number of Counties
Before they examine the proposed patient	19
During the examination of the proposed patient	10
After they examine the proposed patient	3
At no time	5
No standard policy	32
TOTAL NUMBER OF RESPONSES FROM 61 COUNTIES	**69**

(The responses to the remaining inquiries in this section are from 70 counties)

INQUIRY: ARE EXAMINERS ALLOWED TO LISTEN TO TESTIMONY BEFORE WRITING A REPORT?

RESPONSE: Yes 54

INQUIRY: ARE EXAMINERS ALLOWED TO QUESTION THE PROPOSED PATIENT DURING THE HEARING?

RESPONSE: Yes 44

INQUIRY: ARE EXAMINERS REQUIRED TO WRITE SEPARATE REPORTS RATHER THAN CONCUR IN ONE REPORT?

RESPONSE: Yes 28

INQUIRY: ARE EXAMINERS REQUIRED TO TESTIFY AT THE HEARING?

RESPONSE: Yes 61

INQUIRY: DOES THE COURT CONSULT WITH EXAMINERS REGARDING RECOMMENDATIONS FOR PLACES OF COMMITMENT?

RESPONSE: Yes 60

COMMENTS: *Some courts report a problem of retaining the services of examiners with the statutorily requested credentials; others indicated that they only have a problem retaining examiners with training and expertise in the behavioral sciences. As the statute requires no special qualification of medical doctors beyond the medical license, many general practitioners are prevailed upon to assist the courts on matters in which they have no training or special knowledge.*

The nature of the examination by court order "prior" to the commitment hearing varies greatly, to include:

(1) A 5-30 minute examination at the time and location of the hearing; this examination may be on the record and may be in the presence of the judge or judicial officer; the examination may continue into the hearing itself, and the court may refer to the examiners as a "Board" (which may be empowered in that court to make decisions on commitment).

(2) A 5-30 minute examination in the hearing room in the morning when the hearing is scheduled for the afternoon.

(3) An examination of unknown length at the holding facility with a written report submitted at the time of the hearing.

(4) An examination of approximately an hour's length in the office of the examiner; a report may then be available to defense counsel as long as a week before the hearing.

(5) The examination may be called the "initial hearing" which is held one week prior to the "second" (or statutorily required) hearing.

COUNTY ATTORNEYS' QUESTIONNAIRE

INTRODUCTION TO COUNTY ATTORNEYS' QUESTIONNAIRE

Questionnaires were sent to all 87 county attorneys in Minnesota which requested information regarding county attorney practices and procedures governing their role in implementing proceedings under the Minnesota Hospitalization and Commitment Act.

The questionnaire further encouraged comment, criticism and discussion of special practices and local rules relating to the commitment process in each county which may be of interest to the Commission.

This questionnaire (as well as the questionnaire sent to judges) was designed by the staff in consultation with Dr. Norman Hoffmann, the staff's research consultant.

Responses to the questionnaire were received from a total of 61 county attorneys. County attorneys in the following counties did not respond: Beltrami, Big Stone, Carlton, Cass, Chippewa, Clay, Dakota, Fillmore, Hennepin, Houston, Hubbard, Koochiching, Lac Qui Parle, Lake, Martin, Nicollet, Pope, Red Lake, Rice, Rock, Sibley, Saint Louis, Traverse, Washington, Wilkin and Yellow Medicine.

1. PRE-PETITION SCREENING

The Minnesota Hospitalization and Commitment Act makes no provision for any form of pre-petition screening. To institute proceedings under the MHCA:

> Minn. Stat. §253A.07, subd. 1: Any interested person may file in the probate court of the county of the proposed patient's settlement or presence a petition for commitment of a proposed patient, setting forth the name and address of the proposed patient, the name and address of his nearest relatives, and the reasons for the petition. Such petition shall be accompanied either by a written statement by a licensed physician stating that he has examined the proposed patient and is of the opinion that the proposed patient may be mentally ill, mentally deficient, or inebriate and should be hospitalized, or by a written statement by the petitioner that, after reasonable effort, the petitioner has been unable to obtain an examination by a licensed physician or that an examination could not be performed. Before filing, a copy of the petition shall be delivered by the petitioner to the county welfare department.

INQUIRY: DO YOU HAVE A FORMAL OR AN INFORMAL PRE-PETITION PROCEDURE?

RESPONSE:

Counties having FORMAL procedures	11
Counties having INFORMAL Procedures	42
Counties having FORMAL/INFORMAL procedures	2
Counties without pre-petition screening procedures	6
TOTAL RESPONSE	61[9]

[9]PRE-PETITION SCREENING, as interpreted by the responding county attorneys, includes almost any governmental involvement prior to or at the time of the filing of a petition for judicial commitment – usually this involvement takes the form of participation by a professional in the welfare department or in the county attorney's office.

COMMENTS: *Fifty-five counties, or 90% of the counties which responded, indicated some form of pre-petition screening. But, the form of the pre-petition process varies widely from county to county. There were 47 counties claiming a pre-petition screening process and there are probably as many procedures and purposes for the process. At the extremes, the procedures are as follows:*

- *the welfare worker supplies the county attorney's office with the substance of the petitioner's case; and*
- *the county worker interviews 99% of all proposed patients prior to the drafting of a petition.*

Other types of procedures which are included under "Pre-Petition Screening" include:

- *Attempts made to interview proposed patients and look at alternatives to commitment;*
- *Attempts made to interview proposed patients in cases in which there is no physician involved;*
- *Multiple conferences with proposed petitioner and other investigatory procedures;*
- *Multiple conferences with proposed petitioners and no other investigation;*
- *Welfare Department worker discusses alternatives with petitioner;*
- *Welfare Department worker interviews proposed petitioner;*
- *County Attorney drafts petitions based upon interview with proposed petitioner.*

2. ROLE OF EXAMINERS

INQUIRY: DO COURT-APPOINTED EXAMINERS TESTIFY AT COMMITMENT HEARINGS?

RESPONSE:

Always	9
Usually	44
Occasionally	2
Rarely	3
Never	2
TOTAL RESPONSE	**60**

3. STANDARD OF PROOF

The Minnesota Hospitalization and Commitment Act does not specify the standard of proof required for commitment.

INQUIRY: WHAT IS THE STANDARD OF PROOF REQUIRED FOR COMMITMENT IN YOUR COUNTY?

RESPONSE:

	Number of Counties
Beyond a Reasonable Doubt	14
With Reasonable Medical Certainty	1
Beyond a Reasonable Doubt or Clear and Convincing Evidence	1
Clear and Convincing Evidence	17
Preponderance of the Evidence	2
Unspecified (including two which suggested that we ask the court)	26
TOTAL RESPONSE	**61**

4. PETITIONS AND HEARINGS

INQUIRY: DO YOU BELIEVE THAT COUNTY ATTORNEYS HAVE DISCRETION TO DECIDE WHICH PETITIONS MAY BE FILED (prosecutorial discretion)?

RESPONSE:

Yes	33 counties
No	17 counties
Do not know	3 counties
TOTAL RESPONSE	**53 counties**

INQUIRY: WHAT IS THE AVERAGE AMOUNT OF COUNTY ATTORNEY STAFF-TIME PER COMMITMENT PETITION, INCLUDING COURT TIME?

RESPONSE: (from 61 counties)

Average preparation time is 3.7 hours per petition.

Most petitions are drafted by the county attorney's staff, and the time required to prepare for and draft the petition is included in the 3.7 hours.

Preparation time varies greatly from county to county – from an average of one hour per petition in some counties to ten hours per petition in others.

INQUIRY: WHAT IS THE AVERAGE NUMBER OF WITNESSES CALLED BY PETITIONER TO PROVE A PETITION FOR COMMITMENT?

RESPONSE: (from 53 counties)

An average of 1 to 5.5 persons per petition were called by petitioner as witnesses, exclusive of court-appointed examiners.

The average number of persons testifying at hearings in 1977 was 3.17 witnesses, inclusive of court-appointed examiners.

5. INQUIRY: LIST ANY PROBLEMS OR PROBLEM AREAS RELATING TO CIVIL COMMITMENT WHICH ARE OF CONCERN TO YOU AS ATTORNEY FOR PETITIONERS UNDER THE MINNESOTA HOSPITALIZATION AND COMMITMENT ACT.

RESPONSE: The standard of proof for commitment is not specified.

COMMENTS: *At least nine counties indicated that this is a problem. The statute does not specify a standard, and, as the county attorneys responded, there is much variation among the counties.*

The responses included some suggestions as to what the standard of proof should be. Anoka County uses a unique standard, "reasonable medical certainty" which is described as being more stringent than "clear and convincing evidence", but less difficult to prove than "beyond a reasonable doubt."

Pennington County indicated that the "reasonable doubt" standard is too difficult. This same comment was received from other counties.

The only statements in Minnesota regarding the standard of proof in commitment proceedings are in **Lausche v. Commissioner of Public Welfare,** *302 Minn. 65, 225 N.W.2d. 366 (1974), in which the Minnesota Supreme Court stated in* **dicta** *that because of course the standard of proof for an initial commitment is 'beyond a reasonable doubt', this strict standard is not required in supplementary proceedings. Though this opinion seems to answer the question, most counties continue to be unclear as to what standard of proof is required for an initial commitment.*

RESPONSE: There is a need for clarification regarding the use of medical records and examiners' reports in commitment proceedings.

COMMENTS: *Approximately ten (10) counties indicated that they face or have faced the issue of whether or not medical records and reports are admissible at commitment hearings or whether they are inadmissible without the direct testimony of the author of the records.*

Several suggested that the statute should be amended to clarify the proposed patient's medical privilege. Some of the suggestions for clarification include a recommendation that medical records be statutorily allowed in commitment proceedings as business records without the custodian of the records present. Another suggestion is that the statutory provision which removes the medical privilege in commitment proceedings refer to "hospitals" as well as "doctors" so that a hospital official can testify from records about evidence which would otherwise be privileged.

Another suggestion is that medical statements (written) should be allowed without the requirement of the presence of the author.

In contrast to comments of most attorneys raising this issue, one responded as follows: "In our court, as in other jurisdictions within the state where I have practiced, doctor's reports are often admitted into evidence by stipulation without giving respondent right of cross-examination — I see this as a basic albeit time consuming and inconvenient, denial of constitutional rights."

RESPONSE: Many counties lack medical personnel with expertise in the identification of mental illness.

COMMENTS: *Several counties, all in out-state areas, are concerned by their lack of medical expertise for the court to appoint as required by statute. As one county indicated, it is difficult to schedule hearings when examiners are necessary, and, some of them must travel, to hold the hearings within the time limits statutorily prescribed as they have difficulty in obtaining examiners.*

Another type of comment is that court-appointed examiners should be trained and qualified specialists.

The statute does not specify any qualifications of a court-appointed examiner in a mental illness commitment proceeding beyond the requirement of either a medical doctor or a licensed consulting psychologist. This allows for the possibility of a general practitioner serving as a court-appointed examiner. This has also resulted in a licensed consulting psychologist, who has a bachelor's degree but who was grandfathered in when licensing began, serving as an examiner.

There is some question as to the wisdom of requiring two court-appointed examiners, when in fact most often they agree and the two do not consult (according to many of our observations) until after the first examiner has issued a statement; then the second examiner usually agrees with the first. It is the suggestion of Judge Ranier Weis that

thought be given to amending the statute to provide for only one court-appointed examiner. If, after the first examiner has issued his report, the proposed patient requests a further examination, he shall then be entitled to be examined by someone of his choosing (with the proper qualifications). This would save the expense of the second examiner in many cases, allow for an easier scheduling of hearings, and hopefully have available more qualified examiners when they are needed.

RESPONSE: Treating doctors are hesitant or refuse to testify at commitment hearings at which the proposed patient could be committed back to their care.

COMMENTS: *This is a problem most frequently encountered in areas which use the state hospital as the holding facility. Several questionnaire responses directly or indirectly alluded to the basic underlying problem of balancing due process and treatment. This was expressed in statements indicating the reluctance or refusal on the part of state hospital personnel to participate in the commitment process even when they have direct knowledge of the proposed patient.*

The other side of the problem, of course, could be heard from the treaters who do not believe they could continue to treat a person after they testify or provide the court with information in support of commitment. These treatment personnel also must face the issue of whether they should have any say in the commitment process when the proposed patient, if committed, would then be committed to their care.

RESPONSE: Court-appointed examiners should be allowed to question lay witnesses during the commitment hearing.

COMMENTS: *Though this response does not spell out more, the suggestion implies some of the confusion regarding the role which court-appointed examiners are to play in the commitment process. Their role varies greatly from county to county. In some counties, the examiners see the proposed patient in their office a week or so prior to the hearing and then submit a written report to the court. These examiners may or may not be present at the commitment hearing and their reports may be entered into the record without their presence.*

In other counties, the examination is conducted just prior to the commitment hearing. Often this examination appears to observers to be part of the hearing — the judicial officer, witnesses and others may be present in the room at the time of the examination.

In some counties, the court-appointed examiners are allowed to question lay witnesses during the hearing. These hearings have been observed to be a discussion among the persons present, as differing from a question/answer format which most judicial proceedings follow.

The role, therefore, varies from the examiner who does an examination, usually with the aid of past medical records and the commitment petition, to the examiner who acts as part of a "Board" which determines whether or not a person should be committed.

RESPONSE: The rules of evidence should be modified for commitment proceedings.

COMMENTS: *There were several responses which state that the strict adherence to the rules of evidence in commitment proceedings made the proceedings more cumbersome than need be. This response seems to be directed toward the issue of whether or not doctors and medical reports should be admissible without the presence of the author or the custodian of the records.*

This comment raises the question again of the importance of the right of a cross-examination, the right of proposed patients to be confronted by a person recommending involuntary treatment so that there is an opportunity for clarification or other information to be brought out at the hearing. This recognized right has been, without exception, stated in all court decisions which have faced the issue of the right of confrontation in commitment proceedings.

RESPONSE: There is a need for uniform pre-petition screening procedures.

COMMENTS: *Most counties acknowledge some type of formal or informal pre-petition screening process. But, the wide range of procedures which are at present called "pre-petition screening" vary from one county, which refers to the process whereby the county welfare worker gathers the "meat" of the petitioner's case as pre-petition screening , to Anoka County, where 99% of all proposed patients are personally contacted prior to the filing of a petition.*

In several recent sessions, the Minnesota Legislature has been presented with proposed legislation which would establish a uniform pre-petition screening process. To date, there is no statutory or other law or regulations in Minnesota which recognizes or governs the process referred to as Pre-Petition Screening.

RESPONSE: There is a need to define the role of defense Counsel/Guardian *ad litem.*

COMMENTS: *As other data show, most courts appoint one person to serve as both counsel and guardian* ad litem. *In this dual capacity, there is confusion as to just what the responsibilities of the attorney are or should be. Even in instances in which the appointment is as "counsel" only, there is confusion as to whether the role is that of an adversary or whether the role is tempered in commitment proceedings to resemble a guardian* ad litem, *who is appointed to look out for the best interests of the proposed patient, rather than to articulate the proposed patient's desires.*

RECORD REVIEW AND FIELD OBSERVATIONS (in-depth study)

The staff designed a form for the uniform collection of data from county/probate court records.[10] This form, as basically designed, allowed for the collection of all information which the Minnesota Hospitalization and Commitment Act (MHCA) mandates the Clerk of Court cause to be filed. In addition, the form provided space for all other data researchers, from their experience, knew could be gathered from court records. Finally, slight variations were made in the form to adjust it for facilitation of data collection when the county under study was found to have adopted special, or otherwise, practices or recording mechanisms.

There were several other forms designed by the staff to record information gathered during field observations and informal interviews. These forms were designed to require the least amount of writing to avoid any potential for distraction during the proceedings researchers were allowed to observe. Separate forms were designed for pre-hearing proceedings, examinations by court-appointed examiners, commitment hearings, and other court proceedings.

These forms were designed by the staff in consultation with Dr. Norman Hoffmann who advised the staff throughout the project's research, and who provided the expertise for codifying and computerizing the data gathered by the staff.

For the purpose of this portion of the study, sample counties had to be selected for study because of the limited time and resources available to the Commission and its staff. It was concluded that a random sample of counties in Minnesota would not provide a picture of commitment procedures because of the importance in this subject-area of economics, population density, local practices, community values and mores and other factors. Therefore, it was determined that a more valid result would be reached by considering which factors ought to be present in the counties selected, and determining the counties for study as those which include two or more selected factors. The list of factors considered in determining the sample counties is as follows:

a. Minneapolis/Saint Paul: one central county from the seven-county metropolitan area;
b. Suburban County: within the seven-county metropolitan area;
c. Large percent of the population is elderly;
d. Proximity to State Hospital;
e. Proximity to major state correctional facility;
f. Economic base: agricultural, industrial, etc.;
g. Per capita income;
h. Geographic location within the state;
i. Major urban area outside of the seven-county metropolitan area;
j. Ethnicity;
k. Local "holding" facility or lack of "holding" facility;[11]
l. Population density.

The counties selected for study are not the only counties which the staff could have determined appropriate, but they do, under the formula stated above, and in light of researchers' experience through the collection of data, provide the necessary data in fulfillment of the goals and objectives of the study.

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[10]The Clerk of Court is required to keep records and indices of all County Court proceedings and to have custody and care of these records. (Minn. Stat. § 487.11, subd. 5) Family Court Division of all county courts has jurisdiction over proceedings under Minn. Stat. Chapter 253A (Minn. Stat. § 487.27 subd. 2). In Hennepin and Ramsey Counties, Chapter 253A proceedings are under the jurisdiction of the Probate Court.

[11]The Minnesota Hospitalization and Commitment Act provides that each county or group of counties have a hospital or make arrangement for the use of a hospital for the temporary hospitalization of persons pending determination of commitment; state hospitals may be used for this purpose, if agreed to. (Minn. Stat. § 253A.10, subd. 2)

This study of 12 counties, through the record review, informal interviews, and observations of proceedings, did not attempt to state a definite and complete picture of the commitment process as it is implemented in all counties in Minnesota. Rather, through the data gathered from counties under study, it is suggested that the implementation around the state of this statute is not uniform, that there are aspects of the implementation in which there are no apparent standards, and that there are, in fact, model or unique practices which one or more counties have developed and implemented which should be of interest to the other counties within Minnesota.

The counties selected for study and the reasons for the selection of each county are as follows:[12]

AITKIN COUNTY (low per capita income, large Native American population, north-central section of the state)

[13]ANOKA COUNTY (suburban seven-county metropolitan county, site of state hospital whose catchment area includes Minneapolis)

DAKOTA COUNTY (suburban seven-county metropolitan county, high per capita income, combined agricultural/industrial economy, site of state hospital during time of record review, but not during time of observations)

JACKSON COUNTY (agricultural economy, low density population, southwest section of the state)

KANDIYOHI COUNTY (site of state hospital, west-central section of state)

MOWER COUNTY (combined agricultural/industrial economy, south section of the state)

OLMSTED COUNTY (urban center not within seven-county metropolitan area, site of state hospital, large percent professional population, high per capita income)

OTTER TAIL COUNTY (site of state hospital, site of regional mental health center, above-average number of commitment petitions per 1000 residents, northwest section of the state)

RAMSEY COUNTY (includes the City of Saint Paul, below average number of commitment petitions per 1000 residents, large elderly-poor population, community hospital which serves as a holding facility for more than one county)

SAINT LOUIS COUNTY (largest urban center outside of the seven-county metropolitan area, large elderly population, large land area, northeast section of the state)

WASHINGTON COUNTY (suburban seven-county metropolitan area, no local holding facility, site of major state correctional facility)

[14]HENNEPIN COUNTY

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[12]Koochiching County had originally been selected for study as a representative of a northern rural county, sparsely populated, with logging and tourism as its economic base; because sufficient data was gathered in other counties which considered those same criteria, it was determined that, with so few records, it would not enhance the study to include this additional county.

[13]Staff was aware at the time Anoka County was selected that, in addition to the factors listed for consideration, this county had a long-established pre-petition screening process (with written standards and procedures) which has been thought by some persons to be a model for pre-petition screening.

[14]Hennepin County was included in the study as time and resources permitted. As the state's most populous county, with an above-average number of commitment petitions per 1000 residents, a one month (rather than one year) record review study was undertaken: one week of observations was also included in this limited study of Hennepin County. Thus, in Hennepin County ONLY, records were reviewed only for those on the calendar in the month of JANUARY, 1977.

In researching 1977 court records of proceedings under the MHCA in the selected counties, 998 records were reviewed. This total of 998 records represents 26.4% of the total estimated 3781 records of petitions filed in 1977 under the MHCA.

Of the 998 petitions reviewed, the breakdown according to disability group, as alleged in the petitions, is:

46% alleged	mental illness
38% alleged	inebriacy
9.6% alleged	mental illness and inebriacy
2.4% alleged	mental deficiency
2% alleged	mentally ill and dangerous
2% alleged	combinations of two or more disabilities (*e.g.*, mentally deficient and dangerous)

According to the overall statistics for the number of petitions filed in 1977 (see Chart: "1977 Petitions Filed: By County By Type", page 7), the number of petitions filed alleging inebriacy was slightly greater than the number of petitions alleging mental illness. Because the in-depth study included both urban and rural counties, the reason for this is that in urban counties, there is more frequently found a greater number of mental illness petitions; in the rural counties the tendency is toward a greater number of petitions alleging inebriacy. Therefore, because in actual numbers, we reviewed a greater number of records from counties with urban populations, there were slightly more records reviewed in which the allegation is mental illness.

Of the 998 files reviewed, males were the subject of two of every three petitions for judicial commitment (66% were male subjects; 34% were female subjects). The subject of 83% of all files in Washington County were male; this county's extraordinarily high percent of male subjects is in part due to the fact that 25% of the 80 petitions reviewed were brought by the authorities at the Stillwater State Prison for Men.

In nine of the 12 counties studied (Aitkin, Anoka, Dakota, Jackson, Kandiyohi, Mower, Otter Tail, Saint Louis and Washington), more than 66.6% of the subjects of all petitions for commitment in 1977 were male. Over 55% of all petitions in the other three counties under study (Hennepin, Olmsted, and Ramsey) had male subjects.

Researchers were unable to obtain data for 1977 on the male/female ratio in Minnesota State Hospitals, but were able to gather the following data:

MENTAL ILLNESS ADMISSIONS[15]
MALE/FEMALE RATIO

1972	1976	
50/50	67/33	Anoka State Hospital
62/38	52/48	Fergus Falls State Hospital
50/50	52/48	Hastings State Hospital
21/79	48/52	Willmar State Hospital[16]

Minn. Stat. §253A.07, subd. 1 states that any "interested person" may file a petition for commitment, and who may qualify as an interested person has never been defined. In cases in which the proposed patient is an inmate at a correctional facility, the petitioner must be the superintendent of the facility

[15]The figures are compiled in a report by Dr. Gordon Olson, Ph.D., Anoka State Hospital.

[16]In 1972, Willmar State Hospital was used more extensively for treatment of inebriacy; in 1976, it had been changed to the hospital serving the 20 county catchment area in southwest Minnesota for treatment of persons for mental illness, inebriacy, and mental deficiency.

(Minn. Stat. §253.21). Of the 998 petitions reviewed by the researchers, the breakdown according to the "interest" of the petitioner is as follows:

Relationship As:	Number of Petitions
Parent	222
Spouse	207
Adult Child	133
Other Relative	136
Public Official	192
Hospital Personnel	21
Other Interested Adult	40
Prison Superintendent	20

Most petitions were filed and heard in the county of the proposed patient's residence (with the exception of prison initiated petitions which must be filed in the county wherein the prison is located). In Ramsey County, 84% of the proposed patients were county residents; 5% of Ramsey County's petitions had subjects with residency in Washington County. In Hennepin County, 90% of all subjects of petitions were residents of Hennepin County; in Anoka County, 89% of all subjects of petitions were residents of Anoka County.

Of the 998 petitions reviewed, the breakdown according to the month in which the petition was filed is as follows:

- The highest percent of petitions were filed in August (10.4%);
- The lowest percent of petitions were filed in September (5.2%);
- The filing dates are fairly evenly spread out among the 12 months of the year; the months in which less than 1/12 of all petitions were filed were followed by months in which measurably more than 1/12 of all petitions were filed.

Of the 998 records reviewed, the age of the proposed patients is described as follows:

Mean year of birth: 1924 (53 years old in 1977)
Mode year of birth: 1955 (22 years old in 1977)

- 11% of all proposed patients were between the ages of 21 and 24;
- 18% of all proposed patients were 60 years or older at the time of the filing of the petition;
- 1% of all proposed patients were minors, under 18 years of age.

3% of all proposed patients were	50 years old
18%	60 or older
17%	50-59
16%	40-49
18%	30-39
31%	18-29
1%	under 18

FACTUAL ALLEGATIONS

Minn. Stat. § 253A.07, subd. 1:

> Any interested person may file in the probate court of the county of the proposed patient's settlement or presence a petition for commitment of a proposed patient, setting forth the name and address of the proposed patient, the name and address of his nearest relatives, and the reasons for the petition.

In reviewing records, researchers documented the statutorily required factual allegations ("reasons") by recording that section of the petition for commitment which provides space for the petitioner to set forth the "reasons" for the petition. If the factual allegations were stated on the face of the petition in a few sentences, the entire section of the petition was recorded. In those records which contained more lengthy factual allegations, these statements were not recorded in full, but researchers were careful to record complete summaries of that section.

In reviewing the factual allegations, researchers recorded all factual allegations which were in behavioral terms, including the time, place and description of any alleged behavior. Careful documentation was made indicating those records which included only statutory language, medical diagnostic terminology or other non-behavioral language.

Of the 998 records reviewed:

I. 15.5% (155) contained only restatements of **STATUTORY LANGUAGE** with no recitation of behavior, past or present.

II. *41.8% (418) of the petitions contain some **FACTS DESCRIBING BEHAVIOR** even if those facts are not complete as to time, place, and circumstance. Researchers considered "factual" those allegations which include reference (though vague) to the time and circumstances of the alleged facts. An example of this type of allegation is: "proposed patient told petitioner he is Jesus and can talk to God."

III. *19.5% (195) contained **FACTUAL ALLEGATIONS OF DANGEROUSNESS** which specify the behavior, when and where it occurred, as well as less descriptive statements such as "proposed patient struck a member of his family" or "proposed patient believes he can fly and was telling the neighbors that he could take-off from any building."

IV. *20.7% (207) contained **CONCLUSORY STATEMENTS OF DANGEROUSNESS**, such as "he is dangerous" or "proposed patient could be dangerous" or "he is assaultive or uses assaultive language."

V. *23.5% (235) of the petitions included **FACTS DESCRIBING PROPOSED PATIENT'S PAST TREATMENT.**

*The allegations in these categories are not necessarily mutually exclusive. Between 20.7% and 40.2% of the petitions suggest dangerous behavior. At least 59.8% of the total petitions reviewed contain no reference to any dangerous or threatening behavior on the part of the proposed patient. Petitions using statutory language only, and no behavioral language, contain no factual allegations; they may incorporate by reference, a physician's statement into the petition in lieu of the petitioner's "reasons".

FACTUAL ALLEGATIONS BY COUNTY BY TYPE

	NUMBER OF PETITIONS ALLEGING TYPE					
TYPE	I[17]	II	III	IV	V	VI[18]
AITKIN (6)	0	2	1	3	0	6
ANOKA (53)	1	29	23	19	12	32
DAKOTA (78)	0	47	29	14	21	63
HENNEPIN (102)	6	52	29	22	39	72
JACKSON (8)	0	5	2	3	2	7
KANDIYOHI (31)	2	20	6	4	6	24
MOWER (52)	0	38	12	29	2	34
OLMSTED (51)	47	0	2	3	14	18
OTTER TAIL (79)	4	27	20	18	10	62
RAMSEY (327)	29	108	22	57	61	276
ST. LOUIS (131)	9	80	48	27	64	113
WASHINGTON (80)	57	10	1	8	4	24
TOTAL	**155**	**418**	**195**	**207**	**235**	**731**

( ) = number of records reviewed in that county.

I: Statutory Language

II: Facts Describing Behavior

III: Facts Describing Dangerousness

IV: Conclusory Statements of Dangerousness

V: Facts Describing Past Treatment

VI: Other

[17]Petitions with "Statutory Language" only have no other factual allegations, but may include a list of past medical treatment.

[18]"Other" includes any type of allegation not codified under I-V (*e.g.*, "he is mentally ill").

Comments:

Records in which the petitions contain statutory language in lieu of factual allegations were not found in most counties under study. Only in Olmsted, Ramsey, and Washington Counties did researchers review a significant number of these types of allegations. In Olmsted County, 92% of the petitions contained factual allegations with statutory language only. An example of this type of allegation on petitions alleging Inebriacy is:

> The proposed patient is incapable of managing herself or her affairs by reason of the habitual and excessive use of intoxicating liquors, narcotics or other drugs. (*See* Minn. Stat. § 253A.02, subd. 4)

An example of this type of allegation on petitions alleging Mental Illness is:

> The proposed patient clearly shows that his customary self-control, judgment and discretion in the conduct of his daily affairs and social relations is lessened to such an extent that hospitalization is necessary for his own welfare or the protection of society; that is, that the evidence of his conduct clearly shows: (i) that he has attempted to or threatened to take his own life or attempted to seriously physically harm himself or others, or (ii) that he has failed to protect himself from exploitation from others; or, (iii) that he has failed to care for his own needs for food, clothing, shelter, safety or medical care;
> (*See* Minn. Stat. § 253A.02, subd. 3)

Both of these examples of petitions which are codified under Type I recite word for word the language of the statute to fulfill the petitioner's obligation, under the MHCA, to state his "reasons" for the petition. These petitions do not indicate in behavioral terms the underlying reasons for the filing of the petition.

Researchers reviewed ten records in which commitment was ordered wherein the petitions contained only statutory language and no statement by a physician in support of the petition and no statement by the petitioner of his reasonable efforts to obtain a physician's statement. These petitions, statutorily inadequate on their face, formed the underlying basis for the 60-Day commitment of ten persons. Another 51 persons were committed for 60 days in cases in which petitions had statutory language only and a physician's statement which was a short-form with the only individualized portion being the physician's signature.

Eighty-five records were reviewed in which persons were committed for the initial 60-Day period in which the underlying petition contained only conclusory language and did not give notice, on the face of the petition, of any behavior which could justify involuntary confinement.

Two hundred eighty records reviewed indicate that 60-Day commitments were ordered in which the petitions allege no factual or conclusory language regarding dangerousness.

Mower County has developed a form for petitioners to use which assists the petitioner in alleging "reasons" for the petition in behavioral terms. This form asks the petitioner to respond to specific questions. Examples of a few of those questions are as follows:

- Does he (proposed patient) believe someone is poisoning him?
- Does he believe he hears/sees things? Describe.
- Does he believe someone is following him?
- Describe other behavior.

PHYSICIANS' STATEMENTS ACCOMPANYING PETITIONS

Minn. Stat. § 253A.07, subd. 1, states that each petition shall be accompanied by:

> . . . either a written statement by a licensed physician stating that he has examined the proposed patient and is of the opinion that the proposed patient may be mentally ill, mentally deficient, or inebriate, and should be hospitalized or by a written statement by the petitioner that after reasonable effort, the petitioner has been unable to obtain an examination by a licensed physician or that an examination could not be performed.

In reviewing 998 petitions (each of which, therefore, was required to be accompanied by a physician's statement or petitioner's statement of "reasonable efforts"), researchers divided their findings into five categories:

I. **No Physician's Statement/No Reasonable Efforts Stated**: This category comprises 12% of all of the petitions reviewed and is suspect under the statute. These petitions (12%) are used as a basis for further proceedings though they are statutorily insufficient.

II. **Physician's Statement – Signed Form**: This category comprises 45% of all petitions reviewed and includes those statements which physicians, by signing their names and sometimes adding a word or two such as "mentally ill" or "schizophrenic" to a printed form, can satisfy the literal language of the statute.

III. **Physician's Statement**: This category comprises 19% of all petitions reviewed and includes all statements signed by physicians, on forms or non-forms, which contain any narrative information about the proposed patient, whether or not that added information is within the direct knowledge of the physician.

IV. **Conclusory Statement of Petitioner**: This category comprises 20% of the petitions reviewed and includes those petitions which state various conclusory phrases implying reasonable efforts to obtain physicians' statements. The more frequently found phrases include:

> Insufficient time to obtain statement.
> Proposed patient won't see doctor.
> Proposed patient failed to keep appointment.
> Unable to obtain statement.
> Doctor is unavailable.
> Proposed patient has no doctor.
> Reasonable efforts were unsuccessful.

V. **Petitioner's Statement of Reasonable Efforts**: This category comprises 3% of the records and includes all descriptive statements by petitioners concerning their reasonable efforts. Researchers did not consider the value or merit of these statements, but included all which were found to be non-conclusory. For example, researchers included under this category statements describing time of appointment and/or doctor's name which were involved in the "reasonable efforts" even though no further information was included.

PHYSICIANS' STATEMENTS (ACCOMPANYING PETITIONS) BY COUNTY BY TYPE

TYPE OF STATEMENT	I	II	III	IV	V	TOTAL
AITKIN (6)	4	0	1	0	1	6
ANOKA (53)	7	12	23	1	10	53
DAKOTA (78)	10	26	17	25	0	78
HENNEPIN (102)	14	20	52	16	0	102
JACKSON (8)	3	2	0	3	0	8
KANDIYOHI (31)	2	15	11	3	0	31
MOWER (52)	9	3	5	35	0	52
OLMSTED (51)	3	25	20	3	0	51
OTTER TAIL (79)	24	10	13	32	0	79
RAMSEY (327)	32	232	31	22	10	327
ST. LOUIS (131)	9	91	8	12	11	131
WASHINGTON (80)	4	17	12	47	0	80
TOTALS (998)	**121**	**453**	**193**	**199**	**32**	**998**

( ) = number of records reviewed in that county.

Comments:

The implementation of the physician's statement requirement appears to be uniform, with only minor deviations, in the twelve counties under study. Every county had a significant percentage of their files which evidenced questionable compliance with the statute; these 121 suspect files did not in any way take note of the absence of this essential part of the petitioning process.

Researchers found 23 (2.3%) of the files contained petitions which merely recited statutory language (see section on Factual Allegations) and had no accompanying "Physician's Statement" or "reasonable efforts" statement. These records lack evidence of any good faith attempt to properly prepare and file these petitions. Ten of these petitions resulted in the proposed patient being committed.

Researchers noted that most physicians' statements are brief. Of the 646 records which contained a document from a physician accompanying a petition, only 193 or 30% of the 646 records state any information beyond the printed form, a signature and a diagnosis. Of the 193 which include additional information, many are written on 4"x6" prescription blanks, and most give no indication of the physician's most recent contact with the subject of the statement.

There is no time frame within which the physician (who writes a statement) must have examined the proposed patient, and this has resulted in physicians' statements which are based upon examinations from months prior to the writing of the statement. A file can be cited in which the doctor altered a form to reflect that he had examined the medical records, rather than the person, and provided a physician's statement in support of a petition for commitment based upon this review.

The most remarkable physician's statement which was reviewed, states that the doctor believes the proposed patient is mentally ill because:

> She was severely assaulted by her husband recently. She lacks insight of how she provokes such beatings. She plans to return home. I believe she will get herself hurt again, unless she develops some self-understanding.

Twenty percent of the petitions, in which petitioners, in conclusory language state their "reasonable efforts", appeared suspect to researchers. It may be that many of these petitioners, in fact, exercised reasonable (though unsuccessful) efforts in obtaining physicians' statements, and this information simply was not recorded on the face of the petition.

It is interesting to note that of the 32 non-conclusory statements which describe petitioners' reasonable efforts, there are 10 or 11 from each of but three counties. In other words, it may be, that in those three counties, an individual in each county has assisted those petitioners in drafting non-conclusory statements of their reasonable efforts. Statements by petitioners of reasonable efforts to obtain physicians' statements are included on the face of petitions for judicial commitment. For the most part, county attorney and welfare department staff draft these petitions.

WELFARE DEPARTMENT EXPLORATION OF ALTERNATIVES

Minn. Stat. §253A.07, subd. 7, provides that the:

> . . . court shall direct the county welfare department to make an investigation into the financial circumstances, family relationships, residence, social history, and background [of persons alleged to be in need of commitment].

The court may require the report to be filed prior to the hearing on the petition for commitment. (Minn. Stat. §253A.07, subd. 7) In 311 files, 31% of the cases reviewed, no welfare department report was found in the files.

Minn. Stat. §253A.07, subd. 17(a)(2), provides that the court may commit a mentally ill person only:

> . . . after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petitions, out-patient care, informal or voluntary hospitalization, or release before commitment . . . and finds no suitable alternative to involuntary hospitalization.

Some counties have utilized this welfare report requirement to provide information for the required "consideration of alternatives". Other counties have utilized this requirement as a pre-petition screening process. Yet other counties, according to court records, evidence no report or investigation.

In the 69% of the cases in which the welfare report was found in the court file (687 cases), researchers divided the consideration of alternatives by the welfare departments into the following categories:

I. No Alternatives Explored. (Either the space on the form was blank or it stated: None.)

II. Report contained a conclusory statement regarding the exploration of alternatives. (*e.g.,* "Alternatives were explored.") (Some of these conclusory statements were followed by the phrase: "and none were found suitable.")

III. Alternatives considered and specified. (A list containing alternatives and the consideration of each alternative listed.)

IV. The report was unclear regarding the exploration of alternatives by the welfare department.

WELFARE DEPARTMENT: EXPLORATION OF ALTERNATIVES BY COUNTY BY TYPE

	I	II	III	IV	TOTAL NUMBER REPORTS
AITKIN	1	0	0	0	1
[19] ANOKA	0	0	0	0	0
DAKOTA	29	2	4	10	45
[20] HENNEPIN	0	0	0	0	0
JACKSON	3	1	2	0	6
KANDIYOHI	14	8	4	0	26
MOWER	33	3	0	0	36
OLMSTED	13	32	4	0	49
OTTER TAIL	22	48	5	2	77
RAMSEY	76	115	63	19	273
[21] ST. LOUIS	14	16	89	5	124
WASHINGTON	39	20	1	0	60
TOTAL	**244**	**235**	**172**	**36**	**687**

Comments:

Of the 687 records reviewed in which there was a welfare department report, only 25% of the reports listed, in non-conclusory language, the exploration of alternatives.

None of the welfare departments' reports indicated that their investigations into alternatives were done by assessing the proposed patient's needs and developing a plan based upon that assessment. Rather, even the most thorough investigations appeared to only consider what treatment facilities exist, and whether the individual would be appropriate for any existing facility or program.

[19] ANOKA COUNTY had no court-ordered welfare department reports in the files. The welfare investigation takes place at the pre-petition screening stage, and the consideration of alternatives was found to be documented thoroughly through the language of the petition.

[20] HENNEPIN COUNTY court records did not contain welfare department reports.

[21] SAINT LOUIS COUNTY welfare department reports (in the Duluth area) contained complete documentation of their investigation of alternatives; reports were often several pages in length.

ROLE OF COUNSEL

Minn. Stat. §253A.07, subd. 15 provides for the appointment of counsel in all proceedings under the Minnesota Hospitalization and Commitment Act:

> . . . The proposed patient shall be afforded an opportunity to be represented by counsel, and if neither the proposed patient nor others provide counsel, the court at the time the examiners or licensed physicians are appointed shall appoint counsel to represent the proposed patient. Counsel shall consult with the proposed patient prior to the hearing and shall be given adequate time to prepare therefore. Counsel shall have the full right of subpoena.

In the 998 records reviewed by researchers, one or more attorneys were appointed to represent the proposed patient in 919 cases.

Of the 919 cases in which counsel was appointed:

70% (644) of the cases had	1 attorney appointed
22% (204) of the cases had	2 attorneys appointed[22]
6% (57) of the cases had	3 attorneys appointed
1% (12) of the cases had	4 attorneys appointed
.5% (2) of the cases had	5 attorneys appointed

Comments:

In the more populous counties, attorneys are appointed on a rotating basis and will be appointed to represent all of the proposed patients who have hearings scheduled for a particular day or week. Ramsey County, for example, has a pool of seven men who are appointed for a week each, every seventh week. This practice means that when a hearing (or other court appearance) is continued, or a commitment is stayed or continued, and the proposed patient is required to appear again before the court at a later date, the proposed patient is represented by whichever attorney has been appointed for that week, not necessarily the attorney who represented the proposed patient at any previous appearance. In Ramsey County, where continuances are commonly used, the proposed patient is often represented by three, four, or, in two cases, five attorneys appointed by the court, to represent an individual in a single matter.

In Dakota and Hennepin Counties, researchers found that a firm of attorneys was appointed to represent a proposed patient, according to the court files. In other words, the name of the law firm, not the name of an attorney, appears on the face of the court order, the only document shown to or given to the proposed patient. Thus, the proposed patient often does not know who will actually represent him until contacted by an attorney.

Dakota County does have a local court rule which requires the court-appointed attorney to contact the client within 24 hours of appointment, but the court records do not indicate how that rule operates in fact. Reviewing Dakota County records did not inform researchers about which of the attorneys in the appointed law firm represented or appeared on behalf of proposed patients. Researchers concluded that a transcription of court proceedings would be necessary for the determination of which attorney in fact represented proposed patients.

[22]Some of the cases in which two attorneys' names are listed in the record are those in which the court appointed a law firm to represent the proposed patient, and therefore, the Court Order lists both attorneys in a single law firm as appointed counsel; this does not account for all of the multiple appointments.

ROLE OF GUARDIANS AD LITEM

Minn. Stat. §253A.07, subd. 6, is the only reference in the Minnesota Hospitalization and Commitment Act to the appointment of guardians *ad litem*:

> If the court has reason to believe that notice (of the filing of the petition and the order for examination) would likely be injurious to the proposed patient, notice to the proposed patient may be omitted if a guardian ad litem is appointed by the probate court for receipt of such notice. Such guardian shall represent the proposed patient throughout the action of the petition.

The only other applicable reference to guardians *ad litem* appears in the Minnesota Rules of Civil Procedure. Rule 17.02 provides for the appointment of a guardian *ad litem* when a party is an infant or incompetent, and only upon application to the court.

In the 998 files reviewed:

67% of all files (670 cases) had guardians *ad litem* appointed.

99.7% of all guardians *ad litem,* in those cases in which one was appointed, were the same person appointed as the proposed patient's counsel.

25% of all files (247 cases) had no guardian *ad litem* appointed even though an attorney was appointed in those cases as proposed patient's counsel.

Comments:

The practice of appointing guardians *ad litem* varies among counties, but each county appears to have a defined practice with respect to whether or not they are appointed. Of the 12 counties researched, guardians *ad litem* were appointed in almost all cases in Aitkin, Dakota, Jackson, Otter Tail, and Ramsey Counties. The courts in Anoka, Kandiyohi, Mower, Olmsted, and Washington Counties appoint guardians *ad litem* for proposed mentally ill patients, but not for proposed inebriate patients. Only two of the 12 counties, Hennepin and Saint Louis, do not as a matter of course appoint a guardian *ad litem* for proposed patients. In Hennepin County, 5% of proposed patients in 1977 had guardians *ad litem;* in St. Louis County only .8% of the petitionees had guardians *ad litem* appointed to assist them.

Researchers did not find, in any of the 670 files, appointments of guardians *ad litem* through the formal application process set out in Rule 17 of the Rules of Civil Procedure. But, these guardian *ad litem* appointments do not, as well, fit under the provisions of the MHCA in that the proposed patients for whom guardians *ad litem* were appointed were served with notice of the filing of the petition, *etc.;* and, the MHCA only provides for the appointment of a guardian *ad litem* in those cases in which the service of these papers upon the proposed patient is likely to be injurious.

Researchers found that the form used by most courts, in the 12 counties under study, promoted the appointment of the guardian *ad litem,* irrespective of the facts of each case. The first sample form provision is the one used in most counties under study. The second sample is the portion applicable from the Ramsey County form.

SAMPLE 1

J. of P. Assn. 12-67
New Com. Act Form No. 11 Combination Form

IT IS FURTHER ORDERED, that _____ whose address is _____ and whose telephone number is _____ is hereby appointed guardian ad litem for said patient in these proceedings and attorney for said patient subject to the right of said patient to engage any other attorney he may choose.

SAMPLE 2

M.S. 253A.07 Sub. 8
New Com. Act Form No. 14

ORDERED FURTHER, that Mr. _____ St. Paul, Minnesota, whose telephone number is _____, is hereby appointed guardian Ad Litem of said patient, and attorney for said patient subject to patient engaging an attorney, and the Ramsey County Attorney is requested to represent the petitioner herein: and said _____ Hospital is authorized and directed to disclose to said guardian Ad Litem, and to any attorney engaged by said patient, all hospital medical records pertaining to said patient's condition, care and treatment;

FINDINGS OF FACT

Minn. Stat. §253A.07, subd. 13, provides that for commitment of a person as mentally ill, inebriate or mentally deficient:

> . . . the court shall find the facts specifically, (and) state separately its conclusions of law thereon . . .

Where commitment is ordered in which the alleged disability is mental illness, this subdivision further requires that:

> . . . the findings of fact and conclusions of law shall specifically include the proposed patient's conduct which is a basis of determining that each of the requisites of subdivision 17 clause (a) is met . . .
>
> Minn. Stat. 253A.07, subd. 17(a):
> . . . (1) that the evidence of the proposed patient's conduct clearly shows that his customary self-control, judgment and discretion in the conduct of his affairs and social relations is lessened to such an extent that hospitalization is necessary for his own welfare or the protection of society; that is, that the evidence of his conduct clearly shows: (i) that he has attempted to seriously physically harm himself or others; or (ii) that he has failed to protect himself from others; or (iii) that he has failed to care for his own needs for food, clothing, shelter, safety or medical care . . .

Finally, to commit a person as "mentally ill" the court is also required to state the less restrictive alternatives considered and rejected by the court, and the reasons for rejecting each alternative. (See Minn. Stat. 253A.07, subd. 13.)[23]

Therefore, in all files reviewed in which the proposed patient was committed, Findings of Fact should have been included in the court's file. Of the total 998 files reviewed, 639 (64%) of the cases went to the hearing stage and thus should have written Findings of Fact.

Researchers categorized the Findings of Fact according to the following:

I. **STATUTORY LANGUAGE ONLY**: Those in which the court recites the statutory language (boilerplate findings); the name of the proposed patient and the disability type are also written in. These findings include no individualized information about the subject of the proceedings or about the evidence presented to the court.

II. **RESTATEMENT OF FACTS IN PETITION**: The court finds as true facts which the proposed patient's counsel had notice of through the language in the petition.

III. **FINDS FACTS NOT ALLEGED IN PETITION**: The court finds facts which are not alleged in the petition, and for which the proposed patient's counsel received no notice, as evident from the court's records.

IV. **CONCLUSIONS ONLY**: The findings recite conclusory language other than the statutory language, but do not include any descriptive language about behavior or other information which could provide a basis for the court's conclusions.

V. **CONCLUSIONS WITH DESCRIPTIONS OF BEHAVIOR**: The findings describe specifically the behavior upon which the conclusions are premised.

[23]This requirement of the courts' Findings of Facts is discussed more fully in the next section in that it is applicable only to those cases in which the allegations include the disability of mental illness.

FINDINGS OF FACT: BY COUNTY BY TYPE

	NUMBER OF HEARINGS*	NUMBER OF COMMITMENTS**	I	II	III	IV	V
AITKIN (3)	3	3	3	0	0	0	0
ANOKA (33)	24	20	17	0	1	2	24
DAKOTA (51)	47	19	27	0	4	7	3
HENNEPIN (78)	78	58	8	10	28	22	38
JACKSON (4)	3	3	1	0	0	0	0
KANDIYOHI (15)	14	11	2	3	5	6	5
MOWER (20)	12	8	1	2	6	3	5
OLMSTED (37)	25	20	23	0	0	0	1
OTTER TAIL (40)	35	22	2	0	5	17	3
RAMSEY (231)	96	76	0	1	70	11	58
ST. LOUIS (77)	71	53	6	17	24	7	56
WASHINGTON (28)	17	19	14	1	0	0	1
TOTAL	**425**	**312**	**104**	**34**	**143**	**75**	**194**

( ) = number of mental illness and mental deficiency petitions; this includes all petitions not alleging only "Inebriate".

* = number of ( ) petitions which had hearings.
** = number of ( ) petitions which were sustained – *i.e.*, commitment was ordered.

Comments:

Written Findings of Fact are basic to the judicial decision process. By statute, findings in support of civil commitment are to specify behavior relied upon by the court in drawing its conclusions of law. (And, in the case of commitments for mental illness, the court is to specify the alternatives to commitment which were considered.)

The purpose of written Findings of Fact is multiple: to protect against arbitrary decisions; to notify the parties of those facts the court used in determining the matter; for informational purposes; as well as a consideration for deciding the possible merits of an appeal or other further action; and, in cases in which a person is committed for treatment, the receiving treatment facility receives a copy of the Findings of Fact and is thereby notified of the behavior which justified the commitment – the behavior which the hospital is charged with treating.

Findings of Fact that recite facts not alleged in the petition and which form the basis for commitment raise questions of due process. The proposed patient does not have notice that he must explain or defend behavior that is not included in the allegations set out in the petition for commitment. This may be a problem which could be resolved through a more thorough drafting of petitions.

Researchers found that in most counties, Findings of Fact relied heavily on the probate/county court forms on which are printed statutory wording, and courts write in few additional words, if any, describing specific behavior in support of the court's conclusion. Even where the Findings of Fact were individualized, they were frequently couched in conclusory language, or were recitations of conclusions of the medical examiners. For example, researchers found the following types of Findings of Fact:

- proposed patient does not take care of his need for food, clothing and shelter; or
- the Board of Examiners found proposed patient to be mentally ill.[24]

Based upon researchers' observations in counties in which the Findings of Fact were suspect (and, in some cases clearly insufficient), evidence was frequently presented to the court which could have been documented to make the Findings of Fact sufficient or less suspect.

FINDINGS OF FACT: CONSIDERATION OF ALTERNATIVES

Minn. Stat. § 253A.07, subd. 17(a)(2), provides that:

> . . . after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petition, out-patient care, informal or voluntary hospitalization in a private or public facility, appointment of a guardian, or release before commitment as provided in section 253A.12, and finds no suitable alternative to involuntary hospitalization, the court shall commit such patient (as mentally ill) . . .

and (b)(2) provides that in the case of persons alleged to be mentally deficient and in need of institutional care,

> . . . after careful consideration of reasonable alternative dispositions, including, but not limited to, dismissal of petition, informal or voluntary placement in a residential training center or hospital, or appointment of a guardian, and finds no suitable alternative to involuntary commitment to a residential training center or hospital, the court shall commit such person . . .

The requirement for consideration of alternatives to involuntary commitment is found in the statute to apply to proceedings in which the allegations include mental deficiency or mental illness.

Researchers characterized the courts' consideration of alternatives as follows:

I. **No Consideration of Alternatives**: The court did not mention an exploration of alternatives in its findings.

II. **Statement: "Alternatives Considered"**: The court indicated that alternatives were considered without specifications of which alternatives or reasons for rejections.

III. **Alternatives Specified**: The court lists alternatives considered and reasons for rejection.

[24]Minn. Stat. 253A.07, subd. 13, reads ". . . The court shall not be bound by the evidence presented by the examiners . . ."

FINDINGS OF FACT: CONSIDERATION OF ALTERNATIVES BY COUNTY BY TYPE

	NUMBER OF HEARINGS*	NUMBER OF COMMITMENTS**	I	II	III
AITKIN (3)	3	3	1	2	0
ANOKA (33)	24	20	33	0	0
DAKOTA (51)	47	19	32	19	0
HENNEPIN (78)	78	58	26	41	11
JACKSON (4)	3	3	2	1	0
KANDIYOHI (15)	14	11	3	11	1
MOWER (20)	12	8	15	5	0
OLMSTED (37)	25	20	36	1	0
OTTER TAIL (40)	35	22	21	18	1
RAMSEY (231)	96	76	170	39	22
ST. LOUIS (77)	71	53	34	5	38
WASHINGTON (28)	17	19	28	0	0
TOTAL	**425**	**312**	**472**	**142**	**73**

( ) = number of mental illness and mental deficiency petitions.

* = number of ( ) petitions that were heard.
** = number of ( ) petitions that were sustained, i.e., commitment was ordered.

EXAMINERS' REPORTS

Minn. Stat. §253A.07, subd. 2, provides that two examiners shall be appointed by the court to submit a report which:

> . . . shall contain all pertinent information and comments preferred by such qualified person . . . The court may require the examiners to file with the court, prior to the hearing two copies of their report as to the condition of the proposed patient and his need for hospitalization, which report, if filed, shall be available to counsel.

(In all cases, at least one court-appointed examiner must be a physician and in the cases alleging mental deficiency, or inebriacy, one examiner must have expertise in the disability alleged. There is no requirement for special expertise in the case of allegations of mental illness.)

In reviewing 998 records, 599 contained written reports of the court-appointed examiners. In 36% of the cases, both examiners submitted a single report to the court.

EXAMINERS' REPORTS: BY COUNTY BY NUMBER OF REPORTS

NUMBER OF EXAMINER REPORTS IN COURT RECORD	0	1	2
AITKIN (6)	2	3	1
ANOKA (53)	20	31	2
DAKOTA (78)	11	66	1
HENNEPIN (102)	8	94	0[25]
JACKSON (8)	5	1	2
KANDIYOHI (31)	12	1	18
MOWER (52)	20	1	31
OLMSTED (51)	17	32	2
OTTER TAIL (79)	13	6	60
RAMSEY (327)	226	94	7[26]
ST. LOUIS (131)	3	9	119
WASHINGTON (80)	62	17	1
TOTAL	**399**	**355**	**244**

( ) = number of petitions reviewed in that county.

Comments:

The only statutory requirements of these examinations is that they are to be "prior" to the hearing, and a written report is to be filed with the court, if one is available in adequate time.

Many of the examinations by the court-appointed examiners were observed to be conducted immediately prior to the commitment hearing, thus literally satisfying the provisions of the statute. Only in St. Louis and Kandiyohi Counties did researchers find that examinations are held several days prior to the scheduled hearing; and, in both counties, the examinations are conducted in the offices of the examiners, each examination is separate and each examiner writes his own report based upon his separate examination.

[25] In Hennepin County, the examiners' reports are signed jointly by both examiners, and they are typewritten; therefore, in 60 of the 94 files in which there was only one report, it could not be ascertained which examiner wrote the report. The court reporter informed researchers that in those 60 cases, the reports are typed by her from the examiners' handwritten notes after the hearing and subsequent to the examiners signing them.

[26] In Ramsey County, pre-hearing conferences are scheduled to be held one day prior to the hearing on the petition. Only for those not disposed of at the pre-hearing conference are examiners appointed and examinations scheduled for the morning of the hearing.

In Ramsey County, the examinations are usually conducted in the morning, with the hearing to follow that same day. In Dakota and Hennepin Counties, examinations immediately precede each hearing.

In some counties in which the reports contain the least information, or are not filed prior to the hearing, the examiners routinely testify at the commitment hearing and thereby provide the court with information through their testimony rather than through written reports. The proposed patient and his counsel, as well as petitioner, do not have notice or other information about the contents of any testimony or report to be presented by the examiners.

In some counties where the reports contain more information, the examiners' reports are available in advance of the hearing to both the court and the proposed patient's counsel. In these counties, the examiners do not customarily testify at commitment hearings.

Researchers found most examiners' reports are half-page printed forms with a small space for comments by the examiners. Frequently, these form reports contain two signature lines and often one form is signed jointly by both examiners. It could not be determined who wrote some reports because the only marks on the form beyond the signatures are the circling of words describing the patient as "mentally ill" or "inebriate" or both, and "yes" or "no" for "in need of hospitalization." Examiners who examined the proposed patient in their offices approximately one week prior to the hearing wrote their reports on one to several sheets of paper in typewritten form.

STAYS/CONTINUANCES

The Minnesota Hospitalization and Commitment Act does not make reference to stays or continuances as dispositions for petitions for commitment. Extensions of the time during which a hearing may be held (Minn. Stat. §253A.07, subd. 8) are not considered continuances, for the purpose of this section. Only the following are under consideration in this section as "continuances."

> When the matter was scheduled for hearing, and at the hearing, by waiver without hearing, or through other proceeding, was continued upon motion of the court, the petitioner, the proposed patient's attorney, or another;
>
> As a disposition of the petition (in lieu of commitment) — *e.g.*, continued for a month, two months, six months, a year, with dismissal to follow. This use may condition the continuance upon in-patient or other voluntary treatment during the period in which the matter is continued;
>
> When a hearing is begun and reasons exist or arise which require the matter to be held over to better accommodate witnesses, to seek additional witnesses, when the court calendar requires, *etc.* (This use of the continuance is infrequent and usually short in duration.)

The stay, as referred to in this section, is usually imposed in cases in which there is agreement to accept voluntary treatment. This disposition is most frequently used in proceedings in which the alleged disability is inebriacy. Sobriety is often imposed as a condition of a stay.

(THE NUMBERS IN THIS SECTION ARE COMBINED TOTAL NUMBER OF STAYS AND CONTINUANCES)

No. of Stays/Continuances		No. of Records
Researchers found	0 ..... in	533
	1 ..... in	314
	2 ..... in	96
	3 ..... in	34
	4 ..... in	11
	5 ..... in	8
	6 ..... in	1
	8 ..... in	1

53% of all cases were disposed of with no stays/continuances;
31% of all cases were continued once;
10% of all cases were continued twice.

Of the 465 files in which there was one or more Stay/Continuance:

69% (317) conditioned the stay/continuance upon IN-PATIENT TREATMENT;

18% did not condition the stay/continuance upon in-patient care;

13% were unclear as to whether in-patient care was a condition of the stay/continuance.

Of the 465 files which had one or more stay/continuances:

51% (239) were ultimately dismissed;

38% (179) were disposed of more than 74 days after the petition was filed;

58% (270) were disposed of more than 44 days after the petition was filed.

Of the 465 petitions which were stayed or continued, nineteen (19) were disposed of later than one year after the filing date of the petition. An additional sixteen (16) petitions which were filed in 1977 were never disposed of, according to researchers' review of those records in August, 1978.

Comments:

Researchers found that the use of the stay or continuance as a method of disposing of a petition for commitment is used commonly in some counties and rarely, or even never, in others. The use of stays and continuances was found most frequently in metropolitan Twin Cities counties in which voluntary in-patient and out-patient treatment is available within the community or nearby, and in counties which do not rely as heavily on the state hospital as the treatment facility.

Of the 12 counties studied, this practice was most frequently documented in Ramsey County. Their common practice is to have the matter before the court at the pre-hearing conference; at that time, an agreement by the proposed patient to accept the recommended treatment results in the court usually continuing the matter for a stated period of time (usually 30 or 60 days). If there is no further request for court involvement, the court, after the given time, dismisses the petition.

This practice, while not authorized or prohibited by statute or common law, is looked upon by many as a favorable disposition. It is thought to enable society, through friendly persuasion, to involve an individual in treatment without resort to court order. Many persons are more accepting of treatment with the threat of civil commitment. When the continuance or stay is used, persons threatened with involuntary treatment or confinement view this disposition as less abasing, less stigmatic and less intrusive. (Others view this conditioning of a stay or continuance upon "successful" in-patient or other treatment as often more restrictive or confining.)

Those who look upon the practice of the stay/continuance disposition in a less favorable light premise their position on the notion that if a person is mentally disabled AND treatment is available AND the state can legally justify forcing treatment, a person is entitled to treatment as a benefit offered by society and to the legal safeguards provided for committed persons under the MHCA. (See section on 60-Day Report.)

In a recent appeal from a commitment, a three-judge panel in Minnesota's Fifth Judicial District, remanded a Blue Earth commitment order which was stayed. The court held that the stay deprived the patient of the safeguard provided by the mandatory 60-Day review. The court found that commitments "stayed conditionally" are not within the committing court's authority. (In the Matter of the Mental Illness of Marjorie L. _____ , District Court, Blue Earth Court, Files #38826 and #22798, September 12, 1978.)

Another issue which arises with the use of stays or continuances is the tendency to look at a disposition before determining the preliminary questions of whether a person is disabled and whether that disability justifies state intervention. In other words, by offering a proposed patient the less stigmatic and less humilitating route – voluntary treatment – proposed patients are often both induced and encouraged to accept treatment. This offer of voluntary treatment may occur before the proposed patient has had his "day in court" – his opportunity to avoid all treatment. The stay/continuance may promote more acceptance of voluntary treatment, but questions may be raised concerning the justification of this method of promoting treatment.

Finally, there are no standards or guidelines as to what occurs if the conditions of a stay or continuance are not met.

A ramification of the use of the stay/continuance peculiar to some of the state's more populous counties is the role of counsel when these are imposed. In Ramsey County, for example, use of the continuance results in a proposed patient often having two or more attorneys on a single petition. When a proceeding is continued to another week in Ramsey County, the attorney appointed by the court for that other week then assumes responsibility for continuing representation – but only for that week. (See section on Attorneys.)

60-DAY REPORTS

Before a person may be indeterminately committed, Minn. Stat. § 253A.07, subd. 23, provides for what is commonly referred to as the "60-Day Report":

> Whenever a patient is committed under subdivision 17, clause (a) or (c), for a **60 day period,** he shall be held at the hospital during such period for observation, evaluation, diagnosis, treatment, and care. Every patient admitted to a hospital under such clause shall be examined by at least one examiner as soon as practicable after admission. **Within 60 days from the date of the commitment order the head of the hospital shall file a written statement with the court issuing said order,** and a copy thereof with the commissioner and the patient's attorney, setting forth findings as to the condition of the patient; a diagnosis of the patient; whether the patient is in need of further care and treatment; whether such care and treatment, if any, must be provided in a hospital and if so, what type; whether the patient must be committed to a hospital; and whether the patient is dangerous to the public. [Emphasis added]

Minn. Stat. § 253A.07, subd. 25, provides that:

> If the written statement describes the patient as being in need of further institutional care and treatment, the court shall consider such finding in making its final determination, and the court may order hospitalization of the proposed patient for an indeterminate period . . .

Of the 998 petitions reviewed by the staff:

491 of the petitions (49%) resulted in 60-Day commitments.
382 of these 491 commitments resulted in the committed persons being the subjects of 60-Day Reports.
278 of the 382 60-Day Reports (73%) resulted in indeterminate commitment orders being issued.

Of these 278 indeterminate commitments, 5% were for mental deficiency; 15% were for inebriacy; 7% were for mentally ill and inebriate; and 73% were for mental illness.

Fifty percent of all 60-Day commitments for mental illness resulted in indeterminate commitments.

60-DAY REPORTS: BY COUNTY BY TYPE OF STATEMENT

(For persons committed under Minn. Stat. § 253A.07, subd. 17 (a) and (c).)

I. Number of reports which recommend further commitment.

II. Number of reports which say that patient needs to be in a State Hospital for financial reasons.

III. Number of reports in which there is indication that alternatives were considered at the time of the writing of the report.

IV. Number of reports in which there were factual statements in support of the report and its recommendations.

V. Number of reports which state that the patient is, at the time of the writing of the report, dangerous to the public.

TYPE	I	II	III	IV	V
AITKIN (3)	3	2	0	0	0
ANOKA (21)	18	9	5	1	4
DAKOTA (24)	17	10	4	1	8
HENNEPIN (53)	36	23	8	13	8
JACKSON (4)	4	1	0	3	0
KANDIYOHI (23)	18	6	8	6	3
MOWER (18)	8	1	10	3	0
OLMSTED (21)	16	5	8	12	0
OTTER TAIL (31)	17	3	13	13	2
RAMSEY (98)	53	30	14	15	8
ST. LOUIS (83)	52	19	26	20	4
WASHINGTON (17)	16	1	2	7	4
TOTAL	**258**	**110**	**98**	**94**	**41**

( ) = number of 60-Day Reports received by that county.

Reports Recommending Indeterminate Commitment: There were, in some counties, more indeterminate commitments than recommendations for it. In Hennepin County, there were four persons who were indeterminately committed even though the 60-Day Report did not recommend indeterminate commitment. In Mower County, there were five such commitments; Ramsey County which indeterminately committed 66 persons, had thirteen such commitments or 20% of the persons were indeterminately committed without a recommendation from the hospital for that order.

Reports Recommending Continued Treatment: There was a close correlation between the recommendation for continued treatment (as different from continued hospitalized commitment) and the indeterminate commitment of the patient. Overall, 27.1% of the petitions resulted in a recommendation for indeterminate commitment, and 27.7% of the patients were committed indeterminately. Here the difference between the recommendation and the number of patients committed indeterminately ranged from three more commitments (St. Louis County) to five fewer commitments (Ramsey County).

Reports Containing Facts About Patients' Behavior: Because the courts rely on the recommendations of the hospitals for indeterminate commitment and continued treatment, it should be necessary for the courts to know the basis for the hospitals' recommendations, so the court can determine if commitment is justified. Unfortunately, only a small number, 94, of the 380, or 24% of the 60-Day Reports reviewed, contain any facts about the patient's behavior. The use of forms might be a factor in discouraging the inclusion of facts in the 60-Day Report. Researchers were careful to note which 60-Day Reports included facts and which contained conclusions only. Jackson County, which received only four 60-Day Reports, included three, or 75% which state the factual basis for the hospital's recommendations. Of the three Reports sent to Aitkin County Court, none contain any facts. Of the 88 Reports received by Ramsey County, only 17% contain facts and only 24% of St. Louis County's Reports include a factual basis.

Reports Recommending STATE Hospital Commitment: Of the 290 State Hospital Reports, 38%, or 110 Reports state that the patient must remain in a State Hospital for financial reasons. These 110 Reports do not indicate whether available treatment or lack of treatment was a consideration.

Reports Containing Statements About Investigations into Alternatives to Commitment: Researchers noted any information about investigation of alternatives reported on the 60-Day Reports. Researchers found that only 98, or 26% of the 60-Day Reports contained any indication of investigation of alternatives. Reports received by two counties, Aitkin and Jackson, contained no indication of investigation of alternatives. Mower County 60-Day Reports evidence the highest percentage of investigation of alternatives. Again, it is interesting to make a comparison between the two counties receiving the greatest number of 60-Day Reports issued to counties under study. Ramsey County 60-Day Reports showed investigation of alternatives in 16%, or 14 of 88 Reports. St. Louis County Reports showed this information in 31%, or 26 of 83 Reports. It might be worth noting again, that the initial screening in St. Louis County to determine if there were any alternatives to commitment to a State Hospital at the time of the petition impressed researchers. Researchers also noted, in examining St. Louis County records, that the judicial officer did not accept 60-Day Reports which he believed did not provide him sufficient information to form a judgment.

Reports: Numbers In Which "Patient is Dangerous to the Public": Finally, the Report must state whether the patient is dangerous to the public. Of the 380 Reports, only 11%, or 41, state that the patient is dangerous to the public. And of that number, 9 persons were under initial "Mentally Ill and Dangerous" commitments. Therefore, of the 491 persons not originally committed with a "Dangerous" label, only a handful (32) are believed to be dangerous to the public and yet 244 were committed indeterminately with this recommendation.

How Courts "Consider" the 60-Day Report: The 60-Day Reports are "considered" by most courts to be the **only** finding used as the basis for indeterminate commitment. Of the twelve counties researched, it appeared to researchers that ten counties issue indeterminate commitment orders based solely upon the 60-Day Report. Most courts receive the Report from the hospital and upon receipt issue orders consistent with that Report. The number of indeterminate commitments is almost equal to the number of 60-Day Report recommendations for indeterminate commitment.

A copy of the 60-Day Report is not by statute required to be given to the patient. His attorney is to receive a copy; but as these materials indicate, most patients have no contact with their "attorney" after the initial commitment hearing. DPW regulations require State Hospitals to provide their patients with copies of the 60-Day Report. This is often done after the court has received its copy and issued its order.

Researchers found only two of the twelve counties (Dakota and Mower) looked at all beyond the 60-Day Report to other findings. Researchers were most impressed with the practices in Mower County. Upon receiving the Report, the judge sends it to the patient with a letter stating that the Report could provide a basis for the court to indeterminately commit him unless the patient objects. If the patient objects, he is to notify the court and an attorney will be provided and a hearing held.

CRIMINAL CHARGES/CONVICTIONS

Rule 20 of the Minnesota Rules of Criminal Procedure directs criminal courts to refer criminal defendants to county/probate court for commitment proceedings under the Minnesota Hospitalization and Commitment Act if the criminal court finds a defendant unable to proceed because of mental illness, or in cases in which the defendant is found not guilty because of mental illness. This Rule replaces the statutes which automatically required the commitment of all defendants incompetent to proceed in criminal matters and defendants not guilty because of insanity. Therefore, all commitment of persons for mental illness in Minnesota is now governed by the Minnesota Hospitalization and Commitment Act.

In reviewing 998 records, researchers found:

- The vast majority of the records did not indicate whether the subject of the petition had any pending criminal charges or convictions;[27]
- Records which allege recent criminal behavior as an underlying basis for the commitment petition for which no criminal charges were ever filed;
- 34 proposed patients with pending misdemeanor charges (maximum confinement for a misdemeanor is 90 days);
- 37 proposed patients with pending charges or convictions for gross misdemeanors (maximum confinement of one year), or felony (maximum confinement of longer than one year);
- 14 of the 37 proposed patients with pending gross misdemeanor or felony charges were referred to the court under Rule 20 of the Rules of Criminal Procedure;
- 6 proposed patients had pending Driving While Intoxicated charges or convictions;[28]
- 26 other proposed patients had pending charges or convictions, but the gravity of those were unclear; 14 of these were also referred to the commitment courts under Rule 20.
- TOTAL NUMBER OF PROPOSED PATIENTS WITH:

Pending criminal charges or convictions	103	(10%)
Criminal proceedings giving rise to MHCA proceedings pursuant to Rule 20	39	(4%)

[27]Factual allegations suggest, in many cases, recent contact between the proposed patient and the criminal justice system.

[28]There were factual allegations in numerous petitions which suggest underlying problems of driving while intoxicated.

NUMBER OF PETITIONS FILED IN 1977 ALLEGING

COUNTY	MENTAL ILLNESS	INEBRIACY	MENTALLY ILL AND INEBRIACY	MENTALLY ILL AND DANGEROUS	MENTALLY DEFICIENT	TOTAL
AITKIN	3	3	0	0	0	6
ANOKA	28	23	8	6	5	70
BECKER	22	28	2	0	0	52
BELTRAMI	15	12	1	0	0	28
BENTON	9	9	1	0	0	19
BIG STONE	1	3	0	0	0	4
BLUE EARTH	24	26	4	2	3	59
BROWN	20	18	0	1	0	39
CARLTON	NO INFORMATION					
CARVER	9	10	3	0	0	22
CASS	9	12	0	0	0	21
CHIPPEWA	2	5	0	0	0	7
CHISAGO	2	5	0	0	0	7
CLAY	24	19	1	1	4	49
CLEARWATER	2	2	0	0	0	4
COOK	4	7	1	0	0	12
COTTONWOOD	1	4	0	0	0	5
CROW WING	22	4	0	3	7	36
DAKOTA	26	22	18	2	4	72
DODGE	2	5	1	0	0	8
DOUGLAS	11	11	4	0	0	26
FARIBAULT	10	11	5	0	0	26
FILLMORE	9	17	0	0	0	26
FREEBORN	16	40	15	1	2	74
GOODHUE	9	20	0	0	1	30
GRANT	NO INFORMATION					
HENNEPIN	604	497	175	65	14	1,355
HOUSTON	11	19	0	0	0	30
HUBBARD	3	7	0	0	0	10
ISANTI	2	2	1	1	0	6
ITASCA	23	29	2	2	1	57

NUMBER OF PETITIONS FILED IN 1977 ALLEGING (Continued)

COUNTY	MENTAL ILLNESS	INEBRIACY	MENTALLY ILL AND INEBRIACY	MENTALLY ILL AND DANGEROUS	MENTALLY DEFICIENT	TOTAL
JACKSON	5	3	0	0	0	8
KANABEC	NO INFORMATION					
KANDIYOHI	12	16	0	1	2	31
KITTSON	1	2	0	0	0	3
KOOCHICHING	8	15	0	1	1	25
LAC QUI PARLE	2	12	0	0	0	14
LAKE	5	13	1	0	0	19
LAKE O'WOODS	1	1	0	0	0	2
LE SEUER	14	13	3	0	0	30
LINCOLN	1	7	0	0	0	8
LYON	5	4	4	0	0	13
MAHNOMEN	2	8	0	0	0	10
MARSHALL	8	18	0	1	0	27
MARTIN	NO INFORMATION					
McLEOD	9	8	1	0	0	18
MEEKER	8	18	0	1	0	27
MILLE LACS	8	22	0	0	1	31
MORRISON	11	2	0	0	0	13
MOWER	19	35	3	0	0	57
MURRAY	4	3	0	0	1	8
NICOLLET	8	11	1	2	1	23
NOBLES	12	13	2	0	0	27
NORMAN	5	9	1	0	1	16
OLMSTED	27	13	1	0	2	43
OTTER TAIL	28	39	8	2	4	81
PENNINGTON	5	8	2	0	1	16
PINE	15	17	0	0	2	34
PIPESTONE	4	1	1	0	0	6
POLK	4	27	3	0	0	34
POPE	3	3	0	1	0	7
RAMSEY	181	96	34	2	7	320

NUMBER OF PETITIONS FILED IN 1977 ALLEGING (Continued)

COUNTY	MENTAL ILLNESS	INEBRIACY	MENTALLY ILL AND INEBRIACY	MENTALLY ILL AND DANGEROUS	MENTALLY DEFICIENT	TOTAL
RED LAKE	1	4	0	0	0	5
REDWOOD	15	7	0	0	1	23
RENVILLE	11	13	3	0	1	28
RICE	9	14	0	0	2	25
ROCK	6	4	1	0	0	11
ROSEAU	1	0	0	1	0	2
ST. LOUIS	52	53	11	4	8	128
SCOTT	8	11	0	0	0	19
SHERBURNE	11	4	0	1	0	16
SIBLEY	8	7	0	0	0	15
STEARNS	37	29	1	1	5	73
STEELE	5	22	0	1	1	29
STEVENS	NO INFORMATION					
SWIFT	3	0	0	0	0	3
TODD	5	18	1	0	0	24
TRAVERSE	1	0	1	1	0	3
WABASHA	10	4	0	0	0	14
WADENA	4	7	0	0	0	11
WASECA	4	31	10	0	1	46
WASHINGTON	25	52	2	0	0	79
WATONWAN	0	8	0	0	0	8
WILKIN	6	2	3	2	2	15
WINONA	2	6	0	0	2	10
WRIGHT	11	25	0	0	1	37
YELLOW MEDICINE	3	42	0	0	1	46
TOTAL NUMBER OF PETITIONS	**1,576**	**1,670**	**340**	**106**	**89**	**3,781**

NUMBER OF PETITIONS FILED IN 1977 ALLEGING NEED FOR GUARDIAN

COUNTY	MENTALLY DEFICIENT	PERSONS OVER 18	COUNTY	MENTALLY DEFICIENT	PERSONS OVER 18
AITKIN	0	3	KANABEC	N/I	
ANOKA	0	2	KANDIYOHI	0	0
BECKER	0	0	KITTSON	0	0
BELTRAMI	3	0	KOOCHICHING	0	15
BENTON	0	18	LAC QUI PARLE	1	0
BIG STONE	0	1	LAKE	0	1
BLUE EARTH	0	17	LAKE O'WOODS	0	1
BROWN	0	28	LE SEUER	0	10
CARLTON	N/I		LINCOLN	0	0
CARVER	0	13	LYON	0	0
CASS	0	8	MAHNOMEN	0	1
CHIPPEWA	0	2	MARSHALL	1	9
CHISAGO	0	0	MARTIN	N/I	
CLAY	0	0	McLEOD	0	12
CLEARWATER	0	0	MEEKER	0	12
COOK	1	3	MILLE LACS	1	12
COTTONWOOD	0	11	MORRISON	0	19
CROW WING	0	0	MOWER	1	0
DAKOTA	0	0	MURRAY	0	4
DODGE	0	7	NICOLLET	0	14
DOUGLAS	0	0	NOBLES	0	7
FARIBAULT	0	0	NORMAN	0	0
FILLMORE	0	12	OLMSTED	0	23
FREEBORN	0	22	OTTER TAIL	0	30
GOODHUE	0	12	PENNINGTON	0	0
GRANT	N/I		PINE	0	7
HENNEPIN	7	17	PIPESTONE	3	0
HOUSTON	0	12	POLK	0	0
HUBBARD	0	5	POPE	1	14
ISANTI	0	21	RAMSEY	N/I	
ITASCA	0	8	RED LAKE	0	3
JACKSON	0	0	REDWOOD	0	5

NUMBER OF PETITIONS FILED IN 1977 ALLEGING NEED FOR GUARDIAN (Continued)

COUNTY	MENTALLY DEFICIENT	PERSONS OVER 18	COUNTY	MENTALLY DEFICIENT	PERSONS OVER 18
RENVILLE	0	10	TODD	0	6
RICE	0	34	TRAVERSE	0	5
ROCK	0	0	WABASHA	0	8
ROSEAU	0	0	WADENA	0	7
ST. LOUIS	N/I		WASECA	0	0
SCOTT	0	20	WASHINGTON	N/I	
SHERBURNE	0	14	WATONWAN	0	4
SIBLEY	1	6	WILKIN	1	6
STEARNS	0	44	WINONA	2	0
STEELE	0	0	WRIGHT	0	0
STEVENS	N/I		YELLOW MEDICINE	0	11
SWIFT	3	1	**TOTAL**	**26**	**628**

CHAPTER 3

COMMENTS FROM THE PUBLIC

INTRODUCTION: PUBLIC HEARING TESTIMONY SUMMARIES AND WRITTEN STATEMENT SUMMARIES

Six Public Hearings were held by the Commission between May and December, 1978, in Fergus Falls, Saint Paul, Minneapolis, Rochester, Duluth, and Willmar. Comments were solicited and received from consumers, treatment professionals, lawyers, and others interested in the legal rights of the mentally disabled in Minnesota.

Following are summaries of the testimony presented to the Commission. The testimony is summarized and classified according to the general topic the comment addresses. In preparing these summaries, effort was made to list each issue only once, although several speakers may have presented testimony on the same or similar issues. Further effort was made to include representative testimony of all issues raised at all six Public Hearings in these summaries.

All six Public Hearings were tape recorded, and all tapes were transcribed. A limited number of these transcriptions are available, and interested persons should contact Judy Rehak, Supreme Court Administrator, Room 300, 40 N. Milton, St. Paul, MN 55104.

In addition to the testimony received at that Public Hearing, written statements and other materials were submitted to the Commission. These materials include statements supplementary to oral testimony, statements in lieu of Public Hearing testimony, relevant study reports, scholarly writings, newspaper and magazine articles, and program descriptions.

Summaries of written statements, received by the Commission, to supplement or in lieu of Public Hearing testimony are included herein.

GENERAL STATEMENTS

A representative from the Mental Health Association of Minnesota stated that because it is often the case that the proposed patient in commitment proceedings does in fact need some kind of treatment or that his behavior does not conform to society's norm, it is easy for people who are acting in complete good faith to give second priority to a person's fundamental interests and liberty.

The Privacy Act denies family members, in some instances, information which should be shared; was the concern expressed by the parent of a consumer of mental health services.

Hospitalization or main-stream mental health treatment often perpetuates sex-role biases, and this has been researched and documented in an article by Broverman, *et al.*

Eight out of every ten mental patients return to the hospital quite regularly, according to the testimony of a speaker from the Mental Health Advocates' Coalition.

There is a need for advocacy on behalf of mental patients to insure, in the least restrictive environment, treatment most conducive to self-sufficiency.

The Social Action Committee of the Minnesota Psychological Association, through a spokesman, stated that there is a need for programs which would provide a continuum of care, including cost-efficient, community-based services.

The present system for financing mental health treatment is not workable.

Law enforcement officers, attorneys, the courts, and the public need to be educated regarding the characteristic needs and rights of the mentally disabled.

The private institutions should be subject to more regulation and supervision by the state than is presently done.

Hospital staff and family of consumers expressed the need for better community integration and support for persons discharged from psychiatric hospitalizations.

COMMITMENTS

Courts

Patients' records often contain inadequate or no Findings of Fact as courts are required by law to send to the hospital to which a patient is committed, according to hospital staff and Review Board members.

The main problem with Minnesota's commitment statute is not in content, but in implementation, according to several attorneys who testified.

In the commitment process, there appears to be a presumption of "guilt" rather than "innocence," was the impression expressed by a parent of a person who was committed.

We should expand the pool of both court-appointed attorneys and examiners (in Hennepin County); when a small group of persons attempt to work day-to-day on a process, their familiarity tends to weaken the adversarial process which is necessary to preserve the liberty of mentally ill persons, according to a representative from the Mental Health Association.

Because the hearing officer is the same person who selects the "court-appointed" examiners and attorneys, this selection process is suspect. There should be an independent panel to make these appointments, according to a spokesman from MPIRG.

Attorneys

Patients have complained that they have not been adequately represented at their commitment hearings, or that they were not afforded a hearing, according to a Review Board member.

Payment to attorneys on a per-client basis, rather than for the amount of work performed, discourages proper preparation if this preparation time will not be compensated for.

Token representation on the part of the court-appointed attorney suggests indifference or "another buck earned" attitude, testified a family member of a consumer of mental health services.

Court-appointed lawyers get involved in the process too late; persons unable to retain their own counsel are discriminated against in that they are unlikely to be released pending the commitment hearing, according to lay and legal advocates.

A Review Board member and others testified that there is a lack of attorney involvement in indeterminate commitment decisions; following the initial commitment for 60-Days, there is little, if any, involvement of attorneys.

From October 1975 to November 1977, five attorneys represented 94% of all proposed patients in Hennepin County; each court-appointed attorney represented an average of 9.5 clients per day; these facts were discovered as part of a lawsuit according to plaintiff's counsel.

The Ramsey County system for appointment of counsel results in a proposed patient often being represented by more than one lawyer; if a hearing is continued (which frequently occurs), a different attorney will represent the proposed patient the next time the matter is heard, according to the testimony of a court-appointed attorney.

There should be a lawyer in the hospital to advise all proposed patients upon admission to the hospital, was a concern of several persons, including a court-appointed attorney, and a state hospital advocate.

Pre-hearing confinement impedes a client's ability to assist counsel in preparation for the commitment hearing, testified an attorney.

Defense counsel (court-appointed attorneys) are unable to obtain a second professional medical or psychological opinion because of lack of funds to pay for an independent examination, according to a State Hospital Advocate.

The county attorney's role needs to be clarified; county attorneys do not know the law and are not always adequately prepared, according to the experience of a county court judge.

Court-Appointed Examiners

Court-appointed examiners need established guidelines and standards to define their role in the commitment process, testified a psychiatrist and a psychologist.

The requirement of two (rather than one) examiners to examine the proposed patient prior to the commitment hearing is difficult, particularly in rural counties, testified a state hospital unit director.

From October 1975 to November 1977, in Hennepin County, nine examiners were appointed for 97% of all cases; this averaged 9.5 determinations of disability by each examiner per day; because some days there were fewer, more than 9.5 determinations were made on some days, testified an attorney who discovered these data in preparation of a lawsuit.

Five or ten minute examinations which occur in some counties are not long enough for an evaluation, testified a psychiatrist.

Appeals

Committed persons have little or no awareness of their right to appeal from a commitment order, according to hospital staff, a Review Board member, and a spokesman from the Ombudsman for Correction's Office.

That the appeal process takes too long to be meaningful was expressed by an assistant public defender.

Appeals are only taken from the initial determination for the 60-Day Commitment; there is no information that appeal has ever been taken from an order for Indeterminate Commitment.

Hold-Orders and Pre-Hearing Confinement

Apprehend and confine orders are issued as a matter of course in Ramsey County upon the filing of a petition for commitment.

Criminals, at least, are eligible for bail; bail is unavailable to proposed patients who are almost always confined pending their hearing, testified a consumer of mental health services.

A number of persons could be ordered to report for an examination, and there is no need for pre-hearing confinement in these instances, testified an attorney member of a State Hospital Review Board.

The initial evaluation of the proposed patient should not be done at State Hospitals because the patient will be treated at the State Hospital, if he is committed, and that creates a conflict of interest, testified a county court judge.

Officers who pick up proposed patients pursuant to an order to apprehend and confine, should not be in uniform because that is too much like apprehension of a criminal defendant, according to state hospital advocates.

Less Restrictive Alternatives

The burden of showing that there are no "less restrictive alternatives" should be on the petitioner, rather than this being an affirmative defense, according to the testimony of an attorney.

A problem with the requirement that the "less restrictive alternative" be sought is that the requirement is implemented as the "only available alternative", was raised by several mental health and social service professionals.

The search for the less restrictive alternative too often is a sham because we are unwilling to look beyond those few, existing, well-defined community programs, testified a staff person from the Minneapolis Association for Retarded Citizens.

Court Findings of Fact do not always reflect serious consideration of less restrictive alternatives, testified a state hospital advocate.

Criminal

Rule 20 of the Minnesota Rules of Criminal Procedure (which diverts criminal defendants in the commitment process) has resulted in persons who are accused of petty offenses such as disorderly conduct, shoplifting . . . being held, examined in a locked hospital ward for 10-12 days when they would otherwise be sentenced, at worst, to probation, testified a court-appointed attorney.

There are no standard procedures under Rule 20, testified another attorney.

Specific follow-up services are needed for mentally disabled persons after they have been involved in the corrections system, according to a community treatment facility spokesman.

There is a need for appropriate treatment facilities for the mentally disabled offender.

Other Commitment Issues

Physicians' Emergency Holds are used even when courts are in session – when it would be possible to obtain authorization from the court to confine a person on an emergency situation, testified a state hospital employee.

Physicians' Emergency statements contain insufficient information and are too easy to write – often they contain no information beyond the printed form and the physician's signature.

People can be and are committed merely because they are "affronts" to society, testified a former psychiatric patient who is currently a social worker at a nursing home.

The 72-hour detoxification period is insufficient for senior citizens, according to the coordinator of a Senior's Chemical Dependency program.

Persons are "incarcerated" in nursing homes without legal representation.

Commitment business has become the "drop-off center" for persons who may not have a treatable mental illness.

Prison-initiated commitments are usually only when the inmate is approaching mandatory release, and the proceeding lacks basic constitutional safeguards because there is no notice of rights, including the right to appeal; the "court-sent" attorney meets his client 10-15 minutes before the hearing; no witnesses are under oath . . ., according to a representative from the Office of the Ombudsman for Corrections.

Demonstrations of dangerous behavior should not be necessary for commitment, testified a psychiatrist and the parent of a consumer.

State Hospital records lack requisite and individualized treatment programs, testified a psychiatrist and a parent of a patient.

There is not enough cooperation among the agencies which are involved in the commitment petitioning process – particular lack of cooperation or coordination was noted between the county welfare department and the county attorney according to a county court judge and others.

Hospitals should provide legal services for patients with legal problems not related to their hospitalization, but perhaps aggravated by their hospitalization – particularly in matters of family law and landlord/tenant law, testified an attorney who provides this type of legal service to patients at one state hospital.

A patient whose provisional discharge has been revoked should receive a written statement setting out the reasons for the revocation, according to a former Patient Advocate.

Patient Advocates are often faced with a conflict between the interests of their employer (the Hospital Administration) and the patient for whom they are advocates.

Elderly persons are being committed as mentally ill because they are elderly, confused individuals who need supervision – not treatment – testified mental health professionals.

The state needs to develop psychiatric nursing homes because state regulations prohibit the placement of "disturbed" persons in nursing homes.

"Informed Consent" of committed mentally ill patients needs defining.

MENTAL ILLNESS

The kinds of restrictions and expectations placed upon committed mentally ill persons are greater than those which are placed upon many non-mentally ill persons, testified a parent of a consumer of mental health services.

There needs to be better social worker follow-up to assist persons who have been in a mental health treatment program to find employment suitable to their abilities and talents – not just any job for the sake of being employed – testified the parent of a former patient.

There is a need for more resources available to allow every individual to choose a unique combination of services and objectives appropriate to his or her needs.

There is a need to educate the public on schizophrenia and its causes, testified the President of the Minnesota Schizophrenia Association.

It is almost impossible to drop the "dangerous" label after a person has been committed as "mentally ill and dangerous to the public", testified a state hospital administrator.

INEBRIACY

Persons are offered treatment in lieu of jail and are unaware of the length of time for treatment. Often this is a coerced disposition, for alcohol-related offenses, and there is no indication of this person's need for treatment, testified a state hospital advocate and a consumer of services.

Persons committed for Inebriacy are sometimes placed on hospital units which are for treatment of mental illness, and do not offer treatment for chemical dependency.

MENTAL DEFICIENCY

There should be a provision for informal admission procedures for severely retarded, non-objecting mentally deficient individuals, according to a doctor's testimony.

Mentally deficient patients should be entitled to a mandatory 60-Day review under the Minnesota Hospitalization and Commitment Act; they are the only disability group under the MHCA not covered by this review provision.

JUVENILES

Private adolescent psychiatric units have become holding facilities for the juvenile court. Also, there are counties which are promoting the use of Minnesota Security Hospital at Saint Peter for detention of juveniles because of the statute which states that: for any person who is in a state institution, their county of residence shall be liable for $10.00 per month or any portion thereof; any other juvenile treatment would place a far greater financial burden on the juvenile's county of residence.

Juveniles should be afforded full due process commitment hearings before they can be confined contrary to their wishes.

If the courts need a secure holding facility for juveniles, then one should be created rather than using the mental health system inappropriately, testified a former psychiatric aide.

GUARDIANSHIPS/CONSERVATORSHIPS

They are easy to institute and difficult to terminate, and are commonly established without understanding by all concerned of the implications of the relationship, testified attorneys who work with legal services programs for seniors.

There is no right to counsel in guardianship proceedings; there is no right to counsel at the time a guardianship is proposed and no right to counsel when the ward wants to terminate the guardianship.

Northwest Minnesota Judicare, legal services for the northwestern section of the state, does not represent persons in guardianship proceedings, according to a lay advocate.

There should be mandatory appointment of counsel in guardianship proceedings to represent the desires of the proposed ward, urged two attorneys.

Minnesota needs something akin to a Public Guardian or Public Conservator; there is a lack of persons willing to assume responsibilities of a guardian or conservator, testified an attorney.

There is a need for a comprehensive "Protective Services Act" for the elderly, testified an attorney.

Bonds should be for the full amount of the assets of the ward's estate; there needs to be tightening up of accountability of the guardian, testified an attorney.

WRITTEN STATEMENT SUMMARIES

There is a lack of consumer input into mental health planning; planning is currently dominated by treaters; it does not include any meaningful evaluation of existing treatment programs.

There are no rules or guidelines for treatment staff when confronted with committed persons who refuse treatment.

There is need for comprehensive advocacy services, including lay advocates and lawyers.

The Minnesota Hospitalization and Commitment Act is selectively used against poor people.

— State Hospital Advocate —

"Branding" of a person occurs upon the mere filing of a petition.

Pre-hearing confinement promotes a presumption of a need for treatment; pre-hearing confinement should be limited to cases of necessity.

— Attorney —

Given current practices, retaining a private attorney is an important factor in avoiding commitment.

— Proposed patient who was not committed —

The appeal process often outlives the need for treatment; the appeal process should be expedited.

There is a lack of personnel to explore alternatives to commitment; the court should hire an advocate-expeditor.

— Hospital Social Worker —

Patients should continue to be confined pending appeal because the chance of a successful appeal is slight, needed treatment is delayed, and this could be used as a defense counsel tactic. There should be a requirement that the committing court make a specific finding as to whether a person should be confined pending appeal. The appeal process should be expedited.

— Assistant County Attorney —

Cultural and linguistic testing biases must be considered in determination of commitment.

— Attorney —

Patients are not informed of results of psychological testing. Persons are treated for their label, not for their problem.

Patients are treated without explanation of the purpose of that form of treatment.

Hospitals do not provide adequate privacy.

There is a need for more half-way houses, and other residential treatment facilities.

— *former psychiatric patient* —

Medications are often used for convenience and hinder courtroom participation; necessary medications should be indicated on the record, as the law requires.

There should be uniformity in the commitment of juveniles – either there should be proceedings under the Minnesota Hospitalization and Commitment Act (Minn. Stat. §253A) **or** the Juvenile Court Act (Minn. Stat. §260).

— *Attorney* —

Commitment of aging persons is humiliating, weakens family ties and hastens death. There should be special treatment of the elderly under commitment laws.

— *Social Worker* —

Emergency Holds are used as a threat of commitment if "voluntary" treatment isn't accepted.

— *Social Service Worker* —

Current laws make it too difficult to commit inebriates.

Laws should be relaxed to encourage intervention.

— *Psychiatrist* —

The statutory definition of a "Drug Dependent Person" is too restrictive. The definition should be changed to: "Impairs health, adversely affects employment, family and other relationships."

— *Chemical Dependency Treatment Worker* —

Training of therapists at the University of Minnesota did not, as recently as a few years ago, provide adequate background in counseling women.

— *Concerned individual* —

Current laws inhibit voluntary treatment of mentally retarded persons by delaying or withholding voluntary admission. Commitment laws should allow for voluntary treatment to non-objecting mentally retarded persons if there is the endorsement of the professional team.

The court should be informed of availability of treatment at a given facility before a person is committed there.

If commitment is contested, counsel should be informed and prepared to defend the proposed patient.

— *State Hospital Assistant Administrator* —

The mass media perpetuate the myth that mental illness equals violence.

The arrest rate of former mental patients is below that of the general population.

— *Research Psychologist* —

CHAPTER 4

COMMISSION RECOMMENDATIONS

Based on the experience, expertise, and knowledge of the Commission members, and on the data gathered by the Commission staff, and on Public Hearing testimony, and on all other information available to the Commission, it makes the following TWENTY-FOUR RECOMMENDATIONS to Chief Justice Sheran, Associate Justice Wahl and the Minnesota Supreme Court.

The Commission began deliberations on recommendation proposals at Spring Hill Conference Center in February, 1979. Subsequently, the Commission met on four occasions during April and May of this year to discuss and take action on the proposed recommendations.

The Recommendations which follow were adopted by a majority of the Commission members present at the meeting during which that Recommendation proposal was discussed, and not all recommendations are endorsed by each Commission member.

The Recommendations address several aspects of the civil commitment process in Minnesota, and raise areas for further study, which were beyond the scope and resources of this Commission.

(p.) as cited in this chapter refers to the page number of this report on which supporting data is documented.

RECOMMENDATION 1

THE COURT SHOULD APPOINT ONE EXAMINER INITIALLY. THE APPOINTMENT OF A SECOND EXAMINER OF THE PROPOSED PATIENT'S CHOICE SHOULD BE MADE BY THE COURT AT THE REQUEST OF THE PROPOSED PATIENT. THE PATIENT SHOULD BE ALLOWED TO WAIVE THE SECOND EXAMINATION (AND THE APPOINTMENT OF THE SECOND EXAMINER) ONLY IF HE IS FULLY INFORMED OF THE REPORT OF THE FIRST EXAMINER. THE EXPENSE OF BOTH EXAMINERS (INCLUDING TRAVEL TIME, EXAMINATION TIME, REPORT PREPARATION TIME AND COURT TIME) SHOULD NOT BE BORNE BY THE PROPOSED PATIENT.

COMMENTS:

Of the 998 records reviewed in 12 counties, only two counties (Kandiyohi and Saint Louis) had the two examiners, appointed by the court to conduct examinations of a proposed patient prior to a commitment hearing, conduct separate and independent examinations outside of the observations of the other appointed examiner.

In the counties in which staff observed examinations by court-appointed examiners (Dakota, Hennepin, Jackson, Mower, Ramsey and Washington), frequently one of the examiners asked most of the questions of the proposed patient, and then rendered an opinion, sometimes after consultation with the second examiner. The second examiner was then asked if he concurred in the opinion of the first examiner, which he almost always did. This concurrence in a single opinion was further reflected in the written reports which were reviewed by researchers. (pp. 39-40) An overwhelming number of records contained only one report signed by both court-appointed examiners. (pp. 14, 39-40)

In Dakota County, of the 78 records reviewed in which there were examiners' written reports, there was only one case in which the examiners did not concur in their opinion, and did not sign only one report; and, their disagreement in that one case was as to the sufficiency of the information available to them upon which they could make a recommendation.

County Court Judges responded to a Questionnaire inquiry, that they have difficulty finding qualified examiners to fulfill this statutory requirement. (p. 14) By requiring the court to secure the services of only one qualified examiner, the Judges' difficulties in finding qualified examiners, particularly in out-state counties, should be lessened were this recommendation adopted.

In Ramsey County, there has apparently been recognition of the lack of need to expend their limited resources on examinations in matters which will not proceed to a hearing. By weeding-out those petitions which can somehow be disposed of at a pre-hearing conference, there is necessity for court-appointed examiners only in cases which will be the subject of actual hearings. Based upon the high number of concurring opinions of the examiners, implementation of this recommendation will similarly result in economic savings. (pp. 39-40)

Public Hearing testimony indicated the skepticism of several speakers because of the appearance of ties between the court and its appointed personnel – *i.e.*, examiners and attorneys. By allowing the proposed patient the option of selecting an examiner of his own choosing, this area of potential concern should be eliminated.

RECOMMENDATION 2

EXAMINATIONS SHOULD CONFORM TO ACCEPTED PROFESSIONAL STANDARDS FOR EXAMINATIONS CONDUCTED BY PSYCHOLOGISTS AND PSYCHIATRISTS IN ANY ASPECT OF THEIR PROFESSIONAL SERVICES. THESE PROFESSIONAL STANDARDS SHOULD BE CONSIDERED AND SET BY THE APPROPRIATE PROFESSIONAL ASSOCIATIONS, AND SHOULD INCLUDE:

a) EXCEPT AS PROVIDED HEREIN, EXCLUDING FROM THE EXAMINATION ROOM ALL PERSONS OTHER THAN THE PROPOSED PATIENT AND HIS COUNSEL. OTHER PERSONS SHOULD BE PERMITTED TO OBSERVE FOR PROFESSIONAL TRAINING PURPOSES AND ONLY UPON THE EXPRESS CONSENT OF THE PROPOSED PATIENT; AND

b) CONDUCTING THE EXAMINATION IN A PROFESSIONALLY ACCEPTABLE ENVIRONMENT; AND

c) ALLOWING SUFFICIENT TIME FOR A THOROUGH EXAMINATION OF THE SUBJECT.

COMMENTS:

Researchers observed examinations in six counties. In two other counties studied (Kandiyohi and St. Louis), examinations by court order were usually conducted in the examiners' offices prior to the day of the hearing on the petition for commitment, and were, therefore, not observable by researchers. In observing examinations, researchers noted wide variations in the locations, circumstances, length and nature of examinations among the counties in Minnesota.

Dakota County had the examiners conduct the examination in the hearing room immediately preceeding the hearing; the judge removed himself from the room during the examination, but otherwise all persons present for the hearing were allowed in the room during the examination. Examinations of 12 proposed patients were observed and these examinations varied in length from 3 minutes to the longest examination lasting 49 minutes. One examination, according to testimony of the examiner, was only of the proposed patient's medical record and without an interview of the subject of the medical record.

In Hennepin County, one examination lasted only one minute, and of the other approximately 16 examinations observed, none lasted longer than 15 minutes. Some examinations in this county were difficult to distinguish from the hearing itself, and, therefore, the length of examinations were not accurately ascertainable.

In Ramsey County, in which observers sat in on 19 examinations, the length of the examinations was from 7 – 51 minutes each. (The examination time referred to in this comment is the number of minutes during which both examiners, usually jointly, conducted the examination required by both of them.)

The availability of medical records to the examiners prior to the examination varies widely among the counties studied. In St. Louis County, where the proposed patient reports to the examiners' offices for the court-ordered examinations, the only information available to the examiner is a copy of the petition for commitment, and, perhaps the report of the welfare department. (This information about the basis of the examiners' findings is usually contained in the body of the examiners' reports.) In Ramsey, Hennepin and Dakota Counties, the examiners appear to have access to the proposed patient's medical records prior to or during their examination.

In observing a total of approximately 50 examinations in six counties, there were many persons in attendance at the pre-hearing examinations of proposed patients who were not identifiable to researchers. In Hennepin County, the referee who presides over the hearing is present for the examination, but potential witnesses are excluded from the room during the examination. During examinations in several counties, persons freely entered and exited the examination room during the period of time in which the examination was being conducted.

The examinations observed were conducted at the site of the hearing, usually a hospital, and, in some counties, in the hearing room. Though some rooms were inappropriately small for the hearing, they were more appropriate in size for the examination.

Those counties which held hearings in courtrooms, in which the examinations immediately preceded the hearing, also held the examinations at the courthouse. The Commission questions the appropriateness of this environment for the examination.

The Commission also recommends that the commitment process be separated from the treatment process. The examination and the hearing should each be conducted in settings appropriate for that process.

Observations, examiners' reports, and other information clearly point out the wide differences in the type, length and nature of the court-ordered examinations. It is the recommendation of this Commission that standards, which can be established by the appropriate professional bodies, be articulated and uniformly implemented.

RECOMMENDATION 3

WRITTEN REPORTS OF THE COURT-APPOINTED EXAMINERS SHOULD BE SUPPLIED TO THE PROPOSED PATIENT'S COUNSEL AT LEAST 48 HOURS PRIOR TO THE SCHEDULED HEARING. THE EXAMINATION (BY THE COURT-APPOINTED EXAMINER) SHOULD BE CONDUCTED 2-7 DAYS PRIOR TO THE SCHEDULED HEARING. WRITTEN REPORTS SHOULD CONTAIN FACTUAL BASES FOR STATED DIAGNOSES AND OPINIONS AND THE SOURCE THEREOF.

IF A SECOND EXAMINER IS APPOINTED AT PROPOSED PATIENT'S REQUEST, THAT EXAMINER SHOULD WRITE A SEPARATE REPORT BASED UPON HIS SEPARATE AND INDEPENDENT EXAMINATION; THIS EXAMINATION AND REPORT SHOULD BE IN ACCORD WITH THE REQUIREMENTS AS SET OUT IN THE FIRST PARAGRAPH OF THIS RECOMMENDATION.

COMMENTS:

Though Minn. Stat. §253A.07, subd. 2, requires written reports to be filed and provided to patient's counsel only if available beforehand, this recommendation supports the position that both the examination and the written report are to be completed in sufficient time to prepare for the commitment hearing. This recommendation considers the need to conduct the examination in adequate time to determine the advisability and need for another evaluation (at the option of the proposed patient if RECOMMENDATION 1 of this Commission is accepted).

The recommendation that the examination be conducted 2 – 7 days prior to the scheduled hearing is for the purpose of insuring that the examination is not so remote in time as to detract from its usefulness; and in the case of confined proposed patients, the minimum time span of two days between the examination and the hearing is to allow for hearing preparation time without unnecessarily prolonging the pre-hearing confinement.

Research of the records in 12 counties reveal written examiners' reports are filed in all counties for all examinations. (p. 40) But, these filed reports are usually printed forms with few, if any, additions to the forms beyond the examiners' signatures. (p. 40)

Researchers were impressed with some of the written reports in counties in which examinations were held prior to the day of the commitment hearing. (p. 40) On the other hand, some of the reports from those counties, though lengthier than printed-form reports, fail to document the information relied upon by examiners in reaching their conclusions.

The requirements of separate and independent reports by two examiners, in cases in which there would be two examiners appointed, is contrary to the usual practice in many of the counties studied. (pp. 39-40)

RECOMMENDATION 4

OPINIONS OF COURT-APPOINTED EXAMINERS SHOULD NOT BE ADMITTED INTO EVIDENCE UNLESS THE EXAMINER IS PRESENT TO TESTIFY, EXCEPT BY AGREEMENT OF THE PARTIES.

In those counties where the examination was held several days prior to the hearing, the examiner was seldom available to testify, giving the parties no opportunity to examine or cross-examine them. This recommendation was made to assure the parties an opportunity to examine the court-appointed examiners.

RECOMMENDATION 5

ONLY MEDICAL DOCTORS, AND LICENSED CONSULTING PSYCHOLOGISTS, KNOWLEDGEABLE AND TRAINED IN THE DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS SHOULD WRITE STATEMENTS ACCOMPANYING PETITIONS FOR COMMITMENT.

COMMENTS:

The statutory requirement that petitioners exercise reasonable efforts to obtain a physician's statement to accompany every petition for commitment under the Minnesota Hospitalization and Commitment Act does not set out standards or guidelines for this requirement. (p. 29) The only conditions which must be met to satisfy this statutory provision are that the statement be written by a licensed physician who has examined the proposed patient, and the physician believes that the person suffers from a mental disorder and should be hospitalized. The statute does not elaborate on the type of examination which the physician must have conducted, and the statute does not provide any time-frame during which that examination must have been conducted.

Inasmuch as medical doctors do not, by reason of their basic medical training, have special knowledge and training in the diagnosis and treatment of mental disorders, it is recommended herein that only those medical doctors who in fact have special knowledge and training in the diagnosis and treatment of mental disorders write statements in support of petitions for commitment.

The Commission also recommends that those licensed consulting psychologists, who have special knowledge and training in the diagnosis and treatment of mental disorders, be allowed to write statements, in addition to the specially knowledgeable and trained physicians. This recommendation would be consistent with the legislative changes several years ago which began allowing the court to appoint licensed consulting psychologists to serve as court-appointed examiners in commitment proceedings.

In making this recommendation, the Commission recognizes that implementation of this could result in a smaller percent of all petitions which are accompanied by the statement of a professional. This recommendation would most likely disqualify a great number of physicians from writing these statements — physicians, such as general practitioners, who in the past have written statements in support of petitions for commitment.

On the other hand, a greater percent of all petitions could be accompanied by the statement of a qualified professional were this recommendation implemented. By including appropriately trained and experienced psychologists in the class of professionals qualified to write a supporting statement, the result could be that more petitions will be accompanied by a professional's statement.

Finally, this recommendation supports the position that it is preferable to require no accompanying statement of a physician (or other professional) unless that professional possesses special knowledge and training in the diagnosis and treatment of mental disorders.

RECOMMENDATION 6

THE ATTORNEY'S ROLE SHOULD BE TO ADVOCATE ON BEHALF OF HIS CLIENT AS VIGOROUSLY AS IN OTHER ADVERSARY PROCEEDINGS. THE ATTORNEY SHOULD ADVISE AND COUNSEL THE CLIENT, BUT SHOULD ALWAYS FOLLOW THE ARTICULATED DESIRES AND INSTRUCTIONS OF THE CLIENT WITHIN THE BOUNDS OF PROFESSIONAL RESPONSIBILITY.

FOOTNOTE:

MINIMUM ADVERSARY REPRESENTATION SHOULD INCLUDE, BUT IS NOT LIMITED TO:

1. *AT LEAST ONE MEETING WITH EACH CLIENT, NO LATER THAN 24 HOURS AFTER CONFINEMENT PURSUANT TO AN ORDER TO APPREHEND AND/OR CONFINE, OR NO LATER THAN 24 HOURS AFTER SERVICE OF A SUMMONS, AT WHICH TIME THE ATTORNEY SHOULD GIVE A DETAILED DESCRIPTION OF THE COMMITMENT PROCESS; AND*

2. *REVIEWING A PROPOSED PATIENT'S MEDICAL RECORDS, IF THERE ARE ANY, EARLY ENOUGH TO ENSURE SUFFICIENT TIME TO INVESTIGATE AND SECURE ADDITIONAL MEDICAL EVALUATIONS, AND/OR PREPARE FOR THE HEARING; AND*

3. *CONTACTING OR INTERVIEWING ALL PERSONS WHOM THE CLIENT BELIEVES COULD SUPPORT HIS POSITION, AND SUBPOENAING WITNESSES, IF NECESSARY; AND*

4. *ENSURING THE ORDERLINESS OF PROCEEDINGS INCLUDING OBJECTING TO THE ADMISSION OF ANY EVIDENCE WHICH IS OR MAY BE INADMISSIBLE, AND SITTING NEXT TO HIS CLIENT; AND*

5. *BEING FAMILIAR WITH STATUTE AND CASE LAW AND COURT RULES WHICH GOVERN COMMITMENT PROCEEDINGS; AND*

6. *ATTEMPTING TO INTERVIEW, PRIOR TO THE HEARING, ANY WITNESSES OF THE PETITIONER'S WHO MIGHT BE TESTIFYING AT THE HEARING; AND*

7. *ADVERSARY REPRESENTATION SHOULD BE ON BEHALF OF THE PROPOSED PATIENT (and not his guardian* ad litem*) IN EXCEPTIONAL CASES IN WHICH GUARDIANS AD LITEM ARE APPOINTED; AND*

8. *ADEQUATE ASSISTANCE OF COUNSEL SHOULD REQUIRE FURNISHING REPRESENTATION AND COUNSEL AT EVERY CRITICAL STAGE OF THE PROCEEDINGS. ASSISTANCE AT CRITICAL STAGES SHOULD INCLUDE THE FOLLOWING:*
   (a) Deciding whether to seek any remedies for release at the time of confinement and prior to the commitment hearing; and
   (b) Providing advice and assistance to the client with respect to the client's right to request an immediate hearing; and
   (c) Advising the proposed patient with respect to any summons or other order requiring cooperation for the purpose of examination; and
   (d) Investigating, preparing for, etc., the commitment hearing; and
   (e) Advising and counseling with respect to the proposed patient's right to appear at his hearing; and
   (f) Perfecting and prosecuting any appeal, or assisting in securing representation on appeal, unless, after reviewing the record, an appeal would clearly lack merit; and
   (g) Meeting with each client whose 60-Day Report recommends indeterminate commitment, and advising those clients of the possible implications, and of ordinary and extraordinary remedies; and
   (h) Resisting or opposing, through all available legal channels, an order making the commitment indeterminate.

RECOMMENDATION 7

TO THE EXTENT THAT THE CLIENT IS UNABLE OR UNWILLING TO ARTICULATE HIS DESIRES IN ANY PARTICULAR ASPECT OF THE PROCEEDINGS, THE ATTORNEY SHOULD TAKE THE POSITION WHICH PRESERVES THE CLIENT'S LEGAL RIGHTS AND OPPOSE THE PETITION. IN A PROPER CASE, UNLESS PRECLUDED FROM DOING SO BY INSTRUCTIONS OF THE CLIENT, THE ATTORNEY MAY PRESENT EVIDENCE OF THE EXISTENCE OF ALTERNATIVES LESS RESTRICTIVE THAN THOSE SOUGHT IN THE PETITION.

TRANSCRIPTION OF COMMISSION DISCUSSION:[1]

The Commission's deliberations, after RECOMMENDATION SIX was proposed and prior to its adoption, are as set forth in the following transcription from their April 25, 1979 meeting:

(Reading of Proposed Recommendation)

Allen — Eric, did you have any comments you want to make about this recommendation as Chairman of the Task Panel (which proposed this recommendation)?

Janus — Only two comments. First of all, it should be self-evident, but may not be all that [self-evident] in practice. Second of all, the significance of this recommendation is that even where a person may be legally incompetent, and therefor in other normal situations, a guardian *ad litem* would be appointed to stand in the party's shoes and give instructions to the attorney, the idea here is to eliminate that middle-person, the guardian *ad litem,* who would supposedly look after the best interests of the client and instead make sure that the attorney follows the instructions of the client. The theory is that there is already one person whose job it is to look after the best interests of the client: The Judge. What we need in an adversary system is a full presentation of both sides of the issue. And that's what we're working for in this recommendation.

Elwell — As an attorney from the other side of the counsel table, in these kind of proceedings, as is viewed by Mr. Janus, I asked for some interest and participation for a sub-committee the first day this Commission met, to address itself to this, the role of attorney, defense attorney, as a priority consideration, because it is a delicate and different role than that of defending against a murder allegation. The language of this recommendation seems to, in fact it does indeed without qualification, suggest that the attorney should do everything within his legal power to defeat the petition as he would have to, ethically, if he were defending a person accused of a felony.

It would also oblige him to follow the articulated instructions of a paranoid patient who is already suspicious about questions that might be put to him from a friendly person, and I would say that carried to its ultimate extreme, would require the defense attorney in a mental health proceeding to instruct his patient not to answer any questions put to him by an examining doctor. And I think that this would be so counter-productive when put into ultimate effect to the mental health commitment evaluation process that it gets off – it puts a strain on the tracks and sends it way down in the wrong direction.

The role of an attorney in a mental health proceeding – I'm not prepared to tell you exactly what it is, but I'm convinced in my heart that this is not what his role is: to tell his client who's already likely to be suggestible about suspicions of somebody trying to do him in that he should not participate in the process, should not be examined, should not trust anyone, should not say anything, or, for that matter, to call witnesses that his client demands be called to the hearing. I've heard patients delusionally convinced that they were working for the FBI, and the patient wants his attorney to subpoena the head of the FBI to verify the fact that he was out there as an undercover agent or some-such thing. And again, literally, if the attorney should always follow the articulated desires of his mentally ill patient-client, you're going to have some very absurd results, which are totally counter-productive to the interests of the patient. I don't know how else I can say it, but this is just plain wrong.

Dr. Tyce — What ought we do is make the attorney, the patient's attorney, act as his most vigorous advocate, and when he wins the case and the patient is not committed, he's still responsible for him.

[1]This transcription is a complete transcription of the discussion of this proposed recommendation except for approximately 2 – 6 minutes which were not recorded while the tape was being changed.

Cobin In representing patients who are facing the commitment process, I took comfort in the fact that I wasn't able to decide if my client was a paranoid schizophrenic, or was delusional or . . . I should believe this client or not that one, and I took my comfort in the fact that I had a role in the adversary system of representing the articulated desires of the client, and that someone else was stuck with the decision of deciding which client should be believed or not. That's the only way I could operate. The only other alternative is to take the doctor's word which is not representation of the client.

Judge Ring I personally struggled with this trying to define the attorney's role in representing patients, when I was in private practice. And the practice, as I was instructed when I first began, was that you look after the patients' best interests. And I discovered that I had a difficult time (if not now I would conceive impossible) trying to do that.

It seems to me that the role of the lawyer ought to be simply that as leaving the dictation in representing the client. If the client tells you that he wants to go on and take the stand and tell about those people who are trying to kill him, or the arrows in his hair, and the poison in his shoes, let him do it. If he says he wants to subpoena the governor – I've had people who were – no one would claim they were mentally ill. No one would try to commit them. [I had clients] who wanted to subpoena the governor in civil cases, and I had to say: "Listen, as your lawyer, I cannot possibly do that. (The last phrase here [in the Proposed Recommendation] covers that: 'Bound by Professional Responsibility.') I can't subpoena the governor into a case where there's no possible reason for it. And I'm not going to do it, and if you insist on that, then, I'm sorry, you'll have to hire somebody else." And I see no reasons why you couldn't tell your patient when he wants to subpoena the governor in, to show that they're after him, or the head of the FBI, I can't find real value to the case why I should call that person. I just can't do it, and it's just not within (it's just something that I can't do) and relate that to the client.

I guess I really believe strongly that, for the lawyer of any patient, it's impossible to take any other role, without playing God. And I have, in fact, seen lawyers who very carefully plug-up the holes that the petitioner's attorney did not. I think that's wrong. I think that you should not be in the role – you've got two lawyers there that make sure that this poor guy gets into the state hospital. Even if you take issue with instructing him to be silent, the statute doesn't say that we commit those people that we can get to say something that gives us grounds to commit them. It says there are verbal acts. If he shuts his mouth, pursuant to his lawyer's instruction, presumably we should be permitted to consider as proof a few other things he's done.

Elwell Well, why do we have a board of examiners sitting with the board or immediately prior to the hearing to examine the patient if the patient has already been instructed by his lawyer not to talk?

Judge Ring I see the board of examiners as something that should be available to the patient. So that if someone whose actions are different from that of the community, that may not be accepted by the community, but who is not in fact mentally ill, can talk to a professional and who can see that difference. That's a possibility of a veto power, if you will, over the commitment. It gives someone who's not going to help themselves by talking to those physicians. Why should he? That's what I would instruct my client if he was charged with driving under the influence, and they wanted to examine him. . . .

Elwell Mr. Chairman, then I think we should also recommend that the statute be amended to delete the mandatory appointment of clinical examiners, because it's a tremendous waste of tax money if it's only something that the patient may avail himself of if he chooses. I think perhaps we ought to – if we're going to follow the total adversary view of mental health commitment proceedings – then we just simply say that if a patient wants to go and be examined, the court shall pay for it, otherwise why do we have clinical people involved, whatever, in the commitment process, and we make it like a criminal trial. I think that is

the most dreadful thing to have happen to mental health patients. It's what the framers of the new enlightened commitment act of 1968 – the basic change that was so carefully fostered by the people who tried to make this a less traumatizing experience for mental health patients and try to keep it from becoming a criminally adversary or seemingly criminally adversary in a total adversary framework.

If this Commission is diametrically differing from the position of the framers of that statute in trying to keep the spirit of . . . Why don't we just put the badge back on the car and put uniforms back on the people who pick them up and do all the things that they do with criminals in an adversary proceeding and keep reminding a person who is alleged mentally ill that he is being treated the same as a criminal so that he knows he's really in a full adversary proceeding.

Allen I'm not sure I quite understand the tie-in with criminal. I would suppose civil proceedings are adversary too, in the sense that there is somebody on each side, and it's not the attorney who decides; it's the judge. But if you were counsel, whether appointed or retained, for someone against whom a petition for commitment had been filed, and your client said to you: "I don't want to go to that hospital. If you're my lawyer, I would like for you to present my side of the case, so that I don't have to go." And you may have thought if you had been the judge in the case, that it might have been in his long-term best interest to be treated. But, if you undertook the representation would you not have to present his side of the case against commitment as you would in any civil or criminal case as a lawyer or say: "I'm sorry, pal. I cannot represent you because I cannot fully and effectively represent your interests as I would those of a client in another case."

Elwell I think the lawyer's ethics prevent him from plugging-up the holes, as it were, which Gerry seems to think is the necessary alternative. I think that the right of appeal in any framework of advocacy exercises adequate discipline over the kinds of things that you are saying should be guarded against. And I agree should be guarded against. I'm not in favor of any lawyer sitting there like a bump-on-a-log and assisting the petitioner to railroad his client into treatment if he's been retained to do otherwise. I'm simply saying that . . .

Allen Please, his client is not being railroaded. Everybody's acting in perfect good faith.

Elwell Well, plugging-up the holes to help the petitioner additionally get evidence in in support of the petition, that's not the role I see the defense attorney in. But, to mandate that he do everything that his mentally ill client articulates, leaves him no discretionary judgment about what is best in terms of an effective defense. I'm talking about whether some things ought not to be presented that would be counter-productive to the patient's interests in terms of avoiding commitment.

A lawyer is a professional person. He should be allowed discretionary judgment on how he carries out his ethical responsibility to be a defense attorney and not have this Commission or the Legislature or anybody else tell him how he's going to do that. As the judge just said, to prove another point, from the other direction, he said the appellate process is going to take care of that. He said that about a half an hour ago. I say that applies here.

Janus I think it would be real helpful if we had some concrete alternative to talk about. We have two polar extremes at this point; one where the defense attorney puts in the petitioner's case and one that's presented here, which I happen to favor although I'm interested in hearing some other vantages that would help my considerations.

Dr. Tyce If this Commission succeeds now in finding some other way of helping people who need the help, I can understand this.

Dr. Auran The "schism" in schizophrenia is a splitting between what the person feels, what the person says and does, what the person's thinking. Schizophrenia is a peculiar condition in which a

person may say one thing which is contradictory to what they're feeling or believing. This case – suppose I had an attorney interview my client who tells me that "I'm a very evil person, I'm six years old, I've robbed apples from the neighbor's tree, I feel guilty of so many wrong doings in my lifetime I deserve to die, the voice are telling me I should be dead, I want to leave the hospital and go out and end my life. The voices are telling me to do this; I'm an evil person; I owe this to society." As his attorney I would be bound by this to warn him: "For goodness sake, don't mention this to the examiners." I wonder if I could sleep at night if I persuaded my client not to tell the examiners that he feels he is this evil person who must end his life because the voices are telling him to do this.

Dr. Tyce All you've got to do is tell him: "If you talk crazy, they'll commit you."

Allen I'd like to ask Dave Cobin, would that, in your judgment be the ethical responsibility of the lawyer to tell his client: "For God's sake, don't mention those crazy things to the examiners or they'll put you in?"

Cobin I don't think the conversation would stop with that statement. If there is a point when there's a real tough decision, I mean I would try to eliminate it as much as possible. But if I didn't – if I was in a dilemna, where the client is arguing as forcefully as a client can, I don't want to be hospitalized, and the reason is so I can go out and kill myself, then I think at that point the professional responsibility would make me not argue against commitment. At that point, I couldn't do it. I couldn't argue against commitment, because of . . .

Dr. Tyce Then you're not being an advocate.

Cobin But that's the "bounds" of professional responsibility. If the client tells me, "I don't want to be committed . . ."

[END OF TAPE SIDE 1]

Elwell [I move that] Recommendation #10 be amended to read: "The attorney's role should include but is not limited to (a) through (i) (as listed in the proposed recommendation).

Allen All right, you've heard the motion, is it seconded?

Dr. Auran I second it.

Allen It is moved and seconded. Do you understand the motion?

Zerby May I speak against it? I'm really interested in this and frankly have been having a lot of trouble with this. But it does seem to me that, if we're going to operate within the framework of the adversary system, however reluctantly, I think we have to come out where this comes out . . .

Elwell I read "adversary representation" to be on behalf of the proposed patient.

Dr. Tyce I think the motion's a cop-out.

Zerby Well, I think unless you want to look at a whole other alternative, and I think that's entirely possible, that a whole other alternative be examined, but within the present system I don't see how you can escape how this comes out basically with the qualifications that have been discussed here.

Cobin I think that the reason that the recommendation is what's on top and the rest is in the footnote in that the basic message is what's on top, and what's in the footnote is just – if you don't know what that means you ought to look down below.

Allen May I suggest that we pretty thoroughly explored the issue . . . I think there will be those of you whose views will not be changed if we prolong this debate for hours on each side. I would suggest that we bring this . . . to a vote . . .

COMMENTS:

Because the Minnesota Hospitalization and Commitment Act provides that all proposed patients be afforded counsel (court-provided, if necessary), Minn. Stat. § 253A.07, subd. 15, there is a need to define the role of counsel in these proceedings. In researching the commitment process in Minnesota, it is clear that there is no uniformly accepted role for the proposed patient's counsel in those proceedings. According to the information from County Court Judges, the role of counsel in commitment proceedings terminates at significantly differing stages in the process in the many counties (p. 12), and counsel is compensated for services through widely varying schemes – from payment per client in some counties to payment at an hourly rate for services rendered in other counties. (pp. 10-11)

The county attorneys expressed concern for the need to define counsel's role, as well (p. 21); this is of peculiar concern to county attorneys because a definition of proposed patient's counsel's role would better set out the responsibilities and duties of petitioner's counsel – the county attorney.

Informal interviews with court-appointed counsel, and Public Hearing testimony of attorneys and others indicate that because the statute does not define the role of the attorney representing the proposed patient, a great deal of confusion has arisen over what that role should be. Court-appointed attorneys (who represent almost all proposed patients (p. 12) expressed concern that their dual appointment as attorney/guardian *ad litem* is a primary source of confusion; they perceive that the role of attorney may be, and in some instances, has been, in conflict with the role of guardian *ad litem*. (See Appendix E.)

Therefore, the Commission has recommended that the right to counsel be defined and implemented uniformly in all jurisdictions in Minnesota. This recommendation has considered the professional duty of an attorney to his client, the role of an attorney in all other court proceedings with particular emphasis on the analogous juvenile court process, and the developments in the area of legal rights of mentally disabled persons.

Because the statute (and case law) does not define the role of the attorney in commitment proceedings, the Commission has considered and examined the following in their attempt to define the role of counsel as is recommended herein.

CODE OF PROFESSIONAL RESPONSIBILITY

Attorneys are governed in their conduct by the Code of Professional Responsibility which includes Canons, Ethical Considerations, and Disciplinary Rules. Canons are statements of general standards of professional conduct expected of lawyers. Ethical Considerations are principles toward which lawyers should strive. And, lawyers whose actions fall below the standards set out in the Disciplinary Rules are subject to sanctions by their professional body as well as to potential civil and/or criminal liability.

An attorney has a duty "both to his client and to the legal system . . . to represent his client **zealously within the law** [emphasis added] . . ." (Ethical Consideration 7-1) The minimum standard which lawyers must attain is contained in Disciplinary Rule 7-101 (A): "a lawyer shall not intentionally fail to seek the lawful objectives of his client."

Ethical Consideration 7-12 speaks directly to the role of the attorney in representing a client whose mental condition may render him incompetent, and who has no legal representative or guardian. It states that the lawyer should obtain from the client all possible aid, and resolve any questions of the client's state of mind in favor of the client. (See also Ethical Consideration 7-6.)

Further, it is the position of the Commission that because commitment proceedings, by their nature, are to determine the proposed patient's (client's) ability to understand and make decisions, the attorney cannot decide the ultimate question of his client's state of mind. The attorney's role must be to advocate his client's articulated desires and allow the court to make the ultimate determination of the client's state of mind.

Thus, a lawyer, acting within the bounds of the Code of Professional Responsibility, has a duty, not only to his client, but also to our legal system, to represent and advance his client's articulated desires and instructions through professional advice and counseling.

JUVENILE COURT REPRESENTATION

Case law has analogized civil commitment representation to juvenile court representation.[2] Thus, the role of counsel in juvenile proceedings is another useful guide in determining the role of counsel in civil commitment proceedings. Both types of proceedings adjudicate the client's status, and both have the similar goals of helping rather than punishing, and providing treatment or habilitation, rather than mere institutionalization.

The United States Supreme Court has held that a defendant in a juvenile proceeding has, under the Due Process Clause of the Fourteenth Amendment to the United States Constitution, the right to adversary counsel. The Court held that:

> . . . in a proceeding where . . . the child will be . . . subjected to the loss of liberty for years . . . (he) needs the assistance of counsel to cope with the problems of law, to make skilled inquiry into facts, to insist upon regularity of the proceedings, and to ascertain whether he has a defense and to prepare and submit it.[3]

A proposed patient in a civil commitment proceeding is likewise threatened with the loss of his liberty. Almost half (49%) of the 998 records reviewed in the in-depth study resulted in 60-day commitments (or, in the case of Inebriacy, 45-day commitments). (p. 44) Another 239 proposed patients, for whom petitions were stayed or continued, remained under the jurisdiction of the courts for periods of up to a year. (p. 44) Therefore, 73% of all records reviewed indicated that the consequences to a person's liberty of a petition for commitment are far-reaching. In 28% of the 998 files reviewed, this loss of liberty was most acutely noted in that these patients were hospitalized beyond the initial commitment; they were committed indeterminately.

CIVIL COMMITMENT PROCEEDINGS REPRESENTATION

The Minnesota Court and the Minnesota Legislature have not addressed the problem of defining the role of counsel in civil commitment proceedings.

Other jurisdictions have resolved this question. An example of a court which has determined this issue of the role of counsel is the Washington Supreme Court in **Quesnell v. State**[4] which, among others, set out standards for attorneys in commitment proceedings. That court held that assistance of counsel must be "considered and afforded in a meaningful way rather than in form only . . ."[5] Meaningful representation, the court goes on to say, includes interviewing the client with sufficient time to prepare a defense, and pursuing, in fact, the interests of the client.

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[2] **In Re Gault**, 387 U.S. 1 (1966); **Lessard v. Schmidt**, 349 F. Supp. 1078 (E.D. Wis. 1973) (mental health law decision which analogizes to juvenile decisions).

[3] **In Re Gault**, 387 U.S. at 36 (1966).

[4] 517 P.2d. 568 (1974). *See also* **Lynch v. Baxley**, 386 F. Supp. 378 (M.D. Ala. 1974); **Lessard v. Schmidt**, 349 F. Supp. 1078 (E.D. Wis. 1973).

[5] **Quesnell v. State**, 517 P.2d. at 575.

Beyond defining the role of counsel as vigorous adversary representation, the Commission, through this recommendation, has set out aspects of representation of counsel. Comments on some of these aspects are set forth in the following paragraphs:

- Present law and practice under the Minnesota Hospitalization and Commitment Act allow for the apprehension and confinement of a petitionee upon the mere filing of a petition (pp. 8-9); Minn. Stat. §253A.07, subd. 3. Because a petitionee is therefore confined without notice and without an opportunity for a hearing, counsel at this stage is essential to immediately protect and advise a person and to seek any available remedies. The Commission has recommended that this be accomplished by requiring that each confined person be provided the advice of counsel within 24 hours of confinement.

- The Commission recommends that an attorney be familiar with the medical records of his client to determine how to advise that client in the seeking of further medical evaluations or in seeking legal remedies based upon the contents of those records. (See Recommendation 1 on page 61.) The attorney should be familiar with his client's medical records in the event that examination or cross-examination of the author of those records is necessary during the course of legal representation.

- Contacting and interviewing all potential witnesses should be the duty of counsel who has the statutory authority to subpoena witnesses on behalf of the proposed patient. Counsel is the only one with statutory authority to subpoena witnesses on behalf of the proposed patient, Minn. Stat. §253A.07, subd. 15. Observations of hearings in several of the selected counties revealed that witnesses were seldom called to testify on behalf of the proposed patient. This observation is consistent with interviews and Public Hearing testimony which revealed the problem of court-appointed attorneys contacting their clients with insufficient time to contact and/or call to testify persons suggested as witnesses by the proposed patient.

- The Commission believes it necessary to spell out counsel's duty to insure orderly proceedings. Observations of commitment hearings revealed, among other things, witnesses whose testimony was received without the witness first being sworn under oath; attorneys who did not sit next to their clients; no indication of a proposed patient's having been administered medications within the past 48 hours, according to the information received into the record, even though there were other indications, apparent to researchers, of recent medications (see Minn. Stat. §253A.07, subd. 12); medical examiners continuing their pre-hearing examinations during the course of the commitment hearing.

Beyond defining the role of counsel *vis-à-vis* his client, and describing the aspects of representation, the Commission has articulated those times at which the advice of counsel should be available. Because of the serious nature of the commitment process and the potential consequences of that process which may arise upon the filing of a petition for civil commitment (pp. 8-9), there is a need for protection of an individual's right at the outset of the process. Because commitment consequences do not cease upon a court order for commitment, there is need to provide counsel throughout until the individual is unconditionally discharged. Comments on some of the crucial stages for adversary representation, as recommended by the Commission, are as follows:

- Because all counties implement the Minnesota Hospitalization and Commitment Act's provision for court-provided counsel, when necessary, at the initial commitment hearing stage, there is no need to comment on representation at that stage.

- Present practice and law permit the apprehension and confinement of a proposed patient upon the mere filing of a petition (pp. 8-9) without notice or an opportunity to be heard. Such confinement is a crucial stage in the process at which a confined person should receive the advice and representation, if necessary, of counsel. Public Hearing testimony of attorneys who have represented proposed patients indicates that the availability of counsel at this stage of the proceedings is critical if representation of the proposed patient is to be effective. (See Appendix E.) Further, field observations indicate that a great deal of testimony, both lay and expert, presented

at commitment hearings relies upon behavior of the proposed patient during this period of confinement. Finally, because medical records from this confinement are often available to court-appointed examiners (p. 14) this stage may be pivotal to the proposed patient's liberty.

- Counsel is necessary at the time the 60-Day Report is sent to the court. The law provides that the patient's attorney, not the patient, is to receive a copy of the 60-Day Report (Minn. Stat. § 253A.07, subd. 23), and many, if not most, patients do not, at present, have attorneys at this most crucial stage of their commitment. (p. 12)

- The 60-Day Report is, under current practice in most counties, the only extra-judicial input into the court's decision of whether or not to commit a person for an indeterminate period of time. This crucial stage could determine a person's status for some time to come, and there is, therefore, a need to insure legal protections at this stage. (See also RECOMMENDATION 18 which recommends that a hearing be afforded all persons faced with a possibility of indeterminate commitment.) The insufficient information contained in many 60-Day Reports, according to a review of 382 of them (pp. 43-47), should be subject to challenge by the patient who faces the possibility of indeterminate commitment, and this challenge should be with the assistance of counsel.

- There is the statutory right to appeal from a commitment order, but there is no provision in the Minnesota Hospitalization and Commitment Act for the right to counsel on appeal. Some counties have provided, upon request, an attorney to advise the patient as to the merits of an appeal and to represent the appellant. The Commission has recommended that an attorney be made available as a matter of course to all proposed patients for the purpose of perfecting and prosecuting any appeal, unless "after reviewing the record, an appeal would clearly lack merit." Based on information about the current practices in the provision of legal representation to proposed patients and patients (pp. 10-12) the Commission has determined that it is necessary to spell out the need for the attorney to review the transcript of the initial commitment hearing prior to determining that counsel will not be provided for an appeal based upon the determination that an appeal clearly would lack merit.

  The right to counsel on appeal has been resolved in Ramsey County through agreement by the Ramsey County Public Defender to represent all indigent persons committed by the Ramsey County Probate Court for the initial 60-day commitment. The Ramsey County Public Defender, however, has not agreed to provide representation to persons who want to appeal from Indeterminate Commitment Orders.

- Finally, once the court's involvement with the patient ceases (upon entry of an Indeterminate Commitment Order), it is the decision of the hospital to which the patient has been committed to determine when to discharge or provisionally discharge that patient. It has been the practice and policy of most courts that the right to counsel does not extend beyond the time of that Indeterminate Commitment Order (pp. 8-9), and therefore, most patients do not have counsel between the time of that Order (at the latest) and discharge from the commitment.

  It is the position of the Commission that a person should have the benefit of counsel throughout the commitment, until such time as he is unconditionally discharged. Counsel, throughout the period of commitment, should be available to advise and represent the patient, his client, in seeking any ordinary and extraordinary remedies available to the client; this representation is part of the role of any attorney, in representing any client in any type of legal matter.

RECOMMENDATION 8

THERE IS NO ROLE IN COMMITMENT PROCEEDINGS FOR A GUARDIAN AD LITEM *WHOSE ONLY ROLE IS TO DETERMINE THE "BEST INTERESTS" OF THE PROPOSED PATIENT.*

COMMENTS:

In light of the Commission's recommendation for the role of counsel in commitment proceedings (see RECOMMENDATION 6, pp. 65 – 66), it follows that only in cases in which the proposed patient is in need of a guardian *ad litem* under Rule 17 of the Minnesota Rules of Civil Procedure would he be in need of a guardian *ad litem* in a proceeding under the Minnesota Hospitalization and Commitment Act – *i.e.*, in cases of juveniles and adjudicated incompetents.

RECOMMENDATION 9

IT IS IMPORTANT THAT THERE BE A FULL AND VIGOROUS EXPLORATION OF ALL ALTERNATIVES TO COMMITMENT, EVEN WHERE THE PROPOSED PATIENT'S OPPOSITION TO INSTITUTIONALIZATION MAY APPEAR TO BE IRRATIONAL OR WHERE THE PROPOSED PATIENT IS UNABLE TO ARTICULATE HIS OPPOSITION TO INSTITUTIONALIZATION.

RECOMMENDATION 10

EACH COUNTY SHOULD CREATE A PROCEDURE FOR PRE-PETITION SCREENING INDEPENDENT OF THE COUNTY ATTORNEY'S OFFICE WHICH SHOULD INCLUDE:

1. *A PERSONAL INTERVIEW WITH THE PROPOSED PATIENT AND OTHER INDIVIDUALS WHO APPEAR TO HAVE KNOWLEDGE OF THE CONDITION OF THE PROPOSED PATIENT; AND*

2. *EXPLORATION OF ALL ALTERNATIVES TO HOSPITALIZATION OFFERING SUITABLE AND AVAILABLE ALTERNATIVES TO THE PROPOSED PATIENT. WHERE NO SUITABLE ALTERNATIVES ARE AVAILABLE, IDENTIFICATION OF THE TYPE OF ALTERNATIVE TO HOSPITALIZATION, IF ANY, WHICH WOULD BE SUITABLE; AND*

3. *IDENTIFICATION AND LISTING THE REASONS FOR REJECTING OR RECOMMENDING EACH ALTERNATIVE TO INVOLUNTARY HOSPITALIZATION; AND*

4. *IDENTIFICATION AND INVESTIGATION OF SPECIFIC ALLEGED CONDUCT WHICH IS THE BASIS FOR APPLICATION.*

PRE-PETITION SCREENERS SHOULD REPORT THE RESULTS OF THE PRE-PETITION SCREENING IN WRITTEN FORM TO THE COUNTY ATTORNEY. UPON REQUEST, COUNTY ATTORNEYS SHOULD ASSIST IN DRAFTING ALL PETITIONS. EX PARTE *APPREHEND AND/OR CONFINE ORDERS SHOULD BE ISSUED ONLY ON PETITIONS APPROVED BY THE COUNTY ATTORNEY.*

COMMENTS:

Because commitment is a serious curtailment of liberty and affects drastically other civil and human rights, the greatest care should be exercised to ensure that commitment is considered only after a full exploration of all other possible dispositions, including non-intervention. To ensure that commitment is considered only after careful and complete consideration of all other possible alternatives, there should be standardized procedures spelled out for pre-petition screening.

This recommendation proposes the purpose, outlines the process, and defines the objectives the Commission believes are necessary for the effective implementation of a pre-petition screening process.

The Commission considered that, because the Minnesota Hospitalization and Commitment Act mandates that the county attorney's office represent the petitioner (any "interested person") upon request of the petitioner, county attorneys should not be charged with pre-petition screening duties, as well. Pre-petition screening should be impartial, and, therefore, should not have the goal or objective of developing the case for one adversary in a judicial proceeding. (pp. 16-17) Additionally, county attorneys' offices are not staffed by persons whose training and expertise lends itself to this pre-petition screening function. The Commission considered these, among others, as appropriate agencies to be charged with pre-petition screening responsibilities: The county welfare department's social service unit; community mental health centers.

In polling the county attorneys, 55 of the 61 responding stated that their county has adopted some form of pre-petition screening. (pp. 16-17) But, as the responses indicate, there is no uniformity of concept or practice in this process. (pp. 16-17)

Anoka County, which may have one of the longest established pre-petition screening processes in Minnesota, has written standards and procedures for the implementation of their uniform process. In accord with their set procedures, 99% of all proposed petitioners are interviewed by pre-petition screeners prior to the drafting of a petition. The Social Service Unit of the Anoka County Welfare Department, which is charged with the duties of pre-petition screening, reports that the interview of the proposed petitionee prior to the drafting of the petition has proven to be an integral part of what they consider to be a successful pre-petition screening process.[6] (Researchers were informed that Ramsey County's pre-petition screening unit has recently incorporated the requirement of an interview with the proposed petitionee prior to the drafting of a petition, if at all possible.)

Another aspect of Anoka County's process, which they believe important, is the requirement that there be pre-petition screening even in cases in which there is a doctor involved. Hennepin County, on the other hand, does not screen matters in which a physician is involved. (See Appendix A.)

Another portion of a pre-petition screening process is the knowledge on the part of the screeners of available resources and other treatment possibilities which should be considered before consideration of the drastic measures involved in petitioning for commitment.

In cases in which pre-petition screeners do not believe there are alternatives to commitment, this recommendation requires the screeners to document the alternatives which were considered and the reasons for rejecting these alternatives. In Saint Louis County, the welfare department, through its court-ordered report, does this currently, and researchers were impressed with the method and product of documentation in this county. (p. 32) In this county, these welfare department reports provided the committing court with an evidentiary basis for making the statutorily required findings regarding the availability of less restrictive alternatives.

This recommendation promotes the drafting of petitions which provides notice of alleged behavior which, if proven, would justify commitment. Researchers found many petitions lacked the type of factual allegations which are required by law. (pp. 26-28) By training pre-petition screeners to document behavior which could form the basis of a legally sufficient petition, it is hoped that more petitions will contain the information, and thus provide the notice, to which a proposed patient is entitled. As the record review indicated, Anoka County, through the drafting of petitions by their pre-petition screening unit, had only one petition in 1977 which did not allege the factual basis for the petition. (p. 26)

[6]This information was provided by Ms. Barbara Ingrassia, Supervisor, Adult Services Unit, Anoka County Welfare Department.

The final aspect of this recommendation which provides that county attorneys approve all petitions in which *ex parte* apprehend/confine orders are requested would provide some protection against the arbitrary use of "Hold Orders" (pp. 8-9) in cases in which the petition is, on its face, suspect.

RECOMMENDATION 11

PATIENTS SHOULD HAVE A RIGHT OF ACCESS TO THEIR COMPLETE MEDICAL RECORDS.

COMMENTS:

The Minnesota Hospitalization and Commitment Act does not address the issue of accessibility of medical records to persons who are or have been hospitalized under the Act. There is no case law on this subject in Minnesota.

The Privacy Act, Minn. Stat. §15.162, divides information collected and maintained by agencies as confidential (accessible to no one), private (accessible to the subject of the data), and public (accessible to the public). Therefore, all private and public data is available to the subject of the data. But, the Privacy Act does not define what is to be confidential and what is to be private.

The only statute which grants a patient the right of access to his medical records is Minn. Stat. §144.335. The statute states that upon request, a provider shall supply a recipient of medical or psychiatric services, complete and current information possessed by the provider concerning any diagnoses, treatment, and prognosis, in plain language. The statute, though, includes a provision which allows the provider to reasonably determine that the information is detrimental to the physical or mental health of the patient and withhold the information. This statute allows the provider to decide to withhold the information without standards or procedures. The recipient of services thereby loses his right to access without recourse.

The Minnesota Department of Public Welfare has developed a policy which provides State Hospital patients access to their medical records. According to Ms. Joyce Hultberg, Advocate, Moose Lake State Hospital, and Chairman of the State Hospital Advocates, this policy has been successfully implemented at Moose Lake and other State Hospitals.

Patients who are hospitalized under the MHCA in other than State Hospitals are not governed by this Department of Public Welfare policy. There are many, many individuals who are, therefore, not covered by this policy, and who may have no access to their medical records.

RECOMMENDATION 12

THE CURRENT SYSTEM OF LAY ADVOCATES IN STATE HOSPITALS SHOULD BE MADE INDEPENDENT OF THE STATE HOSPITAL ADMINISTRATION, AND AN OPPORTUNITY FOR LEGAL TRAINING SHOULD BE MADE AVAILABLE TO THESE LAY ADVOCATES.

A LAWYER SHOULD BE HIRED TO ASSIST THE ADVOCATES AND REPRESENT PATIENTS.

COMMENTS:

For the past five years, each State Hospital has had one full-time or two part-time staff members designated as that State Hospital's "Patients' Advocate." Prior to their designation as Advocate, each had been employed on the staff of that State Hospital in some other capacity (*e.g.*, nurse, social worker . . .). The Advocates' functions, in practice, vary among the many State Hospitals, and each Advocate is responsible to that State Hospital's Administrative head. None of the Advocates is a trained lawyer. There are no attorneys provided to assist the Advocates in carrying out their duties.

RECOMMENDATION 13

A. PATIENTS SHOULD BE SERVED WITH A COPY OF THE "PHYSICIAN'S EMERGENCY HOLD" STATEMENT IMMEDIATELY UPON INCEPTION OF THE 72-HOUR HOLD PERIOD.

B. THE PHYSICIAN'S EMERGENCY HOLD, AUTHORIZED BY MINNESOTA STATUTES, §253A.04, SHOULD BE ACCOMPANIED BY THE PHYSICIAN'S STATED REASONS, IN BEHAVIORAL TERMS, INCLUDING THE PHYSICIAN'S OWN OBSERVATIONS AS TO WHY HE BELIEVES "THAT THE PERSON IS MENTALLY ILL, INEBRIATE, OR MENTALLY DEFICIENT AND IS IN IMMINENT DANGER OF CAUSING INJURY TO HIMSELF OR OTHERS, IF NOT IMMEDIATELY RESTRAINED, AND THAT AN ORDER OF THE COURT CANNOT BE OBTAINED."

MERE RECITATION OF STATUTORY LANGUAGE DOES NOT MEET THE REQUIREMENT OF THE "STATED REASONS" REQUIRED BY THE STATUTE.

C. COPIES OF THE PHYSICIAN'S EMERGENCY HOLD STATEMENT SHOULD BE MAINTAINED BY THE HOSPITAL HOLDING THE PATIENT, AND FORWARDED TO SOME RESPONSIBLE STATE REVIEWING AGENCY OR OMBUDSMAN FOR REVIEW FOR COMPLIANCE WITH REQUIREMENTS OF THE STATUTE. SUCH REVIEW SHOULD BE CONDUCTED IN SUCH A MANNER AS TO SAFEGUARD THE RIGHT OF PRIVACY OF PATIENTS.

COMMENTS:

Minn. Stat. §253A.04 provides for the confinement of an individual based upon a "physician's emergency hold". The statute does not provide for any monitoring of the use of such confinement. Further, the statute does not require that any notice be provided to an individual being held under the statute's provisions.

In conducting the record review, in the 12 selected counties, only in those counties which use Rochester State Hospital (Mower and Olmsted Counties) as a "holding" facility do any written statements of doctors appear in court files. (There is no agency in the state which receives these statements presently as a matter of law or practice.) These statements are evidently sent to the respective county courts as a matter of hospital policy, and not as a result of any statutory mandate or DPW policy.

Court records in the other ten counties reviewed do not contain copies of physicians' emergency statements. However, other information in the files reviewed indicates that a large number of proposed patients had been originally hospitalized under the physicians' emergency hold provision. This conclusion can be drawn from the court records from a number of sources. Often the factual allegations of a petition for commitment refer to the proposed patient's past or current treatment. In addition, statements in welfare reports and other information in the court file often indicate that the proposed patient had been confined under a physicians' emergency hold.

Public Hearing testimony revealed that "Physician's Emergency Hold" statements are often signed by admitting doctors in hospitals who have no direct information about the subject of the statement and who sign statements upon the request of the person(s) who bring the subject to the door of the hospital. Testimony further revealed that it is not unheard of to learn that many times doctors have signed these statements unaware of legal requirements of the use of the physician's emergency hold. Again, the use of a printed form which recites the statutory language (see RECOMMENDATION 3, p. 63) promotes this failure to "state reasons" for the experts' conclusions.

Because there is no record-keeping system for the receipt and monitoring of the use and documentation of the "Physician's Emergency Hold," this recommendation proposed that a monitoring system be developed to ensure the proper and appropriate use of this statutory authority.

RECOMMENDATION 14

EX PARTE *APPREHEND AND CONFINE ORDERS SHOULD NOT BE USED INITIALLY AS A DEVICE TO OBTAIN AN EXAMINATION OF THE PROPOSED PATIENT. RATHER, EXCEPT IN CIRCUMSTANCES DESCRIBED IN PARAGRAPH TWO OF THIS RECOMMENDATION, A SUMMONS PROCEDURE SHOULD BE UTILIZED IN ORDER TO GIVE THE PROPOSED PATIENT AN OPPORTUNITY TO APPEAR VOLUNTARILY FOR THE PRE-HEARING EXAMINATION.*

EX PARTE *APPREHEND AND CONFINE ORDERS SHOULD BE USED ONLY WHEN THERE IS EITHER A PARTICULARIZED SHOWING BY THE PETITIONER THAT SOME IMMEDIATE HARM IS LIKELY UNLESS THE PROPOSED PATIENT IS APPREHENDED, OR THE PROPOSED PATIENT HAS NOT VOLUNTARILY APPEARED FOR THE PRE-HEARING EXAMINATION PURSUANT TO THE SUMMONS.*

WHERE THERE IS SUCH AN EX PARTE *ORDER, THERE SHOULD BE A PROMPT PROBABLE CAUSE HEARING TO DETERMINE WHETHER OR NOT THE CONFINEMENT IS APPROPRIATE.*

COMMENTS:

Ex parte apprehend and confine orders are used extensively throughout the state. (p. 8) In many counties, these orders issue as a standard operating procedure upon the filing of a petition (p. 8) and/or for the purpose of having the proposed patient examined. (p. 8) In this recommendation, the Commission proposes that the use of these *ex parte* orders be limited to emergency situations, and to situations in which the proposed patient has failed to respond to a summons.

This recommendation supports the use of a summons procedure to notify the proposed patient of the proceedings and to summon the proposed patient to an examination by the court-appointed examiners. This type of summons and notice procedure has been implemented in Saint Louis County and was in effect during the time of the staff's record review, 1977. This process, according to Saint Louis County officials, has been successful in that proposed patients routinely appear for examinations and hearings pursuant to summons.[7] In reviewing records in Saint Louis County, researchers noted that almost all proposed patients who were summoned to appear for examination responded to the summons at the designated times and places.

Elimination of unnecessary pre-hearing confinement will result in an enormous financial savings for each county. The approximate per diem cost of care in the psychiatric unit of a Minneapolis/St. Paul area general hospital is $160.00.

The purpose of the probable cause hearing recommended by the Commission is not to determine the merits of the petition for commitment, but rather to determine whether or not the proposed patient, if not immediately restrained, poses an imminent threat of dangerousness.

RECOMMENDATION 15

THE PETITION SHOULD CONTAIN FACTUAL DESCRIPTIONS OF THE PROPOSED PATIENT'S RECENT BEHAVIOR; INCLUDING A DESCRIPTION OF THE BEHAVIOR, WHERE IT OCCURRED, AND OVER WHAT PERIOD OF TIME IT OCCURRED. EACH FACTUAL ALLEGATION SHOULD BE SUPPORTED BY OBSERVATIONS OF WITNESSES WHO ARE NAMED IN THE PETITION. PETITIONS SHOULD CONTAIN FACTUAL STATEMENTS IN BEHAVIORAL TERMS AND SHOULD NOT CONTAIN JUDGMENTAL OR CONCLUSORY STATEMENTS.

[7]This information was provided by Ms. Julie Baumgarten, Assistant County Attorney, Welfare Division, Saint Louis County.

COMMENTS:

Researchers were concerned with the lack of factual allegations in the petitions for commitment which should provide information about the reasons for the petitions (pp. 26-28). There were many petitions reviewed (155) which recited only statutory language in lieu of citing any behavior of the proposed patient's which would support a commitment. (p. 26) The statutory and constitutional right to notice of the alleged behavior which could justify loss of liberty is possibly being denied in a significant number of cases.

RECOMMENDATION 16

PROPOSED PATIENTS SHOULD BE PROVIDED WITH ALL WRITTEN DOCUMENTS RELATED TO THEIR CASE IN A TIMELY MANNER, INCLUDING THE PETITION, THE PHYSICIAN'S STATEMENT IN SUPPORT OF THE PETITION, THE FINDINGS OF FACT, AND THE 60-DAY REPORT. ("TIMELY MANNER" IS IN SUCH TIME AS IS SUFFICIENT TO ASSIST THE PROPOSED PATIENT OR THE PATIENT IN PREPARING A DEFENSE, OR PERFECTING AN APPEAL.)

PROPOSED PATIENTS SHOULD ALSO BE SERVED WITH A PLAIN LANGUAGE NOTICE OF THE PROCEEDINGS, IN ENGLISH AND IN THE NATIVE LANGUAGE OF THE PROPOSED PATIENT.

COMMENTS:

At present, proposed patients and patients are not, by statute, entitled to a copy of any of the above-listed documents. Several judges indicated in their questionnaire responses that proposed patients are served a copy of the petition. However, that data collected by the Commission staff indicate that proposed patients are generally served only with the notice of the filing of the petition and the order for hearing and appointment of examiners and attorney. (See also RECOMMENDATION 13, p. 78, which recommends serving the proposed patient with a copy of the Physician's Emergency Hold Statement.)

RECOMMENDATION 17

BECAUSE A PROPOSED PATIENT WILL BENEFIT FROM AN AWARENESS OF THE SERIOUSNESS OF THE PROCESS, AND WILL BE HELPED, NOT HARMED, BY A FULL, THOROUGH HEARING WHICH AIRS THE REASONS FOR COMMITMENT, AND TO SEPARATE THE COMMITMENT PROCESS FROM THE TREATMENT PROCESS, IT IS RECOMMENDED THAT THE HEARING TAKE PLACE IN COURT, NOT IN A HOSPITAL OR CHAMBERS, ABSENT A REQUEST BY THE PROPOSED PATIENT OR A SPECIFIC FINDING OF NECESSITY BY THE COURT.

COMMENTS:

Of the hearings observed in eight counties (Dakota, Hennepin, Jackson, Kandiyohi, Mower, Ramsey, St. Louis, and Washington), only those in Jackson, Kandiyohi and Mower Counties were held in courtrooms.[8] The other counties conducted hearings in hospitals.

The settings within the hospitals varied. Ramsey County, at one extreme, used a large conference room with the furniture arranged in a T-shape with the court seated apart from the other participants. (Observers lined the rim of the room and petitioners, respondents and their counsel sat at

[8]In Washington County, for petitions alleging inebriacy, there was a "pre-hearing" which resembled a criminal arraignment; these were held at the courthouse. If the proposed patient contested the proceedings, the petition was dismissed, and therefore no hearings were scheduled or held. Prison-initiated petitions resulted in hearings which were held at the prison.

the tables.) Other counties used a more informal arrangement in small rooms with participants seated around a table in no apparent order. It was in the more informal settings that counsel was observed to sit apart from their clients.

RECOMMENDATION 18

A. THERE SHOULD BE A RIGHT TO A HEARING PRIOR TO INDETERMINATE COMMITMENT.

B. COMMITMENT SHOULD BE FOR A DETERMINATE TIME WITH PROVISION FOR REVIEW AND RENEWAL OF THAT COMMITMENT: COMMITMENTS SHOULD BE REVIEWED NO LESS FREQUENTLY THAN ONCE A YEAR.

COMMENTS:

The Commission makes these two seemingly inconsistent recommendations recognizing that the first part (A.) of the recommendation is intended to accommodate current practice under the Minnesota Hospitalization and Commitment Act. The second part (B.) of the recommendation requires either a different interpretation of the existing MHCA provisions, or it requires legislative change.

At present, there is no hearing and no right to a hearing prior to judicial commitment for an indeterminate period of time. Under the statute, the court, upon receipt of the 60-Day Report, may use the factual statements in that report in making its final determination of Indeterminate Commitment (Minn. Stat. § 253A.07, subd. 25). Usually, the 60-Day Report provides the only factual basis for such determinations of Indeterminate Commitment. Only persons who face Indeterminate Commitment as "mentally ill and dangerous to the public" have a right to a hearing at this stage of the proceedings as spelled out in the MHCA (Minn. Stat. § 253A.07, subd. 26).

Mower and Dakota Counties, of the 12 counties studied, have determined that patients have a right to a hearing at this point in the proceedings. The statute does not prohibit a hearing at this stage of the proceedings; nor however, does the Act affirmatively mandate hearing or notice at the time an order to Indeterminately Commit is being considered.

The second part of the recommendation not only supports the right to a hearing prior to commitment beyond the initial 60 days, but goes further by opposing Indeterminate Commitment in favor of commitment for limited periods of time. This time-limited commitment would be subject to periodic review and renewable without the need to bring a new petition.

Under the Minnesota Hospitalization and Commitment Act, there is no apparent reason why the authority granted the court to indeterminately commit a person could not be interpreted to mean the court has the authority to commit a person for shorter periods of time as well – for example, the court, under this interpretation would have the power to commit a person for a period not to exceed 6 months, with review and possibly renewal of the commitment at that time.

This periodic review and renewal recommendation differs from existing statutory provisions which allow for the contesting, by any interested person, of the need for continued hospitalization, Minn. Stat. § 253A.19, in that under that provision, the burden of showing that there is no longer a need for continued hospitalization has shifted to the patient. Under this recommendation for time-limited commitments and periodic review (and, in some cases, renewal), the burden would remain with the state and/or the hospital to show the need and benefit to the patient from continued commitment.

RECOMMENDATION 19

CONTINUING LEGAL AND MEDICAL EDUCATION RELATING TO THE COMMITMENT PROCESS AND ITS LEGAL AND MEDICAL REQUIREMENTS SHOULD BE OFFERED TO THOSE PERSONS WILLING TO BE APPOINTED AS EXAMINERS AND ATTORNEYS, AND FOR COUNTY ATTORNEYS.

RECOMMENDATION 20

A. *PATIENTS SHOULD HAVE AN ARTICULATED RIGHT TO REFUSE TREATMENT WITHIN LIMITATIONS; THE COMMISSION DID NOT REACH CONCENSUS ON WHAT STANDARDS AND LIMITATIONS THERE SHOULD BE ON A PATIENT'S RIGHT TO REFUSE TREATMENT.*

B. *IT IS RECOMMENDED THAT THERE BE FURTHER STUDY TO ESTABLISH STANDARDS FOR THE RIGHT TO REFUSE TREATMENT; THIS RECOMMENDATION RECOGNIZES THAT THERE EXISTS A PROBLEM, AND THAT THERE IS A BROAD SPECTRUM OF AVAILABLE TREATMENTS, VARYING IN INTRUSIVE QUALITY, WHICH SHOULD BE STUDIED.*

COMMENTS:

Concern was expressed for the need to clarify what is the right to refuse treatment, and what limits should be placed on that right. Recently there has been legal and social attention paid to this area through the enactment of legislation in some jurisdictions, as in Illinois:

> An adult recipient of services, or, if the recipient is under guardianship the recipient's guardian, shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication unless such services are necessary to prevent the recipient from causing serious harm to himself or others. If such services are refused, they shall not be given. The facility director shall inform a recipient or guardian who refuses such services of alternative services available and the risks of such alternative services, as well as the possible consequences to the recipient of refusal of such services. (Illinois Patients' Bill of Rights, 1978 Ill. Laws. Mental Health and Developmental Disabilities Code, Public Act 80-1414, § 2-107)

and through the Report to the President, from the President's Commission on Mental Health:

> The (President's) Commission recommends that . . .
> – Each State review its mental health laws and revise them, if necessary, to ensure that they provide for: . . .
> c) a right to refuse treatment, with careful attention to the circumstances and procedures under which the right may be qualified; and . . .
> (*Report to the President,* President's Commission on Mental Health, Volume I, p. 44, 1978)

This Commission agrees that Minnesota should recognize a right to refuse treatment, but, as a Commission it lacks sufficient information to make a recommendation as to how that right should be defined.

This Commission considered the language quoted above which has been codified in Illinois, and could not, as a Commission, accept that definition. Several members of the Commission found the Illinois definition acceptable.

Part of the notion inherent in the right to refuse treatment is the right to full information about the available treatment which is or may be offered. This sharing of information with the patient who is the subject of the offered treatment is to ensure that there is "Informed Consent." A monograph has been appended to this report which sets out standards and procedures for the insurance of "informed consent" as researched and described by the authors of that monograph. (See Appendix B.)

Even if the monograph's offer of a definition of "informed consent" were accepted, there is still in Minnesota no legislative declaration or common law holding or court rule on when there must be informed consent as a condition precedent to treatment. Thus, both the right to refuse treatment and the concept of informed consent need to be defined and articulated in Minnesota.

RECOMMENDATION 21

A STUDY OF THE USE OF MENTAL HEALTH SYSTEM BY CRIMINAL COURTS SHOULD BE CONDUCTED TO DETERMINE IF THE CRIMINAL COURTS ARE RECOMMENDING TREATMENT IN THE MENTAL HEALTH SYSTEM FOR PEOPLE WHO WILL NOT BENEFIT FROM TREATMENT.

COMMENTS:

Voiced numerous times at several Public Hearings was the concern that the criminal courts may be using the mental health system to divert persons who may, in fact, not be appropriate candidates for treatment. (See Appendices D and G.)

In studying the subjects of commitment petitions in the 12 selected counties, it was not always ascertainable whether a proposed patient was referred from the criminal courts. (p. 47) But, it was apparent, according to Factual Allegations (pp. 26-28), and field observations, particularly in cases alleging inebriacy, that there are proposed patients who had had recent contact with the criminal justice system, though this could not be verified by researchers. (p. 47)

According to Public Hearing testimony of several State Hospital employees and community mental health workers, there are a number of patients in State Hospitals who are there under what is referred to as "Either/Or" sentencing. Under this practice, a defendant in a criminal proceeding is given the choice of entering into and successfully completing treatment or being sentenced for the crime of which he has been convicted. (See Appendices D and G.) According to the testimony, this type of sentencing practice often results in the defendant opting for treatment. However, there is apparently never an exploration of the availability of appropriate treatment for the defendant.

Through field observations of commitment proceedings, researchers observed many proposed patients (particularly in matters alleging Inebriacy) admitting the allegations in the petition. In these proceedings, there was no indication, often times, of the underlying facts, and there was no consideration of the appropriateness or availability of treatment for the proposed patient.

The Commission raised the following specific questions to be answered in a study of the criminal courts *vis-à-vis* mental health treatment. These questions are not the only inquiries to be answered in the recommended study:

- Are persons who are arrested for criminal behavior diverted into the mental health system instead of going to jail, with a result that they lose their liberty for a longer period of time?
- What happens to persons diverted from the criminal system to the mental health system under Rule 20 of the Minnesota Rules of Criminal Procedure?
- Are persons with anti-social personalities who are diverted by the criminal system to the state hospital system causing problems in the state hospitals?

- Are persons being inappropriately diverted from the mental health system to the criminal justice system?
- Is the use of pre-trial hearings and pre-trial diversion effective as an alternative to commitment?
- Do inter-institutional transfers deprive a patient of Due Process of law?

RECOMMENDATION 22

HOSPITALIZATION BY CONSENT SHOULD BE PREFERRED TO NON-CONSENTING ADMISSION TO HOSPITALIZATION; THIS RECOMMENDATION COULD BE IMPLEMENTED BY LEGISLATION OR BY ADMINISTRATIVELY ELIMINATING THE DISCRETION OF THE HEAD OF A STATE HOSPITAL TO DENY ADMISSION WHERE ADMISSION HAS BEEN RECOMMENDED BY A PHYSICIAN.

RECOMMENDATION 23

THE COST-OF-CARE PROVISION IN MINNESOTA STATUTES, §246.54, SHOULD BE CHANGED TO ELIMINATE THE FINANCIAL INCENTIVE FOR HOSPITALIZATION IN STATE HOSPITALS.

IT SHOULD BE A GOAL TO PROVIDE EACH PATIENT, VOLUNTARY OR INVOLUNTARY, HIS NEEDED TREATMENT, IRRESPECTIVE OF THE FINANCIAL RESOURCES NECESSARY TO PROVIDE THAT TREATMENT.

COMMENTS:

Minn. Stat. § 246.54 provides a disincentive to counties to care for and treat in the community persons in need of hospitalization and treatment, even if the community has treatment as appropriate or better than can be offered in the State Hospitals.

> The patient's county (of residence) shall pay annually to the State of Minnesota, $10 for each month or portion thereof the patient spends at a state hospital . . .
> Minn. Stat. § 246.54, amended Laws 1971 to require annual rather than quarterly payments to the state.

In practical terms, if a patient without insurance or other private means is treated in a state institution, the dollar limit of the county's liability is $10 per month, though the State of Minnesota (ultimately reimbursed in part by the Federal government) must incur the actual total cost. On the other hand, to treat a person who has no insurance and no other source of payment, in a local hospital, community or private, the cost to the county could be up to, or perhaps more than, $160.00 per day, or $4,800.00 per month.

This system which encourages the removal of a person from the community, even if contraindicated by treatment professionals, is statutorily sanctioned. It is the removal of this statutory sanction which the Commission recommends.

According to the 382 60-Day Reports reviewed by researchers, 110 reports specifically stated that a state hospital or continued state hospital care is necessary because of financial reasons. (pp. 43-47)

RECOMMENDATION 24

A. GUARDIANSHIPS SHOULD BE LIMITED IN SUCH A MANNER THAT RIGHTS ARE REMOVED, AND SUPERVISION IS PROVIDED, ONLY FOR THOSE ACTIVITIES IN WHICH A PERSON HAS DEMONSTRATED AN INCAPACITY TO ACT COMPETENTLY. GUARDIANSHIP LAWS SHOULD BE REVISED TO INCORPORATE PROCEDURAL PROTECTIONS.

B. A STUDY SHOULD BE CONDUCTED OF THE ADVISABILITY OF ESTABLISHING A SYSTEM OF PROVIDING PUBLIC OR PRIVATE GUARDIANS OR CONSERVATORS AS ALTERNATIVES TO INVOLUNTARY HOSPITALIZATION.

COMMENTS:

At present, Minnesota's guardianship laws for persons alleged to be incompetent or incapacitated are contained in Minnesota Statutes, Chapter 526. The law includes a provision for the appointment of a guardian which deprives the ward of all civil rights. There is also a provision for the appointment of a conservator which allows the court to grant only specific powers to the conservator, and only for the purpose of managing the conservatee's assets; the conservatee may be deprived of only those rights necessary to effectuate the purposes of the conservatorship.

Guardianships for persons who are mentally retarded are established under the provisions of Minnesota Statutes, Chapter 252A, the Mental Retardation and Protection Act. These guardianships have incorporated procedural requirements, including the right to a complete evaluation of the proposed ward, and the right of the proposed ward to counsel (court-provided, when necessary), and the right to a guardianship arrangement specially designed to meet the needs of the ward.

These protections and limitations are not afforded persons in Minnesota who are alleged to be incompetent or incapacitated, and not mentally retarded. Guardianships are general and total, and the proposed ward has no right to court-provided counsel, no right to a periodic review of the guardianship arrangement, and only a difficult-to-enforce right to an annual accounting. The statute does not provide a ward with a right to retain, with his funds, counsel to bring an action for restoration to capacity.

This recommendation supports a limited guardianship, analogous to the limited conservatorship in which there is a determination of what care and supervision is necessary, and what right must be removed to accomplish that end.

This recommendation, in accord with the President's Commission on Mental Health, proposes other changes in the guardianship law to ensure procedural protections for proposed wards and persons under guardianship:

> . . . We also believe that high priority should be given to improving the guardianship system. Because guardianship can lead to a deprivation of legal rights, it is a highly restrictive method of providing supervision and assistance to mentally disabled persons. It is therefore essential that guardianship laws be carefully tailored to avoid any unnecessary restrictions on the rights of individuals. Particular attention must be paid to increased procedural protections and to limiting guardinships to those activities in which a person has demonstrated an incapacity to act competently. The Commission recommends that:
> – Each State review its civil commitment and guardianship laws and revise them, if necessary, to incorporate increased procedural protection.
> – State guardianship laws provide for a system of limited guardianship in which rights are removed, and supervision is provided, for only those activities in which a person has demonstrated an incapacity to act competently.
> (*Report to the President,* President's Commission on Mental Health, Volume I, p. 43, 1978)

There is a model guardianship act which takes these issues into consideration and incorporates them into a unified guardianship code. This model act is contained in "A Working Paper", prepared for the Special Committee on Aging, United States Senate, July, 1977, Protective Services for the Elderly.

The Commission lacks sufficient information to determine the advisability and cost of providing public or private guardians as a less restrictive alternative to commitment. Ramsey County Court Commissioner James Finley, a member of this Commission, and who presides over all commitment proceedings in Ramsey County, has expressed concern over the pressing need for qualified persons who are willing to serve as guardians or conservators; it is his experience that central to the problem of guardianship is the understandable unwillingness of persons to undertake the duties of guardian when it is unlikely that they will be adequately compensated, if at all, for the services necessary to render in fulfilling the responsibilities and obligations of a guardian. Public Hearing testimony corroborated this concern and suggested that there is a need for an "Office of the Public Guardian." Public Guardian systems have been established in other states, and a feasibility study in Minnesota would have the benefit of the experiences of those states with this type of agency.