Mentally Ill and Dangerous Civil Commitment Reform Task Force Report

Recommendations to the Minnesota Legislature

Submitted April 15, 2026

Contents MI&D Task Force

I. Executive Summary

Minnesota has made important investments in its mental health system, yet critical gaps remain that prevent the system from meeting the needs of all people with mental illness—most notably those committed as persons who have a mental illness and are dangerous to the public (MI&D).

These gaps are not theoretical. They are experienced daily by individuals, families, counties, courts, hospitals, and state-operated programs across Minnesota.

The Task Force identified gaps across the continuum of care, including insufficient community-based services to prevent commitment, limited access to qualified treatment and observation facilities needed to fully evaluate individuals during the commitment process, and a lack of appropriate resources for individuals transitioning from state-operated forensic mental health settings following an MI&D commitment. These gaps most acutely affect individuals with complex diagnostic profiles and high service needs. The consequences are significant, predictable, and increasingly evident across criminal justice, hospital, and mental health and treatment systems.

Individuals committed as MI&D frequently experience prolonged waits in county jails, community hospitals, and in the community without treatment or support due to the lack of available state-operated treatment capacity. Others remain in highly restrictive forensic settings longer than clinically necessary because appropriate step-down or community-based placements are either not available or do not have sufficient capacity. And finally, some lack the necessary time to evaluate and observe to find the program that best meets that person's needs and public safety. These delays impede recovery, increase system costs, and place additional strain on facilities that are not designed to serve as long-term treatment settings. These gaps reflect structural limitations within Minnesota's mental health system, including insufficient capacity, limited geographic distribution of services, and a lack of intermediate placement options between acute hospitalization and long-term institutional care.

To better understand these challenges and identify viable paths forward, the Task Force undertook an in-depth review. This included examining current Minnesota statutes, gathering feedback from partners in the work, analyzing available state data, researching approaches used in other states, and gathering input from current and former patients and their families. A consistent theme emerged: better outcomes depend on earlier access to appropriate services, expanded evaluation and placement options, and a system designed to timely move people forward to an appropriate level of care that meets their needs and that of public safety.

Importantly, the Task Force's recommendations extend beyond statutory changes. While targeted updates to statute are necessary to clarify pathways and remove barriers, statutory reform alone will not resolve the underlying challenges. Sustained investment in both community-based services and state-operated mental health systems is essential. People should receive the right services at the right time, in the least restrictive setting appropriate to their clinical needs and risk level.

Addressing these challenges will require the development and exploration of new and expanded options across the continuum of care. Increasing capacity within existing systems is necessary but not sufficient. The Task Force recommends a coordinated, multi-pronged strategy that strengthens the continuum of care and expands less restrictive, clinically appropriate options:

- **Assessment and Crisis Stabilization Facility:** Establish a secure, state-run facility for clinical observation and stabilization early in the commitment process. This setting would allow timely evaluation, documentation, and provisional stabilization, supporting decisions

about final commitment, provisional discharge, or placement in less restrictive settings, including avoiding returns to FMHP.

- **Regional Assertive Community Treatment (ACT) Teams:** Expand funding and flexibility for ACT teams across the state, including rural areas, to provide intensive, team-based care for individuals with severe mental illness in the community.
- **Community Integrated Services (CIS) Enhancements:** Increase capacity for psychiatric assessment, medication management, and clinical support for individuals on Provisional Discharge. Integrating a dedicated psychiatrist into CIS would improve continuity of care, reduce returns to state-operated facilities, and ensure adherence to MI&D treatment requirements.
- **Locked Intensive Residential Treatment Services (IRTS):** Develop community-based locked settings for individuals requiring 24-hour supervision and therapeutic care. These settings could serve individuals with repeated commitments, histories of aggressive behavior, or those struggling in the community post-discharge.
- **Expansion of Community Residential Options:** Support small, supportive residential settings and housing models that promote choice, independence, and peer engagement. Ensure funding and flexibility for alternatives to traditional foster or group homes.
- **Early Intervention Programs:** Expand First Episode Psychosis programs and extend similar support to individuals experiencing first episodes of severe mood disorders, including bipolar disorder, to improve long-term outcomes.
- **Jail Consultation Services:** Permanently fund and expand the existing pilot program to provide expertise, training, and medication management support in county jails. While jails are not ideal treatment settings, this program aligns systems to reduce harm and improve outcomes for incarcerated individuals with serious mental illness.
- **Sustained Investment in Adult Mental Health Initiatives:** Continue and expand funding for programs that fill service gaps, increase access to care, and reduce hospitalizations, including mobile crisis, peer support, clubhouses, and psychiatric services.

These recommendations collectively aim to reduce unnecessary confinement, improve clinical outcomes, and expand community-based, less restrictive options while maintaining public safety. Legislative action is essential to authorize new service models, support statutory alignment, and provide the resources necessary to implement these recommendations statewide. Without decisive action, Minnesota risks continued system inefficiencies, preventable delays in care, and inequitable outcomes for its most vulnerable residents.

The Task Force recognizes that no single agency or system can solve these issues in isolation. Progress will require coordinated action, shared responsibility, and a commitment to building capacity over time. The recommendations in this report are intended to support that work by

providing practical, evidence-informed options that balance individual recovery, public safety, and responsible use of state resources.

Minnesota has an opportunity to move from a system that manages scarcity to one that intentionally builds pathways. Doing so will require legislative leadership, sustained investment, and continued collaboration. The Task Force offers this report as a foundation for that work and invites policymakers to remain engaged as Minnesota continues to strengthen its mental health system for those with the most complex needs.

II. Introduction

The Mentally Ill and Dangerous (MI&D) Civil Commitment Reform Task Force was established by the Legislature to evaluate current state law related to MI&D civil commitments and to develop recommendations to optimize the use of state operated mental health resources and increase equitable access and outcomes for patients[1]. The Task Force is responsible for the following duties:

- Analyzing current trends in civil commitments of persons who have a mental illness and are dangerous to the public, including but not limited to the length of stay for individuals committed in Minnesota as compared to other jurisdictions
- Reviewing national practices and criteria for civil commitment of individuals who have a mental illness and present a danger to the public
- Developing recommended statutory changes necessary to provide services to the high number of individuals committed as persons who have a mental illness and are dangerous to the public
- Developing funding and statutory recommendations for alternatives to the current civil commitment process of persons who have a mental illness and are dangerous to the public
- Identifying the types of placements and services necessary to serve individuals civilly committed as persons who have a mental illness and are dangerous to the public in the community
- Making recommendations to reduce barriers to discharge from the Forensic Mental Health Program for individuals civilly committed as mentally ill and dangerous
- Developing recommended plain language statutory changes to clarify operational definitions for terms used within Minnesota Statutes, section 253B.18
- Developing recommended statutory changes to provide clear direction to the Commissioner of Human Services and facilities to which individuals are civilly committed to address situations in which an individual is committed as person who has a mental illness and is dangerous to the public and is later determined to not have an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory

[1] Note that the term “patient” is used to include the individual throughout the process and includes “respondent”, “client”, “individual,” and “person” who is the subject of the commitment.

- Evaluating and making statutory and funding recommendations for the voluntary return of individuals civilly committed as persons who have a mental illness and are dangerous to the public to community facilities

The Task Force met multiple times and reviewed a variety of materials, including the work of the 2013 MI&D task force. It is important to note the 2013 MI&D task force recommendations submitted to the Legislature had themes that remained prevalent twelve years later. The current task force did review the recommendations that were made in 2013 including: submitting an addendum to the 60 day report if the court directs, allowing for an expedited process in uncontested cases, increasing resources to State Operated Forensic Services, increasing resources towards the establishment of community placement options for persons civilly committed as mentally ill and dangerous, developing an education campaign to promote best practices for provisional discharge documents and educating stakeholders on the roles and responsibilities of parties, and establishing a stakeholder group to review the definition of a person who has a mental illness and is dangerous to the public, discharge criteria, and the constitutionality of the commitment as a person who has a mental illness and is dangerous to the public being of indeterminate length.

This Task Force did approach the tasks assigned with an open mind and fresh perspective despite the common themes.

III. Statute and Scope of Work

A. 2024 Legislation – Establishment

Legislation passed in 2024 (Chapter 127, Article 49, Section 9) to establish a task force on MI&D commitments.

> **Sec. 9. MENTALLY ILL AND DANGEROUS CIVIL COMMITMENT REFORM TASK FORCE.**
>
> **Subdivision 1. Establishment; purpose.** The Mentally Ill and Dangerous Civil Commitment Reform Task Force is established to evaluate current statutes related to mentally ill and dangerous civil commitments and develop recommendations to optimize the use of state-operated mental health resources and increase equitable access and outcomes for patients.
>
> **Subd. 2. Membership.** (a) The Mentally Ill and Dangerous Civil Commitment Reform Task Force consists of the members appointed as follows:
>
> (1) the commissioner of human services or a designee;
>
> (2) two members representing the Department of Direct Care and Treatment who have experience with mentally ill and dangerous civil commitments, appointed by the commissioner of human services;
>
> (3) the ombudsman for mental health and developmental disabilities;
>
> (4) a judge with experience presiding over mentally ill and dangerous civil commitments, appointed by the state court administrator;

(5) a court examiner with experience participating in mentally ill and dangerous civil commitments, appointed by the state court administrator;

(6) a member of the Special Review Board, appointed by the state court administrator;

(7) a county representative, appointed by the Association of Minnesota Counties;

(8) a representative appointed by the Minnesota Association of County Social Service Administrators;

(9) a county attorney with experience participating in mentally ill and dangerous civil commitments, appointed by the Minnesota County Attorneys Association;

(10) an attorney with experience representing respondents in mentally ill and dangerous civil commitments, appointed by the governor;

(11) a member appointed by the Minnesota Association of Community Mental Health Programs;

(12) a member appointed by the National Alliance on Mental Illness Minnesota;

(13) a licensed independent practitioner with experience treating individuals subject to a mentally ill and dangerous civil commitment;

(14) an individual with lived experience under civil commitment as mentally ill and dangerous and who is on a provisional discharge or has been discharged from commitment;

(15) a family member of an individual with lived experience under civil commitment as mentally ill and dangerous and who is on a provisional discharge or has been discharged from commitment;

(16) at least one Tribal government representative; and

(17) a member appointed by the Minnesota Disability Law Center.

(b) A member of the legislature may not serve as a member of the task force.

(c) Appointments to the task force must be made no later than July 30, 2024.

Subd. 3. Compensation; removal; vacancy. (a) Notwithstanding Minnesota Statutes, section 15.059, subdivision 6, members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

(b) A member may be removed by the appointing authority at any time at the pleasure of the appointing authority. In the case of a vacancy on the task force, the appointing authority shall appoint an individual to fill the vacancy for the remainder of the unexpired term.

Subd. 4. Officers; meetings. (a) The commissioner of human services shall convene the first meeting of the task force no later than September 1, 2024.

(b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.

(c) The task force is subject to Minnesota Statutes, chapter 13D.

Subd. 5. Staff. The commissioner of human services must provide staff assistance to support the work of the task force.

Subd. 6. Data usage and privacy. Any data provided by executive agencies as part of the work and report of the task force are subject to the requirements of Minnesota Statutes, chapter 13, and all other applicable data privacy laws.

Subd. 7. Duties. The task force must:

(1) analyze current trends in mentally ill and dangerous civil commitments, including but not limited to the length of stay for individuals committed in Minnesota as compared to other jurisdictions;

(2) review national practices and criteria for civil commitment of individuals who have a mental illness and represent a danger to the public;

(3) develop recommended statutory changes necessary to provide services to the high number of mentally ill and dangerous civilly committed individuals;

(4) develop funding and statutory recommendations for alternatives to the current mentally ill and dangerous civil commitment process;

(5) identify what types of placements and services are necessary to serve individuals civilly committed as mentally ill and dangerous in the community;

(6) make recommendations to reduce barriers to discharge from the forensic mental health program for individuals civilly committed as mentally ill and dangerous;

(7) develop recommended plain language statutory changes to clarify operational definitions for terms used within Minnesota Statutes, section 253B.18;

(8) develop recommended statutory changes to provide clear direction to the commissioner of human services and facilities to which individuals are civilly committed to address situations in which an individual is committed as mentally ill and dangerous and is later determined to not have an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory; and

(9) evaluate and make statutory and funding recommendations for the voluntary return of individuals civilly committed as mentally ill and dangerous to community facilities.

Subd. 8. Report required. By August 1, 2025, the task force shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over mentally ill and dangerous civil commitments a written report that includes the outcome of the duties in subdivision 7, including but not limited to recommended statutory changes.

Subd. 9. Expiration. The task force expires January 1, 2026.

B. 2025 Legislation - Expungement

The 2025 Legislature as part of the Senate Omnibus Bill (SF 3054 2nd Engrossment, 94th Legislature, at 244.6 – 245.13) amended the language to add another purpose to the task force:

> (2) evaluate current statutes related to the process by which a former patient may seek an order to expunge or vacate a prior commitment as mentally ill and dangerous.

The same Legislature added additional duties:

> **Subd. 7a. Duties; expungements and vacaturs. The task force must:**
>
> (1) analyze current trends in civil commitments as mentally ill and dangerous, expungements, and vacaturs, including but not limited to the frequency of expungements and vacaturs in Minnesota as compared to other jurisdictions;
>
> (2) review national practices and criteria for expunging and vacating civil commitments as mentally ill and dangerous;
>
> (3) develop recommended statutory changes necessary to provide clear direction to former patients who are seeking to file a motion to expunge or vacate a civil commitment as mentally ill and dangerous;
>
> (4) develop recommended statutory changes necessary to provide clear direction, criteria to apply, and evidentiary standards to the courts when considering a motion from a former patient to expunge or vacate a civil commitment as mentally ill and dangerous; and
>
> (5) develop recommended statutory changes to provide clear direction to former patients and the courts to address situations in which an individual is civilly committed as mentally ill and dangerous and is later determined to not have an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory.

It finally modified the deadline:

> **Subd. 8. Report required.** (b) By August 1, 2026, the task force shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over civil commitments a written report that includes the outcome of the duties in subdivision 7a, including but not limited to recommended statutory changes.

C. Members of the Task Force

Marshall E. Smith, designee of the Commissioner of the Minnesota Department of Human Services (DHS)

Dr. Soniya Hirachan, Direct Care and Treatment Administration, DHS

Robin Bode, Direct Care and Treatment Administration, DHS

Lisa Harrison-Hadler, Minnesota Ombudsman for Mental Health and Developmental Disabilities

The Hon. Jay Quam, then **The Hon. Julia Dayton Klein**, state district court judge with experience presiding in MI&D civil commitments

Dr. Amber Lindeman, court examiner with experience in MI&D civil commitments

Dr. Kristen Otte, member of the Special Review Board

Casandra Sassenberg, appointed by the Minnesota Association of County Social Service Administrators (MACSSA)

Sue Abderholden, then **Marcus Schmit**, Executive Director, Minnesota Chapter of the National Alliance on Mental Illness (NAMI Minnesota), appointed by NAMI Minnesota

Anne Zimmerman, a county attorney with experience in MI&D civil commitments, appointed by the Minnesota County Attorney's Association (MCAA)

Jinny Palen, Executive Director, Minnesota Association of Community Mental Health Programs (MACHMP), appointed by MACMHP

Dr. Ian Heath, a licensed independent practitioner with experience in treating individuals subject to MI&D civil commitment

Dalaine Remes, appointed by the Minnesota Disability Law Center

Sheila Novak, a family member of someone who has been civilly committed as MI&D, is on provisional discharge or has been discharged from civil commitment, appointed by Gov. Tim Walz

Donna Ennis, tribal representative, appointed by Gov. Tim Walz

Michael Biglow, an attorney with experience representing respondents in MI&D civil commitments, appointed by Gov. Tim Walz

Barbara Weckman Brekke, appointed by the Association of Minnesota Counties

IV. Background on Current Commitment Statute

There are multiple types of commitment under the statute. Some types are short term, determinate commitments (mentally ill and/or chemically dependent) while others are indeterminate (Mentally Ill & Dangerous, Sexually Dangerous Persons, & Sexual Psychopathic Personality), and one is indeterminate with three-year district court reviews (developmental disability). The task force began by reviewing the differences between a mental illness (MI) determinate commitment and an MI&D indeterminate commitment.

A. Definitions

In Minnesota, a person cannot be committed for treatment of a mental illness against their will unless they pose a risk of harm to self or others due to that mental illness and there is no less restrictive alternative.

A "person who poses a risk of harm due to a mental illness" means any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, that is manifested by instances of grossly disturbed behavior or faulty perceptions and who, due to this impairment, poses a substantial likelihood of physical harm to self or others as demonstrated by:

- a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment;
- an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;
- a recent attempt or threat to physically harm self or others; or Ì recent and volitional conduct involving significant damage to substantial property

Minn. Stat. § 253B.02, subd. 17a(a).

A person does not pose a risk of harm due to mental illness under this section if the person's impairment is solely due to:

- epilepsy;
- developmental disability;
- brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or
- dependence upon or addiction to any alcohol, drugs, or other mind-altering substances.

Minn. Stat. § 253B.02, subd. 17a(b).

The MI&D commitment also involves a person who poses a risk due to mental illness but has several differences. The primary differences are that the MI&D statute does not have exemptions to the definition of mental illness and the danger required is higher, requiring a finding that the person poses a clear danger to the safety of others. A "person who has mental illness and is dangerous to the public" is a person who:

> has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, that is manifested by instances of grossly disturbed behavior or faulty perceptions who as a result of that mental illness presents a clear danger to the safety of others as demonstrated by the facts that
>
> > (i) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and
> >
> > (ii) there is a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.

Minn. Stat. § 253B.02, subd. 17.

B. Trial Format & Duration of Commitment

A MI commitment by statute is initially ordered for up to six months after a trial by a district court judge. That commitment can be extended up to an additional year, but only after additional hearings, examinations, and review by the district court. That commitment then ends, and the commitment can only be renewed after the filing of a new petition, additional district court hearings and examinations, and that recommitment can only last up to a year. This process can continue until such time as a petition is not filed, or the district court denies the petition.

Conversely, an MI&D commitment has a two-phase trial with the district court. If the petition is supported by the court at both phases, the person's MI&D commitment will be continuous with no set end date. Once a person is committed indefinitely as MI&D, there are no further reviews by the district court. The person is then ordered into a secure treatment facility, which by statutory definition is the Minnesota Security Hospital, now known as the Forensic Mental Health Program (FMHP), in St. Peter, MN.

Once MI&D commitments are indeterminate, ongoing reviews are conducted by the Special Review Board (SRB) every three years or upon request by the treatment team or individual. These reviews address whether the person is ready for a less restrictive setting than their present setting or supervision. The Special Review Board (SRB), an administrative panel of hearing officers operating under the authority of the Direct Care and Treatment Executive Board[2], reviews the person's status and progress. Reports are prepared by a risk assessment and the treatment team for review by the SRB. The SRB will look at the person's clinical progress and present treatment needs; the need for a secure setting to accomplish continuing treatment; what level of services are able to meet the person's needs; and whether the transfer can be accomplished with a reasonable degree of safety for the public. The recommendation of the SRB is either adopted by the Direct Care and Treatment Executive Board, or it can then be appealed to the Commitment Appeal Panel (CAP), a three-member panel judicial body, for final determination on the appropriate level of care.

V. Current Trends in MI&D Commitments in Minnesota

A few trends were noted when the Task Force reviewed the data. First, there has been an increase in the number of MI&D petitions that are supported by the district courts over the past several years. Second, the number of persons committed as MI&D are by a vast majority men from 26-45 years of age. Finally, the primary race at FMHP is white; however, the percentage of patients who are Black/African American is disproportionate to the population of the state (7% of the population versus 32% at FMHP). These trends are discussed in detail below.

[2] The Direct Care and Treatment (DCT) executive board is a statutorily created body that consists of nine members with seven voting members and two nonvoting members. The board is responsible for the overall management and control of the DCT agency. *See* Minn. Stat. § 246.06. *See also* App. Page 21.

A. The Numbers

Data maintained by the Minnesota Judicial Branch shows there has generally been a slight increase in MI&D commitments filed[3] statewide since 2020. The number of other commitments filed (MI/CD/DD) has also increased since 2020, with the exception of 2024 when numbers dropped to the lowest in five years.

Commitments Filed Statewide

	2020	2021	2022	2023	2024
MI&D Commitments Filed	55	54	63	59	57
Other Commitments Filed (Excluding SDP/SPP)	4,642	4,909	4,742	4,716	4,577

MI&D Commitments Filed by County (Sampling)

Data maintained by the Minnesota Judicial Branch shows that Hennepin and Ramsey Counties have filed the most MI&D commitments each year since 2020. Setting aside Hennepin and Ramsey Counties, St. Louis County consistently filed more MI&D commitments than other counties between 2020 and 2024. The remainder of the counties sampled from the Minnesota Judicial Branch website ranged between filing zero to three MI&D commitments per year from 2020 to 2024. Comparing the counties to themselves, the average number of MI&D commitments filed by each county was above its own average about 45% of the time.

	2020	2021	2022	2023	2024	Average	Above Average Yrs
Anoka County	0	0	3	0	0	0.6	1/5
Beltrami County	0	2	2	2	2	1.6	4/5
Dakota County	1	3	1	3	0	1.6	2/5
Hennepin County	20	17	20	13	25	19	3/5
Ramsey County	10	8	13	8	10	9.8	3/5
St. Louis County	3	3	7	6	2	4.2	2/5
Stearns County	3	1	1	1	3	1.8	2/5
Washington County	2	1	1	1	0	1	1/5

[3] Note that "filed" represents petitions that were filed in court; it does not mean the commitment was granted.

MI&D Commitments Ordered Statewide

Data maintained by the Minnesota Judicial Branch shows that orders for MI&D commitment statewide generally increased year over year from 2014 to 2018. From 2018 to 2020, MI&D commitment orders plateaued at an average of 48 commitments ordered each year. There was a sizeable decrease in MI&D commitments ordered, 34, in 2021. In 2022, the number of commitments ordered jumped back to its previous level at 48. MI&D commitments were at their highest in 2024, with 64 commitments ordered.

Year	MI&D Commitments Ordered
2014	31
2015	26
2016	32
2017	40
2018	49
2019	48
2020	47
2021	34
2022	48
2023	55
2024	64

MI&D Cases Resulting in MI or DD Commitment Statewide

Data maintained by the Minnesota Judicial Branch show that statewide, the number of MI&D cases filed that resulted in a Mental Illness (MI) or Developmental Disability (DD) commitment has ranged between 8 and 16 per year from 2014 to 2023. The years 2017 to 2019, and 2023, reflect the fewest MI&D cases that resulted in MI or DD commitment, ranging between 7 and 9 per year during those years.

Year	MI&D Cases Filed that Resulted in MI or DD Commitment
2014	10
2015	15
2016	15
2017	8
2018	9
2019	8

2020	10
2021	12
2022	16
2023	7
2024	5

Percentage of MI&D Cases Resulting in MI or DD Commitment Statewide

Data maintained by the Minnesota Judicial Branch show that between 2020 and 2022, the number of MI&D cases filed that resulted in MI or DD commitment increased and then dropped in 2023.

	2020	2021	2022	2023	2024
MI&D Cases Filed	55	54	63	59	64
MI&D Cases that Resulted in MI or DD Commitment	10	12	16	7	5
Percentage of MI&D Cases Resulting in MI or DD Commitment	18.2%	22.2%	25.4%	11.9%	7.81%

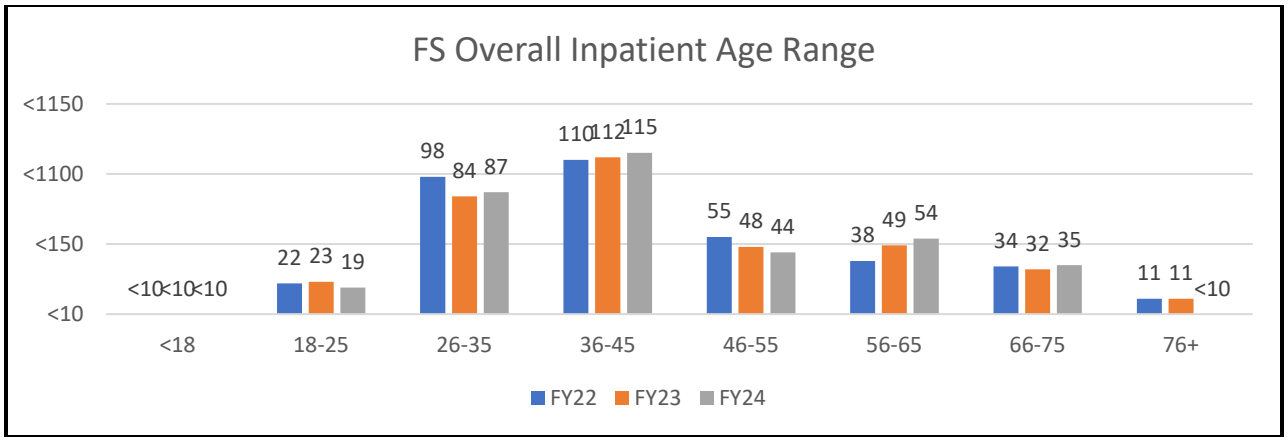
B. Demographics

Nearly all those committed as MI&D are treated at the Forensic Mental Health Program (FMHP). As of the date of this report, an additional 15 individuals within the Department of Corrections are either serving sentences or are dually committed, and 14 individuals in jail settings are awaiting admission to FMHP. These charts provide information on the demographics of who is served, followed by the number of people each year, number of provisional discharges, and length of time at FMHP.

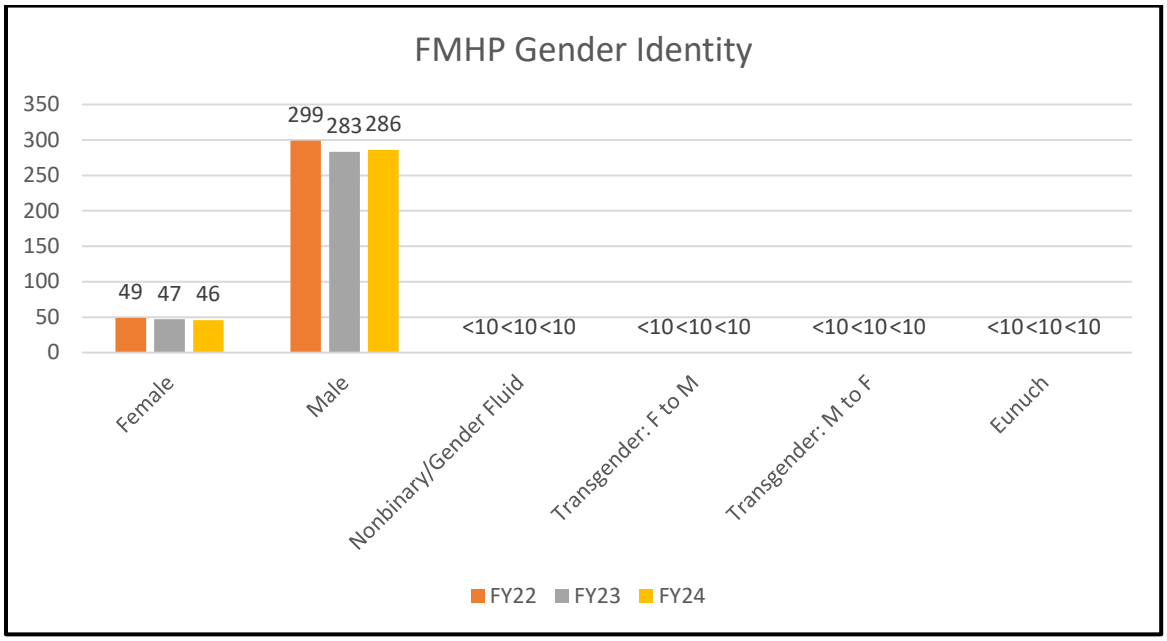
i. Age, Gender, & Race

One can see that patients are largely men, ages 26-45, and White, although the percentage of patients who are Black/African American is disproportionate to the population of the state (7% of the population versus 32% at FMHP).

(Note: FS is the abbreviation for Forensic Services, which includes FMHP, the forensic nursing home, and the community integrates support services. See section VII infra for more details on these programs.)

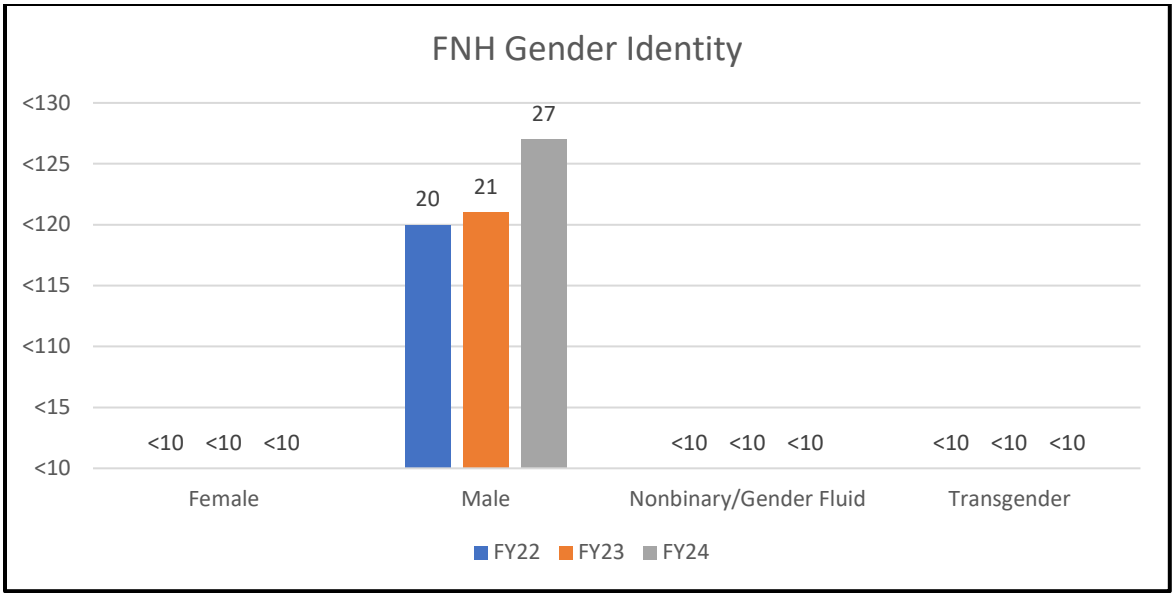


In FY24, the FMHP population served was comprised of 13.8% female and 86.2% male sex identified at birth. This proportion has remained relatively steady over the past three years. Less than 10% of FMHP's population identified as gender diverse. This has been consistent over the past three years. Disclaimer: data removed because low counts under a specific number could identify individuals protected under Minn. Stat. 13.46.

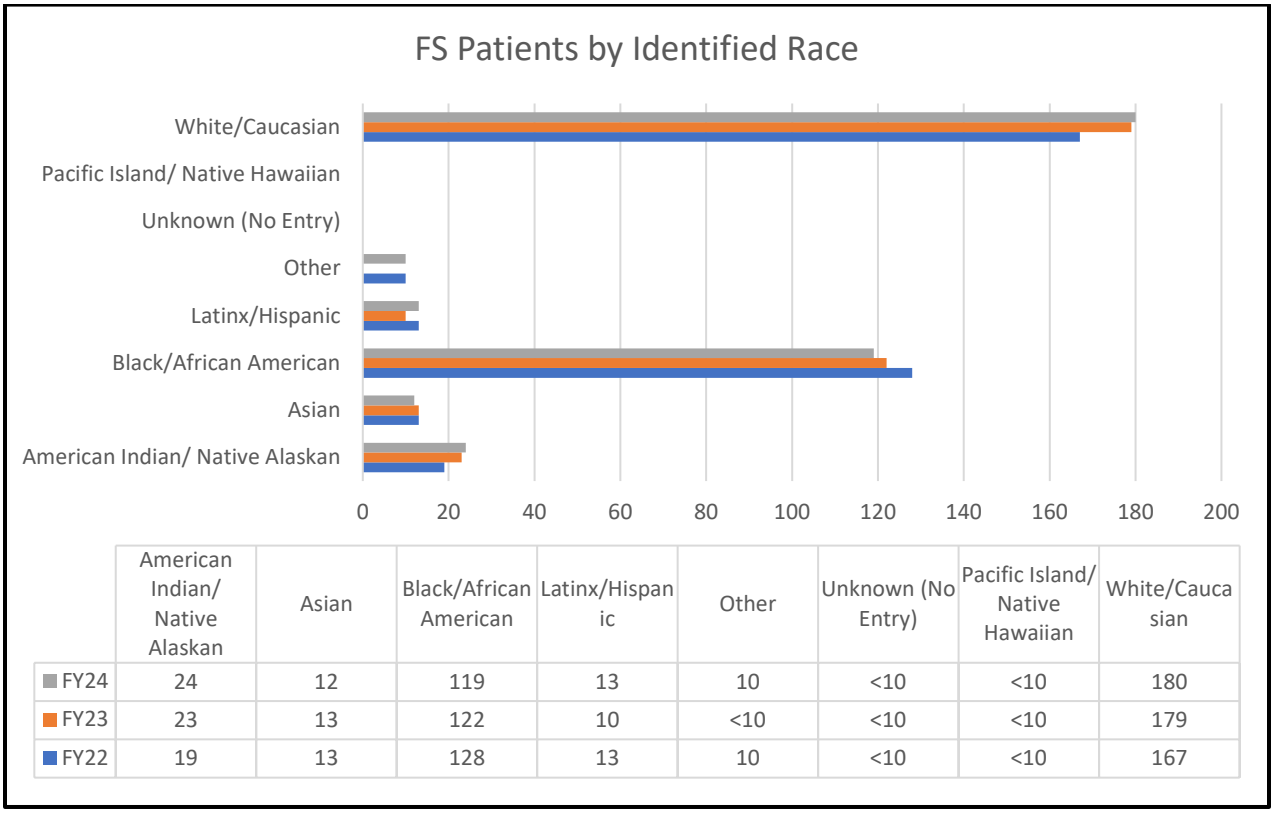


The sex composition of FNH has remained steady for the past three years.[4] The increase in males at the FNH can be attributed to a higher rate of admission for the fiscal year. There were no individuals served at FNH for the past three years who expressed a gender identity different from their sex assigned at birth. Disclaimer: data removed because low counts under a specific number could identify individuals protected under Minn. Stat. 13.46.

[4] Note that the gender charts are not for all of forensic services, but rather a chart for the Forensic Mental Health Program (FMHP) and the Forensic Nursing Home (FNH).



In FY24, the FS patient population was 49.7% White (FY23= 50.3%, FY22= 47.7%), 32.8% Black/African American (FY23= 34.2%, FY22= 36.6%), <10% Native American (FY23= <10%, FY22= <10%), <10% Latinx (FY23= <10%, FY22= <10%), and <10% Asian (FY23= <10%, FY22= <10%). Disclaimer: data removed because low counts under a specific number could identify individuals protected under Minn. Stat. 13.46.



	American Indian/ Native Alaskan	Asian	Black/African American	Latinx/Hispanic	Other	Unknown (No Entry)	Pacific Island/ Native Hawaiian	White/Caucasian
FY24	24	12	119	13	10	<10	<10	180
FY23	23	13	122	10	<10	<10	<10	179
FY22	19	13	128	13	10	<10	<10	167

ii. Other Traits

In FY24, patients identified their ethnicity as 81% Unaffiliated (FY23= 83%, FY22= 83.5%), 12% Unknown (FY23= 11%, FY22= 10.6%), <10% Mexican/Mexican-American/Puerto Rican/Other Latinx (FY23= <10%, FY22= <10%), and <10% Vietnamese/Lao/Hmong (FY23= <10%, FY22= <10%).

Across Forensic Services (FS), identified religious preferences remained relatively consistent year after year. In FY24, patients identified as 13% Catholic, <10% Muslim, <10% Lutheran, <10% Baptist, <10% Native American, and 19.5% "other." 22% of patients identified no religion at the time of admission, with the religious preferences of 16% of patients remaining unknown.

In FY24, FS predominantly served individuals with a preferred language of English (91%, FY23= 92%, FY22= 94%). Less than 10% of individuals served preferred a language other than English (FY23=<10%, FY22=<10%). Notably, each FY less than 10% of individuals served did not have a preferred language identified in their electronic health record. Disclaimer: data removed because low counts under a specific number could identify individuals protected under Minn. Stat. 13.46.

VI. National Practices

In researching and summarizing what other states do, it is important to note there is no national database or any agency that collects information on commitments in all 50 states. However, a 2017 NRI Report on forensic patients[5] noted that:

> *While overall national trend lines show a 76 percent increase in the number of forensic patients in state hospitals from 1999 to 2014, the trend is not consistent across all states. A few states report little change in their inpatient forensic populations. For the many states experiencing increases, the rise is mostly due to the increase in patients deemed incompetent to stand trial. For reasons that are explored in this paper, this is a phenomenon particularly evident during the past decade.*
>
> *The overall nature of the forensic population is complex. Forensic patients (e.g. not guilty by reason of insanity and civilly committed sex offenders) may remain hospitalized for long periods of time. The more beds that are occupied by these patients, the lower the state hospital's turnover rate, which means that there are fewer opportunities for the state hospital to admit new patients. Long periods of stay, low turnover rates, and an overall increase in the number of referrals for inpatient services from the courts have contributed to increasing waitlists in many states. Waitlists hinder the state's ability to admit patients to their state psychiatric hospitals in a timely manner. These waitlists can lead to states being threatened with or held in contempt of court when there are active orders to admit individuals to the hospitals.*

[5] The report defines forensic patients as individuals undergoing competency evaluations, competency restoration, not guilty by reason of mental illness, and deemed incompetent to stand trial and have been committed to a state psychiatric hospital. "Patients residing at state hospitals that are deemed to belong to the 'forensic" population' are normally committed to these hospitals by the criminal courts." Amanda Wik, M.A., Vera Hollen, M.A., and William Fisher, Ph.D., Assessment #9, *Forensic Patients in State Psychiatric Hospitals: 1999-2016*, National Association of State Mental Health Program Directors (Aug. 2017).

> *The results from this study indicate that, over a little less than two decades, states have seen an increase in the number of forensic patients who are present in their state hospitals. In order to cope with the increasing number of forensic patients in the state psychiatric hospitals, as well as those awaiting admission, states have indicated they are implementing a variety of methods. These methods include (but are not limited to): building more beds, adapting the admission process, modifying prioritization of the waitlists, building community- or jail-based programs (e.g. outpatient competency restoration programs, jail-based restoration programs, residential treatment centers), and fostering relationships with other systems (e.g. strengthening the bonds and communication between behavioral healthcare workers and criminal justice agents).*

https://nri-inc.org/our-work/nri-reports/forensic-patients-in-state-psychiatric-hospitals-1999-2016/

The Task Force endeavored to include relevant similar statutes in the attached appendix. Many states had similar commitment statutes to Minnesota's determinate commitments. However, in a review of other states, there was not a direct use of the term "mentally ill and dangerous," but multiple other states used language describing someone who presented as a danger to self or others.

After review of the available resources on other states' civil commitment systems[6], the indeterminate commitment as a person who has a mental illness and is dangerous to the public appears to be a uniquely Minnesotan remedy to address the issue of how to treat and promote public safety for the small subset of individuals with mental illnesses who present a chronic elevated risk of harm to others without prolonged rehabilitation in a secure treatment facility.

Minnesota employs a single civil commitment pathway to long-term secure mental health treatment. Other states employ a patchwork of more than one avenue for entry into secure treatment programs, but with different standards and processes. A review of those pathways is important for understanding national practices. It should be noted that the comparison was difficult for the Task Force as some states had patients admitted to similar treatment modes but through solely the criminal or correctional system.

A. Criminal Conviction Leading to Treatment

The first avenue is criminal conviction and sentencing to prison for violent offenses (usually after a period of treatment for competency attainment.) This avenue is only available for those with sufficiently treatable mental health conditions such that they are found competent and subsequently criminally responsible for a violent or high-level offense. Prisons vary in their resources to meet the needs of this subpopulation and ensure effective aftercare and supervision upon completion of their sentence. However, most, including the federal system, have some form of specialized residential treatment units for these populations run by the correctional system. Minnesota has a program at Oak Park Heights that is run by the Department of Corrections.

[6] See appendix, section B.

For an inmate to transfer to a secure treatment setting in a mental health system facility, a formal judicial hearing and determination is required in most cases, independent of the criminal sentence. In order for an individual to follow this pathway to a mental health system forensic hospital, they must be found competent to stand trial by a judge, found criminally responsible for a high-level charge by jury or judge, and then be found eligible for transfer to a mental health system secure treatment facility by a judicial officer. The standard to be admitted to a mental health system forensic hospital varies by state but can be high in some states.

Upon completion of criminal sentences most states allow for the person to then be civilly committed to a mental health system facility. However, most often require recent evidence of dangerousness and regular review of the commitment. Unlike the MI&D commitment where the onus is on the individual to prove sufficient treatment progression and risk mitigation to qualify for discharge into the community (reduction in custody), most state's civil commitment laws require the state to prove ongoing dangerousness, usually based on recent behavior, similar to Minnesota's determinate commitments for mental illness or chemical dependency. The element of recent danger on post-sentence commitments is a legal barrier to admission to a mental health system forensic hospital through this process.

B. Not Guilty by Reason of Mental Illness (NGRMI)

The second avenue for individuals to qualify for a prolonged or indeterminate commitment like MI&D in other states is through a finding by the criminal court of not guilty by reason of mental illness/insanity (NGRI/NGRMI). States vary by the entity that oversees this type of indeterminate commitment (corrections or mental health), but they are generally the purview of the criminal court, at least initially. Some states like Oregon have developed administrative bodies akin to Minnesota's Special Review Board to oversee discharges (reduction in custody) for these special indeterminate commitments.

The threshold for qualifying for this commitment is high as the patient must first be found competent if that is at issue, then must meet the legal threshold for a finding of NGRI/NGRMI, and in most cases it involves a violent or high-level charge. Even for those in this category, most states, including Minnesota, require demonstration that indeterminate commitment to a mental health system secure treatment facility is the least restrictive option. The problem nationally is that there are few alternatives to these types of secure treatment facilities available to forensic patients.

C. Ongoing Incompetence in Criminal Court

The final pathway is directly from criminal court for those individuals who continue to be deemed incompetent to stand trial on serious person crimes. Some states have established higher thresholds for civil commitment and more stringent renewal requirements, making commitment impractical for some forensic patients. In those states, to address the needs of those patients with serious person crimes and ongoing incompetence, they have carved out an alternative legal path to secure treatment through the jurisdiction of the criminal court. These patients typically are admitted for competency attainment, usually for violent or high-level charges. These cases can run into limitations on the allowable duration for secure treatment imposed by *Jackson v. Indiana* which limited the amount of time an individual could be held for the purpose of competency attainment.

As this subpopulation of forensic patients continues to grow, states are looking for alternative legal methods to address treatment for the person and ensure safety for the community. Some states like California have carved out special civil commitment procedures for this subpopulation when they become eligible for release under *Jackson* but continue to be deemed to pose a significant public safety risk outside of a secure treatment facility. However, in the case of these "Murphy conservatorships" in California, annual renewal is required with the burden remaining on the petitioner to show the ongoing need for the conservatorship. California reported in 2014 about 69 patients under this "murphy conservatorship," with the number growing to 100 patients in 2019 (recent numbers were unavailable).

Other states like Oregon and Ohio have attempted to carve out special commitment procedures for this population but their duration remains subject to the limits of *Jackson.* Further, Ohio's process was curtailed in 2013 after finding by the state appeals court that it was unconstitutional.

D. Conclusion of National Practices

In summary, most states employ a patchwork of legal processes, both civil and criminal, to pursue long-term secure mental health treatment for the small subset of individuals deemed to require it in the interest of public safety. The legal thresholds associated with these processes vary amongst states and depend on the pathway. Minnesota by contrast employs a single pathway to secure treatment that depends entirely on the courts' application and interpretation of the civil commitment criteria as laid out in statute and case law.

This single entry-point to secure forensic treatment has advantages as it provides a relatively straightforward process. It also provides means for ongoing pursuit of liberty goals by those who prove unable to attain competency to stand trial by virtue of their mental illness. It ensures all of these individuals are subject to a uniform process of risk mitigation, supervision and supportive community re-integration that is administered by a single government division.

VII. Services and Placements for People Committed as MI&D

A. Current Services and Options

Forensic Services (FS) is a division within Direct Care and Treatment (DCT) that provides comprehensive treatment, evaluation, and community reintegration services for individuals committed as Mentally Ill, Mentally Ill & Dangerous, and Chemically Dependent. There are three core programs within FS (Forensic Mental Health Program, Forensic Nursing home and Community Integrated Services) while also providing consultative services such as Jail Consultation Services, Competency Attainment Services, and a Forensic Network. Below is a description of the core programs:

- Forensic Mental Health Program (FMHP): residential treatment in both secure and non-secure settings to approximately 330 individuals who have been civilly committed by the courts as a person who poses a risk of harm due to mental illness (MI), a person who has a mental illness and is dangerous to the public (MI&D), a person with a Developmental Disability (DD), and/or a person who is Chemically Dependent (CD). The FMHP is

supported by approximately 850 full-time equivalents (FTEs), representing 90% of FS's total workforce and includes both direct care and support operations staff.

- Forensic Nursing Home (FNH): provides nursing home-level of care in a secure setting to individuals who are civilly committed, as well as incarcerated individuals from the Minnesota Department of Corrections. It is the only secure nursing home in the state. The FNH has an average daily census of 25 residents and is supported by 85 FTEs.
- Community Integrated Services (CIS): delivers monitoring and support services to approximately 260 individuals committed as MI&D who are on provisional discharge from FS. This small team of 13 FTEs works closely with patients and their community-based care teams to promote successful reintegration into the community while maintaining individual and public safety.

Below is a description of the services offered by FS:

- Jail Consultation Services (JCS): a two-year, legislatively funded pilot project within DCT with several FTEs that focuses on the following priorities:
    1. Educating and supporting counties and correctional facilities on protocols and best practices for administering involuntary medications for mental health treatment.
    2. Providing technical assistance to expand access to injectable psychotropic medications within county correctional facilities.
    3. Surveying correctional facilities and their contracted medical providers to assess their capacity to administer injectable psychotropic medications (including involuntary administration) and identifying barriers to providing these services.
- Forensic Evaluation Network: this program is composed of Forensic Examiners who provide competency and pre-sentencing mental health evaluations, risk assessments, MI&D evaluations, and a variety of other forensic assessments. These can be done either inpatient within Forensic Services or in a community setting, including jails. The examiners also provide consultation to treatment teams through Forensic Services and to other programs within Direct Care and Treatment.
- Competency Attainment Services: Following the establishment of Competency Attainment legislation in 2022, Direct Care and Treatment (DCT) created its own service line under Forensic Services, naming it Competency Attainment Services. This allows for competency attainment services to be provided to individuals who are admitted to a DCT program under Chapter 611 procedures.

B. FMHP Treatment Progression

When admitted to the FMHP as MI&D, the following is the general progression of treatment for individuals, though each patient has a treatment plan tailored to them:

1. Admission and Assessment: Each patient has a series of clinical assessments when they first admit to the FMHP program, for example: Psychiatric assessment, nursing assessment,

a physical exam, Psychological and social work assessments. All these evaluations help form an initial treatment plan for the patient. Focus of the treatment at this phase is stabilization of the patient's mental health with medications and therapy.

2. Active Treatment Phase: Following the initial assessment and stabilization phase, patients enter the active phase of treatment where the focus is on maintaining the stability and development of a relapse prevention plan. These plans are developed in conjunction with the patient and really focus on their triggers and coping skills. It is during this phase that patients can achieve graduated levels of privileges depending on their engagement and progress in treatment. The treatment teams use empirically validated tools such as START (Short-term assessment of risk and treatability) for risk management.

The clinical teams utilize a structured, evidence-based approach to support the safe and gradual progression of patients from secure inpatient care to community-based living environments. This is accomplished through coordinated treatment, rigorous assessment, multidisciplinary collaboration, and adherence to legal and procedural safeguards. The goal is to enhance public safety while promoting individual recovery and reintegration.

C. FMHP Treatment Milieu

FMHP currently provides a highly specialized, group-based treatment program that is designed and regulated around rehabilitation, recovery and risk management for people primarily diagnosed with severe and persistent mental illness (SPMI). Individuals solely diagnosed with personality disorders (not including Borderline Personality Disorder), neurodevelopmental disorders such as autism spectrum disorder and / or intellectual developmental disorder (also known as intellectual disability), and / or neurocognitive disorders secondary to medical conditions such as Alzheimer's or due to traumatic brain injuries, have needs, treatment goals and prognoses that differ from the SPMI population. Ultimately, FMHP tailors the treatment to the individual person's unique needs.

SPMI patients have symptoms that respond to treatments with medications which in turn lead to symptom reduction, acute risk reduction and stabilization. Once stabilization is achieved, treatment programming completed at FMHP focuses on intensive rehabilitation through mental health education, treatment adherence, relapse prevention planning, and skill-development for the reintegration back into society. This model focuses on fostering the greatest level of independence possible and moving towards a lesser restrictive, and more community integrated setting in the years following provisional discharge from FMHP. Institutionalization is appropriate for risk mitigation while rehabilitation is pursued but FMHP is not designed or regulated for lifelong placement as a means of addressing chronic, stable needs.

While FMHP has some ancillary capacity and features to address secondary personality and neurocognitive issues, it is presently designed and regulated as a secure rehabilitative treatment program for SPMI. Given that rehabilitative milieu, patients who also have personality disorders and neurocognitive disorders can experience extended hospitalization while also contributing to the disruption of the rehabilitation of other patients. However, as there are no other options, DCT

serves these patients "with complex conditions that other behavioral health care providers cannot or will not serve."[7]

VIII. Transition from FMHP

There are two main pathways to discharge from FMHP: Track 1 which is geared towards gradual liberty progression through the non-secure program and Track 2 which is a discharge facilitated directly from the secure program.

A. **Track 1 transition:** The majority of patients follow the Track 1 transition pathway which allows them to demonstrate integration into the community through a variety of mechanisms. Community integration practices are accomplished primarily through the implementation of pass plans into the community. During such passes, patients can be in the community without staff for up to 4-10 hours. Prior to this stage, the patient must have completed a risk assessment by a Forensic Examiner while ensuring compliance with its recommendations. The Medical Director makes the decision on approvals for pass plans after deliberating on all the information provided by the Forensic Examiner, team and the county case manager. On a quarterly basis, there is a review of the patient's treatment progress and liberty increases.
B. **Track 2 transition:** This is reserved for patients who require consistent staff support for activities of daily living and also for their safety. These patients have demonstrated that they have already achieved maximum benefit from a secure inpatient facility. Again, risk assessment by a Forensic Examiner is crucial to determining readiness for provisional discharge in this case.

Once a patient has been identified by the clinical team as being ready for Provisional Discharge, a Special Review Board petition needs to be filed with the DCT Executive Board. The Special Review Board is a three-member panel composed of an attorney, a psychiatrist or a doctoral level psychologist with forensic experience, and a third person, all of whom are community members and are appointed by the DCT Executive Board. This panel hears all petitions for reductions in custody and makes recommendations to the DCT Executive Board. The Board makes the final determination regarding the petition. The patient and their attorney can appeal the findings to the Commitment Appeal Panel.

There are two reports that are considered by the Special Review Board (SRB): the SRB report completed by the clinical team's psychologist[8] and a Risk Assessment written by a Forensic Examiner. Once both these reports are written, they are brought forward to the Forensic Review Panel (FRP). The FRP is a multi-disciplinary panel composed of clinical department supervisors which is chaired by the Medical Director or designee. The FRP reviews and advises on team- or patient-initiated petitions for transfer or provisional discharge. Once the FRP has deliberated on a petition, they issue a facility opinion on the transfer or provisional discharge issue. The SRB then

[7] Taken from DCT's website. https://mn.gov/dct/about-direct-care-treatment/
[8] An SRB Report is only completed if the patient is at FMHP or Forensic Transition Services.

hears the petition and the FRP's opinion and ultimately makes the recommendation to the DCT Executive Board.

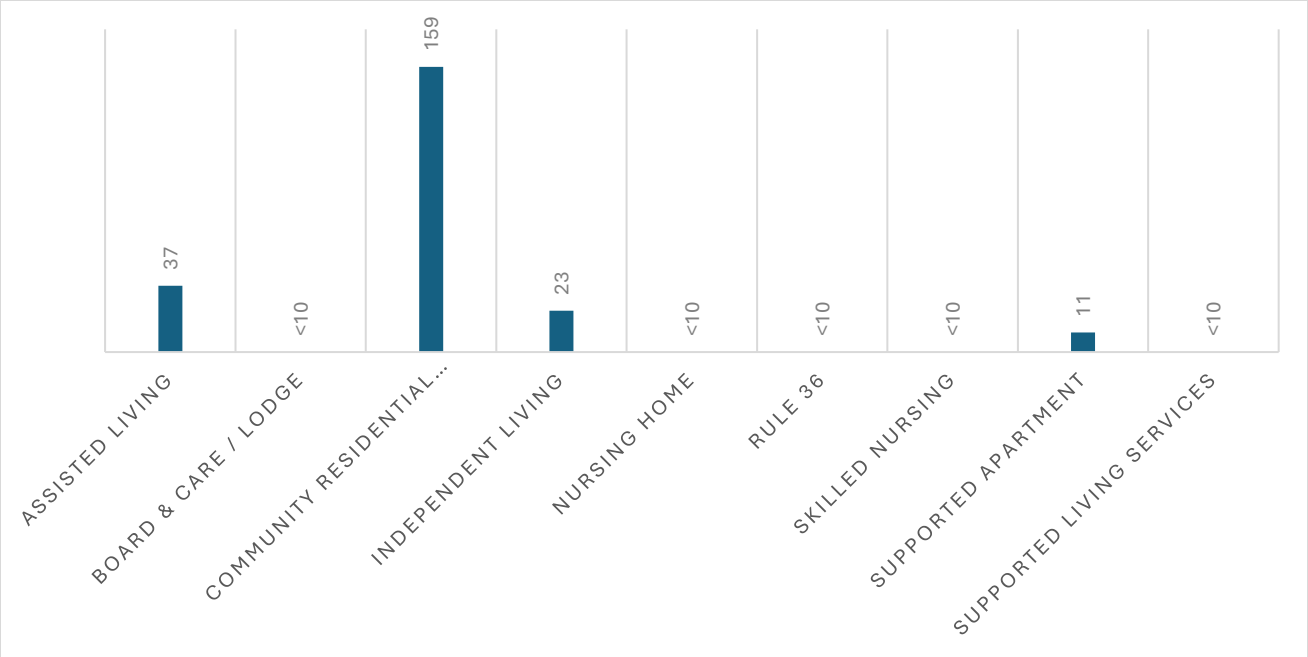
Diversion from FMHP

In the past few years Forensic Services has attempted and has been successful at diverting patients with MI&D directly into the community. Patients who are initially committed as MI&D and present with cognitive impairments[9] are identified by Forensic Services Community Integrated Services (CIS), DCT treatment teams, or County partners as possible candidates for diversion from FMHP. These are patients who were assessed by the clinical team at FMHP and CIS to be candidates who were ill-suited for the program and needed targeted resources in the community to be successful. Contributing to the diversion were also Risk Assessments that were completed by a Forensic Examiner who specifically assessed the individual's risk mitigation strategies to that specific community placement. Less than 10 such individuals were diverted to community settings following their final MI&D commitment and as of this moment, less than 10 are successfully living in their placements. Less than 10 patients were granted a full discharge from their MI&D commitment, while less than 10 are residing in Community Residential Supports program (formerly known as Adult Foster Care). Less than 10 are in a customized living home and less than 10 patients' provisional discharge was revoked back, and they returned to FMHP.

- Disclaimer: data removed because low counts under a specific number could identify individuals protected under Minn. Stat. 13.46.

Aside from the FMHP, individuals committed as MI&D currently reside throughout the state in a wide range of placements. A graph showing the current breakdown of the types of placements, based on their licensing, MI&D patients are provisionally discharged to is below:

[9] Cognitive impairments include intellectual disabilities, neurocognitive disorders, developmental disabilities, and/or traumatic brain injuries (TBI).



- Community Residential Setting is formerly known as Adult Foster Care.
- Disclaimer: data removed because low counts under a specific number could identify individuals protected under Minn. Stat. 13.46.

IX. Discussion and Analysis

A. Introduction

This Task Force was composed of multiple perspectives, interests, and goals from its diverse membership. The Task Force also sought feedback from multiple outside sources including patients, family members, private providers, advocates, and the organizations affiliated with MI&D work. To gain additional perspectives and feedback, a survey was sent out to current and former patients and their family members to obtain their input into the issues surrounding MI&D commitments.[10] Finally, a time was held on the agenda for people to share their thoughts, concerns, and ideas in person.

[10] There were 103 people who responded to the survey, 83% were people with a mental illness who are or were a patient at FMHP and 17% were family members. Less than 10% were from rural Minnesota, 31% from Minneapolis/St. Paul, 24% from suburbs and 25% from a major city in Minnesota. The survey asked about their racial and ethnic identities and 35% were White, 25% were Black or African American, 13% were Native Hawaiian or Pacific Islander, 18% preferred not to answer or self-identified, and 10% were Asian, Latinx, and Native American. Disclaimer: data removed because low counts under a specific number could identify individuals protected under Minn. Stat. 13.46.

While there were differences of opinions on many topics, ultimately there was consensus reached in a few main areas, for meeting the needs of people with mental illnesses, who have high chronic needs and a high level of aggressive behavior including:

- Overall limits in resource availability
- MI&D evaluation process
- Less restrictive alternative
- Community resources limited
- Barriers to discharge
- Lack of funding

The Task Force concluded that many of the issues were not related to the MI&D statute, but the availability of the appropriate resources to meet the patient's needs. The following is a discussion of the areas of consensus as well as an analysis of the issues and proposals for improvement.

B. Overall Resource Availability is Limited

Overwhelming during the yearlong Task Force work, the one constant theme expressed by every point of view at the table was a current inadequacy of resources. Examiners, case managers, Direct Care and Treatment, FMHP, community hospitals, court partners, advocates and community providers all expressed the same concern about a lack of resources to meet the needs of the subgroup of persons with mental illnesses who pose a heightened public safety risk. Many discussed current resources and how those were filling this gap.

That gap in services was further highlighted by the Task Force survey. In wanting to learn more about what happened before the person was committed, the Task Force surveyed patients and families about what services the person was using prior to commitment. The survey results indicated that 63% were on medications, 37% were in therapy, 31% had been in an inpatient unit, 25% were in a group home, 20% were in residential treatment and 14% were in supportive housing. Less than 10% were on a waiver or an ACT team (Assertive Community Treatment), using ARMHS (Adult Rehabilitation Mental Health Services), or involved in a clubhouse (a collaborative, restorative environment where members can recover by gaining access to opportunities for employment, socialization, education, skill development, housing and improved wellness). These are important services that help people live well in the community and prevent crises and hospitalizations. Roughly 20 people noted that they were not receiving any services, had been homeless, or had been in jail.

It was important for the Task Force to hear from Respondents and family members what they saw as the barriers patients faced in accessing treatment and services prior to being committed. The main reasons cited included:

- Waiting lists for services
- No hospital beds available
- Insurance not covering treatment
- No culturally specific providers

- Police would not transport them to the hospital
- Limited in-network providers
- Assessment for waivered services took too long
- Community hospital stays not long enough
- Lack of connection to natural supports (loneliness)

The task force held time on the agenda for people to share their comments in person. Eight people provided comments; all were family members. The main suggestions expressed by family for the patients before commitment were:

- Provide a longer assessment period before someone is committed as MI&D to learn more about the person
- Supply greater education on what the MI&D commitment means in terms of indeterminate length of stay
- Provide greater awareness about the not guilty by reason of mental illness and the Rule 20 process
- Concerned about releasing people after a 72-hour hold or not keeping them long enough in a hospital

Ultimately, this feedback led the Task Force to consider changes to the statutory process but ultimately concurred a change in resources would allow the statute as written to be better used. Below is a summary of some of the ideas to help address areas of resource issues and innovations to overcome the issues.

C. MI&D Evaluation Process

Individuals under consideration for a commitment as a person who has a mental illness and is dangerous to the public are stuck in jails and community-based hospitals without appropriate treatment. Initial evaluations and final commitments frequently occur when people are in these settings where there is no consistent treatment or staff trained to offer clinical observation and documentation of these patients.

One of the most significant challenges in MI&D commitments is the prolonged delay between commitment and admission to the FMHP, leaving many individuals without clinical observation by independent, neutral practitioners during the 60-day period. Instead, they often remain in environments that are ill-equipped or do not have the funding to provide adequate mental health care. Many are held in community jails, where mental health treatment is limited or nonexistent, and there is a lack of consistently trained clinical staff to observe and document their symptoms and needs. Others are placed in community hospitals, which have neither the resources nor the infrastructure to manage long-term, high-acuity patients who cannot engage in ongoing treatment. The clinical and psychiatric observation notes are rarely significant and not often helpful enough to offer true insight into their symptoms and treatment needs. Clinical observation and documentation would provide detailed and relevant information regarding alternative options, information for 60-day evaluations, and/or provide FMHP with better information at intake as to the person's functioning and needs.

Counties demonstrate variation in their reliance on the 60-day final commitment evaluations conducted by the Forensic Evaluation Department within Forensic Services. Access to qualified examiners is uneven across the state. Metropolitan counties typically have a larger pool of evaluators, while rural counties often have fewer resources. Some rely entirely on the 60-day report to finalize commitments, while others do not because some counties find that the report does not always add substantive information beyond what initial evaluations have already provided, apart from offering more detail on whether the individual is deemed appropriate for the FMHP. Concerns were raised that State Forensic reports may not contribute meaningfully to case conceptualization but instead introduce an additional step. County partners on the task force also noted that there is a perception that State Forensic Examiners have increasingly determined that patients meet criteria but are not suitable for treatment at the FMHP, often citing complex diagnoses such as personality disorders, brain injuries, and autism spectrum disorder. This aligns with concerns the FMHP, The Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Disability Law Center task force representatives voiced to the Task Force that FMHP is not the appropriate setting for these complex cases nor consistent with their rights under *Olmstead.* However, as there are no other options, DCT serves these patients "with complex conditions that other behavioral health care providers cannot or will not serve."[11] This perception has contributed to a decline in counties' trust and willingness to defer to the 60-day evaluations. Counties with access to a strong network of Court-Appointed Examiners prioritize independent clinical analysis, incorporating county case management insights into the patient's treatment needs, and forensic evaluations by court-approved professionals to determine the necessity of FMHP placement or alternative options.

In the meantime, patients remaining in jail lack mental health treatment, exacerbating concerns about the incarceration of individuals with severe mental illnesses. These placements often result in deterioration due to medication refusal or unavailability, and repeated decompensation can alter a patient's baseline, making symptom resolution increasingly difficult. Patients committed MI&D who remain in jail for over a year awaiting admission to FMHP run into the same time constraints from *Jackson* as the incompetency issues discussed earlier. As a result, some courts have felt compelled to discharge individuals awaiting placement at the FMHP from jail settings to the community due to the liberties being restrained in these jail settings, resulting in safety concerns for the individual and for the community.

Due to these systemic issues, County Attorneys are generally unwilling to agree to extended observation periods, as they rarely lead to improved circumstances and, in many cases, worsen the situation. Patients may remain in jail or a community hospital for a year or more, and in cases where a patient who has not yet received adequate treatment for their underlying mental illness assaults staff, they are often arrested, transferred to jail, and refused re-entry to the prior mental health facility. Ultimately, this delays access to appropriate treatment, leaving patients without care or observation by an unbiased and dedicated clinical team. In some instances, courts have ordered the release of MI&D committed individuals from jail due to excessive delays in admission to treatment, posing safety risks to both the individual and the public.

[11] Taken from DCT's website. https://mn.gov/dct/about-direct-care-treatment/

D. Less restrictive alternatives

Statute currently allows for a person to be committed to a less restrictive state-operated treatment program or treatment facility consistent with the patient's treatment needs and the requirement of public safety. Statute and Court Rules also allow for a stay of an MI&D commitment as a less restrictive alternative to a final MI&D commitment where an alternative placement to FMHP meets the patient's needs and addresses public safety. Ideally, there are instances where all parties and court roster examiners agree that if the appropriate program existed, a person's needs and the needs of public safety could be met. However, rarely have the options that presently exist not been tried before the MI&D action is brought. Stakeholders such as county attorneys and examiners have no less restrictive options available that meet treatment and public safety needs, resulting in recommendations that increase likelihood of a final MI&D commitment or admission to the FMHP.

Additionally, for an assessment and crisis stabilization facility to be effective in triaging needs and preventing either final MI&D commitments or admission to the FMHP, less restrictive options would need to be available. Points of consideration include:

Lack of secure/locked community placements: Many counties report that there is a lack of secure/locked long-term community options available to patients, especially options with a therapeutic environment and trained staff. Options that offer the supervision necessary to give the patients and the public the safety they need, or the ability to smoothly and quickly return to a more secure setting do not exist. While the Legislature has approved the development of locked Intensive Residential Treatment facilities (IRTS), none have been developed. Initial delays were due to Center for Medicare and Medicaid Services (CMS) not approving the use of Medicaid for these types of facilities but now Medicaid can be used. Start-up funding was and remains appropriated, but no facilities have been developed yet. Barriers remain including reimbursement rates that are too low for these patients, finding and hiring trained staff for these facilities, and continuity of funding following the loss of appropriations in 2027. Supplemental funding from the State of Minnesota may be necessary to maintain locked community placements once established.

Medications: Most available resources are privately owned resources that lack or are unwilling to enforce a Jarvis (medication) order. Having community psychiatric providers with experience with this population and a commitment to getting a family history of mental illness and prior medications would be helpful. Some counties have contracted with the local Certified Community Behavioral Health Center or health care system for mental health care to promote continuity especially when someone leaves the jail. Regional models to assist in increasing access to psychiatric services or the development of a specialized pool of community psychiatric providers to meet these needs could assist in stabilization outside of the FMHP. 2025 legislation requiring patients to continue to receive their current medications in jail, with some exceptions, may promote greater collaboration.

No available options: There is an utter lack of placements willing to take fully committed persons or even persons on a stay of MI&D. This adds to the difficulty when looking for a "less restrictive option." Many facilities fear the liability of housing such a patient, and most cannot secure a patient

if they are eloping or decompensating with aggressive behavior/violence. Further, the lack of immediate return facilities (i.e. a secure psychiatric facility, a crisis stabilization facility, or higher level of care) means insufficient safety measures if a patient decompensates or fails while outside FMHP. Hospital emergency departments are generally full and the bar for using an acute hospital bed is high due to high need and lack of bed space and staffing. Further, many have significant aggressive histories (i.e., sex offenses, arson, assault, weapons). Private sector options decline admission and state options outside of the FMHP are minimal.

Developmental Disability Challenges: Presently, there is a significant lack of placements designed for people committed with development disabilities (DD), brain injuries, ASD spectrum or FASD, and youth who are also dangerous to others, specifically managing their safety risk to vulnerable peers and staff. There is a lack of individualized treatment options with specialized staff.

Sexual History: Most private sector placements have limited willingness to work with patients who require Predatory Offender Registration and/or have sex offense convictions.

Community Supervision: County Case Managers are not probation officers or law enforcement. They lack the time and resources to provide intensive supervision, nor does it fit within their role. As such, often the placement facility is relied upon to supervise day to day. The current structure places a great deal of responsibility on case managers who have no time to supervise and on facilities who do not wish to take the liability of this supervision.

Lack of Intensive Community Residential Programs: Community programs run by nonprofits typically have low Medicaid rates making it difficult for them to provide the intensity of care needed for people with serious mental illnesses who also exhibit aggressive behaviors. Residential providers (Intensive Residential Treatment Services or IRTS) are 16 beds or less. They are not secure facilities and due to the small size may not be able to accept patients with high needs or who are aggressive due to funding and staffing constraints and the vulnerability of other patients in the program. These facilities can prioritize admitting patients with less intense needs and often have long waiting lists. In the meantime, the patient is vulnerable, the public is at risk, and counties struggle to find a higher level of care. Often times counties are searching for an available bed as opposed to our goal of finding the most clinically appropriate setting.

Identified Need – Additional State Operated Facilities: Given the above information, the development of state run, state trained community residential settings scattered throughout the state, regionally at minimum, would be necessary to serve as lesser restrictive settings when there has been an evaluated lesser restrictive need. These settings should:

- Be secure, with the ability to be flex locked/locked, include cameras, and have 24/7 awake staffing
- Offer short-term to long-term options with plans for step down and transition
- Offer connection to local mental health treatment including psychiatric services and therapy
- Enforce Jarvis orders

Additional consideration may be given to regional, developed programs that include the above but are built similarly to assisted living or memory care facilities which have a variety of settings and

services, such as case management, on campus to assist individuals in practicing skills with follow up and support.

E. Community-Based Resources are Limited for People with Chronic, High Needs, and High Level of Aggressive Behavior

Leading up to the decision to petition for an MI&D commitment, patients have often utilized many community-based resources that were ultimately insufficient to avoid an MI&D commitment. The Task Force survey asked patients and families what might have prevented the MI&D commitment. Many cited increased access to services including medication, medication management, case managers, SUD treatment, and better staffing at group homes. Greater awareness and knowledge of mental illnesses, first episode of psychosis programs and access to housing and employment. The survey then asked if people were able to find information and resources about the mental health system prior to commitment.

- 9% strongly agree
- 18% agree
- 11% neither agree nor disagree
- 24% disagree
- 38% strongly disagree

Responses also mentioned the impact of drugs, particularly cannabis. Family members also reported concerns about the defense counsel and why family could not be included more in the court process. Finally, some responses indicated involving family members in the treatment journey may have helped. Family members that responded mentioned the difficulty obtaining services when the person refuses them but needs them and how HIPAA is used to prevent them from sharing information to the mental health professionals and vice versa. One response noted the police denied the family's request for help and others mentioned the need for peer support.

F. Barriers to Discharge after Commitment

The Task Force discussed the numerous challenges that patients leaving the FMHP encounter during the provisional discharge and discharge processes. Some of the issues were very similar to the resource issues with preventing commitment: placements, community-based services, and wrap-around services are limited for this population. However, one area of significant discussion was the legal process for reduction in custody handled, in part, by the Special Review Board process.

i. Special Review Board Report

The Special Review Board (SRB) is required to issue a yearly report on the barriers to people being provisionally discharged.

In review of the Special Review Board (SRB) MI&D Treatment Barriers Reports from 2022, 2023 and 2024, the average number of petitions denied a reduction in custody (provisional discharge) was 56%. The most common barrier identified was that the patient had outstanding treatment needs

(Table 1). This category is broken down in Table 1.A to further delineate what areas of treatment needed to be focused on more. Other common barriers identified were the lack of an appropriate discharge plan and further time needed to determine whether medication changes would work.

ii. Number of times Barrier identified

Table 1: "Barriers Preventing Patient from Progressing in Treatment"	**Number of Times Barrier Identified ***
"The patient has outstanding treatment needs" **(See Table 1.A for subtopics within this item)**	155
"The patient lacks an appropriate Provisional Discharge Plan"	78
"County Case Management has refused or failed to adequately participate in developing an appropriate Provisional Discharge Plan for the patient"	0
"The patient's behavioral/psychological or other needs cannot be met by identified provider(s)"	1
"The identified provider is unable/unwilling to serve the patient because of his/her past history"	0
"The identified provider does not have sufficient staff to meet the patient's needs at this time"	0
"The identified provider has not trained staff to meet the patient's needs at this time"	0
"A placement that would meet the patient's needs is being developed but is not yet available"	1
"There are no current openings with identified provider"	0
"The patient no longer wants to reside with the identified provider, and a new provider has yet to be identified"	0
"Funding has not been secured; the patient declines to apply for benefits; and/or the patient refuses to pay the patient's spend-down portion of costs"	0
"The patient has active warrants that need to be resolved prior to his/her Provisional Discharge/Discharge"	0
"The patient is a dual commitment to the Department of Human Services and the Department of Corrections"	2

Other **(See Table 1.B for subtopics within this item)**	19

*The SRB may select multiple barriers in connection with each denial recommendation.

Table 1.A: Subtopics to: "The patient has outstanding treatment needs"

"The patient needs to address dynamic risk factors (e.g. chemical use, sexually problematic behavior, complete Good Lives/SNS programming, attitude, medication adherence, therapeutic relationships with providers, motivation, etc.)"	126
"The patient requires more time to demonstrate skill acquisition (e.g. programming outside of the secure perimeter (either staff-supervised or unsupervised, based on abilities)"	102
"More time is needed to determine if the patient's recent medication changes will work/are appropriate"	10
"The patient is psychologically and/or behaviorally unstable"	49
"Other: Please specify:" 1. Patient continues to experience fear and anxiety about how to manage if a full discharge were granted and is not able to demonstrate sufficient coping skills to manage the terminal illness and psychiatric stability. 2. Patient needs to develop better insight to mental illness. 3. Patient lacks insight, poor impulse control and lack of a specific plan going forward. 4. Patient lacks insight to mental illness. 5. There is concern about patient's variable sodium levels possibly related to excessive fluid intake at times. 6. Patient remains under treatment for major depressive disorder and OCD. 7. Patient remains under care for neurocognitive disorder secondary to TBI. 8. Patient's needs are best met in the current setting and doesn't seek change. 9. No plan for future living situation if discharged, not fully deinstitutionalized. 10. Incomplete recovery after patient fall in 2021-relapse and lack of engagement with any member of the treatment team. 11. Patient lacks insight into mental illness and need for medication. 12. Risk management factors would be problematic in less structured environment. 13. Elevated risk; lack of insight. 14. Residual symptoms of psychosis.	20

15. Patient does not feel ready for a discharge. 16. Inconsistent participation in treatment programming. 17. Patient is not currently seeking any reduction. 18. Patient lacks insight and judgments. 19. Patient has limited insight, history of medication noncompliance. 20. The structure of the provisional discharge placement is needed to maintain medication compliance; patient does not want a change	

The SRB Report made the following recommendations to the Commissioner based on their observations during hearings:

- Patients that are not supported by the county, or their case management team, often don't have a PD plan in place.
- There are challenges for patients that are dually committed to the Department of Human Services and the Department of Corrections (DOC). Options should be explored with the DOC to meet the mental health needs of patients while in custody of the DOC.
- Some patients require non-traditional placements/plan as not all can handle large group settings. Individualized provisional discharge plans and unique placements may be required for successful progress.

Conversely, when the Task Force survey asked patients and families what the barriers were to being discharged the responses included:

- Progress through the treatment levels too slowly
- Long wait times for the SRB in between application and hearing
- Lack of activities while on a provisional discharge
- Difficult finding community placements
- Feels like a never-ending probation period while on a provisional discharge
- Length of time to be assessed for a CADI waiver
- Lack of dual diagnoses programs
- Pending criminal charges

The Task Force survey also asked responders about their experiences with the Special Review Board. Responses mentioned that the SRB:

- Was not fair
- Lacked diversity on the board
- Did not listen to what they said
- Did not see the changes in the person from the act that landed them at FMHP
- Does not always listen to the team's recommendations for discharge and conversely, they only listen to the team's recommendations
- Was a discouraging experience. A few mentioned it was a good experience and that they appreciated the feedback.

There was also a response from a family member that noted concerns that treatment notes provided to the SRB were not accurate.

Similarly, the Task Force discussed at length some of the challenges to the delays in hearings for both the SRB and the Commitment Appeal Panel (CAP), citing issues with examiner availability, time to do risk assessments and the age of those reports by the time they reach the CAP (if applicable), availability of hearing dates, and ultimately other administrative delays outside the control of the parties.

iii. What is needed for discharge process

Currently, individuals preparing for provisional discharge from FMHP collaborate with their treatment team and County Case Manager to develop a plan that supports their transition into the community. However, these plans are often based on a standardized template that may not adequately address individual risk factors. In some cases, conditions unrelated to an individual's specific needs are imposed—for example, requiring participation in substance use treatment or relapse prevention programs like Alcoholics Anonymous, even when there is no clinical indication of a substance use disorder.

When FMHP staff remove unnecessary standard conditions from the template, the Special Review Board may reinstate them. Additionally, provisional discharge plans may lack essential details. For instance, an individual may be required to cover the cost of their medications upon discharge, but if this requirement is not explicitly stated in the plan or subsequent order, compliance issues may arise, potentially influencing revocation.

Provisional discharges with clearly defined individualized requirements may lead to higher success rates post-discharge. It is recommended that each Provisional Discharge Plan and subsequent order be tailored to address the individual's clinical and safety needs, with a structured process for ongoing review and revisions as circumstances evolve. To support this, the establishment of a collaborative workgroup between FMHP and county human services agencies is proposed to develop policies and procedures guiding the creation and implementation of Provisional Discharge Plans.

The Task Force also analyzed the problems surrounding resources in community placements and how those impact the quality of the discharge plan. While the SRB recommends if people can be discharged, they need community services to be available and appropriate for patients to develop a plan that mitigates their risk sufficiently to support a reduction in custody. Responders to the Task Force survey provided a variety of answers in terms of what services, supports, and treatment would someone need to be able to be discharged to the community. Common answers included:

- on site supports and activities
- anger management
- team support
- group home
- outpatient therapy
- home economics
- medication
- bank account

- Rep Payee
- ACT team, employment
- EMDR therapy
- good case manager
- housing
- SUD treatment
- peer support

During the open comments section of the agenda, eight family members provided comments surrounding the SRB/CAP and provisional discharge process. The comments focused on a variety of topics:

- Educate families on community services to support patients on provisional discharge
- Improve the training and/or staff in group homes
- Plan for a patient's employment after leaving FMHP
- Increase the ability to retrieve records from FMHP when moving to the community

iv. Conclusion

Ultimately, the Task Force concluded that the issues with the discharge process were system resource shortages. Additional resources would be needed for the SRB and CAP to shorten timelines, FS (likely Community Integration Services-CIS) would need additional resources to assist in more detailed discharge planning to include educating family on services, looking at employments, getting records available for disclosure for community services, more case managers at the county level to allow for more personalized supervision and assistance, and the State would need funding for training group home or other service provider staff to understand and better support MI&D patients on provisional discharge. These additional resources would improve a process that is significantly bogged down by delays to the detriment of patients at FMHP.

G. Systemic Issues of Lack of Funding to Support Current and Needed Resources

Overall, with the increased need for available resources, the system is sorely underfunded. What patients and family members tell the Task Force is that more is needed, not less. The Responses focused on needing more at every phase:

- Overall:
    - Recognize the lack of intensive treatment options
    - Increase the access to and the options for community services
    - Provide education on the mental health system and commitment laws to respondents
    - Continue to focus on increasing the treatment and activities at FMHP
    - Continue to examine and streamline the process of the SRB
    - Review the FMHP treatment plan to focus on the way people can progress through the program
    - Address the barriers to discharge

    - Continue the work to shorten the length of stays when appropriate
- During commitment:
    - Provide more training for staff on empathy and how to communicate with families
    - Provide more opportunities to exercise at FMHP
    - Involve families more including history and not limit visiting time if it doesn't interfere with treatment
    - Increase focus on health and wellness (not just medications)
    - Address the health care needs of patients as well as mental health
    - Increase recreational therapy
- Misc.:
    - Do not focus constantly on what happened X number of years ago, focus on the present and be more positive about changes seen in the person
    - Raise the standard of care that is provided

Funding concerns were also voiced by county partners. Counties and local taxpayers often shoulder substantial financial burdens due to the limited capacity within Minnesota's current mental health system. For instance, individuals may be placed in Direct Care and Treatment (DCT) facilities outside the Forensic Mental Health Program (FMHP) while awaiting appropriate placement. These individuals are frequently designated as "Does Not Meet Criteria" (DNMC), yet in the absence of alternatives, they may remain in costly care settings. When a patient is awaiting MI&D commitment and is housed at Anoka Metro Regional Treatment Center (AMRTC) or a Community Behavioral Health Hospital (CBHH) but deemed DNMC, the county becomes fully responsible for the cost of care. As of this report, the per diem rate is $2,492 at AMRTC and $2,033 at a CBHH. Similarly, if a patient is returned to or remains in jail, Medical Assistance is suspended, and the full cost of treatment shifts to the county jail. Counties do not have dedicated revenue streams to cover these expenses, which are instead funded directly by local tax dollars. Over time, these extended care costs can significantly strain or deplete a county's mental health budget.

Forensic Services conducted a comprehensive review of the current patient population as of March 2025 which revealed that 10-15% of the population residing within FMHP did not meet the criteria for serious and persistent mental illness (SPMI), but rather had personality disorders, neurodevelopmental, and / or neurocognitive disorders secondary to medical conditions such as Alzheimer's or due to traumatic brain injuries. A retrospective review of discharged patients who did not meet SPMI incurred a cost of $20 million, in part due to the prolonged stay at FMHP and the many barriers discussed above related to these clients. Conversely, there are costs related to appropriate less restrictive setting, but that cost was not known to the Task Force.

The Task Force agreed that costs are one piece of this important puzzle. Public safety, cost of care, liberties of the patient, and rights of the patient to have treatment delivered all require a balance. What the Task Force is not proposing is shifting resources from one area to another but adding financial resources that appropriately meet the needs of clients.

The Task Force took into consideration these many concerns, addressed *supra* section IX(B-G), and turned to the task of making, if necessary, statutory changes. Robust discussions occurred and ultimately some changes were recommended. Overwhelmingly though, the message was clearly a need for additional funding for more resources.

H. Statutory Considerations with Consensus

i. Minn. Stat. § 253B.18, subd. 3a: Highlight Appeal

The Task Force concluded that because of the significant liberties at stake in MI&D commitments, it was important to highlight the Appeal rights listed in the general provisions of 253B.23, Subdivision 7, to ensure the attorneys representing patients can find and advise the patients of their appellate rights.

> **Subdivision 3a. Appeals.** District court orders issued under this chapter may be appealed following the process described in Minnesota Statute 253B.23, Subd. 7.

ii. Minn. Stat. § 253B.18, subd. 7: Eliminating or Rewording Provisional Discharge Criteria

The Task Force discussed eliminating the requirement of patients having to demonstrate "making an acceptable adjustment to open society" and "and will enable the patient to adjust successfully to the community" as these are vague and subjective requirements. Examiners on the Task Force noted that these were unusual phrases and did not address the issues well, which was the mitigation of risk. As such, the Task Force agreed on the following changes:

> **Subd. 7. Provisional discharge.**
> (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be provisionally discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board, that the ~~patient is capable of making an acceptable adjustment to open society.~~ patient's risk can be adequately managed by a less restrictive setting.
>
> (b) The following factors are to be considered in determining whether a provisional discharge shall be recommended:
>
> (1) whether the patient's course of hospitalization and present mental status indicate there is no longer a need for treatment and supervision in the patient's current treatment setting; ~~and~~
> (2) whether the conditions of the provisional discharge plan will provide for sufficient treatment in a less restrictive setting; and

(~~2~~3) whether the conditions of the provisional discharge plan will provide a reasonable degree of protection to the public. ~~and will enable the patient to adjust successfully to the community~~.

iii. Minn. Stat. § 253B.18, subd. 15: Open Adjustment & Need for Treatment Removed

Similar to *Supra* section IX(e)(ii), the Task Force agreed to align the Discharge criteria language to the Provisional discharge language by eliminating the statement "capable of making an acceptable adjustment to open society." "Need for treatment and supervision" to be removed from the Discharge criteria.

Subd. 15. Discharge.
(a) A patient who is a person who has a mental illness and is dangerous to the public shall not be discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board, that the patient is ~~capable of making an acceptable adjustment to open society, no longer dangerous to the public.~~ the patient's risk can be managed in the community, ~~is no longer in need of treatment and supervision.,~~ and the patient no longer requires court ordered supervision.

(b) In determining whether a discharge shall be recommended, the special review board and executive board shall consider whether specific conditions exist to provide a reasonable degree of protection to the public and to assist the patient in ~~adjusting to~~ living in the community. If the desired conditions do not exist, the discharge shall not be granted.

iv. Minn. Stat. § 253B.18, subd. 10. Provisional discharge revocation alternative.

Another proposed change is to allow for a rare circumstance where patients under provisional discharge status may be revoked to alternative settings including a community hospital/setting as appropriate with the consent of the hospitals. It was discussed the cost of care again for options that act as an alternative to FMHP (i.e. a return to AMRTC instead of FMHP). This alternative return to FMHP does not exist in statute. Some were cautious about diverting current resources further away from regular commitments – as diverting resources has led to increased MI&D Petitions as options run thin. However, the Task Force ultimately concluded using community settings such as a private hospital, with the consent of that setting, would open additional options for patients.

Subd. 10. Provisional discharge; revocation.
(a) The head of the treatment facility or state-operated treatment program from which the person was provisionally discharged may revoke a provisional discharge to a secure treatment facility, or alternative nonstate operated, community settings such as a hospital, with consent of medical director or designee of that alternate

community setting, if appropriate to meet the needs of the individual, if any of the following grounds exist:

(i) the patient has departed from the conditions of the provisional discharge plan;

(ii) the patient is exhibiting signs of a mental illness which may require in-hospital evaluation or treatment; or

(iii) the patient is exhibiting behavior which may be dangerous to self or others.

If placed in a community setting, the community setting may terminate the agreement to keep the patient.

(b) Revocation shall be commenced by a notice of intent to revoke provisional discharge, which shall be served upon the patient, patient's counsel, and the designated agency. The notice shall set forth the grounds upon which the intention to revoke is based, and shall inform the patient of the rights of a patient under this chapter.

v. Minn. Stat. § 253B.18, subd. 14: Voluntary Readmission: Lengthening the Time.

Subd. 14. Voluntary readmission. (a) With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return from provisional discharge for a period of up to ~~30~~60 days, or up to ~~60~~90 days with the consent of the designated agency. If the patient is not returned to provisional discharge status within ~~60~~90 days, the provisional discharge is revoked. Within 15 days of receiving notice of the change in status, the patient may request a review of the matter before the special review board. The special review board may recommend a return to a provisional discharge status.

(b) The treatment facility or state-operated treatment program is not required to petition for a further review by the special review board unless the patient's return to the community results in substantive change to the existing provisional discharge plan. All the terms and conditions of the provisional discharge order shall remain unchanged if the patient is released again.

(c) Voluntary non-psychiatric medical readmission. With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return from provisional discharge for a period of up to six (6) months for non-psychiatric medical reasons, with the consent of the designated agency

Discussion:

The Task Force discussed the current 60-day time limit on voluntary readmission, specifically considering cases in which an individual returns to Forensic Services solely for medical reasons. Often these individuals return to the Forensic Nursing Home to complete transitional care and rehabilitation for medical reasons unrelated to their mental health. There have been cases where a person was at their psychiatric baseline but needed to voluntarily return to Forensic Services for recovery from a medical issue where other facilities offering similar care declined to admit them. Concerns were raised regarding individuals whose voluntary transfer status is revoked simply due to them needing longer than 60 days to complete physical rehabilitation. This subsequently results in the individual needing to petition again for a reduction in custody, attend the SRB, and complete the very lengthy process. After a lengthy discussion the Task Force supported a proposed statutory change to make a longer-term exception for voluntary medical readmissions. In summary, with the medical director's approval, a person that is returning on a voluntary status for a medical reason could be allowed to return for up to six (6) months before an automatic revocation would take effect.

Additionally, the Task Force discussed extending the 30/60 timeline for a voluntary return to a 60/90-day timeline. Allowing an additional 30 days would allow the patient and designated agency additional time to identify a new placement when a placement closes or if the bed was filled during the patient's hospitalization. Discussion also surrounded giving the patient additional time to stabilize and return to the community, preventing early returns to the community to avoid revocation whether the patient may need just a little more time. The Task Force considered concerns about possible loss of waiver services or funding as a result of a longer voluntary hospitalization at FMHP, but the investigation confirmed that these services should not be impacted by this change.

I. Statutory Considerations Without Consensus:

i. Minn. Stat. § 253B.01: Definitions. Subd. 17. "Person who has a mental illness and is dangerous to the public.

A "person who has a mental illness and is dangerous to the public" is a person:

> (1) who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, and is manifested by instances of grossly disturbed behavior or faulty perceptions; and
>
> (2) who as a result of that impairment presents a clear danger to the safety of others as demonstrated by the facts that (i) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and (ii) there is a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.

One area where the Task Force did not have consensus was the definition of mental illness in the statute. The Task Force discussed aligning the definition with the "Person who poses a risk of harm due to a mental illness" exclusionary criteria in Minn. Stat. § 253G.02, subd. 17a(b).

> (b) A person does not pose a risk of harm due to mental illness under this section if the person's impairment is solely due to:
>
> (1) epilepsy;
>
> (2) developmental disability;
>
> (3) brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or
>
> (4) dependence upon or addiction to any alcohol, drugs, or other mind-altering substances.

However, after discussion, there was no consensus on modifying the MI&D statute to include these exclusions.

Some participants raised concerns regarding what they describe as a broad and/or overly inclusive definition of mental illness as it pertains to MI&D commitment laws **(Minn. Stat. § 253B.02, Subd. 17(1)).** These members advocated for adding clear exclusionary criteria of diagnoses such as cognitive impairment, traumatic brain injuries (TBI), acquired brain injuries, neurodevelopmental disorders (e.g., autism spectrum disorders), trauma-related disorders (e.g., Posttraumatic Stress Disorder [PTSD]), dementia, and personality disorders (e.g., Antisocial personality disorder) as justification for commitment. These members argued that these diagnoses went beyond the intended scope of commitment statutes, potentially misclassifying individuals as MI&D who may require alternative forms of support rather than mental health treatment and/or institutionalization. Several members of the group emphasized the importance of aligning the statutory definition of mental illness. They questioned why individuals with developmental disabilities are allowed to be committed as a person who has a mental illness and is dangerous to the public (MI&D), especially when the facilities in question are specifically designed to treat people with mental illnesses, not developmental disabilities. It was noted by those members that individuals being committed as MI&D with developmental or neurocognitive concerns may also have a co-occurring mood disorder for example that technically meets current criteria for commitment as MI&D, but the primary support needed to reduce future violence safety risk exists in the management of the developmental/neurocognitive difficulties, which makes placement in a facility with a primary focus on mental illness treatment inappropriate and inconsistent with the 1999 Supreme Court *Olmstead* Decision establishing the right to receive services in the most integrated setting. They suggested that if separate resources or specialized facilities were developed for individuals with developmental disabilities, it would be more appropriate than indeterminate commitment to FMHP with no viable path forward to a less restrictive setting better suited to their needs.

Conversely, some members voiced opinions that the definition of mental illness was appropriately written in the statute and that there was not a good basis to add exclusionary language to the statutory definition given all the other elements that are required to meet the standard for commitment. Some members in particular were opposed to this exclusionary language, finding it

too restrictive and not allowing a tailored approach to the case. These members emphasized that patients can have these exclusionary diagnoses but also have statutory mental illnesses that require a secure treatment facility. For example, a patient can have a co-occurring personality disorder, substance use disorder, and a statutory mental illness. With no other options but FMHP, exclusionary criteria creates a population that is left unsupported by any placement.

Compounding this issue is the significant reduction in state resources available for individuals who exhibit dangerous behaviors and are diagnosed with cognitive impairment, TBI, neurodevelopmental disorders, or dementia. Historically, specialized State programs were developed to try to serve this population, but those programs were terribly problematic and failed to actually serve the population. The closure of these programs has left a critical gap in services, and current community-based alternatives remain inadequate to meet the need. Some have raised concerns that statutory modifications to definitions for MI&D were being raised and posed to try to address resource shortages, rather than addressing the underlying resource issues for this population.

Without sufficient resources, individuals who require specialized interventions face an alarming reality: placement in jails or prisons rather than placement in appropriate therapeutic environments. This shift not only denies them essential treatment but also places undue strain on the criminal justice system, which is not equipped to provide adequate care.

Ultimately, the Task Force did not reach consensus that a change in statute was necessary. The current statute allows for alternative placement options but many of the members involved in the commitment process noted that the petitions for MI&D are because everything else has been exhausted. Instead, the Task Force emphasized the need for investment in dedicated community resources that offer specialized support for those with complex neurological and psychiatric conditions and offering more alternatives to FMHP that are programs which must accept and work with challenging to serve patients with history of aggressive behavior and/or sexual offending.

ii. Minn. Stat. § 253B.18, Subd. 1 and Criminal Court Referrals Under Minn. R. Crim. P. 20.01/20.02.

> Minn. Stat. § 253B.18, subd. 1(a). Upon the filing of a petition alleging that a proposed patient is a person who has a mental illness and is dangerous to the public, the court shall hear the petition as provided in sections 253B.07 and 253B.08. If the court finds by clear and convincing evidence that the proposed patient is a person who has a mental illness and is dangerous to the public, it shall commit the person to a secure treatment facility or to a treatment facility or state-operated treatment program willing to accept the patient under commitment. The court shall commit the patient to a secure treatment facility unless the patient or others establish by clear and convincing evidence that a less restrictive state-operated treatment program or treatment facility is available that is consistent with the patient's treatment needs and the requirements of public safety. In any case where the petition was filed immediately following the acquittal of the proposed patient for a

crime against the person pursuant to a verdict of not guilty by reason of mental illness, the verdict constitutes evidence that the proposed patient is a person who has a mental illness and is dangerous to the public within the meaning of this section. The proposed patient has the burden of going forward in the presentation of evidence. The standard of proof remains as required by this chapter. Upon commitment, admission procedures shall be carried out pursuant to section 253B.10.

Criminal Court Cross References: Minn. R. Crim. P. 20.01: Subd. 6. Procedure After a Finding of Incompetency.

If the defendant is found incompetent by a preponderance of the evidence, the court should comply with the procedures set forth in Minnesota Statutes, section 611.46. ***If the defendant is not under civil commitment, the court may issue an order directing the designated agency in the county where the criminal case is filed to conduct prepetition screening pursuant to the Minnesota Commitment and Treatment Act to make a recommendation on whether the defendant should be civilly committed under the Act.*** The prepetition screening team must prepare and send a written report to the county attorney and social services agency for that county within five days. The county attorney must determine whether a commitment petition should be filed and may file the petition in the district court on behalf of the county attorney, the designated agency, or another interested person. By agreement between county attorneys, the prepetition screening and county attorney's functions described in this paragraph may be handled in the county of financial responsibility or the county where the defendant is present.

Minn. R. Crim. P. 20.02: Defense of Mental Illness or Cognitively Impairment, Subd. 8 Effect of Not Guilty by Reason of Mental Illness or Cognitive Impairment.

(1) Mental Illness or Cognitive Impairment**.** When a defendant is found not guilty by reason of mental illness or cognitive impairment, and the defendant is under civil commitment as mentally ill or developmentally disabled, the court must order the commitment to continue. ***If the defendant is not under commitment, a petition for commitment must be filed by the county attorney in the county in which the acquittal took place. The court must order the defendant to be detained in a state hospital or other facility pending completion of the proceedings.*** In felony and gross misdemeanor cases, the court must supervise the commitment as provided in Rule 20.02, subd. 8(4).

Discussion:

A cursory review of the commitment statutes in other states offered some information as to how other states are handling commitments. However, absent a thorough and comprehensive comparison of the resources offered, the options for alternatives, and the general outcome, the comparison of other statutes really only offered information, but was neither definitive nor persuasive.

In reviewing other state statutes, it was noted that in some jurisdictions indeterminate commitment or institutionalization is initiated: 1) in correlation to a felony and/or gross misdemeanor cases (tied to criminal court jurisdiction), and/or 2) following a determination of Not Guilty by Reason of Mental Illness or Cognitive Impairment. While these types of cases also can result in MI&D cases in Minnesota, the avenue to commitment is not governed by a different statute. The data indicates that the number of referrals due to criminal incompetence has increased over the past decade. This has put additional strain on an already burdened system, causing some on the Task Force to question whether additional statutory changes should be made to restrict referrals through the 20.01 process. Consensus was not reached on these discussions.

As noted above, expanded referral from 20.01 and consideration for MI&D commitment under 253B.18 is likely correlated to decreased alternative resources for those requiring treatment while keeping the community safe. Resources should be expanded to offer additional safe residential community-based options at earlier interceptions in the process and for periods of time longer than presently offered community options. Many on the Task Force noted struggles to find a placement that would take someone for longer term stabilization and treatment that was a locked or flex lock option who had complex mental health and/or serious criminal charges. A locked, moderate length placement option (perhaps up to one year) would fill a gap between short-term acute care stabilization and/or 90-day residential but unlocked facilities and a long-term, secure MI&D commitment to FMHP, which requires all the discharge steps of the SRB & CAP process.

Creating a middle ground resource would satisfy both the goal of reducing the number of persons under MI&D commitment to only those who require long term, secure setting treatment, while also satisfying the goal of meeting the needs of our jail housed patients in need of longer-term treatment and support in a locked setting.

X. List of final recommendations

A. Recommendations for Statutory Changes

Ultimately, the Task Force supports statutory changes in five areas of Minn. Stat. § 253B.18. Those areas are discussed in detail *Supra* IX(e) but the changes are concisely listed below:

Subd. 3a. Appeals. District court orders issued under this chapter may be appealed following the process described in Minnesota Statute 253B.23, Subd. 7.

Subd. 7. Provisional discharge.

(a) A patient who is a person who has a mental illness and is dangerous to the public shall not be provisionally discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board,

that the ~~patient is capable of making an acceptable adjustment to open society.~~ patient's risk can be adequately managed by a less restrictive setting.

(b) The following factors are to be considered in determining whether a provisional discharge shall be recommended:

(1) whether the patient's course of hospitalization and present mental status indicate there is no longer a need for treatment and supervision in the patient's current treatment setting; ~~and~~

(2) whether the conditions of the provisional discharge plan will provide for sufficient treatment in a less restrictive setting; and

(~~2~~3) whether the conditions of the provisional discharge plan will provide a reasonable degree of protection to the public. ~~and will enable the patient to adjust successfully to the community~~.

Subd. 10. Provisional discharge; revocation.

(a) The head of the treatment facility or state-operated treatment program from which the person was provisionally discharged may revoke a provisional discharge to a secure treatment facility, or alternative nonstate operated, community settings such as a hospital, with consent of medical director or designee of that alternate community setting, if appropriate to meet the needs of the individual, if any of the following grounds exist:

(i) the patient has departed from the conditions of the provisional discharge plan;

(ii) the patient is exhibiting signs of a mental illness which may require in-hospital evaluation or treatment; or

(iii) the patient is exhibiting behavior which may be dangerous to self or others.

If placed in a community setting, the community setting may terminate the agreement to keep the patient.

Subd. 14. Voluntary readmission.

(a) With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return from provisional discharge for a period of up to ~~30~~60 days, or up to ~~60~~90 days with the consent of the designated agency. If the patient is not returned to provisional discharge status within ~~60~~90 days, the provisional discharge is revoked. Within 15 days of receiving notice of the change in status, the patient may request a review of the matter before the special review board. The special review board may recommend a return to a provisional discharge status.

(b) The treatment facility or state-operated treatment program is not required to petition for a further review by the special review board unless the patient's return to the community results in substantive change to the existing provisional discharge

plan. All the terms and conditions of the provisional discharge order shall remain unchanged if the patient is released again.

(c) Voluntary non-psychiatric medical readmission. With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return from provisional discharge for a period of up to six (6) months for non-psychiatric medical reasons, with the consent of the designated agency

Subd. 15. Discharge.

(a) A patient who is a person who has a mental illness and is dangerous to the public shall not be discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board, that the patient is ~~capable of making an acceptable adjustment to open society, no longer dangerous to the public.~~ the patient's risk can be managed in the community, ~~is no longer in need of treatment and supervision.,~~ and the patient no longer requires court ordered supervision.

(b) In determining whether a discharge shall be recommended, the special review board and executive board shall consider whether specific conditions exist to provide a reasonable degree of protection to the public and to assist the patient in ~~adjusting to~~ living in the community. If the desired conditions do not exist, the discharge shall not be granted.

B. Recommended resources needed:

The greatest place of consensus amongst Task Force members was the need to expand commitment resources on both the front and back end of commitment. The following summarizes the areas of expansion in resources the Task Force recommends.

i. Dedicated Funding for County Case Management of MI&D Patients

County case management is provided inconsistently to individuals committed as mentally ill and dangerous. While some counties provide case management throughout an individual's commitment, others become more actively involved as provisional discharge approaches. Several factors contribute to these variations:

- **Funding Limitations:** Counties fund adult mental health case management through targeted case management, which is a Medicaid benefit. Counties do not receive targeted case management funding for individuals residing in FMHP as they are not eligible for the service. High-volume counties and counties with significant geographical distance, in particular, would face significant financial strain if required to provide routine adult mental health case management services to individuals residing at the FMHP without additional resources. Some counties have collaborated using Whatever It Takes (WIT) grant funds to develop a regional model for offering supportive case management to individuals at the FMHP. Expanding those funds to other counties or developing a service to provide reimbursement is a significant need. With other proposed budget shifts and impacts, this unfunded service is identified by county human services agencies as a place that may see less prioritization.

- **Workload and Travel Constraints:** High caseloads and/or physical locations limit case managers' ability to travel to FMHP on a regular basis.
- **County Expertise:** Larger counties with frequent MI&D commitments may have more experience and established processes, whereas rural counties may have little to no familiarity with these cases.
- **Lack of Clear Requirements:** There are no statutory mandates outlining how or when these services should be provided. As a result, counties interpret and implement case management differently based on available resources, workload demands, and geographic considerations.

Inconsistent case management services can result in limited knowledge of a patient's progress and readiness for discharge. This, in turn, may hinder a county case manager's ability to effectively identify needs, build rapport, and participate in discharge planning. At times, counties voice a lack of consistent communication regarding potential discharge readiness.

Providing dedicated funding for county case management services for individuals residing at FMHP would be essential in ensuring counties or regions have the necessary resources to offer consistent supportive services. Additionally, establishing clear expectations for case management services, should funding become available, would help standardize service provision across the state. The development of a Task Force to determine needed resources and prescribed practice would assist in enhancing continuity of care and potentially improve outcomes for individuals throughout their treatment and provisional discharge process.

Community Integrated Services (CIS) at FMHP collaborates closely with case managers and can offer education on the provisional discharge process and patient-specific needs. It is recommended that this collaboration be expanded, and that CIS develop formalized training and support for regions upon request.

Given the disparity in experience levels between counties – some having extensive expertise with MI&D commitments and others having little to none – it is further recommended that counties establish a mentorship program to provide guidance and support to those with limited experience. This could be done statewide or at the regional level.

i. Secure Placement Options

Individuals provisionally discharging from FMHP often relocate to sites that are geographically distant from their families and county case managers, making it challenging to provide consistent and effective case management services.

Securing appropriate community discharge options remains difficult. While some counties have multiple community residential services providers, others have none. Additionally, privately operated providers have the discretion to deny admission or discharge individuals based on complex diagnoses, offenses, or behavioral concerns. Variability in provider availability, training, and staffing further complicates placement options across the state.

To address these challenges, the development and exploration of new and expansive options should be prioritized, including increasing current capacity and exploring additional service models. The development of state-run, state-trained community residential settings—distributed regionally at a minimum—could serve as less restrictive placement options when clinically appropriate. These settings would be designed to balance individual success with public safety, offering tailored support based on specific needs. Some locations may be focused on groups (either adult foster care homes or apartment type settings depending on level of independence) while others could provide individualized placements. Ideally, these settings would meet the recommendations included earlier and would be in close proximity to services.

ii. Additional Service Recommendations

Development of an Assessment and Crisis Stabilization Facility: The development of a secure, state-run assessment and crisis stabilization facility would assist in addressing barriers within the MI&D commitment process. A facility of this type would provide robust clinical observation and documentation, trained staff, and an opportunity for patients to stabilize prior to a final determination. With the existence of this type of setting, changes in process could support outcomes that lead to stays of commitment, provisional discharges, or the identification of less restrictive settings. Recommendations would include:

- When an MI&D commitment is filed, a county case manager would be assigned, if one is not already assigned.
- Following initial commitment, which continues to include the Court-Appointed Examiner(s) report and trial (if needed), the individual would transfer to the assessment and crisis stabilization facility.
- Following the 60-day review, a review period would be identified by the Courts with clear recommendation of the need to be observed in a clinically appropriate setting with staff trained to observe and document mental health symptoms. The clinical team that would be composed of a psychiatrist, psychologist, nurses, social workers, behavior analysts, recreation/occupational therapists, and county case managers would make recommendations to the Court as to the length of additional observation period needed, beyond the 60 days. Options could include observation of periods for up to one year or transfer to FMHP.
- The Court determines the length of observation and frequency of reports. The facility informs the case manager of any significant incidents. The case manager completes the report to court. The County Attorney may still motion to send to FMHP.
- At the end of the identified observation period, the clinical team and county case manager make a final report and recommendations to the court. All parties have the option to request a court roster examiner to evaluate and opine. Examiners would have a better opportunity to weigh in on the need for the D and the possibility of less restrictive options. Options at the end of the observation period could include:
    - Final MI&D commitment with a provisional discharge to a lesser restrictive environment identified. PD can be revoked to the FMHP.
    - Stayed MI&D commitment with lesser restrictive, supportive environments identified. Stay can be revoked. Placement could be FMHP.
    - Commitment type is determined to be MI or DD instead. Follow statute for placement options. No placement at FMHP.

- To promote alternative paths to the MI&D commitment, this process may also be recommended for individuals who have experienced multiple prior commitments, have significant histories of aggressive behavior, have been declined by multiple other placement types, or are in jail with no other options available. These individuals could be evaluated at the assessment and crisis stabilization facility, with pathways to discharge identified in a similar manner.
- This assessment and crisis stabilization facility could also be used when a provisionally discharged patient is struggling in the community. The ability to evaluate medications and adjust if needed and assist in stabilization outside of the FMHP may influence fewer revocations.

Development of regional Assertive Community Treatment (ACT) teams: Many regions do not have access to ACT teams, and providers lack the funding and resources to establish or staff ACT teams designed to support individuals with severe and persistent mental illness. Providing funding for start-up costs for new ACT teams and providing flexibility for rural areas where psychiatrists are rare would help develop more teams.

Expand Community Integrated Services (CIS) to include medication management or provision: Community Integrated Services currently has 12 clinicians that includes one Registered Nurse for the approximately two hundred fifty patients on Provisional Discharge status in the community. As mentioned previously, this team provides a wide array of services both to the patients who are under commitment as MI&D and to the county and community partners who support the same individuals. When an individual discharges from Forensic Services, psychiatric care is established with a community provider for ongoing management of their mental health needs. Finding community psychiatric practitioners who are willing to work with MI&D patients is becoming increasingly challenging. Even more so is the difficulty of finding practitioners who are knowledgeable about and willing to comply with the specific expectations of the MI&D commitment including reporting requirements and medication change protocols. Having a dedicated psychiatrist who can help assess, diagnose and treat these individuals with complex needs is a critical void that needs to be fulfilled. It would ensure that this patient population would have an expert who is not only trained to provide care but also be a direct liaison with the Forensic Services Medical Director. Ultimately having a psychiatrist be part of the CIS team would improve the quality, timeliness and continuity of care for individuals residing in the community on Provisional Discharge thus reducing the number of returns to FMHP and opening up beds for those needing immediate inpatient care.

Expand funding for Adult Mental Health Initiatives: Adult mental health initiatives across the state receive funding to fill gaps in service delivery, increase access to services, and reduce hospitalizations. Initiatives use these funds for services including mobile crisis, expansion of clubhouses, peer support, and psychiatry. Continuing to expand this funding is necessary to ensure consistent and effective access to mental health services.

Development of locked Intensive Residential Treatment Services (IRTS) facilities: Minnesota is lacking locked settings for adults with mental illnesses who require a balance of security, 24-hour supervision, and a therapeutic environment. Locked IRTS facilities could be recommended for individuals who have experienced multiple prior commitments, have significant histories of

aggressive behavior, have been declined by multiple other placement types, or are in jail with no other options available. Locked IRTS facilities could also be used when a provisionally discharged patient is struggling in the community. The ability to evaluate medications and adjust if needed and assist in stabilization outside of the FMHP may influence fewer revocations. Despite legislative appropriations, barriers to these facilities remain including reimbursement rates that are too low for these complex patients, finding and hiring trained staff for these complex patients, and continuity of funding following the loss of appropriations in 2027. Supplemental funding from the State of Minnesota may be necessary to create and maintain locked community placements.

Expand Access to Community Resources

In addition, expanding IRTS and ACT teams needs to be alternatives to community residential settings (formerly known as corporate foster care settings or group homes). There are models, such as Rising Cedars, that have proven to be effective in providing the supports needed for people who have been in and out of institutional programs - hospitals, state operated facilities, incarceration. The DHS will no longer allow facilities such as these because they limit having 25% of the building to people on Waivers. The problem is that small community residential settings often do not collect enough funding for 4-5 people to be able to hire people who are mental health professionals. There is an exception process that is difficult to go through. People need choice in housing but many people with more serious mental illnesses want to live in their own apartments but with peers in the building. Recognizing the impact of loneliness and isolation is important. Additionally, because of changes to the waiver where assisted living is only available for people over the age of 55, these types of programs have had to move from customized living to integrated community supports (ICS). One fall out is that meal programs are no longer covered.

Knowing the impact of substance use on psychosis it is important that the state increase funding for First Episode of Psychosis programs which are highly effective in changing the trajectory of people's lives and expanding these programs to people experiencing their first episode of mood disorders, namely bipolar disorders.

Promote and expand the jail consultation services program and look to expand it to meet the growing need for medications in county jails: The Jail Consultation Services Program is currently a two-year pilot. In its first year, it has developed its foundation by building a multidisciplinary team and collected data about the individual needs and barriers facing county jails statewide with respect to treating mentally ill incarcerated individuals. It has also begun partnering with county jails, training its internal clinical staff how to recognize serious mental illness, petition for commitment, and seek a court order for treatment with antipsychotic medications. Concurrently, the team has been developing resources and guides for jail partners, including sample court petitions, advice on testifying for court hearings, and technical training for administration of intramuscular medications. Collaboration with current jail partners (eight as of this writing), as well as communications with the Minnesota Department of Corrections and Minnesota Sheriff's Association, has underscored that this consultation service is valued and highly welcomed in this community. It is critical that this program be renewed and granted permanent funding mechanism to allow for broader statewide availability. Further, ongoing funding of this pilot will help the nature of this consultation continue to develop, including leveraging the expertise of DCT clinical staff to provide direct consultation, and to broaden its

scope to promote additional training. Although it is no one's intent or desire for jails to be responsible for caring for individuals with serious mental illness, it is an unfortunate reality that our jails will at times house some of these individuals, even with diversion initiatives. Accordingly, we must align our allied systems to provide mutual support and share expertise.

iii. Revocation of Provisional Discharge

As individuals adjust to living in the community, they may encounter behavioral or mental health challenges that require a higher level of care than their current placement. Currently, individuals can voluntarily return to FMHP for up to 60 days, or in extreme cases where no safe alternatives exist, a patient's provisional discharge may be revoked, and they are returned to FMHP.

When an individual's provisional discharge is revoked, they must return to FMHP—either to secure or non-secure units based on their care needs—and go through the Special Review Board (SRB) process before progressing again to lower levels of care, and to provisionally discharge. Individuals may voluntarily return for a variety of reasons including a need for medication adjustments or medical care at the forensic nursing home. However, because voluntary returns are limited to 60 days, individuals who do not stabilize within that timeframe often face revocation. A revocation typically results in a prolonged stay at FMHP, often lasting **2 to 5 years,** even when such an extended period may not be clinically necessary. Conversely, a 60-day voluntary return may not always be sufficient for stabilization. Extending the voluntary return timeline beyond 60 days for specific circumstances, such as physical health needs, could provide individuals with the necessary time to stabilize without requiring full revocation.

Stakeholders have raised concerns about the lack of timely support or intervention for individuals experiencing decompensation after provisional discharge. Allowing individuals to return to an evaluation and stabilization facility, as previously recommended, could provide a structured environment for observation, assessment, and treatment—enabling them to safely return to their previous level of care without requiring a revocation. This approach could reduce unnecessary FMHP returns, free up space for those on the waitlist or in acute need of care and improve overall safety by meeting treatment needs quickly.

XI. Conclusion

The duties assigned to the Task Force were long and comprehensive. In a relatively short amount of time, the Task Force members were able to conduct research, gather opinions, and discuss recommendations for addressing the issues before us. Members looked at the issue from a "front door" and a "back door" perspective: How can we prevent more people from being committed as a person who has a mental illness and is dangerous to the public (MI&D) and how can we support those that are committed as MI&D to be served in the least restrictive manner and be returned to their communities as soon as possible.

As with so many task force reports on the mental health system over the last decade, it comes down to funding and resource development. Earlier and effective intervention, easy access to community

resources, and stable supportive housing can lead to fewer people with mental illnesses ending up in our criminal justice system and being committed as MI&D. Additional resources are also needed to help patients return to the community.

The task force also recommended statutory changes to update the MI&D commitment law.

Similar to the recommendations in 2013, this Task Force recommends that the State of Minnesota invest in our state operated and nonprofit community mental health system to build a more robust resource network for persons with chronic, high needs and high level of aggressive behavior. Our hope is that more of the recommendations from this task force will be implemented.

Appendix

A. Minnesota State Statute on MI&D Commitment

253B.18 PERSONS WHO ARE MENTALLY ILL AND DANGEROUS TO THE PUBLIC.

Subdivision 1. **Procedure.** (a) Upon the filing of a petition alleging that a proposed patient is a person who has a mental illness and is dangerous to the public, the court shall hear the petition as provided in sections 253B.07 and 253B.08. If the court finds by clear and convincing evidence that the proposed patient is a person who has a mental illness and is dangerous to the public, it shall commit the person to a secure treatment facility or to a treatment facility or state-operated treatment program willing to accept the patient under commitment. The court shall commit the patient to a secure treatment facility unless the patient or others establish by clear and convincing evidence that a less restrictive state-operated treatment program or treatment facility is available that is consistent with the patient's treatment needs and the requirements of public safety. In any case where the petition was filed immediately following the acquittal of the proposed patient for a crime against the person pursuant to a verdict of not guilty by reason of mental illness, the verdict constitutes evidence that the proposed patient is a person who has a mental illness and is dangerous to the public within the meaning of this section. The proposed patient has the burden of going forward in the presentation of evidence. The standard of proof remains as required by this chapter. Upon commitment, admission procedures shall be carried out pursuant to section 253B.10.

(b) Once a patient is admitted to a treatment facility or state-operated treatment program pursuant to a commitment under this subdivision, treatment must begin regardless of whether a review hearing will be held under subdivision 2.

Subd. 2. **Review; hearing.** (a) A written treatment report shall be filed by the treatment facility or state-operated treatment program with the committing court within 60 days after commitment. If the person is in custody of the commissioner of corrections when the initial commitment is ordered under subdivision 1, the written treatment report must be filed within 60 days after the person is admitted to the state-operated treatment program or treatment facility. The court shall hold a hearing to make a final determination as to whether the patient should remain committed as a person who has a mental illness and is dangerous to the public. The hearing shall be held within the earlier of 14 days of the court's receipt of the written treatment report, or within 90 days of the date of initial commitment or admission, unless otherwise agreed by the parties.

(b) The court may, with agreement of the county attorney and the patient's attorney:

(1) waive the review hearing under this subdivision and immediately order an indeterminate commitment under subdivision 3; or

(2) continue the review hearing for up to one year.

(c) If the court finds that the patient should be committed as a person who poses a risk of harm due to mental illness, but not as a person who has a mental illness and is dangerous to the

public, the court may commit the patient as a person who poses a risk of harm due to mental illness and the court shall deem the patient not to be dangerous to the public for the purposes of subdivisions 4a to 15. Failure of the treatment facility or state-operated treatment program to provide the required treatment report at the end of the 60-day period shall not result in automatic discharge of the patient.

Subd. 3.**Indeterminate commitment.** If the court finds at the final determination hearing held pursuant to subdivision 2 that the patient continues to be a person who has a mental illness and is dangerous to the public, then the court shall order commitment of the proposed patient for an indeterminate period of time. After a final determination that a patient is a person who has a mental illness and is dangerous to the public, the patient shall be transferred, provisionally discharged or discharged, only as provided in this section.

Subd. 4. [Repealed, 1997 c 217 art 1 s 118]

Subd. 4a. **Release on pass; notification.** A patient who has been committed as a person who has a mental illness and is dangerous to the public and who is confined at a secure treatment facility or has been transferred out of a secure treatment facility according to section 253B.18, subdivision 6, shall not be released on a pass unless the pass is part of a pass plan that has been approved by the medical director of the secure treatment facility. The pass plan must have a specific therapeutic purpose consistent with the treatment plan, must be established for a specific period of time, and must have specific levels of liberty delineated. The county case manager must be invited to participate in the development of the pass plan. At least ten days prior to a determination on the plan, the medical director of the secure treatment facility shall notify the designated agency, the committing court, the county attorney of the county of commitment, an interested person, the local law enforcement agency where the facility is located, the county attorney and the local law enforcement agency in the location where the pass is to occur, the petitioner, and the petitioner's counsel of the plan, the nature of the passes proposed, and their right to object to the plan. If any notified person objects prior to the proposed date of implementation, the person shall have an opportunity to appear, personally or in writing, before the medical director of the secure treatment facility, within ten days of the objection, to present grounds for opposing the plan. The pass plan shall not be implemented until the objecting person has been furnished that opportunity. Nothing in this subdivision shall be construed to give a patient an affirmative right to a pass plan.

Subd. 4b. **Pass-eligible status; notification.** (a) The following patients committed to a secure treatment facility shall not be placed on pass-eligible status unless that status has been approved by the medical director of the secure treatment facility:

> (1) a patient who has been committed as a person who has a mental illness and is dangerous to the public and who:

(i) was found incompetent to proceed to trial for a felony or was found not guilty by reason of mental illness of a felony immediately prior to the filing of the commitment petition;

(ii) was convicted of a felony immediately prior to or during commitment as a person who has a mental illness and is dangerous to the public; or

(iii) is subject to a commitment to the commissioner of corrections; and

(2) a patient who has been committed as a psychopathic personality, a sexually psychopathic personality, or a sexually dangerous person.

(b) At least ten days prior to a determination on the status, the medical director of the secure treatment facility shall notify the committing court, the county attorney of the county of commitment, the designated agency, an interested person, the petitioner, and the petitioner's counsel of the proposed status, and their right to request review by the special review board. If within ten days of receiving notice any notified person requests review by filing a notice of objection with the executive board and the head of the secure treatment facility, a hearing shall be held before the special review board. The proposed status shall not be implemented unless it receives a favorable recommendation by a majority of the special review board and approval by the executive board. The order of the executive board is appealable as provided in section 253B.19.

(c) Nothing in this subdivision shall be construed to give a patient an affirmative right to seek pass-eligible status from the special review board.

Subd. 4c. **Special review board.** (a) The executive board shall establish one or more panels of a special review board. The special review board shall consist of three members experienced in the field of mental illness. One member of each special review board panel shall be a psychiatrist or a doctoral level psychologist with forensic experience and one member shall be an attorney. No member shall be affiliated with Direct Care and Treatment. The special review board shall meet at least every six months and at the call of the executive board. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. Patients may be transferred by the executive board between secure treatment facilities without a special review board hearing.

Members of the special review board shall receive compensation and reimbursement for expenses as established by the executive board.

(b) For purposes of this section, "reduction in custody" means transfer from a secure treatment facility, discharge, and provisional discharge.

(c) The special review board must review each denied petition under subdivision 5 for barriers and obstacles preventing the patient from progressing in treatment. Based on the cases before the special review board in the previous year, the special review board shall provide to the

executive board an annual summation of the barriers to treatment progress, and recommendations to achieve the common goal of making progress in treatment.

(d) A petition filed by a person committed as a person who has a mental illness and is dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253D, or committed as both a person who has a mental illness and is dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253D.27.

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for a reduction in custody or revocation of provisional discharge shall be filed with the executive board and may be filed by the patient or by the head of the treatment facility or state-operated treatment program to which the person was committed or has been transferred. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The head of the state-operated treatment program or head of the treatment facility must schedule a hearing before the special review board for any patient who has not appeared before the special review board in the previous three years and schedule a hearing at least every three years thereafter. The medical director of the secure treatment facility may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the executive board of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the executive board at least 21 days before the hearing. The special review board shall provide the executive board with written findings of fact and recommendations within 21 days of the hearing. The executive board shall issue an order no later than 14 days after receiving the recommendation of the special review board. A copy of the order shall be mailed to every person entitled to statutory notice of the hearing within five days after the order is signed. No order by the executive board shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the executive board agree that it may become effective sooner.

(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the executive board. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the executive board.

(d) Prior to the final decision by the executive board, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and executive board must consider any statements received from victims under subdivision 5a.

Subd. 5a. **Victim notification of petition and release; right to submit statement.** (a) As used in this subdivision:

(1) "crime" has the meaning given to "violent crime" in section 609.1095, and includes criminal sexual conduct in the fifth degree and offenses within the definition of "crime against the person" in section 253B.02, subdivision 4e, and also includes offenses listed in section 253D.02, subdivision 8, paragraph (b), regardless of whether they are sexually motivated;

(2) "victim" means a person who has incurred loss or harm as a result of a crime the behavior for which forms the basis for a commitment under this section or chapter 253D, and includes the family members, guardian, conservator, or custodian of a minor, incompetent, incapacitated, or deceased person; and

(3) "convicted" and "conviction" have the meanings given in section 609.02, subdivision 5, and also include juvenile court adjudications, findings under Minnesota Rules of Criminal Procedure, rule 20.02, that the elements of a crime have been proved, and findings in commitment cases under this section or chapter 253D that an act or acts constituting a crime occurred or were part of their course of harmful sexual conduct.

(b) A county attorney who files a petition to commit a person under this section or chapter 253D shall make a reasonable effort to provide prompt notice of filing the petition to any victim of a crime for which the person was convicted. In addition, the county attorney shall make a reasonable effort to promptly notify the victim of the resolution of the petition and the process for requesting notification of an individual's change in status as provided in paragraph (c).

(c) A victim may request notification of an individual's discharge or release as provided in paragraph (d) by submitting a written request for notification to the executive director of the facility in which the individual is confined. The Department of Corrections or a county attorney who receives a request for notification from a victim under this section shall promptly forward the request to the executive director of the treatment facility in which the individual is confined.

(d) Before provisionally discharging, discharging, granting pass-eligible status, approving a pass plan, or otherwise permanently or temporarily releasing a person committed under this section from a state-operated treatment program or treatment facility, the head of the state-operated treatment program or head of the treatment facility shall make a reasonable effort to notify any victim of a crime for which the person was convicted that the person may be discharged or released

and that the victim has a right to submit a written statement regarding decisions of the medical director of the secure treatment facility, special review board, or executive board with respect to the person. To the extent possible, the notice must be provided at least 14 days before any special review board hearing or before a determination on a pass plan. Notwithstanding section 611A.06, subdivision 4, the executive board shall provide the judicial appeal panel with victim information in order to comply with the provisions of this section. The judicial appeal panel shall ensure that the data on victims remains private as provided for in section 611A.06, subdivision 4. These notices shall only be provided to victims who have submitted a written request for notification as provided in paragraph (c).

(e) The rights under this subdivision are in addition to rights available to a victim under chapter 611A. This provision does not give a victim all the rights of a "notified person" or a person "entitled to statutory notice" under subdivision 4a, 4b, or 5 or section 253D.14.

Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be transferred out of a secure treatment facility unless it appears to the satisfaction of the executive board, after a hearing and favorable recommendation by a majority of the special review board, that the transfer is appropriate. Transfer may be to another state-operated treatment program. In those instances where a commitment also exists to the Department of Corrections, transfer may be to a facility designated by the commissioner of corrections.

(b) The following factors must be considered in determining whether a transfer is appropriate:

(1) the person's clinical progress and present treatment needs;

(2) the need for security to accomplish continuing treatment;

(3) the need for continued institutionalization;

(4) which facility can best meet the person's needs; and

(5) whether transfer can be accomplished with a reasonable degree of safety for the public.

(c) If a committed person has been transferred out of a secure treatment facility pursuant to this subdivision, that committed person may voluntarily return to a secure treatment facility for a period of up to 60 days with the consent of the head of the treatment facility.

(d) If the committed person is not returned to the original, nonsecure transfer facility within 60 days of being readmitted to a secure treatment facility, the transfer is revoked, and the committed person must remain in a secure treatment facility. The committed person must immediately be notified in writing of the revocation.

(e) Within 15 days of receiving notice of the revocation, the committed person may petition the special review board for a review of the revocation. The special review board shall review the

circumstances of the revocation and shall recommend to the executive board whether or not the revocation should be upheld. The special review board may also recommend a new transfer at the time of the revocation hearing.

(f) No action by the special review board is required if the transfer has not been revoked and the committed person is returned to the original, nonsecure transfer facility with no substantive change to the conditions of the transfer ordered under this subdivision.

(g) The head of the treatment facility may revoke a transfer made under this subdivision and require a committed person to return to a secure treatment facility if:

(1) remaining in a nonsecure setting does not provide a reasonable degree of safety to the committed person or others; or

(2) the committed person has regressed clinically and the facility to which the committed person was transferred does not meet the committed person's needs.

(h) Upon the revocation of the transfer, the committed person must be immediately returned to a secure treatment facility. A report documenting the reasons for revocation must be issued by the head of the treatment facility within seven days after the committed person is returned to the secure treatment facility. Advance notice to the committed person of the revocation is not required.

(i) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report must be served upon the committed person, the committed person's counsel, and the designated agency. The report must outline the specific reasons for the revocation, including but not limited to the specific facts upon which the revocation is based.

(j) If a committed person's transfer is revoked, the committed person may re-petition for transfer according to subdivision 5.

(k) A committed person aggrieved by a transfer revocation decision may petition the special review board within seven business days after receipt of the revocation report for a review of the revocation. The matter must be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and, after considering the factors in paragraph (b), shall recommend to the executive board whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure treatment facility at the time of the revocation hearing.

Subd. 7. **Provisional discharge.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be provisionally discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board, that the patient is capable of making an acceptable adjustment to open society.

(b) The following factors are to be considered in determining whether a provisional discharge shall be recommended: (1) whether the patient's course of hospitalization and present mental status indicate there is no longer a need for treatment and supervision in the patient's current treatment setting; and (2) whether the conditions of the provisional discharge plan will provide a reasonable degree of protection to the public and will enable the patient to adjust successfully to the community.

Subd. 8. **Provisional discharge plan.** A provisional discharge plan shall be developed, implemented, and monitored by the designated agency in conjunction with the patient, the treatment facility or state-operated treatment program to which the person is committed, and other appropriate persons. The designated agency shall, at least quarterly, review the provisional discharge plan with the patient and submit a written report to the facility or program concerning the patient's status and compliance with each term of the provisional discharge plan.

Subd. 9. **Provisional discharge; review.** A provisional discharge pursuant to this section shall not automatically terminate. A full discharge shall occur only as provided in subdivision 15. The executive board shall notify the patient that the terms of a provisional discharge continue unless the patient requests and is granted a change in the conditions of provisional discharge or unless the patient petitions the special review board for a full discharge and the discharge is granted.

Subd. 10. **Provisional discharge; revocation.** (a) The head of the treatment facility or state-operated treatment program from which the person was provisionally discharged may revoke a provisional discharge if any of the following grounds exist:

(i) the patient has departed from the conditions of the provisional discharge plan;

(ii) the patient is exhibiting signs of a mental illness which may require in-hospital evaluation or treatment; or

(iii) the patient is exhibiting behavior which may be dangerous to self or others.

(b) Revocation shall be commenced by a notice of intent to revoke provisional discharge, which shall be served upon the patient, patient's counsel, and the designated agency. The notice shall set forth the grounds upon which the intention to revoke is based and shall inform the patient of the rights of a patient under this chapter.

(c) In all nonemergency situations, prior to revoking a provisional discharge, the head of the facility or program shall obtain a revocation report from the designated agency outlining the specific reasons for recommending the revocation, including but not limited to the specific facts upon which the revocation recommendation is based.

(d) The patient must be provided a copy of the revocation report and informed orally and in writing of the rights of a patient under this section.

Subd. 11. **Exceptions.** If an emergency exists, the head of the treatment facility or state-operated treatment program may revoke the provisional discharge and, either orally or in writing, order that the patient be immediately returned to the facility or program. In emergency cases, a revocation report shall be submitted by the designated agency within seven days after the patient is returned to the facility or program.

Subd. 12. **Return of patient.** After revocation of a provisional discharge or if the patient is absent without authorization, the head of the treatment facility or state-operated treatment program may request the patient to return to the facility or program voluntarily. The head of the treatment facility or state-operated treatment program may request a health officer or a peace officer to return the patient to the facility or program. If a voluntary return is not arranged, the head of the treatment facility or state-operated treatment program shall inform the committing court of the revocation or absence and the court shall direct a health or peace officer in the county where the patient is located to return the patient to the facility or program or to another state-operated treatment program or to another treatment facility willing to accept the patient. The expense of returning the patient to a state-operated treatment program shall be paid by the executive board unless paid by the patient or other persons on the patient's behalf.

Subd. 13. **Appeal.** Any patient aggrieved by a revocation decision or any interested person may petition the special review board within seven days, exclusive of Saturdays, Sundays, and legal holidays, after receipt of the revocation report for a review of the revocation. The special review board shall schedule the matter within 30 days. The special review board shall review the circumstances leading to the revocation and shall recommend to the executive board whether or not the revocation shall be upheld. The special review board may also recommend a new provisional discharge at the time of a revocation hearing.

Subd. 14. **Voluntary readmission.** (a) With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return from provisional discharge for a period of up to 30 days, or up to 60 days with the consent of the designated agency. If the patient is not returned to provisional discharge status within 60 days, the provisional discharge is revoked. Within 15 days of receiving notice of the change in status, the patient may request a review of the matter before the special review board. The special review board may recommend a return to a provisional discharge status.

(b) The treatment facility or state-operated treatment program is not required to petition for a further review by the special review board unless the patient's return to the community results in substantive change to the existing provisional discharge plan. All the terms and conditions of the provisional discharge order shall remain unchanged if the patient is released again.

Subd. 15. **Discharge.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board, that the

patient is capable of making an acceptable adjustment to open society, is no longer dangerous to the public, and is no longer in need of treatment and supervision.

(b) In determining whether a discharge shall be recommended, the special review board and executive board shall consider whether specific conditions exist to provide a reasonable degree of protection to the public and to assist the patient in adjusting to the community. If the desired conditions do not exist, the discharge shall not be granted.

History:

1982 c 581 s 18; 1983 c 216 art 1 s 83; 1983 c 251 s 19-22; 1983 c 348 s 11; 1984 c 623 s 6,7; 1984 c 654 art 5 s 58; 1986 c 444; 1991 c 148 s 3,4; 1992 c 571 art 3 s 4; 1997 c 217 art 1 s 86-99; 1998 c 313 s 20,21; 1999 c 118 s 3-5; 2000 c 260 s 97; 2002 c 221 s 29-36; 2005 c 136 art 3 s 19,20; art 5 s 3; 2008 c 326 art 2 s 7-9; 2010 c 300 s 24,25; 2012 c 155 s 6; 2013 c 49 s 22; 2013 c 59 art 1 s 1; 2015 c 71 art 2 s 18,19; 2016 c 158 art 1 s 103; 2018 c 194 s 1; 1Sp2020 c 2 art 6 s 82-97,123; 1Sp2021 c 11 art 6 s 1; 2022 c 98 art 10 s 1; 2024 c 79 art 5 s 11-17; art 10 s 3; 2024 c 123 art 2 s 3; 2024 c 125 art 5 s 43; 2024 c 127 art 50 s 43; 2025 c 38 art 3 s 44

B. Other State's Commitment Laws

ALABAMA

Outpatient treatment; burden of proof.

(a) A respondent may be committed to outpatient treatment if the probate court, based upon clear and convincing evidence, finds all of the following:

(1) The respondent has a mental illness or a mental illness with a secondary diagnosis of co-occurring substance use disorder.

(2) As a result of the mental illness or mental illness with secondary diagnosis of co-occurring substance use disorder, the respondent, if not treated, will suffer mental distress and experience deterioration of the ability to function independently.

(3) The respondent is unable to maintain consistent engagement with outpatient treatment on a voluntary basis, as demonstrated by either of the following:

a. The respondent's actions occurring within the two-year period immediately preceding the hearing.

b. Specific aspects of the respondent's clinical condition that significantly impair the respondent's ability to consistently make rational and informed decisions as to whether to participate in treatment for mental illness.

(b) Upon a recommendation made by the designated mental health facility currently providing outpatient treatment that the respondent's outpatient commitment order should be renewed, a probate court may enter an order to renew the commitment order upon the expiration of time allotted for treatment by the original outpatient treatment order if the judge of probate finds, based upon clear and convincing evidence, all of the following:

(1) The respondent has a mental illness or a mental illness with a secondary diagnosis of co-occurring substance use disorder.

(2) As a result of the mental illness or mental illness with a secondary diagnosis of co-occurring substance use disorder, the respondent, if treatment is not continued, will suffer mental distress and experience deterioration of the ability to function independently.

(3) The respondent remains unable to maintain consistent engagement with outpatient treatment on a voluntary basis.

Code of Ala. § 22-52-10.2

ALASKA

Initial involuntary commitment procedures.

(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520 — 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

(c) When a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility admits a minor respondent under this section, the center or facility shall inform the parent or guardian of the location of the minor as soon as possible after the arrival of the minor at the center or facility. When a crisis stabilization center, crisis residential center, evaluation facility, or treatment facility admits an adult for whom a guardian has been appointed and the center or facility is aware of the appointment, the center or facility shall inform the guardian of the location of the adult as soon as possible after the arrival of the adult at the center or facility.

Alaska Stat. § 47.30.700

ARIZONA

Petition for treatment. [Full section not reflected. See hyperlink]

A. The petition for court-ordered treatment shall allege:

1. That the patient is in need of a period of treatment because the patient, as a result of mental disorder, is a danger to self or to others or has a persistent or acute disability or a grave disability.
2. The treatment alternatives that are appropriate or available.
3. That the patient is unwilling to accept or incapable of accepting treatment voluntarily.

B. The petition shall be accompanied by the affidavits of the two physicians who participated in the evaluation and by the affidavit of the applicant for the evaluation, if any. In a county with a population of less than five hundred thousand persons, the petition may be accompanied by the affidavits of one physician and either one physician assistant who is experienced in psychiatric matters or one psychiatric and mental health nurse practitioner who conducted an independent evaluation and by the affidavit of the applicant for the evaluation, if any. The affidavits of the physicians or other health professionals shall describe in detail the behavior that indicates that the person, as a result of mental disorder, is a danger

to self or to others or has a persistent or acute disability or a grave disability and shall be based on the physician's or other health professional's observations of the patient and study of information about the patient. A summary of the facts that support the allegations of the petition shall be included. The affidavit shall also include any of the results of the physical examination of the patient if relevant to the patient's psychiatric condition.

C. The petition shall request the court to issue an order requiring the person to undergo a period of treatment. If a prosecutor filed a petition pursuant to section 13-4517, the petition must be accompanied by any known criminal history of the person and any previous findings of incompetency.

D. If the petition requests the court to determine that the patient is chronically resistant to treatment pursuant to section 36-550.09, the petition shall allege the facts that support the request.

A.R.S. § 36-533

ARKANSAS

Petition for involuntary commitment.

(a) Any person having any reason to believe that a person is homicidal, suicidal, or gravely disabled may file a petition with the clerk of the circuit court of the county in which the person alleged to be addicted to alcohol or other drugs resides or is detained and be represented by the prosecuting attorney or by any other licensed attorney within the State of Arkansas.

(b) The petition for involuntary commitment shall:

(1) State whether the person is believed to be homicidal, suicidal, or gravely disabled;

(2) Describe the conduct, signs, and symptoms upon which the petition is based. The descriptions shall be limited to facts within the petitioner's personal knowledge;

(3) Contain the names and addresses of any witnesses having knowledge relevant to the allegations contained in the petition; and

(4) Contain a specific prayer for commitment of the person to an appropriate designated receiving facility or program, including residential inpatient or outpatient treatment for his or her addiction to alcohol or other drugs.

(c) Personal service of the petition shall be made in accordance with the Arkansas Rules of Civil Procedure and shall include:

(1) A notice of the date, time, and place of hearing; and

(2) A notice that if the person shall fail to appear, the court shall issue an order directing a law enforcement officer to place the person in custody for the purpose of a hearing unless the court finds that the person is unable to appear by reason of physical infirmity or that the

appearance would be detrimental to his or her health, well-being, or treatment.

Arkansas Code § 20-64-815

CALIFORNIA

Detention upon probable cause; Assessment; Alternative services; Application for admission; Personal property of person taken into custody; Advisement, record of advisement

[Full section not reflected. See hyperlink]

(a) When a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. The 72-hour period begins at the time when the person is first detained. At a minimum, assessment, as defined in Section 5150.4, and evaluation, as defined in subdivision (a) of Section 5008, shall be conducted and provided on an ongoing basis. Crisis intervention, as defined in subdivision (e) of Section 5008, may be provided concurrently with assessment, evaluation, or any other service.

(b) When determining if a person should be taken into custody pursuant to subdivision (a), the individual making that determination shall apply the provisions of Section 5150.05, and shall not be limited to consideration of the danger of imminent harm.

Cal Wel & Inst Code § 5150

COLORADO

Involuntary commitment of a person with a substance use disorder. [Full section not reflected. See hyperlink]

(1) The court may commit a person to the custody of the BHA upon the petition of the person's spouse or guardian, a relative, a physician, an advanced practice registered nurse, the administrator in charge of an approved treatment facility, a certified peace officer, or any other responsible person. The petition must allege that the person has a substance use disorder and that the person has threatened or attempted to inflict or inflicted physical harm on the person's self or on another and that unless committed, the person is likely to inflict physical harm on the person's self or on another or that the person is incapacitated by substances. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition must be accompanied by a certificate of a licensed physician who has examined the person within ten days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal must be alleged in the petition, or an examination cannot be made of the person due to the person's condition. The certificate must set forth the physician's findings in support of the petition's allegations.

(2) A court shall not accept a petition submitted pursuant to subsection (1) of this section unless there is documentation of the refusal by the person to be committed to accessible and affordable voluntary treatment. The documentation may include, but is not limited to, notations in the person's medical or law enforcement records or statements by a physician, advanced practice registered nurse, or witness.

C.R.S. 27-81-112

CONNECTICUT

Hearing on commitment application. Notice. Rights of respondent. Examination by physicians. Order of commitment. Election of voluntary status prior to adjudication. Review of confinement. [Full section not reflected. See hyperlink]

(3) If the court finds by clear and convincing evidence that the respondent has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, the court shall make an order for his or her commitment, considering whether or not a less restrictive placement is available, to a hospital for psychiatric disabilities to be named in such order, there to be confined for the period of the duration of such psychiatric disabilities or until he or she is discharged or converted to voluntary status pursuant to section 17a-506 in due course of law. Such court order shall further command some suitable person to convey such person to such hospital for psychiatric disabilities and deliver him or her, with a copy of such order and of such certificates, to the keeper thereof. In appointing a person to execute such order, the court shall give preference to a near relative or friend of the person with psychiatric disabilities, so far as the court deems it practicable and judicious. Notice of any action taken by the court shall be given to the respondent and his or her attorney, if any, in such manner as the court concludes would be appropriate under the circumstances.

Conn. Gen. Stat. § 17a-498

DELAWARE

Emergency detention of a person with a mental condition; justification; procedure.

[Full section not reflected. See hyperlink]

(a) Any person who believes that another person's behavior is both the product of a mental condition and is dangerous to self or dangerous to others may notify a peace officer or a credentialed mental health screener or juvenile mental health screener and request assistance for said person. Upon the observation by a peace officer or a credentialed mental health screener or juvenile mental health screener that such individual with an apparent mental condition likely constitutes a danger to self or danger to others, such person with an apparent mental condition shall be promptly taken into custody for the purpose of an emergency detention by any peace officer in the State without the necessity of a warrant. Any such observation shall be described in writing and shall include a description of the behavior and symptoms which led the peace officer or credentialed mental health screener or juvenile mental health screener to such conclusion. The documentation required herein shall set forth any known relationship between the person making the complaint and any other connection to the person with an apparent mental condition and, if known, the name of the nearest known relative.

16 Del. C. § 5004

DISTRICT OF COLUMBIA

Commitment by Court order.

[Full section not reflected. See hyperlink]

(a) The Court may, on a petition of the Corporation Counsel on behalf of the Mayor, filed and heard before the period of detention for detoxification and diagnosis expires, order a person to be committed to the custody of the Mayor for inpatient treatment and care if: (1) the Court determines that the person is a chronic alcoholic and that as a result of chronic or acute intoxication such person is in immediate danger of substantial physical harm; and (2) such person received notice of the filing of such petition within a reasonable time before the hearing held by the Court. The period of such commitment, computed from the date of admission to a detoxification center, shall not exceed: (1) thirty days in the case of the first or second such commitment within any 24-month period; or (2) ninety days in the case of the third or subsequent such commitment within any 24-month period.

D.C. Code § 24–607

FLORIDA

Involuntary inpatient placement and involuntary outpatient services.

[Full section not reflected. See hyperlink]

(2) Criteria for involuntary services. A person may be ordered by a court to be provided involuntary services upon a finding of the court, by clear and convincing evidence, that the person meets the following criteria:

(a) Involuntary outpatient services. A person ordered to involuntary outpatient services must meet the following criteria:

1. The person has a mental illness and, because of his or her mental illness:

a. He or she is unlikely to voluntarily participate in a recommended service plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary; or

b. Is unable to determine for himself or herself whether services are necessary.

2. The person is unlikely to survive safely in the community without supervision, based on a clinical determination.

3. The person has a history of lack of compliance with treatment for mental illness.

4. In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s.394.463(1).

5. It is likely that the person will benefit from involuntary outpatient services.

6. All available less restrictive alternatives that would offer an opportunity for improvement of the person's condition have been deemed to be inappropriate or unavailable.

Fla. Stat. § 394.467

GEORGIA

Emergency admission of persons arrested for penal offenses; report by officer; entry of report into clinical record.

(a)

(1) A peace officer may take any person to a physician within the county or an adjoining county for emergency examination by the physician, as provided in Code Section 37-3-41, or directly to an emergency receiving facility if (i) the person is committing a penal offense, and (ii) the peace officer has probable cause for believing that the person is a mentally ill person requiring involuntary treatment. The peace officer need not formally tender charges against the individual prior to taking the individual to a physician or an emergency receiving facility under this Code section. The peace officer shall execute a written report detailing the circumstances under which the person was taken into custody; and this report shall be made a part of the patient's clinical record.

(2) A peace officer may take any person to an emergency receiving facility if: (i) the peace officer has probable cause to believe that the person is a mentally ill person requiring

involuntary treatment; and (ii) the peace officer has consulted either in-person or via telephone or telehealth with a physician, as provided in Code Section 37-3-41, and the physician authorizes the peace officer to transport the individual for an evaluation. To authorize transport for evaluation, the physician shall determine, based on facts available regarding the person's condition, including the report of the peace officer and the physician's communications with the person or witnesses, that there is probable cause to believe that the person needs an examination to determine if the person requires involuntary treatment. The peace officer shall execute a written report detailing the circumstances under which the person is detained; and this report shall be made a part of the patient's clinical record.

(b) Any psychologist may perform any act specified by this Code section to be performed by a physician. Any reference in any part of this chapter to a physician acting under this Code section shall be deemed to refer equally to a psychologist acting under this Code section. For purposes of this subsection, the term "psychologist" means any person authorized under the laws of this state to practice as a licensed psychologist.

O.C.G.A. § 37-3-42

HAWAII

Civil commitment for substance abuse outpatient treatment. Petition.

Any family member may petition the family court for an order requiring a respondent to enter into an outpatient treatment program for substance abuse. The petition shall be in writing under penalty of perjury and include facts relating to:

(1) The conduct of the respondent that indicates substance abuse or addiction;

(2) The respondent's history of substance abuse, treatment, and relapse;

(3) The effects of the respondent's conduct on the family;

(4) The petitioner's good faith belief that the respondent poses an imminent danger to self or to others if the respondent does not receive treatment;

(5) The availability of treatment and financial resources to pay for treatment; and

(6) Any other reason for seeking court intervention.

HRS § 334-142

IDAHO

Commitment to department director upon court order — Judicial procedure.

[Full section not reflected. See hyperlink]

(1) Proceedings for the involuntary care and treatment of mentally ill persons by the department of health and welfare may be commenced by the filing of a written application with a court of competent jurisdiction by a friend, relative, spouse or guardian of the proposed patient, by a licensed physician, by a physician assistant or advanced practice registered nurse practicing in a hospital, by a prosecuting attorney or other public official of a municipality, county or of the state of Idaho, or by the director of any facility in which such patient may be.

(2) The application shall state the name and last known address of the proposed patient; the name and address of the spouse, guardian, next of kin, or friend of the proposed patient; whether the proposed patient can be cared for privately in the event commitment is not ordered; whether the proposed patient is, at the time of the application, a voluntary patient; whether the proposed patient has applied for release pursuant to section 66-320, Idaho Code; and a simple and precise statement of the facts showing that the proposed patient is mentally ill and either likely to injure himself or others or is gravely disabled due to mental illness.
(3) Any such application shall be accompanied by a certificate of a designated examiner stating that he has personally examined the proposed patient within the last fourteen (14) days and is of the opinion that the proposed patient is: (i) mentally ill; (ii) likely to injure himself or others or is gravely disabled due to mental illness; and (iii) lacks capacity to make informed decisions about treatment;
or a written statement by the applicant that the proposed patient has refused to submit to examination by a designated examiner.
Idaho Code § 66-329

ILLINOIS
Involuntary admission; petition.
(a) When a person is asserted to be subject to involuntary admission on an inpatient basis and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present. The petition may be prepared by the facility director of the facility.
(b) The petition shall include all of the following:

1. A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence.
2. The name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If the petitioner is unable to supply any such names and addresses, the petitioner shall state that diligent inquiry was made to learn this information and specify the steps taken.
3. The petitioner's relationship to the respondent and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the respondent. If the petitioner has a legal or financial interest in the matter or is involved in litigation with the respondent, a statement of why the petitioner believes it would not be practicable or possible for someone else to be the petitioner.

4. The names, addresses and phone numbers of the witnesses by which the facts asserted may be proved. [...]

(c) Knowingly making a material false statement in the petition is a Class A misdemeanor.

405 ILCS 5/3-601

MAINE

Reception of involuntary patients.

[Full section not reflected. See hyperlink]

3. **Involuntary treatment.** Except for involuntary treatment ordered pursuant to the provisions of section 3864, subsection 7-A, involuntary treatment of a patient at a designated nonstate mental health institution or a state mental health institute who is an involuntarily committed patient under the provisions of this subchapter may be ordered and administered only in conformance with the provisions of this subsection. For the purposes of this subsection, involuntary treatment is limited to medication for the treatment of mental illness and laboratory testing and medication for the monitoring and management of side effects.

A. If the patient's primary treating physician proposes a treatment that the physician, in the exercise of professional judgment, believes is in the best interest of the patient and if the patient lacks clinical capacity to give informed consent to the proposed treatment and the patient is unwilling or unable to comply with the proposed treatment, the patient's primary treating physician shall request in writing a clinical review of the proposed treatment by a clinical review panel. For a patient at a state mental health institute, the request must be made to the superintendent of the institute or the designee of the superintendent. For a patient at a designated nonstate mental health institution, the request must be made to the chief administrative officer or the designee of the chief administrative officer.

34-B M.R.S. § 3861

MASSACHUSETTS

Commitment — Procedure for Persons with Alcohol Use Disorder.

[Full section not reflected. See hyperlink]

For the purposes of this section the following terms shall, unless the context clearly requires otherwise, have the following meanings:

"Alcohol use disorder", the chronic or habitual consumption of alcoholic beverages by a person to the extent that (1) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning, or (2) the person has lost the power of self-control over the use of such beverages.

"Facility", a public or private facility that provides care and treatment for a person with an alcohol or substance use disorder.

"Substance use disorder", the chronic or habitual consumption or ingestion of controlled substances or intentional inhalation of toxic vapors by a person to the extent that: (i) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning; or (ii) the person has lost the power of self-control over the use of such controlled substances or toxic vapors.

Any police officer, physician, spouse, blood relative, guardian or court official may petition in writing any district court or any division of the juvenile court department for an order of commitment of a person whom he has reason to believe has an alcohol or substance use disorder. Upon receipt of a petition for an order of commitment of a person and any sworn statements the court may request from the petitioner, the court shall immediately schedule a hearing on the petition and shall cause a summons and a copy of the application to be served upon the person in the manner provided by section twenty-five of chapter two hundred and seventy-six. In the event of the person's failure to appear at the time summoned, the court may issue a warrant for the person's arrest. Upon presentation of such a petition, if there are reasonable grounds to believe that such person will not appear and that any further delay in the proceedings would present an immediate danger to the physical well-being of the respondent, said court may issue a warrant for the apprehension and appearance of such person before it. If such person is not immediately presented before a judge of the district court, the warrant shall continue day after day for up to 5 consecutive days, excluding Saturdays, Sundays and legal holidays, or until such time as the person is presented to the court, whichever is sooner; provided, however that an arrest on such warrant shall not be made unless the person may be presented immediately before a judge of the district court. The person shall have the right to be represented by legal counsel and may present independent expert or other testimony. If the court finds the person indigent, it shall immediately appoint counsel. The court shall order examination by a qualified physician, a qualified psychologist or a qualified social worker.
ALM GL ch. 123 § 35

MICHIGAN

"Person requiring treatment" defined; exception.

(1) As used in this chapter, "person requiring treatment" means (a), (b), or (c):

(a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

(b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

(c) An individual who has mental illness, whose judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

MCLS § 330.1401

NEW YORK

Involuntary admission on medical certification. See additional relevant code sections here.

(a) The director of a hospital may receive and retain therein as a patient any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians, accompanied by an application for the admission of such person. The examination may be conducted jointly but each examining physician shall execute a separate certificate.

(b) Such application must have been executed within ten days prior to such admission. It may be executed by any one of the following:

1. any person with whom the person alleged to be mentally ill resides.
2. the father or mother, husband or wife, brother or sister, or the child of any such person or the nearest available relative.
3. the committee of such person.
4. an officer of any public or well recognized charitable institution or agency or home, including but not limited to the superintendent of a correctional facility, as such term is defined in paragraph (a) of subdivision four of section two of the correction law, in whose institution the person alleged to be mentally ill resides and the designee authorized by the commissioner of the department of corrections and community supervision responsible for community supervision in the region where such person alleged to be mentally ill has been released to any form of supervision following incarceration.
5. the director of community services or social services official, as defined in the social services law, of the city or county in which any such person may be.
6. the director of the hospital or of a general hospital, as defined in article twenty-eight of the public health law, in which the patient is hospitalized.
7. the director or person in charge of a facility providing care to alcoholics, or substance abusers or substance dependent persons.
8. the director of the division for youth, acting in accordance with the provisions of section five hundred nine of the executive law.
9. subject to the terms of any court order or any instrument executed pursuant to section three hundred eighty-four-a of the social services law, a social services official or authorized agency which has, pursuant to the social services law, care and custody or

guardianship and custody of a child over the age of sixteen.

10. subject to the terms of any court order a person or entity having custody of a child pursuant to an order issued pursuant to section seven hundred fifty-six or one thousand fifty-five of the family court act.

11. a qualified psychiatrist who is either supervising the treatment of or treating such person for a mental illness in a facility licensed or operated by the office of mental health.

(c) Such application shall contain a statement of the facts upon which the allegation of mental illness and need for care and treatment are based and shall be executed under penalty of perjury but shall not require the signature of a notary public thereon.

(d) Before an examining physician completes the certificate of examination of a person for involuntary care and treatment, he shall consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization. If the examining physician knows that the person he is examining for involuntary care and treatment has been under prior treatment, he shall, insofar as possible, consult with the physician or psychologist furnishing such prior treatment prior to completing his certificate. Nothing in this section shall prohibit or invalidate any involuntary admission made in accordance with the provisions of this chapter.

(e) The director of the hospital where such person is brought shall cause such person to be examined forthwith by a physician who shall be a member of the psychiatric staff of such hospital other than the original examining physicians whose certificate or certificates accompanied the application and, if such person is found to be in need of involuntary care and treatment, he may be admitted thereto as a patient as herein provided.

(f) Following admission to a hospital, no patient may be sent to another hospital by any form of involuntary admission unless the mental hygiene legal service has been given notice thereof.

(g) Applications for involuntary admission of patients to residential treatment facilities for children and youth or transfer of involuntarily admitted patients to such facilities may be reviewed by the office or commissioner's designee serving such facility in accordance with section 9.51 of this article and in consultation with the residential treatment facility receiving an involuntary admission or transfer of an involuntarily admitted patient.

(h) If a person is examined and determined to be mentally ill, the fact that such person suffers from alcohol or substance abuse shall not preclude commitment under this section.

(i) After an application for the admission of a person has been completed and both physicians have

examined such person and separately certified that he or she is mentally ill and in need of involuntary care and treatment in a hospital, either physician is authorized to request peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department, to take into custody and transport such person to a hospital for determination by the director whether such person qualifies for admission pursuant to this section. Upon the request of either physician an ambulance service, as defined by subdivision two of section three thousand one of the public health law, is authorized to transport such person to a hospital for determination by the director whether such person qualifies for admission pursuant to this section.
NY CLS Men Hyg § 9.27

TEXAS

Order for Temporary Inpatient Mental Health Services.

[Full section not reflected. See hyperlink]

(a) The judge may order a proposed patient to receive court-ordered temporary inpatient mental health services only if the judge or jury finds, from clear and convincing evidence, that:

(1) the proposed patient is a person with mental illness; and

(2) as a result of that mental illness the proposed patient:

(A) is likely to cause serious harm to the proposed patient;

(B) is likely to cause serious harm to others; or

(C) is:

(i) suffering severe and abnormal mental, emotional, or physical distress;

(ii) experiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health, or safety; and

(iii) unable to make a rational and informed decision as to whether or not to submit to treatment. […]

Tex. Health & Safety Code § 574.034

WISCONSIN

Involuntary commitment for treatment.

[Full section not reflected. See hyperlink]

1. The individual is mentally ill or, except as provided under subd. 2. e., drug dependent or developmentally disabled and is a proper subject for treatment.

2. The individual is dangerous because he or she does any of the following:

a. Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.

b. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm. [...]

c. Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself or other individuals. [...]

d. Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation, or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. [...]

e. For an individual, other than an individual who is alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. [...]

Wis. Stat. § 51.20

C. Minnesota Direct Care and Treatment Statute

246C.06 EXECUTIVE BOARD; MEMBERSHIP; GOVERNANCE.

Subdivision 1. **Establishment.** The Direct Care and Treatment executive board is established.

Subd. 2. **Membership.** (a) The Direct Care and Treatment executive board consists of nine members with seven voting members and two nonvoting members. The seven voting members must include six members appointed by the governor with the advice and consent of the senate in accordance with paragraph (b) and the commissioner of human services or a designee. The two nonvoting members must be appointed in accordance with paragraph (c). Section 15.0597 applies to all executive board appointments except for the commissioner of human services.

(b) The executive board voting members appointed by the governor must meet the following qualifications:

(1) one member must be a licensed physician who is a psychiatrist or has experience in serving behavioral health patients;

(2) two members must have experience serving on a hospital or nonprofit board; and

(3) three members must have experience working: (i) in the delivery of behavioral health services or care coordination or in traditional healing practices; (ii) as a licensed health care professional; (iii) within health care administration; or (iv) with residential services.

(c) The executive board nonvoting members must be appointed as follows:

(1) one member appointed by the Association of Counties; and

(2) one member who has an active role as a union representative representing staff at Direct Care and Treatment appointed by joint representatives of the following unions: American Federation of State, County and Municipal Employees (AFSCME); Minnesota Association of Professional Employees (MAPE); Minnesota Nurses Association (MNA); Middle Management Association (MMA); and State Residential Schools Education Association (SRSEA).

(d) Membership on the board must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

(e) A voting member of the executive board must not be or must not have been within one year prior to appointment: (1) an employee of Direct Care and Treatment; (2) an employee of a county, including a county commissioner; (3) an active employee or representative of a labor union that represents employees of Direct Care and Treatment; or (4) a member of the state legislature. This paragraph does not apply to the nonvoting members or the commissioner of human services or designee.

Subd. 3. **Procedures.** Except as otherwise provided in this section, the membership terms and removal and filling of vacancies for the executive board are governed by section 15.0575.

Subd. 4. **Compensation.** (a) Notwithstanding section 15.0575, subdivision 3, paragraph (a), the nonvoting members of the executive board must not receive daily compensation for executive board activities. Nonvoting members of the executive board may receive expenses in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. Nonvoting members who, as a result of time spent attending board meetings, incur child care expenses that would not otherwise have been incurred may be reimbursed for those expenses upon board authorization.

(b) Notwithstanding section 15.0575, subdivision 3, paragraph (a), the Compensation Council under section 15A.082 must determine the compensation for voting members of the executive board per day spent on executive board activities authorized by the executive board. Voting members of the executive board may also receive the expenses in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. Voting members who, as a result of time spent attending board meetings, incur child care expenses that would not otherwise have been incurred may be reimbursed for those expenses upon board authorization.

(c) The commissioner of management and budget must publish the daily compensation rate for voting members of the executive board determined under paragraph (b) on the Department of Management and Budget's website.

(d) Voting members of the executive board must adopt internal standards prescribing what constitutes a day spent on board activities for the purposes of making payments authorized under paragraph (b).

(e) All other requirements under section 15.0575, subdivision 3, apply to the compensation of executive board members.

Subd. 5. **Acting chair; officers.** (a) The governor shall designate one member from the voting membership appointed by the governor as acting chair of the executive board.

(b) At the first meeting of the executive board, the executive board must elect a chair from among the voting membership appointed by the governor.

(c) The executive board must annually elect a chair from among the voting membership appointed by the governor.

(d) The executive board must elect officers from among the voting membership appointed by the governor. The elected officers shall serve for one year.

Subd. 6. **Terms.** (a) Except for the commissioner of human services, executive board members must not serve more than two consecutive terms unless service beyond two consecutive terms is approved by the majority of voting members. The commissioner of human services or a designee shall serve until replaced by the governor.

(b) An executive board member may resign at any time by giving written notice to the executive board.

(c) The initial term of the member appointed under subdivision 2, paragraph (b), clause (1), is two years. The initial term of the members appointed under subdivision 2, paragraph (b), clause (2), is three years. The initial term of the members appointed under subdivision 2, paragraph (b), clause (3), and the members appointed under subdivision 2, paragraph (c), is four years.

(d) After the initial term, the term length of all appointed executive board members is four years.

Subd. 7. **Conflicts of interest.** Executive board members must recuse themselves from discussion of and voting on an official matter if the executive board member has a conflict of interest. A conflict of interest means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an executive board member's decision in matters related to Direct Care and Treatment or the conduct of activities under this chapter.

Subd. 8. **Meetings.** The executive board must meet at least four times per fiscal year at a place and time determined by the executive board.

Subd. 9. **Quorum.** A majority of the voting members of the executive board constitutes a quorum. The affirmative vote of a majority of the voting members of the executive board is necessary and sufficient for action taken by the executive board.

Subd. 10. **Immunity; indemnification.** (a) Members of the executive board are immune from civil liability for any act or omission occurring within the scope of the performance of their duties under this chapter.

(b) When performing executive board duties or actions, members of the executive board are employees of the state for purposes of indemnification under section 3.736, subdivision 9.

Subd. 11. **Rulemaking.** (a) The executive board is authorized to adopt, amend, and repeal rules in accordance with chapter 14 to the extent necessary to implement this chapter or any responsibilities of Direct Care and Treatment specified in state law. The 18-month time limit under section 14.125 does not apply to the rulemaking authority under this subdivision.

(b) Until July 1, 2027, the executive board may adopt rules using the expedited rulemaking process in section 14.389.

(c) In accordance with section 15.039, all orders, rules, delegations, permits, and other privileges issued or granted by the Department of Human Services with respect to any function of Direct Care and Treatment and in effect at the time of the establishment of Direct Care and Treatment shall continue in effect as if such establishment had not occurred. The executive board may amend or repeal rules applicable to Direct Care and Treatment that were established by the Department of Human Services in accordance with chapter 14.

(d) The executive board must not adopt rules that go into effect or enforce rules prior to July 1, 2025.

History:

2024 c 79 art 1 s 23; 2024 c 125 art 5 s 35; 2024 c 127 art 50 s 35; 2025 c 38 art 3 s 32