Report to the Commissioner:

Commitment Act Task Force

February, 1988

Minnesota Department of Human Services

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Section I

INTRODUCTION

During the 1987 legislative session, several pieces of important legislation were passed to create a unified, accountable, and comprehensive system of mental health services for the people of Minnesota. One important statute which was not reviewed was Chapter 253B, the Minnesota Commitment Act, which governs the admission of voluntary and committed persons for treatment of mental illness, mental retardation and chemical dependency.

The passage of the mental health legislation influenced the deliberations of the Committee members. Some members felt that extensive changes to the commitment statute were required as an immediate follow-up. Others felt that a more conservative approach was indicated until the Mental Health Act had established a comprehensive array of services throughout the State of Minnesota.

STATEMENT OF THE PROBLEM

For some time the Department of Human Services had been hearing comments that the current Commitment Act was not working well. Consumers, family members, mental health professionals, advocates, members of the legal profession and others felt that the mental health system was not working for two identifiable groups of persons: the first, persons with identifiable mental health problems who need and want treatment, but for a variety of reasons are not receiving it; and secondly, persons with serious mental health problems, who might benefit from treatment, but are resistant to treatment and were not receiving it. Clearly, many persons felt that there was a problem. What was not clear was whether or not the problems were related to specific language in the statute, or related to other identifiable system issues such as case management, funding, or treatment availability.

CREATION OF THE TASK FORCE

In July, 1987, the Commissioner appointed a task force to examine issues related to Minnesota Statutes, chapter 253B, the Minnesota Commitment Act. The purpose of the task force was to identify specific problems and their causes and to propose possible solutions. The task force was created, in part, as a response to the Omnibus Health and Human Services Bill, M.S. chapter 403 (1987) which directed the Department of Human Services to study issues related to outpatient commitment and to prepare a report to the Legislature.

Under the direction of Allyson Ashley, Assistant Commissioner for Mental Health, the initial meeting of the task force occurred on July 16, 1987, and brought together representatives of treatment facilities, advocates, county social services, the Legislature, care professionals, the Department of Corrections, provider organizations, consumers and family members, the legal profession, the Governor's Commission on Mental Health, and mental health centers.

The task force developed subcommittees to be responsible for sections of the original charge. Between July and December, 1987, the task force met at least monthly, and the subcommittees more frequently. Committee members utilized many forms of information gathering to assist in the development of their final recommendations. These included the review of reports, case law, statutes, research materials, and pertinent articles. In addition, some subcommittee members participated in on-site visits, or invited speakers to their meetings to discuss and clarify issues.

The report submitted to the Commissioner includes the final recommendations of the task force.

CHARGE TO THE TASK FORCE

In order to provide direction to the task force, the Department identified specific issues to be addressed. However, task force members were advised that they were not limited in their deliberations to only the specified areas.

1. Issues Related to Informed Consent:

a. The use of involuntary medication and the patient's right to participate in treatment decisions in emergency and non-emergency situations.

b. The role of substitute decision makers, such as a guardian, conservator, or the committing court.

c. Informed consent relating to voluntary admission.

2. Standards for Inpatient and Outpatient Commitment:

a. The standard of commitment for both inpatient and outpatient, including whether the standard of gravely disabled can or should be applies.

b. The due process protection which should be available.

c. Aftercare case management, including the use of provisional discharge and the revocation procedures which must be used.

d. Precommitment issues, including the standards to use for 72 hour holds.

3. Issues Related to Persons with Mental Retardation:

a. Review the procedures and statutes which govern the admission and treatment of persons with mental retardation to treatment facilities.

b. Establish a uniform review procedure for continued commitment as required by the April, 1986, Supreme Court decision, In re Harhut.

c. Review the case management responsibilities in the Commitment Act including aftercare and discharge planning to make them consistent with the responsibilities of Minn. Rules 9525 (formerly known as Rule 185).

4. Issues Related to Persons Committed/Diagnosed as a Psychopathic Personality:

a. Compare Minnesota's Psychopathic Personality statute to those in states with similar provisions. Compare commitment criteria, hearing process, the term of the commitment, the location of the commitment, any right to treatment granted through statutory language or case law and discharge criteria.

b. Review discharge criteria which are currently required by statute to be applied to persons with this commitment.

5. Issues Related to Adolescents:

a. Informed consent for admission and treatment. Review the role of the adolescent and the parent in the admission and treatment process.

b. Data privacy issues relating to the treatment of adolescents.

SUMMARY OF LEGISLATION

During the 1987 legislative session, several important pieces of legislation were passed to create a unified, accountable, and comprehensive system of mental health services for the State of Minnesota. The legislation included:

I. THE 1987 MINNESOTA COMPREHENSIVE MENTAL HEALTH ACT WHICH CONSISTED OF THREE PARTS:

A. PLANNING FOR A MENTAL HEALTH SYSTEM:

Requires that the Commissioner and county agencies plan for the development of a unified mental health system. The first county mental health plan was due January 1, 1988 for the period July 1, 1988 through December 31, 1989.

B. SERVICE REQUIREMENTS:

Counties are required to develop a complete array of services for people with mental illness. The following services must be available by July 1, 1988.

1. Education and Prevention Services
2. Emergency Services
3. Outpatient Services
4. Community Support Services
5. Residential Treatment Services
6. Acute Care Inpatient Services
7. Regional Treatment Center Inpatient Services

By July 1, 1989, the following services must be available:

1. Screening for inpatient and residential treatment
2. Case management activities

Day treatment services must be available by July 1, 1989, unless waived.

C. FUNDING:

New funds are to be provided through existing funding mechanisms to implement these new service requirements.

II. CREATION OF A MENTAL HEALTH DIVISION:

While the Department of Human Services has had a Mental Health Program Office for some time, Minnesota Statutes section 245.696 (1986) provides a statutory basis for a Mental Health Division, within the Department of Human Services, with specific responsibilities for overseeing and coordinating services to people with mental illness in both community programs and state operated regional centers.

III. STATE ADVISORY COUNCIL ON MENTAL HEALTH:

Minnesota Statutes section 245.697 (1986) created a State Advisory Council on Mental Health consisting of twenty-five members appointed by the Governor. Its duties include: advising the Governor and the Legislature about policies, programs and services which affect persons with mental illness; advising the Commissioner of Human Services on the development of the biennial budget pertaining to mental health; educating the public about mental illness; encouraging research in the field of mental illness; and reviewing grants related to mental health issues.

IV. CREATION OF THE OMBUDSMAN OFFICE:

The Office of Ombudsman for Mental Health and Mental Retardation was created to mediate or advocate on the behalf of clients. In addition, a five member Medical Review Subcommittee was created to review deaths of clients in residential treatment. The subcommittee is part of a fifteen member Ombudsman's Committee which advises and assists the Ombudsman. Also, reporting requirements were amended with respect to the Maltreatment of Children and Vulnerable Adult Act statutes.

TASK FORCE MEMBERS

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In addition, the Department would like to express its appreciation and thanks to the numerous unnamed agencies and individuals who lent their time and expertise to this effort.

Section II

INFORMED CONSENT SUBCOMMITTEE REPORT

CHARGE TO THE TASK FORCE

This subcommittee was charged with reviewing issues pertaining to informed consent in the following areas: informed consent relating to voluntary admissions to treatment facilities; the role of substitute decision-makers for treatment decisions; the use of involuntary medication; and the client's right to participate in treatment decisions in both emergency and non-emergency situations.

ISSUES RELATED TO THE CHARGE

The subcommittee identified the following issues to be considered in its discussion about informed consent:

1. How is informed consent defined? Is it a legal or a medical issue?

2. Does a committed patient ever have the right to refuse treatment? Is there a point at which the public can or should decide that a patient cannot refuse treatment?

3. If the patient refuses treatment and that decision can be overruled, what due process protections are considered adequate to override a refusal?

4. When should the decision to override the patient be made and who should make it? Is it a legal issue to be decided at the time of commitment? Should clinicians have authority to override patient refusals? Should a guardian or "proxy" be a substitute decision-maker?

5. What kinds of treatment require informed consent? Does it include more than the issue of involuntary medication?

6. How should clinicians deal with clients who voluntarily accept medication or other treatment, but who clearly are not competent to give actual consent?

BACKGROUND INFORMATION

The scope of committed patients' right to refuse treatment has engendered substantial debate throughout the country in recent years. The controversy has focused on patients' refusals of antipsychotic medication, the most common and generally the most effective treatment for severe mental illness. Numerous courts have mandated procedural protections and substantive limitations on the use of such medication because of the risk of side effects, in particular tardive dyskinesia, a condition marked by abnormal movements of the facial, limb and occasionally truncal muscles.

Because of the short time allotted for the subcommittee's work, the group focused on the difficult area of medication refusal. A major impetus for this narrowing of the issues was a recognition that patients who refuse medication are a concern to community hospitals and treatment facilities as well as the state regional centers. Private community hospitals and outpatient treatment settings, uncertain about their

authority to override medication refusals, often do not accept patients who refuse medication. Another reason for the focus on medication refusal was the desire by some members to make the process currently in use at state facilities less cumbersome and costly and to more fairly allocate treatment resources.

The subcommittee reviewed constitutional developments and the provisions of the Minnesota Commitment Act in this area. Patients have a qualified right to refuse antipsychotic drugs because the side effects could unjustifiably intrude on their personal security. To protect this right, states have adopted widely varying standards and procedures, ranging from ensuring that medication decisions are professionally acceptable through peer review, to providing judicial review by which courts make a substituted decision for the patient.

In Minnesota, the Commitment Act currently does not require facilities to obtain informed consent from patients prior to medication treatment. It provides that patients have the right to consent to medical treatment other than the treatment for mental illness. However, the Commitment Act explicitly gives patients a right to treatment that is "best adapted, according to contemporary professional standards, to rendering further custody, institutionalization, or other services unnecessary."

The Department of Human Services, in 1981, adopted a policy which sets forth standards and procedures for reviewing medication decisions. This policy recognizes that the state must accept a patient's refusal unless the patient is not competent to make a rational treatment decision or an emergency exists. In non-emergency circumstances, the policy provides for multiple levels of review of the patient's lack of competency and of the medical necessity for medication. The treatment team's decision to use medication over a patient's objection is reviewed by a Treatment Review Panel (TRP) consisting of facility staff who are not involved with the patient's treatment. The TRP's decision can be appealed to the facility medical director, who makes the final clinical decision. The process is also reviewed by the hospital's review board for compliance with the procedures. The Department of Human Services has overall responsibility for implementation of the policy.

The DHS involuntary medication policy is currently being challenged by a patient who contends that the medical director's decision should be appealable to the committing court. A decision in this case, Jarvis v. Levine, is expected from the Minnesota Supreme Court in the spring of 1988. The Court of Appeals' decision in that case upheld the TRP process. Consistent with its previous decisions, the Court of Appeals found that the committing court should not be involved in such decisions and that treatment decisions are appropriately made by state professionals, subject to review by the hospital's Review Board. The Court of Appeals in Jarvis held that post-medication judicial review is available if the TRP procedures are not followed, or if the decision to medicate does not meet professional standards.

In private hospitals, there is no state-mandated procedure for overriding patient refusals. Each hospital has developed its own protocol, but the overall tendency

is to avoid the committed patient who may refuse medication. These facilities are deterred by potential liability because of the lack of clarity about their legal authority to treat patients without informed consent. Such patients are typically transferred to state facilities if they refuse medication.

In this context, the subcommittee sought to reach consensus on ways to clarify the legal standards and procedures. The following areas were discussed at great length.

DISCUSSION AREAS

1. Defining informed consent for treatment: subcommittee members engaged in a general discussion about the meaning of informed consent. The basic elements to be included, when informed consent is required, are:

a. a reasonable description of the proposed treatment, which includes the reasonably foreseeable benefits, risks and side effects;

b. the rationale for the proposed treatment;

c. a statement that the patient is being asked to give consent for the treatment and that the patient has the option of refusing to give consent without jeopardizing his or her relationship with the treatment center;

d. an offer to answer any questions the patient may have now and in the future;

e. a statement that the patient may withdraw consent at any time; and

f. a description of alternative treatments, if any, that may be beneficial.

2. Should competency be a legal issue to be decided at the time of commitment?

Subcommittee members discussed whether to support an amendment to the Commitment Act which would allow the committing court to commit the person only if he or she is not competent to make treatment decisions, in addition to meeting the current commitment criteria. The subcommittee defined competency as the patient's ability to engage in a rational decision-making process and to weigh the possible benefits and risks of treatment.

Opinion was split on this issue. Some members argued that there are persons committed primarily because of public safety concerns and not because they lack the ability to seek treatment on their own. In addition, the client's ability to weigh the risks and benefits of treatment can change frequently during the course of treatment. The possibility of the patient's changing condition would have to be taken into consideration at the time of commitment. Those who opposed incompetency as a criterion for commitment expressed the opinion that the person should not be labeled incompetent since the individual may accept medications voluntarily after commitment. According to this view, it is unfair to subject a proposed patient to a competency assessment when the person is already facing a confusing and difficult judicial process.

However, other subcommittee members felt that commitment is the best time for a competency determination. They reasoned that treatment is the purpose for commitment, including nonconsensual modes of treatment. Antipsychotic medication is the treatment of choice for most patients. When a patient is committed, the facility has a legal responsibility to provide the most appropriate treatment. A competency determination, members believe, should be made before the person enters the facility or program so that treatment can begin as soon as possible. Some members favored a short period of court determined incompetency to insure necessary treatment and to allow overriding the patient's refusal for a minimal time. From a clinical perspective, most severely ill, psychotic patients respond to antipsychotic medication within a short time after initiation of therapeutic doses.

A majority of the group did not favor making incompetency a criterion for commitment, but there was support for a court determination of competency at the time of commitment.

3. What due process protections should be provided after commitment?

Pending the Supreme Court's decision in Jarvis, the members approved of internal procedures for overriding medication refusals. They disagreed on how elaborate those procedures should be, however. The options mentioned included: assessment of competency and determination of the necessity for medication solely by the patient's treatment team; appointment of surrogates to make treatment decisions for persons adjudicated incompetent by courts; retention of a decision-making process similar to the treatment review panel (TRP) model; and use of a second opinion by another psychiatrist (peer review).

The subcommittee agreed that private hospitals should be able to treat committed patients, including those who object to medication. A representative of the private hospitals stated that hospitals desire clear authority, in statute, to treat such patients. A hearing on competency or on the authority to override treatment refusal at the time of commitment would enable hospitals to begin treatment expeditiously. If the patient's refusal persists, there is more of a need for expanded due process protections because this suggests there may not be clear medication efficacy, and the risk of tardive dyskinesia is increased.

The appropriate options were narrowed to two: the TRP model, and second-opinion peer review. Some members supported the TRP model and wanted it adopted at private hospitals because they perceived that it better protected the patient's right to refuse treatment. The use of staff not on the patient's treatment team is valuable, in their view, because outside staff can be more impartial in deciding whether to support the patient's refusal, and a multi-disciplinary review, rather than a peer review by a psychiatrist, would insure a more thorough examination of alternative modes of treatment, including those that would be less intrusive. They believe the process would provide a good quality assurance mechanism.

The "second-opinion" procedure was favored by those who argued that since medication treatment is a complex medical decision, it is best made by psychiatrists who have the necessary clinical expertise.

Some members advocated streamlining the process. They believe the TRP system is burdensome because it requires substantial staff resources. It also leads to treatment delays in many instances, and does not always provide sufficient psychopharmacologic expertise. The TRP process diverts treatment resources to a particular segment of the patient population at the expense of other patients. Some members advocated improving quality assurance reviews for all patients, especially for those who consent to treatment, but who may not be fully competent.

The subcommittee also reviewed legislation proposed in New York regarding the health care proxy concept. Under this proposal, the proxy would be able to make decisions based on instructions from the individual, devised at a time when that person had the capacity to make decisions. This theoretically could apply to instructions regarding medication. While the bill was discussed, no specific recommendations were made, some members believing that it would not be a workable solution.

Most members agreed that all committed patients should have access to quality assurance mechanisms for review of treatment, regardless of whether or not they actively refused treatment. Currently, the hospital review boards, established pursuant to the Commitment Act, constitute the primary quality assurance system for the regional centers. The committee supports additional resources devoted to improve quality assurance and psychiatric availability in the regional centers.

RECOMMENDATIONS

The subcommittee presented the following two alternative proposals to the task force. Proposal A represents a general concept rather than a detailed proposal and requires further refinement.

Proposal A

1. Court determination of competency only at time of commitment. Where incompetent, the facility could medicate for a thirty (30) day period provided that the decision was reviewed and approved by a second psychiatrist; suggestions from the patient's treatment team were obtained; and sufficient documentation to justify involuntary medication existed.

2. At any time, if the patient or physician chose, the decision would be reviewable by a court to determine if adequate documentation, suggestions from the treatment team and peer review existed to support the decision. The court could order compliance with these requirements.

3. At the end of the thirty (30) day period, a treatment review process of some sort would be instituted, either through a process similar to the TRP process or court review, perhaps depending upon the length of the involuntary treatment.

Proposal B

Statutory language should be drafted directing the Department of Human Services to promulgate regulations governing forced medication of committed patients that would be in accordance with the standards and criteria outlined in the current TRP process, or as directed by the Supreme Court in Jarvis v. Levine.

Those regulations would implement the forthcoming decision in Jarvis, which may set forth the requirements of an internal process, the extent of court review required, and the time lines required. The convening of a rulemaking task force could provide a forum for discussion of specific problems with the current TRP process and how to "streamline" it, and for those specific concerns of private facilities in adapting the process to their settings.

TASK FORCE RECOMMENDATION

The Task Force discussed both of the subcommittee's proposals for approving the use of involuntary medication. By a narrow margin, Proposal A was approved. The Task Force members who expressed preference for Proposal A gave reasons similar to those advanced by the subcommittee. They indicated their belief that it provides a fair, less expensive and burdensome procedure than the TRP, and could be more readily adopted by private hospitals. It would give clear authority to override treatment refusals, at an early stage, after commitment to the facility.

Suggestions and criticism of Proposal A included the following:

1) there was concern by a representative of the private hospitals that the proposal would delay treatment if the patient could bring an unlimited number of appeals on the facility's adherence to the procedural requirements;

2) some members desired explicit immunity from liability for treatment decisions in accordance with professional standards despite the facility's failure to follow the procedures. The court could order adherence to the requirements, but it would not be the basis for a malpractice suit for monetary damages. It was argued that immunity should not be afforded if the professionals have seriously deviated from professional standards;

3) Allyson Ashley pointed out that most commitments to community hospitals would occur in the Twin City area because of the unavailability of psychiatrists for second opinions in rural areas. In rural and urban areas it will be difficult for both regional centers and private facilities to obtain second psychiatric opinions; and

4) those who opposed the proposal expressed the view that it provided too much discretion to the treating psychiatrist to use medication against the patient's wishes. Proposal B was preferred because it provides more extensive review, including review by persons outside the treatment team. It also allows for further development of a procedure, through rulemaking, to implement the Supreme Court's decision in Jarvis.

OUTPATIENT SUBCOMMITTEE REPORT

CHARGE TO THE TASK FORCE

In the Omnibus Health and Human Services bill, Chapter 403 (1987), the Minnesota Legislature directed the Department of Human Services to study issues related to involuntary outpatient commitment and to report to the Legislature on those issues. The work of the subcommittee on standards for inpatient/outpatient commitment focuses most directly on this legislative charge.

In addition to addressing the central issue of whether some new approaches to outpatient commitment are needed, the subcommittee initially noted the following as areas to explore:

a. The standards for both inpatient and outpatient commitment, including whether a standard of "gravely disabled" can or should be applied.

b. The due process protections which should be available.

c. Aftercare case management, including the use of provisional discharge and revocation procedures for the same.

d. Precommitment issues, including standards to use for initial emergency holds.

Given the limited time available to the subcommittee, the group had to narrow its focus and not all of these issues received equal attention. Although the commitment act provides provisions for commiting persons with mental retardation and chemical dependency, this subcommittee focused on persons with mental illness. Therefore ,in reviewing whether and how well the commitment process is working in Minnesota, this report focuses primarily on those concerns related to standards for commitment and adequacy of dispositional alternatives, with a particular emphasis on outpatient commitment.

BACKGROUND INFORMATION

In exploring issues related to its charge, this subcommittee was concerned about two groups of persons with identifiable mental health problems:

1. persons with identifiable mental health problems who need and want help or treatment, but who, for a variety of reasons, do not receive it; and
2. persons with serious identifiable mental health problems who may benefit from but are resisting treatment.

While the committee acknowledged a lack of data about the scope of the problem, numbers of persons involved and precise etiology, committee members agreed that the current commitment statute was not applied uniformly nor in accord with what is currently allowed within the commitment statute, i.e., outpatient commitment and commitment when persons are mentally ill and unable to provide for food, clothing, shelter or medical care. Committee members agreed, however that current information reveals a serious lack of appropriate and accessible communnity-based services, including community support and case management services, housing, and early treatment intervention. The research and information about other state's experiences shows that without adequate outpatient and other community services, outpatient commitment either does not work or is ignored as an alternative.

This lack of resources in terms of accessible, coordinated services is a critical factor, although not the only factor, in the problem of persons going untreated. Without adequate treatment resources, the problem simply cannot be solved.

The commitment process should insure both the protection of civil rights and the provision of quality treatment. At present, the unavailability of resources all too often drives the system. The dearth of resources may even lead to a failure to invoke existing rights and processes under the commitment statute. For example, outpatient commitment options may go unutilized because of an absence of outpatient treatment resources.

The subcommittee noted that there are significant differences from county to county in practices under the commitment statute as well as in statutory interpretation. Courts and prepetition screening services may not always respond promptly and consistently. Moreover, although the present commitment act has provisions for outpatient commitment, those provisions are generally not used operationally.

The subcommittee also thought it important to acknowledge at the outset that stigma and labeling may play a very important role in keeping people from seeking treatment voluntarily. While problems of stigma and prejudice demand long-term attention and may not be amenable to quick fixes, the subcommittee members believed that many of the problems described above are capable of solution.

The remaining sections of this portion of the report explore the dimensions of the problem and the issues encompassed within it. The report then offers recommendations about limited and concrete solutions that can begin to address the problems of assuring both rights protection and quality treatment within the framework of present knowledge and ongoing changes in our mental health system.

OVERVIEW OF THE MINNESOTA COMMITMENT ACT

In 1982 the Legislature revised the commitment statutes in significant ways. Chapter 253B sets forth the procedures and standards for commitment. Although the statute contains parallel provisions related to commitments for persons with mental retardation and chemical dependency, the work of this subcommittee concentrated on mental illness commitments.

Responding to concerns that rights of proposed patients frequently went unprotected, the Minnesota Commitment Act of 1982 sought to ensure substantive and procedural fairness. Commitment is predicated on presence of a substantial mental illness, coupled with behavioral evidence of dangerousness to self or others, including inability to provide for basic needs. A prepetition screening procedure requires an initial investigation to rule out alternatives to commitment.

STANDARD FOR COMMITMENT

In some respects, the act follows a criminal justice model, with both preliminary and commitment hearings within strict timelines. Legal representation is guaranteed, and commitment is to be ordered only if the court finds by clear and convincing evidence that the proposed patient is "mentally ill" and there is no suitable alternative to judicial commitment.

A "mentally ill person," as defined by the act, is:

"any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which (a) is manifested by instances of grossly disturbed behavior or faulty perceptions; and (b) poses a substantial likelihood of physical harm to self or others as demonstrated by (i) a recent attempt or threat to physically harm self or others, or (ii) a failure to obtain necessary food, clothing, shelter, or medical care, as a result of the impairment." Minn. Stat. 253B.02, subd. 13.

Thus, in addition to the psychiatric disorder, a person must be found likely to harm self or others; this likelihood of harm is not limited to acts or threats of violence but may also be grounded upon the individual's failure to provide for his or her own basic needs. Some commentators categorize commitments based upon an inability to provide for basic needs as commitments for the "gravely disabled."

While the law clearly permits such commitments, information provided to the subcommittee made clear that practices vary substantially from county to county. Although a few counties may make extensive use of commitments based on inability to provide for basic needs, this statutory provision may be invoked rarely, if ever, in other counties.

DEFINING INVOLUNTARY OUTPATIENT COMMITMENT

The phrase "Involuntary outpatient commitment" can have multiple meanings. The term may be used to refer to a disposition to outpatient treatment in place of hospitalization following a full commitment hearing under usual standards. Another variety of outpatient commitment utilized in some jurisdictions is a preventive commitment, designed to attempt to obviate a need for eventual inpatient commitment. Outpatient commitment is also sometimes used to describe a conditional

release or release on provisional discharge, after a period of inpatient hospitalization, with discharge conditioned on compliance with an outpatient treatment plan.

Because of the varying ways in which the phrase has been used and the resultant potential for confusion, it is important to be clear about the nature, purpose, and focus of treatment. The varying definitions also highlight a principal consideration that emerges in the discussion of outpatient commitment, the question of whether criteria and standards should be the same as, or different from, inpatient criteria and standards.

In the discussion that follows, the attempt is made to be clear about the use and context of the term.

EXISTING STATUTORY PROVISIONS FOR OUTPATIENT COMMITMENT

The Minnesota Commitment Act currently has several different ways in which outpatient commitment can be accomplished which are set forth below.

1. **Minn. Stat. 253B.09, subd. 4. Release before commitment.** "After the hearing and before a commitment order has been issued, the court may release a proposed patient to the custody of any individual or agency upon conditions which guarantee the care and treatment of the patient. No person against whom a criminal proceeding is pending shall be released.

The court, on its own motion or upon the petition of any person, and after notice and a hearing, may revoke any release and commit the proposed patient pursuant to this chapter."

Comments

Minn. Stat. 253B.09, subd. 4, provides for release before commitment, with consequences for lack of compliance that make release less than voluntary. In other words, this procedure which allows release after the heearing and the proposed patient to be placed in the custody of an individual or agency "upon conditions which guarantee the care and treatment of the patient," is in fact a variety of outpatient commmitment. This statute further allows the court to revoke the release and commit the individual, after notice and hearing. See In re Rice, 410 NW 2nd 907 (Mn. Ct. App. 1987).

In addition to this statutory provision, courts may achieve a similar result simply by continuing the commitment hearing or, in the alternative, by staying imposition of the commitment order. Any structure or mechanisms for monitoring a stay or continuance are at present largely within each court's discretion.

2. **Minn. Stat. 253B.09, subd. 1. Standard of proof.** "If the court finds by clear and convincing evidence that the proposed patient is a mentally ill, mentally retarded, or chemically dependent person and, that after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petition, voluntary outpatient care, informal admission to a treatment facility, appointment of a guardian or conservator, or release before commitment as provided for in subdivision 4, it finds that there is no suitable alternative to judicial commitment, the court shall commit the patient to the least restrictive treatment facility which can meet the patient's treatment needs consistent with section 253B.03, subdivision 7.

Comments

Minn. Stat. 253B.09, subd. 1 requires that the commitment be to the least restrictive treatment facility capable of meeting the patient's needs. Particularly in view of the language in this subdivision requiring consideration of, inter alia, voluntary outpatient care is a contemplated disposition.

3. **Minn. Stat. 253B.15, subd. 1. Provisional Discharge.** The head of the treatment facility may provisionally discharge any patient without discharging the commitment, unless the patient was found by the committing court to be mentally ill and dangerous to the public.

Each patient released on provisional discharge shall have an aftercare plan developed which specifies the expected period of provisional discharge, the precise goals for the granting of a final discharge, and conditions or restrictions on the patient during the period of the provisional discharge.

The aftercare plan shall be reviewed on a quarterly basis by the patient, designated agency and other appropriate persons. The aftercare plan shall contain the grounds upon which a provisional discharge may be revoked. The provisional discharge shall terminate on the date specified in the plan unless specific action is taken to revoke or extend it."

Comments

3. Minn. Stat. 153B.15, subd. 1, allows the head of a treatment facility to release committed patients on provisional discharge. This subdivision contemplates an aftercare plan, with a timetable, goals and conditions or restrictions, and a specified termination date. The statute also sets forth a procedure for revocation if the conditions of the provisional discharge are violated. The provisional discharge thus is intended to function as outpatient commitment subsequent to inpatient status.

Minn. Stat. 253B.15, subd. 11. Partial Institutionalization. "The head of a treatment facility may place any committed person on a status of partial institutionalization. The status shall allow the patient to be absent from the facility for certain fixed periods of time. The head of the facility may terminate the status at any time."

As shown in the language just quoted, the head of a treatment facility can place a patient on a status of "partial institutionalization," a status that could amount to a hybrid in-and-outpatient commitment.

After discussing the provisions for outpatient treatment already present in the commitment act, the task force considered whether these sections of the act were known to those agencies and individuals responsible for implementing the act as well as whether utilization of the outpatient sections could and should be enhanced.

DISCUSSION

ISSUES RELATED TO THE CHARGE

In an effort to acquaint itself with the nature and scope of the issues related to outpatient commitment, the subcommittee received and reviewed some of the rapidly expanding literature on the issues, held a series of discussion meetings, and invited individuals and groups concerned about the issues to attend and speak at subcommittee meetings. The group also was furnished with some statistical data regarding the use of commitment in Minnesota.

In its initial meetings, the subcommitee identified a series of issues, based in part on a review of the literature. A bibliography of some of that literature is contained in an appendix to this report.

After several meetings, the committee determined that it would focus on in/out patient standards and provisional discharge issues. With respect to outpatient commitment, subcommittee members noted several initial considerations:

1. the question of whether standards for commitment need to be changed was preceded by an analysis of the nature and causes of the problems at issue. Some members questioned the assumption that there is something wrong with current statutory standards and suggested the need to explore whether the problems lie more in the province of the "system", involved with the commitment process, lack of accountability and monitoring, absence of case management. (Not all members were of the view that the problems lay only in these areas.) Some members also noted the need to avoid an outpatient commitment process that would simply result in a new "label";

2. if an expanded outpatient commitment statute is needed, standards for commitment, settings, liabilities of providers, resources, due process protections, sanctions for violations, and time periods aree among the many issues that would need to be specified;

3. even before those issues are broached, the question of whether there should be separate standards for in-and-outpatient commitments needed to be resolved. Members noted that states which have looser standards for outpatient commitment have found that those procedures are not being used because, among other things, community resources are not available;

4. timing of changes was also a consideration from the outset of the group's deliberations. Members discussed whether it was premature to consider changes to the commitment act before we see how the new mental health legislation will change the system through increased case management and other resources. These changes may help to clarify the extent to which the problem lies with resources, systems and implementation processes rather than with statutory standards; and

5. the role of education about the commitment act and standards of liability for treatment providers were also considered as factors bearing upon the issues.

After its first meetings, the committee felt it had not yet identified a thorough listing and analysis of the problems for which outpatient commitment might provide a solution, from the perspective of its proponents. The committee requested presentations from this and other perspectives and issued an open invitation to persons to present their views to the subcommittee.

At its subsequent meetings, the subcommittee received oral presentations and, in some cases, written materials from three persons representing the Alliance for the Mentally Ill, one representative of the Minnesota Psychiatric Society, and two parents, as well as several persons who have been consumers of mental health services. Several members of the Task Force and subcommittee also made presentations.

Representatives of the Alliance for the Mentally Ill (AMI) expressed their desire for a greater emphasis on need for treatment in the commitment process and their support for procedures which would impose treatment before persons deteriorate to an out-of-control state.

Several AMI members who are also relatives of persons with mental illness described their experiences and perceptions to the group. For example, one representative, who has a mentally ill sibling, expressed the belief that many families would prefer to have treatment forced on an acutely ill individual who is unwilling to cooperate with psychiatric treatment recognizing families' desire to obtain treatment with the need to balance patients' rights.

Two mothers related their sons' experiences with mental illness, reflecting breakdowns in the system. In one instance, a mother related that the unwillingness of the commitment system to respond appropriately resulted in arrest and an injury in jail, before her son received needed treatment. Another mother told the painful story of her son's suicide, during the pendency of a monitored continuance of commitment proceedings.

The Director of Forensic Services at St. Paul Ramsey Medical Center also spoke before the subcommittee. He stressed the need for early intervention, a preference for using mechanisms other than commitment, and the sometimes cumbersome nature of the commitment process. This psychiatrist emphasized that outpatient commitment could be a useful adjunct. He also stressed the fact that professionals and facilities would need to be more available for and amenable to accepting committed outpatients, and that changing statutes without addressing this problem might not result in a substantial increase in the use of outpatient commitments. Another need mentioned, from the psychiatric community's perspective was simply that of increasing understanding of commitment law and processes.

Several persons who have experienced mental illness also addressed the subcommittee. A woman who has been a client of the mental health system stressed the following concerns: commitment and its accompanying loss of rights and privileges can create a real sense of loss of power and self-worth; and commitment cannot force anyone to get better; the need is for quality, community-based programs that can help people to get better, not for a revolving cycle of forced hospitalization.

A second individual, who has also been a client of the mental health system, echoed these concerns, adding that he opposed commitment in the absence of some sort of threat of harm because it created too much opportunity for prejudice or difference

in opinion about lifestyle choices that could lead to commitment. He also emphasized the fact that even when mentally ill, individuals can make decisions about what they want and need. He stressed the importance of including the individual with mental illness in the decision-making process, rather than forcing treatment, because, in his view, no program will help unless the individual has decided to get well. Even when he himself was in a psychotic state, he concluded, he knew what he needed: someone to reach out and care.

In its further deliberations, the subcommittee considered this information, together with extensive anecdotal information provided by members of the committee. Personal and professional experiences related by subcommittee members included information on programs and approaches that appear to be working as well as information related to the importance of rights protection. In addition to reviewing a significant amount of the legal and psychiatric literature on point, much of which is noted in the appended bibliography, the subcommittee also examined and considered some statistical data regarding the use of commitment in Minnesota.

DEFINING THE PROBLEM

In exploring the question of whether and how well the commitment process has been working and in considering what steps to improve it might be warranted, the subcommittee identified several sets of subissues. Knowing that it could not answer all of these questions, the subcommittee, nonetheless, felt that identifying the salient issues was a very important initial step.

I. NATURE AND EXTENT OF THE PROBLEM

The central issue before the subcommittee involved determining the extent to which persons with serious mental health problems are not receiving beneficial treatment because of the commitment act itself, or its interpretation and implementation. Answering this question necessarily involved some weighing of values, as well as information about resources and technology, in deciding how to balance liberty and autonomy interests with a need for treatment.

To answer this query in a meaningful way, the subcommittee needed to know which persons were not receiving treatment and how many were involved. To begin to isolate causative factors, the subcommittee also needed to identify what problems existed, in terms of lack of understanding and uniform interpretation of the commitment act, as well as variations in interpretation and ignorance of statutory language.

II. ROLE OF FACTORS OTHER THAN THE COMMITMENT ACT

In the course of its deliberations, the subcommittee identified a number of factors apart from the commitment statutes themselves that appeared to play critical roles in the problem of persons not receiving appropriate and timely treatment. The very limited success of outpatient commitment in other jurisdictions is attributed largely, in the literature, to the dearth of services available. In exploring what other factors may be involved, the subcommittee also raised the following concerns:

1) How much of a factor is a lack of an appropriate range of services and treatment resources? Lack of case management? High caseloads? Lack of continuity between hospital and community? Inadequate funding? What will be the effect of the new comprehensive mental health act on these factors?

2) How should efforts to address the problem be related to the implementation of the new mental health act?

3) What do we know about the efficacy, as well as detriments, of available treatment modalities and, in particular, the efficacy and potential detriments of involuntary outpatient treatments on the population at issue?

In the course of its meetings, the subcommittee heard significant concerns raised about the unresponsiveness of persons administering the commitment act. Thus the committee also thought it important to consider the extent to which the human dimension, in terms of unresponsiveness, an overworked court, social service personnel, or the lack of an identified resource to which to address questions and concerns about the mental health commitment process, compounds the problem.

III. SYSTEM CONSEQUENCES

Any recommended change in commitment processes not only needs to be accompanied by necessary resources, but also needs to be viewed in terms of potential consequences for the mental health system. Among the system consequences that need to be addressed are the following concerns:

1) What resources and services, in addition to or in lieu of statutory change, would need to be in place to reach the population at issue? What role does lack of an appropriate range of resources play in the problem?

2) What system consequences, intended or unintended, might a broadened commitment process have?

3) What role do questions of professional responsibility, quality of care and availability of care, issues of cost and financing, stigma and prejudice, and legal liability or immunity have in creating the problem? What alterations in these areas might help in alleviating the problem?

The subcommittee could not, within the time allocated, answer all of these questions and recognized that, perhaps, it was not possible to answer them with the data available.

IV. IMPROVING STATUTORY IMPLEMENTATION OR LANGUAGE:

The subcommittee sought to identify what areas of administration and execution of the present act, if improved upon, might rectify many of the perceived problems. The committee also thought it important to identify ways in which the dimensions and causes of the problem could be better ascertained, in the near future.

As part of the charge, the committee had to consider whether the present standard for both inpatient and outpatient commitment should change, or whether a separate category of outpatient commitment, governed by alternative standards should be created. If a new outpatient commitment category were created, what should be its relation to and consequences for inpatient commitment? Conversely, since the current statute already permits various outpatient dispositions, does a uniform standard have advantages in terms of a simpler, more understandable system? The committee also had to consider what enhanced role stays and continuances might play in a uniform system.

IDENTIFICATION OF MAJOR PROBLEM AREAS APPROPRIATE TO BE ADDRESSED IN THE IMMEDIATE FUTURE

While the subcommittee could not provide answers to all of the queries contained above, to say nothing of solutions to all of the problems encompassed within those queries, the process of issue identification helped the subcommittee separate those issues which it felt were capable of being addressed in the immediate future. Without knowing fully the causes or dimensions of the problems, the subcommittee proceeded with some caution.

The subcommittee, therefore, identified the following problem areas for concentration:

1. Lack of clarity about outpatient alternatives possible under the present commitment act. A variety of outpatient dispositions is already theoretically possible under the present statute. Patients may be outside the system or receiving inadequate services because courts, lawyers and social workers do not understand and utilize these possibilities, nor the possibility of commitment for inability to provide for basic needs. The subcommittee concluded that various outpatient commitment possibilities and analogs, including stays, continuances and provisional discharges, needed to be better highlighted and clarified by some limited changes in statutory structure and language. While opting for a uniform standard for both in-and-outpatient commitment, the committee also identified other areas in which several changes in statutory organization and definitions might enhance use of treatment options.

2. Absence of accountability and client protections in certain varieties of outpatient commitment. The committee concluded that stays, continuances, provisional discharges, etc. needed mechanisms of control designed both to protect client rights and to ensure that services are provided and clients are not lost to the system.

3. Lack of resources and receptivity to support outpatient commitments. Financial resources, treatment resources, monitoring capabilities, and facilities and programs willing to accept committed outpatients are essential, if outpatient commitment is to work. Some counties continue to lack the basic resources needed to support outpatient dispositions. Statutory change alone, as demonstrated in a number of other states, will not result in enhanced outpatient commitments.

4. Inadequate information and education about the commitment act, procedures, resources and alternatives. The committee concluded that gaps in education and the absence of any centralized resource to which professionals, family members and others could turn for information was a pervasive problem inhibiting better functioning of the system. Poorly prepared lawyers, social service personnel, or the simple absence of a place to which a family member might turn for information at an early stage appear to cause major, yet potentially solvable, impediments to a well-balanced commitment system. The committee also concluded that persons throughout the the state, and not just those in Hennepin County, should have the benefit of a trained panel of lawyers knowledgeable about mental health issues, resources and alternatives.

RECOMMENDATIONS OF THE SUBCOMMITTEE

(Note: All recommendations are directed at ordinary mental illness commitment situations and not at "mentally ill and dangerous to the public" commitments under 253B.18)

1. RECODIFICATION/CLARIFICATION OF THE COMMITMENT ACT: CRITERIA TERNATIVES, OUTPATIENT OPTIONS

1.1 A limited recodification of the commitment act should be undertaken ring together in one subheading or otherwise to highlight the various provisions for outpatient commitment that already exist but frequently go unrecognized. See Minn. Stat. 253B.09, subd. 4, and subd. 1 and 253B.14, subd. 1. The intent is not to change the standards or requirements for these varieties of commitment, but to clarify them and highlight their availability.

Clarifying related statutory structure and definitions

1.2 While the definition of mental illness should not be changed, see 253B.02, subd. 13, it should be clarified by the use of outline format and/or reordering of clause (b) i and ii, in order to make clear, among other things, that failure to provide for basic needs can provide the grounds for meeting (b), the likelihood of physical harm requirement. The possibility for commitments based on grave disability could thus be highlighted.

1.3 Minn. Stat. 253B.09, subd. 1, should be amended by the addition of language to the following effect:

"In considering what is the least restrictive facility,* the court shall consider a range of treatment alternatives, including but not limited to outpatient treatment, day treatment, community support services, community residential treatment, foster care, partial hospitalization, acute care hospital and regional treatment center services. The court shall also consider the proposed patient's willingness to participate in the treatment alternatives. The court shall not commit to a facility that is not capable of meeting the patient's needs."
(* or replace "facility" with "program")

1.4 The definition of "treatment facility" in 253B.02 should be expanded by the addition of "or other treatment providers" or words to similar effect.

Other accompanying statutory additions

1.5 Mechanisms are needed to ensure that there is someone accountable for each outpatient and to ensure appropriate follow-up and court review, so that the outpatient receives quality services. While a single definition of "mentally ill" should apply to both in- and outpatient commitments, commitments to settings other than a regional treatment center or acute care hospital require some special additional protections. Those provisions should include, but not necessarily be limited to the following:

a. a person responsible for monitoring must be identified in the court order (while the court should have discretion in naming that person, it was the sense of the group that in most instances the person should be county-employed, or a contracted case manager, who does not have a conflict of interest);

b. the monitor must report to the court at least every 90 days, with more frequent reporting as needed, and with an obligation to report promptly a substantial failure to comply with the conditions of the outpatient commitment;

c. the order should specify the conditions the person has to meet to comply with, and the consequences for failure to comply, such as further hearings or commitment to another setting;

d. at the time of the hearing and outpatient disposition, there must be presented to the court and thereafter incorporated into the findings, to the extent possible, a written preliminary plan of services, and the court should ascertain that financial resources, from public or private sources, are available to pay for the proposed treatment;

e. Minnesota Statutes section 253B.17 or other appropriate section should be modified so as to permit the monitor to petition for a reopening of the commitment hearing, or a new hearing upon substantial non-compliance with the outpatient plan;

f. appropriate statutory language should also be enacted to permit modifications of the outpatient commitment upon agreement of the parties and approval of the court; and

g. forced treatment with psychotropic medications shall not be given to committed persons in any setting, except in emergencies, or under rules adopted by the Commissioner of Human Services which provide due process protections and take into account the client's qualitied right to refuse treatment.

1.6 A mechanism should be created to increase the willingness of outpatient providers to accept committed patients, e.g., some form of limited immunity from liability vis-a-vis third parties. Without specifying the particulars, the subcommittee agreed that there was a need to limit liabilty for those providers outside the traditional hospital context who might otherwise refuse to accept the increased liability of committed patients.

2. FUNDING FOR OUTPATIENT ALTERNATIVES

The subcommittee strongly believes that procedural or statutory changes will not solve current problems unless there is increased funding for outpatient alternatives, and for monitoring outpatients and the treatment system that serves them. Increased funding must accompany the procedural and definitional modifications suggested above and must be available in proportion to the use of outpatient dispositions.

It must also be recognized that outpatient treatment services cannot be effective unless the persons served by them first have their basic human needs - food, clothing and shelter - adequately met.

3. CREATION OF A COMMITMENT RESOURCE CENTER

A Commitment Act Resource/Information Education Program should be created and funded to: 1) provide continuing education on the commitment process, resources, alternatives, etc., to defense attorneys, prosecutors, judges, court personnel, social service personnel, mental health professionals, etc., and to family members and consumers; 2) assist in establishing and coordinating commitment defense panels; 3) serve as a central, identifiable, and responsive resource for family members and others concerned about the commitment process; 4) assist in identifying resources to divert people from commitment; 5) provide and disseminate information about precommitment interventions and alternatives; 6) serve as a point of accountability for monitoring the commitment act and gathering information about its implementation throughout the State; and 7) identify emerging problems with the commitment process and suggest solutions.

In making this recommendation, the subcommittee believed that new financial resources would be needed to implement the activities described. While the subcommittee lacked the time and resources to render a precise cost estimate, it did think it was important to note that the proposed services might be very cost-effective, by providing people with information and alternatives that might help to obviate the need for expensive commitment proceedings or dispositions. While making no final recommendations about where these services might best be located, the committee noted that it might not need to be entirely state-operated and that providing seed money for contracted services might be one option.

4. FORMALIZING THE USE OF STAYS AND CONTINUANCES

The uses of stays and continuances should be more formalized and should include greater protections and provisions for accountability. 253B.09, subd. 4, (release before commitment), and related statutory sections should be modified to this end.

In particular, all stays of imposition of commitment and any continuance or series of continuances that extend longer than 14 days beyond the date of the initially scheduled hearing should be accompanied by the following protections:

4.1 the maximum duration of the stay or continuance should parallel the time limits for commitments, i.e., a maximum initial period of 6 months, with a 12 month extension permissible by order of the court.

4.2 a person responsible for monitoring must be identified (while the court should have discretion in naming that person, it was the sense of the group that, in most instances, the person should be a county-employed or contracted case manager, who does not have a conflict of interest);

4.3 the monitor must report to the court at least every 90 days, with more frequent reporting as needed, and with an obligation to report promptly a substantial failure to comply with the conditions of the stay/continuance;

4.4 the order should specify the conditions the person has to meet to avoid a further hearing for commitment and/or imposition of the stayed commitment order;

4.5 at the time of the hearing on the stay/continuance, there must be presented to the court a written preliminary plan of services, to which the proposed patient has agreed, and the court should ascertain that financial resources are available, from public or private sources, to pay for the proposed treatment. Before entering an order for a stay or continuance, the court should also ascertain that at least one examiner has found that the proposed patient is mentally ill and, in the case of a continuance, is competent to waive the hearing. The subcommittee assumes the active involvement of the patient's counsel in the process; and

4.6 appropriate statutory language should also be enacted to permit modifications of the stay or continuance upon agreement of the parties and approval of the court.

5. INSURANCE/HMO/MEDICAL ASSISTANCE AVAILABILITY

Appropriate statutory changes should be enacted so that group health insurers and health maintenance organizations are not able to deny mental health treatment coverage on the grounds that treatment is court-ordered, part of a stay, or a continuance plan approved by a court. Funding should be available on the basis of need and not subject to arbitrary time limits.

6. FUNDING FOR MONITORING STAYS AND CONTINUANCES

The comments noted above, with respect to the need for enhanced funding of outpatient commitments, are equally applicable to stays and continuances.

7. IMPROVING THE PROVISIONAL DISCHARGE PROCESS

Provisional discharges should be restructured to include provisions for monitoring and accountability similar to those suggested above. The following specific changes should be implemented through appropriate amendments to 253B.15 and related sections.

7.1 In connection with the aftercare plan developed for the provisional discharge under 253B.15, subd. 1, a representative of the "designated agency" should be identified as responsible for monitoring and assisting the patient.

7.2 The aftercare plan should also specify the services and/or treatment to be provided as part of the aftercare plan, as well as the financial resources that are available to pay for those services. (We note again that there may be significant financial implications and costs associated with carefully planned and monitored provisional discharges that work to help patients remain in the community.)

7.3 The individual identified as the monitor, i.e., the case manager from the designated agency, should become involved with the patient and hospital in planning the provisional discharge several months in advance of discharge and should serve as a link assuring continuity of care. Appropriate strengthening of the language in 253B.03, subd. 7, may help to facilitate this role. In addition, any case management rule developed by the Commissioner should also reflect this concept of the role of the case manager in the provisional discharge contect.

7.4 Language should be added to 253B.15 to allow for modification of the provisional discharge plan, as needed, upon agreement of the parties.

7.5 The monitor or case manager, rather than the head of the treatment facility from which the patient has been discharged, should play a more central role in decisions related to whether to seek to revoke the discharge. Prior to 60 days post discharge, the monitor should be the one to request that the head of the facility revoke the discharge. After 60 days, the monitor, not the head of the facility, should be individually designated, under subd. 5, as the one to apply to the court for a return order.

7.6 The patient's attorney shall receive notice of any revocation under subd. 6, as well as all other notices of intended revocation.

7.7 Incorporate the provisions of In Re Peterson, 360 N.W.2d 333 (Minn. 1984) regarding revocation procedures to be followed within the first 60 days of a provisional discharge.

AREAS FOR FURTHER EXPLORATION

The recommendations above do not address all of problems and questions raised in this report. We see a clear need for ongoing work and study. In fact, one of our recommendations addresses this need by suggesting creation of a commitment act resource center or program that could serve as a focal point for data collection and study.

In addition to collecting data, we see a need to monitor any legislative changes to determine their effect on the problems identified in this report. Long-term work may also be required to improve the manner in which mental health services are funded and in identifying sources of revenue. Further study is also needed to quantify the scope of the problem of persons not getting treatment, to track the effect of the new comprehensive mental health act on resolving the problem, and to identify the role of other causative factors. These data, together with advances in our knowledge of treatment modalities and their effectiveness, could be of significant assistance in crafting further solutions.

DEPARTMENT OF HUMAN SERVICES
CIVIL COMMITMENT TASK FORCE
OUTPATIENT COMMITMENT MINORITY REPORT ANALYSIS

By: Steven P. Doheny, M.D.
State Forensic Director
Department of Human Services

Representative Dave Bishop
Minnesota Legislature

While the sub-group for outpatient commitment considered many questions, they concluded that the current Commitment Act contained enough authority to administer effective outpatient alternatives to hospitalization. They specifically felt that stays of commitments and continuances of commitment proceedings would allow patients and responsible parties and programs to investigate the delivery of outpatient care and avoid acute inpatient care. They completely ignored the issue of informed consent and took no stance on the ability of outpatients to receive medications against their will. They felt that an emphasis on the grave disability aspect of the Commmitment Act, that is, inability to meet one's basic needs for food, clothing, shelter, and medical care could be somehow high-lighted in the Commitment Act to move away from the need for determination of dangerousness, which is required for inpatient commitment. We respectfully disagree with these conclusions based on our analysis.

Certain authors have reviewed the use of outpatient commitment in other states, including Susan Stefan, who reported in the MPDLR/Vol. 11, No.4, that the issues of competency to refuse treatment, availability of treatment, funding for treatment, coordination of care, and enforcement were poorly dealt with in existing outpatient commitment statutes in other states. Paul Applebaum, a nationally recognized expert forensic psychiatrist, reported in the American Journal of Psychiatry in October of 1986, that outpatient commitment is really an old idea with new popularity. He indicated that there is a critical need to solve the revolving door problem, but that crucial items need to be addressed in formulating effective outpatient commitment. 1) The criteria used for outpatient commitment could not be identical for those used for inpatient commitment. The threshold of entrance into the outpatient commitment system should be lower and that a determination of dangerousness should not be required to use outpatient commitment. 2) Using hospitalization as an enforcer of failed outpatient treatment doesn't solve the initial problem of attempting to do preventative outpatient treatment. 3) More responsive and creative community mental health systems that are funded might be able to work successfully with outpatients if they have the authority to do so. 4) The attitude of legal advocates will be crucial to the success of outpatient commitment. If they continue to challenge outpatient commitment (somewhat along the lines that Susan Stefan does in her report) by portraying it as probably more intrusive to civil rights than inpatient hospitalization, then it cannot succeed as a preventative and successful measure in maintaining continuity of care for the seriously and persistently mentally ill.

While we applaud the efforts of the main body of the outpatient subcommittee of the Commissioner's task force, we must point out that their considerations fall short of the necessary requirements for successful outpatient commitment. We should look to the examples of other states and we should be progressive enough to correct problems that are clearly seen in those states' statutes. After all, if our eventual aim is to deliver timely and effective care to the seriously and persistently mentally ill in order to avoid tragedies, we should not rely on a system that can act only after the fact.

DEPARTMENT OF HUMAN SERVICES

MENTAL HEALTH COMMITMENT TASK FORCE

OUTPATIENT COMMITMENT MINORITY REPORT

By: Steven P. Doheny, M.D.
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Department of Human Services

Representative Dave Bishop
Minnesota Legislature

For outpatient commitment to be successful, the following components are necessary:

1. The threshold of outpatient commitment must be lower than that for inpatient commitment. It should not include the elements of dangerousness or even grave disability as prerequiste, but only the elements of identified psychiatric illness and availability of beneficial treatment.

2. Outpatient commitment must empower the ability to administer medication as one form of treatment. This will require that the issue of informed consent be addressed at outpatient commitment and that a determination of incompetency to make a treatment decision about medication be made that will enable authorities to administer treatment.

3. The enforcement of outpatient civil commitment procedures cannot rely on inpatient care as its mainstay. Somehow a mechanism should be developed which would allow mental health authorities to administer necessary treatments short of requiring acute care hospitalization status.

SUBCOMMITTEE REPORT ON ISSUES PERTAINING TO PERSONS WITH MENTAL RETARDATION

CHARGE TO THE SUBCOMMITTEE

This subcommittee was charged with the following:

1) Review the procedures and statutes which govern the admission and treatment of persons with mental retardation to treatment facilities.

2) Establish a uniform review procedure for continued commitment as required by the April, 1986, Supreme Court decision In re Harhut.

3) Review the case management responsibilities in the commitment act, including aftercare and discharge planning to make them consistent with the responsibilities of Minnesota Rules, parts 9525.0015 to 9525.0165 (formerly inown as Rule 185).

MATERIALS REVIEWED

Members of the subcommittee reviewed materials summarizing admission and release practices for persons with mental retardation in other states, as well as the case management rule for persons with mental retardation,

DISCUSSION AND RECOMMENDATIONS

The subcommittee recommends that the following be included in recommendations by the Task Force to the Commissioner:

1. Review of Treatment Issues

Some members of the group felt that since commitment is a judicial process there should be a provision for a judicial route for the review and enforcement of treatment issues. The subcommittee recommends that language be added to the Commitment Act which would allow the committing court to enforce rights, and to hear claims with respect to treatment issues.

Persons with mental retardation may currently seek administrative review of treatment issues by means of a case management appeal. Details regarding this process are contained in Instructional Bulletin #87-78B. However, other persons affected by the Commitment Act apparently do not have such recourse at this time. If a change were made, it would apply to members of all groups affected by the Commitment Act.

2. The Need for A Uniform Review Procedure for Continued Commitment for Persons with Mental Retardation

The Harhut decision requires the periodic review (every three years) of commitments for persons with mental retardation. This is, in part, related to the fact that mental retardation is a condition which is not usually "cured" by treatment, although persons with mental retardation can acquire skills which will make them less dependent upon caregivers. People with mental retardation could be served in the community rather than in regional treatment centers. It is an issue of developing adequate resources in the community, rather than waiting for persons to be "ready" to live in the community. The subcommittee recommends that persons with mental

retardation no longer be committed for indeterminate periods of time. We recommended instead that the Commissioner seek legislation amending Minnesota Statutes 253B.13 to establish a determinate period of commitment for persons with mental retardation, which is similar to that established for other groups affected by the Commitment Act.

3. Provisional Discharge:

The subcommittee recommends that the Commissioner seek legislation limiting the use of provisional discharges for persons with mental retardation to a period of 60 days. In addition, subcommittee members recommend that the inability of a community facility to provide service should not be the basis for revoking a provisional discharge. The county should be required to take whatever action is necessary to meet the person's needs in the community, and to document those efforts. This action would be consistent with requirements of the case management rule for persons with mental retardation (Rule 185). In addition, the subcommittee recommends that the due process provisions, governing revocation of a provisional discharge which are specified in Minnesota Statutes 253B.15, should apply to the revocation of any provisional discharge, not only to those which occur after a period of 60 days.

4. The Need to Determine that a Person is no Longer in Need of Institutional Services in Order to Allow Discharge:

At the present time, there is conflict between the rule governing case management for persons with mental retardation and the Commitment Act. In Minnesota Statute 256B.092, the county case manager has been charged with the responsibility for assessing service needs, developing a service plan, authorizing placement for services for persons with mental retardation, as well as evaluating and monitoring the services provided. This is a dynamic process because a person's needs will change over time. The county is obligated to continue to provide case management services from the time the person is determined to be in need of such services, until such time as the person is determined to be no longer in need of such services.

It is possible for a person to continue to need "institutional care and treatment" (for example, residential services from an ICF/MR), or to continue to need some or most of the services provided by a regional treatment center, at the time of a proposed discharge. However, it is often possible for a case manager to arrange for the person to receive the services in the community using a combination of generic and specialized services. These decisions are not made by the case manager in isolation, but by a statutorily constituted "screening team" which uses input from current providers of services, and other sources to make decisions regarding the level of service needed by a person. Details of this process are included in Rule 185 and Instructional Bulletin #87-78D.

The subcommittee recommends that Minnesota Statutes, section 253B.16, be amended to reflect the county's statutory responsibility for providing case management to persons with mental retardation. This could be accomplished by amending Minnesota Statutes 253B.16 with language such as:

The head of a treatment facility shall discharge any patient admitted as mentally ill, ~~mentally retarded~~ or chemically dependent when certified by the head of the facility to be no longer in need of institutional care and treatment or at the conclusion of any period of time specified in the commitment order, whichever occurs first. The head of a treatment facility shall discharge any person admitted as mentally retarded when that person's screening team has determined pursuant to Minnesota Statutes, section 256B.092, subd. 8 that the person's needs can be met by services provided in the community and a plan has been developed in consultation with the regional center interdisciplinary team to provide available community services to the person.

5. Consent:

During the last legislative session, language was passed specifying that a person with mental retardation, or that person's guardian, must give consent for the use of aversive and deprivation procedures (including the use of restraints) and psychotropic medications for persons with mental retardation. The subcommittee recommends that the language be maintained in the Commitment Act. Perhaps the language regarding consent for the other groups affected by the Commitment Act should be reviewed.

ADDITIONAL COMMENTS

Temporary Care:

Temporary care (formerly known as respite care) in the regional treatment centers has been available to persons with mental retardation without a formal commitment. Previously, this was custodial care; treatment was limited. At the present time, temporary care in a regional treatment center is available for any person with mental retardation provided that the temporary care is specified in the person's Individual Service Plan. Temporary care cannot now exceed 90 days in a calendar year and must be provided according to the person's Individual Habilitation Plan.

ADVISORY TASK FORCE ON COMMITMENT ACT
SUBCOMMITTEE ON ISSUES PERTAINING TO
PERSONS WITH MENTAL RETARDATION

MINORITY REPORT

One of the tasks with which this subcommittee was charged was to review the case management responsibilities in the Commitment Act, including aftercare and discharge planning and to make them consistent with the responsibilities of case managers under Minnesota Rules, parts 9525.0015 to 9525.0165 (formerly known as Rule 185).

Minnesota Statutes, section 256B.092, charges the county case manager with the responsibility for planning and obtaining services, including case management, for persons with mental retardation. This is a dynamic process since a person's needs change over time. The county is obligated to continue to provide case management services from the time the person is determined to be in need of them until such time as it is determined that the person is no longer in need of such services. The case manager does not work in isolation. The statute provides for the development of screening teams to determine the eligibility of any person for services and to determine the level of service needed by that person. Details of this process are given in Minnesota Rules, parts 9525.0015 to 9525.0165 and in Instructional Bulletin 87-78D.

At the present time, there is conflict between the rule governing case management for persons with mental retardation and the Commitment Act. The Commitment Act (Minnesota Statutes, section 253B.16) states that no person who has been committed to a facility shall be discharged until the commitment expires or until it has been determined by the head of the treatment facility that the person is no longer in need of institutional care and treatment. Many persons with mental retardation will continue to need a significant amount of care and supervision throughout their lives. Acquisition of independent living skills may be very slow or the person may continue to need supervision because of inability to independently apply learned skills in new situations. At the present time, placement into community-based services is more reflective of the capacity of the service system to provide needed services than of the status or skill level of the person with mental retardation. It is possible for a person to continue to need "institutional care and treatment" (for example residential services from an ICF/MR) or to continue to need some or most of the services provided by the regional treatment center at the time of a proposed discharge. It is often possible for a case manager to arrange for the person to receive the services in the community using a combination of generic and specialized services. Thus, it is possible for a screening team to have determined (pursuant to Minnesota Rules 9525.00) that services which will meet the needs of the person can be provided in another environment, yet be in conflict with the head of the facility which is currently providing services to the person.

In the recent past there have been conflicts between county case managers and the heads of some facilities over whether a person should be discharged or should continue to reside in the regional treatment center. Although recent bulletins contain procedures for resolving these issues, the procedures are cumbersome and we recommend that the situation be clarified in the Commitment Act. The subcommittee recommends that Minnesota Statutes section 253B.16 be amended to reflect the counties' statutory responsibility to provide case management to persons with mental retardation (Minnesota Statutes, section 256B.092). This could be accomplished by amending Minnesota Statutes, section 253B.16 using language such as:

The head of a treatment facility shall discharge any patient admitted as mentally ill, ~~mentally retarded,~~ or chemically dependent when certified by the head of the facility to be no longer in need of institutional care and treatment or at the conclusion of any period of time specified in the commitment order, whichever occurs first. The head of a treatment facility shall discharge any person admitted as mentally retarded when that person's screening team has determined pursuant to Minnesota Statutes Section 256B.092 Subdivision 8 that the person's needs can be met by services provided in the community and a plan has been developed in consultation with the interdisciplinary team to place the person in the available community services.

PSYCHOPATHIC PERSONALITIES SUBCOMMITTEE REPORT

CHARGE TO THE TASK FORCE

This subcommittee was charged with reviewing issues related to the current psychopathic personality commitment statute, Minnesota Statutes Chapter 526. The charge mandated a comparison of Chapter 526 with similar provisions in other states. The subcommittee was to compare commitment criteria, hearing procedures, the duration of the commitment, the physical location of the patient for treatment purposes, and the right to treatment granted through statutory language or case law; and to review the appropriateness of the discharge criteria contained in the current statutory scheme in Minnesota.

ISSUES RELATED TO THE CHARGE

The subcommittee members identified the following as issues to be considered:

1. What is the nature and purpose of the psychopathic personality commitment?

2. Should Chapter 526 be repealed?

3. What would be the consequences of repeal of the chapter?

4. If the chapter is not repealed, should there be new discharge criteria established for psychopathic personalities?

BACKGROUND INFORMATION

FACTS

The psychopathic personality commitment, Minn. Stat. 526.09-.11 originated in 1939, in Minnesota. Many other states also enacted similar statutes in the 1930's. At that time it was commonly assumed that:

1. there was a specific mental disability called sexual psychopathy;

2. persons suffering from sexual psychopathy were more likely to commit dangerous sex offenses than "normal" offenders;

3. mental health professionals could easily identify a sexual psychopath;

4. sexual psychopaths were amenable to treatment; and

5. treatment was available and successful for large numbers of sexual psychopaths.

At the time Chapter 526 was enacted, there was little hard data to support these assumptions. Now, it appears, that the laws based on these assumptions lack clinical validity. A recent report by the Group for Advancement of Psychiatry (GAP) found that "sexual psychopathy is a questionable category from a legal standpoint and a meaningless grouping from a diagnostic and treatment standpoint." The same report found no reliable data demonstrating the effectiveness of treatment provided by sexual psychopathic treatment programs. Consequently, at least 13 states have repealed their sexual psychopath statutes and 12 other states have modified their statutes.

Only four states (Minnesota, Massachusetts, Illinois, Colorado) and the District of Columbia currently allow indefinite commitment of sexual psychopaths. While Massachusetts, Illinois, and Colorado all permit placement of sexual psychopaths within correctional facilities, the District of Columbia and Minnesota commit sexual psychopaths to hospitals for the mentally ill.

In Minnesota, a person with a psychopathic personality is usually committed to Minnesota Security Hospital (MSH). If, however, the psychopathic personality client has also been convicted of a criminal offense, he/she will have a dual commitment to Corrections and Human Services. Human Services generally prefers to have the psychopathic personality client fulfill his/her commitment to Corrections, prior to being transferred to MSH for treatment.

At the present time, there are approximately twenty-four persons committed as psychopathic personalities in Minnesota. Approximately eight of these are in correctional facilities, while most of the remainder are at MSH.

The psychopathic personality commitment generally poses a problem for the Department of Human Services in one of two ways. First, a problem arises when a convicted sex offender is also civilly committed as a psychopathic personality and is sent immediately to MSH for treatment, in lieu of placement in Corrections, i.e., probation, stay of execution of sentence.

The Intensive Treatment Program for Sexual Aggressives (ITPSA) at MSH is geared toward rehabilitation of the sex offender and his/her eventual reentry into open society. In order to accomplish this treatment objective, the program involves incremental trial periods away from the facility. However, these trial periods are unavailable to persons with a correctional sentence. If the psychopath were serving his/her sentence at Oak Park Heights, instead of MSH, he/she would not be allowed to leave the facility. Consequently, the Department of Corrections objects to the psychopath's freedom in leaving MSH, even for therapeutic reasons. Since MSH's treatment program is less effective when an individual is not allowed to participate in a critical phase of the treatment, MSH generally recommends that convicted sex offenders serve all, or most, of their sentence in a correctional facility and then transfer to MSH for treatment.

The second instance in which DHS is frustrated by the psychopathic personality commitment occurs when the psychopath has served his/her time in a correctional facility, and is subsequently transferred to MSH for treatment. Often these psychopathic clients refuse treatment, are found to be unamenable to treatment, pose such a serious risk of imminent danger to staff and patients that extra staff must be hired to guard them, or they must be placed in protective isolation. Nonetheless, DHS is statutorily required to provide these psychopathic clients with proper care and treatment.

DISCUSSION

1. Treatment Issues:

Early on, the committee members identified major differences between persons committed as mentally ill and dangerous (MI&D) and persons committed as psychopathic personalities (PP). The MI&D patient, generally, shows signs of major mental illness and is often out of touch with reality. The psychopathic personality, generally, is a sex offender who has an anti-social personality, and a behavioral disorder, rather than a major mental illness, and who is in touch with reality. Psychiatrically "psychopath" generally means "anti-social personality" and does not exclusively include sexual acting out. Treatment consists of attempts to change behavior which has evolved over a period of many years, rather than treating an active psychosis. Treatment of patients with psychopathic personalities primarily consists of psychotherapy, both individual and group. While sometimes successful, frequently it is not, due to the seriousness of the behavioral problems manifested in the psychopath.

Several members of the subcommittee suggested that we separate psychotic individuals from the psychopathic personalities. Patients with psychosis tend to be extremely vulnerable, therefore psychopaths frequently prey on these individuals. Several members of the subcommittee also felt that persons exhibiting this degree of dangerousness add to the stigma of the mentally ill because the public may perceive all mentally ill persons as dangerous.

Dr. Doheny, then state forensic director and medical director of MSH, raised the issue of whether we have been successful in treating psychopathic personalities. He opined that we have not. He stated that an important reason for the lack of successful treatment is that patients are placed into the program involuntarily. Therefore, cooperation with treatments such as psychotherapy becomes a problem.

Dr. Doheny suggested that:

1. The Department of Corrections be the ultimate responsible authority for this commitment;

2. Entry into treatment should be voluntary;

3. Indeterminate commitment be avoided;

4. Programs must be structured to ensure effective behavioral controls and discipline; and

5. The sex offender programs should control admission to and discharge from their programs.

At one meeting, Dr. Myron Malecha, Medical Director at the Anoka-Metro Regional Treatment Center, lectured subcommittee members regarding personality disorders. At that time Richard Seely, Unit Director of ITPSA, pointed out that while he had some success in treating those patients with schioid type personality disorders and pedophilia, he had been much less successful with anti-social personalities and sadistic rapists.

Terminology issues plagued the subcommittee members during the course of their meetings because the psychiatric definition of psychopath is substantially different from the statutory language defining psychopathic personality. Dick Seely and Dr. Doheny advocated repeal of chapter 526. They contended that there appeared to be no reasonable way that the statutory definition of psychopathic personality could be changed to reflect current psychiatric thinking. Furthermore, they contended that as a clinical matter, it is not appropriate for MSH to be a warehouse for anti-social personalities who are not mentally ill. Moreover, neither the vulnerable mentally ill patient population, nor the staff at MSH should have to fear the predation characteristic of the psychopath. They felt increased time in a correctional facility, such as Oak Park Heights or Lino Lakes, which offers treatment for sex offenders better satisfies the dual needs of security and treatment for psychopaths than does civil commitment to MSH.

II. Public Safety Issues:

In considering repeal of Chapter 526, safety to the public is clearly of paramount concern. Hennepin County Adult Protection, Richard Hoffman (Assistant Ramsey County Attorney), Judge Lindsay Arthur, and Representative David Bishop advocated retaining the Chapter because it was needed to provide a reasonable degree of safety to the public in general, and also to victims of sexual abuse. The commitment protects the public by retaining individuals, indeterminately, in the mental health system who may not have been convicted of a sex offense, because of the reluctance of young and/or scared victims to testify against perpetrators of sexual abuse. The subcommittee members also noted the tendency of county attorneys to plea bargain these cases. As a result, many perpetrators of violent sex offenses are convicted for third or fourth degree criminal sexual conduct and receive comparatively short correctional sentences. If these individuals are also civilly committed as psychopathic personalities, after they have satisfied their correctional sentence, they are transferred to the mental health system until they can prove that they are capable of making an acceptable adjustment to open society, are no longer dangerous to the public, and are no longer in need of inpatient treatment and supervision.

ALTERNATIVES CONSIDERED

1. Revision of Current Statute - Issues Considered

a. Subcommittee members discussed revising the definition of psychopathic personality to reflect a clinical psychiatric diagnosis.

Conclusion: Even with the expertise of four psychiatrists, the subcommittee was not able to agree on a definition which satisfied both the legal and clinical concerns of the committee members.

b. Require a finding of amenability to treatment before civil commitment could be imposed.

Conclusion: This suggestion was rejected because psychopaths may recognize that exhibiting behavior which suggests unamenability to treatment would possibly result in shorter incarceration periods through a correctional sentence, rather than commitment for treatment. In addition, the judge could commit the individual as a psychopathic personality even though a clinical team found the individual not amenable to treatment.

c. Require a criminal conviction for a sex offense as a prerequisite to commitment as a psychopathic personality.

Conclusion: The subcommittee decided that this would be a step backward, since a former similar statute (now repealed Minn. Stat. 246.43) had not proven to be more effective. Several members of the committee also expressed concern that a person may be dangerous but evade conviction due to the high burden of proof required in criminal cases.

d. Limiting the treatment rights of persons committed as psychopathic personality.

Conclusion: The subcommittee members were concerned about the unconstitutionality of limiting patients' rights and, therefore, did not pursue this matter.

e. Delete all references to the MI&D provisions in Chapter 526 (sections 253B.18 & 19).

Conclusion: The subcommittee spent considerable time considering this issue and was unable to devise a better statutory scheme.

f. Change the criteria for discharge of psychopathic personalities.

Conclusion: The subcommittee was unable to reach a consensus on new discharge criteria.

g. Eliminate the indeterminate commitment.

Conclusion: Several members of the subcommittee strongly felt that the indeterminate nature of the commitment was necessary to provide adequate protection to society.

h. Commitment to the Department of Corrections.

Conclusion: This idea was discarded based on legal advice that it was unconstitutional to commit a person to a correctional facility without a criminal conviction.

i. Retain the commitment to the Commissioner of Human Services, and provide a program run by DHS staff, but located in a correctional facility.

Conclusion: The Department of Corrections was opposed to this idea.

J. Creation of a separate program for treatment of psychopathic personalities.

Conclusion: The subcommittee recognizes this as a viable alternative, contingent on adequate funding from the Legislature.

2. Creation of a New Statutory Scheme

The subcommittee generally favored this idea, but felt it lacked the expertise to actually write the statute.

3. Repeal Chapter 526 with Corresponding Amendment to Minn. Stat. 244.10 (sentencing Guidelines)

At one of the later subcommittee meetings, the members discussed repeal of Chapter 526, in conjunction with an amendment to section 244.10, to expressly allow, or even mandate, upward departure from the sentencing guidelines when an offender exhibits those behaviors described in section 526.09 as characteristic of a psychopathic personality.

This proposal, however, does not prevent the eventual release of sex offenders into the community, nor does it confine individuals who escape conviction due to a lack of evidence, or unwillingness of the victim to testify against the perpetrator of sexual misconduct. At this particular meeting, all members present were willing to support this proposal, if it included a provision that all persons previously committed pursuant to Chapter 526 would continue to be governed by the same discharge procedures that apply to persons committed as MI&D (sections 253B.18 & 19).

However, neither Representative Bishop, Richard Hoffman, nor Orville Pung, Commissioner of Corrections, attended this subcommittee meeting. At a later meeting attended by Commissioner Pung, he made a strong argument against this proposal, questioning whether it would be legal with respect to the current system.

This proposal was submitted to the full task force committee November 24, 1982. Many of the individuals who had opposed repeal of the commitment were not present, although many of the clinicians who favored repeal were. In general, clinicians on the full committee saw the great difficulty with treating the client with a psychopathic personality and favored repeal of the statute. They were greatly concerned about public safety, and about who might be released to the general public, if this statute did not exist. The clinicians were concerned with public safety as well, but pointed out that safety issues had to be reflected within the institutions themselves. In other words, by keeping psychopathic personalities indeterminately committed in facilities where there are extremely vulnerable individuals, other patients are at risk, thus, slowing the treatment process for all treatable people within the mental health system, and using an inordinate amount of resources in an attempt to treat the few patients with psychopathic personalities. The clinicians also believed that the proposed sentencing guidelines amendment was a solution which would provide a reasonable degree of safety. Others disagreed, stating that adequate sentencing would not take place if this were strictly a correctional issue, because it was frequently quite difficult to gain a conviction on serious sex crimes. However, at that time, the motion to repeal the commitment passed by a vote of ten (10) to five (5). Dr. Ferron, State Medical Director, thought it was important to indicate in this report that at the previous meeting of the full committee there had been much opposition to repealing the commitment.

CONCLUSION

The issue of repealing the psychopathic personality statute was discussed by the full committee three (3) times.

Though the last vote favored repeal, it was clearly affected, as it had been on previous occasions, by the presence or absence of clinicians, advocates, attorneys and other members of the legal profession who strongly affected the discussions and the outcome of votes. Clearly, the recommendation to repeal the statute was not a strong consensus among the committee members. During the meetings of the subcommittee and the full committee, it was apparent that repeal of the statute was not an isolated issue. Discussing repeal of the statute also included a recognition of the great difficulty clinicians face in trying to treat the psychopathic personality client, the use of limited resources, and the risk to other more vulnerable, mentally ill clients when psychopathic personality clients are put in the same treatment program. Issues related to public safety were also of paramount importance to the committee members.

The Psychopathic Personality Subcommittee met subsequent to the last meeting of the full committee. It was at this meeting that Commissioner Pung discussed at some length his relictance to alter the sentencing guidelines. The committee again deadlocked and further review of the following was suggested:

1. the criteria of the current psychopathic personality statute;

2. the correct treatment setting for the psychopathic personality; and

3. a separate commitment statute for the psychopathic personality as an option, rather than the current situation which requires that the provisions of the mentally ill and dangerous sections of the commitment act be applied to persons with psychopathic personalities.

The inability of the subcommittee to develop more specific recommendations demonstrates both the complexity and the polarity of the clinical and public safety issues.

ADOLESCENT SUBCOMMITTEE REPORT

CHARGE TO THE SUBCOMMITTEE

The original charge to the subcommittee included reviewing issues related to juveniles who are affected by the provisions of the Minnesota Commitment Act. These issues included informed consent for admission and treatment; review of the role of the juvenile and parent in the admission and treatment process; and data privacy as it related to the mental health treatment of juveniles.

ISSUES RELATED TO THE CHARGE

BACKGROUND

At its first meeting, subcommittee members attempted to limit its discussion to how juveniles are affected by provisions of the Minnesota Commitment Act for purposes of admission and treatment. It soon became apparent that this limitation resulted in a distorted picture of other significant concerns about the provision of mental health services to juveniles.

The subcommittee frequently commented that due to the lack of data regarding this population certain assumptions were being made about the mental health system based only on the personal knowledge and experiences of group members. Two basic assumptions were made that affected the ongoing discussions:

1. There are some juveniles with an identifiable mental health problem who want services, but for a variety of reasons cannot obtain them; this could be due to lack of appropriate resources, or lack of funding.

2. There are some adolescents who have been identified as possibly benefiting from mental health services, but may be resistant to accepting these services.

Initially, the subcommittee was concerned about the following issues and questions:

1. There appears to be a great deal of confusion among the courts, mental health professionals, and providers regarding whether the Minnesota Commitment Act (Chapter 253B) or the Juvenile Code (Chapter 260) is the appropriate statute to utilize for involuntary admissions for treatment.

2. Does the community have certain rights to expect that adolescents identified to be in need of treatment receive that care? What are the rights of the parent and child to decide who is to provide the treatment, under what circumstances, and what are the limits of the treatment?

3. What would be the consequences of recommending that the Commissioner seek a statutory change which would prevent minors from being admitted or committed under the provisions of the Commitment Act? What would the overall effect be?

DISCUSSION OF PERCEIVED PROBLEMS:

1. Should the Commitment Act or the Juvenile Code, or both, be revised to provide standards and procedures specifically tailored to the needs of juveniles?

The members of the subcommittee discussed the longstanding view of the Attorney General's Office that juvenile courts do not have statutory authority to commit juveniles to treatment in state facilities. The Commitment Act, chapter 253B, is the vehicle for treatment of juveniles in treatment facilities, including regional centers under the administrative authority of the Department of Human Services.

Juveniles may be either admitted or involuntarily committed to treatment facilties. Minn. Stat. 253B.04, subd. 1 states a preference for "informal" or voluntary admission. Any person 16 years or older may request to be admitted to a treatment facility as an informal patient for observation, evaluation, diagnosis, care and treatment without making formal written application. For persons under the age of 16, informal admission is allowed provided there is: 1) consent of a parent or legal guardian; and 2) an independent examination has been completed providing reasonable evidence that the proposed patient is mentally ill, mentally retarded, or chemically dependent and suitable for treatment.

A parent or guardian cannot informally admit persons aged 16 or older. The involuntary commitment procedures of chapter 253B must be followed if the person is 16 or older and unwilling to seek treatment himself. The involuntary commitment procedures can be used for a person of any age. The definition of "patient" is not limited to specific age groups. (See Minn. Stat. 253B.02, subd. 15.) Judicial commitment procedures are applicable to any "proposed patient". (See Minn. Stat. 253B.07.) In most cases it is not necessary to use involuntary commitment because the parent or guardian can informally admit the child.

Some members of the committee pointed out that commitment, under chapter 253B, may stigmatize the child. Further, it does not allow as much family involvement as does the juvenile code. The definitions of mental illness and chemical dependency in the Commitment Act may be too restrictive to meet the needs of juveniles. Unlike juvenile proceedings, commitment hearings are open to the public.

However, the subcommittee recognized the problems with juvenile courts ordering children into treatment. In some circumstances, such as when the parents in a dependency action admit the petition, a juvenile may be ordered into treatment without a formal hearing. The assessment of the child's need for treatment may be less comprehensive than would occur in a commitment proceeding because of the lack of specific standards for the court's determination. (See Minn. Stat. 260.185, subd. 1; 260.191, subd. 1 (c).)

Subcommittee members discussed three alternatives:

a) Should the current Commitment Act be modified?

Discussion

The subcommittee concurred that any changes to chapter 253B would also require corresponding changes to the Juvenile Court Act to ensure a mechanism for involuntary commitment of juveniles into treatment. Any modification to the existing Commitment Act should include an amendment of section 253B.04, subd. 1 to clarify the nature of the "independent examination", which is required for informal admission of persons under age sixteen. It would also appear appropriate to include minimal requirements for the examination, such as a personal interview with the child, unless the child refuses; a review of the child's background from all available sources, including but not limited to parents, school and other agencies; and a provision allowing for the presence of the child's attorney or other representative. (It was suggested by the subcommittee members that attorneys should be trained and knowledgeable in the area of commitments.) For purposes of the admission of juveniles, the standard definition of "examiner", in section 253B.02, subd. 7 could be used or a new definition of examiner developed.

b. Should the juvenile courts be given exclusive jurisdiction in this area?

Discussion

Recognizing the jurisdiction of juvenile courts could have several advantages. First, it could legitimize what is already occurring; Secondly, it would allow juvenile courts to develop expertise in mental health law; and thirdly, it would provide better coordination of services to and dispositions of juveniles.

c. Should there be a separate commitment act for juveniles?

Discussion

Some committee members favored the development of a separate commitment statute for juveniles. They recommended that any statutory provision should include adequate protection for the rights of the child and criteria for civil commitment for mental illness, which is different for children than for adults. However, the admission procedures should be different when a child objects to admission. Due process protections should not depend on the type of out-of-home facility providing treatment. Juveniles may voluntarily admit themselves to treatment over parental objection, but maturity, including age is a determining factor. Statutory procedures are required when a child voluntarily enters a treatment program over parental objection. Issues regarding financial responsibility should also be addressed.

2. There should be an adequately funded information system.

One of the major problems faced by the subcommittee in discussing the needs of adolescents, was the lack of informative, accurate data. As previously

noted, assumptions were made based solely on the expertise and experiences of subcommittee members, rather than upon a reliable data base of information. There did not appear to be any centralized data regarding the use of the juvenile court to admit juveniles into treatment; the treatment provided to juveniles; or the effectiveness of the treatment provided. The subcommittee recognized that adolescent treatment facilities are currently required to provide the Department of Human Services with certain demographic information. However, the end of December 1987 will be the first year for which data has been received. A preliminary report is expected some time in February, 1988. The subcommittee also noted that while the Legislature had specifically requested that certain data be collected by the Department, it had not made any provision for staffing and funding. The committee members felt strongly that when data collection is required by the Legislature, it should also be properly funded to ensure its future availability.

3. Training, Monitoring and Accountabilty

The subcommittee generally agreed that the mental health system for juveniles in Minnesota has not been held accountable. Frequently, there were a variety of children's needs which required responses from many agencies. It was often unclear which agency was or should have been primarily responsible for coordinating services to help the child. Too often, services were provided based upon available funding sources, rather than because the child's treatment needs had been clearly identified. Without a centralized, responsible authority, providers, case managers, and families were unable to identify what resources were available, and what rights parents and children had during the treatment process. Subcommittee members were also concerned that families and children in crisis cannot always and easily locate early intervention services, or necessary support during aftercare periods.

4. Out of state placements:

Members of the subcommittee expressed concern about the placement of juveniles from other states into Minnesota for treatment purposes. Frequently these children are placed into facilities with no involvement from the local county agency and without adequate compliance with the Interstate Compact Agreement. While county agencies should not have the responsibility to supervise or to monitor the placement, it was generally felt that the host county should be aware of them, in the event that some emergency response was necessary. Members of the subcommittee were also concerned about what rights and protections are afforded to children placed in this manner, and whether permanency planning guidelines are a part of each placement.

CONCLUSIONS

The subcommittee concluded that it lacked adequate time and expertise to fully evaluate the problems associated with juveniles. Clearly committee

members agreed that treatment issues related to juveniles could not be reviewed in isolation. The issues require input from a variety of other agencies and organizations such as education, corrections, and health to assist in the development of a uniform, accountable, and effective system of services. The subcommittee, therefore, determined that it would not make specific recommendations for changes at this time. Instead, it recommended that an agency be identified by the Legislature to coordinate and review service needs of juveniles, and to make comprehensive recommendations to the Legislature.

The subcommittee strongly advised that this should be an ongoing process, properly funded and staffed to recommend and implement necessary changes. The subcommittee also recommended that there be close coordination between the Department's Adolescent Services Unit of the Childrens Division and the Childrens and Adolescent Mental Health Consultant, in the Mental Health Division, of the Department of Human Services.

Section III

RECOMMENDATIONS TO THE COMMISSIONER FROM THE FULL MEMBERSHIP OF THE COMMITMENT ACT TASK FORCE

The following is a summary of the final task force recommendations made to the Commissioner of Human Services. The recommendations are based upon review and discussion of each report submitted by the subcommittees. It should be noted that, in many instances, the recommendations are conceptual, rather than recommendations for specific statutory language changes. For more detailed information regarding each recommendation you may refer to the appropriate subcommittee report located in Section II.

INFORMED CONSENT

By a narrow margin, the full committee recommended that there should be a limited court determination of competency, at the time of commitment. When a person has been found incompetent, the facility would be allowed to medicate for a limited thirty-day (30) period, providing the treatment decision was reviewed and approved by a second psychiatrist, input was received from the patient's treatment team, and sufficient documentation existed to justify involuntary medication. The decision would be reviewable at the request of the patient or physician to determine if the above criteria had been followed. At the end of thirty (30) days, some form of treatment review, either through a court review or a process similar to the treatment review procedure currently followed by the state regional treatment centers would occur.

Some members of the committee expressed concern that this proposal could delay treatment in the early stages, if the patient brought an unlimited number of appeals on the facility's adherence to the procedural requirements; it does not address the issue of immunity from liability for treatment decisions in accordance with professional standards despite the facility's failure to follow the procedure; and in addition, psychiatrists may be less available in rural areas for second-opinion consultation than in the metropolitan area.

The task force also recognized that the pending decision by the Supreme Court in the Jarvis case is likely to have an impact on any recommendations to involuntarily medicate a patient.

On January 15, 1988, the Minnesota Supreme Court decided the case of Jarvis v. Levine, involving involuntary medication treatment of committed mentally ill persons. The court decision requires court approval before antipsychotic medications are involuntarily administered. The Attorney General's office has requested reconsideration and clarification of the decision.

OUTPATIENT/INPATIENT STANDARDS FOR COMMITMENT

(Note: All recommendations are directed toward ordinary mental illness commitment situations, and not at "mentally ill and dangerous to the public" commitments under 253B.18.)

1. RECODIFICATION/CLARIFICATION OF THE COMMITMENT ACT: CRITERIA, ALTERNATIVES, OUTPATIENT OPTIONS

1.1 A limited recodification of the commitment act should be undertaken to bring together in one subheading, or otherwise to highlight the various provisions for outpatient commitment that already exist but frequently go unrecognized. See Minn. Stat. 253B.09, subd. 4, and subd. 1 and 253B.14, subd. 1. The intent is not to change the standards or requirements for these varieties of commitment, but to clarify them and highlight their availability.

Clarifying related statutory structure and definitions

1.2 While the definition of mental illness should not be changed, see 253B.02, subd. 13, it should be clarified by the use of outline format and/or reordering of (b) i and ii, in order to make clear, among other things, that failure to provide for basic needs can provide the grounds for meeting (b), the likelihood of physical harm requirement. The possibility for commitments based on grave disability could thus be highlighted.

1.3 Minn. Stat. 253B.09, subd. 1, should be amended by the addition of language to the following effect:

"In considering what is the least restrictive facility,* the court shall consider a range of treatment alternatives, including but not limited to outpatient treatment, day treatment, community support services, community residential treatment, foster care, partial hospitalization, acute care hospital and regional treatment center services. The court shall also consider the proposed patient's willingness to participate in the treatment modalities and the court shall not commit to a facility that is not capable of meeting the patient's needs."
(* or replace "facility" with "program")

1.4 The definition of "facility" in 253B.02 should be expanded by the addition of "and other treatment providers" or words to similar effect.

Other accompanying statutory additions

1.5 Mechanisms are needed to ensure that there is someone accountable for each outpatient and to ensure appropriate follow-up and court review, so that the outpatient receives quality services. While a uniform standard should apply to both in-and-outpatient commitments, commitments to settings other than a regional treatment center, or acute care hospital require some special additional protections. Those provisions should include, but not necessarily be limited to the following:

a. a person responsible for monitoring must be identified in the court order (while the court should have discretion in naming that person, it was the sense of the group that in most instances the person should be county-employed, or a contracted case manager, who does not have a conflict of interest);

b. the monitor must report to the court at least every 90 days, with more frequent reporting as needed, and with an obligation to report promptly a substantial failure to comply with the conditions of the outpatient commitment;

c. the order should specify the conditions the person has to meet to comply with, and the consequences for failure to comply, such as further hearings or commitment to another setting;

d. at the time of the hearing and outpatient disposition, there must be presented to the court and thereafter incorporated into the findings, to the extent possible, a written preliminary plan of services, and the court should ascertain that financial resources, from public or private sources, are available to pay for the proposed treatment;

e. Minnesota Statutes section 253B.17 or other appropriate section should be modified so as to permit the monitor to petition for a reopening of the commitment hearing, or a new hearing upon substantial non-compliance with the outpatient plan;

f. appropriate statutory language should also be enacted to permit modifications of the outpatient commitment upon agreement of the parties and approval of the court; and

g. forced treatment with psychotropic medications shall not be given to committed persons in any setting, except in emergencies, or under rules adopted by the Commissioner of Human Services which provide due process protections and take into account the client's qualitied right to refuse treatment.

1.6 A mechanism should be created to increase the willingness of outpatient providers to accept committed patients, e.g., some form of limited immunity from liability vis-a-vis third parties. Without specifying the particulars, the subcommittee agreed that there was a need to limit liabilty for those providers outside the traditional hospital context who might otherwise refuse to accept the increased liability of committed patients.

2. FUNDING FOR OUTPATIENT ALTERNATIVES

The subcommittee strongly believes that procedural or statutory changes will not solve current problems unless there is increased funding for outpatient alternatives, and for monitoring outpatients and the treatment system that serves them. Increased funding must accompany the procedural and definitional modifications suggested above and must be available in proportion to the use of outpatient dispositions.

It must also be recognized that outpatient treatment services cannot be effective unless the persons served by them first have their basic human needs - food, clothing and shelter - adequately met.

3. CREATION OF A COMMITMENT RESOURCE CENTER

A Commitment Act Resource/Information Education Program should be created and funded to: 1) provide continuing education on the commitment process, resources, alternatives, etc., to defense attorneys, prosecutors, judges, court personnel, social service personnel, mental health professionals, etc., and to family members and consumers; 2) assist in establishing and coordinating commitment defense panels; 3) serve as a central, identifiable, and responsive resource for family members and others concerned about the commitment process; 4) assist in identifying resources to divert people from commitment; 5) provide and disseminate information about precommitment interventions and alternatives; 6) serve as a point of accountability for monitoring the commitment act and gathering information about its implementation throughout the State; and 7) identify emerging problems with the commitment process and suggest solutions.

In making this recommendation, the subcommittee believed that new financial resources would be needed to implement the activities described. While the subcommittee lacked the time and resources to render a precise cost estimate, it did think it was important to note that the proposed services might be very cost-effective, by providing people with information and alternatives that might help to obviate the need for expensive commitment proceedings or dispositions. While making no final recommendations about where these services might best be located, the committee noted that it might not need to be entirely state-operated and that providing seed money for contracted services might be one option.

4. FORMALIZING THE USE OF STAYS AND CONTINUANCES

The uses of stays and continuances should be more formalized and should include greater protections and provisions for accountability. 253B.09, subd. 4, (release before commitment), and related statutory sections should be modified to this end.

In particular, all stays of imposition of commitment and any continuance or series of continuances that extend longer than 14 days beyond the date of the initially scheduled hearing should be accompanied by the following protections:

4.1 the maximum duration of the stay or continuance should parallel the time limits for commitments, i.e., a maximum initial period of 6 months, with a 12 month extension permissible by order of the court.

4.2 a person responsible for monitoring must be identified (while the court should have discretion in naming that person, it was the sense of the group that, in most instances, the person should be a county-employed or contracted case manager, who does not have a conflict of interest);

4.3 the monitor must report to the court at least every 90 days, with more frequent reporting as needed, and with an obligation to report promptly a substantial failure to comply with the conditions of the stay/continuance;

4.4 the order should specify the conditions the person has to meet to avoid a further hearing for commitment and/or imposition of the stayed commitment order;

4.5 at the time of the hearing on the stay/continuance, there must be presented to the court a written preliminary plan of services, to which the proposed patient has agreed, and the court should ascertain that financial resources are available, from public or private sources, to pay for the proposed treatment. Before entering an order for a stay or continuance, the court should also ascertain that at least one examiner has found that the proposed patient is mentally ill and, in the case of a continuance, is competent to waive the hearing. The subcommittee assumes the active involvement of the patient's counsel in the process; and

4.6 appropriate statutory language should also be enacted to permit modifications of the stay or continuance upon agreement of the parties and approval of the court.

5. INSURANCE/HMO/MEDICAL ASSISTANCE AVAILABILITY

Appropriate statutory changes should be enacted so that group health insurers and health maintenance organizations are not able to deny mental health treatment coverage on the grounds that treatment is court-ordered, part of a stay, or a continuance plan approved by a court. Funding should be available on the basis of need and not subject to arbitrary time limits.

6. FUNDING FOR MONITORING STAYS AND CONTINUANCES

The comments noted above, with respect to the need for enhanced funding of outpatient commitments, are equally applicable to stays and continuances.

7. IMPROVING THE PROVISIONAL DISCHARGE PROCESS

Provisional discharges should be restructured to include provisions for monitoring and accountability similar to those suggested above. The following specific changes should be implemented through appropriate amendments to 253B.15 and related sections.

7.1 In connection with the aftercare plan developed for the provisional discharge under 253B.15, subd. 1, a representative of the "designated agency" should be identified as responsible for monitoring and assisting the patient.

7.2 The aftercare plan should also specify the services and/or treatment to be provided as part of the aftercare plan, as well as the financial resources that are available to pay for those services. (We note again that there may be significant financial implications and costs associated with carefully planned and monitored provisional discharges that work to help patients remain in the community.)

7.3 The individual identified as the monitor, i.e., the case manager from the designated agency, should become involved with the patient and hospital in planning the provisional discharge several months in advance of discharge and should serve as a link assuring continuity of care. Appropriate strengthening of the language in 253B.03, subd. 7, may help to facilitate this role. In addition, any case management rule developed by the Commissioner should also reflect this concept of the role of the case manager in the provisional discharge contect.

7.4 Language should be added to 253B.15 to allow for modification of the provisional discharge plan, as needed, upon agreement of the parties.

7.5 The monitor or case manager, rather than the head of the treatment facility from which the patient has been discharged, should play a more central role in decisions related to whether to seek to revoke the discharge. Prior to 60 days post discharge, the monitor should be the one to request that the head of the facility revoke the discharge. After 60 days, the monitor, not the head of the facility, should be individually designated, under subd. 5, as the one to apply to the court for a return order.

7.6 The patient's attorney shall receive notice of any revocation under subd. 6, as well as all other notices of intended revocation.

7.7 Incorporate the provisions of In Re Peterson, 360 N.W.2d 333 (Minn. 1984) regarding revocation procedures to be followed within the first 60 days of a provisional discharge.

AREAS FOR FURTHER EXPLORATION

The recommendations above do not address all of problems and questions raised in this report. We see a clear need for ongoing work and study. In fact, one of our recommendations addresses this need by suggesting creation of a commitment act resource center or program that could serve as a focal point for data collection and study.

In addition to collecting data, we see a need to monitor any legislative changes to determine their effect on the problems identified in this report. Long-term work may also be required to improve the manner in which mental health services are funded and in identifying sources of revenue. Further study is also needed to quantify the scope of the problem of persons not getting treatment, to track the effect of the new comprehensive mental health act on resolving the problem, and to identify the role of other causative factors. These data, together with advances in our knowledge of treatment modalities and their effectiveness, could be of significant assistance in crafting further solutions.

PERSONS WITH MENTAL RETARDATION

Persons with mental retardation should be committed for a determinate period of time.

Provisional discharge for persons with mental retardation should be for a limited period of time. In addition, the provisions of In re Peterson, 360 N.W. 2d 333 (Minn. 1984) regarding revocation procedures within the first 60 days should be added to the commitment act for all disability groups.

There was disagreement among the full committee membership whether the subcommittee had recommended that there should be a provision for a judicial route to review and to enforce treatment issues, and that the discharge criteria applicable to persons with mental retardation should be amended. The full committee had several questions about these proposals and their impact on either limiting these recommendations to persons with mental retardation, or on including other disability groups in these recommendations. Members of the subcommittee were not available on the date this was discussed, and the full committee felt that a lack of adequate information prevented a recommendation from being made.

PSYCHOPATHIC PERSONALITIES

By a narrow margin, the full committee voted to repeal the psychopathic personality statute. As noted in the subcommittee report, the committee members were widely separated on the issues of public protection, treatment, and civil liberties.

ADOLESCENTS

The full committee agreed that a number of problems exist in this area and that more tome is needed to study the issues thoroughly. The full committee recommended that there be ongoing and close cordination between the Department's newly created Childrens Division and the new Adolescent Consultant position in the Mental Health Division. In addition, ongoing studies should be properly staffed and funded and involve other agencies, such as health, education, corrections, and other community agencies which are involved in the provision of services to adolescents. The committee also suggested that any proposed changes in the Commitment Act be reviewed in conjunction with the Juvenile Code to ensure that potential conflicts between the statutes are resolved.

FURTHER RECOMMENDATIONS TO THE COMMISSIONER:

The above recommendations do not address all of the issues that were discussed by the members of the Task Force. The absence of discussion of certain issues does not reflect, in any way, the importance attached to a particular item; it does show the lack of time and resources available to completely study all the issues.

The committee recognized the need for the development of a data collection system to assist in monitoring the commitment process, and to provide a means of further

identifying problem areas. In addition, the committee suggested that the role and responsibilities of the Regional Center Review Boards need to be clarified. Several members expressed concern that lack of time meant that issues pertaining to the chronically chemically dependent and the geriatric populations were not studied and felt that these populations, given their special needs, should be reviewed and recommendations made regarding appropriate admission and treatment alternatives.

The committee recognizes a strong need for ongoing work and study. The committee agreed that an agency should be specifically charged with the responsibility of reviewing the Commitment Act, on an ongoing basis, making recommendations for changes to the legislature, as needed. In order to accomplish this, the committee further recognized that an agency would require proper staffing and resources to continue the work needed to ensure that the commitment process, in Minnesota, properly balances civil rights protections with its provisions for quality treatment.

Section IV

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