

Thanks to a large group of stakeholders, organized by NAMI Minnesota, the legislature passed a comprehensive re-write of the civil commitment law. It included changes to definitions, clarification of transport and emergency holds, a new section on engagement services, resolving paperwork issues, and numerous other technical changes. The changes better reflect our current mental health system. The standard for being civilly committed was not changed, and no substantive changes were made to the section around the commitment of people who are found by the court to be mentally ill and dangerous.

Definitions: The definition of community-based programs was expanded to include the wide array of services such as crisis services, Assertive Community Treatment (ACT) teams, Adult Mental Health Rehabilitation Services (ARMHS), supportive housing and Medicaid waivers (such as CADI) along with typical outpatient services such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Person first language is used throughout. For example, in defining who can be committed, instead of referring to “person who is mentally ill” it reads “person who poses a risk of harm due to a mental illness.” Before someone is committed they are referred to as a “person” and once committed they are referred to as a “patient.”

The phrase “regional treatment center” was changed to “state operated treatment programs” and modernized to better reflect the current state system. This includes all the different types of services provided, including residential, outpatient, and community behavioral health hospitals. Instead of “physician” the term “medical practitioner or other qualified medical provider” is used to recognize the other health care professionals who can prescribe medications and conduct other health assessments.

The definition of health officer was expanded to include any mental health professional, as well as a mental health practitioner working on a mobile crisis team under the supervision of mental health professional. Mental health professionals include psychiatrists, certain nurses including, APRNs, independent clinical social worker, psychologist, marriage and family therapists, or licensed professional clinical counselor. An examiner can now be any mental health professional or an APRN who has not specialized in mental health and who is practicing in an emergency room – in the past it was a physician, psychologist, an APRN or a physician assistant. Examiners can initiate a 72- hour hold and author examiner statements in support of a petition for commitment. A new category of “court examiner” was added and only court examiners (physician or psychologist with a doctoral degree) can serve as court-appointed examiners or examiners for the purposes of Rule 20.

The previous language used the term “treatment facility” to interchangeably refer to community-based treatment, treatment at a residential facility or hospital, or state-operated treatment programs. The new language makes clear which type of program is being referenced. “Treatment facility” means a non-state-operated hospital, residential treatment provider, crisis residential withdrawal management center, or corporate foster home, while “state-operated treatment program” refers to all state-operated programs.

The new law also recognizes the importance of health care or psychiatric directives. The definition of “interested person” is limited to people who have a specific interest in the welfare of the person. The development and review of a treatment plan is to be done according to the provider’s license or certification. If there are no requirements, it must be reviewed quarterly. Admission criteria should be consistent with standards established by professional organizations, including the American Society of Addiction Medicine.

The legislation replaces court-ordered early intervention with new language to promote early intervention by working to engage a person in treatment voluntarily. The goal is to engage someone to accept treatment, services and supports early on, when symptoms are appearing and to prevent someone from being hospitalized, committed or going to jail. In order to be eligible for engagement services, the person must be at least 18 years old, have a mental illness, and either (1) be exhibiting the signs of a serious mental illness such as hallucinations, mania, delusional thoughts or able to care for themselves; or (2) have a history of failing to adhere with treatment for their mental illness that has been a key factor in the past for a hospitalization or incarceration, and the person is now showing the symptoms that may lead to hospitalization, incarceration, or court-ordered treatment.

Families and others can contact pre-petition screening at the county and ask for help. Engagement services include assertive attempts to engage the individual in mental health treatment, engaging the person’s support network (family) including educating them on means restriction and suicide prevention, and meeting the person’s immediate needs for food, housing, medication, income, disability verification and treatment for medical conditions. Engagement services must consider a person’s personal preferences and can last for up to 90 days. Engagement services must be person-centered can be provided even if someone is in jail. Services end if the person meets the criteria for civil commitment or if the person agrees to voluntary treatment. When an individual agrees to voluntary treatment, the engagement team must facilitate the referral to an appropriate mental health provider including help obtaining insurance. Engagement staff can be county staff or through a contracted agency. They can include but are not limited to members of a mobile crisis teams, certified peer specialists, and homeless outreach workers. Counties may, but are not required to offer engagement in treatment services.

A change was made to the section about health plans. There was a lot of extra verbiage about how health plans pay for court ordered treatment. The extra language was struck, and it simply says health plans have to pay for mental health services ordered by a court.

Another key set of changes were around the transport holds and emergency holds. Both sections were re-written to increase clarity. A transport hold is ordered by a peace or health officer to transport someone involuntarily to a treatment facility, state-operated program or community-based treatment program for assessment due to being a danger to self or others. The peace or health officer can use direct observation of the person’s behavior or reliable information provided by someone. A transport hold issued by a health officer or examiner is sufficient authority for a police officer to transport the person with a mental illness to a treatment program. So for example if a member of a mobile crisis team believes the person should be transported to a treatment program, the peace officer does not have to make their own assessment, they can

simply use the health officer's written statement. This legislation also clarifies that protected transportation can be used for a transport hold if this service is available. The legislation states that someone taken to a hospital under a transport hold must be assessed by an examiner as soon as possible but within 12 hours of the person's arrival. The transport hold ends when the person agrees to treatment voluntarily, an emergency hold is initiated, the examiner decided not to issue an emergency hold, or 12 hours after the person's arrival.

An emergency hold is ordered by an examiner, for the purpose of conducting a more thorough evaluation to see if the person will seek treatment voluntarily or if the person meets the criteria for civil commitment. It cannot last more than 72 hours (excluding weekends and holidays). When the 72-hour hold is placed, the examiner must immediately provide the patient with the written statement.

The pre-petition screening team may seek input from the patient's health plan about relevant treatment history and current treatment providers. The pre-petition screening team must provide its decision to any specific individuals named in the examiner's statement. For example, if a family member was named in the statement, the pre-petition screening team must inform them of their decision. There is a preference for doing in-person interviews for pre-petition screening.

When someone has been determined incompetent to stand trial, the county where the criminal matter is pending is responsible for conducting the pre-petition screening and if the statutory conditions for commitment are met, to file the commitment petition. By agreement between the county attorneys, prepetition screening and filing the petition may be handled in the county of financial responsibility or the county where the patient is present. If there is a motion filed for a change of venue, the county attorney from the proposed county must be notified and provided an opportunity to respond.

There is a greater focus on placing the person in the least restrictive alternative and recognizing the lack of beds at state operated programs. An individual committed to the Commissioner and in a community facility or program while waiting for admission to a state operated facility may be provisionally discharged by that community facility or program if the community facility or program deems provisional discharge clinically appropriate. Separately, there is also now specific authorization for a "dual commitment" to a community-based program or treatment facility that is willing to treat the patient and the Commissioner of Human Services. If the patient in the future needs a higher level of care, they can transfer to the commissioner. If the patient is in a state-operated program and no longer needs that level of care, the patient can be released to the community-based program. The community program or treatment facility can conduct a provisional discharge if the person is ready. There is to be coordination between the state-operated and community-based programs to facilitate timely access and coordinated treatment planning. The treatment facility or state-operated program where the patient is when the commitment is ordered, can continue to confine and provide treatment to the patient until the patient is transferred to the program to which they have been committed.

Under 253B.092, which pertains to the use of neuroleptic medication and Jarvis orders, a number of changes have been made. That section now applies to all individuals committed under 253B or 253D, who meet applicable criteria. A medical practitioner can continue a medication the person

was previously on when the person lacks capacity to consent through the hearing date or until the court issues an order. If someone is in the community, county jail or correctional facility, a Jarvis order can be carried out if they have appropriate medical staff to administer medication and reassess the individual's condition. Nasogastric tubes are explicitly banned from use in situations where medication must be given using physical force. The new law states that there is a rebuttable presumption that a patient has the capacity to make decision regarding administration of neuroleptic medication. Instead of saying the person is making a clear choice not based on a delusion, it is not based on a symptom of the patient's mental illness.

The 48-hour law was not changed. However, for those patients referred to the Commissioner of Human Services for admission under that law, treatment records of the patient from the previous two years (hospital, treatment facility, jail) must be provided to the commissioner of human services upon request, for purposes of preadmission planning.

Commitments do not end if a county worker forgets to file the paperwork at 30, 60 or 90 days. The court will notify the county and remind them submit the paperwork within five business days. If the reports is still not filed, a hearing must be held within three business days. The reports to the court must include, if possible, a statement from the patient.

For continuation of commitments some changes were made. If the petition was filed before the end of the previous commitment, and for good cause shown, the court has not completed the hearing and the determination by the end of the commitment period, the court may extend the previous commitment by 14 days to allow the completion of the hearing and the issuance of the determination.

If the patient while committed leaves the treatment program and is to be apprehended, the patient will be returned to any treatment program willing to accept the person.

Several changes have been made to provisional discharge. For a revocation of the provisional discharge the court can look at the need for a more restrictive setting or more intensive community services. The authority to modify or extend an existing provisional discharge now lies with the designated agency, not the treatment facility. To extend a provisional discharge the designated agency must provide an opportunity for the patient to object or make suggestions for an alternative. Unless the court orders otherwise, a provisional discharge which is written to run until the end of the initial commitment period is automatically extended if the court continues the commitment or recommits the individual.

(SS Chapter 2, Article 6)