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Mentally Ill, or Mentally Ill and Dangerous?: Rethinking Civil Commitments in Minnesota

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I. INTRODUCTION

John Stuart Mill wrote, “the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others.”¹ This principle is most commonly regarded in relation to the criminal law, where Justice Anthony Kennedy acknowledged that “incarceration . . . is the most common and one of the most feared instruments of state oppression and state indifference . . . .”² Going further, he wrote that “freedom from this restraint is essential to the basic definition of liberty in the Fifth and Fourteenth Amendments of the Constitution.”³

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¹ JOHN STUART MILL, ON LIBERTY 22 (1859).
³ Id.
Mill’s statement is equally applicable in cases of civil commitment. “[P]atients face lengthy—even indeterminate—[commitments.]”4 At the same time because the commitments are civil and not criminal, patients have no constitutional right to a speedy trial.5 These patients are not without rights; indeed, the courts have found that not providing procedural safeguards would violate the constitutional rights of a patient.6 Yet, looming in the shadows is the disturbing fact that “it is the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment hearings is likely to be ineffective.”7

The United States Supreme Court has found that “incapacitation may be a legitimate end of the civil law.”8 This is the case even if no treatment is available to speed their recovery and release.9 Additionally, patients who are involuntarily hospitalized are subjected to psychiatric treatment, which may include the forced taking of medications.10 The result is that civil commitments invade not only the privacy of the patient, but also their person.

The reality of how these civil commitment decisions are made under the Minnesota Commitment and Treatment Act (MCTA).11 The MCTA ought to be closely scrutinized. Michael Perlin wrote that “the overwhelming number of cases involving mental disability law issues are ‘litigated’ in pitch darkness. Involuntary civil commitment cases are routinely disposed of in minutes behind closed courtroom doors.”12 In 1979, the United States Supreme

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5. Id.
6. See Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated, 414 U.S. 473 (1974) (a statute that fails to provide an allegedly mentally ill person with adequate procedural rights is unconstitutional); see also Jackson v. Indiana, 406 U.S. 715 (1972) (holding that a statute which condemned a defendant to permanent institutionalization deprived him of his equal protection and due process under the Fourteenth Amendment).
9. Id.
Court noted that the average time for an involuntary civil commitment hearing was 9.2 minutes.\textsuperscript{13} While that has certainly not been this author’s experience, the important thing is to realize that a short hearing, whether 9.2 minutes or four hours, has major implications in the life of a human being.

The American Psychiatric Association once acknowledged “that ‘dangerousness’ is neither a psychiatric nor a medical diagnosis, but involves issues of legal judgment and definition, as well as issues of social policy.”\textsuperscript{14} Because of the monumental effect on the life and liberty of a person that a civil commitment has, the process for determining whether a civil commitment should occur ought to be narrowly defined and readily discernable for all parties to follow. Unfortunately, that is not the case.

The MCTA is, like any piece of legislation, a flawed statute. It lacks sorely needed definitions of “serious physical harm” as well as “dangerous” that would allow district courts the necessary guidance to make decisions in a consistent manner. As a result, the case law is inconsistent, leaving statutory ambiguities unresolved.

Section II of this article addresses in detail both the MCTA standards for commitment as mentally ill and mentally ill and dangerous. Each type of commitment is discussed with regard to the requirements to make such a finding, and the process that follows after such a finding is made. Section III addresses two points of ambiguity within the MCTA itself: how to determine what constitutes “serious physical harm” and how to determine whether a person is “dangerous.” Finally, Section IV offers some suggestions on how the MCTA could be more coherent, and whether the responsibility to make these changes lies with the courts or the legislature.

\textbf{II. DEFINITIONS}

Before delving too deeply into the MCTA distinctions between a person who is mentally ill and a person who is mentally ill and dangerous, a definition of mental illness is needed. The MCTA defines mental illness as:

\begin{itemize}
  \item \textsuperscript{13} Parham v. J.R., 442 U.S. 584, 609 (1979).
  \item \textsuperscript{14} AM. PSYCHIATRIC ASS’N, TASK FORCE REPORT 7: CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 33 (1974).
\end{itemize}
[A]n organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person’s capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.\textsuperscript{15}

In commitment evaluations, this definition informs the findings of both mentally ill and mentally ill and dangerous.

\textit{A. Defining Mentally Ill}

The MCTA provides a definition of what constitutes a person who is mentally ill. A person who is mentally ill is any person who:

[H]as 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 is manifested by instances of grossly disturbed behavior or faulty perceptions and poses a substantial likelihood of physical harm to self or others.\textsuperscript{16}

The substantial likelihood of physical harm to others can be manifested by the following:

(1) failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment;\textsuperscript{17}

(2) inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;\textsuperscript{18}

(3) a recent attempt or threat to physically harm self or others;\textsuperscript{19} or

\textsuperscript{15} MINN. STAT. § 245.462, subdiv. 20(a) (2018).
\textsuperscript{16} MINN. STAT. § 253B.02, subdiv. 13(a) (2018).
\textsuperscript{17} MINN. STAT. § 253B.02, subdiv. 13(a)(1) (2018).
\textsuperscript{18} MINN. STAT. § 253B.02, subdiv. 13(a)(2) (2018).
\textsuperscript{19} MINN. STAT. § 253B.02, subdiv. 13(a)(3) (2018).
(4) recent and volitional conduct involving significant damage to substantial property.  

A person is not considered mentally ill under the MCTA if their impairment is solely due to epilepsy; developmental disability; brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or dependence upon or addiction to any alcohol, drugs or other mind-altering substances.

For a court to order that a person be civilly committed under this statute, the court must find by clear and convincing evidence that the patient to be committed is mentally ill, developmentally disabled, or chemically dependent. The court is to consider “reasonable alternative dispositions” including but not limited to, dismissal of the petition, voluntary outpatient care, voluntary admission to a treatment facility, appointment of a guardian or conservator, or release before commitment. If the court finds that no suitable alternative to judicial commitment exists, the court shall commit the patient to the least restrictive treatment or an alternative treatment program which meets the patient’s treatment needs. Should the court order a commitment, then the initial commitment period begins on the date that the court issues an order or a warrant committing the patient to the care of the treatment facility. The initial commitment itself is not to exceed six months.

The MCTA requires that the head of the treatment facility to which a patient is committed file a treatment report with the court. If the patient is discharged from commitment within the first sixty days after the initial commitment order, the head of the facility must file a report with the court detailing the patient’s need for continuing treatment. A copy of the report must be supplied to the county attorney, the patient, and the patient’s counsel. When a patient remains in treatment longer than sixty days from the date of the initial commitment order, the head of the treatment facility that has

23. Id.
24. Id.
26. Id.
custody of the patient must file a written report with the court at least sixty days but no later than ninety days after the date of the order.29 A copy of this report must also be supplied to the county attorney, the patient, and the patient’s counsel.30

B. Defining Mentally Ill and Dangerous

The MCTA also defines “a person who is mentally ill and dangerous to the public.”31 A person who is mentally ill and dangerous to the public is a person who is: (1) mentally ill;32 and (2) who, due to their mental illness, presents a clear danger to the safety of others.33 Whether a person presents a clear danger to the safety of others is demonstrated by (1) either an overt act causing or attempting to cause harm to another34 and (2) a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.35 A person committed as a sexual psychopathic personality or a sexually dangerous person may also be subject to commitment as mentally ill and dangerous to the public.36 In order to commit a person as mentally ill and dangerous, the court must find by clear and convincing evidence that the above criteria have been met.37 These statutory requirements must be strictly interpreted.38 A finding of mentally ill and dangerous does not require that a person be convicted of a crime.39 Neither does an acquittal foreclose the possibility of commitment as mentally ill and dangerous.40

Minnesota case law provides a troublingly large range of scenarios which can satisfy the “overt act” requirement. For example, it is not necessary for murder or mayhem to occur in order

29. MINN. STAT. § 253B.12, subdiv. 1(b) (2018).
30. MINN. STAT. § 253B.12, subdiv. 1(b) (2018).
33. MINN. STAT. § 253B.02, subdiv. 17(a)(2) (2018).
36. MINN. STAT. § 253B.02, subdiv. 17(b) (2018).
38. In re Knops, 536 N.W.2d 616, 620 (Minn. 1995) (citing In re Jasmer, 447 N.W.2d 192, 195 (Minn. 1989)).
40. Id.
to meet the standard. A series of attacks has been found sufficient, as has a single, severe beating of a child. Nor does the act need to be related to the events which led to the commitment action. In re Welfare of Hofmaster involved the commitment as mentally ill and dangerous of a man arrested for entering the Dallas Saloon in Faribault, Minnesota. During this incident Hofmaster threatened to kill the people there, as well as the responding police officers and their families, and then threatened to “blow up the earth.” Despite these actions, Hofmaster was found to be mentally ill and dangerous based only on a stabbing which had occurred eleven years earlier.

Additionally, we know that “the remoteness of an overt act does not necessarily preclude a commitment as mentally ill and dangerous.” Events preceding the commitment by more than a decade have been found sufficient to satisfy the overt act requirement, which raises questions as to whether a remote, prior overt act can be shown to be a product of mental illness. For the Hofmaster court, such evidence was deemed unnecessary.

Sometimes the case law is contradictory. A particular area of concern involves the intent of the patient. In In re Kottke, the Minnesota Supreme Court reversed a finding of mentally ill and dangerous in part because Kottke’s behavior did not cause and was not intended to cause serious physical harm. At the same time, courts have found that intent is not relevant in determining whether conduct constitutes an overt act.

There are other issues as well concerning the distinction between mentally ill and mentally ill and

41. Carroll, 706 N.W.2d, at 531.
42. Id. at 528–29.
44. See In re Welfare of Hofmaster, 434 N.W.2d 279 (Minn. Ct. App. 1989) (affirming a district court ruling which found that a stabbing 11 years prior to the actions precipitating the commitment hearing was not too remote.).
45. Id. at 280.
46. Id.
47. Id.
49. Hofmaster, 434 N.W.2d at 279.
50. Id. at 280.
51. In re Kottke, 433 N.W.2d 881, 884 (Minn. 1988).
52. In re Civil Commitment of Carroll, 706 N.W.2d 527, 530 (Minn. Ct. App. 2005).
53. Id.
dangerous. Among these issues are differentiating between “substantial harm” and “serious physical harm,” and defining “dangerous.”

C. Two Ambiguities

1. Physical Harm v. Serious Physical Harm

Despite a lengthy definitions section with twenty-three subdivisions, some of which have multiple subsections, the MCTA fails to define what constitutes “serious physical harm.” The difference may seem obvious with “serious physical harm” being a more extreme type of physical harm. However, because “physical harm” is such a general concept, it is arguable that “physical harm” includes within its definition “serious physical harm.”

The Minnesota Supreme Court has ruled that the word “serious” in mentally ill and dangerous cases is limited to the common understanding of the word “serious.”\(^{54}\) Perhaps the most relevant definition of “serious” is “having important or dangerous possible consequences.”\(^{55}\) Therefore, “serious physical harm” can be defined as “physical harm having important or dangerous consequences.”\(^{56}\)

Any physical harm can have important or dangerous possible consequences. By requiring the interpretation of the word “serious” to be based upon a common understanding of its meaning, a determination of “serious” necessarily becomes a subjective determination, likely to change from court to court or even day to day.

These distinctions may seem merely a quibble over semantics, or even the type of pettifoggery that gives lawyers a bad name, but that would be a cynical and unfair assessment. Civil commitments often occur without related criminal convictions. It is one scenario to order that a person convicted of a crime be confined because that person has usually (though admittedly not always) been the beneficiary of all of the due process rights afforded to criminal defendants. It is something else entirely for the State to step in and

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54. *In re Knops*, 536 N.W.2d 616, 620 (Minn. 1995).
56. It bears noting that the courts have found that it is not necessary to refer to criminal statutes to define “serious.” *In re Lufsky*, 388 N.W.2d 763, 766 (Minn. Ct. App. 1986).
deprive a person of their liberty through an arguably subjective standard, often clumsily wielded by individuals who are not mental health professionals. The seriousness of such an action deserves more than the interpretation of a word by a judge on any given day. Such a power should be strictly limited, and its terms narrowly defined.

2. Defining and Diagnosing “Dangerous”

Also missing from the MCTA is a definition of dangerousness. *Merriam-Webster* defines “dangerous” as “able or likely to inflict injury or harm.” So mentally ill and dangerous could be construed as “mentally ill and able or likely to inflict injury or harm.” That is a low bar to set when determining whether to deprive a person of his or her liberty.

Compounding this issue is the fact that mental health professionals are themselves unable to predict future dangerousness precisely and with absolute certainty. Dr. Robert Phillips outlines three methods relied upon by clinicians to determine whether or not a person will be dangerous in the future: (1) the actuarial approach; (2) the clinical approach; and (3) the structural clinical judgment approach. Dr. Phillips further warns that these different methodological approaches are polarizing within the clinical community.

The actuarial approach attempts to predict an individual’s dangerousness by using information sourced from group data instead of individualized assessment. Supporters of this approach argue that it is effective because it is devoid of any clinician bias. On the other hand, its accuracy in predicting dangerousness is low because its prediction is limited to individuals who are similar to those from whom the prediction data were drawn.

59. Id.
60. Id.
61. Id.
62. Id.
63. Phillips, supra note 58, at 474.
“Clinical approaches reportedly achieve better-than-chance levels of accuracy.” Detractors, however, dismiss this approach as “anecdotal.” Advocates state that clinical approaches are based upon the clinician’s intuition, experience, and clinical orientation. They worry that these factors, allegedly, lead to clinicians being vulnerable to individual bias.

Structured professional judgment approaches attempt to estimate a risk of dangerousness by “reviewing and scoring a set list of empirically validated risk factors known to be associated with violence.” “Structure is imposed on which risk factors should be considered and how they should be measured.” The mental health professional’s weighing of the importance of these factors is said to be a result of clinical judgment. Such judgment is, however, subject to the same criticisms as the pure clinical approach.

It should be troubling that mental health professions cannot decide amongst themselves on the best methods to use for diagnosing dangerousness, especially when viewed in light of the fact that different experts utilizing different methods may offer different assessments on substantially similar cases. Equally troubling is the empirical data about success rates of predicting dangerous acts resulting from mental illness. In a recent article assessing mental illness and mass shootings, doctors Jonathan Metzl and Kenneth MacLeish wrote:

Data supporting the predictive value of psychiatric diagnosis in matters of gun violence is thin at best. Psychiatric diagnosis is largely an observational tool, not an extrapolative one. Largely for this reason, research dating back to the 1970s suggests that psychiatrists using clinical judgment are not much better than laypersons at

64. Id. at 475.
65. Id.
66. Id.
67. Phillips, supra note 58, at 475.
68. Id.
69. Id.
predicting which individual patients will commit violent crimes and which will not.71

Writing in 1978, Steadman and Cocozza found that there is “very little literature that provides empirical evidence dealing with psychiatric predictions of dangerousness.”72 They further found that “despite statutory and procedural trends to the contrary, the data available suggest no reason for involving psychiatrists in the dispositional processes of violent offenders under the expectation of predictive expertise.”73

The inability of mental health professionals to precisely predict future dangerousness is further compounded by the independence of the district courts in determining whether a patient is dangerous. In the Matter of re DeWayne Colbert,74 the Minnesota Supreme Court addressed a situation where the district court issued a ruling of mentally ill, but not mentally ill and dangerous, despite the examiners concluding that Colbert was dangerous. Colbert arose from a hearing to continue the commitment of Colbert as mentally ill and dangerous.75

At the hearing, one expert, a licensed psychologist at Minnesota Security Hospital, testified that while Colbert was not dangerous when using drugs prescribed to him, there was a significant likelihood that he would discontinue using them if released and that there would then be a substantial likelihood of him posing a danger to the safety of others.76 A psychiatrist appointed as an examiner by the court also generally agreed with the first expert.77 This expert, however, stated her opinion differently. She testified that Colbert’s psychosis had been alleviated almost entirely by the medications and that he did not present any substantial likelihood of engaging in acts capable of inflicting serious bodily harm on someone.78 She

73. Id. at 230.
74. In re DeWayne Colbert, 454 N.W.2d 614, 614 (Minn. 1990).
75. Id.
76. See id. at 615.
77. Id.
78. Id.
also opined that Colbert might be non-compliant with taking his medications if not at a facility; additionally she testified that she did not trust him to continue taking his medications on his own.  

Colbert himself testified that he realized the importance of taking his medication and that he would continue to take his medications once he was released.

Despite the misgivings of these experts, the district court found that Colbert was mentally ill, but not mentally ill and dangerous. The court of appeals reversed, finding that the district court’s decision was clearly erroneous. The Minnesota Supreme Court, in turn, reversed the court of appeals. The outcome of this saga of reversals is that the Minnesota Supreme Court validated the ability of the district court to substitute its own judgment for that of the experts. Why then, have experts in the first place?

D. Solutions

1. Serious Physical Harm

What constitutes “serious physical harm?” As noted above, the Minnesota Supreme Court determined that “serious” should be limited to the common understanding of the word “serious.” This provides little guidance and opens the door to a broad range of interpretations by the mental health professionals examining the patient and by the judge presiding over the commitment hearing.

The district court should ideally limit its decision to the plain language of the statute. In the event that the statutory language is ambiguous, legislative history may provide guidance, though it should not be considered binding. Here, however, there is little in the legislative history that is of use in determining how “serious physical harm” should be interpreted.

One possible definition of “serious physical harm” could be “physical harm that is life-threatening, fatal, or likely to result in temporary or permanent disability.” One benefit of this narrow

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79. Colbert, 454 N.W.2d at 615.
80. Id.
81. Id.
82. Id.
83. Id. at 616.
84. In re Knops, 536 N.W.2d 616, 620 (Minn. 1995).
definition is that it limits the range of violent acts that can be considered serious. On a given day, a district court judge might consider an assault in which a person is struck in the back, resulting in a fall and a sprained thumb, to be sufficient to believe that a patient who committed the attack might commit further acts resulting in serious physical harm.\textsuperscript{85} It is hardly defensible to compare such a minor attack to a situation wherein a person suffering from a mental illness stabbed the wife of the man she believed loved her.\textsuperscript{86}

While it is possible that the Minnesota Supreme Court could take it upon itself to offer a definition of “serious physical harm,” the responsibility to create such a definition truly rests with the State Legislature. Defining “serious physical harm” would allow the Legislature to guide the courts towards effectively interpreting the statute as intended.

2. A Definition of Dangerous

In a 1974 article, the editors of the \textit{Harvard Law Review} noted that because the level of dangerousness must be great enough to outweigh the severe deprivations in individual liberty, very few people should be committable under the police power.\textsuperscript{87} Without a definition of “dangerousness,” district courts have held that a single incident involving a severe beating is enough for someone to be considered dangerous,\textsuperscript{88} while a person with a history of assaults and threatening behavior (including threatening someone with an open knife) is not dangerous.\textsuperscript{89} Regardless of how a judge might value legislative history, it provides little help in interpreting the law. So, with just the plain language of the text to guide the district courts, more guidance is needed from the legislature.

I would argue that the MCTA should be amended to include a definition of “dangerous.” A possible definition could be “a person is considered ‘dangerous’ if they have a prior history of violent acts

\textsuperscript{85} See \textit{In re} Kottke, 433 N.W.2d 881, 882 (Minn. 1988) (The Minnesota Supreme Court ultimately disagreed with the district court and reversed).
\textsuperscript{86} See \textit{In re} Mikulanec, 356 N.W.2d 683, 685 (Minn. 1984).
\textsuperscript{88} See, e.g., \textit{Clemens}, 494 N.W.2d 519 (Minn. Ct. App. 1993).
\textsuperscript{89} See, e.g., \textit{Colbert}, 454 N.W.2d 614 (Minn. 1990).
related to, or there is a high probability that they will commit a violent act as a result of, their mental illness.” A prior history of violent acts related to a patient’s mental health creates a strong presumption that a person is dangerous. The Minnesota Supreme Court has stated that when considering whether a person is mentally ill and dangerous, the court should consider the person’s entire history. 90 Conversely, a history of violent acts unrelated to the patient’s mental health is simply indicative of a propensity towards violence. In the latter case, those violent acts should not be used as a vehicle to deprive a person, not charged with a crime, of their liberty and their privacy. 91 There should be a demonstrable nexus between the mental illness and the prior or potential violent acts.

The second part of this definition, that there is a high probability that the patient will commit a violent act as a result of their mental illness, is slightly more challenging. As argued above, empirical evidence shows that even mental health professionals are unable to predict violence with a high degree of accuracy. 92 Unfortunately, there is little choice other than to depend on the opinions of professionals and the discretion of judges. For that purpose, a narrow definition of “dangerous” offers some degree of guidance that does not currently exist.

3. Mental Health Courts

A final suggestion is to extend the jurisdiction of mental health courts to include civil commitment hearings. Mental health courts are part of a movement towards therapeutic jurisprudence designed to address specific offender populations who do not respond well to traditional correctional methods. 93 Therapeutic jurisprudence aims at a problem-solving approach. 94 To that end, the earliest example of a problem-solving court was the Miami-Dade drug court in

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90. See Hofmaster, 434 N.W.2d at 281.
91. This is arguably getting into the realm of multiple punishments for one act.
92. See Phillips, supra note 58, at 474.
94. Id.

The success of drug courts has led to the establishment of other problem-solving courts, including DWI courts, juvenile courts, and mental health courts. The unique issues facing the mentally ill were first addressed from a therapeutic jurisprudence when Broward County, Florida opened what is considered to be the first modern mental health court in 1997. There are now several mental health courts in Minnesota as well.

The argument for giving mental health courts jurisdiction over civil commitments rests on the knowledge and experience gained by the personnel regularly involved in those programs. Michael Perlin has argued that counsel representing patients in civil commitment hearings can be “woefully inadequate—disinterested, uninformed, roleless, and often hostile.” Conversely, Perlin has argued that the petitioner in civil commitment issues (usually the state) also has a lackluster track record. Such was the concern when late Chief Justice Warren Burger once wrote that at retrial, “I would hope these sensitive and important issues would have the benefit of more effective presentation and articulation on behalf of petitioner.”

The team-based approach often found in problem-solving courts, including mental health courts, offers the presiding judge insight from members of the criminal justice system as well as treatment agencies. Given the wide range of expertise and specialized knowledge available to such a team, and considering the

95. Id. at 951.
96. Id. at 954.
97. Id. at 955.
98. Id. at 960.
99. Id.
103. Perlin, supra note 101, at 947.
body of research showing that it is difficult even for professionals to predict dangerousness in mental health patients, it is reasonable to think that a mental health court would be better situated to determine whether a patient is mentally ill and dangerous than a typical district court. At worst, the court could not be found to have failed due to lack of expertise, interest from involved parties, or negligence of counsel.

There are, of course, counter-arguments to be made against transferring jurisdiction to mental health courts. First, there are a limited number of mental health courts available in Minnesota. Few counties have a mental health court, and even some larger counties, such as Olmsted County, lack such a court. One possible answer to this argument is that not every county needs a mental health court. A metropolitan county may have need for its own mental health court, but for rural counties it may be more efficient for the judicial district itself to establish one mental health court. Ultimately, if the State is willing to ask that a person have their liberty wrested from them without an attendant criminal conviction, the State ought to be willing to provide a forum capable of reaching the most informed decision possible, and then be willing to travel to that forum as well.

A second, related argument against transferring jurisdiction to mental health courts is that it would be expensive to set up new mental health courts in the first place. Costs are, of course, always a concern, especially when it comes to spending taxpayer money. Even so, mental health courts provide a unique opportunity to create meaningful partnerships which involve the entire mental health community. As an example, grants are often a means by which problem-solving courts find funding to cover startup costs and operations. Partnering with an organization, such as a medical school psychiatry program, would allow the new court to include the clinical expertise of the professors, provide access to further grant money meant for research, and generate research data as which may in turn improve the ability of professionals to further assess whether an individual who is mentally ill is also dangerous. In a data driven age, such a partnership would be ideal; yet it is only one possible method of using a partnership to help establish and fund a mental health court.

104. See Guthmann, supra note 93, at 960.
4. The Role of the Legislature

It bears mentioning that none of these changes should be made by the courts. While courts certainly have a degree of latitude in determining ambiguous statutory language, correcting that language and creating, funding, and implementing new policy is inherently the nature of the legislature. The role of the district courts in civil commitments should not be that of fact-finder, legal arbiter, and amateur forensic psychiatrist. Nor should the Minnesota Supreme Court or the court of appeals be responsible for determining, from vague statutes, how to assess complicated medical issues. This guidance must come from the legislature and the legislature alone.

III. CONCLUSION

When considering whether to commit a person as mentally ill or mentally ill and dangerous, the district court carries a heavy burden. Not only does the court, staffed by psychiatric amateurs, determine whether a patient’s freedom should be involuntarily surrendered without an attendant criminal conviction, but the court must do so with only the personal judgment of the presiding judge and with the aid of mental health professionals who are themselves ill-equipped to adequately determine if an individual is dangerous. This is further exacerbated by the ambiguous text of the MCTA.

There are no easy solutions to this problem, but a starting point would be to narrow the scope of the statute by providing definitions of “serious physical harm” and “dangerous”. Doing so would give courts the guidance necessary to determine whom to send to the state hospital and whom to commit to local mental health care. Additionally, transferring jurisdiction for civil commitments to mental health courts would serve the purpose of consolidating mental health expertise and experience into a team setting, providing the best likelihood that a district court judge will make the best decision. These small steps may not solve the issues of the MCTA, but it is better to attempt to change what we know does not work, than to be complacent with the rights of the vulnerable.