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The Minnesota Commitment Act of 1982
Summary and Analysis

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Abstract
Minnesota law governing commitments has been substantially revised and recodified in the Minnesota Commitment Act of 1982. The prior law is repealed and the new law is substituted for it effective August 1, 1982.

This article has three purposes. First, the significant changes in the civil commitment law are identified and their implications explored. Second, where appropriate, the legal background underlying the changes is explored in order to place the changes in context. Third, the article identifies ambiguities and inconsistencies in the Act, posits resolutions, and suggests areas for legislative attention.

Keywords
commitment act, mentally ill, chemically dependent, judicial commitment

Disciplines
Constitutional Law | Law and Psychology | Social Welfare Law

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THE MINNESOTA COMMITMENT ACT OF 1982
SUMMARY AND ANALYSIS

by Eric S. Janus & Richard M. Wolfson*

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INTRODUCTION

Minnesota law governing commitments has been substantially revised and recodified in the Minnesota Commitment Act of 1982. The prior law is repealed and the new law is substituted for it effective August 1, 1982.

The Act is the result of a gradual reform process designed to strengthen the due process accorded those subject to commitment procedures. Many of the revisions are foreshadowed in existing consent decrees. In *Vickerman v. Hennepin County Probate Court*, detailed changes in the judicial procedures leading to commitment were implemented. In *Anderson v. Likins*, and *Flick v. Noot*, procedures were established governing the revocation of provisional discharges for those committed as mentally ill and mentally retarded respectively.

Many of the changes accomplished by the Act can be traced to recommendations in the Report of the Supreme Court Study Commission on the Mentally Disabled and the Courts. The report con-
tained twenty-four separate recommendations, the great majority concerned the civil commitment process and provided the major impetus for the Act. Subsequent to the report's publication, the Minnesota Supreme Court appointed a commission to implement the recommendations, to the extent possible, by court rule. The result of the Commission's work was the Special Rules of Procedure Governing Proceedings Under the Minnesota Commitment Act of 1982.

This article has three purposes. First, the significant changes in the civil commitment law are identified and their implications explored. Second, where appropriate, the legal background underlying the changes is explored in order to place the changes in context. Third, the article identifies ambiguities and inconsistencies in the Act, posits resolutions, and suggests areas for legislative attention.

I. DISABILITY CATEGORIES AND DEFINITIONS

Many of the significant policy changes incorporated in the Act are in the definitions section. The more important of these changes have been made in defining the disability categories, the official persons involved in the commitment process and the treatment facilities.

Each of the definitions of the four disability categories is significantly changed by the Act. In addition to making substantive changes, the amendments simplify the definitions by avoiding confusing cross-references to the operative portion of the Act.

Chemically Dependent Person

The term "chemically dependent person" replaces the term "inebriate person." The Act retains the bulk of the old definition, but expands it in an effort to add precision. The old law simply required finding the person was "incapable of managing himself or his affairs by reason of the habitual and excessive use of liquor, narcotics or other drugs.”

The Act adds to this rather vague criterion a requirement that

8. Final Report, supra note 7 at 61-86.
10. MINN. STAT. § 253B.02 (1982).
11. MINN. STAT. § 253B.02 subd. 2 (1982) replaces MINN. STAT. § 253A.02 subd. 4 (1980) (repealed August 1, 1982) which defined "inebriate persons."
12. MINN. STAT. § 253A.02 subd. 4 (1980) (repealed August 1, 1982).
the person's use of chemicals or drugs poses a "substantial likelihood of physical harm" to self or others as a result of the chemical abuse. In adding the requirement of a demonstrated likelihood of harm, the Act extends to chemically dependent persons the same sort of definitional protections previously provided to persons alleged to be mentally ill under the old law. Further, the type of evidence which may be used to demonstrate the likelihood of harm is specified. Admissible evidence includes: "(i) a recent attempt or threat to do physical harm; (ii) evidence of recent serious physical problems; (iii) a failure to provide necessary food, clothing, shelter or medical care for himself."13 The idea of physical harm is central to the new definition. Harm which does not amount to physical harm would be insufficient to support a commitment. Examples of harm which would not be sufficient to support a commitment include harm to the family structure of the chemically dependent person; harm to the financial estate of the person through waste or mismanagement of assets; "self-destructive" behavior such as missing work or other obligations; or emotional harm to family and friends.

Mentally Ill Person

The new definition of "mentally ill person" modifies and tightens the requirement that some harm be shown in order to commit.14 It also makes significant changes in the "non-behavioral" aspect of the definition, which specifies the type of mental disability which must be demonstrated in order to commit.

The old law contained a broad definition of "mentally ill person" which provided few interpretive guideposts. The definition included any person diagnosed as having a "psychiatric or other disorder which substantially impairs his mental health. . . ."15 The Act tightens this definition substantially. The pertinent part of the new definition reads, "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. . . ."16

A full exploration of the implications of the new definition of "mentally ill persons" is beyond the scope of this article, and must

13. MINN. STAT. § 253B.02 subd. 2 (1982).
15. MINN. STAT. § 253A.02 subd. 3 (1980) (repealed August 1, 1982).
16. MINN. STAT. § 253B.02 subd. 13 (1982).
await authoritative judicial construction. However, a number of points and practical comments about the definition can be made. The new definition contains many terms which carry some meaning outside of the context of the Act. It must be assumed that each of these terms is intended to have some operative effect, that is, including certain disorders and excluding others from the definition of mentally ill person.

The definition of mentally ill person might be divided into seven elements. The individual must have a disorder which is psychiatric. As noted above, the old definition referred to “psychiatric or other disorders.” The legislature must have intended some change in meaning by the omission of the word “other.” The disorder must be of one or more of the following: thought, mood, perception, orientation, or memory. These are terms of art for psychologists and psychiatrists. Careful attention should be paid to the technical definitions of these terms in determining whether a certain disorder falls within the legal definition of “mentally ill person.”

The disorder must be “substantial” and impair judgment, behavior, capacity to recognize reality, or to reason or understand. Finally the impairment must be “gross”. The use of the terms “substantial” and “gross” is significant. In close cases, practitioners

17. (1) A disorder, (2) which is psychiatric, (3) of one of enumerated types, (4) which is substantial in character, (5) and grossly, (6) impairs, (7) judgment, behavior, capacity to recognize reality, or to reason or understand.

18. See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980) (hereinafter cited as DSM III). The definition of “mental disorder” given there emphasizes that there must be a “behavioral psychologic, or biologic disfunction” and that the disturbance not be “limited to a conflict between an individual and society . . . ” Id. at 363.

19. See Johnson v. Noot, 323 N.W.2d 724 (Minn. 1982) in which the Minnesota Supreme Court discussed the application of the old definition to character disorders. The court’s language suggests that “character disorders” did not fall within the term “traditional psychiatric disorders”:

[W]e hold that a character disorder substantially impairs mental health and therefore constitutes mental illness [under prior law] only when the disorder takes away the person’s ability to control his conduct. Only at that point . . . does the character disorder’s effect on mental health reach the degree of impairment caused by traditional psychiatric disorders.

Id. at 727.

20. For example, “mood” is defined as “[a] persuasive and sustained emotion that in the extreme, markedly colors the person’s perception of the world. Mood is to affect as climate is to weather. Common examples of mood include depression, elation, anger, and anxiety.” DSM III, supra note 20, at 363. “Orientation” is defined as “[a]wareness of where one is in relation to time, place, and person.” Id. at 365.

21. For example, antisocial personality.
should insist upon explication of the examiner's standards in order to determine whether or not the impairment is "substantial" or "gross".

Although it is premature to attempt a definitive comment on the new definition, it appears to these authors that the legislature intended for the most part to eliminate personality or character disorders\textsuperscript{22} from the definition. This reading would be consistent with

\textsuperscript{22} "Personality disorder" is defined as:
Deeply ingrained patterns of behavior, which include the way one relates to, receives, and thinks about the environment and oneself. Personality traits are prominent aspects of personality, and do not imply pathology. Personality disorder implies inflexible and maladaptive patterns of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

\textit{DSM III, supra} note 20, at 366 (emphasis in original).

Indeed it is arguable that the definition includes only psychoses. Thus the definition of "mentally ill person" at \textit{Minn. Stat.} § 253B.02 subd. 12 (1982), is strikingly similar to the definition of "psychotic" in \textit{DSM III, supra} note 20, at 367-68:

\textit{PSYCHOTIC}. A term indicating gross impairment in reality testing. It may be used to describe the behavior of an individual at a given time, or a mental disorder in which at some time during its course all individuals with the disorder have grossly impaired reality testing. When there is gross impairment in reality testing, the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. The term psychotic does not apply to minor distortions of reality that involve matters of relative judgment. For example, a depressed person who underestimated his achievements would not be described as psychotic, whereas one who believed he had caused a natural catastrophe would be so described.

Direct evidence of psychotic behavior is the presence of either delusions or hallucinations without insight into their pathological nature. The term psychotic is sometimes appropriate when an individual's behavior is so grossly disorganized that a reasonable inference can be drawn that reality testing is disturbed. Examples included markedly incoherent speech without apparent awareness by the person that the speech is not understandable, and the agitated, inattentive, and disoriented behavior seen in Alcohol Withdrawal Delirium.

The term psychotic was applied to individuals whose "mental functions [were] sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life," whether or not there was impaired reality testing. \textit{American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders} (2d ed. 1968). This definition of psychotic did not conform to common usage, which generally limited the use of the term to impairment in reality testing, as does the \textit{DSM III} definition. As a result, the value of the term for communication was diminished, since it was then unclear whether or not an individual described as being psychotic had gross impairment in reality testing. It should also be noted that an individual with a nonpsychotic mental disorder may exhibit psychotic behavior, though rarely. For example, an individual with Obsessive Compulsive Disorder may at times come to believe in the reality of the danger of being contaminated by shaking hands with strangers.

In \textit{DSM III} the psychotic disorders include Pervasive Developmental Disorders, Schizophrenic and Paranoid Disorders, Psychotic Disorders Not Elsewhere Classified, some Organic Mental Disorders, and some Affective Disorders.
the Minnesota Supreme Court's recent holding in *Johnson v. Noot*,\(^{23}\) that character disorders are not included under the old law except where the disorder takes away the person's ability to control his conduct. However, individual evaluations might show that some people with character disorders still fit the definition. Nevertheless, the main thrust of the new definition seems to be toward including only traditional "psychiatric" disorders.\(^{24}\) To the extent others pose danger to society through violent behavior which violates the criminal law, they are more properly dealt with in the criminal justice system. Traditional psychiatric hospitals are generally not equipped to deal with people whose danger to society stems from a personality disorder. Society is less likely to think of these individuals as "ill," and more likely to think of them as "bad." Additionally, as opposed to those with psychotic illnesses, persons with personality disorders do not exhibit the lack of orientation and impaired perceptual system which often leads to a sense of reduced legal and social responsibility.

The definition of mentally ill person continues in two additional segments. The first requires that the psychiatric disorder be "manifested by instances of grossly disturbed behavior or faulty perceptions."\(^{25}\) This requirement is added to insure that only those disorders which have had some impact on the person's interaction with the outside world are included. For example, the report of the Supreme Court Study Commission\(^ {26}\) emphasized the need to support petitions for commitment with "factual statements in behavioral terms."

Finally, the definition requires a "substantial likelihood of physical harm" to self or others. As with the definition of chemically dependent person,\(^{27}\) this definition specifies that the types of

\(^{23}\) 323 N.W.2d 724 (Minn. 1982).

\(^{24}\) Note that in DSM III personality disorders are catalogue on Axis II, separately from the more Florid Axis I disorders. *See also* Bursten, What If Antisocial Personality Is An Illness, 10 BULL. AM. ACAD. PSYCHIATRY & LAW 97 (1982).

\(^{25}\) MINN. STAT. § 253B.02 subd. 13 (1982).

\(^{26}\) Final Report, supra note 7, at 79. Recommendation 15 provides:

The petition should contain factual descriptions of the proposed patient's recent behavior, where it occurred, and over what period of time it occurred. Each factual allegation should be supported by observations of witnesses who are named in the petition. Petitions should contain factual statements in behavioral terms and should not contain judgmental or conclusory statements.

*Id.*

\(^{27}\) *See supra* text accompanying note 13.
behavioral evidence which must be used to demonstrate likelihood of harm are:

(i) A recent attempt or threat to physically harm self or others;
(ii) A failure to provide necessary food, clothing, shelter or medical care for himself, as a result of the impairment. 28

The first behavioral element changes the old law in three ways. First, it requires that the attempt or threat be recent. Second, the old law did not include threats to harm others. 29 Finally, the old law required a demonstrated threat or attempt to cause serious physical harm, while the new law makes no mention of the degree of harm required.

The second behavioral element varies from the old law in two ways. The new law omits failure to protect oneself from exploitation. 30 To the extent that the exploitation causes physical harm or deprives the person of necessary food, clothing, shelter or medical care, it would still be covered by the definition. If the exploitation does not rise to that level, guardianship, conservatorship or other forms of protective services might still be available. 31 The old law also referred to failure to “care for his own needs for food, clothing, shelter, safety or medical care”. 32 The new law omits “safety”, and makes clear that only failure to provide “necessary” services is grounds for commitment. It would, of course, be impermissible bootstrapping to include failure to obtain psychiatric care within the definition of “medical care.” 33

29. Under the old law, a threat of suicide was sufficient to satisfy this behavioral element. *Minn. Stat.* § 253A.07 subd. 17(a) (1980) (repealed August 1, 1982).
30. Under the old law, this behavioral element could be satisfied by a showing that the proposed patient “failed to protect himself from exploitation from others.” *Id.* At times this provision was interpreted to include exploitation that was strictly material and posed no threat of physical harm to the proposed patient.
31. Under *Minn. Stat.* § 525.54 subd. 3 (1982) a guardian or conservator of the estate may be appointed for a person “who is impaired to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his estate or financial affairs. . . .” Social Security and welfare benefits can often be protected from dissipation through exploitation by means of a “protective” or representative payee. For example, 20 C.F.R. § 404.2001 (1981) provides:

> When it appears to the [Social Security] Administration that the interest of a beneficiary entitled to a payment . . . would be served thereby, certification of payment may be made by the Administration, regardless of the legal competency or incompetency of the beneficiary entitled thereto, either for direct payment to such beneficiary, or for his use and benefit to a relative or some other person and the “representative payee” of the beneficiary.

33. The whole purpose of the Act is to determine which persons are to be required to undergo involuntary psychiatric hospitalization. The universe from which these persons are
Mentally Retarded Person

The Act adopts the term "mentally retarded person" in place of "mentally deficient person." The new definition retains the core of the old, stating "significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior..." Following the pattern set by the mental illness definition, the drafters have limited the definition of mentally retarded persons to those who "pose a substantial likelihood of physical harm" to self or others. As with the other two disability categories, the types of behavioral evidence which can be used to demonstrate the likelihood of harm are set out.

In a change from the old law, the new definition of "mentally retarded person" omits failure to protect against exploitation as a ground for commitment. The drafters evidently felt that remedies less drastic than commitment could respond to exploitation which did not produce any danger of physical harm. With respect to physical harm to self or others, the old definition included only attempts to do serious harm, and was not limited to recent attempts.

Person Mentally Ill and Dangerous

In framing the new definition of "person mentally ill and dangerous to the public," the Act sharpens the distinction between this category and the definition of mentally ill person. The definition is in two major parts. First, it includes only those persons who are designated is, of course, the class of persons who refuse psychiatric care. If such refusal is, in and of itself, sufficient to satisfy the behavioral element of the statute, then there would be no role for the other behavioral elements. This follows from the fact that all of those for whom involuntary commitment is appropriate must, by definition, have refused appropriate psychiatric care, thus making the other behavioral elements superfluous.

See supra text accompanying note 28.

34. MINN STAT. § 253B.02 subd. 14 (1982).
35. MINN. STAT. § 253A.02 subd. 5 (1980) (repealed August 1, 1982).
36. These are basically the same behavioral elements as apply to the definition of mentally ill persons, (i) a recent threat or attempt to physically harm self or others, or (ii) a "failure and inability to provide necessary food, clothing, shelter, safety, or medical care."
See supra text accompanying note 28.
37. Compare with the definition of "mentally ill" persons, supra note 17.
38. For example, under the Mental Retardation Protection Act, the Commissioner of Public Welfare can be appointed guardian or conservator of a mentally retarded person "in need of the supervision and protection of a conservator or guardian." MINN. STAT. § 252A subd. 10 (1980) (repealed August 1, 1982). No showing of physical harm is necessary for such an appointment to be appropriate.
39. MINN. STAT. § 253A.02 subd. 5 (1980) (repealed August 1, 1982).
40. Hereinafter referred to as M.I. & D.
41. MINN. STAT. § 253B.02 subd. 17 (1982). See supra notes 16-35.
"mentally ill." This represents a clarification of the old law, which included mentally deficient persons, as well as those found to be mentally ill. Second, the definition requires a finding that the person "as a result of that mental illness presents a clear danger to the safety of others..." This must be demonstrated by two facts. First, that there has been an "overt act causing or attempting to cause serious physical harm to another;" and second, that there is a "substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another."

The phrase "as a result of that mental illness," is a change from the old language. It is intended to limit the application of the mentally ill and dangerous (MI&D) label to those whose dangerousness is caused by their mental illness.

This definition, in contrast to those for the other disability categories, refers to "serious" physical harm. Mere threats of harm would be insufficient to satisfy the definition, although there is no requirement that the person have succeeded in his attempts to inflict serious harm. Threats, of course, might be relevant in satisfying the second part of the "danger" definition, the prediction of future harm. However, in order to satisfy that part of the definition, it is insufficient to show merely that the person is likely to attempt to harm another. It must be shown that the attempt will be "capable" of inflicting serious harm. This, presumably, would require a showing that the person has both the intent and the means to inflict harm.

**Examiner**

The Act defines "examiner" as "a licensed physician or a licensed consulting psychologist, knowledgeable, trained and practicing in the diagnosis and treatment of the alleged impairment." The definition of "examiner" contains a number of significant changes. Under the old law, psychologists could be used as examiners only where a licensed physician "especially qualified in the diagnosis of mental illness" was unavailable. Under the new law, a licensed consulting psychologist may be used without any such restriction. In addition, any examiner whether physician or psychologist, must

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42. *Id.*, subd. 17.
43. **MINN. STAT. § 252A.02** subd. 17 (1980) (repealed August 1, 1982).
44. **MINN. STAT. § 253B.02** subd. 17 (1982).
45. *Id.*
46. **MINN. STAT. § 253B.02** subd. 7 (1982).
47. **MINN. STAT. § 253A.02** subd. 6 (1980) (repealed August 1, 1982).
be qualified in the particular disability area involved. Psychiatrists may not fit that definition with respect to chemical dependency and mental retardation. Of particular import is the requirement that the examiner actually be practicing in the diagnosis and treatment of the alleged impairment. This could eliminate the "professional witness" from eligibility to serve as an examiner.

Note that the term "examiner" has a much broader application in the Act than it did under the old law. The term formerly referred solely to persons who were appointed by the court to examine the proposed patient prior to commitment. Now the term is used in a number of other contexts. The use of the term in these contexts should not be understood as requiring the court to appoint the same "examiners" it appoints to undertake the statutory examination. Rather, the use of the term indicates that the statements supporting emergency holds and petitions must be made by persons — either physicians or licensed consulting psychologists — knowledgeable, trained and practicing in the field involved.

Health Officer

The Act makes two changes in the definition of "health officer". In addition to changing the archaic "certified consulting psychologist" to "licensed consulting psychologist", it adds "formally designated members of a pre-petition screening unit established by § 253B.07." Health officers have the power to take a person into custody pursuant to the provision for emergency holds. Since the Act provides no guidelines at all as to who may be a member of the pre-petition screening unit, this change in the Act significantly broadens the class of persons who may use the health officer's hold.

48. For example, an emergency hold requires a statement of an examiner. Minn. Stat. § 253B.05 subd. 1 (1982). Any petition for judicial commitment must be accompanied by a statement from an examiner to the effect that he has recently examined the subject and believes that commitment is appropriate. Minn. Stat. § 253B.07 subd. 2 (1982).

49. Minn. Stat. § 253A.02 subd. 16 (1980) (repealed August 1, 1982) provided that a "health officer" was "a licensed physician, certified consulting psychologist, psychiatric social worker, or psychiatric or public health nurse."


51. The "pre-petition screening unit" is appointed by the designated agency to conduct an investigation to determine whether commitment is appropriate. Minn. Stat. § 253B.07 subd. 1 (1982).
Treatment Facility

The Act makes one final important definitional change. The definition of the new term "treatment facility" closely parallels the definition of "hospital" in the old law. 52 "Treatment facility" means a "hospital, community mental health center, or other institution qualified to provide care, and treatment for mentally ill, mentally retarded, or chemically dependent persons." 53 The change in name was made to emphasize the Act's mandate that commitment be to the least restrictive appropriate setting, which might not be a hospital. 54

II. PATIENTS' RIGHTS

The Act collects in one section a number of provisions of the old law. 55 While many of the changes are not of major significance, there are a few changes of policy that must be considered.

Correspondence Rights

Correspondence rights may be restricted only where the "medical welfare" of the patient requires it. 56 Otherwise, patients may "correspond freely without censorship." Visitation with personal physicians, spiritual advisors and counsel must be permitted at all reasonable times. 57

Consent

In the section dealing with consent for medical procedures, 58 the Act changes the emphasis of the old law, with no major change in meaning. 59 As before, consent is required prior to surgical operations. Under the old law, the consent of the patient was required only when the head of the hospital determined that he had "sufficient capacity to make a responsible decision." 60 In other cases,

52. MINN. STAT. § 253A.02 subd. 8 (1980) (repealed August 1, 1982) defined "hospital" as: "a public or private hospital, community mental health center, or other institution or part thereof equipped to provide care and treatment for mentally ill, mentally deficient, or inebriate persons."
53. MINN. STAT. § 253B.02 subd. 19 (1982).
54. See MINN. STAT. § 253B.09 subd. 1 (1982).
55. MINN. STAT. § 253B.03 (1982).
56. MINN. STAT. § 253B.03 subd. 2 (1982).
57. Id., subd. 3.
58. Id., subd. 6.
59. MINN. STAT. § 253A.17 subd. 8 (1980) (repealed August 1, 1982).
60. Id.
"substitute" consent from a guardian, relative, or head of hospital, was sufficient. The new law changes the implicit presumption of incapacity. Under the new law, consent is required from adult patients unless the patient is subject to guardianship or conservatorship, the head of the facility determines that the patient is not competent to consent, or there is an emergency.61

Consent to both surgical and medical procedures is now required; formerly the consent requirement specifically applied only to surgery. But the Act excludes treatment for mental illness, mental retardation or chemical dependency from the broad requirement for prior consent. This exclusion represents the Legislature's reluctance to deal with the thorny problem of involuntary treatment for committed persons.62 The new language apparently leaves the law where it stood with regard to such treatment. There is no statutory law regulating the involuntary treatment of committed persons. The Minnesota Supreme Court has articulated the constitutionally required standards governing involuntary "intrusive" treatment, such as electroshock therapy.63 By excluding the treatment of mental illness, mental retardation and chemical dependency from the consent section, the legislature has said nothing affirmative about the subject. The section does not say that such treatment may be carried on without prior consent. Rather, it simply excludes such treatment from the statutory requirement of prior consent. Other sources of law — such as the Constitution or administrative rules and regulations — may well impose consent requirements.64

61. MINN. STAT. § 253B.03 subd. 6 (1982).
62. The issue of involuntary treatment entails a number of difficult questions. First, to what extent is "consent" a requirement for treatment of committed persons? To the extent that it is a requirement, who is competent (legally) to give consent? Does commitment ipso facto render the patient incompetent to give or withhold consent? If not, how does one judge such competence? If the patient is incompetent, who can give "substitute" consent? Are there limitations on the types of treatment for which substitute consent is adequate, or the circumstances under which it can (or must) be exercised? Can the state force treatment without obtaining consent, either direct or substitute? If so, under what circumstances? Is involuntary institutionalization so inherently coercive as to make truly voluntary consent a fiction?

dition, the legislature recently instructed the Department of Public Welfare to promulgate rules governing the imposition of “aversive and deprivation” procedures on mentally retarded persons. If the rules follow the pattern of previously proposed rules on the same subject, they will certainly contain extensive requirements regarding prior informed consent for such treatment procedures.

**Right to Treatment**

The new Act repeats verbatim, the language of old law enunciating the “[R]ight to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further custody, institutionalization, or other services unnecessary.” This right takes on new significance however, because it is now tied to the commitment determination made by the court. The Act provides that if commitment is warranted, it shall be to the “least restrictive treatment facility which can meet the patient’s treatment needs consistent with” the right to treatment section. The right to treatment section, taken in conjunction with the commitment section, should have a substantial impact. It should prevent “dumping” of committed patients into community facilities which are not appropriate for their treatment needs; and it should prevent overly restrictive commitment — that is, commitment to a hospital when a community-based facility would be appropriate. It could also be used to defend against the commitment of persons with special needs to state hospitals which are not equipped to provide adequate treatment.

**Medical Records**

The provision entitled “Medical Records” entails a major change from prior law. The old Hospitalization and Commitment Act did not address the right of access to medical records. A law of

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67. MINN. STAT. § 2538.03 subd 7 (1982) replaces MINN. STAT. § 253A.17 subd. 9 (1980) (repealed August 1, 1982).
68. MINN. STAT. § 253B.03 subd. 1 (1982).
69. MINN. STAT. § 253B.03 subd. 7 (1982).
70. For example, hearing impaired persons and autistically impaired persons.
71. MINN. STAT. § 253B.03 subd. 8 (1982).
general applicability provides for access but allows hospitals and
doctors to limit access under certain circumstances. 72 The new law
essentially removes all barriers to a committed person’s access to his
or her medical records.

The section has two main provisions. First, it states that a “pa­
tient” has the “right to access to his medical records.” 73 This provi­
sion apparently allows unlimited access by committed patients to
their medical records. In addition, the use of the term “institu­tion­
alized” in the definition of “patient” suggests that persons who are
in facilities under the emergency hold or informal admission provi­sions of the Act, but not committed, also have such access to their
records.

The second part of the access section deals with people who are
“subject to a proceeding or receiving services pursuant to” the Act. 74
Such persons are granted the same access to medical records with
regard to their commitment as institutionalized persons. This provi­sion
would allow “proposed patients” to obtain records from previous
hospitalizations, as well as current records, if they were needed
in or relevant to current commitment proceedings. The use of the
term “complete access” suggests that the access provision is to be
broadly construed.

The Civil Commitment Rules of Procedure provide additional
guidance about access to medical records. 75 Upon request, a party
in a commitment proceeding must allow the other party access to
medical records in the first party’s control. The court is instructed to
exclude from evidence any “testimony based upon” or any portion
of any medical record “improperly withheld.” The term “improper­
ly withheld” evidently refers not only to records which the Peti­tioner failed to provide to the proposed patient upon request, but
also to records which a hospital or other provider failed to make
available to the proposed patient pursuant to the statute. Note that
the option of excluding records is available by rule, only to the pro­
posed patient.

Right to Counsel

The proposed patient’s right to counsel has long been a part of

72. MINN STAT. § 144.335 (1982).
73. “Patient” is defined as any person “institutionalized or committed” under the Act.
MINN. STAT. § 253B.02 subd. 15 (1982).
74. MINN. STAT. § 253B.03 subd. 8 (1982).
75. MINN. R. CIV. COMMITMENT 5.
Minnesota Commitment Law.\footnote{76} The Supreme Court Study Commission found, "[I]t is clear that there is no uniformly accepted role for the proposed patient's counsel in [commitment] proceedings."\footnote{77} The Commission set out extensive recommendations regarding the role of the proposed patient's attorneys.

In the subdivision dealing with right to counsel, the legislature implemented the key parts of the Commission's Recommendation.\footnote{78} These are the appointment of counsel immediately upon the petition being filed; the requirement that counsel be available "throughout the proceeding;" and the definition of the role of counsel as that of "vigorous advocate" for his client. The Civil Commitment Procedural Rules elaborate on these basic themes, adopting many of the more detailed parts of Recommendation 6.\footnote{79} Counsel is to be appointed when a petition for commitment is filed. A proposed patient is entitled to an appointed attorney "at any proceeding" under the Act. Once appointed, a lawyer must continue to represent the proposed patient unless released by the court. Thus, the lawyer's duty clearly extends beyond representing the proposed patient at the commitment hearing. Counsel must also be provided for: any appeal that is taken, proceedings to review a commitment, and proceedings initiated by the proposed patient to obtain his release.\footnote{80} In addition, it appears that persons committed as mentally ill and dangerous are entitled to counsel at special review board hearings, if these are considered to be proceedings "under the Act." Patients on provisional discharge are entitled to counsel in connection with proceedings to revoke the provisional discharge.\footnote{81}

The Act specifies that the proposed patient's counsel "shall ad-
vocate vigorously on behalf [of his client]." This mandate should put to rest the controversy which has raged over the proper role of the proposed patient's counsel. The term "vigorous advocate" is not consistent with the position advanced by some, that the proposed patient's counsel is to function in a role akin to that of a guardian ad litem, deciding what is "in the best interests" of the proposed patient, and acquiescing in commitment if such a course appeared best. The Act makes clear that, as in other proceedings, counsel should take his instructions from his client, and advocate vigorously within ethical bounds for that position. Moreover, the role of advocate for his client is ethically mandated. Advocacy has also been urged as the proper role by the American Bar Association.

The role of the attorney as a forceful advocate for his client cannot be overemphasized. Many helping professionals will be telling the client to follow the course they believe to be in his best interest. Only the attorney will be representing the client's stated goal. If the attorney abdicates his role, the client will have no one on whom to rely.

The role of counsel as a "vigorous advocate" is characteristic of the adversary system. The adversary method of justice is particularly important in cases of civil commitment. There is evidence showing this method is especially helpful in counteracting bias on behalf of the decision-maker. Furthermore, the adversary system "introduces a systematic evidentiary bias in favor of the party disadvantaged by the discovered facts," because advocates confronted with initially unfavorable facts more vigorously investigate the situation. Given the involvement of psychiatrists, psychologists, social

82. MINN. STAT. § 253B.03 subd. 9 (1982). See also MINN. R. CIV. COMMITMENT 4.01.
83. For example, in comments submitted to the Minnesota Supreme Court in connection with the Court's consideration of the proposed Special Rules of Procedure Governing Proceedings Under the Hospitalization and Commitment Act, one attorney suggested the following system:
   A more workable system [than the proposed "advocacy model"] would be for the court to appoint lawyers [as] guardians ad litem and not as counsel. The guardian ad litem would exercise fiduciary responsibility. If a lawyer as guardian ad litem believes it is in the patient's best interests to fight a proposed commitment, he should be able to request the court to appoint him counsel and then he could act as an advocate.
workers, family members and many others, and the general perception of treatment as a positive factor, these counteracting effects of the adversary system are vital. Finally, there is evidence that advocacy is effective in reducing the number of commitments in two ways: the number of court-ordered releases rises and psychiatrists are more likely to discharge patients without seeking commitment.88

Without effective advocacy, the determination of a client's future will be abdicated to the "medical, more particularly the psychiatric, profession with the legal process and the attorney assuming a ceremonial function."89 Commitment is a legal act. The power of the state, properly invoked, is the agent forcing someone into treatment. "[W]henever unalterable interferences with bodily integrity place deprivations of liberty in issue, the law and not medicine is the ultimate decision-maker."90 It violates the fundamental principles of the legal system to allow the decision to become effectively non-judicial. Furthermore, treatment may not really be in the client's best interest:

The attorney who focuses on the parens patriae foundation for civil commitment overlooks the deprivation of freedom involved in these proceedings. He also overlooks other deprivations that accompany involuntary placement in a mental hospital. A committed person loses his right to privacy because he is under constant observation by both hospital staff and other patients; he may lose his autonomy through compulsory medication and other intrusive treatment. A committed person may be subjected to a hospital that is inadequately staffed, overcrowded, unsanitary, deplorably maintained and unable to offer protection from the brutality of patients and attendants. A committed person suffers the social stigma of being a hospitalized mental patient, and worse, one who has been found dangerous enough to be forcibly hospitalized. This stigma also may involve more serious long term consequences, such as the inability to obtain employment. Attention to the negative consequences of involuntary hospitalization may undermine the attorney's view of civil commitment as beneficial.91

90. Romeo v. Youngberg, 644 F.2d 147, 166 (3d Cir. 1980), vacated and remanded, 102 S. Ct. 2452 (1982).
At a more abstract level, a paternalistic proceeding damages the public perception of justice. The adversary system is familiar to the public and is more likely to be perceived as fair.92 The United States Supreme Court has stated: “Departures from established principles have frequently resulted not in enlightened procedure, but in arbitrariness.”93 These departures demean both the client and the legal system. The lawyer is charged with protecting both.

Occasionally a client may direct his attorney not to contest a commitment petition. If the client is making a rational decision, the attorney should, of course, follow the client’s direction.94 If the client is unable to make rational decisions or communicate effectively, then the attorney may seek the appointment of a guardian ad litem.95

III. INFORMAL ADMISSION PROCEDURE

The Act’s preference for voluntary treatment is explicit.96 This preference is implicit in the provision which requires a finding that no less restrictive alternative to commitment exists before an order for commitment can be issued.97 It is also consistent with the Minnesota Alcoholism and Intoxication Act which specifies a preference for treating alcoholics voluntarily.98 Most important, the preference for voluntarism is constitutionally required.99

The Act’s provision for informal admission has two important elements. First, anyone age sixteen or over may request admission as an informal patient.100 A hospital may admit some minors for voluntary care and treatment, although payment may have to be arranged with an adult. Second, the statute states that “[t]he head of the facility shall not arbitrarily withhold consent to informed hospitalization.”101 Some treatment facilities are reluctant to accept volunteers. This provision emphasizes state policy favoring voluntarism, and is intended to make these denials less frequent.

95. Id. at 199 and 213 (DR7-101). See also MINN. R. CIV. COMMITMENT 13.
96. MINN. STAT. § 253B.04 subd. 1 (1982) provides “Informal admission by consent is preferred over involuntary commitment.”
97. MINN. STAT. § 253B.04 subd. 2 (1982).
98. MINN. STAT. § 254A.02 (1982).
100. MINN. STAT. § 253B.04 subd. 1 (1982).
101. Id.
Any patient informally admitted must be informed of his right to leave the facility within twelve hours of his request for admission unless he is held under another provision of the Act, or was admitted as chemically dependent. Anyone admitted as chemically dependent may leave within seventy-two hours after his request, excluding Saturdays, Sundays and holidays. The patient's request to leave must be written and submitted to the head of the treatment facility. After receiving a request to leave, the head of the facility must either honor the request or petition for commitment of the person. This petition is mandatory if the head of the treatment facility deems it in the "best interests" of the patient, his family or the public.

Under the Act a great deal more than the proposed patient's "best interests" must be alleged in a petition in order to state any cognizable cause of action. The head of the treatment facility's obligation to file a petition when he believes it to be in the "best interests" of the patient, his family or the public, must be read in conjunction with the statutory criteria for commitments.

IV. EMERGENCY HOLD

Anyone may be admitted for emergency care and treatment if the head of the facility consents after receiving a written report from an examiner. The examiner's report must show that the person was examined not more than fifteen days earlier; is in imminent danger of causing injury to himself or others if not immediately restrained; is mentally ill, mentally retarded or chemically dependent; and that a court order cannot be obtained in time to prevent the injury.

The contents of the report must be behavioral and specific enough to allow review; mere conclusions are insufficient. A copy of the examiner's report must be served on the patient immediately.

102. MINN. STAT. § 253B.04 subd. 2 (1982).
103. Id.
104. Id.
105. MINN. STAT. § 253B.05 subd. 3 (1982).
106. MINN. STAT. § 253B.09 (1982).
107. MINN. STAT. § 253B.05 subd. 1 (1982).
108. Id. Recall that an "examiner" is a physician or licensed consulting psychologist who is "trained and practicing in the diagnosis and treatment of the alleged impairment." See supra note 46-48 and accompanying text.
109. See supra notes 26, 33, & 36 describing the requisite behavioral descriptions.
upon admission. The facility must keep a duplicate.\footnote{MINN. STAT. § 253B.05 subd. 1 (1982).}

Police and health officers may also institute an emergency hold.\footnote{A "peace officer" is either a sheriff, municipal, or other local police officer or a State Highway Patrol officer engaged in the authorized duties of his office. MINN. STAT. § 253B.02 subd. 16 (1982). A "health officer" is one licensed to practice medicine in Minnesota, a medical officer of the United States performing his official duties, a licensed consulting psychologist, a psychiatric social worker, a psychiatric nurse, a public health nurse, or members of a formally designated pre-petition screening team. \textit{Id.}, subd. 9 & 12.} A peace or health officer may take a person into custody and transport him to a treatment facility if the officer has reason to believe the person is in imminent danger of harming himself or others if not immediately restrained and is either mentally ill, mentally retarded or chemically dependent.\footnote{MINN. STAT. § 253B.05 subd. 2 (1982). If the person is believed to be chemically dependent but not a danger to person or property, the officer may return the person to his home.} The officer must make application for admission of the person to the treatment facility. Like the examiner's statement supporting emergency confinement,\footnote{See supra notes 26, 33, & 36.} the officer's application must specify the reasons and circumstances for the detention. A copy of the officer's statement must be "made available" to the person held.\footnote{MINN. STAT. § 253B.05 subd. 2 (1982).}

After a person is brought to a treatment facility and application for admission has been made by the peace or health officer, the person may be admitted for emergency care and treatment if the head of the facility consents and there is a written statement from the medical officer on duty after a preliminary examination. This statement must be to the effect that the person is in imminent danger of harming himself or others, and has symptoms of mental illness, retardation or chemical dependency.\footnote{MINN. STAT. § 253B.05 subd. 2 (1982).} Admission to the facility is not automatic upon the application of the police or health officer; the preliminary examination provides additional assurance that admission is for a proper purpose. Note that this statement, unlike the statement supporting the "head of the treatment facility" hold, need not be made by an "examiner." Therefore, the statement will not be insufficient merely because the medical officer on duty is not knowledgeable, trained and practicing in the diagnosis and treatment of the particular disability involved.

These provisions for emergency holds allow curtailment of civil rights on relatively weak grounds. To limit the danger of abuse, the
duration of the emergency confinement is limited to 72 hours, excluding Saturdays, Sundays and legal holidays.\textsuperscript{116} Tacking two or more consecutive holds violates the Act. This is not to say only one such hold can be used during the course of a long hospitalization. However, it would be improper to use emergency holds in such a way as to create a period of\textit{ involuntary} hospitalization longer than seventy-two hours. It would be improper to use a second period of emergency detention unless a period of truly voluntary hospitalization had intervened subsequent to the first emergency hold. A period of hospitalization would be truly voluntary if the patient knew of, and understood, his right to leave the hospital if he so chose.

A person may be held longer than seventy-two hours only upon a court order issued in a commitment proceeding.\textsuperscript{117} If the head of the facility believes a petition for commitment is "required" and none has been filed, then he must petition. It should be emphasized that a petition for commitment is not required after every seventy-two hour hold. There is evidently a belief by some facilities that a petition must follow emergency confinement. Perhaps this is an effort to avoid future liability by showing good faith. Whatever the reason, a petition is unwarranted unless the head of the facility believes one is needed for protection of the patient or others.

At the written request of the patient, and with the consent of the treatment facility, anyone admitted on an emergency hold must be changed to informal status.\textsuperscript{118} This underscores the point that a commitment petition is not inevitable. Emergency provisions are available for crisis management. After the crisis has passed, the person has his usual opportunity to receive voluntary care and treatment.

Anyone held under the emergency provisions must be informed, in writing at the time of admission, of his rights: to leave after seventy-two hours, to have a medical exam within forty-eight hours, to have the venue of any commitment petition changed to his Minnesota county of residence\textsuperscript{119} and to become an informal patient.\textsuperscript{120} Furthermore, the head of the treatment facility must assist

\textsuperscript{116} MINN. STAT. § 253B.05 subd. 3 (1982).
\textsuperscript{117} Id. The proceeding must be held either in the person's county of residence or where a facility is located.
\textsuperscript{118} MINN. STAT. § 253B.05 subd. 4 (1982).
\textsuperscript{119} Under MINN. STAT. § 253B.05 subd 3 (1982), if the head of the facility believes commitment is required and the facility is not located in the patient's county of residence, the patient may move to have the venue changed.
\textsuperscript{120} MINN. STAT. § 253B.05 subd. 5 (1982).
the person in the exercise of these rights if requested to do so.121

Additional protection is provided by the requirement that the patient be examined by a physician within at least forty-eight hours of admission.122 Anyone held under an emergency provision must be discharged if there is no exam within forty-eight hours or if the physician does not conclude that the person is either mentally ill, retarded or chemically dependent and in need of care, treatment or evaluation.123 Thus emergency confinement requires rapid examination; continued emergency confinement requires at least some corroboration.

V. JUDICIAL COMMITMENT - PRELIMINARY PROCEDURES

Screening Team Investigation

Before filing a petition, a prospective petitioner must ask the county to conduct a preliminary investigation.124 The request is made to the “designated agency,” i.e., the agency selected by the county board to provide services under the Act. The agency must then appoint a screening team to conduct the investigation. The composition of the “screening team” is unspecified in the statute. One example is Hennepin County where there is an eighteen-member team composed of one psychiatrist, one licensed consulting psychologist, four social workers, five chemical dependency counselors, three mental health workers, and four nurses.

The investigation includes four elements. The screening team should interview the proposed patient.125 If this interview does not take place the reasons for failure to do so must be documented. The team must also interview other persons with knowledge of the proposed patient’s condition.126 The specific alleged conduct which serves as the basis for the petition must be identified and investigated;127 and the screening team must identify and explore alternatives to involuntary commitment.128 Specific reasons must be given for rejecting any of the alternatives.

The screening team has an affirmative duty to refuse to support

121. Id.
122. MINN. STAT. § 253B.06 (1982).
123. Id.
124. MINN. STAT. § 253B.07 subd. 1 (1982).
125. Id., subd. 1(a)(i).
126. Id.
127. Id., subd. 1(a)(ii).
128. Id., subd. 1(a)(iii).
a petition if its investigation fails to indicate that commitment is proper. The prospective petitioner must be given notice of this decision.\textsuperscript{129} The prospective petitioner may appeal the decision of the screening team to the county attorney, who must decide whether to proceed with the petition and must convey his decision to the prospective petitioner.\textsuperscript{130} The statute is silent about the procedure if the county attorney should refuse, but the law allows “any interested person” to file a petition in the probate court.\textsuperscript{131}

If commitment is recommended by the screening team, the team must send a written report to the county attorney in the county where the petition will be filed.\textsuperscript{132} The county attorney’s representation of the petitioner is presumed here and elsewhere.\textsuperscript{133} The old law provided that the petitioner had to request that the county attorney appear.\textsuperscript{134} The county attorney may file the petition prior to receiving the screening team’s report. Clearly, this should occur only in emergency situations where it can be demonstrated that harm may result if the petitioner awaits the report.

The Act provides that in conducting its investigation the screening team may have access to all relevant medical records of proposed patients who are currently in treatment facilities.\textsuperscript{135} These records, in the hands of the team, are “private data on individuals,”\textsuperscript{136} and use thereof is governed by the Minnesota Government Data Practices Act.\textsuperscript{137}

The interrelationship between the Commitment Act and the Data Practices Act raises two questions. First, the Data Practices Act imposes certain requirements for disclosures to subjects of private data prior to the collection of the data. To what extent do these requirements govern the screening team’s access to medical records? Second, what is the effect of the “private” classification on the screening team’s right to disseminate the data it has collected?

At the core of the Data Practices Act is the requirement that the

\begin{enumerate}
\item[129.] \textit{Id.}, subd. 1(d).
\item[130.] \textit{Id.}, subd. 1(e).
\item[131.] \textit{Id.}, subd. 2.
\item[132.] \textit{Id.}, subd. 1(g).
\item[133.] \textit{See, e.g.}, \textsc{Minn. Stat.} § 253B.07 subd. 5 (1982) providing that “The county attorney and the patient’s attorney may be present during the [pre-hearing] examination.”
\item[134.] \textsc{Minn. Stat.} § 253A.07 subd. 5 (1980) (repealed August 1, 1982).
\item[135.] \textsc{Minn. Stat.} § 253B.07 subd. 1(b) (1982).
\item[136.] \textit{Id.}
\item[137.] \textit{See generally Minn. Stat. §§13.01--.87 (1982).} “Private data on individuals” is defined as “data which is made by statute . . . (a) not public; and (b) accessible to the individual subject of that data.” \textsc{Minn. Stat. § 13.02 subd. 12 (1982).}
collection, storage and dissemination of private data be governed by the purposes stated to the subject of the data at the time of collection.\textsuperscript{138} While there are exceptions to this general rule,\textsuperscript{139} none apply to the collection of private data. Thus, the Data Practices Act seems to require that the screening team give the proposed patient, who is the subject of the private data to be collected, the statement of "purpose and intended use" prior to the "collection" of the medical records.\textsuperscript{140}

The second question involving the Data Practices Act concerns the dissemination of information from the medical records, or the records themselves, by the screening team. Dissemination of private data is governed by two provisions of the Data Practices Act. In general, private data can be disseminated only in accordance with the purposes stated to the subject of the data at the time the data was collected.\textsuperscript{141} Second, the screening team is permitted to allow another governmental agency access to the data only when the access is "authorized or required" by law.\textsuperscript{142} Arguably, the screening team's obligation to submit a report to the county attorney concerning petitions it recommends "authorizes" the dissemination of the medical records. However, further clarity would be useful in this regard.

In the view of the authors, allowing the screening team unbridled access to medical records without the proposed patient's consent poses a potentially serious threat of unauthorized invasion of privacy. It must be recalled that the pre-petition screening team is an arm of the government. This provision purports to provide these governmental agents seemingly uncontrolled access to medical records, the type of information which heretofore has been accorded extraordinary protections. Regardless of the outcome under the

\textsuperscript{138} Minn. Stat. § 13.05 subd. 4 (1982) provides that private data on individuals may be disseminated only if the individual has given his or her informed consent. Informed consent exists where the subject has signed a dated statement which, in plain language, specifically identifies the person or agency authorized to disclose the information, the nature of the information to be disclosed, the persons or agencies to whom the information may be disclosed, the purposes for which the information may be used, and the expiration date of the informed consent. \textit{Id.}, subd. 4(d). Further, the subject must be informed of the "purpose and intended use" of the requested information, whether he is legally required to supply the information, any known consequences from refusing to supply the information, and the identity of other persons or entities authorized by law to receive the information. Minn. Stat. § 13.04 (1982).

\textsuperscript{139} Minn. Stat. § 13.05 subd. 4(a)-(c) (1982).

\textsuperscript{140} See supra note 138.

\textsuperscript{141} Minn. Stat. § 13.05 subd. 4 (1982).

\textsuperscript{142} \textit{Id.}, subd. 9.
Data Practices Act, access to medical records without consent should rarely be necessary to determine that a petition ought to be brought. If the sort of grossly disturbed behavior required by the Act as a precondition to commitment has not been publicly observed, then it is probable that the proposed patient is functioning adequately and need not be committed. There may be instances of course, where hospital records may reveal that despite the recommendation of a physician, commitment is not required. In such cases, it should be adequate to rely on the proposed patient’s consent in order to gain access to the records.

In any event, it should be recalled that “[c]ollection and storage of . . . private . . . data on individuals and use and dissemination of private . . . data on individuals shall be limited to that necessary for the administration and management” of the program of pre-petition screening. Thus, the screening team should not attempt to collect information pursuant to this section unless it can determine that the information is “necessary” to its function, pre-petition screening. In order to make this determination, the team should have some probable cause to believe that specific information in the records will make a material difference as to whether commitment should be recommended.

Two virtually identical federal statutes appear to limit release of records kept by federally assisted drug abuse prevention programs. The statutes are based on a belief that drug abuse treatment is best served by assuring confidentiality to participants. The applicable records are confidential and may be disclosed only as authorized and “may not otherwise be divulged in any civil, criminal, administrative, or legislative proceeding conducted by any Federal, State, or local authority . . . .” This prohibition is strict and, pursuant to the statute, regulations have sharply limited even the use of informers in drug treatment programs.

These records may be disclosed pursuant to narrow exceptions to the general rule of confidentiality. A court may order disclosure if it finds good cause shown, restricts disclosure only to that required to satisfy such good cause and protects against unauthorized disclo-

143. Id., subd. 3.
sure of the information. 147 "Good cause" is found only when the public interest in disclosure outweighs the "injury to the patient, to the physician-patient relationship and to the treatment services." 148 Disclosure must be limited to items essential to the objective of the order and to "those persons whose need for information is the basis for the order." 149 Generally, only objective data may be disclosed, e.g., dates of enrollment, attendance, and discharge. Communications by a patient to program personnel are barred unless put in issue by the patient.150

Presuming a court uses the proper test and finds it appropriate to require disclosure of the data, a subpoena plus a court order is required. The order merely removes the barrier; the subpoena then compels disclosure.

The penalty for violation of the statute is a fine of not more than $500 for the first offense and not more than $5,000 for subsequent offenses. 151 A violation may also give rise to a private cause of action for invasion of privacy.152

The Petition

Any interested person may file a petition for commitment. 153 The petition may be filed in the probate court of the county of the proposed patient’s residence or presence. 154 The petition must contain the name of the proposed patient, his address, the names and addresses of his nearest relatives and the reasons for the petition. 155 The reasons for the petition must be presented in factual descriptions of recent behavior and not just psychiatric and medical diagnoses. The vagaries of psychiatric diagnoses and prognoses are well documented. 156 Indeed, there is little doubt that past behavior is the

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149. 42 C.F.R. § 2.64(g)(1) and (2) (1981).
155. Id.
best predictor of future behavior. 157 Therefore the Act correctly focuses on behavior and provides that petitions "shall not contain judgmental or conclusory statements." 158

A written report of an examiner must accompany the petition. 159 This report must show that the proposed patient was examined within the fifteen days preceding the filing of the petition. A finding that the proposed patient is suffering a designated disability must be in the report, as well as a finding that commitment to a treatment facility is appropriate. The reasons for this opinion must also be set out in detail. This written report is unnecessary if the petitioner is unable to obtain an examination and can document a reasonable effort to secure one. In this event, a determination to commit would presumably be based entirely on behavioral evidence. However, the pre-petition screening team will often be able to provide this report.

The court may order a proposed patient held or taken into custody and transported to a treatment facility at this point if there has been a particularized showing that "serious imminent physical harm" to the proposed patient or others is likely, the proposed patient has failed to appear voluntarily for either the examination or the hearing, or there has been a request for commitment of a person held under the emergency provisions. 160 The apprehend and hold order may be executed at any time and by use of all necessary means including restraining the proposed patient. 161

Anyone held pursuant to an apprehend and hold order may be held no more than seventy-two hours, excluding Saturdays, Sundays, and legal holidays. 162 Thereafter there must be a preliminary hearing to determine whether there is probable cause for a continu-

158. Minn Stat. § 253B.07 subd. 2 (1982). The behavioral descriptions must be specific as to where, duration and witnesses to the behavior documented.
159. Id.
160. Minn Stat. § 253B.07 subd. 6 (1982). The court should consider whether the emergency provisions have been properly invoked before issuing a hold order on the basis that there has been a request for commitment under the emergency provisions. Minn. R. Civ. Commitment 2.02, makes it clear that an apprehend and confine order on this ground may not be issued unless the court specifically finds, that "serious imminent physical harm is likely" if the order is not issued. Note that this provision is permissive, the court may issue the order in these cases, and only these cases.
161. Minn. R. Civ. Commitment 2.02. Unless otherwise ordered by the court, a peace officer executing the order shall not be in uniform or a marked car.
162. Minn Stat. § 253B.07 subd. 7(a) (1982).
ing hold. The hearing is constitutionally required. The proposed patient must be represented by counsel at the hearing; and written notice of the hearing and the alleged grounds for confinement must precede the preliminary hearing by at least twenty-four hours. Notice must be given to the proposed patient, his attorney, the county attorney, the petitioner, and others as the court may direct.

The only ground supporting an order for continued pre-hearing confinement is a finding that "serious imminent physical harm" to the proposed patient or others is likely if the proposed patient is not confined. The burden of proof is on the petitioner; the standard of proof is a preponderance of the evidence. "Reliable" hearsay evidence, including written reports, is admissible.

**Pre-Hearing Examination**

The Act changes the old law relating to the pre-hearing examination of the proposed patient in subtle, but important ways. An examination has always been required to precede the commitment hearing. The Act, however, more rigidly separates the examination from the hearing in terms of time. The report of the examiner must be filed in triplicate with the court at least forty-eight hours before the hearing. Only the attorney for the proposed patient can agree to a lesser time.

As under the old law, the examination must occur in a suitable place determined unlikely to affect the proposed patient adversely. Altering prior practice, the Act expressly grants the

163. *Id.*
165. MINN. STAT. § 253B.07 subd. 7(b) (1982).
166. The notice must state the time, place and the alleged grounds for the confinement.
168. MINN. STAT. § 253B.07 subd. 7(b) (1982). "Reliability" of hearsay evidence is to be determined by the court.
169. MINN. STAT. § 253B.07 subd. 5 (1982). Copies are also to be sent to the proposed patient and his attorney.
170. Any questions about the suitability of the place of the examination would be appropriately raised either by motion prior to the hearing or at the hearing. The Act does not specify the consequence which follows from a showing that an examination was conducted in an unsuitable place. Four alternatives present themselves. The court might dismiss the petition. Such an action would be premised on the assumption that a proper examination is a necessary element of the petitioner's case. More likely, the court would order the examination redone. However, the commitment hearing must be held within 14 days of the filing of the petition, unless "good cause" is shown for an extension of that time period. MINN. STAT.
county attorney and the attorney for the proposed patient the right to be present during the examination, though either party may waive this right. Formerly, presence at the examination required authorization by the examiners.

In another significant change from the old law, the Act requires court appointment of only one examiner initially. The court must appoint a second examiner "of the patient's choosing" at the request of the proposed patient.\textsuperscript{172} This second examiner is to be paid by the county at a rate set by the court. The court must prepare a list of regularly employed examiners but neither the court nor the proposed patient is limited to the examiners on the list.\textsuperscript{173} Each county or court may adopt local rules governing the timing of the request for a second examiner.\textsuperscript{174} A rule requiring the request to be made in time to allow the second report to be filed with the court at least 48 hours before the hearing would be proper. This would put the two reports on the same footing and give each side the same minimum time to prepare its case. However, a local rule requiring the request to be made prior to the filing of the first report would lead cautious defense counsel to request a second examination as a matter of course.

The proposed patient must be summoned to appear for the exam and for the hearing.\textsuperscript{175} Thus apprehend and hold orders,\textsuperscript{176} are conceived of as the exceptional case. The proposed patient must be personally served with this summons, a plain language notice of proceedings and notice that the petition has been filed, a copy of the petition, a copy of the physician's supporting statement,\textsuperscript{177} the order for examination, and a copy of the pre-petition screening report.\textsuperscript{178}

\textsuperscript{172} MINN. STAT. § 253A.07 subd. 2 (1980) (repealed August 1, 1982).

\textsuperscript{173} MINN. R. CIV. COMMITMENT 7 and Comment A.

\textsuperscript{174} MINN. R. CIV. COMMITMENT 7.03.

\textsuperscript{175} MINN. STAT. § 253B.07 subd. 4 (1982).

\textsuperscript{176} See supra notes 160-67 and accompanying text.

\textsuperscript{177} A statement from an "examiner" is required generally. The term "physician" in MINN. STAT. § 253B.07 subd. 4 (1982) appears to be simply an inadvertent vestige of the prior law.

\textsuperscript{178} Supra note 170. Unless otherwise ordered by the court, service must be made by a non-uniformed person.
Service of these documents must also be made on the attorney for the proposed patient, the petitioner, all interested persons and others as the court directs.

If the proposed patient fails to respond to the summons, an apprehend and hold order may issue.\textsuperscript{179} This results in a maximum of seventy-two hours of confinement unless serious physical harm to the proposed patient or others is found likely. A logistical problem arises. If the orders for the exam and for the hearing are ignored, two apprehend and hold orders would be needed unless the hearing were held within the seventy-two hour allowable confinement period or likelihood of imminent harm is found. Given the requirement that the reports of the examination(s) be filed at least forty-eight hours before the hearing, it would be difficult to hold the hearing within the seventy-two hour period of confinement. Hopefully this will not result in an unnecessarily large number of findings that imminent and serious physical harm is likely without continued confinement.

\textit{Hearing Procedures}

The hearing must take place within fourteen days of the date the petition is filed.\textsuperscript{180} The court can extend this time up to thirty more days for "good cause shown." Therefore, one could be confined by court order up to forty-four days without a hearing on the merits of the petition.\textsuperscript{181} This is a large invasion of civil liberties and "good cause" should be rigidly construed. An example of good cause might be physical illness of the proposed patient. Any continuance should be limited to the minimum time necessary to proceed with the trial. Arguably, "good cause" would not exist where the only reason for the extension of time was to allow another week of treatment in the hope that the proposed patient would then be ready for release. This would in essence use the order for hearing and confinement as a therapeutic lever. However benevolent this might appear, it constitutes a violation of due process. The penalty for failure to hold the hearing in the required time is mandatory dismissal of the petition.\textsuperscript{182}

An immediate hearing may be demanded in writing by either

\begin{flushleft}\textbf{References}
\begin{itemize}
\item \textsuperscript{179} \textsc{Minn. Stat.} \textsuperscript{\textcopyright} \textsc{\$ 253B.07 subd. 6 (1982).} \textit{See supra} note 160 for discussion of apprehend and hold orders.
\item \textsuperscript{180} \textsc{Minn. Stat.} \textsuperscript{\textcopyright} \textsc{\$ 253B.08 subd. 1 (1982).}
\item \textsuperscript{181} \textit{See State ex rel. Doe v. Madonna, 295 N.W.2d 356 (Minn. 1980).}
\item \textsuperscript{182} \textsc{Minn. Stat.} \textsuperscript{\textcopyright} \textsc{\$ 253B.08 subd. 1 (1982).}
\end{itemize}
\end{flushleft}
the head of the treatment facility or the proposed patient. Following this demand, the hearing must be held within five days of the “date of demand,” excluding Saturdays, Sundays, and legal holidays.183 The term “date of demand” is undefined but likely means the date the demand is filed. The demand is, after all, made on the court. If the hearing is not timely held after such a demand, the proposed patient must be discharged. For good cause shown the court can, however, extend the time for hearing an additional ten days. Again, “good cause shown” should be narrowly construed to avoid subversion of the statute. The penalty for failure to hold an immediate hearing within the allotted time is discharge of the patient if he is being held under court order. However, the petition need not be dismissed.

At least five days’ notice that a hearing will be held must be given to the proposed patient, the patient’s attorney, the petitioner, the Commissioner of Public Welfare if the proposed patient is not a Minnesotan, and others as the court may direct.184 At least two days’ notice of the specific date of the hearing must be given to the same persons.185 Notice to the proposed patient may be waived by his counsel. Note that the statute no longer requires notice “by the court.” Thus, as in the preliminary notices, notice should be given by petitioner.

The court must notify all those receiving notices of the hearing, except the proposed patient’s attorney, that they also have a right to be present and testify. However, anyone unnecessary for the conduct of the hearing may be excluded by the court, except those whose presence is requested by the proposed patient.186

The proposed patient has a right to be present at all proceedings. The right to be present may be waived if the waiver is on the record and determined to be freely given.187 In rare instances the court may exclude a proposed patient who is “seriously disruptive” or who is “totally incapable of comprehending and participating in

183. Id.
184. Id., subd. 2.
185. Id.
186. The purpose of the provision allowing the court to exclude unnecessary persons from the hearing is to protect the privacy of the proposed patient. For example, the court might exclude reporters or casual courtroom observers who have no connection to the proceeding. Those whose presence is requested by the proposed patient must be allowed to attend. This insures that the proceeding will be open to outside scrutiny if the proposed patient so requests.
the proceedings.” At the hearing, the proposed patient must not be so under the influence of the medication or other treatment that it hampers his participation in the hearing. If the discontinuance of the medication or treatment is deemed not in his best interest, then a record of the medication or treatment given in the prior forty-eight hours shall be presented at the hearing.

The hearing need not be in the courthouse but must be in a “courtroom.” This room may be in a treatment facility but it must meet standards prescribed by local court rule. In a nutshell, the courtroom must be separate from treatment areas of the hospital and must provide adequate room to separate the participants in the proceeding. The hearing must be conducted in a manner consistent with orderly courtroom procedure. This alters prior law which mandated a hearing as “informal as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the mental health of the proposed patient.” There is now a move toward formalizing the commitment process. There is little reason not to hold the vast majority of hearings at the courthouse. This will clearly distinguish the judicial proceeding from the psychiatric case conference. The cost of transporting proposed patients is probably less than having the court personnel travel. Very few proposed patients are too physically ill to travel or suffer any harm from the trip. If the proposed patient is temporarily too ill, a continuance would be possible.

Both parties may present and cross-examine witnesses, and the court may in its discretion receive the testimony of anyone else. All relevant evidence shall be admitted at the hearing. This does

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188.MINN. R. CIV. COMMITMENT 10. Before excluding a proposed patient who is “seriously disruptive,” the court should make specific findings, on the record, of the proposed patient’s behavior. Since exclusion should occur only “in rare instances,” only disruption which renders it impossible to continue the hearing should result in exclusion.

Prior to excluding a proposed patient on the grounds that he is “totally incapable of comprehending and participating in the proceedings,” a hearing should be held at which the parties can produce evidence concerning that subject. The proposed patient should be at that hearing. Clearly, no proposed patient should be excluded on this ground over his objection since an objection indicates an ability to “participate” in the proceeding. However, the converse does not hold true. Since the Act permits exclusion only for “total” incapacity, the mere lack of an objection to exclusion would not be sufficient to justify exclusion.

189. MINN. STAT. § 253B.08 subd. 5 (1982).
190. MINN. R. CIV. COMMITMENT 9.02, sets forth minimum standards for courtrooms which are located in treatment facilities.
191. MINN. STAT. § 253B.08 subd. 6 (1982).
192. MINN. STAT. § 253A.07 subd. 13 (1980) (repealed August 1, 1982).
193. MINN. STAT. § 253B.08 subd. 4 and 7 (1982).
not alter the usual standards, for the same provision requires that
the court's determination be made "upon the entire record pursuant
to the rules of evidence."\footnote{194} Commitment is a "massive curtailment
of liberty,"\footnote{195} and "[t]he loss of liberty produced by an involuntary
commitment is more than a loss of freedom from confinement."\footnote{196} The
dangers inherent in hearsay and the consequences of its admission
are as significant in commitments as in criminal cases. Hearsay
should be admissible only under an exception to hearsay rule. Reliable
hearsay may be admissible under one of the catch-all exceptions.\footnote{197} However,
the general hearsay rule should be followed, including adequate prior notice of the intent to use it.\footnote{198}

The report of a court-appointed examiner is inadmissible unless the examiner is present and available for examination or the parties agree.\footnote{199} The new law omits the formerly explicit point that the opinions of the examiners are not binding on the court.\footnote{200} Given the ultimately legal nature of the proceeding, however, it is clear that the decision is for the court and not the examiners.

The standard of proof is clear and convincing evidence.\footnote{201} There was need for clarification because dictum in \textit{Lausche v. Commissioner of Public Welfare}\footnote{202} suggested a stricter standard,\footnote{203} and in \textit{Addington v. Texas},\footnote{204} the United States Supreme Court cited Minnesota as a state requiring proof beyond a reasonable doubt.

The court must commit the proposed patient if it finds that he is either mentally ill, chemically dependent, or mentally retarded and

\begin{itemize}
  \item \textit{Id.}
  \item Humphrey v. Cady, 405 U.S. 504 (1972).
  \item Minn. R. Evid. 803(24), 804.
  \item See 4 Louisell & Mueller, Federal Evidence 472, 491 (1980).
  \item Minn. Stat. § 253B.08 subd. 4 (1982).
  \item Minn. Stat. § 253A.07 subd. 13 (1980) (repealed August 1, 1982).
  \item 302 Minn. 65, 225 N.W.2d 366 (1974).
  \item \textit{Id.} at 369. At proceedings to determine whether to grant petition to release patient committed as MI & D, the probate court of appeals panel reversed the commissioner's order to discharge. The patient asserted that the standard of proof at these supplementary proceedings must be proof beyond a reasonable doubt that the patient is mentally ill. The Minnesota Supreme Court responded to this argument as follows: "Although this is the necessary standard to be employed with regard to the initial commitment . . . we cannot extend it to supplementary proceedings. . . ." \textit{Id.}
  \item 441 U.S. at 431 n. 5.
\end{itemize}
there is no less restrictive alternative to commitment.\textsuperscript{205} As noted earlier, the definitions of all three mental conditions include the requirement that the person has recently demonstrated that he is a danger to himself or to others.\textsuperscript{206} This element is constitutionally required.\textsuperscript{207}

Any mental impairment will actually be inferred from behavior.\textsuperscript{208} Thus, the statute properly focuses on past behavior by requiring a demonstrated failure to care for oneself or a demonstrated risk to another. Moreover, the findings must "specifically state the proposed patient's conduct which is a basis for determining that each of the requisites for commitment is met."\textsuperscript{209} Documentation of past behavior is crucial given the fledgling status of prediction in the mental health field and the well established fact that past behavior is the best predictor of future behavior.\textsuperscript{210}

If commitment is ordered, the court's findings must list the less restrictive alternatives which were rejected and the reasons for rejection.\textsuperscript{211} The court must find that there is no suitable alternative 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 to the care and custody of another person or to an agency on conditions guaranteeing care and treatment of the proposed patient.\textsuperscript{212} This section is similar to the old provision.\textsuperscript{213} The Act adds the possibility that release could be to "an agency". This opens significant possibilities to explore new alternatives to commitment, for example, release to a hospital. No one against whom criminal proceedings are pending can be released under this section.

\textsuperscript{205} MINN. STAT. § 253B.08 subd. 1 (1982).

\textsuperscript{206} "Mentally ill" see supra note 17 and accompanying text. "Chemically dependent" see supra note 13 and accompanying text. "Mentally retarded" see supra notes 35-36 and accompanying text.

\textsuperscript{207} "Assuming that that term can be given a reasonably precise context and that the 'mentally ill' can be identified with a reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).


\textsuperscript{209} MINN. STAT. § 253B.08 subd. 2 (1982).


\textsuperscript{211} MINN. STAT. § 253B.08 subd. 2 (1982).

\textsuperscript{212} MINN. STAT. § 253B.09 subd. 1 (1982).

\textsuperscript{213} MINN. STAT. § 253A.12 subd. 1 (1980) (repealed August 1, 1982).
A guardian or conservator of the person has the power to establish the place of abode for the incapacitated person. A ward or conservatee, however, may not be admitted to any “state institution” except pursuant to commitment. Note, however, that the Commissioner of Public Welfare as guardian or conservator of a mentally retarded ward can admit a ward or conservatee to a state institution for up to ninety days in any calendar year for “temporary care.” This would be a less restrictive alternative than commitment for mentally retarded wards of the Commissioner.

The burden to establish that there is no less restrictive alternative to commitment rests on petitioner, for it is an essential element of his case. This is grounded in the principle that even where the goal is worthy, it “cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved.” This burden is not carried merely by alleging that a particular outcome is best or clinically the most appropriate for the proposed patient. It is also important from a clinical point of view that less restrictive alternatives be ruled out. There is evidence that too many people are institutionalized and that institutionalization is often dysfunctional.

The least restrictive alternative principle has a second application in the Act. Once it is determined that the criteria for commitment have been met, and that there is no alternative available less restrictive than involuntary treatment, the court must determine which treatment facility can meet the proposed patient’s needs consistent with the statutory “right to treatment” provisions, in the least restrictive manner. This is a separate question from whether less restrictive alternatives to commitment itself exist. This is a question of the destination of the committed patient.

The term “least restrictive manner” is not defined in the Act. Often, the relative degrees of restrictiveness between two alternatives are obvious. Thus, being committed to an outpatient medica-

215. Id.
218. See Chambers, Alternatives to Civil Commitment, 70 Mich. L. Rev. 1107 (1972); Kiesler, Mental Hospitals and Alternative Care, 37 Am. Psychiatry 349 (1982).
tion clinic in one’s home community is clearly less restrictive than being committed to a state hospital. Other comparisons are not so clear. Some would argue that commitment to a state hospital is less restrictive than commitment to a board and care home located in a high crime area of a city. Similarly some might argue that it is less restrictive to be committed to the security hospital than to be kept on a locked ward at an “open” hospital.

Several factors should be considered in making the restrictiveness determination. The degree to which the patient’s normal pattern of life is disrupted is an important factor. Thus, while the campus-like setting of a state hospital may appear more pleasant than the inner city setting of a community treatment facility, the latter may more closely approximate the life from which the patient has come, and to which he will return. Second, attention should be paid to the treatment methods used by the facility. Facilities which use aversive or deprivational techniques should be viewed as more restrictive than those emphasizing positive reinforcement and voluntary participation in treatment. Lastly, the views of the patient should not be overlooked in determining restrictiveness. In the long run, the patient’s cooperation and trust is critical in insuring successful treatment.

It seems most appropriate to request the pre-petition screening team to designate an appropriate facility in the event that commitment is ordered. Of course the petitioner may request another facility. The requirement that the least restrictive treatment facility be used suggests that commitment to outpatient care is possible. The definition of “treatment facility,” is broad enough to encompass an outpatient facility. A fine line would appear to exist, however, between those appropriate for voluntary outpatient treatment, and hence not committable, and those who may be committed to outpatient care.

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220. The pre-petition screening unit must determine whether there are alternatives less restrictive than commitment. This should entail a study of the proposed patient’s treatment needs. The pre-petition screening unit should be able to recommend a facility which can meet those needs in the least restrictive manner.


222. Some patients who refuse voluntary treatment may participate in outpatient treatment as committed patients simply because they have been ordered by the committing court to do so. Others may participate as committed patients because they are aware that the consequence for failure to participate is commitment on an in-patient basis.

It follows that the committing court should not reject outpatient treatment as a disposition merely because the proposed patient would not voluntarily cooperate with such treatment. The relevant questions are, first, whether such treatment would meet the proposed
If commitment is ordered, a copy of the findings of fact, conclusions of law and of the order must accompany the patient “at the time of admission.”\textsuperscript{223} The law is clear but will create a logistical problem. Hopefully this provision will be amended to allow the committing court administrative leeway, seventy-two hours, perhaps.

VI. POST-COMMITMENT

The initial commitment period is not more than six months,\textsuperscript{224} unless the person is mentally ill and dangerous to the public\textsuperscript{225} or the petition resulting in the commitment was filed while the person was committed and the petition results in a period of continuous commitment.\textsuperscript{226} This changes the old law significantly. Formerly the only finite commitment related to inebriates; a first commitment could last no longer than forty-five days; subsequent commitments for inebriety terminated by law in not more than eighteen months.\textsuperscript{227} Commitments for an indefinite period are very likely unconstitutional.\textsuperscript{228}

The head of the treatment facility must file a treatment report with the committing court\textsuperscript{229} “at least 60 days but not more than 90 . . . days after the commencement of the initial commitment. . . .”\textsuperscript{229} This “commencement of the initial commitment” is from the date of the order for commitment. The patient must be discharged and the proceedings terminated if this report is either not timely filed, or describes the patient as not in need of further institutionalization.\textsuperscript{230} If the patient is discharged before sixty days, then the report is due at the time of discharge.

This report must contain the following: a diagnosis with supporting data; an anticipated discharge date; a detailed description of the discharge planning process; a suggested aftercare plan; an opinion on whether further care and treatment are needed and the evi-

\textsuperscript{223} MINN. STAT. § 253B.10 subd. 1 (1982).
\textsuperscript{224} MINN. STAT. § 253B.09 subd. 5 (1982).
\textsuperscript{225} See MINN. STAT. § 253B.02 subd. 17 (1982).
\textsuperscript{226} See supra text accompanying note 117.
\textsuperscript{227} MINN. STAT. § 253A.07 subd. 17 (1980) (repealed August 1, 1982).
\textsuperscript{228} See Comment, Substantive Due Process Limits on the Duration on Civil Commitment for the Treatment of Mental Illness, 16 HARV. C.R.-C.L. L. REV. 205 (1981).
\textsuperscript{229} MINN. STAT. § 253B.09 subd. 5 (1982).
\textsuperscript{230} Id.
dence supporting this conclusion; whether further care and treatment must be provided in a treatment facility and the evidence supporting this conclusion, whether the head of the facility believes continued commitment is statutorily justifiable and documentation supporting this conclusion. This information must be in narrative form,231 and a copy must be sent to the patient and his attorney. No hearing is necessary after this report is filed.

In addition to the sixty to ninety day report, a second report is required either upon discharge or at the end of the initial six month commitment period, whichever is sooner.232 If the report is not timely filed, the patient must be discharged and the proceedings terminated.233 In this report, the head of the treatment facility must state his opinion as to whether continued treatment is necessary. If this opinion states the patient is not in need of further commitment, he must be discharged.234 If the opinion is that continued commitment is necessary, the court must hold a hearing before making a final decision.235 A representative of the treatment facility is the moving party at the hearing.236

Continued Commitment

The hearing must be held within fourteen days after the committing court receives the report of the head of the treatment facility.237 For good cause shown, the court may continue the hearing. At least five days notice of the time and place of the hearing must be given to the patient, his attorney, the original petitioner, and others as the court may direct.

Continued commitment is unjustified unless, after a hearing, the court finds that the patient continues to be mentally ill, retarded, or chemically dependent, commitment is required for the protection

231. The Minnesota Supreme Court Study Commission's Report found that many reports by the hospital to the court were extremely brief and conclusory. "Most reports state conclusions and recommendations with no supporting factual-behavioral basis." Final Report, supra note 7, at 45. To remedy this and meet the Act's requirement that reports be in "narrative form," the report should specify the facts which underlie its conclusions and recommendations.
232. MINN. STAT. § 253B.12 subd. 1 (1982).
233. Id., subd. 2.
234. Id.
235. MINN. STAT. § 253B.12 subd. 4 (1982). The patient, after consulting with counsel, may waive this hearing. MINN. STAT. § 253B.12 subd. 6 (1982).
236. This is appropriate because the facility will have the most knowledge of the patient at this point.
237. MINN. STAT. § 253B.12 subd. 5 (1982).
of the patient or others, and there is no alternative to commitment. The standard of proof is once again clear and convincing evidence. There is, however, an apparent difference between the criteria for continued commitment of the mentally ill and those for the chemically dependent and mentally retarded. Continued commitment of the mentally ill does not require a finding of a recent attempt or threat to physically harm self or others, or a recent failure to provide essentials for oneself. However, it must be found this type of behavior is "likely" to occur. A finding that a person continues to be mentally retarded or chemically dependent is required for continued commitment of these persons. It must be recalled, however, that the definitions of "mentally retarded" and "chemically dependent" include behavioral components. Taking this along with the language requiring a finding that continued commitment is the only alternative, it is clear that the Act requires the usual grounds for commitment to exist before continuing the commitment of the chemically dependent or mentally retarded.

Not requiring a recent, overtly dangerous act or threat before ordering continued commitment of the mentally ill raises some interesting constitutional questions. In any case, the basis of the court's decision should be the behavior of the patient in the treatment facility. Mere conclusions about his expected behavior or his current lack of "insight" should not justify continued confinement. If continued commitment is ordered, the findings of fact and conclusions of law must state specifically the behavioral basis for the determination, that the statutory criteria for commitment continue to be satisfied, the alternatives considered and the reasons they were rejected.

If, after the required hearing, the court finds the patient meets the statutory criteria for continued commitment as mentally ill, the court must determine the probable length of needed commitment.

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238. Id., subd. 4.
239. See Minn. Stat. § 253B.08 subd. 1 (1982).
240. See supra text accompanying notes 30-32.
243. Id., subd. 3.
244. See supra note 35 ("mentally retarded") and note 13 ("chemically dependent").
The length of continued commitment cannot exceed the lesser of the recommended length or twelve months.

The statute is not free from ambiguity, but it appears the maximum total length of commitment for a person mentally ill, including the initial period of six months, is eighteen months. The statute states that "[n]o period of commitment shall exceed this length of time\textsuperscript{248} or twelve months, whichever is less.\textsuperscript{249} The words "no period" may indicate that the total length of commitment is twelve months. More likely they acknowledge the fact that there are two periods of commitment; the initial period, limited to six months, and a continued period limited to twelve months. Further, the twelve-month limit noted above is allowable after a hearing which may be held as much as six months following the original order for commitment. Legislative clarification would undoubtedly be useful.

At the expiration of the total eighteen-month period of commitment, only a new petition can cause further commitment.\textsuperscript{250} The same burden and standard of proof as apply at the six-month hearing on continued commitment also apply at the proceeding following the eighteen-month commitment.\textsuperscript{251} The length of this consecutive commitment resulting from a new petition cannot exceed the lesser of twelve months or the probable length of commitment needed. Presumably, at the end of the lesser of twelve months or the period found probably necessary, the continued commitment provisions would again apply and another twelve-month period could be added. Thus, a consecutive commitment could result in up to twenty-four months of additional confinement before yet another petition were needed. However, if a time gap exists between the expiration of a continued commitment and the filing of another petition, the usual provision for a six-month initial commitment period will apply again.

\textit{Indeterminate} continued commitment can be ordered if the court finds, after receiving the six-month treatment report, that a person continues to be mentally retarded.\textsuperscript{252} The Act is unclear as to the mentally retarded patient’s right to a hearing before an order

\textsuperscript{248} For example, the judicially determined probable length of continued commitment.
\textsuperscript{249} \textsc{Minn. Stat.} § 253B.13 subd. 1 (1982).
\textsuperscript{250} Id. The new petition and determination thereon are governed by the provisions for the original commitment.
\textsuperscript{251} Id.
\textsuperscript{252} \textsc{Minn. Stat.} § 253B.13 subd. 2 (1982). Note that the definition of "mentally retarded person" requires both below average intellectual abilities and behavioral evidence of likely harm to self or others. \textit{See} \textsc{Minn. Stat.} § 253B.02 subd. 14 (1982).
for indeterminate commitment. On one hand, the provision regarding the duration of the continued commitment suggests that indeterminate commitment of the mentally retarded can occur without a hearing, since it allows such an order after only a review of the treatment report.\(^{253}\) On the other hand, the provision for review of commitments\(^{254}\) requires a hearing before continued commitment of the mentally retarded.

Continued commitment for a chemically dependent person can be ordered after a hearing for up to one year. Again a total of eighteen months is potentially involved. The subdivision states: “[T]he court shall order the continued commitment of the person for a period of time not to exceed one year.”\(^{255}\) Continued commitment requires a finding that the person continues to be chemically dependent. If commitment beyond this eighteen-month period is sought, a new petition and hearing will be required.\(^{256}\) The length of the initial commitment pursuant to this successive petition is the lesser of twelve months or the probably necessary time. As in the case of mentally ill persons,\(^{257}\) only if the commitment periods are consecutive will the initial period of six months be avoided.

VII. PROVISIONAL DISCHARGE FOR PERSONS NOT COMMITTED AS MENTALLY ILL AND DANGEROUS

The Act specifies in considerable detail procedures governing provisional discharge and revocation of provisional discharge. It does not, however, explicitly define the term “provisional discharge.” In practice, a provisional discharge entails a release from the hospital or other treatment facility to a less structured setting in the community. The characteristics of a provisional discharge are outlined by the substantive provisions of the Act.\(^{258}\) A provisional discharge is a discharge of the patient without a discharge of the commitment.\(^{259}\) The provisional discharge may entail conditions or restrictions on the patient, some of which may subsequently serve as grounds for revoking the provisional discharge. A provisional discharge is often used as an intermediate step between commitment to

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256. Id.
259. Id., subd. 1.
a hospital and full, outright discharge. The procedures for those committed as mentally ill and dangerous differ from those for persons committed under the other categories and are discussed later in this article. In both cases, though, the Act calls for notice and opportunity for a hearing concerning the revocation of a provisional discharge, and sets forth the grounds upon which provisional discharge can be revoked.

For persons not committed as mentally ill and dangerous, the new Act, like the old law, provides that the head of the treatment facility may grant a provisional discharge. The patient must have an "aftercare plan" which specifies, among other things, the expected length of time for the provisional discharge, and the conditions or restrictions on the patient. The plan must also contain the conditions upon which the provisional discharge may be revoked. The provisional discharge terminates, making the discharge absolute, on the date specified in the plan, unless the provisional discharge is extended or revoked. No provisional discharge can extend beyond the end of the commitment period as set by the court.

**Revocation**

The Act authorizes the head of the treatment facility to revoke provisional discharges for two reasons. There must be either a violation of a material condition of the provisional discharge plan which creates a need to return the patient to the facility, or a serious likelihood that the safety of the patient or others will be jeopardized. In order to establish the latter ground, conditions similar to those necessary to support an initial commitment must be shown.

The Act takes a middle-ground in defining permissible grounds for revocation. It does not permit revocation for naked violations of the provisional discharge plan. Such revocations might result in people being returned to the hospital who did not medically belong there. Provisional discharge plans often contain three kinds of conditions. Some are intended to protect the patient or the public from

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260. *Id.*
261. *Id.*
262. Where appropriate, the court could extend the commitment period for a person on provisional discharge provided that the criteria for continued commitment are met.
264. Failure to provide food, clothing, shelter, medical care, or an attempt or threat to seriously harm self or others physically may result in revocation of the provisional discharge. *Id.*
harm.\textsuperscript{265} Other conditions are intended to benefit the patient and speed his recovery.\textsuperscript{266} A third category of conditions might be described as administrative. They are imposed to enable social services agencies to provide service to the provisionally discharged person, and to monitor the provisional discharge plan.\textsuperscript{267} Clearly, a violation of a condition of the second category might not indicate a need to return the individual to the treatment facility, while a violation of a condition in the first would cause greater concern. Hospitalization for violation of the second or third type of condition would be punitive rather than therapeutic. The Act also avoids the other extreme which is allowing revocation only under the same conditions as the initial commitment. Making revocation too difficult might cause heads of facilities to be more cautious, thus deterring or delaying releases on provisional discharge.

As mentioned above, the Act conditions revocation upon either a showing that the criteria similar to those for initial commitment are met, or upon a showing that the patient has violated the provisional discharge plan, and that the violation creates a need to return to the facility. The last phrase is not defined. Presumably, a need to return to the facility would have to be connected to the purpose of confinement in a facility. As suggested, “punishment” for violating the provisional discharge plan would not, in these authors’ view, constitute “need” to return to the facility. Likewise, a likelihood of physical harm need not be shown in order to establish necessity. Rather, the Act would appear to allow revocation as a means of intervening at a somewhat earlier stage of a crisis, with the aim of averting more serious deterioration.\textsuperscript{268}

Revocation is commenced by the head of the treatment facility serving a notice of intent to revoke on the patient, his attorney and the designated agency. Any party, including the designated agency, may request the head of the facility to revoke.\textsuperscript{269} Prior to taking

\textsuperscript{265} For example, a requirement that the patient take his psychiatric medication, refrain from using drugs, or refrain from possessing firearms.
\textsuperscript{266} For example, a requirement that the patient attend recreational sessions at a local club.
\textsuperscript{267} The requirement that the patient notify the social service agency of a change in address.
\textsuperscript{268} The most common example of this situation might be a provisional discharge plan which requires the patient to take certain medication. The violation of that provision might create the need to return the patient to the hospital to restabilize even though the mental condition has not yet deteriorated to the point where an initial commitment could be justified.
\textsuperscript{269} \textit{Minn. Stat.} § 253B.15 subd. 3 (1982).
such a step, however, the designated agency must notify the patient of the possibility of revocation. All possible steps must be taken to avoid revocation. Such steps would entail attempts to meet the patient's needs without returning him to the treatment facility. For example, if the need for revocation is evidenced by the patient's failure to provide shelter for himself, the first step in avoiding revocation would be to attempt to provide shelter.

No hearing is held unless the patient or another interested person requests a hearing. Upon such a request, the head of the facility must file a petition for review with the committing court. Alternatively, the patient or other interested person can file the petition for review. The committing court must hold a hearing on the revocation within fourteen days or within five days of a request for an immediate hearing. If no one requests a review hearing within fourteen days of service of notice of intent to revoke, the revocation becomes final and the court may order the patient returned to the facility without a hearing.

In general, the Act contemplates that notice and hearing, if requested, will precede a return to the facility. However, in an emergency, the court may order the patient returned to the facility prior to a review hearing. In order to take this extraordinary step, the court must find that immediate return is necessary in order to avoid serious, imminent physical harm.

The first sixty days of a provisional discharge are excepted from the procedural requirements described above. During that time period, the head of the facility may revoke a provisional discharge without providing the notice and opportunity for hearing otherwise required. Although the Act is somewhat unclear as to what grounds the head of the facility may rely upon to revoke during the sixty-day period, it appears that the grounds are the same as those applicable to the remainder of the commitment period. The rationale for

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270. Id., subd. 4.
271. Id. The burden of proof at the hearing is on the party seeking revocation. This might be the designated agency or the treatment facility from which the patient was provisionally discharged.
273. Id., subd. 6.
274. The Act says the head of the treatment facility may revoke "upon a finding that either of the conditions set forth in subd. 1 [of Minn. Stat. Ann. § 253B.15 (West 1982)] exists." Subdivision 1 does not set forth two conditions as suggested by this language, although it does refer to the conditions imposed on the patient. Subdivision 2 does set forth the conditions upon which revocation is normally permitted. These authors believe the reference to subdivision 1 is an error. It is subdivision 2 of Minn. Stat. Ann. § 253B.15 (West
excepting the first sixty days from the procedural requirements is that simplifying the procedure for revocation will encourage treatment facilities to be more liberal in granting provisional discharges.

The Act contains provisions governing the extension of provisional discharges. No hearing is provided. The extension of a provisional discharge cannot extend the commitment beyond the period designated by the committing court.

The Act contains changes which allow a patient on provisional discharge to return voluntarily to the treatment facility without causing a revocation of the provisional discharge. Under prior practice, a patient on provisional discharge could return to the facility in only two ways: as an informal patient, or as a committed patient. In the first case, the commitment would be discharged. In the second, the provisional discharge would be revoked. The head of the hospital could choose which alternative to offer the patient. The new law adds a third alternative. The patient can return "temporarily from provisional discharge." Under this alternative, both the commitment and the provisional discharge remain in effect. The patient would be free to leave the facility at any time as if he were an informal patient, but remains subject to the provisional discharge plan. This new provision adds a flexible tool which will allow treatment facilities to shape treatment programs more accurately to meet the individual needs of their patients without an artificially induced change in legal status. Under prior practice, return to the treatment facility from provisional discharge was problematic because it involved a change in status. The change will be particularly useful where patients on provisional discharge suffer a temporary setback which can best be remedied by a short stay in the hospital. For example, a patient on provisional discharge may have stopped taking his medications. The treating physician may feel that patient needs to be hospitalized briefly in order to restabilize him on the medications. If the patient is willing, there is no need, under the Act, to revoke the provisional discharge merely to have the patient in the hospital for a brief period for a discrete purpose.

1982) which should govern the revocation process during the first sixty days of provisional discharge.

276. *Id.*, subd. 8.
277. *Id.*, subd. 10.
VIII. JUDICIAL RELEASE

The Act retains provisions of the old law allowing a patient to petition the court for release from commitment. The procedures remain essentially unchanged, with four exceptions. The new law makes clear what was implicit in the old, that this petition for release is unavailable to those committed as mentally ill and dangerous. Second, the new law provides that the patient as well as any interested person may petition for an order that further institutionalization is not required. Under the old law, only “interested persons” could petition and some argued that this term excluded patients. Third, the new law omits any reference to “restoration to capacity.” The reference in the old law was a vestige of prior law, under which commitment entailed a finding of legal incompetency. Finally, the new law provides for the appointment of examiners in connection with the hearing on the petition for release. Carrying over the process of the initial commitment hearing, the law provides that only one examiner need be appointed. A second examiner of the patient’s choosing is to be appointed only upon request. The burden of proving mental capacity appears to be on the patient.

IX. COMMITMENT AS MENTALLY ILL AND DANGEROUS

In general, the initial commitment of a person as mentally ill and dangerous to the public follows the same procedures as those set forth for the other disability groups. The main differences are that MI & D commitments may be made indeterminate, while commitments for mentally ill and chemically dependent must be determinate, and the discharge and release provisions for MI & D are different and more stringent than for the others. These differences are intended to make it more difficult for patients labeled “dangerous to the public” to obtain release from commitment. By permitting indeterminate commitments of those committed as MI &


281. See In re K.B.C., 308 N.W.2d 495 (Minn. 1981).


D, the Act places the burden on the committed patient to prove that he is entitled to release. In order to be released, an MI & D patient must, therefore, convince the fact-finder that he is no longer dangerous. This is an extremely heavy burden, for a number of reasons. First, the prediction of dangerousness, or a lack thereof, is an inexact science. The burden of this inexactness will fall on the patient who desires a discharge, rather than on the petitioner who desires to maintain the commitment. Second, past behavior will be considered probative of the patient's future behavior. However, generally the MI & D patient who is seeking a discharge will have been hospitalized for some period of time immediately preceding the consideration of his request for a discharge. The fact that hospitalization entails structure and supervision will be used to undercut the predictive significance of a history of non-dangerous behavior while hospitalized. Finally, even the speculative possibility that the patient might engage in violence may be enough to deter some decisionmakers from certifying that the patient is no longer dangerous. Such speculation might not, however, be sufficient to sustain a finding that the patient remains dangerous. The net effect of making MI & D commitment indeterminate is that it is extremely difficult for patients with this type of commitment to obtain discharges. The difficulty stems from the nature of the patient's burden, which requires him to prove a negative fact, based upon an inexact science, and a data base which is of questionable relevance. As a result, some patients who are no longer in fact dangerous may be denied a discharge because they are unable to prove that they will not be dangerous in the future. The burden is on the petitioner to prove his case by clear and convincing evidence.287

The Act suggests, though it does not say so explicitly, that a commitment as MI & D may be made only upon a petition alleging that the person is mentally ill and dangerous to the public. The Act refers to a “petition alleging that a proposed patient is mentally ill and dangerous to the public,” in specifying the procedures to be used in MI & D cases.288 Although the Act does not specifically prohibit a commitment as MI & D without such an explicit pleading, basic principles of due process would require that the proposed patient have advanced notice of the allegations being made against him. The Civil Commitment Rules of Procedure support this con-

287. MINN. STAT. § 253B.18 subd. 1 (1982). This burden is required for the original MI & D commitment, presumably the same standard would be required for release.
288. Id.
clusion. They require that the petition in a commitment case "specify the disposition sought." 289

The commitment must be reviewed at the end of sixty days. 290 On the basis of the review, the court has three options. The person may be committed as MI & D for an indeterminate period, or as mentally ill only for a determinate period, 291 or discharged from the commitment. 292 The procedures surrounding the review of the MI & D commitment following the first sixty-day period are somewhat unclearly stated in the Act, but are clarified in the Civil Commitment Rules of Procedure. 293

In the authors' view, the legislature intended to require a hearing prior to the indeterminate commitment of a person as mentally ill and dangerous. This conclusion follows from a close reading of the language of the Act, and is made explicit in the Civil Commitment Rules of Procedure. 294

The new Act retains the basic framework of the old law relating to transferring and discharging people committed as MI & D. 295 The power to make modifications in the commitment is vested in the Commissioner of Public Welfare, who may act only after receiving a favorable recommendation from the Special Review Board. 296

The new law provides for time limitations to govern the Special Review Board's consideration of petitions. Interested parties must be notified of the date of the Special Review Board hearing within forty-five days of the filing of the petition. 297 Although the language of the Act is ambiguous on this point, it seems that this passage intends that the hearing and not merely the notice, must be held

289. MINN. R. CIV. COMMITMENT 1.02. The old law contained no such pleading requirement, explicitly or implicitly.
290. MINN. STAT. § 253B.18 subd. 2 (1982).
292. The third alternative, though only implicit in the Act, is explicit in MINN. R. CIV. COMMITMENT 12.02.
293. MINN. R. CIV. COMMITMENT 12.
294. MINN. R. CIV. COMMITMENT 12.01.
296. The Act does not specify the membership of the Special Review Board. MINN. STAT. § 253B.18 subd. 4 (1982). This omission is clearly due to a typographical error, and will likely be remedied during the next legislature. In the interim, the Commission of Public Welfare will probably continue the practice, required by prior law, of appointing threemember Special Review Boards. Of these three, one was required to be a physician qualified in the diagnosis of mental illness or mental retardation; one was required to be an attorney; and no member could have any connection with the Department of Public Welfare. MINN. STAT. § 253A.16 subd. 5 (1980) (repealed August 1, 1982).
within forty-five days of the filing of the petition.\textsuperscript{298} The Commissioner must issue his order within fourteen days of receiving the Special Review Board's recommendation. The Commissioner's order can be effective no sooner than fifteen days after it is issued.\textsuperscript{299}

\textit{Transfer or Discharge}

The Act sets out factors to be considered in determining whether to transfer or provisionally discharge a patient. In either case, the Commissioner must find that the action can be accomplished with a "reasonable degree" of safety or protection for the public.\textsuperscript{300} This standard acknowledges the imprecision of predictions of dangerousness.\textsuperscript{301} No ironclad guarantee of safety is required.

The Act sets out three criteria for the discharge of a person committed as MI & D.\textsuperscript{302} First, the person must be "capable of making an acceptable adjustment to open society." Second, the person must be no longer dangerous to the public. Third, it must be found that the person "is no longer in need of inpatient treatment and supervision."\textsuperscript{303} Under the old law, a person could be discharged upon a finding that he could make "an acceptable adjustment in society."\textsuperscript{304} Under the Act, the person must be able to adjust to an "open" society. This change was intended to address the specific problem arising when a person committed as MI & D has been provisionally discharged to a prison to serve a prison sentence previously imposed. Under the old law, the person could argue that he had made, and would continue to make, an acceptable adjustment in the society in which he found himself — the prison. The addition of the term "open" apparently is intended to preclude this interpretation of the term "society."

In \textit{Johnson v. Noot},\textsuperscript{305} the Supreme Court construed for the first

\begin{itemize}
\item \textsuperscript{298} If the 45-day limit applies only to the notice, and not to the hearing, it would provide little if any protection to the patient, because there is no requirement governing the length of time which may follow the notice prior to a hearing. Since a hearing before the Special Review Board is a necessary precondition to obtaining release, it would be appropriate to require that the hearing be held promptly upon request.
\item \textsuperscript{299} \textsc{Minn. Stat.} \textsuperscript{226} § 253A.15 subd. 2(2) (1980) (repealed August 1, 1982) provided that the order could not be effective any sooner than 30 days after entry thereof.
\item \textsuperscript{300} \textsc{Minn. Stat.} \textsuperscript{226} § 253B.18 subd. 6, 7, & 15 (1982).
\item \textsuperscript{301} See \textit{Johnson v. Noot}, 323 N.W.2d 724, 728 (Minn. 1982).
\item \textsuperscript{302} \textsc{Minn. Stat.} \textsuperscript{226} § 253B.18 subd. 15 (1982).
\item \textsuperscript{303} \textit{Id.}
\item \textsuperscript{304} \textsc{Minn. Stat.} \textsuperscript{226} § 253A.15 subd. 2(2) (1980) (repealed August 1, 1982).
\item \textsuperscript{305} 323 N.W.2d 724 (Minn. 1982).
\end{itemize}
time the language of the old law limiting discharges to those patients capable of making an acceptable adjustment in society. The Commissioner of Public Welfare argued that he and the Special Review Board had discretion to determine whether the patient was "dangerous in the ordinary sense of that word, irrespective of the patient's mental condition."\textsuperscript{306} The Court rejected that argument, holding that it was contrary to the plain meaning of the statute. The Court pointed out that the statutory definition of the term "dangerous to the public" included the elements of mental illness or deficiency. For that reason, the Court concluded that a patient who was no longer mentally ill should be discharged from an MI & D commitment even if he was still dangerous, "[W]e hold that the statutory criteria for discharge of a person committed as mentally ill and dangerous — that the patient is "capable of making an acceptable adjustment in society" — be construed to mean that the patient is either no longer mentally ill or no longer dangerous."\textsuperscript{307}

The Act adds two criteria to the "acceptable adjustment" standard of the old law. The patient must be "no longer dangerous to the public" and "no longer in need of inpatient treatment and supervision."\textsuperscript{308} Neither of these additions should change the Johnson construction of the "acceptable adjustment" standard. The term "dangerous to the public" is part of the statutorily defined phrase "mentally ill and dangerous to the public."\textsuperscript{309} The definition clearly requires a causal link between the mental illness and the dangerousness. The requirement of a causal connection is more stringent than the old law, which was satisfied by the mere coincidence of the mental condition and dangerous behavior.\textsuperscript{310} Thus, the new definition of "dangerous to the public" is consistent with the Johnson discharge standard. Finally, the criterion regarding inpatient treatment and supervision is consistent with Johnson. A patient who is no longer mentally ill no longer needs to be an "inpatient," and thus should satisfy this criterion.

In addition to the three criteria mentioned above, the Act requires the Special Review Board and Commissioner to consider whether conditions exist "to provide a reasonable degree of protec-

\textsuperscript{306} Id. at 728.
\textsuperscript{307} Id.
\textsuperscript{308} Minn. Stat. § 253B.18 subd. 15 (1982).
\textsuperscript{309} Minn. Stat. § 253B.02 subd. 17 (1982).
\textsuperscript{310} Id.
tion to the public." If these conditions do not exist, the discharge is not to be granted. This provision may be meant to add a fourth criterion to the three set forth previously in the Act. Alternatively, it may be intended simply to clarify that the determination regarding "danger to the public" need not be an absolute one, but may be measured by the concept of "reasonable" protection. In view of the Act's insistence on a causal connection between the mental illness and the dangerousness, it appears that the first alternative should be rejected. The Act should not be read in a way that would retain people under commitment who are no longer mentally ill. The second alternative would be consistent with the idea that dangerousness is difficult to predict accurately.

Unlike the provisional discharge for the other disability groups, provisional discharges for persons committed as MI & D do not terminate automatically with the passage of time. Rather, such patients can be discharged only after a hearing by the Special Review Board.

Revocation of Provisional Discharge

Three grounds for revocation of provisional discharge are set out. These differ in several respects from the grounds applicable to non-dangerous committed persons. First the provisional discharge may be revoked if the patient has departed from the conditions of the provisional discharge. There is no explicit requirement that the departure have created a need for rehospitalization. Thus, it is theoretically possible that a person who has violated a condition of his provisional discharge could end up back in the hospital without a need to be there. Such a person would, presumably, be immediately ready for provisional discharge, since there would be no reason to keep him in the hospital. As pointed out below, the Special Review Board, in reviewing revocations, has the authority to recommend amendment of provisional discharges.

312. In Johnson the Minnesota Supreme Court emphasized this difficulty "[T]o date, no valid clinical experience or statistical evidence reliably describes psychological or physical signs or symptoms that can be reliably used to discriminate between the harmless and the potentially dangerous individual." 323 N.W.2d at 728.
313. See supra notes 262-63.
315. See supra notes 265-67 and accompanying text.
Such an amendment might be more productive than returning a person to the hospital who has no need to be there.

Second, it is grounds for revocation if the person is exhibiting “signs of mental illness which may require in-hospital evaluation or treatment.” Third, if the person is exhibiting behavior which “may be dangerous” to self or others, his provisional discharge may be revoked.

In general, the revocation provisions for MI & D are more permissive than those applicable to the other disability categories. However, the main thrust of revocations ought to be therapeutic and protective, not punitive. Thus, provisional discharge conditions should be carefully framed to attempt to insure that only those conditions which are of material importance in allowing the patient to live successfully in the community are included. This will avoid returning people to the hospital for violations if they do not need hospitalization.

The head of the treatment facility is authorized to revoke provisional discharges. Except in emergency situations, notice and an opportunity for a hearing before the Special Review Board must precede the revocation. The patient must be given a copy of a “revocation report,” along with a statement of his rights under the Act. He then has forty-eight hours to request review. In an emergency, the head of the facility can have the patient returned to the hospital prior to notice. Notice of his rights in connection with a provisional discharge revocation must be provided to the patient within seven days of his return to the hospital. Thereafter, review is obtained as above.

**CONCLUSION**

Commitment is a legal process not a medical process. It raises fundamental questions regarding the state and individual rights.

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317. *Id.*, subd. 10(ii).
318. *Id.*, subd. 10(iii).
319. For example, while it may be therapeutically sound to suggest that a person on provisional discharge attend recreational sessions in addition to taking his medications, failure to attend the sessions may not in itself, be indicative of a need for hospitalization. Instead of making recreation a “condition” of the provisional discharge, it might be wiser to label it a suggestion or recommendation or offer of service.
320. MINN. STAT. § 253B.18 subd. 10 (1982).
321. The term “emergency” is not defined at this point in the Act. It would be reasonable to allow re-hospitalization in connection with a provisional discharge revocation under the same standards as govern the emergency hold prior to a petition. MINN. STAT. § 253B.05 subd. 1 (1982).
There is no doubt commitment represents a "massive curtailment of liberty." It is sometimes argued in a particular case that a person needs "the protection of a commitment." This phrasing reveals an underlying and continuing problem in the field. Because physicians and psychologists are involved and because the terminology employed speaks of treatment or help for the person, the true nature of the process is sometimes forgotten. Commitment is viewed by many as a benevolent process rather than a massive invasion of civil rights. In the commitment process, the law is frequently perceived as an impediment to needed help. This perspective fails to recognize the process as a legal one. The decision of when to use the power of the state to coerce an individual is appropriately made by the legislature. The commitment law represents the legislative balancing of individual rights and the state interest in protecting its citizens.

The process accorded persons subject to the commitment laws is due them. It is not to be seen as merely a roadblock on the path to better health. If commitment is viewed purely as a way to obtain help for an ill person the burden will shift and the proposed patient will, in effect, be forced to prove he does not require treatment. Society has placed the burden on the petitioner; it subverts that decision to view commitments purely as a medical decision.

The new Act provides more due process for those subject to commitment. It represents the legislative decision regarding the price society will pay for mental health and individual rights.