Current Trends in MI&D Commitments in Minnesota

Data maintained by the Minnesota Judicial Branch shows there has generally been a slight increase in MI&D commitments filed statewide each year from 2020 to 2024. The number of other commitments filed (MI/CD/DD) has remained fairly steady between 2020 to 2024, with the exception of 2021, when commitments filed increased by more than five percent.

Commitments Filed Statewide

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

Data maintained by the Minnesota Judicial Branch shows that Hennepin and Ramsey Counties have filed the most MI&D commitments each year since 2020. Hennepin County filed 25 percent more MI&D commitments in 2024 than it did in 2020. Setting aside Hennepin and Ramsey Counties, St. Louis County consistently filed more MI&D commitments than other counties between 2020 and 2024. The remainder of the counties sampled from the Minnesota Judicial Branch website ranged between filing zero to three MI&D commitments per year from 2020 to 2024.

MI&D Commitments Filed by County (Sampling)

	2020	2021	2022	2023	2024
Anoka County	0	0	3	0	0
Beltrami County	0	2	2	2	2
Dakota County	1	3	1	3	0
Hennepin County	20	17	20	13	25
Ramsey County	10	8	13	8	10
St. Louis County	3	3	7	6	2
Stearns County	3	1	1	1	3
Washington County	2	1	1	1	0

Data maintained by the Minnesota Judicial Branch shows that orders for MI&D commitment statewide have increased by 77% since 2014. MI&D commitment orders generally increased year over year from 2014 to 2018. From 2018 to 2020, MI&D commitment orders plateaued at an average of 48 commitments ordered each year. There was a sizeable decrease in MI&D commitments ordered, 34, in 2021. In 2022, the number of commitments ordered jumped back to its previous level at 48. MI&D commitments were at an all-time high in 2023, with 55 commitments ordered.

MI&D Commitments Ordered Statewide

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

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

MI&D Cases Resulting in MI or DD Commitment Statewide

Year	MI&D Cases Filed that Resulted in MI or DD Commitment
2014	10
2015	15
2016	15
2017	8
2018	9
2019	8
2020	10
2021	12
2022	16
2023	7

Data maintained by the Minnesota Judicial Branch shows that between 2020 and 2022, the percentage of MI&D cases filed that resulted in MI or DD commitment steadily increased. In 2023, however, the percentage of MI&D cases filed that resulted in MI or DD commitment dropped significantly- by nearly

half. 2023 shows the lowest number of MI&D cases that resulted in MI or DD commitment going back to 2020, despite 2023 being a year where the second highest number of MI&D cases were filed.

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

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

Current Trends in MI&D Commitments in Other States

A 2017 NRI Report on forensic services noted that:

While overall national trend lines show a 76 percent increase in the number of forensic patients in state hospitals from 1999 to 2014, the trend is not consistent across all states. A few states report little change in their inpatient forensic populations. For the many states experiencing increases, the rise is mostly due to the increase in patients deemed incompetent to stand trial. For reasons that are explored in this paper, this is a phenomenon particularly evident during the past decade.

The overall nature of the forensic population is complex. Forensic patients (e.g. not guilty by reason of insanity and civilly committed sex offenders) may remain hospitalized for long periods of time. The more beds that are occupied by these patients, the lower the state hospital's turnover rate, which means that there are fewer opportunities for the state hospital to admit new patients. Long periods of stay, low turnover rates, and an overall increase in the number of referrals for inpatient services from the courts have contributed to increasing waitlists in many states. Waitlists hinder the state's ability to admit patients to their state psychiatric hospitals in a timely manner. These waitlists can lead to states being threatened with or held in contempt of court when there are active orders to admit individuals to the hospitals.

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

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

Can anyone access this article? https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(24)00164-0/abstract

National Practices and Criteria for MI&D Commitments

Minnesota has two separate categories for commitment. One is a person with a mental illness who poses a risk of harm. The other is a person with a mental illness and is dangerous to the public. Dangerous is defined as "a clear danger to the safety of others as demonstrated by the facts that (i) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and (ii) there is a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another."

The Treatment Advocacy Center issued a report "Grading the States: An Analysis of U.S. Psychiatric Treatment Laws." There is no mention of MI&D commitments. They looked at the definitions for "danger to self or others." There were nine states given a grade of A (including Minnesota). It seemed helpful to look at the definitions from those states and a few others.

Florida: There is substantial likelihood that in the near future he or she will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm;

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

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

West Virginia: Likely to cause serious harm" means an individual is exhibiting behaviors consistent with a medically recognized mental disorder or addiction, excluding, however, disorders that are manifested only through antisocial or illegal behavior and as a result of the mental disorder or addiction:(1) The individual has inflicted or attempted to inflict bodily harm on another; (2) The individual, by threat or action, has placed others in reasonable fear of physical harm to themselves; (3) The individual, by action or inaction, presents a danger to herself or others in his or her care; (4) The individual has threatened or attempted suicide or serious bodily harm to himself or herself;

North Dakota: "Serious risk of harm" means a substantial likelihood of: a. Suicide, as manifested by suicidal threats, attempts, or significant depression relevant to suicidal potential; b. Killing or inflicting serious bodily harm on another individual or inflicting significant property damage, as manifested by acts or threats;

Vermont: 17) "A person in need of treatment" means a person who has a mental illness and, as a result of that mental illness, his or her capacity to exercise self-control, judgment, or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others: (A) A danger of harm to others may be shown by establishing that: (i) he or she has inflicted or attempted to inflict bodily harm on another; or (ii) by his or her threats or actions he or she has placed others in reasonable fear of physical harm to themselves; or (iii) by his or her actions or inactions he or she has presented a danger to persons in his or her care. (B) A danger of harm to himself or herself

may be shown by establishing that: (i) he or she has threatened or attempted suicide or serious bodily harm;

Arkansas: As used in this subsection, "a clear and present danger to himself or herself" is established by demonstrating that:(A) The person has inflicted serious bodily injury on himself or herself or has attempted suicide or serious self-injury, and there is a reasonable probability that the conduct will be repeated if admission is not ordered; (B) The person has threatened to inflict serious bodily injury on himself or herself, and there is a reasonable probability that the conduct will occur if admission is not ordered; …(3) As used in this subsection, "a clear and present danger to others" is established by demonstrating that the person has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another, and there is a reasonable probability that the conduct will occur if admission is not ordered.

National Council for Mental Wellbeing conducted a review of states' commitment statutes. These statutes to not use the term "mentally ill and dangerous," but they include descriptions in which a court or other system may commit individuals presenting danger to others or themselves.

ALABAMA

Outpatient treatment; burden of proof.

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

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

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

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

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

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

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

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

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

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

Code of Ala. § 22-52-10.2

ALASKA

Initial involuntary commitment procedures.

(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520 — 47.30.620 or another mental health

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

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

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

Alaska Stat. § 47.30.700

ARIZONA

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

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

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

B. The petition shall be accompanied by the affidavits of the two physicians who participated in the evaluation and by the affidavit of the applicant for the evaluation, if any. In a county with a population of less than five hundred thousand persons, the petition may be accompanied by the affidavits of one physician and either one physician assistant who is experienced in psychiatric matters or one psychiatric and mental health nurse practitioner who conducted an independent evaluation and by the affidavit of the applicant for the evaluation, if any. The affidavits of the physicians or other health professionals shall describe in detail the behavior that indicates that the person, as a result of mental disorder, is a danger to self or to others or has a persistent or acute disability or a grave disability and shall be based on the physician's or other health professional's observations of the patient and study of information about the patient. A summary of the facts that support the allegations of the petition shall be included. The affidavit shall also include any of the results of the physical examination of the patient if relevant to the patient's psychiatric condition.

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

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

A.R.S. § 36-533

ARKANSAS

Petition for involuntary commitment.

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

(b) The petition for involuntary commitment shall:

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

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

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

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

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

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

(2) A notice that if the person shall fail to appear, the court shall issue an order directing a law enforcement officer to place the person in custody for the purpose of a hearing unless the court finds that the person is unable to appear by reason of physical infirmity or that the appearance would be detrimental to his or her health, well-being, or treatment.

CALIFORNIA

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

[Full section not reflected. See hyperlink]

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

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

Cal Wel & Inst Code § 5150

COLORADO

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

(1) The court may commit a person to the custody of the BHA upon the petition of the person’s spouse or guardian, a relative, a physician, an advanced practice registered nurse, the administrator in charge of an approved treatment facility, a certified peace officer, or any other responsible person. The petition must

allege that the person has a substance use disorder and that the person has threatened or attempted to inflict or inflicted physical harm on the person's self or on another and that unless committed, the person is likely to inflict physical harm on the person's self or on another or that the person is incapacitated by substances. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition must be accompanied by a certificate of a licensed physician who has examined the person within ten days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal must be alleged in the petition, or an examination cannot be made of the person due to the person's condition. The certificate must set forth the physician's findings in support of the petition's allegations.
(2) A court shall not accept a petition submitted pursuant to subsection (1) of this section unless there is documentation of the refusal by the person to be committed to accessible and affordable voluntary treatment. The documentation may include, but is not limited to, notations in the person's medical or law enforcement records or statements by a physician, advanced practice registered nurse, or witness.

C.R.S. 27-81-112

CONNECTICUT

Hearing on commitment application. Notice. Rights of respondent. Examination by physicians. Order of commitment. Election of voluntary status prior to adjudication. Review of confinement.

[Full section not reflected. See hyperlink]

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

Conn. Gen. Stat. § 17a-498

DELAWARE

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

[Full section not reflected. See hyperlink]

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

16 Del. C. § 5004

DISTRICT OF COLUMBIA

Commitment by Court order.

[Full section not reflected. See hyperlink]

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

D.C. Code § 24–607

FLORIDA

Involuntary inpatient placement and involuntary outpatient services.

[Full section not reflected. See hyperlink]

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

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

1. The person has a mental illness and, because of his or her mental illness:
   a. He or she is unlikely to voluntarily participate in a recommended service plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary; or
   b. Is unable to determine for himself or herself whether services are necessary.
2. The person is unlikely to survive safely in the community without supervision, based on a clinical determination.
3. The person has a history of lack of compliance with treatment for mental illness.
4. In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1).
5. It is likely that the person will benefit from involuntary outpatient services.
6. All available less restrictive alternatives that would offer an opportunity for improvement of the person's condition have been deemed to be inappropriate or unavailable.

Fla. Stat. § 394.467

GEORGIA

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

(a)

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

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

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

O.C.G.A. § 37-3-42

HAWAII

Civil commitment for substance abuse outpatient treatment. Petition.

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

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

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

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

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

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

(6) Any other reason for seeking court intervention.

HRS § 334-142

IDAHO

Commitment to department director upon court order — Judicial procedure.

[Full section not reflected. See hyperlink]

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

(2) The application shall state the name and last known address of the proposed patient; the name and address of the spouse, guardian, next of kin, or friend of the proposed patient; whether the proposed patient can be cared for privately in the event commitment is not ordered; whether the proposed patient is, at the time of the application, a voluntary patient; whether the proposed patient has applied for release pursuant to section 66-320, Idaho Code; and a simple and precise statement of the facts showing that the proposed patient is mentally ill and either likely to injure himself or others or is gravely disabled due to mental illness.

(3) Any such application shall be accompanied by a certificate of a designated examiner stating that he has personally examined the proposed patient within the last fourteen (14) days and is of the opinion that the proposed patient is: (i) mentally ill; (ii) likely to injure himself or others or is gravely disabled due to mental illness; and (iii) lacks capacity to make informed decisions about treatment;

or a written statement by the applicant that the proposed patient has refused to submit to examination by a designated examiner.

Idaho Code § 66-329

ILLINOIS

Involuntary admission; petition.

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

(b) The petition shall include all of the following:

1. A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence.

2. The name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If the petitioner is unable to supply any such names and addresses, the petitioner shall state that diligent inquiry was made to learn this information and specify the steps taken.

3. The petitioner's relationship to the respondent and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the respondent. If the petitioner has a legal or financial interest in the matter or is involved in litigation with the respondent, a statement of why the petitioner believes it would not be practicable or possible for someone else to be the petitioner.

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

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

405 ILCS 5/3-601

MAINE

Reception of involuntary patients.

[Full section not reflected. See hyperlink]

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

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

34-B M.R.S. § 3861

MASSACHUSETTS

Commitment — Procedure for Persons with Alcohol Use Disorder.

[Full section not reflected. See hyperlink]

For the purposes of this section the following terms shall, unless the context clearly requires otherwise, have the following meanings:
"Alcohol use disorder", the chronic or habitual consumption of alcoholic beverages by a person to the extent that (1) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning, or (2) the person has lost the power of self-control over the use of such beverages.
"Facility", a public or private facility that provides care and treatment for a person with an alcohol or substance use disorder.
"Substance use disorder", the chronic or habitual consumption or ingestion of controlled substances or intentional inhalation of toxic vapors by a person to the extent that: (i) such use substantially injures the person's health or substantially interferes with the person's social or economic functioning; or (ii) the person has lost the power of self-control over the use of such controlled substances or toxic vapors.

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

ALM GL ch. 123 § 35

MICHIGAN

"Person requiring treatment" defined; exception.

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

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

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

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

MCLS § 330.1401

NEW YORK

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

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

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

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

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

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

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

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

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

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

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

NY CLS Men Hyg § 9.27

TEXAS

Order for Temporary Inpatient Mental Health Services.

[Full section not reflected. See hyperlink]

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

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

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

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

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

(C) is:

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

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

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

Tex. Health & Safety Code § 574.034

WISCONSIN

Involuntary commitment for treatment.

[Full section not reflected. See hyperlink]

1. The individual is mentally ill or, except as provided under subd. 2. e., drug dependent or developmentally disabled and is a proper subject for treatment.
2. The individual is dangerous because he or she does any of the following:

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

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

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

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

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

Wis. Stat. § 51.20

After review of the available resources on other states' civil commitment systems, the mentally ill and dangerous commitment appears in many aspects to be a uniquely Minnesotan remedy to the issue of how to promote public safety as well as humane treatment of the small subset of individuals with severe and persistent mental illnesses who present a chronic elevated risk of harm to others without prolonged rehabilitation in a secure treatment facility. The key finding from the review is that while Minnesota employs a single civil-commitment based pathway to long-term secure treatment, other states employ a patchwork of three main avenues with relatively high barriers to entry when allocating secure treatment resources.

The first avenue is criminal conviction and sentencing to prison for violent offenses (usually after a period of treatment for competency attainment.) This avenue is only available for those with sufficiently treatable mental health conditions such that they are found competent and subsequently criminally responsible for a violent or high-level offense. Post-conviction carceral systems vary in their resources to

meet the needs of this subpopulation and ensure effective aftercare and supervision upon completion of sentence. However, most, including the federal system, have some form of specialized residential treatment units for these populations run by the correctional institution. To transfer to a secure treatment setting beyond the correctional facility, a formal judicial hearing and determination is required in most cases. In order for an individual to follow this pathway to a non-carceral forensic hospital, they must be found competent to stand trial, criminally responsible for a high level charge and then be found eligible for transfer out of the carceral setting to a secure treatment facility. These barriers in other states serve as gate-keeping function for non-carceral secure treatment beds. Upon completion of criminal sentences most states allow for civil commitment but often require recent evidence of dangerousness and regular renewal of commitment. California's Mentally Disordered Offender (MDO) statute is an example of a specialized civil commitment procedure for this population. Unlike the MI&D commitment where the onus is on the individual to prove sufficient treatment progression and risk mitigation to qualify for reduction in custody, most state's civil commitment laws require the state to prove ongoing dangerousness, usually based on recent behavior. These limitations on post-sentence commitment serve a further gate-keeping function for secure treatment bed utilization.

The second avenue for individuals to qualify for a prolonged or indeterminate commitment like MI&D in other states is through a finding by the criminal court of not guilty by reason of mental illness/insanity (NGRI/NGRMI). States vary by the entity that oversees this type of indeterminate commitment but they are generally the purview of the criminal court, at least initially. Some states like Oregon have developed administrative bodies akin to Minnesota's Special Review Board to oversee reductions in custody for these special indeterminate commitments. However, the threshold for qualifying for this commitment is generally higher, given that the individual must first be found competent, then clear the relatively high legal threshold for a finding of NGRI/NGRMI in most cases for a violent or high level charge. Even for those in this category, most states require demonstration that indeterminate commitment to a secure treatment facility is the least restrictive option. These legal thresholds serve an addition gate-keeping function for indeterminate commitment and utilization of secure treatment beds in these states.

Finally, in states with relatively high thresholds for civil commitment and more stringent serial renewal requirements, an alternative legal path to secure treatment is to be held under the jurisdiction of the criminal court for competency attainment, usually for violent or high-level charges. These cases can run into limitations on the allowable duration for secure treatment imposed by *Jackson v. Indiana* which limited the amount of time an individual could be held for the purpose of competency attainment. Some states like California have carved out special civil commitment procedures for this subpopulation when they become eligible for release under *Jackson* but continue to be deemed to pose a significant public safety risk outside of a secure treatment facility. However, in the case of these "Murphy conservatorships" in California, annual renewal based on a finding of "current dangerousness" is required. Other states like Oregon and Ohio have attempted to carve out special commitment procedures for this population but their duration remains subject to the limits of *Jackson* and Ohio's process was curtailed in 2013 after finding by the state appeals court that it was unconstitutional. It is posited that the limits imposed by *Jackson* as well as emphasis on "current dangerousness" to justify long-term commitment in other states serves as a gate-keeping function to indeterminate commitment and utilization of secure treatment resources in other states. This is supported by the fact that according to recent reports, only about 100 individuals in the entire state of California (a state nearly seven times more populous than Minnesota) are held under Murphy conservatorship, while Minnesota maintains approximately 600 MI&D commitments (not to mention hundreds more held indeterminately under alternative commitment types such as sexually dangerous person (SDP), sexually psychopathic personality (SPP) and long-term developmental disability (DD) commitments.)

In summary, most states employ a patchwork of legal processes, both civil and criminal, to pursue long-term secure mental health treatment for the small subset of individuals deemed to require it in the interest

of public safety. The legal thresholds associated with these processes tend to be high and serve a gate-keeping function for this highly restrictive and resource-intensive form of treatment. Minnesota by contrast employs a single pathway to secure treatment that depends entirely on the courts' application and interpretation of the civil commitment criteria as laid out in statute and case law.

This single entry-point to secure forensic treatment has advantages as it provides a relatively straightforward process and alleviates public anxieties about high risk individuals being released on a legal technicality without appropriate aftercare or supervision. It also provides means for ongoing pursuit of liberty goals by those who prove unable to attain competency to stand trial by virtue of their mental illness. It ensures all of these individuals are subject to a uniform process of risk mitigation, supervision and supportive community re-integration that is administered by a single government division under the Department of Human Services.

Nevertheless, because the process is subject to the application of non-clinically validated definitions of mental illness and dangerousness in individual courtrooms across the state, it is hypothesized that the gatekeeping function of the civil court in Minnesota is not as robust as the multiple avenues to long-term secure treatment in other states. Because the legal threshold to qualify for dedicated, long-term or indeterminate treatment in a secure setting is somewhat lower than other states, the system is vulnerable to the overrun of resources even with minor shifts in the rate of commitment. Due to the natural human bias toward harm avoidance and the relative ease with which this scarce resource can be mandated in perpetuity in some cases in compensation for lack of community resources, long waitlists are virtually guaranteed. Even a slight skew toward over-application of MI&D resulting in a handful of additional or inappropriate commitments per year can in the course of several years result in intractable and insurmountable wait times.