



STATE OF MINNESOTA

**Office of the Ombudsman for Mental Health and Mental Retardation
Civil Commitment Training and Resource Center**

Ste 420, Metro Square Bldg, St. Paul, MN 55101

Voice: 651-296-3848 Toll Free: 1-800-657-3506 Fax: 651-296-1021

<http://www.ombudmhm.state.mn.us>

Ombudsman Discussion Paper Fall/Winter 2002

**Civil Commitment Court Related Issues and Discussion of a
Consolidated Metro Area Mental Health Court**

*The Office of Ombudsman is charged under MN Stat. 245.91-.97 with promoting the highest attainable standards of treatment, competency, efficiency and justice for persons receiving for Mental Illness, Developmental Disabilities, Chemical Dependence and Emotional Disturbance. Through the Ombudsman's work in death and serious injury review process, our **Civil Commitment Training and Resource Center**, direct client assistance and systemic reviews, the agency is able to view what is working and where the gaps are. We have a view of the system and the way it works, not in policy but in practice for real citizens. We see that the laws, rules, policies and practice do not always reflect the true needs of the citizens served and that implementation and system intent do not always match.*

Preface

Civil Commitment is one of the most intrusive actions that can be taken in the life of a person with mental illness, chemical dependency or developmental disabilities. It is one of the few ways that an individual can lose their liberty without having committed a crime. Accordingly it should be used only as a last resort and only in the best interest of the individual with the cognitive disability. The commitment act should strike a balance of needs, allowing for ample "due process" for the person proposed being committed. The commitment process is filled with inconsistencies, inaccuracies, ignorance of the law and confusion that is inherent with 87 different counties directing the process as well as many medical professionals in many different hospitals who may not have complete or adequate legal knowledge or context given different procedures in different counties. It can be very frightening and abusive for the person proposed to be committed. In addition it creates inefficiencies for providers that can lead to delays in providing needed treatment and expensive extended hospital stays using scarce mental health bed capacity.

In addition to the potential to be abusive to citizen's civil rights, the civil commitment process is very expensive, ties up scarce medical, social and legal resources and contributes expensive delays in receiving treatment. This discussion paper does not propose to do away with the civil commitment system, when it is used, it should be done in both the most humane and most efficient manner. Currently this process is used because there is a lack of community based, early intervention options available to prevent a person's illness from deteriorating to a level where there is a need for civil commitment. This results in persons reaching a crisis level, presenting at hospital emergency rooms with commitment being used a method to access needed care. This is both inhumane and an expensive abuse of public resources.

One option that is being discussed as a suggestion for possible improvement of the system is to establish a single

mental health court for the metropolitan area. If successful could be duplicated throughout the state. This discussion paper is meant to spur broad stakeholder discussion of the problems and the feasibility of establishing a mental health court in Minnesota. However, many of the problems raised in this paper could and should be dealt with regardless of whether or not a single Mental Health Court is established.

Background

This discussion paper came from a series of discussions that included the representatives of Minnesota's major health plans, hospitals, the Ombudsman for Mental Health and Mental Retardation, the Department of Health, the Department of Human Services and the Attorney General. The purpose of the meetings was to examine the crisis of a lack of availability of inpatient mental health beds in Minnesota, especially in the metropolitan area. In addition to discussions with this group, the Office of Ombudsman for Mental Health and Mental Retardation has drawn upon the cases it receives and discussions with numerous stakeholders within the system to develop this briefing paper.

Issues with the civil commitment process have been around for a long time. While these issues may cause concern, confusion and difficulty for professionals that work with people with disabilities, the people who suffer the most are the individuals with disabilities whose lives are impacted directly.

The discussion about the bed shortage has pointed out a number of problems that lead to patients being held in acute hospital beds longer than their acute needs would normally justify. Many of the issues are caused, or made worse, by confusion that exists about how the commitment process is handled in different counties and how hospitals must react when they have patients from several different counties. While these issues are not unique to the metropolitan area, the volume from the metropolitan area makes it a prime area to begin addressing these issues. Because of the vagaries in how the system is dealt with in different counties as well as a variety of interpretations of the commitment act, there is a strong feeling among those who must navigate this system, that a single mental health court, with consistent processes, forms, timelines and interpretations would provide for a more humane, more efficient and more effective system.

The Office of Ombudsman for Mental Health and Mental Retardation has been the home to the Minnesota Civil Commitment Training and Resource Center. Many of the issues raised in this paper have come out of the training of professionals and discussions with clients, families and professionals.

Problems

This office believes the problems with the commitment process fall under five major areas. They include the Law, Implementation of the Law, Forms, Transportation and Funding. The issues of the language of the law and the funding of the system can best be dealt with through legislative action. Those two sections will be discussed at the end of the Problem section. Issues of Implementation of the Law, Forms and Transportation are matters more appropriately handled by the Court System and are highlighted here for discussion.

Implementation of the law

- Throughout the system, professionals are involved in the commitment processes that are not fully aware of what the commitment law says. This agency has had numerous interactions with case managers, physicians, hospital social workers, attorneys and court personnel who do not know or do not understand what the law actually says, yet these individuals have a great deal of power and control over the lives of patients who are extremely vulnerable at that point in time. This contributes to the confusion and inconsistency within the system. Judges may readily accept the recommendations of the case manager or other professional even though that professional is working from incorrect information about the commitment act.
- Problems exist with the length of time it takes to file the order of commitment or stay of commitment. In some cases the court doesn't even issue a warrant. Hospitals and patients don't know what they are required to comply with. The Civil Commitment Training and Resource Center has been consulted because the court has not issued an order and there has been a considerable amount of time since the hearing. There have been times where it has taken up to one month for commitments or stays of commitment. This is particularly troublesome when it involves a patient placed on a stay of commitment. The commitment act requires the court to issue an order that includes a written plan of services to which the patient has agreed. It also must contain conditions the patient must meet to avoid revocation of the stay. One county maintains that it has 30 days to file these orders. That means the patient may be in violation of the order, yet be unaware that this has occurred. It also creates the problem that the provider may not be aware that the patient has violated the terms and therefore does not know to contact the county. This situation is unfair to all parties.
- Problems exist with recommitting a person for the purpose of extending a provisional discharge. The law [253B.15 subd. 7] requires that the county recommend extension of the commitment in writing to the head of the facility. This is not consistently done when the county is pursuing a recommitment. The county and court usually recommit the individual and the facility never finds out about this unless they return the individual on a revocation. If the facility hasn't been informed, they discharge the individual from the commitment and send the required notice. Even this has not led to the facility being notified in all cases.
- There is over use of the immediate return to the facility for revocation of provisional discharges (PD). There have been situations where the county has requested the court immediately return the individual to the treatment facility even though the person has not presented a danger to self or others. Many times it is done because the community placement no longer wants the individual there or because the person under a PD has not followed one or more of the provisions of the PD but is not necessarily in need of acute inpatient hospitalization. The county case manager has sole discretion for revocation which gives them admitting privileges to the RTC without having the necessary medical background. The courts need to pay closer attention to the facts involved in the request before issuing an order.
- One issue that the Ombudsman's Office receives numerous complaints about is the fact that court appointed attorneys are difficult to reach, spend very little time with and seldom return calls to the client. Ombudsman staff knows from experience that this does indeed happen. The commitment act requires the attorneys to meet with their clients. The Ombudsman does not believe that meeting with the patient ½ -1 hour before the commitment hearing fulfills the intent of this requirement. It is too difficult to prepare a defense in such a short time when complex medical and mental health treatment issues are involved. The issue of an attorney's lack of preparation is a serious one when a patient's personal liberty

is at stake. In addition, many court appointed attorneys feel that their representation ends after commitment hearing and will not assist clients during the entire period of the commitment, as required by law.

- The law specifically states that the courts can not commit someone to a facility that can not meet their treatment needs. However this does happen because case managers, hospitals and courts do not know what else to do. They want the person someplace they perceive as safe and they are not aware of what else may be available or do not have the time to research what may be available and appropriate including community based options. Minnesota does not have adequate programs for those individuals who are both mentally ill and chemically dependent and the funding systems often make the counties choose a program that treats only one condition or the other when neither one alone can meet the patient's needs. This is true as well for other disorders like eating disorders, multiple personality disorders or persons with three or four co-occurring disorders. Many assume that if a person is committed to a State Operated Facility, that it is the State of Minnesota's job to develop the appropriate treatment program needed for each specific case. This is at a time when there is both public policy and financial pressure to reduce state operated services as well as a shortage of psychiatric practitioners. There is also a perception that sometimes a commitment placement is based on the funding streams and bed availability rather than the unique treatment needs of the individual.

Forms

- There are problems with the forms that are used in the commitment process. Not all forms are approved by the Supreme Court. The forms that are developed by the individual counties do not always contain the required information. Some do not contain correct information. Two examples of these problems would be the revocation of stays of commitment and revocation of a PD.
- Revocation of PD forms often contains inaccurate information. Some counties use timelines that do not follow the law. There are counties that will request the court to immediately return the patient to the treatment facility prior to the review hearing. 253B.15 requires two different methods. One is when an individual has violated a material condition of the PD. but does not pose a serious likelihood of danger to self or others. In this case, the patient has five days to petition for a review hearing, after which the court may order the person returned to a treatment facility. The second process is when a patient poses a danger to self or others. In this case, the county may request the court to order the patient to immediately return to a treatment facility. If this process is used, the patient has 14 days to petition for a review hearing. Many times, when the latter process is used, the order issued by the court states that the respondent has five days to submit the required affidavit and petition. The origin of this problem is that the legislation passed (which was based on the Civil Commitment Task Force recommendations back in 1997) had the same requirement for filing the affidavit and petition for both cases. Originally, it was five days. It was done this way to avoid confusion. The next year, in the legislation proposed to correct problems with the original bill, an amendment set up separate timelines for the different situations. It appears that the counties are unaware of the differences.
- There is inconsistency in forms and they may also fail to fully inform the patient of the right to request a hearing and how to do so.

- Revocations of Stays of Commitment forms many times look like a district court hold order. [This confusion also occurs with revocation of PD's at times.]. The order does not specifically state that the court is revoking the stay and committing the patient. This is confusing to staff at the facilities and for the patient. Again, the form does not notify the patient of the right to request a hearing and how to do so.

Transportation

- Providing transportation is a resource issue for counties. Generally law enforcement is the entity used by counties. For some counties, the issue does not arise very often. However in other counties there are numerous requests for the services of law enforcement. This is often viewed by law enforcement as a low priority so patients and providers must wait when law enforcement is responding to other priority calls or when there are officer shortages. This contributes to the costly back up in a system already in crisis and is not therapeutic for patients who must wait for their treatment. Transportation can remove an officer from other service for long periods of time when patients are transported to hospitals hundreds of miles from their home city or county causing a resource shortage for the county.
- Police and county law enforcement generally use caged cars and uniformed officers even though the law encourages the use of unmarked cars and non-uniformed officers. Use of handcuffs is the normal practice, even in a caged car. At least one county has routinely used shackles to transport individuals even though the patients pose little or no safety risk to the officer or the public. This is very disrespectful and sometimes traumatizing to patients who are not a danger and who are already experiencing significant problems in their life.
- “Hold Orders” are used to get Law Enforcement to do transportation because insurance companies will not pay.
- No entity is responsible for transportation if the individual is discharged off the hold order. Individuals are left to own their devices for transportation. This is a significant problem with the current in-patient bed shortage when a person may be hospitalized hundreds of miles from where they live. Many can't afford the bus fare home or are unable to find anyone to pick them up. In Greater Minnesota nurses have pooled their own money to buy a bus ticket for a person to go back to the metro area after being placed outside the metro area on a hold order.

Other Related Problems

As discussed earlier, the following issues are listed for context. They are better dealt with through the legislative process but would benefit from comment from the judicial system.

Law

- In MN Stat. § 253B.02 subd. 13 (1) (2) the definition of mentally ill person has two clauses that are so similar that they are confusing. Both have to do with providing for basic needs with (1) stating “failure to provide” and (2) stating “inability to provide”. Parenthesis 2 was added because a couple counties would not commit the person if someone else provided these needs for the individual. Most

other counties considered this to be a “failure.” Persons involved with the request for this change indicated that the problem came about because of the situation where family or insurance providers who had been providing or should have been providing these services were refusing to provide or pay for them. Advocates felt the person proposed to be committed should not be punished with loss of liberty because services were no longer being paid for. Counties and hospitals have been using the commitment process as a means of accessing payment sources. Now, all counties must use the new clause. Paragraph 2 only allows for commitment to community based treatment, not a Regional Treatment Center (RTC). Since there is a lack of community beds, this compounds the problem. Discussion should take place on language clarification to insure there is a difference between those who fail to provide for their basic needs as a result of the illness from those who are mentally able to provide for their basic needs but can not do so because of a lack of resources such as funding for treatment.

- 253B.04 subd.1b was added to allow the appointment of a substitute decision maker (SDM) to consent to admission of a person lacking capacity but willing to accept treatment. This is an attempt to avoid having to commit the person. Since 253B.092 does not allow this SDM to authorize administration of neuroleptics, the Department of Human Services (DHS) won’t accept this type of admission to an RTC. DHS does accept voluntary admissions to its facilities, but the criteria are very tight and many do not meet their criteria. DHS wants to ensure that those more appropriate for community placement be treated in the community and that there is sufficient “due process” to protect the rights of those persons lacking capacity to make those decisions. Discussion should take place regarding amending 253B.092 to allow a SDM under .04 subd. 1b to give consent to neuroleptics when the person is not refusing.
- The term used in 253B.09 subd. 1c is “community based program.” It appears that the author meant to use “community based treatment,” which is defined, as there was an amendment in 2002 to include community hospital inpatient beds. These were not allowed previously in the definition of community based treatment. Legislation should use defined terms to avoid confusion.
- Under current law, a minor child 16 years or older can consent to inpatient treatment, with or without parental consent. However, there is no provision for the same child to consent to outpatient treatment. In order for a minor child to avail themselves of this provision it would require the more restrictive and expensive inpatient care, using up one of the limited number of beds or go without any treatment. While we would encourage open communication and support between parents and adolescent children, there are situations where a child may want and need treatment but can not obtain the consent or support of their parent or guardian. Making expensive in-patient treatment the only option is very expensive and will deter some adolescents from seeking needed treatment.

Funding

- The Ombudsman’s office has received reports that hospitals are being told by at least one metro county that the county will only pay for emergency hold orders at Hennepin County Medical Center and RTCs even though there were no beds at those facilities when the patient was placed on a hold order. There may be some provision that allows counties to contract for these services with specific providers. However, physicians in the ERs and the hospitals may not be aware of this when they place a hold order on a patient and then arrange for them to be transported to facilities outside of the

county due to the lack of beds.

- Greater Minnesota hospitals are being told by another metro county that the county will pay for emergency holds, but not if the only reason the person is there is due to a lack of beds in the metro area.
- EMTALA (Emergency Medical Treatment and Active Labor Act - Federal Law) requires hospitals to accept a person if they have an open bed and the person meets their admission criteria. However, based on counties refusing to pay for out of area hold orders, the hospital ends up having to absorb the cost of care or expend health care resources to pursue legal action to recover payment from the county. Some have indicated that they may have to close their mental health units if they are unable to recover the cost of care. This would only add to the bed shortage crisis.
- Because of a lack of adequate community based transitional and permanent housing, as well as community based comprehensive prevention and support services, hospitals are overcrowded. Then commitment is used because of the perception that the RTCs only take hold order and committed patients even though the law allows for voluntary admission. As discussed previously, the RTCs do take voluntary admissions but the criteria are very narrow for reasons previously outlined. Additional community treatment and housing options must be developed which in the long run will be more cost effective not to mention more humane.

Additional Problem Discussion Points Raised by Others

Our office has received a list of concerns from hospitals. While some of the issues may be addressed in the Ombudsman's comments, it was felt that in fairness to hospitals, the list should be presented separately as they were presented to the Work Group. The Ombudsman has added some clarification or comments in italics after some of the issues raised.

Court/Commitment Issues

1. Varying thresholds between counties related to interpretation of dangerousness.

The difference between various counties and their interpretation of dangerousness is a real issue for providers. However, it is allowed by the law.

2. Varying levels of pre-petition screening involvement in reviewing cases and denying petitions.

The law sets up the process which a county must follow in pre-petition screening. Counties may vary in their aggressiveness in fact finding. This can also be true within the same county on different cases. Since the metro area hospitals take patients from many different counties, this presents a problem in consistency and being able to develop an appropriate and workable treatment plan.

3. Some counties take up to a week to start the five day notification to patient before [a] hearing can be scheduled on the court calendar.

The law states the court has to give five days notice to the patient that there will be a hearing and two days notice of the time and place. Most counties have the information on the DCHO (Hold Order). There could be confusion with this provision and how counties schedule their hearings.

4. Patients are continued for trial but not placed on court hold.

The court is allowed to make findings of probable cause at the preliminary hearing which would include letting the individual go home pending the court hearing. It is at the court's discretion. There may be confusion as to whether there is an expectation that the patient should be staying in the hospital. There needs to be clarity of expectations by all parties involved.

5. Patients are committed to a 45 day [contract] bed but there is not an available bed.

It is important to remember that these contract beds did not add any additional in-patient beds to the current capacity but used existing beds for diversion from the RTC. This is a real problem since most counties are still learning of the new amendments to the definition of a mentally ill person, and due to the fact they can only commit the patient to community based programs under certain provisions of the law.

6. Court process timeline between pretrial and trial varies from 2 to 3 days in some counties to one week in others.

The court has 72 hrs, with the exclusion of weekends and holidays, to hold preliminary hearings and 14 days for the commitment hearings. Any delays while the patient is in the hospital is difficult on the patient and ties up scarce and needed acute in-patient hospital beds.

7. Different forms specific to each county for administrative petitions (pretrial reports, Exhibits A's, etc) and very redundant.

8. Timely 2nd opinion by independent examiners

The law only requires the examiner's report to be filed 48 hours before the commitment hearing. Many defense attorneys wait until they see the first examiner's report before requesting a second opinion. They won't request a second examiner if the initial report is favorable to their client. This issue may be one of a balance of efficiency and client rights. However, once a decision to seek a second opinion is made, availability of the examiner could cause a delay in the process.

9. Refusing and/or placing odd limits on ITP's (Individual Treatment Plan) that deviate from the treating physician's recommendations. As well as, inconsistent requests from counties on when and if ITP's are needed.

In certain cases such as stays, the court is required to set up criteria the person must meet to avoid commitment. The new funding requirements also require a CTP (Community Treatment Plan). One would hope the treating professionals would be consulted on this to ensure that plans that are developed are therapeutic for the patient.

10. Demands for in-person testimony by psychiatrists rather than telephonic.

This is an inherent problem for treating professionals. Many courts/attorneys prefer face to face examination or cross examination. Video conferencing may work but the use of teleconferencing is not viewed favorably by many people involved with the commitment process. However, due to the shortage of psychiatrists, the demands on their time, rules and reimbursements of the managed care system this becomes unworkable. Again this presents a conflict between patient rights and the inefficiencies of the system.

11. Delays in forwarding paperwork to Anoka RTC to get patients on the waiting list.

Miscellaneous Issues Related To Courts

1. Transportation to state hospitals is a significant problem causing a 2 to 3 day delay; deputies are not available to transport patients to Anoka when a bed is available.

Given the relatively short distance to AMRTC from most metro counties, this should not be a problem except to the extent that law enforcement is used as the method of transportation. Given the competing priorities of law enforcement, it would appear that this function has a low priority.

2. A case manager is not routinely or quickly assigned as patient goes through the court process.

The law only requires that a case manager be assigned after a person is committed. It does require a screening process that includes county social workers. However, activating and including the county case management system before commitment might provide better options for the clients and result in less hospital and RTC beds being needed.

3. Timely Rule 25 assessments, in the hospital. Some counties refuse to come onsite at the hospital to perform the Rule 25 assessment

This has been a problem throughout Minnesota. There are reports of counties taking weeks, to well over a month, to do the Rule 25 assessment even after they have committed the individual to CD treatment. It would seem to make sense that this should have been done before the commitment hearing as a part of the pre-petition screening process and have appropriate timeline requirements. Failure to do this assessment in a timely manner contributes to patients being committed to facilities that can not meet their needs.

Strategies

It is believed by many that the establishment of a single, regionally based Mental Health Court would significantly improve the civil commitment process for all parties concerned. Some of the ways such a court could operate and improve the system include:

- Judges and court personnel would work exclusively in this area and therefore become experts in what

the law says, how the process was intended to work and make proposals for needed clarifications in the law. This would lead to more consistency for providers in knowing what cases to bring forward and what process to use. More importantly, it would provide for better protection of the rights of persons who are proposed to be committed.

- Explore the possibility of a mental health public defenders office who work exclusively with the mental health court.
- This court could provide for standardized forms for counties, providers and professionals that will ensure that consistent information is gathered and considered in all cases and that definitions are consistent throughout the system.
- This court could establish a more humane and efficient transportation system that is assigned solely for this process. It could employ law enforcement or other specially trained individuals who can provide for risk assessment, use non-uniformed staff in un-marked vehicles. The law does not require that transportation be provided by law enforcement but does specify that when officers do transport patients, unmarked cars with non-uniformed officers should be used whenever possible. However, this is almost never the case in the current system and often criminal precautions or protocols are implemented such as the use of handcuffs and shackles. This is disrespectful, dehumanizing, traumatizing and non-therapeutic for the patient as well as furthering the public stigma and falsehood that all mentally ill people are dangerous.
- Funding for the various parts of the process including notices, pre-petition screenings, forms, notifications, transportation and other aspects should be redirected to this court to allow for efficient processes and better monitoring of the true cost of the civil commitment system.

Conclusion

The court system should consider this option along with other ideas to improve the efficiency and effectiveness of the current process in consultation with a broader group of stakeholders including citizens who have been affected by civil commitment. Ultimately, improving the efficiencies, while protecting patient rights, could reduce costs that could be better used for timely early treatment, in an effort to reduce the need for costly hospitalization.

The Office of Ombudsman presents this discussion with the understanding that some of these items may require funding which might not be available at this time. However, we present them so that policy decision-makers will know what is needed in this system. In addition while funding is and remains a critical issue, not every problem requires additional funding but may require removing barriers by changes in laws and rules along with creativity and altering assumptions and out-of-date practices. It is the Ombudsman's goal to raise the issues for discussion and hope that some action can be taken now and the balance of changes when funding is available. In the end a more efficient and effective system should lead to funds being used in the most cost effective manner and also result in a more humane system for patients, families and the public at large.



STATE OF MINNESOTA

**Office of the Ombudsman for Mental Health and Mental Retardation
Civil Commitment Training and Resource Center**

Ste 420, Metro Square Bldg, St. Paul, MN 55101

Voice: 651-296-3848 Toll Free: 1-800-657-3506 Fax: 651-296-1021

<http://www.ombudmhr.state.mn.us>