CHAPTER 253B

CIVIL COMMITMENT

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253B.001 MS 2006 [Renumbered 15.001]

253B.01 CITATION.

This chapter may be cited as the "Minnesota Commitment and Treatment Act."

History: *1982 c 581 s 1; 1997 c 217 art 1 s 5*

253B.02 DEFINITIONS.

Subdivision 1. **Definitions.** For purposes of this chapter, the terms defined in this section have the meanings given them.

Subd. 1a. **Case manager.** "Case manager" has the definition given in section 245.462, subdivision 4, for persons with mental illness.

Subd. 2. **Chemically dependent person.** "Chemically dependent person" means any person (a) determined as being incapable of self-management or management of personal affairs by reason of the habitual and excessive use of alcohol, drugs, or other mind-altering substances; and (b) whose recent conduct as a result of habitual and excessive use of alcohol, drugs, or other mind-altering substances poses a substantial likelihood of physical harm to self or others as demonstrated by (i) a recent attempt or threat to physically harm self or others, (ii) evidence of recent serious physical problems, or (iii) a failure to obtain necessary food, clothing, shelter, or medical care. "Chemically dependent person" also means a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following substances

or their derivatives: opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine, tetrahydrocannabinol, or alcohol.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 4. **Committing court.** "Committing court" means the district court where a petition for commitment was decided. In a case where commitment proceedings are commenced following an acquittal of a crime or offense under section 611.026, "committing court" means the district court in which the acquittal took place.

Subd. 4a. MS 2018 [Renumbered subd 4e]

Subd. 4b. **Community-based treatment program.** "Community-based treatment program" means non-state-operated treatment and services provided at the community level, including but not limited to community support services programs defined in section 245.462, subdivision 6; day treatment services defined in section 245.462, subdivision 8; outpatient services defined in section 245.462, subdivision 21; mental health crisis services under section 245.462, subdivision 14c; outpatient services defined in section 245.462, subdivision 21; assertive community treatment services under section 256B.0622; adult rehabilitation mental health services under section 256B.0623; home and community-based waivers; supportive housing; and residential treatment services as defined in section 245.462, subdivision 23.

Subd. 4c. **County of financial responsibility.** (a) "County of financial responsibility" has the meaning specified in chapter 256G. This definition does not require that the person qualifies for or receives any other form of financial, medical, or social service assistance in addition to the services under this chapter. Disputes about the county of financial responsibility shall be submitted for determination to the executive board through the commissioner of human services in the manner prescribed in section 256G.09.

(b) For purposes of proper venue for filing a petition pursuant to section 253B.07, subdivision 1, paragraph (a), or 253D.07, where the designated agency of a county has determined that it is the county of financial responsibility, then that county is the county of financial responsibility until a different determination is made by the appropriate county agencies or the commissioner pursuant to chapter 256G.

Subd. 4d. **Court examiner.** "Court examiner" means a person appointed to serve the court, and who is a physician or psychologist who has a doctoral degree in psychology, and is either licensed in Minnesota or who holds current authority to practice in Minnesota under an approved interstate compact.

Subd. 4e. **Crime against the person.** "Crime against the person" means a violation of or attempt to violate any of the following provisions: sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.224 (assault in the fifth degree); 609.2242 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse); 609.233 (criminal neglect); 609.2335 (financial exploitation of a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.245 (aggravated robbery); 609.247 (carjacking); 609.25 (kidnapping); 609.255 (false imprisonment); 609.265 (abduction); 609.27, subdivision 1, clause (1) or (2) (coercion); 609.28 (interfering with religious observance) if violence or threats of violence were used; 609.322, subdivision 1, paragraph (a), clause (2) (solicitation); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3458 (sexual extortion); 609.365 (incest); 609.498, subdivision 1 (tampering with a witness); 609.50, clause (1) (obstructing legal

process, arrest, and firefighting); 609.561 (arson in the first degree); 609.562 (arson in the second degree); 609.595 (damage to property); and 609.72, subdivision 3 (disorderly conduct by a caregiver); and Minnesota Statutes 2012, section 609.21.

Subd. 5. **Designated agency.** "Designated agency" means an agency selected by the county board to provide the social services required under this chapter.

Subd. 6. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 7. **Examiner.** "Examiner" means a person who is knowledgeable, trained, and practicing in the diagnosis and assessment or in the treatment of the alleged impairment, and who is a licensed physician; a mental health professional qualified under section 245I.04, subdivision 2; a licensed physician assistant; or an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3, who is practicing in the emergency room of a hospital, so long as the hospital has a process for credentialing and recredentialing any APRN acting as an examiner in an emergency room.

Subd. 7a. MS 2012 [Renumbered 253D.02, subd 8]

Subd. 7b. **Executive board.** "Executive board" has the meaning given in section 246C.015.

Subd. 8. **Head of the facility or program.** "Head of the facility or program" means the person who is charged with overall responsibility for the professional program of care and treatment of the treatment facility, state-operated treatment program, or community-based treatment program.

Subd. 9. **Health officer.** "Health officer" means:

(1) a licensed physician;

(2) a mental health professional qualified under section 245I.04, subdivision 2;

(3) a licensed social worker;

(4) a registered nurse working in an emergency room of a hospital;

(5) an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3;

(6) a physician assistant as defined in section 147A.01, subdivision 18;

(7) a mental health practitioner as defined in section 245.462, subdivision 17, providing mental health mobile crisis intervention services as described under section 256B.0624 with the consultation and approval by a mental health professional; or

(8) a formally designated member of a prepetition screening unit established by section 253B.07.

Subd. 10. **Interested person.** "Interested person" means:

(1) an adult who has a specific interest in the patient or proposed patient, including but not limited to a public official, including a local welfare agency acting under section 260E.31; a health care or mental health provider or the provider's employee or agent; the legal guardian, spouse, parent, legal counsel, adult child, or next of kin; or other person designated by a patient or proposed patient; or

(2) a health plan company that is providing coverage for a proposed patient.

Subd. 10a. **Licensed physician.** "Licensed physician" means a person licensed in Minnesota to practice medicine or a medical officer of the government of the United States in performance of official duties.

Subd. 11. **Licensed psychologist.** "Licensed psychologist" means a person licensed by the Board of Psychology and possessing the qualifications for licensure provided in section 148.907.

Subd. 12. MS 2018 [Renumbered subd 10a]

Subd. 12a. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 12b. **Pass.** "Pass" means any authorized temporary, unsupervised absence from a state-operated treatment program.

Subd. 13. MS 2018 [Renumbered subd 17a]

Subd. 13a. **Pass plan.** "Pass plan" means the part of a treatment plan for a patient who has been committed as a person who has a mental illness and is dangerous to the public that specifies the terms and conditions under which the patient may be released on a pass.

Subd. 14. MS 2018 [Renumbered subd 17b]

Subd. 14a. **Pass-eligible status.** "Pass-eligible status" means the status under which a patient committed as a person who has a mental illness and is dangerous to the public may be released on passes after approval of a pass plan by the head of a state-operated treatment program.

Subd. 15. **Patient.** "Patient" means any person who is receiving treatment or committed under this chapter.

Subd. 16. **Peace officer.** "Peace officer" means a sheriff or deputy sheriff, or municipal or other local police officer, or a State Patrol officer when engaged in the authorized duties of office.

Subd. 17. **Person who has a mental illness and is dangerous to the public.** A "person who has a mental illness and is dangerous to the public" is a person:

(1) who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, and is manifested by instances of grossly disturbed behavior or faulty perceptions; and

(2) who as a result of that impairment presents 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.

Subd. 17a. **Person who poses a risk of harm due to a mental illness.** (a) A "person who poses a risk of harm due to a mental illness" means any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, that is manifested by instances of grossly disturbed behavior or faulty perceptions and who, due to this impairment, poses a substantial likelihood of physical harm to self or others as demonstrated by:

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

(2) an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial

harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;

(3) a recent attempt or threat to physically harm self or others; or

(4) recent and volitional conduct involving significant damage to substantial property.

(b) A person does not pose a risk of harm due to mental illness under this section if the person's impairment is solely due to:

(1) epilepsy;

(2) developmental disability;

(3) brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or

(4) dependence upon or addiction to any alcohol, drugs, or other mind-altering substances.

Subd. 17b. **Person with a developmental disability.** "Person with a developmental disability" means any person:

(1) who has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior and who manifests these conditions prior to the person's 22nd birthday; and

(2) whose recent conduct is a result of a developmental disability and poses a substantial likelihood of physical harm to self or others in that there has been (i) a recent attempt or threat to physically harm self or others, or (ii) a failure and inability to obtain necessary food, clothing, shelter, safety, or medical care.

Subd. 18. MS 2018 [Renumbered subd 18d]

Subd. 18a. **Secure treatment facility.** "Secure treatment facility" means the Minnesota Security Hospital but does not include services or programs administered by the Minnesota Security Hospital outside a secure environment.

Subd. 18b. MS 2012 [Renumbered 253D.02, subd 15]

Subd. 18c. MS 2012 [Renumbered 253D.02, subd 16]

Subd. 18d. **State-operated treatment program.** "State-operated treatment program" means any state-operated program including community behavioral health hospitals, crisis centers, residential facilities, outpatient services, and other community-based services developed and operated by the state and under the executive board's control for a person who has a mental illness, developmental disability, or chemical dependency.

Subd. 19. **Treatment facility.** "Treatment facility" means a non-state-operated hospital, residential treatment provider, crisis residential withdrawal management center, or corporate foster care home qualified to provide care and treatment for persons who have a mental illness, developmental disability, or chemical dependency.

Subd. 20. **Verdict.** "Verdict" means a jury verdict or a general finding by the trial court sitting without a jury pursuant to the Rules of Criminal Procedure.

Subd. 21. MS 2018 [Renumbered subd 12b]

Subd. 22. MS 2018 [Renumbered subd 13a]

Subd. 23. MS 2018 [Renumbered subd 14a]

Subd. 24. MS 2012 [Renumbered 253D.02, subd 2]

Subd. 25. MS 2012 [Renumbered 253D.02, subd 12]

Subd. 26. MS 2012 [Renumbered 253D.02, subd 14]

History: *1981 c 37 s 2; 1982 c 581 s 2; 1983 c 251 s 1-4; 1983 c 348 s 1-3; 1984 c 623 s 1-3; 1984 c 654 art 5 s 58; 1986 c 351 s 1; 1986 c 444; 1Sp1986 c 3 art 1 s 66; 1987 c 309 s 24; 1988 c 623 s 1-4; 1989 c 290 art 5 s 2,3; 1990 c 378 s 1; 1991 c 255 s 17,19; 1Sp1994 c 1 art 1 s 1-3; art 2 s 29; 1995 c 189 s8; 1995 c 229 art 4 s 12; 1995 c 259 art 3 s 2; 1996 c 277 s 1; 1996 c 424 s 23; 1997 c 217 art 1 s 6-18; 1Sp2001 c 9 art 9 s 20,21; 2002 c 221 s 18-21; 2002 c 379 art 1 s 113; 2003 c 22 s 1,2; 1Sp2003 c 14 art 6 s 44; 2004 c 288 art 3 s 14-16; 2005 c 56 s 1; 2005 c 165 art 3 s 1,2; 2006 c 260 art 2 s 18; 2007 c 69 s 1; 2009 c 159 s 87; 2010 c 299 s 14; 2010 c 357 s 1; 2011 c 86 s 5; 2013 c 49 s 1,2,22; 2017 c 40 art 1 s 121; 1Sp2020 c 2 art 6 s 1-14,123; 1Sp2021 c 11 art 4 s 31; 2022 c 58 s 122; 2023 c 52 art 20 s 9; 2024 c 79 art 5 s 2-4; art 10 s 3; 2024 c 85 s 57,58; 2024 c 123 art 13 s 4; 2026 c 88 art 1 s 109*

253B.03 RIGHTS OF PATIENTS.

Subdivision 1. **Restraints.** (a) A patient has the right to be free from restraints. Restraints shall not be applied to a patient in a treatment facility or state-operated treatment program unless the head of the treatment facility, head of the state-operated treatment program, a member of the medical staff, or a licensed peace officer who has custody of the patient determines that restraints are necessary for the safety of the patient or others.

(b) Restraints shall not be applied to patients with developmental disabilities except as permitted under section 245.825, the rules of the commissioner of human services, and the rules of the executive board. Consent must be obtained from the patient or patient's guardian except for emergency procedures as permitted under rules of the commissioner of human services adopted under section 245.825 or rules of the executive board adopted under chapter 246C.

(c) Each use of a restraint and reason for it shall be made part of the clinical record of the patient under the signature of the head of the treatment facility.

Subd. 1a. MS 2012 [Renumbered 253D.18]

Subd. 2. **Correspondence.** A patient has the right to correspond freely without censorship, subject to section 253B.25. The head of the treatment facility or head of the state-operated treatment program may restrict correspondence if the patient's medical welfare requires this restriction. For a patient in a state-operated treatment program, that determination may be reviewed by the executive board. Any limitation imposed on the exercise of a patient's correspondence rights and the reason for it shall be made a part of the clinical record of the patient. Any communication which is not delivered to a patient shall be immediately returned to the sender.

Subd. 3. **Visitors and phone calls.** Subject to the general rules of the treatment facility or state-operated treatment program and section 253B.25, a patient has the right to receive visitors and make phone calls. The head of the treatment facility or head of the state-operated treatment program may restrict visits and phone calls on determining that the medical welfare of the patient requires it. Any limitation imposed on the exercise

of the patient's visitation and phone call rights and the reason for it shall be made a part of the clinical record of the patient.

Subd. 4. **Special visitation; religion.** A patient has the right to meet with or call a personal physician, advanced practice registered nurse, or physician assistant; spiritual advisor; and counsel at all reasonable times. The patient has the right to continue the practice of religion.

Subd. 4a. **Disclosure of patient's admission.** Upon admission to a treatment facility or state-operated treatment program where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

Subd. 5. **Periodic assessment.** A patient has the right to periodic medical assessment, including assessment of the medical necessity of continuing care and, if the treatment facility, state-operated treatment program, or community-based treatment program declines to provide continuing care, the right to receive specific written reasons why continuing care is declined at the time of the assessment. The treatment facility, state-operated treatment program, or community-based treatment program shall assess the physical and mental condition of every patient as frequently as necessary, but not less often than annually. If the patient refuses to be examined, the treatment facility, state-operated treatment program, or community-based treatment program shall document in the patient's chart its attempts to examine the patient. If a patient is committed as developmentally disabled for an indeterminate period of time, the three-year judicial review must include the annual reviews for each year regarding the patient's need for continued commitment.

Subd. 6. **Consent for medical procedure.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) notwithstanding section 253B.02, subdivision 10, "interested person" has the meaning given under section 524.5-102, subdivision 7;

(2) notwithstanding section 253B.02, subdivision 15, "patient" includes a person committed under chapter 253D who is in a state-operated treatment program; and

(3) "proper relative" means, in the following order, the patient's spouse, parent, adult child, or adult sibling.

(b) A patient has the right to give prior consent to any medical treatment, including but not limited to surgery, other than treatment for chemical dependency or nonintrusive treatment for mental illness.

(c) The following procedures shall be used to obtain consent for any treatment necessary to preserve the life or health of any committed patient:

(1) the written, informed consent of a competent adult patient for the treatment is sufficient;

(2) if the patient is subject to guardianship which includes the provision of medical care, the written, informed consent of the guardian for the treatment is sufficient;

(3) for a patient in a treatment facility, if the head of the treatment facility determines that the patient is not competent to consent to the treatment and the patient has not been adjudicated incompetent, written, informed consent for the medical treatment shall be obtained from the person appointed the health care

power of attorney, the patient's agent under the health care directive, or the nearest proper relative. If the nearest proper relative cannot be located, refuses to consent to the procedure, or is unable to consent, the head of the treatment facility or an interested person may petition the committing court for approval for the treatment or may petition a court of competent jurisdiction for the appointment of a guardian. The determination that the patient is not competent, and the reasons for the determination, shall be documented in the patient's clinical record;

(4) for patients in a state-operated treatment program, if (i) the patient does not have a health care power of attorney or an agent under a health care directive or the patient's health care agent is not reasonably available to make the necessary health care decision for the patient, and (ii) the patient's treating physician determines that the patient lacks decision-making capacity to consent to the medical treatment, the state-operated treatment program must make a good faith attempt to locate the patient's nearest proper relative to obtain written informed consent for the medical treatment;

(5) if the state-operated treatment program is unable to reasonably locate a proper relative, the executive medical director has decision-making authority for the health care decision for the patient subject to the provisions under subdivision 6e;

(6) if the state-operated treatment program consults with the patient's nearest proper relative under clause (4) and the patient's nearest proper relative and the patient's treating physician are not in agreement with respect to a medical treatment decision, the state-operated treatment program or an interested person may petition the committing court for approval of the treatment. The state-operated treatment program may also petition a court of competent jurisdiction for the appointment of a guardian at any time. If a court determines that a patient is not competent, the determination and the reasons for the determination must be documented in the patient's clinical record;

(7) consent to treatment of any minor patient shall be secured in accordance with sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization, routine diagnostic evaluation, and emergency or short-term acute care; and

(8) in the case of an emergency when the persons ordinarily qualified to give consent cannot be located in sufficient time to address the emergency need, the head of the treatment facility or state-operated treatment program may give consent.

(d) No person who consents to treatment pursuant to the provisions of this subdivision shall be civilly or criminally liable for the performance or the manner of performing the treatment. No person shall be liable for performing treatment without consent if written, informed consent was given pursuant to this subdivision. This provision shall not affect any other liability which may result from the manner in which the treatment is performed.

Subd. 6a. MS 1990 [Renumbered subd 6c]

Subd. 6a. **Consent for treatment for developmental disability.** A patient with a developmental disability, or the patient's guardian, has the right to give or withhold consent before:

(1) the implementation of any aversive or deprivation procedure except for emergency procedures permitted in rules of the commissioner of human services adopted under section 245.825 or rules of the executive board adopted under chapter 246C; or

(2) the administration of psychotropic medication.

Subd. 6b. **Consent for mental health treatment.** A competent patient admitted voluntarily to a treatment facility or state-operated treatment program may be subjected to intrusive mental health treatment only with the patient's written informed consent. For purposes of this section, "intrusive mental health treatment" means electroconvulsive therapy and neuroleptic medication and does not include treatment for a developmental disability. An incompetent patient who has prepared a directive under subdivision 6d regarding intrusive mental health treatment must be treated in accordance with this section, except in cases of emergencies.

Subd. 6c. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 6d. **Adult mental health treatment.** (a) A competent adult patient may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments. A declaration of preferences or instructions may include a health care directive under chapter 145C or a psychiatric directive.

(b) A declaration may designate a proxy to make decisions about intrusive mental health treatment. A proxy designated to make decisions about intrusive mental health treatments and who agrees to serve as proxy may make decisions on behalf of a declarant consistent with any desires the declarant expresses in the declaration.

(c) A declaration is effective only if it is signed by the declarant and two witnesses. The witnesses must include a statement that they believe the declarant understands the nature and significance of the declaration. A declaration becomes operative when it is delivered to the declarant's physician, advanced practice registered nurse, physician assistant, or other mental health treatment provider. The physician, advanced practice registered nurse, physician assistant, or provider must comply with the declaration to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. The physician, advanced practice registered nurse, physician assistant, or provider shall continue to obtain the declarant's informed consent to all intrusive mental health treatment decisions if the declarant is capable of informed consent. A treatment provider must not require a patient to make a declaration under this subdivision as a condition of receiving services.

(d) The physician, advanced practice registered nurse, physician assistant, or other provider shall make the declaration a part of the declarant's medical record. If the physician, advanced practice registered nurse, physician assistant, or other provider is unwilling at any time to comply with the declaration, the physician, advanced practice registered nurse, physician assistant, or provider must promptly notify the declarant and document the notification in the declarant's medical record. The physician, advanced practice registered nurse, physician assistant, or provider may subject the declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only if the declarant is committed as a person who poses a risk of harm due to mental illness or as a person who has a mental illness and is dangerous to the public and a court order authorizing the treatment has been issued or an emergency has been declared under section 253B.092, subdivision 3.

(e) A declaration under this subdivision may be revoked in whole or in part at any time and in any manner by the declarant if the declarant is competent at the time of revocation. A revocation is effective when a competent declarant communicates the revocation to the attending physician, advanced practice registered nurse, physician assistant, or other provider. The attending physician, advanced practice registered nurse, physician assistant, or other provider shall note the revocation as part of the declarant's medical record.

(f) A provider who administers intrusive mental health treatment according to and in good faith reliance upon the validity of a declaration under this subdivision is held harmless from any liability resulting from a subsequent finding of invalidity.

(g) In addition to making a declaration under this subdivision, a competent adult may delegate parental powers under section 524.5-211 or may nominate a guardian under sections 524.5-101 to 524.5-502.

Subd. 6e. **Health care decisions made by executive medical director.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) notwithstanding section 253B.02, subdivision 10, "interested person" has the meaning given under section 524.5-102, subdivision 7; and

(2) notwithstanding section 253B.02, subdivision 15, "patient" includes a person committed under chapter 253D who is in a state-operated treatment program.

(b) Any health care decision made by the executive medical director under subdivision 6, paragraph (c), clause (5), must be consistent with any documented patient health care directive and with reasonable medical practice and applicable law.

(c) Before proceeding with treatment under subdivision 6, paragraph (c), clause (5), a state-operated treatment program must inform the patient of the determination by the patient's treating physician that the patient lacks decision-making capacity to consent to the medical treatment, the proposed treatment, and the right to request review. Upon the request of the patient or an interested person a second physician not directly involved in the patient's current treatment must review the incapacity determination. The executive medical director must review the proposed treatment decision and the second physician's review of the incapacity determination and make an updated determination. A state-operated treatment program may proceed with treatment of the patient while a review under this paragraph is pending.

(d) When a determination is made under paragraph (c), the state-operated treatment program must document the following information in the patient's clinical record:

(1) the determination of incapacity and the clinical basis for the determination;

(2) the specific treatment authorized;

(3) the person who provided consent or who made the determination allowing the treatment;

(4) the efforts made to locate and consult with a health care agent or nearest proper relative; and

(5) the patient's expressed preferences regarding the treatment, if known, and how the preferences were considered.

(e) The executive medical director must review a determination that a patient lacks capacity periodically as medically appropriate, but not less than every six months. The outcome of a review under this paragraph must be documented in the patient's clinical record.

(f) If a patient or interested person is dissatisfied with the outcome of the review under paragraph (c), the patient or interested person may petition the committing court under section 253B.17 for review of the incapacity determination made under paragraph (c). Filing a petition under section 253B.17 does not stay treatment under this subdivision unless otherwise ordered by the court. In reviewing the executive medical director's decision under paragraph (c) and issuing a determination, the court must determine if the patient lacks capacity. If the patient lacks capacity, the court must determine if the patient clearly stated what the

patient would choose to do in the situation when the patient had the capacity to make a reasoned decision. Evidence of the patient's wishes may include written instruments, including a durable power of attorney for health care under chapter 145C or a declaration under section 253B.03, subdivision 6d. If the court finds that the patient clearly stated what the patient would choose to do in the situation, the patient's wishes must be followed. If the court determines that the evidence of the patient's wishes regarding the situation are conflicting or lacking, the court must make a decision based on what a reasonable person would do, taking into consideration:

(1) the patient's family, community, moral, religious, and social values;

(2) the medical risks, benefits, and alternatives to the proposed treatment;

(3) past efficacy and any extenuating circumstances of past experience with the particular medical treatment; and

(4) any other relevant factors.

Subd. 7. **Treatment plan.** A patient receiving services under this chapter has the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary. The treatment facility, state-operated treatment program, or community-based treatment program shall devise a written treatment plan for each patient which describes in behavioral terms the case problems, the precise goals, including the expected period of time for treatment, and the specific measures to be employed. The development and review of treatment plans must be conducted as required under the license or certification of the treatment facility, state-operated treatment program, or community-based treatment program. If there are no review requirements under the license or certification, the treatment plan must be reviewed quarterly. The treatment plan shall be devised and reviewed with the designated agency and with the patient. The clinical record shall reflect the treatment plan review. If the designated agency or the patient does not participate in the planning and review, the clinical record shall include reasons for nonparticipation and the plans for future involvement. The commissioner shall monitor the treatment plan and review process for state-operated treatment programs to ensure compliance with the provisions of this subdivision.

Subd. 8. **Medical records.** A patient has the right to access to personal medical records. Notwithstanding the provisions of section 144.292, every person subject to a proceeding or receiving services pursuant to this chapter and the patient's attorney shall have complete access to all medical records relevant to the person's commitment. A provider may require an attorney to provide evidence of representation of the patient or an authorization signed by the patient.

Subd. 9. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 10. **Notification.** (a) All patients admitted or committed to a treatment facility or state-operated treatment program, or temporarily confined under section 253B.045, shall be notified in writing of their rights regarding hospitalization and other treatment.

(b) This notification must include:

(1) patient rights specified in this section and section 144.651, including nursing home discharge rights;

(2) the right to obtain treatment and services voluntarily under this chapter;

(3) the right to voluntary admission and release under section 253B.04;

(4) rights in case of an emergency admission under section 253B.051, including the right to documentation in support of an emergency hold and the right to a summary hearing before a judge if the patient believes an emergency hold is improper;

(5) the right to request expedited review under section 62M.05 if additional days of inpatient stay are denied;

(6) the right to continuing benefits pending appeal and to an expedited administrative hearing under section 256.045 if the patient is a recipient of medical assistance or MinnesotaCare; and

(7) the right to an external appeal process under section 62Q.73, including the right to a second opinion.

Subd. 11. **Proxy.** A legally authorized health care proxy, agent, or guardian may exercise the patient's rights on the patient's behalf.

History: *1982 c 581 s 3; 1983 c 251 s 5,6; 1986 c 444; 1987 c 185 art 2 s 2,3; 1988 c 623 s 5; 1988 c 689 art 2 s 118,119; 1989 c 282 art 2 s 100; 1990 c 568 art 5 s 31; 1991 c 148 s 2; 1993 c 54 s 4,5; 1995 c 136 s 5,6; 1995 c 189 s 2,3; 1997 c 217 art 1 s 19-28; 1998 c 313 s 1; 2001 c 26 s 1; 1Sp2001 c 9 art 9 s 22-24; 2002 c 379 art 1 s 11; 2004 c 146 art 3 s 21-25; 2004 c 288 art 3 s 17; 2005 c 56 s 1; 2007 c 147 art 10 s 15; 2013 c 49 s 3,22; 2016 c 158 art 2 s 50; 2020 c 115 art 4 s 100,101; 1Sp2020 c 2 art 6 s 15-24; 2022 c 58 s 123,124; 2024 c 79 art 5 s 5,6; art 10 s 3; 2026 c 95 art 1 s 10-13*

253B.04 VOLUNTARY TREATMENT AND ADMISSION PROCEDURES.

Subdivision 1. **Voluntary admission and treatment.** (a) Voluntary admission is preferred over involuntary commitment and treatment. Any person 16 years of age or older may request to be admitted to a treatment facility or state-operated treatment program as a voluntary patient for observation, evaluation, diagnosis, care and treatment without making formal written application. Any person under the age of 16 years may be admitted as a patient with the consent of a parent or legal guardian if it is determined by independent examination that there is reasonable evidence that (1) the proposed patient has a mental illness, developmental disability, or chemical dependency; and (2) the proposed patient is suitable for treatment. The head of the treatment facility or head of the state-operated treatment program shall not arbitrarily refuse any person seeking admission as a voluntary patient. In making decisions regarding admissions, the treatment facility or state-operated treatment program shall use clinical admission criteria consistent with the current applicable inpatient admission standards established by professional organizations including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the Joint Commission, and the American Society of Addiction Medicine. These criteria must be no more restrictive than, and must be consistent with, the requirements of section 62Q.53. The treatment facility or head of the state-operated treatment program may not refuse to admit a person voluntarily solely because the person does not meet the criteria for involuntary holds under section 253B.051 or the definition of a person who poses a risk of harm due to mental illness under section 253B.02, subdivision 17a.

(b) In addition to the consent provisions of paragraph (a), a person who is 16 or 17 years of age who refuses to consent personally to admission may be admitted as a patient for mental illness or chemical dependency treatment with the consent of a parent or legal guardian if it is determined by an independent examination that there is reasonable evidence that the proposed patient is chemically dependent or has a mental illness and is suitable for treatment. The person conducting the examination shall notify the proposed patient and the parent or legal guardian of this determination.

(c) A person who is voluntarily participating in treatment for a mental illness is not subject to civil commitment under this chapter if the person:

(1) has given informed consent or, if lacking capacity, is a person for whom legally valid substitute consent has been given; and

(2) is participating in a medically appropriate course of treatment, including clinically appropriate and lawful use of neuroleptic medication and electroconvulsive therapy. The limitation on commitment in this paragraph does not apply if, based on clinical assessment, the court finds that it is unlikely that the patient will remain in and cooperate with a medically appropriate course of treatment absent commitment and the standards for commitment are otherwise met. This paragraph does not apply to a person for whom commitment proceedings are initiated pursuant to rule 20.01 or 20.02 of the Rules of Criminal Procedure, or a person found by the court to meet the requirements under section 253B.02, subdivision 17.

(d) Legally valid substitute consent may be provided by a proxy under a health care directive, a guardian or conservator with authority to consent to mental health treatment, or consent to admission under subdivision 1a or 1b.

Subd. 1a. **Voluntary treatment or admission for persons with a mental illness.** (a) A person with a mental illness may seek or voluntarily agree to accept treatment or admission to a state-operated treatment program or treatment facility. If the mental health provider determines that the person lacks the capacity to give informed consent for the treatment or admission, and in the absence of a health care directive or health care power of attorney that authorizes consent, the designated agency or its designee may give informed consent for mental health treatment or admission to a treatment facility or state-operated treatment program on behalf of the person.

(b) The designated agency shall apply the following criteria in determining the person's ability to give informed consent:

(1) whether the person demonstrates an awareness of the person's illness, and the reasons for treatment, its risks, benefits and alternatives, and the possible consequences of refusing treatment; and

(2) whether the person communicates verbally or nonverbally a clear choice concerning treatment that is a reasoned one, not based on delusion, even though it may not be in the person's best interests.

(c) The basis for the designated agency's decision that the person lacks the capacity to give informed consent for treatment or admission, and that the patient has voluntarily accepted treatment or admission, must be documented in writing.

(d) A treatment facility or state-operated treatment program that provides treatment in reliance on the written consent given by the designated agency under this subdivision or by a substitute decision maker appointed by the court is not civilly or criminally liable for performing treatment without consent. This paragraph does not affect any other liability that may result from the manner in which the treatment is performed.

(e) A patient who receives treatment or is admitted to a treatment facility or state-operated treatment program under this subdivision or subdivision 1b has the right to refuse treatment at any time or to be released from a treatment facility or state-operated treatment program as provided under subdivision 2. The patient or any interested person acting on the patient's behalf may seek court review within five days for a determination of whether the patient's agreement to accept treatment or admission is voluntary. At the time a patient agrees to treatment or admission to a treatment facility or state-operated treatment program under this subdivision, the designated agency or its designee shall inform the patient in writing of the patient's rights under this paragraph.

Subd. 1b. **Court appointment of substitute decision maker.** If the designated agency or its designee declines or refuses to give informed consent under subdivision 1a, the person who is seeking treatment or admission, or an interested person acting on behalf of the person, may petition the court for appointment of a substitute decision maker who may give informed consent for voluntary treatment and services. In making this determination, the court shall apply the criteria in subdivision 1a, paragraph (b).

Subd. 2. **Release.** Every patient admitted for mental illness or developmental disability under this section shall be informed in writing at the time of admission that the patient has a right to leave the treatment facility or state-operated treatment program within 12 hours of making a request, unless held under another provision of this chapter. Every patient admitted for chemical dependency under this section shall be informed in writing at the time of admission that the patient has a right to leave the treatment facility or state-operated treatment program within 72 hours, exclusive of Saturdays, Sundays, and legal holidays, of making a request, unless held under another provision of this chapter. The request shall be submitted in writing to the head of the treatment facility or state-operated treatment program or the person's designee.

History: *1982 c 581 s 4; 1983 c 251 s 7; 1986 c 444; 1997 c 217 art 1 s 29; 1998 c 399 s 28; 1999 c 32 s 1; 2000 c 316 s 2; 1Sp2001 c 9 art 9 s 25-27; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 6 s 45; 2005 c 56 s 1; 1Sp2020 c 2 art 6 s 25-27,123*

253B.041 SERVICES FOR ENGAGEMENT IN TREATMENT.

Subdivision 1. **Eligibility.** (a) The purpose of engagement services is to avoid the need for commitment and to enable the proposed patient to voluntarily engage in needed treatment. An interested person may apply to the county where a proposed patient resides to request engagement services.

(b) To be eligible for engagement services, the proposed patient must be at least 18 years of age, have a mental illness, and either:

(1) be exhibiting symptoms of serious mental illness including hallucinations, mania, delusional thoughts, or be unable to obtain necessary food, clothing, shelter, medical care, or provide necessary hygiene due to the patient's mental illness; or

(2) have a history of failing to adhere to treatment for mental illness, in that:

(i) the proposed patient's mental illness has been a substantial factor in necessitating hospitalization, or incarceration in a state or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding filing the application for engagement; or

(ii) the proposed patient is exhibiting symptoms or behavior that may lead to hospitalization, incarceration, or court-ordered treatment.

Subd. 2. **Administration.** (a) Upon receipt of a request for engagement services, the county's prepetition screening team shall conduct an investigation to determine whether the proposed patient is eligible. In making this determination, the screening team shall seek any relevant information from an interested person.

(b) If the screening team determines that the proposed patient is eligible, engagement services must begin and include, but are not limited to:

(1) assertive attempts to engage the patient in voluntary treatment for mental illness for at least 90 days. Engagement services must be person-centered and continue even if the patient is an inmate in a non-state-operated correctional facility;

(2) efforts to engage the patient's existing systems of support, including interested persons, unless the engagement provider determines that involvement is not helpful to the patient. This includes education on restricting means of harm, suicide prevention, and engagement; and

(3) collaboration with the patient to meet immediate needs including access to housing, food, income, disability verification, medications, and treatment for medical conditions.

(c) Engagement services regarding potential treatment options must take into account the patient's preferences for services and supports. The county may offer engagement services through the designated agency or another agency under contract. Engagement services staff must have training in person-centered care. Engagement services staff may include but are not limited to mobile crisis teams under section 245.462, certified peer specialists under section 256B.0615, community-based treatment programs, and homeless outreach workers.

(d) If the patient voluntarily consents to receive mental health treatment, the engagement services staff must facilitate the referral to an appropriate mental health treatment provider including support obtaining health insurance if the proposed patient is currently or may become uninsured. If the proposed patient initially consents to treatment, but fails to initiate or continue treatment, the engagement services team must continue outreach efforts to the patient.

Subd. 3. **Commitment.** Engagement services for a patient to seek treatment may be stopped if the proposed patient is in need of commitment and satisfies the commitment criteria under section 253B.09, subdivision 1. In such a case, the engagement services team must immediately notify the designated agency, initiate the prepetition screening process under section 253B.07, or seek an emergency hold if necessary to ensure the safety of the patient or others.

Subd. 4. **Evaluation.** Counties may, but are not required to, provide engagement services. The commissioner may conduct a pilot project evaluating the impact of engagement services in decreasing commitments, increasing engagement in treatment, and other measures.

History: *1Sp2020 c 2 art 6 s 28*

253B.045 TEMPORARY CONFINEMENT.

Subdivision 1. **Restriction.** Except when ordered by the court pursuant to a finding of necessity to protect the life of the proposed patient or others or as provided under subdivision 1a, no person subject to the provisions of this chapter shall be confined in a jail or correctional institution, except pursuant to chapter 242 or 244.

Subd. 1a. MS 2012 [Renumbered 253D.10, subd 2]

Subd. 2. **Facilities.** (a) Each county or a group of counties shall maintain or provide by contract a facility for confinement of persons held temporarily for observation, evaluation, diagnosis, treatment, and care. When the temporary confinement is provided at a state-operated treatment program, the executive board shall charge the county of financial responsibility for the costs of confinement of patients hospitalized under sections 253B.051 and 253B.07, subdivision 2b, except that the executive board shall bill the responsible health plan first. Any charges not covered, including co-pays and deductibles shall be the responsibility of the county. If the patient has health plan coverage, but the hospitalization does not meet the criteria in subdivision 6 or section 62M.07, 62Q.53, or 62Q.535, the county is responsible.

(b) For the purposes of this subdivision, "county of financial responsibility" has the meaning specified in section 253B.02, subdivision 4c, or, if the patient has no residence in this state, the county which initiated

the confinement. The charge for confinement in a facility operated by the executive board shall be based on the executive board's determination of the cost of care pursuant to section 246.50, subdivision 5. When there is a dispute as to which county is the county of financial responsibility, the county charged for the costs of confinement shall pay for them pending final determination of the dispute over financial responsibility.

Subd. 3. **Cost of care.** Notwithstanding subdivision 2, a county shall be responsible for the cost of care as specified under section 246.54 for a patient hospitalized at a state-operated treatment program in accordance with section 253B.09 and the patient's legal status has been changed to a court hold under section 253B.07, subdivision 2b, pending a judicial determination regarding continued commitment pursuant to sections 253B.12 and 253B.13.

Subd. 4. **Treatment.** The designated agency shall take reasonable measures to assure proper care and treatment of a person temporarily confined pursuant to this section.

Subd. 5. **Health plan company; definition.** For purposes of this section, "health plan company" has the meaning given it in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in section 256B.69, subdivision 2, paragraph (b); and a county or group of counties participating in county-based purchasing according to section 256B.692.

Subd. 6. **Coverage.** (a) For purposes of this section, "mental health services" means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.

(b) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

History: *1982 c 581 s 11; 1983 c 141 s 1; 1989 c 209 art 2 s 1; 1996 c 451 art 5 s 8; 1997 c 217 art 1 s 64,65,117; 1998 c 313 s 2,3; 1999 c 245 art 5 s 12,13; 1Sp2001 c 9 art 9 s 28; 2002 c 277 s 4; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 11 s 11; 2006 c 212 art 1 s 12; 2008 c 299 s 9-11; 2008 c 326 art 2 s 4-6; 2010 c 357 s 2; 2013 c 49 s 4,22; 2013 c 59 art 2 s 13; 1Sp2020 c 2 art 6 s 29-32; 2024 c 79 art 10 s 3*

253B.05 Subdivision 1. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 2. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 2a. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 2b. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 3. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 4. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 5. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

253B.051 EMERGENCY ADMISSION.

Subdivision 1. **Peace officer or health officer authority.** (a) If a peace officer or health officer has reason to believe, either through direct observation of the person's behavior or upon reliable information of the person's recent behavior and, if available, knowledge or reliable information concerning the person's past behavior or treatment that the person:

(1) has a mental illness or developmental disability and is in danger of harming self or others if the officer does not immediately detain the patient, the peace officer or health officer may take the person into custody and transport the person to an examiner or a treatment facility, state-operated treatment program, or community-based treatment program;

(2) is chemically dependent or intoxicated in public and in danger of harming self or others if the officer does not immediately detain the patient, the peace officer or health officer may take the person into custody and transport the person to a treatment facility, state-operated treatment program, or community-based treatment program; or

(3) is chemically dependent or intoxicated in public and not in danger of harming self, others, or property, the peace officer or health officer may take the person into custody and transport the person to the person's home.

(b) An examiner's written statement or a health officer's written statement in compliance with the requirements of subdivision 2 is sufficient authority for a peace officer or health officer to take the person into custody and transport the person to a treatment facility, state-operated treatment program, or community-based treatment program.

(c) A peace officer or health officer who takes a person into custody and transports the person to a treatment facility, state-operated treatment program, or community-based treatment program under this subdivision shall make written application for admission of the person containing:

(1) the officer's statement specifying the reasons and circumstances under which the person was taken into custody;

(2) identifying information on specific individuals to the extent practicable, if danger to those individuals is a basis for the emergency hold; and

(3) the officer's name, the agency that employs the officer, and the telephone number or other contact information for purposes of receiving notice under subdivision 3.

(d) A copy of the examiner's written statement and officer's application shall be made available to the person taken into custody.

(e) The officer may provide the transportation personally or may arrange to have the person transported by a suitable medical or mental health transportation provider. As far as practicable, a peace officer who provides transportation for a person placed in a treatment facility, state-operated treatment program, or community-based treatment program under this subdivision must not be in uniform and must not use a vehicle visibly marked as a law enforcement vehicle.

Subd. 2. **Emergency hold.** (a) A treatment facility, state-operated treatment program, or community-based treatment program, other than a facility operated by the Minnesota Sex Offender Program, may admit or hold a patient, including a patient transported under subdivision 1, for emergency care and treatment if the head of the facility or program consents to holding the patient and an examiner provides a written statement in support of holding the patient.

(b) The written statement must indicate that:

(1) the examiner examined the patient not more than 15 days prior to admission;

(2) the examiner interviewed the patient, or if not, the specific reasons why the examiner did not interview the patient;

(3) the examiner has the opinion that the patient has a mental illness or developmental disability, or is chemically dependent and is in danger of causing harm to self or others if a facility or program does not immediately detain the patient. The statement must include observations of the patient's behavior and avoid conclusory language. The statement must be specific enough to provide an adequate record for review. If danger to specific individuals is a basis for the emergency hold, the statement must identify those individuals to the extent practicable; and

(4) the facility or program cannot obtain a court order in time to prevent the anticipated injury.

(c) Prior to an examiner writing a statement, if another person brought the patient to the treatment facility, state-operated treatment program, or community-based treatment program, the examiner shall make a good-faith effort to obtain information from that person, which the examiner must consider in deciding whether to place the patient on an emergency hold. To the extent available, the statement must include direct observations of the patient's behaviors, reliable knowledge of the patient's recent and past behavior, and information regarding the patient's psychiatric history, past treatment, and current mental health providers. The examiner shall also inquire about health care directives under chapter 145C and advance psychiatric directives under section 253B.03, subdivision 6d.

(d) The facility or program must give a copy of the examiner's written statement to the patient immediately upon initiating the emergency hold. The treatment facility, state-operated treatment program, or community-based treatment program shall maintain a copy of the examiner's written statement. The program or facility must inform the patient in writing of the right to (1) leave after 72 hours, (2) have a medical examination within 48 hours, and (3) request a change to voluntary status. The facility or program shall assist the patient in exercising the rights granted in this subdivision.

(e) The facility or program must not allow the patient nor require the patient's consent to participate in a clinical drug trial during an emergency admission or hold under this subdivision. If a patient gives consent to participate in a drug trial during a period of an emergency admission or hold, it is void and unenforceable. This paragraph does not prohibit a patient from continuing participation in a clinical drug trial if the patient was participating in the clinical drug trial at the time of the emergency admission or hold.

Subd. 3. **Duration of hold, release procedures, and change of status.** (a) If a peace officer or health officer transports a person to a treatment facility, state-operated treatment program, or community-based treatment program under subdivision 1, an examiner at the facility or program must examine the patient and make a determination about the need for an emergency hold as soon as possible and within 12 hours of the person's arrival. The peace officer or health officer hold ends upon whichever occurs first: (1) initiation of an emergency hold on the person under subdivision 2; (2) the person's voluntary admission; (3) the examiner's decision not to admit the person; or (4) 12 hours after the person's arrival.

(b) Under this section, the facility or program may hold a patient up to 72 hours, exclusive of Saturdays, Sundays, and legal holidays, after the examiner signs the written statement for an emergency hold of the patient. The facility or program must release a patient when the emergency hold expires unless the facility or program obtains a court order to hold the patient. The facility or program may not place the patient on a consecutive emergency hold under this section.

(c) If the interested person files a petition to civilly commit the patient, the court may issue a judicial hold order pursuant to section 253B.07, subdivision 2b.

(d) During the 72-hour hold, a court must not release a patient under this section unless the court received a written petition for the patient's release and the court has held a summary hearing regarding the patient's release.

(e) The written petition for the patient's release must include the patient's name, the basis for the hold, the location of the hold, and a statement explaining why the hold is improper. The petition must also include copies of any written documentation under subdivision 1 or 2 that support the hold, unless the facility or program holding the patient refuses to supply the documentation. Upon receipt of a petition, the court must comply with the following:

(1) the court must hold the hearing as soon as practicable and the court may conduct the hearing by telephone conference call, interactive video conference, or similar method by which the participants are able to simultaneously hear each other;

(2) before deciding to release the patient, the court shall make every reasonable effort to provide notice of the proposed release and reasonable opportunity to be heard to:

(i) any specific individuals identified in a statement under subdivision 1 or 2 or individuals identified in the record who might be endangered if the person is not held;

(ii) the examiner whose written statement was the basis for the hold under subdivision 2; and

(iii) the peace officer or health officer who applied for a hold under subdivision 1; and

(3) if the court decides to release the patient, the court shall direct the patient's release and shall issue written findings supporting the decision. The facility or program must not delay the patient's release pending the written order.

(f) Notwithstanding section 144.293, subdivisions 2 and 4, if a treatment facility, state-operated treatment program, or community-based treatment program releases or discharges a patient during the 72-hour hold; the examiner refuses to admit the patient; or the patient leaves without the consent of the treating health care provider, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall immediately notify the agency that employs the peace officer or health officer who initiated the transport hold. This paragraph does not apply to the extent that the notice would violate federal law governing the confidentiality of alcohol and drug abuse patient records under Code of Federal Regulations, title 42, part 2.

(g) If a patient is intoxicated in public and a facility or program holds the patient under this section for detoxification, a treatment facility, state-operated treatment program, or community-based treatment program may release the patient without providing notice under paragraph (f) as soon as the treatment facility, state-operated treatment program, or community-based treatment program determines that the person is no longer in danger of causing harm to self or others. The facility or program must provide notice to the peace officer or health officer who transported the person, or to the appropriate law enforcement agency, if the officer or agency requests notification.

(h) A treatment facility or state-operated treatment program must change a patient's status to voluntary status as provided in section 253B.04 upon the patient's request in writing if the head of the facility or program consents to the change.

History: *1Sp2020 c 2 art 6 s 33*

253B.06 INITIAL ASSESSMENT.

Subdivision 1. **Persons with mental illness or developmental disability.** A physician must examine every patient hospitalized due to mental illness or developmental disability pursuant to section 253B.04 or 253B.051 as soon as possible but no more than 48 hours following the patient's admission. The physician

must be knowledgeable and trained in diagnosing the patient's mental illness or developmental disability, forming the basis of the patient's admission.

Subd. 2. **Chemically dependent persons.** A treatment facility, state-operated treatment program, or community-based treatment program must examine a patient hospitalized as chemically dependent pursuant to section 253B.04 or 253B.051 within 48 hours of admission. At a minimum, the facility or program must physically examine the patient according to procedures established by a physician, advanced practice registered nurse, or physician assistant, and staff examining the patient must be knowledgeable and trained in the diagnosis of the alleged disability forming the basis of the patient's admission as a chemically dependent person.

Subd. 2a. **Patient refusal.** If a patient refuses to be examined, the determination of the patient's need for treatment may be based on other available information and documented in the patient's medical record.

Subd. 3. **Discharge.** At the end of a 48-hour period, the facility or program shall discharge a patient admitted pursuant to section 253B.051 if an examination has not been held or if the examiner or evaluation staff person fails to notify the head of the facility or program in writing that in the examiner's or staff person's opinion the patient is in need of care, treatment, and evaluation as a person who has a mental illness, developmental disability, or chemical dependency.

History: *1982 c 581 s 6; 1983 c 251 s 10; 1986 c 444; 1997 c 217 art 1 s 35; 2002 c 221 s 22; 2005 c 56 s 1; 2020 c 115 art 4 s 102; 1Sp2020 c 2 art 6 s 34-36; 2022 c 58 s 125*

253B.064 MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

253B.065 MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

253B.066 MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

253B.07 JUDICIAL COMMITMENT; PRELIMINARY PROCEDURES.

Subdivision 1. **Prepetition screening.** (a) Prior to filing a petition for commitment of a proposed patient, an interested person shall apply to the designated agency in the county of financial responsibility or the county where the proposed patient is present for conduct of a preliminary investigation as provided in section 253B.23, subdivision 1b, except when the proposed patient has been acquitted of a crime under section 611.026 and the county attorney is required to file a petition for commitment. The designated agency shall appoint a screening team to conduct an investigation. The petitioner may not be a member of the screening team. The investigation must include:

(1) an interview with the proposed patient and other individuals who appear to have knowledge of the condition of the proposed patient, if practicable. In-person interviews with the proposed patient are preferred. If the proposed patient is not interviewed, specific reasons must be documented;

(2) identification and investigation of specific alleged conduct which is the basis for application;

(3) identification, exploration, and listing of the specific reasons for rejecting or recommending alternatives to involuntary placement;

(4) in the case of a commitment based on mental illness, information that may be relevant to the administration of neuroleptic medications, including the existence of a declaration under section 253B.03, subdivision 6d, or a health care directive under chapter 145C or a guardian, conservator, proxy, or agent with authority to make health care decisions for the proposed patient; information regarding the capacity of

the proposed patient to make decisions regarding administration of neuroleptic medication; and whether the proposed patient is likely to consent or refuse consent to administration of the medication;

(5) seeking input from the proposed patient's health plan company to provide the court with information about the patient's relevant treatment history and current treatment providers; and

(6) in the case of a commitment based on mental illness, information listed in clause (4) for other purposes relevant to treatment.

(b) In conducting the investigation required by this subdivision, the screening team shall have access to all relevant medical records of proposed patients currently in treatment facilities, state-operated treatment programs, or community-based treatment programs. The interviewer shall inform the proposed patient that any information provided by the proposed patient may be included in the prepetition screening report and may be considered in the commitment proceedings. Data collected pursuant to this clause shall be considered private data on individuals. The prepetition screening report is not admissible as evidence except by agreement of counsel or as permitted by this chapter or the rules of court and is not admissible in any court proceedings unrelated to the commitment proceedings.

(c) The prepetition screening team shall provide a notice, written in easily understood language, to the proposed patient, the petitioner, persons named in a declaration under chapter 145C or section 253B.03, subdivision 6d, and, with the proposed patient's consent, other interested parties. The team shall ask the patient if the patient wants the notice read and shall read the notice to the patient upon request. The notice must contain information regarding the process, purpose, and legal effects of civil commitment. The notice must inform the proposed patient that:

(1) if a petition is filed, the patient has certain rights, including the right to a court-appointed attorney, the right to request a second court examiner, the right to attend hearings, and the right to oppose the proceeding and to present and contest evidence; and

(2) if the proposed patient is committed to a state-operated treatment program, the patient may be billed for the cost of care and the state has the right to make a claim against the patient's estate for this cost.

The ombudsman for mental health and developmental disabilities shall develop a form for the notice which includes the requirements of this paragraph.

(d) When the prepetition screening team recommends commitment, a written report shall be sent to the county attorney for the county in which the petition is to be filed. The statement of facts contained in the written report must meet the requirements of subdivision 2, paragraph (b).

(e) The prepetition screening team shall refuse to support a petition if the investigation does not disclose evidence sufficient to support commitment. Notice of the prepetition screening team's decision shall be provided to the prospective petitioner, any specific individuals identified in the examiner's statement, and to the proposed patient.

(f) If the interested person wishes to proceed with a petition contrary to the recommendation of the prepetition screening team, application may be made directly to the county attorney, who shall determine whether or not to proceed with the petition. Notice of the county attorney's determination shall be provided to the interested party.

(g) If the proposed patient has been acquitted of a crime under section 611.026, the county attorney shall apply to the designated county agency in the county in which the acquittal took place for a preliminary investigation unless substantially the same information relevant to the proposed patient's current mental

condition, as could be obtained by a preliminary investigation, is part of the court record in the criminal proceeding or is contained in the report of a mental examination conducted in connection with the criminal proceeding. If a court petitions for commitment pursuant to the Rules of Criminal or Juvenile Procedure or a county attorney petitions pursuant to acquittal of a criminal charge under section 611.026, the prepetition investigation, if required by this section, shall be completed within seven days after the filing of the petition.

Subd. 2. **The petition.** (a) Any interested person, except a member of the prepetition screening team, may file a petition for commitment in the district court of the county of financial responsibility or the county where the proposed patient is present. If the head of the treatment facility, state-operated treatment program, or community-based treatment program believes that commitment is required and no petition has been filed, that person shall petition for the commitment of the proposed patient.

(b) The petition shall set forth the name and address of the proposed patient, the name and address of the patient's nearest relatives, and the reasons for the petition. The petition must contain factual descriptions of the proposed patient's recent behavior, including a description of the behavior, where it occurred, and the time period over which it occurred. Each factual allegation must be supported by observations of witnesses named in the petition. Petitions shall be stated in behavioral terms and shall not contain judgmental or conclusory statements.

(c) The petition shall be accompanied by a written statement by an examiner stating that the examiner has examined the proposed patient within the 15 days preceding the filing of the petition and is of the opinion that the proposed patient has a designated disability and should be committed to a treatment facility, state-operated treatment program, or community-based treatment program. The statement shall include the reasons for the opinion. In the case of a commitment based on mental illness, the petition and the examiner's statement shall include a statement and opinion regarding the proposed patient's need for treatment with neuroleptic medication and the patient's capacity to make decisions regarding the administration of neuroleptic medications, and the reasons for the opinion. If use of neuroleptic medications is recommended by the treating medical practitioner or other qualified medical provider, the petition for commitment must, if applicable, include or be accompanied by a request for proceedings under section 253B.092. Failure to include the required information regarding neuroleptic medications in the examiner's statement, or to include a request for an order regarding neuroleptic medications with the commitment petition, is not a basis for dismissing the commitment petition. If a petitioner has been unable to secure a statement from an examiner, the petition shall include documentation that a reasonable effort has been made to secure the supporting statement.

Subd. 2a. **Petition originating from criminal proceedings.** (a) If criminal charges are pending against a defendant, the court shall order simultaneous competency and civil commitment examinations in accordance with Minnesota Rules of Criminal Procedure, rule 20.04, when the following conditions are met:

(1) the prosecutor or defense counsel doubts the defendant's competency and a motion is made challenging competency, or the court on its initiative raises the issue under section 611.42 or Minnesota Rules of Criminal Procedure, rule 20.01; and

(2) the prosecutor and defense counsel agree simultaneous examinations are appropriate.

No additional examination under subdivision 3 is required in a subsequent civil commitment proceeding unless a second examination is requested by defense counsel appointed following the filing of any petition for commitment.

(b) Only a court examiner may conduct an assessment as described in section 611.43 or Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, and 20.02, subdivision 2.

(c) Where a county is ordered to consider civil commitment following a determination of incompetency under section 611.45 or Minnesota Rules of Criminal Procedure, rule 20.01, the county in which the criminal matter is pending is responsible to conduct prepetition screening and, if statutory conditions for commitment are satisfied, to file the commitment petition in that county. By agreement between county attorneys, prepetition screening and filing the petition may be handled in the county of financial responsibility or the county where the proposed patient is present.

(d) Following an acquittal of a person of a criminal charge under section 611.026, the petition shall be filed by the county attorney of the county in which the acquittal took place and the petition shall be filed with the court in which the acquittal took place, and that court shall be the committing court for purposes of this chapter. When a petition is filed pursuant to subdivision 2 with the court in which acquittal of a criminal charge took place, the court shall assign the judge before whom the acquittal took place to hear the commitment proceedings unless that judge is unavailable.

Subd. 2b. **Apprehend and hold orders.** (a) The court may order the treatment facility or state-operated treatment program to hold the proposed patient or direct a health officer, peace officer, or other person to take the proposed patient into custody and transport the proposed patient to a treatment facility or state-operated treatment program for observation, evaluation, diagnosis, care, treatment, and, if necessary, confinement, when:

(1) there has been a particularized showing by the petitioner that serious physical harm to the proposed patient or others is likely unless the proposed patient is immediately apprehended;

(2) the proposed patient has not voluntarily appeared for the examination or the commitment hearing pursuant to the summons; or

(3) a person is held pursuant to section 253B.051 and a request for a petition for commitment has been filed.

(b) The order of the court may be executed on any day and at any time by the use of all necessary means including the imposition of necessary restraint upon the proposed patient. Where possible, a peace officer taking the proposed patient into custody pursuant to this subdivision shall not be in uniform and shall not use a vehicle visibly marked as a law enforcement vehicle. Except as provided in section 253D.10, subdivision 2, in the case of an individual on a judicial hold due to a petition for civil commitment under chapter 253D, assignment of custody during the hold is to the executive board. The executive board is responsible for determining the appropriate placement within a secure treatment facility under the authority of the executive board.

(c) A proposed patient must not be allowed or required to consent to nor participate in a clinical drug trial while an order is in effect under this subdivision. A consent given while an order is in effect is void and unenforceable. This paragraph does not prohibit a patient from continuing participation in a clinical drug trial if the patient was participating in the clinical drug trial at the time the order was issued under this subdivision.

Subd. 2c. **Right to counsel.** A patient has the right to be represented by counsel at any proceeding under this chapter. The court shall appoint a qualified attorney to represent the proposed patient if neither the proposed patient nor others provide counsel. The attorney shall be appointed at the time a petition for commitment is filed or when simultaneous competency and civil commitment examinations are ordered under subdivision 2a, whichever is sooner. In all proceedings under this chapter, the attorney shall:

(1) consult with the person prior to any hearing;

(2) be given adequate time and access to records to prepare for all hearings;

(3) continue to represent the person throughout any proceedings under this chapter unless released as counsel by the court; and

(4) be a vigorous advocate on behalf of the person.

Subd. 2d. **Change of venue.** Either party may move to have the venue of the petition changed to the district court of the Minnesota county where the person currently lives, whether independently or pursuant to a placement. The county attorney of the proposed county of venue must be notified of the motion and provided the opportunity to respond before the court rules on the motion. The court shall grant the motion if it determines that the transfer is appropriate and is in the interests of justice. If the petition has been filed pursuant to the Rules of Criminal or Juvenile Procedure, venue may not be changed without the agreement of the county attorney of the proposed county of venue and the approval of the court in which the juvenile or criminal proceedings are pending.

Subd. 3. **Court-appointed examiners.** After a petition has been filed, the court shall appoint a court examiner. Prior to the hearing, the court shall inform the proposed patient of the right to an independent second examination. At the proposed patient's request, the court shall appoint a second court examiner of the patient's choosing to be paid for by the county at a rate of compensation fixed by the court.

Subd. 4. **Prehearing examination; notice and summons procedure.** (a) A summons to appear for a prehearing examination and the commitment hearing shall be served upon the proposed patient. A plain language notice of the proceedings and notice of the filing of the petition shall be given to the proposed patient, patient's counsel, the petitioner, any interested person, and any other persons as the court directs.

(b) The prepetition screening report, the petition, and the examiner's supporting statement shall be distributed to the petitioner, the proposed patient, the patient's counsel, the county attorney, any person authorized by the patient, and any other person as the court directs.

(c) All papers shall be served personally on the proposed patient. Unless otherwise ordered by the court, the notice shall be served on the proposed patient by a nonuniformed person.

Subd. 5. **Prehearing examination; report.** The examination shall be held at a treatment facility or other suitable place the court determines is not likely to harm the health of the proposed patient. The county attorney and the patient's attorney may be present during the examination. Either party may waive this right. Unless otherwise agreed by the parties, a court examiner shall file the report with the court not less than 48 hours prior to the commitment hearing. The court shall ensure that copies of the court examiner's report are provided to the county attorney, the proposed patient, and the patient's counsel.

Subd. 6. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 7. **Preliminary hearing.** (a) No proposed patient may be held in a treatment facility or state-operated treatment program under a judicial hold pursuant to subdivision 2b longer than 72 hours, exclusive of Saturdays, Sundays, and legal holidays, unless the court holds a preliminary hearing and determines that the standard is met to hold the proposed patient.

(b) The proposed patient, patient's counsel, the petitioner, the county attorney, and any other persons as the court directs shall be given at least 24 hours written notice of the preliminary hearing. The notice shall include the alleged grounds for confinement. The proposed patient shall be represented at the preliminary hearing by counsel. The court may admit reliable hearsay evidence, including written reports, for the purpose of the preliminary hearing.

(c) The court, on its motion or on the motion of any party, may exclude or excuse a proposed patient who is seriously disruptive or who is incapable of comprehending and participating in the proceedings. In such instances, the court shall, with specificity on the record, state the behavior of the proposed patient or other circumstances which justify proceeding in the absence of the proposed patient.

(d) The court may continue the judicial hold of the proposed patient if it finds, by a preponderance of the evidence, that serious physical harm to the proposed patient or others is likely if the proposed patient is not immediately confined. If a proposed patient was acquitted of a crime against the person under section 611.026 immediately preceding the filing of the petition, the court may presume that serious physical harm to the patient or others is likely if the proposed patient is not immediately confined.

(e) Upon a showing that a proposed patient subject to a petition for commitment may need treatment with neuroleptic medications and that the proposed patient may lack capacity to make decisions regarding that treatment, the court may appoint a substitute decision-maker as provided in section 253B.092, subdivision 6. The substitute decision-maker shall meet with the proposed patient and provider and make a report to the court at the hearing under section 253B.08 regarding whether the administration of neuroleptic medications is appropriate under the criteria of section 253B.092, subdivision 7. If the substitute decision-maker consents to treatment with neuroleptic medications and the proposed patient does not refuse the medication, neuroleptic medication may be administered to the proposed patient. If the substitute decision-maker does not consent or the proposed patient refuses, neuroleptic medication may not be administered without a court order, or in an emergency as set forth in section 253B.092, subdivision 3.

History: *1982 c 581 s 7; 1983 c 251 s 11-13; 1983 c 348 s 4-8; 1984 c 623 s 4; 1986 c 444; 1995 c 189 s 8; 1996 c 277 s 1; 1997 c 217 art 1 s 39-48; 1998 c 313 s 5,6; 1998 c 399 s 29; 1999 c 245 art 5 s 14; 1Sp2001 c 9 art 9 s 32-34; 2002 c 335 s 2; 2002 c 379 art 1 s 113; 2005 c 56 s 1; 2010 c 300 s 20; 2010 c 357 s 5-7; 2013 c 49 s 22; 2014 c 171 s 1,2; 2015 c 21 art 1 s 51; 2016 c 120 s 4; 1Sp2020 c 2 art 6 s 37-44; 2022 c 99 art 1 s 14; 2025 c 38 art 3 s 39*

253B.08 JUDICIAL COMMITMENT; HEARING PROCEDURES.

Subdivision 1. **Time for commitment hearing.** (a) The hearing on the commitment petition shall be held within 14 days from the date of the filing of the petition, except that the hearing on a commitment petition pursuant to section 253D.07 shall be held within 90 days from the date of the filing of the petition. For good cause shown, the court may extend the time of hearing up to an additional 30 days. The proceeding shall be dismissed if the proposed patient has not had a hearing on a commitment petition within the allowed time.

(b) The proposed patient, or the head of the treatment facility or state-operated treatment program in which the patient is held, may demand in writing at any time that the hearing be held immediately. Unless the hearing is held within five days of the date of the demand, exclusive of Saturdays, Sundays, and legal holidays, the petition shall be automatically dismissed if the patient is being held in a treatment facility or state-operated treatment program pursuant to court order. For good cause shown, the court may extend the time of hearing on the demand for an additional ten days. This paragraph does not apply to a commitment petition brought under section 253B.18 or chapter 253D.

Subd. 2. **Notice of hearing.** The proposed patient, patient's counsel, the petitioner, the county attorney, and any other persons as the court directs shall be given at least five days' notice that a hearing will be held and at least two days' notice of the time and date of the hearing, except that any person may waive notice. Notice to the proposed patient may be waived by patient's counsel.

Subd. 2a. **Place of hearing.** The hearing shall be conducted in a manner consistent with orderly procedure. The hearing shall be held at a courtroom meeting standards prescribed by local court rule which may be at a treatment facility or state-operated treatment program. The hearing may be conducted by interactive video conference under General Rules of Practice, rule 131, and Minnesota Rules of Civil Commitment, rule 14.

Subd. 3. **Right to attend and testify.** All persons to whom notice has been given may attend the hearing and, except for the proposed patient's counsel, may testify. The court shall notify them of their right to attend the hearing and to testify. The court may exclude any person not necessary for the conduct of the proceedings from the hearings except any person requested to be present by the proposed patient. Nothing in this section shall prevent the court from ordering the sequestration of any witness or witnesses other than the petitioner or the proposed patient.

Subd. 4. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 5. **Absence permitted.** (a) The court may permit the proposed patient to waive the right to attend the hearing if it determines that the waiver is freely given. At the time of the hearing, the proposed patient shall not be so under the influence of drugs, medication, or other treatment so as to be hampered in participating in the proceedings. When the professional responsible for the proposed patient's treatment is of the opinion that the discontinuance of medication or other treatment is not in the best interest of the proposed patient, the court, at the time of the hearing, shall be presented a record of all medication or other treatment which the proposed patient has received during the 48 hours immediately prior to the hearing.

(b) The court, on its own motion or on the motion of any party, may exclude or excuse a proposed patient who is seriously disruptive or who is incapable of comprehending and participating in the proceedings. In such instances, the court shall, with specificity on the record, state the behavior of the proposed patient or other circumstances justifying proceeding in the absence of the proposed patient.

Subd. 5a. **Witnesses.** The proposed patient or the patient's counsel and the county attorney may present and cross-examine witnesses, including court examiners, at the hearing. The court may in its discretion receive the testimony of any other person. Opinions of court examiners may not be admitted into evidence unless the court examiner is present to testify, except by agreement of the parties.

Subd. 6. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 7. **Evidence.** The court shall admit all relevant evidence at the hearing. The court shall make its determination upon the entire record pursuant to the Rules of Evidence.

In any case where the petition was filed immediately following a criminal proceeding in which the proposed patient was acquitted under section 611.026, the court shall take judicial notice of the record of the criminal proceeding.

Subd. 8. **Record required.** The court shall keep accurate records containing, among other appropriate materials, notations of appearances at the hearing, including witnesses, motions made and their disposition, and all waivers of rights made by the parties. The court shall take and preserve an accurate stenographic record or tape recording of the proceedings.

History: *1982 c 581 s 8; 1983 c 348 s 9; 1984 c 623 s 5; 1986 c 444; 1991 c 255 s 19; 1997 c 217 art 1 s 49-54; 2005 c 136 art 14 s 2; 2008 c 299 s 12; 2009 c 86 art 1 s 43; 2013 c 49 s 22; 2015 c 65 art 2 s 1; 1Sp2020 c 2 art 6 s 45-48*

253B.09 DECISION; STANDARD OF PROOF; DURATION.

Subdivision 1. **Standard of proof.** (a) If the court finds by clear and convincing evidence that the proposed patient is a person who poses a risk of harm due to mental illness, or is a person who has a developmental disability or chemical dependency, and after careful consideration of reasonable alternative dispositions including but not limited to dismissal of petition; voluntary outpatient care; voluntary admission to a treatment facility, state-operated treatment program, or community-based treatment program; appointment of a guardian or conservator; or release before commitment as provided for in subdivision 4, it finds that there is no suitable alternative to judicial commitment, the court shall commit the patient to the least restrictive treatment program or alternative programs which can meet the patient's treatment needs consistent with section 253B.03, subdivision 7.

(b) In deciding on the least restrictive program, the court shall consider a range of treatment alternatives including but not limited to community-based nonresidential treatment, community residential treatment, partial hospitalization, acute care hospital, assertive community treatment teams, and state-operated treatment programs. The court shall also consider the proposed patient's treatment preferences and willingness to participate voluntarily in the treatment ordered. The court may not commit a patient to a facility or program that is not capable of meeting the patient's needs.

(c) If, after careful consideration of reasonable alternative dispositions, the court finds no suitable alternative to judicial commitment and the court finds that the least restrictive alternative as determined in paragraph (a) is a treatment facility or community-based treatment program that is less restrictive or more community based than a state-operated treatment program, and there is a treatment facility or a community-based treatment program willing to accept the civilly committed patient, the court may commit the patient to both the treatment facility or community-based treatment program and to the executive board, in the event that treatment in a state-operated treatment program becomes the least restrictive alternative. If there is a change in the patient's level of care, then:

(1) if the patient needs a higher level of care requiring admission to a state-operated treatment program, custody of the patient and authority and responsibility for the commitment may be transferred to the executive board for as long as the patient needs a higher level of care; and

(2) when the patient no longer needs treatment in a state-operated treatment program, the program may provisionally discharge the patient to an appropriate placement or release the patient to the treatment facility or community-based treatment program if the program continues to be willing and able to readmit the patient, in which case the commitment, its authority, and responsibilities revert to the non-state-operated treatment program. Both agencies accepting commitment shall coordinate admission and discharge planning to facilitate timely access to the other's services to meet the patient's needs and shall coordinate treatment planning consistent with section 253B.03, subdivision 7.

(d) If a person is committed to a state-operated treatment program as a person who poses a risk of harm due to mental illness or as a person who has a developmental disability or chemical dependency, the court shall order the commitment to the executive board. The executive board shall designate the placement of the person to the court.

(e) If the court finds a proposed patient to be a person who poses a risk of harm due to mental illness under section 253B.02, subdivision 17a, paragraph (a), clause (4), the court shall commit the patient to a treatment facility or community-based treatment program that meets the proposed patient's needs.

Subd. 2. **Findings.** (a) The court shall find the facts specifically, and separately state its conclusions of law. Where commitment is ordered, the findings of fact and conclusions of law shall specifically state the

proposed patient's conduct which is a basis for determining that each of the requisites for commitment is met.

(b) If commitment is ordered, the findings shall also identify less restrictive alternatives considered and rejected by the court and the reasons for rejecting each alternative.

(c) If the proceedings are dismissed, the court may direct that the person be transported back to a suitable location including to the person's home.

Subd. 3. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 3a. **Reporting judicial commitments; private treatment program or facility.** Notwithstanding section 253B.23, subdivision 9, when a court commits a patient to a non-state-operated treatment facility or program, the court shall report the commitment to the executive board through the supreme court information system for purposes of providing commitment information for firearm background checks under section 246C.15. If the patient is committed to a state-operated treatment program, the court shall send a copy of the commitment order to the executive board.

Subd. 4. MS 1986 [Repealed, 1988 c 623 s 17]

Subd. 5. **Initial commitment period.** The initial commitment begins on the date that the court issues its order or warrant under section 253B.10, subdivision 1. For a person committed as a person who poses a risk of harm due to mental illness, a developmental disability, or chemical dependency, the initial commitment shall not exceed six months.

History: *1982 c 581 s 9; 1986 c 444; 1988 c 623 s 6; 1997 c 217 art 1 s 55-59; 1998 c 313 s 7; 1Sp2001 c 9 art 9 s 35; 2002 c 221 s 23; 2002 c 335 s 3; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 6 s 47; 2005 c 56 s 1; 1Sp2020 c 2 art 6 s 49-52,123; art 8 s 145; 2024 c 79 art 5 s 7; art 10 s 2,3; 2025 c 38 art 3 s 40*

253B.091 MS 1996 [Repealed, 1997 c 217 art 1 s 118]

253B.092 ADMINISTRATION OF NEUROLEPTIC MEDICATION.

Subdivision 1. **General.** Neuroleptic medications may be administered, only as provided in this section, to patients subject to civil commitment under this chapter or chapter 253D. For purposes of this section, "patient" includes a proposed patient who is the subject of a petition for commitment and a committed person as defined in section 253D.02, subdivision 4.

Subd. 2. **Administration without judicial review.** (a) Neuroleptic medications may be administered without judicial review in the following circumstances:

(1) the patient has the capacity to make an informed decision under subdivision 4;

(2) the patient does not have the present capacity to consent to the administration of neuroleptic medication, but prepared a health care power of attorney, a health care directive under chapter 145C, or a declaration under section 253B.03, subdivision 6d, requesting treatment or authorizing an agent or proxy to request treatment, and the agent or proxy has requested the treatment;

(3) the patient has been prescribed neuroleptic medication prior to admission to a treatment facility, but lacks the present capacity to consent to the administration of that neuroleptic medication; continued administration of the medication is in the patient's best interest; and the patient does not refuse administration of the medication. In this situation, the previously prescribed neuroleptic medication may be continued for up to 14 days while the treating medical practitioner:

(i) is obtaining a substitute decision-maker appointed by the court under subdivision 6; or

(ii) is requesting a court order authorizing administering neuroleptic medication or an amendment to a current court order authorizing administration of neuroleptic medication;

(4) a substitute decision-maker appointed by the court consents to the administration of the neuroleptic medication and the patient does not refuse administration of the medication; or

(5) the substitute decision-maker does not consent or the patient is refusing medication, and the patient is in an emergency situation.

(b) For the purposes of paragraph (a), clause (3), if a person requests a substitute decision-maker or requests a court order administering neuroleptic medication within 14 days, the treating medical practitioner may continue administering the medication to the patient through the hearing date or until the court otherwise issues an order.

Subd. 3. **Emergency administration.** A treating medical practitioner may administer neuroleptic medication to a patient who does not have capacity to make a decision regarding administration of the medication if the patient is in an emergency situation. Medication may be administered for so long as the emergency continues to exist, up to 14 days, if the treating medical practitioner determines that the medication is necessary to prevent serious, immediate physical harm to the patient or to others. If a request for authorization to administer medication is made to the court within the 14 days, the treating medical practitioner may continue the medication through the date of the first court hearing, if the emergency continues to exist. If the request for authorization to administer medication is made to the court in conjunction with a petition for commitment and the court makes a determination at the preliminary hearing under section 253B.07, subdivision 7, that there is sufficient cause to continue the medical practitioner's order until the hearing under section 253B.08, the treating medical practitioner may continue the medication until that hearing, if the emergency continues to exist. The treatment facility, state-operated treatment program, or community-based treatment program shall document the emergency in the patient's medical record in specific behavioral terms.

Subd. 4. **Patients with capacity to make informed decision.** A patient who has the capacity to make an informed decision regarding the administration of neuroleptic medication may consent or refuse consent to administration of the medication. The informed consent of a patient must be in writing.

Subd. 5. **Determination of capacity.** (a) There is a rebuttable presumption that a patient has the capacity to make decisions regarding administration of neuroleptic medication.

(b) A patient has the capacity to make decisions regarding the administration of neuroleptic medication if the patient:

(1) has an awareness of the nature of the patient's situation, including the reasons for hospitalization, and the possible consequences of refusing treatment with neuroleptic medications;

(2) has an understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives; and

(3) communicates verbally or nonverbally a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on a symptom of the patient's mental illness, even though it may not be in the patient's best interests.

(c) Disagreement with the medical practitioner's recommendation alone is not evidence of an unreasonable decision.

Subd. 6. **Patients without capacity to make informed decision; substitute decision-maker.** (a) Upon request of any person, and upon a showing that administration of neuroleptic medications may be recommended and that the patient may lack capacity to make decisions regarding the administration of neuroleptic medication, the court shall appoint a substitute decision-maker with authority to consent to the administration of neuroleptic medication as provided in this section. A hearing is not required for an appointment under this paragraph. The substitute decision-maker must be an individual or a community or institutional multidisciplinary panel designated by the local mental health authority. In appointing a substitute decision-maker, the court shall give preference to a guardian, proxy, or health care agent with authority to make health care decisions for the patient. The court may provide for the payment of a reasonable fee to the substitute decision-maker for services under this section or may appoint a volunteer.

(b) If the patient's treating medical practitioner recommends treatment with neuroleptic medication, the substitute decision-maker may give or withhold consent to the administration of the medication, based on the standards under subdivision 7. If the substitute decision-maker gives informed consent to the treatment and the patient does not refuse, the substitute decision-maker shall provide written consent to the treating medical practitioner and the medication may be administered. The substitute decision-maker shall also notify the court that consent has been given. If the substitute decision-maker refuses or withdraws consent or the patient refuses the medication, neuroleptic medication must not be administered to the patient except with a court order or in an emergency.

(c) A substitute decision-maker appointed under this section has access to the relevant sections of the patient's health records on the past or present administration of medication. The designated agency or a person involved in the patient's physical or mental health care may disclose information to the substitute decision-maker for the sole purpose of performing the responsibilities under this section. The substitute decision-maker may not disclose health records obtained under this paragraph except to the extent necessary to carry out the duties under this section.

(d) At a hearing under section 253B.08, the petitioner has the burden of proving incapacity by a preponderance of the evidence. If a substitute decision-maker has been appointed by the court, the court shall make findings regarding the patient's capacity to make decisions regarding the administration of neuroleptic medications and affirm or reverse its appointment of a substitute decision-maker. If the court affirms the appointment of the substitute decision-maker, and if the substitute decision-maker has consented to the administration of the medication and the patient has not refused, the court shall make findings that the substitute decision-maker has consented and the treatment is authorized. If a substitute decision-maker has not yet been appointed, upon request the court shall make findings regarding the patient's capacity and appoint a substitute decision-maker if appropriate.

(e) If an order for civil commitment did not provide for the appointment of a substitute decision-maker or for the administration of neuroleptic medication, a treatment facility, state-operated treatment program, or community-based treatment program may later request the appointment of a substitute decision-maker upon a showing that administration of neuroleptic medications is recommended and that the patient lacks capacity to make decisions regarding the administration of neuroleptic medications. A hearing is not required in order to administer the neuroleptic medication unless requested under subdivision 10 or if the substitute decision-maker withholds or refuses consent or the patient refuses the medication.

(f) The substitute decision-maker's authority to consent to treatment lasts for the duration of the court's order of appointment or until modified by the court.

(g) If there is no hearing after the preliminary hearing, then the court shall, upon the request of any interested party, review the reasonableness of the substitute decision-maker's decision based on the standards under subdivision 7. The court shall enter an order upholding or reversing the decision within seven days.

Subd. 7. **When patient lacks capacity to make decisions about medication.** (a) When a patient lacks capacity to make decisions regarding the administration of neuroleptic medication, the substitute decision-maker or the court shall use the standards in this subdivision in making a decision regarding administration of the medication.

(b) If the patient clearly stated what the patient would choose to do in this situation when the patient had the capacity to make a reasoned decision, the patient's wishes must be followed. Evidence of the patient's wishes may include written instruments, including a durable power of attorney for health care under chapter 145C or a declaration under section 253B.03, subdivision 6d.

(c) If evidence of the patient's wishes regarding the administration of neuroleptic medications is conflicting or lacking, the decision must be based on what a reasonable person would do, taking into consideration:

(1) the patient's family, community, moral, religious, and social values;

(2) the medical risks, benefits, and alternatives to the proposed treatment;

(3) past efficacy and any extenuating circumstances of past use of neuroleptic medications; and

(4) any other relevant factors.

Subd. 8. **Procedure when patient refuses neuroleptic medication.** (a) If the substitute decision-maker or the patient refuses to consent to treatment with neuroleptic medications, and absent an emergency as set forth in subdivision 3, neuroleptic medications may not be administered without a court order. Upon receiving a written request for a hearing, the court shall schedule the hearing within 14 days of the request. The matter may be heard as part of any other district court proceeding under this chapter. By agreement of the parties or for good cause shown, the court may extend the time of hearing an additional 30 days.

(b) The patient must be examined by a court examiner prior to the hearing. If the patient refuses to participate in an examination, the court examiner may rely on the patient's medical records to reach an opinion as to the appropriateness of neuroleptic medication. The patient is entitled to counsel and a second court examiner, if requested by the patient or patient's counsel.

(c) The court may base its decision on relevant and admissible evidence, including the testimony of a treating medical practitioner or other qualified physician, a member of the patient's treatment team, a court examiner, witness testimony, or the patient's medical records.

(d) If the court finds that the patient has the capacity to decide whether to take neuroleptic medication or that the patient lacks capacity to decide and the standards for making a decision to administer the medications under subdivision 7 are not met, the treatment facility, state-operated treatment program, or community-based treatment program may not administer medication without the patient's informed written consent or without the declaration of an emergency, or until further review by the court.

(e) If the court finds that the patient lacks capacity to decide whether to take neuroleptic medication and has applied the standards set forth in subdivision 7, the court may authorize the treatment facility, state-operated treatment program, or community-based treatment program and any other facility or program to which the patient may be transferred or provisionally discharged, to involuntarily administer the medication to the patient. A copy of the order must be given to the patient, the patient's attorney, the county attorney,

and the treatment facility, state-operated treatment program, or community-based treatment program. The treatment facility, state-operated treatment program, or community-based treatment program may not begin administration of the neuroleptic medication until it notifies the patient of the court's order authorizing the treatment.

(f) A finding of lack of capacity under this section must not be construed to determine the patient's competence for any other purpose.

(g) The court may authorize the administration of neuroleptic medication until the termination of a determinate commitment. If the patient is committed for an indeterminate period, the court may authorize treatment of neuroleptic medication for not more than two years, subject to the patient's right to petition the court for review of the order. The treatment facility, state-operated treatment program, or community-based treatment program must submit annual reports to the court, which shall provide copies to the patient and the respective attorneys.

(h) The court may limit the maximum dosage of neuroleptic medication that may be administered.

(i) If physical force is required to administer the neuroleptic medication, the facility or program may only use injectable medications. If physical force is needed to administer the medication, medication may only be administered in a setting where the person's condition can be reassessed and medical personnel qualified to administer medication are available, including in the community, a county jail, or a correctional facility. The facility or program may not use a nasogastric tube to administer neuroleptic medication involuntarily.

Subd. 9. **Immunity.** A substitute decision-maker who consents to treatment is not civilly or criminally liable for the performance of or the manner of performing the treatment. A person is not liable for performing treatment without consent if the substitute decision-maker has given written consent. This provision does not affect any other liability that may result from the manner in which the treatment is performed.

Subd. 10. **Review.** A patient or other person may petition the court under section 253B.17 for review of any determination under this section or for a decision regarding the administration of neuroleptic medications, appointment of a substitute decision-maker, or the patient's capacity to make decisions regarding administration of neuroleptic medications.

History: *1997 c 217 art 1 s 60; 1998 c 313 s 8,9; 1998 c 399 s 30,31; 2013 c 49 s 5,22; 2014 c 291 art 3 s 3; 1Sp2020 c 2 art 6 s 53*

253B.0921 ACCESS TO MEDICAL RECORDS.

A treating medical practitioner who makes medical decisions regarding the prescription and administration of medication for treatment of a mental illness has access to the relevant sections of a patient's health records on past administration of medication at any facility, program, or treatment provider, if the patient lacks the capacity to authorize the release of records. Upon request of a treating medical practitioner under this section, a facility, program, or treatment provider shall supply complete information relating to the past records on administration of medication of a patient subject to this chapter. A patient who has the capacity to authorize the release of data retains the right to make decisions regarding access to medical records as provided by sections 144.291 to 144.298.

History: *1997 c 217 art 1 s 61; 1998 c 313 s 10; 2007 c 147 art 10 s 15; 1Sp2020 c 2 art 6 s 54*

253B.093 [Renumbered 253B.097]

253B.095 RELEASE BEFORE COMMITMENT.

Subdivision 1. **Court release.** (a) After the hearing and before a commitment order has been issued, the court may release a proposed patient to the custody of an individual or agency upon conditions that guarantee the care and treatment of the patient.

(b) A person against whom a criminal proceeding is pending may not be released.

(c) A continuance for dismissal, with or without findings, may be granted for up to 90 days.

(d) When the court stays an order for commitment for more than 14 days beyond the date of the initially scheduled hearing, the court shall issue an order that must include:

(1) a written plan for services to which the proposed patient has agreed;

(2) a finding that the proposed treatment is available and accessible to the patient and that public or private financial resources are available to pay for the proposed treatment;

(3) conditions the patient must meet to avoid revocation of the stayed commitment order and imposition of the commitment order; and

(4) a condition that the patient is prohibited from giving consent to participate in a clinical drug trial while the court order is in effect.

(e) Notwithstanding paragraph (d), clause (4), during the period of a stay of commitment, the court may allow the patient to give consent to participate in a specific psychiatric clinical drug trial if the treating psychiatrist testifies or submits an affidavit that the patient may benefit from participating in the trial because, after providing other treatment options for a reasonable period of time, those options have been ineffective. The treating psychiatrist must not be the psychiatrist conducting the psychiatric clinical drug trial. The court must determine that, under the circumstances of the case, the patient is competent to choose to participate in the trial, that the patient is freely choosing to participate in the trial, that the compulsion of the stayed commitment is not being used to coerce the person to participate in the clinical trial, and that a reasonable person may choose to participate in the clinical trial.

(f) A person receiving treatment under this section has all rights under this chapter.

Subd. 2. **Case manager.** When a court releases a patient under this section, the court shall direct the case manager to report to the court at least once every 90 days and shall immediately report a substantial failure of a patient or provider to comply with the conditions of the release.

Subd. 3. **Duration.** The maximum duration of a stayed order under this section is six months. The court may continue the order for a maximum of an additional 12 months if, after notice and hearing, under sections 253B.08 and 253B.09 the court finds that (1) the person continues to have a mental illness, developmental disability, or chemical dependency, and (2) an order is needed because the person is likely to attempt to physically harm self or others or fail to obtain necessary food, clothing, shelter, or medical care unless the person is under the supervision of a stayed commitment.

Subd. 4. **Modification of order.** An order under this section may be modified upon agreement of the parties and approval of the court.

Subd. 5. **Revocation of order.** The court, on its own motion or upon the motion of any party that the patient has not complied with a material condition of release, and after notice and a hearing unless otherwise ordered by the court, may revoke any release and commit the proposed patient under this chapter.

Subd. 6. [Renumbered subd 4]

Subd. 7. [Renumbered subd 5]

History: *1988 c 623 s 8; 1997 c 217 art 1 s 62; 1998 c 313 s 11; 2005 c 56 s 1; 2009 c 58 s 1; 1Sp2020 c 2 art 6 s 55*

253B.097 COMMUNITY-BASED TREATMENT.

Subdivision 1. **Findings.** In addition to the findings required under section 253B.09, subdivision 2, an order committing a person to a community-based treatment program must include:

(1) a written plan for services to the patient;

(2) a finding that the proposed treatment is available and accessible to the patient and that public or private financial resources are available to pay for the proposed treatment;

(3) conditions the patient must meet in order to obtain an early release from commitment or to avoid a hearing for further commitment; and

(4) consequences of the patient's failure to follow the commitment order. Consequences may include commitment to another setting for treatment.

Subd. 2. **Case manager.** When a court commits a patient with mental illness to a community-based treatment program, the court shall appoint a case manager from the county agency or other entity under contract with the county agency to provide case management services.

Subd. 3. **Reports.** The case manager shall report to the court at least once every 90 days. The case manager shall immediately report to the court a substantial failure of the patient or provider to comply with the conditions of the commitment.

Subd. 4. **Modification of order.** An order for community-based treatment may be modified upon agreement of the parties and approval of the court.

Subd. 5. **Noncompliance.** The case manager may petition for a reopening of the commitment hearing if a patient or provider fails to comply with the terms of an order for community-based treatment.

Subd. 6. **Immunity from liability.** No treatment facility, community-based treatment program, or person is financially liable, personally or otherwise, for the patient's actions if the facility or person follows accepted community standards of professional practice in the management, supervision, and treatment of the patient. For purposes of this subdivision, "person" means official, staff, employee of the treatment facility, community-based treatment program, physician, or other individual who is responsible for a patient's management, supervision, or treatment under this section.

History: *1988 c 623 s 7; 1997 c 217 art 1 s 117; 1Sp2020 c 2 art 6 s 56-59*

253B.10 PROCEDURES UPON COMMITMENT.

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The executive board shall prioritize civilly committed patients being admitted from jail or a correctional institution or who are referred to a state-operated treatment facility for competency attainment or a competency examination under sections 611.40 to 611.59 for admission to a medically appropriate state-operated direct care and treatment bed based on the decisions of physicians in the executive medical director's office, using a priority admissions framework. The framework must account for a range of factors for priority admission, including but not limited to:

(1) the length of time the person has been on a waiting list for admission to a state-operated direct care and treatment program since the date of the order under paragraph (a), or the date of an order issued under sections 611.40 to 611.59;

(2) the intensity of the treatment the person needs, based on medical acuity;

(3) the person's revoked provisional discharge status;

(4) the person's safety and safety of others in the person's current environment;

(5) whether the person has access to necessary or court-ordered treatment;

(6) distinct and articulable negative impacts of an admission delay on the facility referring the individual for treatment; and

(7) any relevant federal prioritization requirements.

Patients described in this paragraph must be admitted to a state-operated treatment program within the timelines specified in section 253B.1005. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (d). Patients committed to a secure treatment facility or less restrictive setting as ordered by the court under section 253B.18, subdivisions 1 and 2, must be prioritized for admission to a state-operated treatment program using the priority admissions framework in this paragraph.

(c) Upon the arrival of a patient at the designated treatment facility, state-operated treatment program, or community-based treatment program, the head of the facility or program shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the facility or program.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the prepetition report, and any medical and behavioral information available shall be provided at the time of admission of a patient to the designated treatment facility or program to which the patient is committed. Upon a patient's referral to the executive board for admission pursuant to paragraph (b), any inpatient hospital, treatment facility, jail, or correctional facility that has provided care or supervision to the patient in the previous two years shall, when requested by the treatment facility or executive board, provide copies of the patient's medical and behavioral records to the executive board for purposes of preadmission planning. This information shall be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws.

(e) Within four business days of determining which state-operated direct care and treatment program or programs are appropriate for an individual, the executive medical director or a designee must notify the source of the referral and the responsible county human services agency, the individual being ordered to direct care and treatment, and the district court that issued the order of the determination. The initial notice shall include the individual's relative priority status by quartile and contact information for the Direct Care

and Treatment central preadmissions office. Detailed information on factors impacting the individual's priority status is available from the central preadmissions office upon request, consistent with section 13.04. Any interested person or the individual being ordered to direct care and treatment may provide additional information to or request updated priority status about the individual from the executive medical director or a designee while the individual is awaiting admission. Priority status information for an individual will only be disclosed to interested persons who are legally authorized to receive private information about the individual, including the designated agency and the facility to which the individual is awaiting admission. Specific updated priority status information may be withheld from the individual being ordered to direct care and treatment if, in the judgment of the physicians in the executive medical director's office, the information will jeopardize the individual's health or well-being.

(f) For any individual not admitted to a state-operated direct care and treatment program within 60 business days after the initial notice under paragraph (e), the executive medical director or a designee must provide additional notice to the responsible county human services agency, the individual being ordered to direct care and treatment, and the district court that issued the order of the determination. The additional notice must include updates to the same information provided in the previous notice.

(g) When an available bed has been identified, the executive medical director or a designee must notify the designated agency and the facility where the individual is awaiting admission that the individual has been accepted for admission to a particular state-operated direct care and treatment program and the earliest possible date the admission can occur. The designated agency or facility where the individual is awaiting admission must transport the individual to the admitting direct care and treatment program no more than 48 hours after the offered admission date.

Subd. 2. **Transportation.** (a) When a patient is about to be placed in a treatment facility, state-operated treatment program, or community-based treatment program, the court may order the designated agency, treatment facility, state-operated treatment program, or community-based treatment program, or any responsible adult to transport the patient. A protected transport provider may transport the patient according to section 256B.0625, subdivision 17. Whenever possible, a peace officer who provides the transportation shall not be in uniform and shall not use a vehicle visibly marked as a law enforcement vehicle. The proposed patient may be accompanied by one or more interested persons.

(b) When a patient who is at a state-operated treatment program requests a hearing for adjudication of a patient's status pursuant to section 253B.17, the executive board shall provide transportation.

Subd. 3. **Notice of admission.** Whenever a committed person has been admitted to a treatment facility, state-operated treatment program, or community-based treatment program under the provisions of section 253B.09 or 253B.18, the head of the facility or program shall immediately notify the patient's spouse, health care agent, or parent and the county of financial responsibility if the county may be liable for a portion of the cost of treatment. If the committed person was admitted upon the petition of a spouse, health care agent, or parent, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall notify an interested person other than the petitioner.

Subd. 3a. **Interim custody and treatment of committed person.** When the patient is present in a treatment facility or state-operated treatment program at the time of the court's commitment order, unless the court orders otherwise, the commitment order constitutes authority for that facility or program to confine and provide treatment to the patient until the patient is transferred to the facility or program to which the patient has been committed.

Subd. 4. **Private treatment.** Patients or other responsible persons are required to pay the necessary charges for patients committed or transferred to treatment facilities or community-based treatment programs. Treatment facilities or community-based treatment programs may not refuse to accept a committed person solely based on the person's court-ordered status. Insurers must provide treatment and services as ordered by the court under section 253B.045, subdivision 6, or as required under chapter 62M.

Subd. 5. **Transfer to voluntary status.** At any time prior to the expiration of the initial commitment period, a patient who has not been committed as a person who has a mental illness and is dangerous to the public or a sexually dangerous person or a sexual psychopathic personality may be transferred to voluntary status upon the patient's application in writing with the consent of the head of the facility or program to which the person is committed. Upon transfer, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall immediately notify the court in writing and the court shall terminate the proceedings.

Subd. 6. **State-operated services for persons with mental illness.** The executive board shall determine to which state-operated services facility persons with mental illness from each county shall be committed and notify the judges exercising probate jurisdiction over each county of the commitment. The executive board shall also notify judges of any changes made by the executive board to the commitment location.

History: *1947 c 491 s 1; 1951 c 10 s 2; 1965 c 45 s 27; 1982 c 581 s 10; 1984 c 654 art 5 s 58; 1985 c 21 s 41; 1986 c 444; 1989 c 282 art 6 s 24; 1Sp1993 c 1 art 7 s 35; 1995 c 189 s 8; 1996 c 277 s 1; 1997 c 217 art 1 s 63; 1Sp2001 c 9 art 9 s 36; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 6 s 40; 2009 c 108 s 7; 2010 c 300 s 21; 2010 c 357 s 8; 2013 c 59 art 2 s 12; 2013 c 108 art 4 s 11; 1Sp2017 c 6 art 6 s 2; 1Sp2020 c 2 art 6 s 60; 2023 c 61 art 4 s 7; 2024 c 79 art 5 s 1,8; art 10 s 1,3; 2024 c 125 art 4 s 5; art 5 s 38; 2024 c 127 art 49 s 5; art 50 s 38; 2025 c 38 art 3 s 41; 1Sp2025 c 9 art 5 s 4; 2026 c 88 art 1 s 110*

253B.1005 ADMISSION TIMELINES.

Subdivision 1. **Admission required within 48 hours.** Unless required otherwise under this section, patients described in section 253B.10, subdivision 1, paragraph (b), must be admitted to a state-operated treatment program within 48 hours.

Subd. 2. **Temporary alternative admission timeline.** Patients described in section 253B.10, subdivision 1, paragraph (b), must be admitted to a state-operated treatment program within 48 hours of the Office of Executive Medical Director, under section 246C.09, or a designee determining that a medically appropriate bed is available. This subdivision expires on June 30, 2027.

History: *2025 c 38 art 3 s 42*

253B.11 Subdivision 1. [Renumbered 253B.045, subdivision 1]

Subd. 2. [Renumbered 253B.045, subd 2]

Subd. 2a. [Renumbered 253B.045, subd 3]

Subd. 3. [Renumbered 253B.045, subd 4]

253B.12 TREATMENT REPORT; REVIEW; HEARING.

Subdivision 1. **Reports.** (a) If a patient who was committed as a person who poses a risk of harm due to a mental illness, or as a person who has a developmental disability or chemical dependency, is discharged from commitment within the first 60 days after the date of the initial commitment order, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall file a

written report with the committing court describing the patient's need for further treatment. A copy of the report must be provided to the county attorney, the patient, and the patient's counsel.

(b) If a patient who was committed as a person who poses a risk of harm due to a mental illness, or as a person who has a developmental disability or chemical dependency, remains in treatment more than 60 days after the date of the commitment, then at least 60 days, but not more than 90 days, after the date of the order, the head of the facility or program that has custody of the patient shall file a written report with the committing court and provide a copy to the county attorney, the patient, and the patient's counsel. The report must set forth in detailed narrative form at least the following:

(1) the diagnosis of the patient with the supporting data;

(2) the anticipated discharge date;

(3) an individualized treatment plan;

(4) a detailed description of the discharge planning process with suggested after care plan;

(5) whether the patient is in need of further care and treatment, the treatment facility, state-operated treatment program, or community-based treatment program that is needed, and evidence to support the response;

(6) whether the patient satisfies the statutory requirement for continued commitment with documentation to support the opinion;

(7) a statement from the patient related to accepting treatment, if possible; and

(8) whether the administration of neuroleptic medication is clinically indicated, whether the patient is able to give informed consent to that medication, and the basis for these opinions.

(c) Prior to the termination of the initial commitment order or final discharge of the patient, the head of the facility or program that has custody or care of the patient shall file a written report with the committing court with a copy to the county attorney, the patient, and the patient's counsel that sets forth the information required in paragraph (b).

(d) If the patient has been provisionally discharged from a facility or program, the report shall be filed by the designated agency, which may submit the discharge report as part of its report.

(e) If a report describes the patient as not in need of further court-ordered treatment, the proceedings must be terminated by the committing court and the patient discharged from the treatment facility, state-operated treatment program, or community-based treatment program, unless the patient chooses to voluntarily receive services.

(f) If no written report is filed within the required time, the court must notify the county, facility or program to which the person is committed, and designated agency and require a report be filed within five business days. If a report is not filed within five business days a hearing must be held within three business days.

Subd. 2. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

Subd. 2a. **Time and place for hearing.** (a) Unless the proceedings are terminated under subdivision 1, paragraph (e), a review hearing must be held within 14 days after receipt by the committing court of the report required under subdivision 1, paragraph (c) or (d), and before the time the commitment expires. For

good cause shown, the court may continue the hearing for up to an additional 14 days and extend any orders until the review hearing is held.

(b) The patient, the patient's counsel, the petitioner, and other persons as the court directs must be given at least five days' notice of the time and place of the hearing. The hearing may be conducted by interactive video conference under General Rules of Practice, rule 131, and Minnesota Rules of Civil Commitment, rule 14.

Subd. 3. **Examination.** Prior to the review hearing, the court shall inform the patient of the right to an independent examination by a court examiner chosen by the patient and appointed in accordance with provisions of section 253B.07, subdivision 3. The report of the court examiner may be submitted at the hearing.

Subd. 4. **Hearing; standard of proof.** (a) The committing court shall not make a final determination of the need to continue commitment unless the court finds by clear and convincing evidence that (1) the patient continues to have a mental illness, developmental disability, or chemical dependency; (2) involuntary commitment is necessary for the protection of the patient or others; and (3) there is no alternative to involuntary commitment.

(b) In determining whether a patient continues to require commitment due to mental illness, developmental disability, or chemical dependency, the court need not find that there has been a recent attempt or threat to physically harm self or others, or a recent failure to provide necessary food, clothing, shelter, or medical care. Instead, the court must find that the patient is likely to attempt to physically harm self or others, or to fail to obtain necessary food, clothing, shelter, or medical care unless involuntary commitment is continued.

Subd. 5. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 6. **Waiver.** A patient, after consultation with counsel, may waive any hearing under this section or section 253B.13 in writing. The waiver shall be signed by the patient and counsel. The waiver must be submitted to the committing court.

Subd. 7. **Record required.** Where continued commitment is ordered, the findings of fact and conclusions of law shall specifically state the conduct of the proposed patient which is the basis for the final determination, that the statutory criteria of commitment continue to be met, and that less restrictive alternatives have been considered and rejected by the court. Reasons for rejecting each alternative shall be stated. A copy of the final order for continued commitment shall be forwarded to the head of the facility or program to which the person is committed and, if the patient has been provisionally discharged, to the designated agency responsible for monitoring the provisional discharge.

Subd. 8. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

History: *1982 c 581 s 12; 1983 c 251 s 14; 1983 c 348 s 10; 1986 c 444; 1990 c 378 s 2; 1995 c 189 s 6; 1997 c 217 art 1 s 66-69; 1998 c 313 s 12; 2002 c 221 s 24; 2005 c 56 s 1; 2015 c 65 art 2 s 2; 1Sp2020 c 2 art 6 s 61-64*

253B.13 DURATION OF CONTINUED COMMITMENT.

Subdivision 1. **Persons with mental illness or chemical dependency.** (a) If at the conclusion of a review hearing the court finds that the person continues to have mental illness or chemical dependency and need treatment or supervision, the court shall determine the length of continued commitment. No period of commitment shall exceed this length of time or 12 months, whichever is less.

(b) At the conclusion of the prescribed period under paragraph (a), commitment may not be continued unless a new petition is filed pursuant to section 253B.07 and hearing and determination made on it. If the petition was filed before the end of the previous commitment and, for good cause shown, the court has not completed the hearing and the determination by the end of the commitment period, the court may for good cause extend the previous commitment for up to 14 days to allow the completion of the hearing and the issuance of the determination. The standard of proof for the new petition is the standard specified in section 253B.12, subdivision 4. Notwithstanding the provisions of section 253B.09, subdivision 5, the initial commitment period under the new petition shall be the probable length of commitment necessary or 12 months, whichever is less.

Subd. 2. **Persons who are developmentally disabled.** If, at the conclusion of a review hearing the court finds that the person continues to be developmentally disabled, the court shall order commitment of the person for an indeterminate period of time, subject to the reviews required by section 253B.03, subdivisions 5 and 7, and subject to the right of the patient to seek judicial review of continued commitment.

Subd. 3. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

History: *1982 c 581 s 13; 1983 c 251 s 15; 1985 c 231 s 1; 1997 c 217 art 1 s 70,71; 2005 c 56 s 1; 1Sp2020 c 2 art 6 s 65*

253B.14 TRANSFER OF COMMITTED PERSONS.

The executive board may transfer any committed person, other than a person committed as a person who has a mental illness and is dangerous to the public, a sexually dangerous person, or a sexual psychopathic personality, from one state-operated treatment program to any other state-operated treatment program capable of providing proper care and treatment. When a committed person is transferred from one state-operated treatment program to another, written notice shall be given to the committing court, the county attorney, the patient's counsel, and to the person's parent, health care agent, or spouse or, if none is known, to an interested person, and the designated agency.

History: *1982 c 581 s 14; 1986 c 444; 1997 c 217 art 1 s 72; 2009 c 108 s 8; 2010 c 300 s 22; 1Sp2020 c 2 art 6 s 66; 2024 c 79 art 10 s 3*

253B.141 AUTHORITY TO DETAIN AND TRANSPORT A MISSING PATIENT.

Subdivision 1. **Report of absence.** (a) If a patient committed under this chapter or detained in a treatment facility or state-operated treatment program under a judicial hold is absent without authorization, and either: (1) does not return voluntarily within 72 hours of the time the unauthorized absence began; or (2) is considered by the head of the facility or program to be a danger to self or others, then the head of the facility or program shall report the absence to the local law enforcement agency. The head of the facility or program shall also notify the committing court that the patient is absent and that the absence has been reported to the local law enforcement agency. The committing court may issue an order directing the law enforcement agency to transport the patient to an appropriate treatment facility, state-operated treatment program, or community-based treatment program.

(b) Upon receiving a report that a patient subject to this section is absent without authorization, the local law enforcement agency shall enter information on the patient into the missing persons file of the National Crime Information Center computer according to the missing persons practices.

Subd. 2. **Apprehension; return to facility or program.** (a) Upon receiving the report of absence from the head of the treatment facility, state-operated treatment program, or community-based treatment program or the committing court, a patient may be apprehended and held by a peace officer in any jurisdiction pending

return to the facility or program from which the patient is absent without authorization. A patient may also be returned to any state-operated treatment program or any other treatment facility or community-based treatment program willing to accept the person. A person who has a mental illness and is dangerous to the public and detained under this subdivision may be held in a jail or lockup only if:

(1) there is no other feasible place of detention for the patient;

(2) the detention is for less than 24 hours; and

(3) there are protections in place, including segregation of the patient, to ensure the safety of the patient.

(b) If a patient is detained under this subdivision, the head of the facility or program from which the patient is absent shall arrange to pick up the patient within 24 hours of the time detention was begun and shall be responsible for securing transportation for the patient to the facility or program. The expense of detaining and transporting a patient shall be the responsibility of the facility or program from which the patient is absent. The expense of detaining and transporting a patient to a state-operated treatment program shall be paid by the executive board unless paid by the patient or persons on behalf of the patient.

Subd. 3. **Notice of apprehension.** Immediately after an absent patient is located, the head of the facility or program from which the patient is absent, or the law enforcement agency that located or returned the absent patient, shall notify the law enforcement agency that first received the absent patient report under this section and that agency shall cancel the missing persons entry from the National Crime Information Center computer.

History: *1997 c 217 art 1 s 73; 1998 c 313 s 13; 2002 c 221 s 25; 2009 c 59 art 6 s 6; 2011 c 102 art 2 s 1; 1Sp2020 c 2 art 6 s 67; 2025 c 38 art 3 s 43*

253B.15 PROVISIONAL DISCHARGE; PARTIAL INSTITUTIONALIZATION.

Subdivision 1. **Provisional discharge.** (a) The head of the treatment facility, state-operated treatment program, or community-based treatment program may provisionally discharge any patient without discharging the commitment, unless the patient was found by the committing court to be a person who has a mental illness and is dangerous to the public, a sexually dangerous person, or a sexual psychopathic personality.

(b) When a patient committed to the executive board becomes ready for provisional discharge before being placed in a state-operated treatment program, the head of the treatment facility or community-based treatment program where the patient is placed pending transfer to the executive board may provisionally discharge the patient pursuant to this subdivision.

(c) Each patient released on provisional discharge shall have a written provisional discharge plan developed with input from the patient and the designated agency which specifies the services and treatment to be provided as part of the provisional discharge plan, the financial resources available to pay for the services specified, the expected period of provisional discharge, the precise goals for the granting of a final discharge, and conditions or restrictions on the patient during the period of the provisional discharge. The provisional discharge plan shall be provided to the patient, the patient's attorney, and the designated agency.

(d) The provisional discharge plan shall be reviewed on a quarterly basis by the patient, designated agency and other appropriate persons. The provisional discharge plan shall contain the grounds upon which a provisional discharge may be revoked. The provisional discharge shall terminate on the date specified in the plan unless specific action is taken to revoke or extend it.

Subd. 1a. **Representative of designated agency.** Before a provisional discharge is granted, a representative of the designated agency must be identified to ensure continuity of care by being involved with the treatment facility, state-operated treatment program, or community-based treatment program and the patient prior to the provisional discharge. The representative of the designated agency shall coordinate plans for and monitor the patient's aftercare program. When the patient is on a provisional discharge, the representative of the designated agency shall provide the treatment report to the court required under section 253B.12, subdivision 1.

Subd. 2. **Revocation of provisional discharge.** (a) The designated agency may initiate with the court a revocation of a provisional discharge if revocation is the least restrictive alternative and either:

(1) the patient has violated material conditions of the provisional discharge, and the violation creates the need to return the patient to a more restrictive setting or more intensive community services; or

(2) there exists a serious likelihood that the safety of the patient or others will be jeopardized, in that either the patient's need for food, clothing, shelter, or medical care are not being met, or will not be met in the near future, or the patient has attempted or threatened to seriously physically harm self or others.

(b) Any interested person may request that the designated agency revoke the patient's provisional discharge. Any person making a request shall provide the designated agency with a written report setting forth the specific facts, including witnesses, dates and locations, supporting a revocation, demonstrating that every effort has been made to avoid revocation and that revocation is the least restrictive alternative available.

Subd. 3. **Procedure; notice.** Revocation shall be commenced by the designated agency's written notice of intent to revoke provisional discharge given or sent to the patient, the patient's attorney, the facility or program from which the patient was provisionally discharged, and the current community services provider. The notice shall set forth the grounds upon which the intention to revoke is based, and shall inform the patient of the rights of a patient under this chapter.

Subd. 3a. **Report to the court.** Within 48 hours, excluding weekends and legal holidays, of giving notice to the patient, the designated agency shall file with the court a copy of the notice and a report setting forth the specific facts, including witnesses, dates and locations, which (1) support revocation, (2) demonstrate that revocation is the least restrictive alternative available, and (3) show that specific efforts were made to avoid revocation. The designated agency shall provide copies of the report to the patient, the patient's attorney, the county attorney, and the treatment facility or program from which the patient was provisionally discharged within 48 hours of giving notice to the patient under subdivision 3.

Subd. 3b. **Review.** The patient or patient's attorney may request judicial review of the intended revocation by filing a petition for review and an affidavit with the committing court. The affidavit shall state specific grounds for opposing the revocation. If the patient does not file a petition for review within five days of receiving the notice under subdivision 3, revocation of the provisional discharge is final and the court, without hearing, may order the patient into a facility or program from which the patient was provisionally discharged, another treatment facility, state-operated treatment program, or community-based treatment program that consents to receive the patient, or more intensive community treatment. If the patient files a petition for review, the court shall review the petition and determine whether a genuine issue exists as to the propriety of the revocation. The burden of proof is on the designated agency to show that no genuine issue exists as to the propriety of the revocation. If the court finds that no genuine issue exists as to the propriety of the revocation, the revocation of the provisional discharge is final.

Subd. 3c. **Hearing.** (a) If the court finds under subdivision 3b that a genuine issue exists as to the propriety of the revocation, the court shall hold a hearing on the petition within three days after the patient

files the petition. The court may continue the review hearing for an additional five days upon any party's showing of good cause. At the hearing, the burden of proof is on the designated agency to show a factual basis for the revocation. At the conclusion of the hearing, the court shall make specific findings of fact. The court shall affirm the revocation if it finds:

(1) a factual basis for revocation due to:

(i) a violation of the material conditions of the provisional discharge that creates a need for the patient to return to a more restrictive setting or more intensive community services; or

(ii) a probable danger of harm to the patient or others if the provisional discharge is not revoked; and

(2) that revocation is the least restrictive alternative available.

(b) If the court does not affirm the revocation, the court shall order the patient returned to provisional discharge status.

Subd. 4. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 5. **Return to facility.** When the designated agency gives or sends notice of the intent to revoke a patient's provisional discharge, it may also apply to the committing court for an order directing that the patient be returned to the facility or program from which the patient was provisionally discharged or another treatment facility, state-operated treatment program, or community-based treatment program that consents to receive the patient. The court may order the patient returned to a facility or program prior to a review hearing only upon finding that immediate return is necessary because there is a serious likelihood that the safety of the patient or others will be jeopardized, in that (1) the patient's need for food, clothing, shelter, or medical care is not being met, or will not be met in the near future, or (2) the patient has attempted or threatened to seriously harm self or others. If a voluntary return is not arranged, the head of the treatment facility, state-operated treatment program, or community-based treatment program may request a health officer or a peace officer to return the patient to the facility or program from which the patient was released or to any other treatment facility, state-operated treatment program, or community-based treatment program that consents to receive the patient. If necessary, the head of the treatment facility, state-operated treatment program, or community-based treatment program may request the committing court to direct a health officer or peace officer in the county where the patient is located to return the patient to the facility or program or to another treatment facility, state-operated treatment program, or community-based treatment program that consents to receive the patient. The expense of returning the patient to a state-operated treatment program shall be paid by the executive board unless paid by the patient or the patient's relatives. If the court orders the patient to return to the facility or program, or if a health officer or peace officer returns the patient to the facility or program, and the patient wants judicial review of the revocation, the patient or the patient's attorney must file the petition for review and affidavit required under subdivision 3b within 14 days of receipt of the notice of the intent to revoke.

Subd. 6. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 7. **Modification and extension of provisional discharge.** (a) A provisional discharge may be modified upon agreement of the parties.

(b) A provisional discharge may be extended only in those circumstances where the patient has not achieved the goals set forth in the provisional discharge plan or continues to need the supervision or assistance provided by an extension of the provisional discharge. In determining whether the provisional discharge is to be extended, the designated agency shall consider the willingness and ability of the patient to voluntarily obtain needed care and treatment.

(c) The designated agency must provide any proposed extension in writing to the patient and the patient's attorney at least 30 days prior to the expiration of the provisional discharge unless the patient cannot be located or is unavailable to receive the notice. The proposal for extension shall include: the specific grounds for proposing the extension, the anniversary date of the provisional discharge, the termination date of the provisional discharge, and the proposed length of extension. If the grounds for proposing the extension occur less than 30 days before its expiration, the designated agency must submit the written proposal for extension as soon as practicable.

(d) The designated agency shall extend a provisional discharge only after providing the patient an opportunity for a meeting to object or make suggestions for alternatives to an extension. The designated agency shall provide a written decision to the patient and the patient's attorney regarding extension within five days after receiving the patient's input or after holding a meeting with the patient or after the patient has declined to provide input or participate in the meeting. The designated agency may seek input from the community-based treatment team or other persons the patient chooses.

Subd. 8. **Effect of extension.** No provisional discharge, revocation, or extension shall extend the term of the commitment beyond the period provided for in the commitment order.

Subd. 8a. **Provisional discharge extension.** If the provisional discharge extends until the end of the period of commitment and, before the commitment expires, the court extends the commitment under section 253B.12 or issues a new commitment order under section 253B.13, the provisional discharge shall continue for the duration of the new or extended period of commitment ordered unless the commitment order provides otherwise or the designated agency revokes the patient's provisional discharge pursuant to this section. To continue the patient's provisional discharge under this subdivision, the designated agency is not required to comply with the procedures in subdivision 7.

Subd. 9. **Expiration of provisional discharge.** (a) Except as otherwise provided, a provisional discharge is absolute when it expires. If, while on provisional discharge or extended provisional discharge, a patient is discharged as provided in section 253B.16, the discharge shall be absolute.

(b) The designated agency shall give notice of the expiration of the provisional discharge to the committing court; the petitioner, if known; the patient's attorney; the county attorney in the county of commitment; and the facility or program that provisionally discharged the patient.

Subd. 10. **Voluntary return.** (a) With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return to inpatient status as follows:

(1) as a voluntary patient, in which case the patient's commitment is discharged;

(2) as a committed patient, in which case the patient's provisional discharge is voluntarily revoked; or

(3) on temporary return from provisional discharge, in which case both the commitment and the provisional discharge remain in effect.

(b) Prior to readmission, the patient shall be informed of status upon readmission.

Subd. 11. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

History: *1982 c 581 s 15; 1983 c 251 s 16-18; 1986 c 444; 1988 c 623 s 9-14; 1997 c 217 art 1 s 74-82; 1998 c 313 s 14-19; 2002 c 221 s 26; 2010 c 300 s 23; 1Sp2020 c 2 art 6 s 68-79; 2024 c 79 art 10 s 3*

253B.16 DISCHARGE OF COMMITTED PERSONS.

Subdivision 1. **Date.** The head of a treatment facility, state-operated treatment program, or community-based treatment program shall discharge any patient admitted as a person who poses a risk of harm due to mental illness, or a person who has a chemical dependency or a developmental disability when the head of the facility or program certifies that the person is no longer in need of care and treatment under commitment or at the conclusion of any period of time specified in the commitment order, whichever occurs first. The head of a facility or program shall discharge any person admitted as a person with a developmental disability when that person's screening team has determined, under section 256B.092, subdivision 8, that the person's needs can be met by services provided in the community and a plan has been developed in consultation with the interdisciplinary team to place the person in the available community services.

Subd. 2. **Notification of discharge.** Prior to the discharge or provisional discharge of any committed patient, the head of the treatment facility, state-operated treatment program, or community-based treatment program shall notify the designated agency and the patient's spouse or health care agent, or if there is no spouse or health care agent, then an adult child, or if there is none, the next of kin of the patient, of the proposed discharge. The facility or program shall send the notice in writing and shall include the following: (1) the proposed date of discharge or provisional discharge; (2) the date, time and place of the meeting of the staff who have been treating the patient to discuss discharge and discharge planning; (3) the fact that the patient will be present at the meeting; and (4) the fact that the next of kin or health care agent may attend that staff meeting and present any information relevant to the discharge of the patient.

History: *1982 c 581 s 16; 1986 c 444; 1988 c 623 s 15; 1997 c 217 art 1 s 83; 2002 c 221 s 27; 2005 c 56 s 1; 2009 c 108 s 9; 1Sp2020 c 2 art 6 s 80*

253B.17 PETITIONS; JUDICIAL DETERMINATION.

Subdivision 1. **Petition for release from commitment.** Any patient, except one committed as a sexually dangerous person or a person with a sexual psychopathic personality or as a person who has a mental illness and is dangerous to the public as provided in section 253B.18, subdivision 3, or any interested person may petition the committing court or the court to which venue has been transferred for an order that the patient is not in need of continued care and treatment under commitment or for an order that an individual is no longer a person who poses a risk of harm due to mental illness, or a person who has a developmental disability or chemical dependency, or for any other relief.

Subd. 1a. **Petition for hearing concerning administration of neuroleptic medication.** A patient committed as a person who poses a risk of harm due to mental illness, a person who has a mental illness and is dangerous to the public, a sexually dangerous person, or a person with a sexual psychopathic personality may petition the committing court or the court to which venue has been transferred for a hearing concerning the administration of neuroleptic medication.

Subd. 2. **Notice of hearing.** Upon the filing of the petition, the court shall fix the time and place for the hearing on it. Ten days' notice of the hearing shall be given to the county attorney, the patient, patient's counsel, the person who filed the initial commitment petition, the head of the facility or program to which the person is committed, and other persons as the court directs. Any person may oppose the petition.

Subd. 3. **Court examiners.** The court shall appoint a court examiner and, at the patient's request, shall appoint a second court examiner of the patient's choosing to be paid for by the county at a rate of compensation to be fixed by the court. Unless otherwise agreed by the parties, a court examiner shall file a report with the court not less than 48 hours prior to the hearing under this section.

Subd. 4. **Evidence.** The patient, patient's counsel, the petitioner, and the county attorney shall be entitled to be present at the hearing and to present and cross-examine witnesses, including court examiners. The court may hear any relevant testimony and evidence offered at the hearing.

Subd. 5. **Order.** Upon completion of the hearing, the court shall enter an order stating its findings and decision and mail the order to the head of the treatment facility, state-operated treatment program, or community-based treatment program.

History: *1982 c 581 s 17; 1986 c 444; 1988 c 689 art 2 s 120; 1990 c 568 art 5 s 32; 1995 c 189 s 7; 1997 c 217 art 1 s 84,85; 1999 c 118 s 2; 2002 c 221 s 28; 2005 c 56 s 1; 2013 c 49 s 6; 1Sp2020 c 2 art 6 s 81; 2024 c 79 art 5 s 9,10*

253B.18 PERSONS WHO ARE MENTALLY ILL AND DANGEROUS TO THE PUBLIC.

Subdivision 1. **Procedure.** (a) Upon the filing of a petition alleging that a proposed patient is a person who has a mental illness and is dangerous to the public, the court shall hear the petition as provided in sections 253B.07 and 253B.08. If the court finds by clear and convincing evidence that the proposed patient is a person who has a mental illness and is dangerous to the public, it shall commit the person to a secure treatment facility or to a treatment facility or state-operated treatment program willing to accept the patient under commitment. The court shall commit the patient to a secure treatment facility unless the patient or others establish by clear and convincing evidence that a less restrictive state-operated treatment program or treatment facility is available that is consistent with the patient's treatment needs and the requirements of public safety. In any case where the petition was filed immediately following the acquittal of the proposed patient for a crime against the person pursuant to a verdict of not guilty by reason of mental illness, the verdict constitutes evidence that the proposed patient is a person who has a mental illness and is dangerous to the public within the meaning of this section. The proposed patient has the burden of going forward in the presentation of evidence. The standard of proof remains as required by this chapter. Upon commitment, admission procedures shall be carried out pursuant to section 253B.10.

(b) Once a patient is admitted to a treatment facility or state-operated treatment program pursuant to a commitment under this subdivision, treatment must begin regardless of whether a review hearing will be held under subdivision 2.

Subd. 2. **Review; hearing.** (a) A written treatment report shall be filed by the treatment facility or state-operated treatment program with the committing court within 60 days after commitment. If the person is in the custody of the commissioner of corrections when the initial commitment is ordered under subdivision 1, the written treatment report must be filed within 60 days after the person is admitted to the state-operated treatment program or treatment facility. The court shall hold a hearing to make a final determination as to whether the patient should remain committed as a person who has a mental illness and is dangerous to the public. The hearing shall be held within the earlier of 14 days of the court's receipt of the written treatment report, or within 90 days of the date of initial commitment or admission, unless otherwise agreed by the parties.

(b) The court may, with agreement of the county attorney and the patient's attorney:

(1) waive the review hearing under this subdivision and immediately order an indeterminate commitment under subdivision 3; or

(2) continue the review hearing for up to one year.

(c) If the court finds that the patient should be committed as a person who poses a risk of harm due to mental illness, but not as a person who has a mental illness and is dangerous to the public, the court may

commit the patient as a person who poses a risk of harm due to mental illness and the court shall deem the patient not to be dangerous to the public for the purposes of subdivisions 4a to 15. Failure of the treatment facility or state-operated treatment program to provide the required treatment report at the end of the 60-day period shall not result in automatic discharge of the patient.

Subd. 3. **Indeterminate commitment.** If the court finds at the final determination hearing held pursuant to subdivision 2 that the patient continues to be a person who has a mental illness and is dangerous to the public, then the court shall order commitment of the proposed patient for an indeterminate period of time. After a final determination that a patient is a person who has a mental illness and is dangerous to the public, the patient shall be transferred, provisionally discharged or discharged, only as provided in this section.

Subd. 4. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 4a. **Release on pass; notification.** A patient who has been committed as a person who has a mental illness and is dangerous to the public and who is confined at a secure treatment facility or has been transferred out of a secure treatment facility according to section 253B.18, subdivision 6, shall not be released on a pass unless the pass is part of a pass plan that has been approved by the medical director of the secure treatment facility. The pass plan must have a specific therapeutic purpose consistent with the treatment plan, must be established for a specific period of time, and must have specific levels of liberty delineated. The county case manager must be invited to participate in the development of the pass plan. At least ten days prior to a determination on the plan, the medical director of the secure treatment facility shall notify the designated agency, the committing court, the county attorney of the county of commitment, an interested person, the local law enforcement agency where the facility is located, the county attorney and the local law enforcement agency in the location where the pass is to occur, the petitioner, and the petitioner's counsel of the plan, the nature of the passes proposed, and their right to object to the plan. If any notified person objects prior to the proposed date of implementation, the person shall have an opportunity to appear, personally or in writing, before the medical director of the secure treatment facility, within ten days of the objection, to present grounds for opposing the plan. The pass plan shall not be implemented until the objecting person has been furnished that opportunity. Nothing in this subdivision shall be construed to give a patient an affirmative right to a pass plan.

Subd. 4b. **Pass-eligible status; notification.** (a) The following patients committed to a secure treatment facility shall not be placed on pass-eligible status unless that status has been approved by the medical director of the secure treatment facility:

(1) a patient who has been committed as a person who has a mental illness and is dangerous to the public and who:

(i) was found incompetent to proceed to trial for a felony or was found not guilty by reason of mental illness of a felony immediately prior to the filing of the commitment petition;

(ii) was convicted of a felony immediately prior to or during commitment as a person who has a mental illness and is dangerous to the public; or

(iii) is subject to a commitment to the commissioner of corrections; and

(2) a patient who has been committed as a psychopathic personality, a sexually psychopathic personality, or a sexually dangerous person.

(b) At least ten days prior to a determination on the status, the medical director of the secure treatment facility shall notify the committing court, the county attorney of the county of commitment, the designated agency, an interested person, the petitioner, and the petitioner's counsel of the proposed status, and their

right to request review by the special review board. If within ten days of receiving notice any notified person requests review by filing a notice of objection with the executive board and the head of the secure treatment facility, a hearing shall be held before the special review board. The proposed status shall not be implemented unless it receives a favorable recommendation by a majority of the special review board and approval by the executive board. The order of the executive board is appealable as provided in section 253B.19.

(c) Nothing in this subdivision shall be construed to give a patient an affirmative right to seek pass-eligible status from the special review board.

Subd. 4c. **Special review board.** (a) The executive board shall establish one or more panels of a special review board. The special review board shall consist of three members experienced in the field of mental illness. One member of each special review board panel shall be a psychiatrist or a doctoral level psychologist with forensic experience and one member shall be an attorney. No member shall be affiliated with Direct Care and Treatment. The special review board shall meet at least every six months and at the call of the executive board. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. Patients may be transferred by the executive board between secure treatment facilities without a special review board hearing.

Members of the special review board shall receive compensation and reimbursement for expenses as established by the executive board.

(b) For purposes of this section, "reduction in custody" means transfer from a secure treatment facility, discharge, and provisional discharge.

(c) The special review board must review each denied petition under subdivision 5 for barriers and obstacles preventing the patient from progressing in treatment. Based on the cases before the special review board in the previous year, the special review board shall provide to the executive board an annual summation of the barriers to treatment progress, and recommendations to achieve the common goal of making progress in treatment.

(d) A petition filed by a person committed as a person who has a mental illness and is dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253D, or committed as both a person who has a mental illness and is dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253D.27.

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for a reduction in custody or revocation of provisional discharge shall be filed with the executive board and may be filed by the patient or by the head of the treatment facility or state-operated treatment program to which the person was committed or has been transferred. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The head of the state-operated treatment program or head of the treatment facility must schedule a hearing before the special review board for any patient who has not appeared before the special review board in the previous three years, and schedule a hearing at least every three years thereafter. The medical director of the secure treatment facility may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the executive board of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may

be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the executive board at least 21 days before the hearing. The special review board shall provide the executive board with written findings of fact and recommendations within 21 days of the hearing. The executive board shall issue an order no later than 14 days after receiving the recommendation of the special review board. A copy of the order shall be mailed to every person entitled to statutory notice of the hearing within five days after the order is signed. No order by the executive board shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the executive board agree that it may become effective sooner.

(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the executive board. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the executive board.

(d) Prior to the final decision by the executive board, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and executive board must consider any statements received from victims under subdivision 5a.

Subd. 5a. **Victim notification of petition and release; right to submit statement.** (a) As used in this subdivision:

(1) "crime" has the meaning given to "violent crime" in section 609.1095, and includes criminal sexual conduct in the fifth degree and offenses within the definition of "crime against the person" in section 253B.02, subdivision 4e, and also includes offenses listed in section 253D.02, subdivision 8, paragraph (b), regardless of whether they are sexually motivated;

(2) "victim" means a person who has incurred loss or harm as a result of a crime the behavior for which forms the basis for a commitment under this section or chapter 253D, and includes the family members, guardian, conservator, or custodian of a minor, incompetent, incapacitated, or deceased person; and

(3) "convicted" and "conviction" have the meanings given in section 609.02, subdivision 5, and also include juvenile court adjudications, findings under Minnesota Rules of Criminal Procedure, rule 20.02, that the elements of a crime have been proved, and findings in commitment cases under this section or chapter 253D that an act or acts constituting a crime occurred or were part of their course of harmful sexual conduct.

(b) A county attorney who files a petition to commit a person under this section or chapter 253D shall make a reasonable effort to provide prompt notice of filing the petition to any victim of a crime for which the person was convicted. In addition, the county attorney shall make a reasonable effort to promptly notify the victim of the resolution of the petition and the process for requesting notification of an individual's change in status as provided in paragraph (c).

(c) A victim may request notification of an individual's discharge or release as provided in paragraph (d) by submitting a written request for notification to the executive director of the facility in which the individual is confined. The Department of Corrections or a county attorney who receives a request for notification from a victim under this section shall promptly forward the request to the executive director of the treatment facility in which the individual is confined.

(d) Before provisionally discharging, discharging, granting pass-eligible status, approving a pass plan, or otherwise permanently or temporarily releasing a person committed under this section from a state-operated treatment program or treatment facility, the head of the state-operated treatment program or head of the treatment facility shall make a reasonable effort to notify any victim of a crime for which the person was convicted that the person may be discharged or released and that the victim has a right to submit a written statement regarding decisions of the medical director of the secure treatment facility, special review board, or executive board with respect to the person. To the extent possible, the notice must be provided at least 14 days before any special review board hearing or before a determination on a pass plan. Notwithstanding section 611A.06, subdivision 4, the executive board shall provide the judicial appeal panel with victim information in order to comply with the provisions of this section. The judicial appeal panel shall ensure that the data on victims remains private as provided for in section 611A.06, subdivision 4. These notices shall only be provided to victims who have submitted a written request for notification as provided in paragraph (c).

(e) The rights under this subdivision are in addition to rights available to a victim under chapter 611A. This provision does not give a victim all the rights of a "notified person" or a person "entitled to statutory notice" under subdivision 4a, 4b, or 5 or section 253D.14.

Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be transferred out of a secure treatment facility unless it appears to the satisfaction of the executive board, after a hearing and favorable recommendation by a majority of the special review board, that the transfer is appropriate. Transfer may be to another state-operated treatment program. In those instances where a commitment also exists to the Department of Corrections, transfer may be to a facility designated by the commissioner of corrections.

(b) The following factors must be considered in determining whether a transfer is appropriate:

(1) the person's clinical progress and present treatment needs;

(2) the need for security to accomplish continuing treatment;

(3) the need for continued institutionalization;

(4) which facility can best meet the person's needs; and

(5) whether transfer can be accomplished with a reasonable degree of safety for the public.

(c) If a committed person has been transferred out of a secure treatment facility pursuant to this subdivision, that committed person may voluntarily return to a secure treatment facility with the consent of the head of the treatment facility for a period of up to:

(1) 90 days if due to a psychiatric medical condition; or

(2) six months if due to a nonpsychiatric medical condition.

(d) If the committed person is not returned to the original, nonsecure transfer facility within 90 days of being readmitted to a secure treatment facility if due to a psychiatric medical condition or within six months of being readmitted to a secure treatment facility if due to a nonpsychiatric medical condition, the transfer is revoked and the committed person must remain in a secure treatment facility. The committed person must immediately be notified in writing of the revocation.

(e) Within 15 days of receiving notice of the revocation, the committed person may petition the special review board for a review of the revocation. The special review board shall review the circumstances of the

revocation and shall recommend to the executive board whether or not the revocation should be upheld. The special review board may also recommend a new transfer at the time of the revocation hearing.

(f) No action by the special review board is required if the transfer has not been revoked and the committed person is returned to the original, nonsecure transfer facility with no substantive change to the conditions of the transfer ordered under this subdivision.

(g) The head of the treatment facility may revoke a transfer made under this subdivision and require a committed person to return to a secure treatment facility if:

(1) remaining in a nonsecure setting does not provide a reasonable degree of safety to the committed person or others; or

(2) the committed person has regressed clinically and the facility to which the committed person was transferred does not meet the committed person's needs.

(h) Upon the revocation of the transfer, the committed person must be immediately returned to a secure treatment facility. A report documenting the reasons for revocation must be issued by the head of the treatment facility within seven days after the committed person is returned to the secure treatment facility. Advance notice to the committed person of the revocation is not required.

(i) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report must be served upon the committed person, the committed person's counsel, and the designated agency. The report must outline the specific reasons for the revocation, including but not limited to the specific facts upon which the revocation is based.

(j) If a committed person's transfer is revoked, the committed person may re-petition for transfer according to subdivision 5.

(k) A committed person aggrieved by a transfer revocation decision may petition the special review board within seven business days after receipt of the revocation report for a review of the revocation. The matter must be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and, after considering the factors in paragraph (b), shall recommend to the executive board whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure treatment facility at the time of the revocation hearing.

Subd. 7. **Provisional discharge.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be provisionally discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board, that the patient is capable of making an acceptable adjustment to open society.

(b) The following factors are to be considered in determining whether a provisional discharge shall be recommended: (1) whether the patient's course of hospitalization and present mental status indicate there is no longer a need for treatment and supervision in the patient's current treatment setting; and (2) whether the conditions of the provisional discharge plan will provide a reasonable degree of protection to the public and will enable the patient to adjust successfully to the community.

Subd. 8. **Provisional discharge plan.** A provisional discharge plan shall be developed, implemented, and monitored by the designated agency in conjunction with the patient, the treatment facility or state-operated treatment program to which the person is committed, and other appropriate persons. The designated agency shall, at least quarterly, review the provisional discharge plan with the patient and submit a written report

to the facility or program concerning the patient's status and compliance with each term of the provisional discharge plan.

Subd. 9. **Provisional discharge; review.** A provisional discharge pursuant to this section shall not automatically terminate. A full discharge shall occur only as provided in subdivision 15. The executive board shall notify the patient that the terms of a provisional discharge continue unless the patient requests and is granted a change in the conditions of provisional discharge or unless the patient petitions the special review board for a full discharge and the discharge is granted.

Subd. 10. **Provisional discharge; revocation.** (a) The head of the treatment facility or state-operated treatment program from which the person was provisionally discharged may revoke a provisional discharge if any of the following grounds exist:

(i) the patient has departed from the conditions of the provisional discharge plan;

(ii) the patient is exhibiting signs of a mental illness which may require in-hospital evaluation or treatment; or

(iii) the patient is exhibiting behavior which may be dangerous to self or others.

(b) Revocation shall be commenced by a notice of intent to revoke provisional discharge, which shall be served upon the patient, patient's counsel, and the designated agency. The notice shall set forth the grounds upon which the intention to revoke is based, and shall inform the patient of the rights of a patient under this chapter.

(c) In all nonemergency situations, prior to revoking a provisional discharge, the head of the facility or program shall obtain a revocation report from the designated agency outlining the specific reasons for recommending the revocation, including but not limited to the specific facts upon which the revocation recommendation is based.

(d) The patient must be provided a copy of the revocation report and informed orally and in writing of the rights of a patient under this section.

Subd. 11. **Exceptions.** If an emergency exists, the head of the treatment facility or state-operated treatment program may revoke the provisional discharge and, either orally or in writing, order that the patient be immediately returned to the facility or program. In emergency cases, a revocation report shall be submitted by the designated agency within seven days after the patient is returned to the facility or program.

Subd. 12. **Return of patient.** After revocation of a provisional discharge or if the patient is absent without authorization, the head of the treatment facility or state-operated treatment program may request the patient to return to the facility or program voluntarily. The head of the treatment facility or state-operated treatment program may request a health officer or a peace officer to return the patient to the facility or program. If a voluntary return is not arranged, the head of the treatment facility or state-operated treatment program shall inform the committing court of the revocation or absence and the court shall direct a health or peace officer in the county where the patient is located to return the patient to the facility or program or to another state-operated treatment program or to another treatment facility willing to accept the patient. The expense of returning the patient to a state-operated treatment program shall be paid by the executive board unless paid by the patient or other persons on the patient's behalf.

Subd. 13. **Appeal.** Any patient aggrieved by a revocation decision or any interested person may petition the special review board within seven days, exclusive of Saturdays, Sundays, and legal holidays, after receipt of the revocation report for a review of the revocation. The special review board shall schedule the matter

within 30 days. The special review board shall review the circumstances leading to the revocation and shall recommend to the executive board whether or not the revocation shall be upheld. The special review board may also recommend a new provisional discharge at the time of a revocation hearing.

Subd. 14. **Voluntary readmission.** (a) With the consent of the head of the treatment facility or state-operated treatment program, a patient may voluntarily return from provisional discharge with the consent of the designated agency for a period of up to:

(1) 30 days;

(2) 90 days if due to a psychiatric medical condition; or

(3) six months if due to a nonpsychiatric medical condition.

(b) If the patient is not returned to provisional discharge status within 90 days of being readmitted if due to a psychiatric medical condition or within six months of being readmitted if due to a nonpsychiatric medical condition, the provisional discharge is revoked. Within 15 days of receiving notice of the change in status, the patient may request a review of the matter before the special review board. The special review board may recommend a return to a provisional discharge status.

(c) The treatment facility or state-operated treatment program is not required to petition for a further review by the special review board unless the patient's return to the community results in substantive change to the existing provisional discharge plan. All the terms and conditions of the provisional discharge order shall remain unchanged if the patient is released again.

Subd. 15. **Discharge.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be discharged unless it appears to the satisfaction of the executive board, after a hearing and a favorable recommendation by a majority of the special review board, that the patient is capable of making an acceptable adjustment to open society, is no longer dangerous to the public, and is no longer in need of treatment and supervision.

(b) In determining whether a discharge shall be recommended, the special review board and executive board shall consider whether specific conditions exist to provide a reasonable degree of protection to the public and to assist the patient in adjusting to the community. If the desired conditions do not exist, the discharge shall not be granted.

History: *1982 c 581 s 18; 1983 c 216 art 1 s 83; 1983 c 251 s 19-22; 1983 c 348 s 11; 1984 c 623 s 6,7; 1984 c 654 art 5 s 58; 1986 c 444; 1991 c 148 s 3,4; 1992 c 571 art 3 s 4; 1997 c 217 art 1 s 86-99; 1998 c 313 s 20,21; 1999 c 118 s 3-5; 2000 c 260 s 97; 2002 c 221 s 29-36; 2005 c 136 art 3 s 19,20; art 5 s 3; 2008 c 326 art 2 s 7-9; 2010 c 300 s 24,25; 2012 c 155 s 6; 2013 c 49 s 22; 2013 c 59 art 1 s 1; 2015 c 71 art 2 s 18,19; 2016 c 158 art 1 s 103; 2018 c 194 s 1; 1Sp2020 c 2 art 6 s 82-97,123; 1Sp2021 c 11 art 6 s 1; 2022 c 98 art 10 s 1; 2024 c 79 art 5 s 11-17; art 10 s 3; 2024 c 123 art 2 s 3; 2024 c 125 art 5 s 43; 2024 c 127 art 50 s 43; 2025 c 38 art 3 s 44; 2026 c 95 art 1 s 14,15*

253B.185 Subdivision 1. MS 2012 [Paragraph (a) renumbered 253D.07, subdivision 1]

[Paragraph (b) renumbered 253D.07, subd 2]

[Paragraph (c) renumbered 253D.07, subd 3]

[Paragraph (d) renumbered 253D.07, subd 4]

Subd. 1a. MS 2012 [Renumbered 253D.10, subdivision 1]

Subd. 1b. MS 2012 [Renumbered 253D.08]

Subd. 2. MS 2012 [Renumbered 253D.22]

Subd. 3. MS 2012 [Renumbered 253D.07, subd 5]

Subd. 4. MS 2012 [Paragraph (a) renumbered 253D.11, subdivision 1]

[Paragraph (b) renumbered 253D.11, subd 2]

Subd. 5. MS 2012 [Paragraph (a) renumbered 253D.12, subdivision 1]

[Paragraph (b) renumbered 253D.12, subd 2]

[Paragraph (c) renumbered 253D.12, subd 3]

[Paragraph (d) renumbered 253D.12, subd 4]

Subd. 6. MS 2008 [Repealed by amendment, 2010 c 300 s 26]

Subd. 7. MS 2012 [Paragraph (a) renumbered 253D.19, subdivision 1]

[Paragraph (b) renumbered 253D.19, subd 2]

Subd. 8. MS 2012 [Renumbered 253D.09]

Subd. 9. MS 2012 [Paragraph (a) renumbered 253D.27, subdivision 1, para (a)]

[Paragraph (b) renumbered 253D.27, subdivision 1, para (b)]

[Paragraph (c) renumbered 253D.27, subd 2]

[Paragraph (d) renumbered 253D.27, subd 3, para (a)]

[Paragraph (e) renumbered 253D.27, subd 3, para (b)]

[Paragraph (f) renumbered 253D.27, subd 4]

Subd. 10. MS 2012 [Paragraph (a) renumbered 253D.14, subdivision 1]

[Paragraph (b) renumbered 253D.14, subd 2]

[Paragraph (c) renumbered 253D.14, subd 3]

[Paragraph (d) renumbered 253D.14, subd 4]

[Paragraph (e) renumbered 253D.14, subd 5]

Subd. 10a. MS 2012 [Paragraph (a) renumbered 253D.32, subdivision 1]

[Paragraph (b) renumbered 253D.32, subd 2, para (a)]

[Paragraph (c) renumbered 253D.32, subd 2, para (b)]

[Paragraph (d) renumbered 253D.32, subd 2, para (c)]

[Paragraph (e) renumbered 253D.32, subd 2, para (d)]

[Paragraph (f) renumbered 253D.32, subd 3]

Subd. 11. MS 2012 [Renumbered 253D.29, subdivision 1]

Subd. 11a. MS 2012 [Renumbered 253D.29, subd 2]

Subd. 11b. MS 2012 [Renumbered 253D.29, subd 3]

Subd. 12. MS 2012 [Renumbered 253D.30, subdivision 1]

Subd. 13. MS 2012 [Renumbered 253D.30, subd 2]

Subd. 14. MS 2012 [Renumbered 253D.30, subd 3]

Subd. 14a. MS 2012 [Renumbered 253D.30, subd 4]

Subd. 15. MS 2012 [Renumbered 253D.30, subd 5]

Subd. 16. MS 2012 [Paragraph (a) renumbered 253D.24, subdivision 1]

[Paragraph (b) renumbered 253D.24, subd 2]

[Paragraph (c) renumbered 253D.24, subd 3]

[Paragraph (d) renumbered 253D.24, subd 4]

[Paragraph (e) renumbered 253D.24, subd 5]

[Paragraph (f) renumbered 253D.24, subd 6]

[Paragraph (g) renumbered 253D.24, subd 7]

[Paragraph (h) renumbered 253D.24, subd 8]

Subd. 17. MS 2012 [Renumbered 253D.30, subd 6]

Subd. 18. MS 2012 [Renumbered 253D.31]

Subd. 19. MS 2012 [Paragraph (a) renumbered 253D.35, subdivision 1]

[Paragraph (b) renumbered 253D.35, subd 2]

253B.19 JUDICIAL APPEAL PANEL; PATIENTS WHO ARE MENTALLY ILL AND DANGEROUS TO THE PUBLIC.

Subdivision 1. **Creation.** The supreme court shall establish an appeal panel composed of three judges and four alternate judges appointed from among the acting judges of the state. Panel members shall serve for terms of one year each. Only three judges need hear any case. One of the regular three appointed judges shall be designated as the chief judge of the appeal panel. The chief judge is vested with power to fix the time and place of all hearings before the panel, issue all notices, subpoena witnesses, appoint counsel for the patient, if necessary, and supervise and direct the operation of the appeal panel. The chief judge shall designate one of the other judges or an alternate judge to act as chief judge in any case where the chief judge is unable to act. No member of the appeal panel shall take part in the consideration of any case in which that judge committed the patient. The chief justice of the supreme court shall determine the compensation of the judges serving on the appeal panel. The compensation shall be in addition to their regular compensation as judges. All compensation and expenses of the appeal panel and all allowable fees and costs of the patient's counsel shall be established and paid by the executive board.

Subd. 2. **Petition; hearing.** (a) A patient committed as a person who has a mental illness and is dangerous to the public under section 253B.18, or the county attorney of the county from which the patient was committed or the county of financial responsibility, may petition the judicial appeal panel for a rehearing and reconsideration of a decision by the executive board under section 253B.18, subdivision 5. The judicial appeal panel must not consider petitions for relief other than those considered by the executive board from which the appeal is taken. The petition must be filed with the supreme court within 30 days after the decision of the executive board is signed. The hearing must be held within 45 days of the filing of the petition unless an extension is granted for good cause.

(b) For an appeal under paragraph (a), the supreme court shall refer the petition to the chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county attorney of the county of commitment, the designated agency, the executive board, the head of the facility or program to which the patient was committed, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing.

(c) Any person may oppose the petition. The patient, the patient's counsel, the county attorney of the committing county or the county of financial responsibility, and the executive board shall participate as parties to the proceeding pending before the judicial appeal panel and shall, except when the patient is committed solely as a person who has a mental illness and is dangerous to the public, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of their position. The judicial appeal panel may appoint court examiners and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all proceedings. The patient, the patient's counsel, and the county attorney of the committing county or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions. The petitioning party seeking discharge or provisional discharge bears the burden of going forward with the evidence, which means presenting a prima facie case with competent evidence to show that the person is entitled to the requested relief. If the petitioning party has met this burden, the party opposing discharge or provisional discharge bears the burden of proof by clear and convincing evidence that the discharge or provisional discharge should be denied. A party seeking transfer under section 253B.18, subdivision 6, must establish by a preponderance of the evidence that the transfer is appropriate.

Subd. 3. **Decision.** A majority of the judicial appeal panel shall rule upon the petition. The panel shall consider the petition de novo. The order of the judicial appeal panel shall supersede an order of the executive board under section 253B.18, subdivision 5. No order of the judicial appeal panel granting a transfer, discharge or provisional discharge shall be made effective sooner than 15 days after it is issued. The panel may not consider petitions for relief other than those considered by the executive board or special review board from which the appeal is taken. The judicial appeal panel may not grant a transfer or provisional discharge on terms or conditions that were not presented to the executive board or the special review board.

Subd. 4. **Effect of petition.** The filing of a petition shall immediately suspend the operation of any order for transfer, discharge or provisional discharge of the patient. The patient shall not be discharged in any manner except upon order of a majority of the appeal panel.

Subd. 5. **Appeal.** A party aggrieved by an order of the appeal panel may appeal from the decision of the appeal panel to the court of appeals as in other civil cases. A party may seek review of a decision by the appeals panel within 60 days after a copy is sent to the parties by the clerk of appellate courts. The filing of

an appeal shall immediately suspend the operation of any order granting transfer, discharge or provisional discharge, pending the determination of the appeal.

History: *1982 c 581 s 19; 1983 c 216 art 1 s 37; 1983 c 247 s 106; 1983 c 251 s 23; 1983 c 348 s 12; 1984 c 654 art 5 s 58; 1986 c 444; 1987 c 377 s 4; 1991 c 148 s 5; 1994 c 636 art 8 s 2; 1997 c 217 art 1 s 101-104; 1998 c 313 s 23; 2002 c 221 s 38; 2008 c 326 art 2 s 13,14; 2010 c 300 s 27; 2011 c 102 art 5 s 1; 2013 c 49 s 8; 1Sp2020 c 2 art 6 s 98; 2024 c 79 art 5 s 18; art 10 s 3; 2025 c 38 art 3 s 45*

253B.20 DISCHARGE; ADMINISTRATIVE PROCEDURE.

Subdivision 1. **Notice to court.** When a committed person is discharged, provisionally discharged, or transferred to another treatment facility, state-operated treatment program, or community-based treatment program, or when the patient dies, is absent without authorization, or is returned, the treatment facility, state-operated treatment program, or community-based treatment program having custody of the patient shall notify the committing court, the county attorney, and the patient's attorney.

Subd. 2. **Necessities.** (a) The state-operated treatment program shall make necessary arrangements at the expense of the state to insure that no patient is discharged or provisionally discharged without suitable clothing. The head of the state-operated treatment program shall, if necessary, provide the patient with a sufficient sum of money to secure transportation home, or to another destination of the patient's choice, if the destination is located within a reasonable distance of the state-operated treatment program.

(b) The commissioner shall establish procedures by rule to help the patient receive all public assistance benefits provided by state or federal law to which the patient is entitled by residence and circumstances. The rule shall be uniformly applied in all counties. All counties shall provide temporary relief whenever necessary to meet the intent of this subdivision.

(c) The commissioner and the executive board may adopt joint rules necessary to accomplish the requirements under paragraph (b).

Subd. 3. **Notice to designated agency.** The head of the treatment facility, state-operated treatment program, or community-based treatment program, upon the provisional discharge of any committed person, shall notify the designated agency before the patient leaves the facility or program. Whenever possible the notice shall be given at least one week before the patient is to leave the facility or program.

Subd. 4. **Aftercare services.** Prior to the date of discharge or provisional discharge of any committed person, the designated agency of the county of financial responsibility, in cooperation with the head of the treatment facility, state-operated treatment program, or community-based treatment program, and the patient's mental health professional, if notified pursuant to subdivision 6, shall establish a continuing plan of aftercare services for the patient including a plan for medical and psychiatric treatment, nursing care, vocational assistance, and other assistance the patient needs. The designated agency shall provide case management services, supervise and assist the patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and aid in the patient's readjustment to the community.

Subd. 5. **Consultation.** In establishing the plan for aftercare services the designated agency shall consult with persons or agencies, including any public health nurse as defined in section 145A.02, subdivision 18, and vocational rehabilitation personnel, to insure adequate planning and periodic review for aftercare services.

Subd. 6. **Notice to mental health professional.** The head of the treatment facility, state-operated treatment program, or community-based treatment program shall notify the mental health professional of any committed person at the time of the patient's discharge or provisional discharge, unless the patient objects to the notice.

Subd. 7. MS 2018 [Repealed, 1Sp2020 c 2 art 6 s 124]

History: *1982 c 581 s 20; 1986 c 444; 1987 c 309 s 24; 1997 c 217 art 1 s 105-109; 2005 c 56 s 1; 2010 c 357 s 10; 1Sp2020 c 2 art 6 s 99-103; 2024 c 79 art 5 s 19*

253B.21 COMMITMENT TO AN AGENCY OF THE UNITED STATES.

Subdivision 1. **Administrative procedures.** If the patient is entitled to care by any agency of the United States in this state, the commitment warrant shall be in triplicate, committing the patient to the joint custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program and the federal agency. If the federal agency is unable or unwilling to receive the patient at the time of commitment, the patient may subsequently be transferred to it upon its request.

Subd. 2. **Applicable regulations.** Any person, when admitted to an institution of a federal agency within or without this state, shall be subject to the rules and regulations of the federal agency, except that nothing in this section shall deprive any person of rights secured to patients of state-operated treatment programs, treatment facilities, and community-based treatment programs by this chapter.

Subd. 3. **Powers.** The chief officer of any treatment facility operated by a federal agency to which any person is admitted shall have the same powers as the heads of state-operated treatment programs within this state with respect to admission, retention of custody, transfer, parole, or discharge of the committed person.

Subd. 4. **Foreign judgments.** The judgment or order of commitment by a court of competent jurisdiction of another state committing a person to a federal agency for care or treatment in this state, shall have the same force and effect as to the committed person while in this state as in the jurisdiction in which is situated the court entering the judgment or making the order. The committing state consents to the authority of the chief officer of any treatment facility of a federal agency in this state, to retain custody of, transfer, parole, or discharge the committed person.

Subd. 5. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

History: *1982 c 581 s 21; 1983 c 348 s 13; 1986 c 444; 1997 c 217 art 1 s 110; 1Sp2020 c 2 art 6 s 104-106*

253B.212 COMMITMENT; RED LAKE BAND OF CHIPPEWA INDIANS; WHITE EARTH BAND OF OJIBWE.

Subdivision 1. **Cost of care; commitment by Tribal court order; Red Lake Band of Chippewa Indians.** The Direct Care and Treatment executive board may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the Red Lake Band of Chippewa Indians who have been committed by Tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service may not transfer any person for admission to a state-operated treatment program unless the commitment procedure utilized by the Tribal court provided due process protections similar to those afforded by sections 253B.051 to 253B.10.

Subd. 1a. **Cost of care; commitment by Tribal court order; White Earth Band of Ojibwe Indians.** The Direct Care and Treatment executive board may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of the White Earth Band of Ojibwe Indians who have been committed by Tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The Tribe may also contract directly with the executive board for treatment of those members

of the White Earth Band who have been committed by Tribal court order to the White Earth Department of Health for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service and the White Earth Band shall not transfer any person for admission to a state-operated treatment program unless the commitment procedure utilized by the Tribal court provided due process protections similar to those afforded by sections 253B.051 to 253B.10.

Subd. 1b. **Cost of care; commitment by Tribal court order; any federally recognized Indian Tribe within the state of Minnesota.** The Direct Care and Treatment executive board may contract with and receive payment from the Indian Health Service of the United States Department of Health and Human Services for the care and treatment of those members of any federally recognized Indian Tribe within the state, who have been committed by Tribal court order to the Indian Health Service for care and treatment of mental illness, developmental disability, or chemical dependency. The Tribe may also contract directly with the executive board for treatment of those members of any federally recognized Indian Tribe within the state who have been committed by Tribal court order to the respective Tribal Department of Health for care and treatment of mental illness, developmental disability, or chemical dependency. The contract shall provide that the Indian Health Service and any federally recognized Indian Tribe within the state shall not transfer any person for admission to a state-operated treatment program unless the commitment procedure utilized by the Tribal court provided due process protections similar to those afforded by sections 253B.051 to 253B.10.

Subd. 2. **Effect given to Tribal commitment order.** (a) When, under an agreement entered into pursuant to subdivision 1, 1a, or 1b, the Indian Health Service or the placing Tribe applies to a state-operated treatment program for admission of a person committed to the jurisdiction of the health service by the Tribal court due to mental illness, developmental disability, or chemical dependency, the executive board may treat the patient with the consent of the Indian Health Service or the placing Tribe.

(b) A person admitted to a state-operated treatment program pursuant to this section has all the rights accorded by section 253B.03. In addition, treatment reports, prepared in accordance with the requirements of section 253B.12, subdivision 1, shall be filed with the Indian Health Service or the placing Tribe within 60 days of commencement of the patient's stay at the program. A subsequent treatment report shall be filed with the Indian Health Service or the placing Tribe within six months of the patient's admission to the program or prior to discharge, whichever comes first. Provisional discharge or transfer of the patient may be authorized by the head of the program only with the consent of the Indian Health Service or the placing Tribe. Discharge from the program to the Indian Health Service or the placing Tribe may be authorized by the head of the state-operated treatment program after notice to and consultation with the Indian Health Service or the placing Tribe.

History: *1983 c 251 s 24; 1984 c 654 art 5 s 58; 2002 c 221 s 39; 2005 c 56 s 1; 1Sp2011 c 9 art 8 s 2; 2015 c 78 art 3 s 1,2; 1Sp2020 c 2 art 6 s 107-110; 2024 c 79 art 5 s 20; art 10 s 3*

253B.22 REVIEW BOARDS.

Subdivision 1. **Establishment.** The executive board shall establish a review board of three or more persons for the Anoka-Metro Regional Treatment Center, Minnesota Security Hospital, and Minnesota Sex Offender Program to review the admission and retention of patients of that program receiving services under this chapter. One member shall be qualified in the diagnosis of mental illness, developmental disability, or chemical dependency, and one member shall be an attorney. The executive board may, upon written request from the appropriate federal authority, establish a review panel for any federal treatment facility within the state to review the admission and retention of patients hospitalized under this chapter. For any review board

established for a federal treatment facility, one of the persons appointed by the executive board shall be the commissioner of veterans affairs or the designee of the commissioner of veterans affairs.

Subd. 2. **Right to appear.** Each program specified in subdivision 1 shall be visited by the review board at least once every six months. Upon request each patient in the program shall have the right to appear before the review board during the visit.

Subd. 3. **Notice.** The head of each program specified in subdivision 1 shall notify each patient at the time of admission by a simple written statement of the patient's right to appear before the review board and the next date when the review board will visit that program. A request to appear before the review board need not be in writing. Any employee of the program receiving a patient's request to appear before the review board shall notify the head of the program of the request.

Subd. 4. **Review.** The review board shall review the admission and retention of patients at the program. The review board may examine the records of all patients admitted and may examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement in the program. The review board shall report its findings to the executive board and to the head of the program. The review board may also receive reports from patients, interested persons, and employees of the program, and investigate conditions affecting the care of patients.

Subd. 5. **Compensation.** Each member of the review board shall receive compensation and reimbursement as established by the executive board.

History: *1982 c 581 s 22; 1983 c 251 s 25; 1986 c 444; 1997 c 217 art 1 s 111; 2005 c 56 s 1; 1Sp2020 c 2 art 6 s 111-114; 2024 c 79 art 5 s 21-23; art 10 s 3*

253B.23 GENERAL PROVISIONS.

Subdivision 1. **Costs of hearings.** (a) In each proceeding under this chapter the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each examiner a reasonable sum for services and for travel; to persons conveying the patient to the place of detention, disbursements for the travel, board, and lodging of the patient and of themselves and their authorized assistants; and to the patient's counsel, when appointed by the court, a reasonable sum for travel and for the time spent in court or in preparing for the hearing. Upon the court's order, the county auditor shall issue a warrant on the county treasurer for payment of the amounts allowed, excluding the costs of the court examiner, which must be paid by the state courts.

(b) Whenever venue of a proceeding has been transferred under this chapter, the costs of the proceedings shall be reimbursed to the county where the proceedings were conducted by the county of financial responsibility.

Subd. 1a. MS 1996 [Repealed, 1997 c 217 art 1 s 118]

Subd. 1b. **Responsibility for conducting prepetition screening and filing commitment petitions.** (a) The county of financial responsibility is responsible to conduct prepetition screening pursuant to section 253B.07, subdivision 1, and, if statutory conditions for commitment are satisfied, to file a petition pursuant to section 253B.07, subdivision 2, paragraph (a), or 253D.07.

(b) Except in cases under chapter 253D, if the county of financial responsibility refuses or fails to conduct prepetition screening or file a petition, or if it is unclear which county is the county of financial responsibility, the county where the proposed patient is present is responsible to conduct the prepetition screening and, if statutory conditions for commitment are satisfied, file the petition.

(c) In cases under chapter 253D, if the county of financial responsibility refuses or fails to file a petition, or if it is unclear which county is the county of financial responsibility, then (1) the county where the conviction for which the person is incarcerated was entered, or (2) the county where the proposed patient is present, if the person is not currently incarcerated based on conviction, is responsible to file the petition if statutory conditions for commitment are satisfied.

(d) When a proposed patient is an inmate confined to an adult correctional facility under the control of the commissioner of corrections and commitment proceedings are initiated or proposed to be initiated pursuant to section 241.69, the county where the correctional facility is located may agree to perform the responsibilities specified in paragraph (a).

(e) Any dispute concerning financial responsibility for the costs of the proceedings and treatment will be resolved pursuant to chapter 256G.

(f) This subdivision and the sections of law cited in this subdivision address venue only. Nothing in this chapter is intended to limit the statewide jurisdiction of district courts over civil commitment matters.

Subd. 2. **Legal results of commitment status.** (a) Except as otherwise provided in this chapter and in sections 246.15 and 246.16, no person by reason of commitment or treatment pursuant to this chapter shall be deprived of any legal right, including but not limited to the right to dispose of property, sue and be sued, execute instruments, make purchases, enter into contractual relationships, vote, and hold a driver's license. Commitment or treatment of any patient pursuant to this chapter is not a judicial determination of legal incompetency except to the extent provided in section 253B.03, subdivision 6.

(b) Proceedings for determination of legal incompetency and the appointment of a guardian for a person subject to commitment under this chapter may be commenced before, during, or after commitment proceedings have been instituted and may be conducted jointly with the commitment proceedings. The court shall notify the head of the facility or program to which the patient is committed of a finding that the patient is incompetent.

(c) Where the person to be committed is a minor or owns property of value and it appears to the court that the person is not competent to manage a personal estate, the court shall appoint a general conservator of the person's estate as provided by law.

Subd. 3. **False reports.** Any person who willfully makes, joins in, or advises the making of any false petition or report, or knowingly or willfully makes any false representation for the purpose of causing the petition or report to be made or for the purpose of causing an individual to be improperly committed under this chapter, is guilty of a gross misdemeanor. The attorney general or the attorney general's designee shall prosecute violations of this section.

Subd. 3a. **Signatures on documents and statements under oath.** (a) Notwithstanding sections 358.07 to 358.09, written statements or documents made within this state in connection with proceedings under this chapter are deemed to be made under oath or affirmation without notarization if the person signing the document attests, at the end of the document, in substantially the following form:

"I declare under penalty of perjury under the laws of the state of Minnesota that the foregoing is true and correct.

Executed on .....(date) in the county of .....(county name) in the state of Minnesota.

.....(signature)

.....(signer's address and telephone number)."

A document that is sworn to or affirmed under this paragraph without notarization must include a telephone number and address where the signer can be contacted.

(b) If a document is required to be signed in order to be effective, an electronic document qualifies as a signed document:

(1) without the person's physical signature, if an entity has an electronic signature system that meets a minimum security standard of two-factor authentication, such as name and password, or biometric identification that is uniquely reconcilable to a single actor and that results in a nonmodifiable document after the electronic signature is affixed, and the document indicates an electronic signature in some manner, such as "s/.....(name of signer)"; or

(2) with the person's physical signature, if the document is optically scanned into the entity's records.

(c) Notwithstanding paragraph (b), the committing court may determine that an entity's electronic signature system does not provide sufficient assurance of authenticity of signed documents or that an electronic signature system different from that described in paragraph (b) provides sufficient assurance of authenticity.

(d) An electronically transmitted facsimile of a document, including a document described in paragraph (a) or (b), may be filed with the committing court and received into evidence in the same manner and with the same effect as the original document.

(e) Nothing in this subdivision alters any statute, rule, standard, or practice for accepting documents for filing or admitting documents as evidence, except with respect to:

(1) the manner of making written statements under oath or affirmation;

(2) the acceptability of electronically transmitted facsimile copies; and

(3) the acceptability of electronic signatures.

Paragraph (b) addresses only the acceptability of documents obtained from an entity's electronic records system and does not determine whether the committing court is required or permitted to accept electronic filing of documents.

Subd. 4. **Immunity.** All persons acting in good faith, upon either actual knowledge or information thought by them to be reliable, who act pursuant to any provision of this chapter or who procedurally or physically assist in the commitment of any individual, pursuant to this chapter, are not subject to any civil or criminal liability under this chapter. Any privilege otherwise existing between patient and physician, patient and advanced practice registered nurse, patient and registered nurse, patient and physician assistant, patient and psychologist, patient and examiner, or patient and social worker, is waived as to any physician, advanced practice registered nurse, registered nurse, physician assistant, psychologist, examiner, or social worker who provides information with respect to a patient pursuant to any provision of this chapter.

Subd. 5. **Habeas corpus.** Nothing in this chapter shall be construed to abridge the right of any person to the writ of habeas corpus.

Subd. 6. **Court commissioner.** The Ramsey County court commissioner may hear and act upon petitions for commitment.

Subd. 7. **Appeal.** The executive board or any other aggrieved party may appeal to the court of appeals from any order entered under this chapter as in other civil cases. Any district court order or judgment under this chapter or related case law may be appealed within 60 days after the date of filing of the order or entry of judgment. A judgment under section 253B.18, subdivision 1, may be appealed within 60 days after the date of the order entered under section 253B.18, subdivision 2.

Upon perfection of the appeal, the return shall be filed forthwith. The court of appeals shall hear the appeal within 90 days after service of the notice of appeal. This appeal shall not suspend the operation of the order appealed from until the appeal is determined, unless otherwise ordered by the court of appeals.

Subd. 8. **Transcripts.** For purposes of taking an appeal or petition for habeas corpus or for a judicial determination of mental competency or need for commitment, transcripts of commitment proceedings, or portions of them, shall be made available to the parties upon written application to the court. Upon a showing by a party that the party is unable to pay the cost of a transcript, it shall be made available at no expense to the party. The state courts shall pay the cost of the transcript.

Subd. 9. **Sealing of records.** Upon a motion by a person who has been the subject of a judicial commitment proceeding, the court may seal all judicial records of the commitment proceedings if it finds that access to the records creates undue hardship for the person. The county attorney shall be notified of the motion and may participate in the hearings. All hearings on the motion shall be in camera. The files and records of the court in proceedings on the motion shall be sealed except to the moving party, the person's attorney, the county attorney, or other persons by court order.

History: *1982 c 581 s 23; 1983 c 247 s 107; 1983 c 251 s 26; 1983 c 348 s 14; 1986 c 444; 1987 c 363 s 13; 1990 c 378 s 3; 1993 c 60 s 1; 1993 c 302 s 1; 1994 c 618 art 1 s 29; 1Sp1994 c 1 art 2 s 30; 1995 c 189 s 8; 1996 c 277 s 1; 1997 c 217 art 1 s 112-116; 1998 c 376 s 4; 1999 c 61 s 1; 1999 c 216 art 7 s 19,20; 2005 c 10 art 4 s 12; 2006 c 221 s 1; 2010 c 220 s 1; 2010 c 357 s 11,12; 2013 c 49 s 22; 2020 c 115 art 4 s 103; 1Sp2020 c 2 art 6 s 115-117; 2022 c 58 s 126; 2024 c 79 art 10 s 3*

253B.24 TRANSMITTAL OF DATA TO NATIONAL INSTANT CRIMINAL BACKGROUND CHECK SYSTEM.

When a court:

(1) commits a person under this chapter due to mental illness, developmental disability, or chemical dependency, or as a person who has a mental illness and is dangerous to the public;

(2) determines in a criminal case that a person is incompetent to stand trial or not guilty by reason of mental illness; or

(3) restores a person's ability to possess a firearm under section 609.165, subdivision 1d, or 624.713, subdivision 4,

the court shall ensure that this information is electronically transmitted within three business days to the National Instant Criminal Background Check System.

History: *2009 c 139 s 1,7; 2013 c 86 art 4 s 2; 1Sp2020 c 2 art 6 s 118*

253B.25 PATIENT ACCESS TO INFORMATION ON FACILITY EMPLOYEES.

The head of a treatment facility or state-operated treatment program may restrict patient access to correspondence and telephone calls that the head of the facility reasonably believes will be used to harass, intimidate, or assault employees of the treatment facility or state-operated treatment program.

History: *2026 c 95 art 1 s 16*