STATE OF MINNESOTA
IN COURT OF APPEALS
A25-1637

In the Matter of the Civil Commitment of:
Michaela Atterberry.

Filed February 17, 2026
Affirmed
Florey, Judge[*]

Hennepin County District Court
File No. 27-MH-PR-25-840

Lauren E. Pockl, Hennepin County Adult Representation Services, Minneapolis, Minnesota (for appellant Michaela Atterberry)

Mary F. Moriarty, Hennepin County Attorney, Brittany D. Lawonn, Senior Assistant County Attorney, Minneapolis, Minnesota (for respondent Hennepin County Medical Center)

Considered and decided by Smith, Tracy M., Presiding Judge; Ross, Judge; and Florey, Judge.

NONPRECEDENTIAL OPINION

FLOREY, Judge

On appeal from an order for civil commitment, appellant argues that (1) there is insufficient evidence to support a finding that she poses a significant risk of harm to herself or others, (2) the order conflicts with a prior order denying a judicial hold based on a lower

[*] Retired judge of the Minnesota Court of Appeals, serving by appointment pursuant to Minn. Const. art. VI, § 10.

evidentiary standard, and (3) the district court erred by concluding that there were no suitable less-restrictive alternatives to commitment. We affirm.

FACTS

In 2025, appellant Michaela Atterberry moved to Minnesota with her minor sister, of whom she has custody. Atterberry has diagnoses of several mental-health disorders. Before the incident giving rise to this matter, Atterberry attempted suicide on multiple occasions and also has a history of self-harming behaviors.

In June 2025, Atterberry called 9-1-1 and reported that she had ingested 150 capsules of Propranolol in a suspected suicide attempt. She is prescribed Propranolol to assist in controlling her rapid heart rate. Atterberry was hospitalized and placed on a 72-hour hold. While at the hospital, Atterberry indicated that she was unsure whether the overdose was a suicide attempt and denied feeling suicidal. Healthcare providers reported that she "appears to have limited insight into the seriousness of [the] ingestion and hospitalization need" and that "[s]he minimizes the reported . . . overdose."

While hospitalized in this matter, providers applied restraints to Atterberry on several occasions after she engaged in apparent self-harming behaviors by biting herself, hitting her head on the wall or bed, and wrapping blankets around her neck. Atterberry additionally removed or loosened her restraints and began exhibiting self-harming behaviors. Providers also reported that she refused certain medications and medical tests. Atterberry's medical records indicate that she threw a cannister and liquid at one or more providers. She also expressed fear of the bathroom, tipped over furniture, temporarily blocked entry to her room, and made purportedly threating statements to providers.

Atterberry maintains that, although she pushed furniture, pressed up against hospital staff, and bit herself, she did so to feel grounded as a way of managing manifestations of her autism and never acted with intent to hurt anyone.

On July 30, 2025, a petition for civil commitment was filed. A referee held a preliminary hearing on the petition shortly thereafter. In an order recommended by the referee and countersigned by the district court, the district court ordered Atterberry's release prior to the commitment hearing because the preliminary record failed to establish by a preponderance of the evidence that she had to be held to prevent serious physical harm. The order indicated that the district court considered the petition and an accompanying exhibit, an examiner's statement, and a prepetition screening report. In support of its decision, the district court explained that "[n]o evidence was submitted regarding current symptoms or dangers, what current treatment was occurring," or why a hold was still necessary. It added that the prepetition screening team did not support commitment and that there was an indication that an extended stay in a psychiatric unit caused Atterberry to decompensate.

On August 7, the district court held a hearing on the commitment petition, at which Atterberry testified. It received as evidence three exhibits of health records, a prepetition screening report, and information about domestic violence. It also took judicial notice of a court examiner's report. The district court ordered that Atterberry be civilly committed as a person who poses a risk of harm due to a mental illness.

Atterberry appeals.

DECISION

"In reviewing [an order for civil] commitment, we are limited to an examination of whether the district court complied with the requirements of the commitment act." *In re Civ. Commitment of Janckila*, 657 N.W.2d 899, 902 (Minn. App. 2003) (reviewing district court's mentally-ill determination under Minn. Stat. § 253B.02, subd. 13(a) (2002)). "We review de novo whether there is clear and convincing evidence in the record to support the district court's conclusion that [an individual] meets the standards for commitment." *In re Thulin*, 660 N.W.2d 140, 144 (Minn. App. 2003). However, appellate courts review the underlying factual findings for clear error. *In re McGaughey*, 536 N.W.2d 621, 623 (Minn. 1995). A finding is clearly erroneous when it is "manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." *In re Civ. Commitment of Kenney*, 963 N.W.2d 214, 221 (Minn. 2021) (quotation omitted). In conducting a review for clear error, appellate courts "view the evidence in a light favorable to the findings" and "will not conclude that a fact[-]finder clearly erred unless, on the entire evidence, [the reviewing court is] left with a definite and firm conviction that a mistake has been committed." *Id.* (quotations omitted).

The district court committed Atterberry as a person who poses a risk of harm due to a mental illness. To commit Atterberry as a person who poses a risk of harm due to mental illness, the district court must find "by clear and convincing evidence that [Atterberry] is a person who poses a risk of harm due to mental illness" and "there is no suitable alternative to judicial commitment." Minn. Stat. § 253B.09, subd. 1(a) (2024). Under the Minnesota

Commitment and Treatment Act, a "person who poses a risk of harm due to mental illness" is defined as:

> [A]ny 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.

Minn. Stat. § 253B.02, subd. 17a(a) (2024) (emphasis added). In committing Atterberry, the district court relied on subdivision 17a(a)(3) in explaining that Atterberry, "due to her impairment, poses a substantial likelihood of physical harm to self or others as demonstrated by a recent attempt or threat to physically harm self or others."

Atterberry raises three arguments in challenging the district court's civil-commitment order. We address each in turn.

I. Clear and convincing evidence supports the district court's determination that Atterberry poses a substantial likelihood of physical harm.

Atterberry first argues that there is insufficient evidence to support the determination that she poses a substantial likelihood of physical harm so as to warrant

commitment. As stated above, clear and convincing evidence must support a commitment order. Minn. Stat. § 253B.09, subd. 1(a). Clear and convincing evidence requires proof that is "more than a preponderance of the evidence but less than proof beyond a reasonable doubt." *Limberg v. Mitchell*, 834 N.W.2d 211, 218 (Minn. 2013) (quotation omitted). Under this standard, "a party's evidence should be unequivocal, intrinsically probable and credible, and free from frailties." *Riley v. State*, 819 N.W.2d 162, 170 (Minn. 2012) (quotation omitted). Although we review de novo whether clear and convincing evidence supports commitment, *Thulin*, 660 N.W.2d at 144, we review the district court's underlying factual findings for clear error, *McGaughey*, 536 N.W.2d at 623.

In determining that clear and convincing evidence supports commitment, the district court found that, "[a]s a consequence of her mental illness, [Atterberry] engages in grossly disturbed behaviors or experiences faulty perceptions, and, due to this impairment, she poses a substantial likelihood of causing physical harm as demonstrated by the following facts." The district court described several relevant events that occurred shortly before and during Atterberry's hospitalization. Notably, the district court described the purported suicide attempt; Atterberry's behavior in the hospital, including being uncooperative, engaging in harmful behaviors requiring restraints, refusing to allow hospital staff to schedule appointments; and her minimization of the seriousness of the situation. The district court added that "[t]he severity of the circumstances leading to [Atterberry's] hospitalization and [her] lack of insight into the severity of these circumstances are concerning."

Atterberry first argues that the record refutes the explanation that she intended to self-harm by ingesting the Propranolol because she took it for medicinal purposes, she did not require extraordinary lifesaving measures, she immediately called 9-1-1 for medical assistance, she expressed uncertainty about whether she intended to self-harm, and she likely ingested significantly less Propranolol than she initially reported.

There is sufficient support in the record to justify the district court's finding that Atterberry ingested Propranolol with intent to engage in self-harm. Although there is dispute over the amount of Propranolol she ingested, the parties do not dispute that she ingested an amount that she reasonably believed required medical attention, allowing an inference of intent to engage in self-harm. Bolstering this interpretation is Atterberry's history of previous suicide attempts and other self-harming behaviors. Because the record supports the district court's interpretation of the overdose incident, its finding is not clearly erroneous.

Atterberry next argues that the record does not support the finding that she lacked insight into her mental illness. In support of this argument, Atterberry maintains that she readily acknowledges her various mental-health diagnoses, voluntarily sees a therapist, recognizes the manifestations of her autism, and any minimization of her behavior stems from the fact that it was not a suicide attempt. The district court agrees that Atterberry is aware of her mental illnesses and that she has voluntarily engaged in certain services. Nonetheless, the district court expressed a belief that Atterberry broadly minimized the seriousness of the situation that led to the hospitalization. As stated previously, the record supports the district court's corresponding interpretation.

Atterberry last argues that the district court improperly conflated her autism-related dysregulation with a demonstration of self-harm. In support of this argument, Atterberry contends that certain behaviors in which she engaged while hospitalized, such as pushing furniture and pushing against providers, do not constitute attempts to harm herself or others. Rather, "she was trying to regulate in an environment that did not provide her with her customary regulation tools." Even if some of these behaviors do not show an intent to harm herself or others, the statute merely requires that there be a "substantial likelihood of physical harm to self or others" based on "a recent attempt or threat to physically harm self or others" without expressly requiring that an individual intend to cause harm. Minn. Stat. § 253B.02, subd. 17a(a). The record demonstrates several occasions in which Atterberry engaged in behavior likely to cause harm to herself or others, including instances of biting herself, hitting her head, wrapping a blanket around her neck, and throwing items at healthcare providers. Because the motivations behind Atterberry's behaviors are immaterial to whether they are likely to cause harm, her argument is unpersuasive.[1]

II. The commitment order is not inconsistent with a previous order denying the judicial hold based on a lower evidentiary standard.

Atterberry additionally argues that the commitment order is inconsistent with a previous order denying a judicial hold based on a lower evidentiary standard. She contends

[1] Atterberry additionally argues that her posthospitalization conduct undermines the district court's conclusion because she was able to live independently without incident. These purported lack of incidents do not rise to the level of impacting the conclusion that clear and convincing evidence supports commitment.

that, because a previous order denied a continued hold pending the commitment hearing under the preponderance-of-the-evidence standard, it is legally inconsistent to civilly commit her under the heightened clear-and-convincing-evidence standard.

Under Minn. Stat. § 253B.07, subd. 7(d) (2024), a district court may only extend an initial 72-hour judicial hold "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." In denying a continued hold prior to the commitment hearing, the district court in Atterberry's case explained that "[n]o evidence was submitted regarding current symptoms or dangers, what current treatment was occurring, or why a hold was necessary 11 days after the hospitalization and how it would keep her safer than a later discharge."

However, in making this determination, the district court only considered an exhibit to the commitment petition, the examiner's statement, and the prepetition screening report. Notably, the district court, in denying the continued hold, did not consider the voluminous medical records that were submitted at the commitment hearing or the examiner's report. It appears that the medical records and the examiner's report were not available to the district court at the time of the preliminary hearing. Atterberry's argument that the holdings are inconsistent is therefore unpersuasive. Moreover, practically, the district court denied the judicial hold because of a failure to provide the district court with evidence necessary to allow it to grant that hold, which is different from denying the judicial hold because the evidence necessary to grant that hold did not exist.

III. The district court did not improperly determine that there were no less-restrictive alternatives to commitment.

Atterberry's final argument is that the district court erred by concluding that there were no suitable less-restrictive alternatives to commitment. She contends that the district court did not specify the less-restrictive alternatives that it considered and the record contradicts the determination that she was unable or unwilling to engage in voluntary outpatient care.

Prior to civilly committing an individual, a district court must carefully consider "reasonable alternative dispositions" to commitment. Minn. Stat. § 253B.09, subd. 1(a). These alternatives include "dismissal of [the] 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." *Id.* If a district court orders commitment, "the findings shall also identify less restrictive alternatives considered . . . and the reasons for rejecting each alternative." *Id.*, subd. 2(b) (2024). In the case *In the Matter of Danielson*, for example, we explained that a district court's summary statement that there were no less-restrictive alternatives to commitment was inadequate because it did not identify the alternatives or the reasons for rejecting them. 398 N.W.2d 32, 37 (Minn. App. 1986).

Contrary to Atterberry's argument that the district court failed to specify the less-restrictive alternatives it considered, the order, in contrast to *Danielson*, does specify the less-restrictive alternatives that the district court considered and the reasons for rejecting them. Notably, the order states that "[Atterberry's] illness cannot be adequately treated by

dismissal of the [p]etition, voluntary inpatient or outpatient care, the appointment of a guardian or conservator, or a conditional release." It adds that "[t]he least restrictive, appropriate, available placement is a commitment to the Direct Care and Treatment Executive Board and the head of University of Minnesota Medical Center. The Court [considered] less restrictive alternatives but rejected them due to their inability to cope with [Atterberry's] present behavior and needs." And although the district court did not give a separate explanation for rejecting each alternative to commitment, its statement that it rejected these alternatives "due to their inability to cope with [Atterberry's] present behavior and needs" indicates that it intended to apply this rationale to each of the alternatives to commitment. Atterberry's argument that the district court failed to consider alternatives to commitment therefore lacks merit.

Atterberry next argues that the record contradicts the determination that she was unable or unwilling to engage in voluntary outpatient care. She adds that the record demonstrates that she routinely scheduled her own medical appointments, voluntarily engaged in therapy, engaged in emotional regulation tools, and served as the guardian of her younger sister. She further asserts that a brief lapse in therapy was the result of having to change providers following her move to Minnesota. However, to the extent that the record demonstrates that Atterberry engages in some voluntary outpatient care, the record nonetheless supports the determination that voluntary outpatient care would not suffice to address Atterberry's needs. Notably, Atterberry engaged in several harmful behaviors, especially while hospitalized, that required intensive medical intervention. These behaviors included biting herself, hitting her head on the wall or bed, wrapping blankets

around her neck, and throwing objects at providers. Atterberry's argument is therefore unpersuasive.

Affirmed.