



Recommendations for Updating the Texas Mental Health Code

A Response to Decades of Dramatic
Change in Texas' Mental Health System





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Texas Appleseed Mission

Texas Appleseed's mission is to promote social and economic justice for all Texans by leveraging the skills and resources of volunteer lawyers and other professionals to find practical solutions to broad-based problems facing the most vulnerable, including individuals with intellectual disabilities.

Acknowledgements

We are grateful to the **Hogg Foundation for Mental Health** for generously funding this in-depth examination of the Texas Mental Health Code led by **Dr. Susan Stone**, a recognized expert in the mental health field, and a Steering Committee of judges, attorneys, law professors, and clinicians with special expertise in mental health and the law. This report reflects input from stakeholder meetings conducted across the state and recommends how best to update the state Code to reflect the major changes in mental health service delivery over the past 25 years.

Texas Appleseed would also like to thank **Disability Rights Texas** for their partnership on this project.

DESIGN: Iliana Gilman and Vivify Creative Communications, Inc.

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OVERVIEW

In the fall of 2009, the Texas Department of State Health Services convened the Continuity of Care Task Force (Task Force) to make recommendations about ways to address state hospital bed capacity. Through wide-ranging discussions and significant public input, the Task Force released a report in September of 2010 that included both short-term and long-term recommendations addressing statutory changes, policy issues and clinical care. One resulting pivotal long-term recommendation was to conduct a full-scale update of the Texas Mental Health Code (Subtitle C of the Texas Health and Safety Code). While minor modifications were made to the Texas Mental Health Code (Code) in recent years, it has not been substantially revised since 1985. During this time, however, the Texas mental health system has undergone dramatic change.

Subsequently, the Hogg Foundation for Mental Health awarded a two-year public policy grant to Texas Appleseed, with partner organization Disability Rights Texas, to make recommendations about changes to the Code. Texas Appleseed contracted with Dr. Susan Stone, an attorney and board-certified psychiatrist, to facilitate the process.

This report lays out some of the broader policy issues on needed revisions to the Texas Mental Health Code. Next steps will include a crosswalk of existing statutory provisions, an analysis of how they relate to these recommendations, and drafting of corresponding legislation. Community and stakeholder input will continue to be solicited as those processes proceed.

PROCESS OF DEVELOPING RECOMMENDATIONS

A Steering Committee (Committee), composed of judges, attorneys, law professors, and clinicians was formed to lead this process. A list of Committee members is included in *Appendix 1* to this report. The Committee gathered input

from a broad list of stakeholders across the state after hosting 43 public meetings and statewide presentations. Stakeholders heard at the public meetings included consumers, family members, mental health professionals and administrators, hospital administrators, lawyers, advocates, and many others. Particular attention was given to the differences between urban and rural jurisdictions.

FUNDAMENTAL ISSUES

Because of the complexities in application of the current Code, the Committee recommends wholesale repeal, replacing it with a new structure as outlined below. The exception is that Section 577 of the Code relating to psychiatric hospital regulation should remain intact or be imported into a more appropriate Section of the Health and Safety Code.

Every change to the Mental Health Code will impact other areas of Texas law but, with a few exceptions outlined below, we limit our recommendations to Sections 571-576 and 578 of the Texas Health and Safety Code.

There was a great deal of interest and a wide array of ideas presented through this process, as well as unanimous agreement that change is needed. The current Code is unwieldy and difficult to navigate. It has been suggested that the increased number of forensic commitments to State Hospitals through the criminal justice system is in part a product of the difficulties in navigating the civil commitment process.

There are many areas of consensus across the state about changes to the Code. However, there are other areas where opinions differ so widely that the Committee could not make any recommendations. The reasoning behind these areas of disagreement is included in this report. While this report is not intended to “draft” legislation, the Committee’s general recommendations regarding legislative language are included in appendices to this report.

ORGANIZATIONAL STRUCTURE

One major point of consensus is to reorganize the Code to better reflect the way that individuals move through the behavioral health system in Texas. Below is the recommended organizational structure:

I. Short Title

II. Purpose

- Preference for Voluntary Services
- Rights of Patients
- Least Restrictive Alternative
- Informed Consent/Shared Decision Making
- Evidence-Based Practices
- Continuity of Care

III. Definitions and Administrative Provisions

IV. Voluntary Admissions

V. Emergency Detention

- Emergency Detention Criteria
- Warrantless Detention
- Medical Clearance
- Transportation
- Securing Weapons

VI. Court-Ordered Mental Health Treatment

- Inpatient
- Extended Inpatient
- Involuntary Medication Orders
- ECT
- Outpatient Commitment
- Modification
- Restraint/Seclusion

VII. Court Processes, Penalties and Fees

- Notice
- Court Fees
- Associate Judges
- Attorney Roles
- Court Jurisdiction and Transfer
- Video-Conferencing/Tele-Medicine

NOTE: *Recommendations in this report will track this new organizational structure to the fullest extent possible. After this draft report is published for comment, the Committee will begin working on a matrix document to ensure that all essential language in the current Code is incorporated into this new organizational structure.*

DISCUSSION AND RECOMMENDATIONS

I. TITLE

RECOMMENDATION 1:

No Change to the Title of the Texas Mental Health Code

Stakeholders asked whether there was a real need for a “Mental Health Code.”

With increased proof that psychiatric illnesses are medical conditions, many participants questioned which specific legal protections are necessary in statute. Others had concerns about losing critical ground in the civil rights of individuals with psychiatric illness if the Code did not exist. The Code should acknowledge, however, that best practices require a combination of biological and psychosocial approaches.

II. PURPOSE

RECOMMENDATION 2:

Clarify the Preference for Voluntary over Involuntary Interventions

It is generally, but not unanimously, agreed that this section of the Code should include a preamble stating the following:

- Voluntary interventions are preferred, when available;
- Involuntary interventions are utilized only when necessary to protect the health and safety of the proposed patient or the safety of others, including treatment providers; and
- These provisions apply to individuals seeking voluntary services after being initially hospitalized under Emergency Detention or an Order of Protective Custody, but who later desire voluntary services.¹

It makes organizational sense to also include least restrictive alternative provisions and rights of patients in this section. There were no suggested changes to those provisions, except to include language that rights of patients should “include, but not be limited to…” and to incorporate the *Olmstead* decision into the “least restrictive alternative” language in the Code. In 2009, the Civil Rights

Division of the U.S. Department of Justice launched an aggressive effort to enforce the Supreme Court’s decision in *Olmstead v. L.C.* (1999), a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

During statewide hearings on proposed revisions to the Code, suggestions were also made to include language on recent evidence-based practices promulgated by the National Alliance for Suicide Prevention. The Committee opted not to add specific language regarding treatment methodologies with some exceptions discussed below.

RECOMMENDATION 3:

Move Least Restrictive Alternative Provisions to this Section of the Code, and Add Language Reflecting the *Olmstead* Decision to the Code

RECOMMENDATION 4:

Move Rights of Patients Provisions to this Section of the Code, and Clarify That These Rights Are Fundamental, but Not Comprehensive

III. DEFINITIONS

Many definitions in the current Mental Health Code are outdated. There will be many ramifications to their change, so more work will be needed to craft consistent terminology, in acknowledgement of the impact of other state laws and the impact of these definitions on treatment and funding decisions.

RECOMMENDATION 5:

Eliminate References to the Texas Department of Mental Health and Mental Retardation and Board Functions

Most obviously, reference to the Texas Department of Mental Health and Mental Retardation Authority and its Board should be removed, as this agency is no longer in existence.

¹ It must be noted that some individuals who desire a status change from involuntary to voluntary services may not have the capacity to follow treatment recommendations.

RECOMMENDATION 6:

Clarify Terminology Around Behavioral Health Facilities

The terms “mental health facility,” “inpatient mental health facility,” and “mental hospital” are defined and utilized in several different ways in the current Code, creating confusion and conflicts throughout the state. These definitions need to be updated, but we acknowledge that there will be many ramifications to these changes.

RECOMMENDATION 7:

Clarify Definitions of Local Mental Health Authorities and Community Centers

Similarly, “Local Mental Health Authority” and “Community Center” definitions overlap and are not consistent with the current system. While the definition of Single Portal Authority was removed from the Code several years ago, the function seems more important now in terms of system changes and conflicts about resource issues.

RECOMMENDATION 8:

Revise the Definition of Mental Illness

The definition of “mental illness” under the current Code also creates great concerns for stakeholders statewide. While there were discussions about changing the definition of mental illness under the Code to “behavioral health,” there is concern that this would increase attempts to “commit” individuals with intellectual and developmental disabilities (IDD) into long-term hospital settings, which could amplify the current inpatient care capacity crisis.

The Code should clarify that civil commitments for individuals with intellectual and developmental disabilities, in the absence of co-occurring psychiatric illness, should be carefully scrutinized.

It was generally acknowledged that references to epilepsy and alcoholism should be removed from the definition, as these are no longer relevant specifically to behavioral health service systems. Similarly, the term “mental deficiency” should be replaced with the term “intellectual disability,” in keeping with current statutory and policy language. There was strong consensus for replacing the term “senility” with “dementia,” which is more consistent with current diagnostic terminology.

While there were suggestions to add the term “anosagnosia” to definitions under the Code, there was general consensus that it would further complicate the Code rather than simplify it.

RECOMMENDATION 9:

Standardize Definitions of Hazardous Weather

Various inconsistent definitions of “hazardous weather” or “disaster conditions” are scattered across the Code. We recommend one definition be used consistently throughout the Code:

“extremely hazardous weather conditions exist or a disaster occurs that threatens the safety of proposed patients or other essential parties to proceedings under this Code.”

IV. VOLUNTARY MENTAL HEALTH SERVICES

RECOMMENDATION 10:

Clarify Age of Consent

There is statewide consensus that the provisions in the Texas Health and Safety Code and the Texas Family Code with regard to age of consent to behavioral health services are confusing and difficult to navigate. The revised Code should clarify that the age of consent for mental health services, both inpatient and outpatient, is 16. It should also be made explicitly clear that foster parents or agencies such as Child Protective Services or non-profit corporations must obtain judicial approval to enroll a minor under their care into mental health services. Children under the supervision of those agencies or non-profit entities must be provided with judicial scrutiny over the need for their hospitalization, including hospitalization in maximum-security settings.

Furthermore, the Code should clarify that children under the age of 18 should not be civilly committed under the Mental Health Code unless required by another statute or rule. All other children should have a parent, managing conservator, or guardian who can consent to inpatient care.

Another exception is that, if a Local Mental Health Authority has concerns about safety issues regarding transportation of a child by the parent or guardian, law enforcement agencies can be utilized to decrease that risk. Law enforcement officers would not be required to remain in the facility once the adolescent is transported.

V. EMERGENCY DETENTION

Law enforcement officers actively participated in the development of these recommendations reflecting the changing role of law enforcement in the behavioral health system.

RECOMMENDATION 11:

Promulgate Statewide Training Forms Around Emergency Detention

There is general consensus that current Emergency Detention criteria are clear in the law, but inconsistently applied across the state. Most believe that this would be remedied by enhanced training for law enforcement officers and standardized forms to help guide decision-making processes, in addition to curricula around the use of the Code for law enforcement officers, consumers, family members, attorneys, and judges.

Furthermore, the Code should clarify that there is no preclusion to the execution of Emergency Detention by law enforcement when an individual is admitted to a medical facility, whether it is an emergency room or general medical facility.

RECOMMENDATION 12:

Eliminate Provisions Under the Code Requiring Warrants for Emergency Detention

While current law allows Emergency Detention by a law enforcement officer without a warrant, several jurisdictions continue to require officers to obtain a warrant, either before or after apprehension in a dangerous situation. This wastes valuable resources and creates potentially risky delays in needed care if a judge or magistrate with the authority to authorize a detention is unavailable. This issue has been further complicated by a recent Attorney General's Opinion suggesting that warrants are required. The Committee recommends removing Emergency Detention Warrant provisions from the Code.

RECOMMENDATION 13:

Clarify Medical Clearance Provisions

Similarly, there is wide variation across the state with regard to the need to obtain medical clearance from a general medical hospital before transportation to a psychiatric facility. While a recent Texas Attorney General's Opinion clarified that this is not universally necessary, the statewide consensus is that this should be clarified in the Code to emphasize reliance on the judgment of peace officers as to when medical clearance is necessary. Federal law still governs medical stabilization for transfer from emergency departments or general medical hospitals when proposed patients are placed in those facilities because of lack of service system capacity. Guidelines developed by the Texas Council of Community Centers should be utilized as a basis for these statutory guidelines.

RECOMMENDATION 14:

Forcible Entry

Law enforcement officers should be allowed forcible entry into a house or building if there is reasonable suspicion of imminent danger. The Code should explicitly direct law enforcement officers to first knock and announce their purpose for entry.

RECOMMENDATION 15:

Furlough

Consideration should be given to the development of a furlough process for individuals under Emergency Detention who need transport to general medical facilities. Suggestions were made to allow the furlough of a patient who is subjected to Emergency Detention to a general medical facility; this would prevent people from being lost between medical and behavioral health care facilities.

RECOMMENDATION 16:

No Change in Emergency Detention Time Periods

Several jurisdictions recommended extending the preliminary examination time after Emergency Detention from 48 hours to 72 hours. There are arguments and literature supporting extension of the evaluation time frame, including the possibility of avoiding a commitment due to stabilization of the psychiatric condition, but there is not consensus about this approach. After extensive discussion, the Committee recommends retaining the 48-hour Emergency Detention time frame, as 72 hours can easily become an extended time period during weekends, holidays, and emergency situations.

RECOMMENDATION 17:

Securing Dangerous Weapons

There is general consensus across the state that law enforcement officers who work in Emergency Detention situations should have statutory authority and liability protection to secure dangerous weapons that present a risk of harm to the officers or to the individuals being detained. Language proposed by the law enforcement community is included as *Appendix 2* to this report. We agree with adding this language to the Code to provide additional liability protections for police officers.

Similarly, there should be statutory provisions for disposition and return of those weapons, but changes to the relevant sections of the Code of Criminal Procedure are outside of the scope of this project. However, if the legislature develops a process for return of lethal weapons

under these circumstances, those decisions should be made by a court with mental health jurisdiction and should take into account the levels of mental health detention when evaluating return of the items.

RECOMMENDATION 18:

Temporary Emergency “Hold” Provisions

Under current law, emergency departments and hospitals have no legal authorization to hold an individual who initially requested services, but later requests to leave. This provides hospital employees with few options other than calling law enforcement in the case of emergency. There is statewide consensus that the Emergency Detention provisions of the Code should allow for emergency departments, general medical hospitals, psychiatric emergency departments, and psychiatric hospitals to detain an individual for four hours if they deem that a psychiatric emergency exists in order to begin processes for either Emergency Detention or application for an order of protective custody. Written documentation about the reason for the four-hour holding period would be required. The four-hour period would begin at the time the individual requests release from the facility.

Transportation

While legislation on transportation under Emergency Detention passed during the 82nd legislative session, many believe it has created more confusion than clarity. Questions remaining include responsibility for transportation, funding, and appropriate standards for facilities that accept individuals under Emergency Detention. Statewide variation and lack of consensus prohibit substantive recommendations in this report. There is consistent concern, however, about family members transporting people meeting the criteria for Emergency Detention. While the Committee certainly respects the desire for family member involvement, it can create undue risk in these circumstances.

VI. COURT-ORDERED MENTAL HEALTH TREATMENT

There were five major substantive discussions with regard to court-ordered mental health treatment under the Code.

RECOMMENDATION 19:

Explore Better Ways to Use Para-professionals in Mental Health Commitment Processes

Psychiatrists are in short supply in Texas. Many participants discussed ways to better utilize para-professionals, such as nurse practitioners and physicians’ assistants with regard

to proceedings under the Mental Health Code. There is not general consensus about this issue, and the Texas State Constitution limits issuance of Certificates of Medical Examination under the Code to physicians.

RECOMMENDATION 20:

Consider Incorporation of “Gravely Disabled” Language in Inpatient Civil Commitment Criteria

There is clear consensus that the third criterion for court-ordered inpatient mental health services is neither clear nor consistently applied across the state. Proposed revised legislative language for the criteria for Inpatient Court-Ordered Mental Health Treatment is included as *Appendix 3* to this report.

There were suggestions that consideration be given to changing the Code with regard to civil commitment of individuals with charges pending related to serious injury, but there was not consensus about this recommendation.

Assisted Outpatient Treatment

While there is significant energy in some areas of the state to modify outpatient commitment standards under the Health and Safety Code, there is not total consensus within the state or among the Committee as to the need for change. At least one large jurisdiction in the State has been successful in implementing Assisted Outpatient Treatment under the current statute. Issues include the abilities of judges to compel medications, the consequences of non-adherence, mandatory drug testing, and provisions around modification from outpatient to inpatient commitment. Some argue that the Code should be strengthened in the area of court-ordered treatment, particularly for patients who are dangerous and remain resistant to “all attempts at treatment.”

It must also be noted that Assisted Outpatient Treatment Programs are more successful with increased service system support and resources. If changes are to be made to outpatient commitment statutes under the Code, however, the Committee agreed that the legislative construct set out in *Appendix 4* to this report is most consistent with the statewide consensus.

Involuntary Medication Orders

Another concern reported statewide is delay with regard to involuntary medication hearings. Several jurisdictions reported more than two-week waiting periods for medication hearings after final civil commitment. This seems to be a self-imposed delay as current law allows a psychoactive

medication hearing to be held immediately after the commitment hearing, and the application for a psychoactive medication order may be filed before the commitment hearing is held. Experts on the Steering Committee clarified that, under current law, final commitment hearings and the involuntary medication hearings can be held as quickly as 72 hours after detention under an order of protective custody as long as both attorneys and the judge agree.

Electroconvulsive Therapy

There is not consensus about ECT provisions in the Code. Physicians are concerned that the ability to utilize ECT in emergency situations is not clear, and that there is no reason for a specific treatment method to be included in statutory law. Consumers and advocates continue to worry about its abuse. We were not able to reach total consensus about this issue, but have proposed language included in *Appendix 5* to this report as a potential compromise.

Restraint/Seclusion

There were suggestions to include stronger references in the Code with regard to restraint and seclusion. The requirement of physician involvement in restraint and seclusion (rather than nursing, as is done in other states) is unique to Texas. While hospital participants urged removing this requirement, the general consensus across the state is that considerable progress has been made in the area of restraint and seclusion perhaps in part because of this requirement. Furthermore, the provisions around restraint and seclusion are not currently in the Texas Mental Health Code.

VII. COURT PROCESSES, PENALTIES

Court processes are not as clear under the Mental Health Code as in other sections of Texas law.

RECOMMENDATION 21:

Notice

Citation and Notice regarding civil commitment under the Texas Mental Health Code should be issued by the Court Clerk and served by a Constable or Sheriff to the individual, or in the event that the individual is in a mental health facility, to the head of the facility or designee, who will then have the responsibility to ensure the prospective patient is provided with that information. Nothing in the Code should allow opening of mail outside of the individual's consent and presence.

RECOMMENDATION 22:

Associate Judges

It should be made clear that Associate Judges appointed under Texas Government Code Section 54A.001, et. seq. have the same authority as Probate Judges under the Mental Health Code.

RECOMMENDATION 23:

Court Administration Fees

Court costs shall be paid by the applicant except when the prospective patient is receiving services from the Local Mental Health Authority, or provider designated by the Local Mental Health Authority, even if the designated facility is private. Local Mental Health Authorities are not expected to pay court costs.

RECOMMENDATION 24:

Attorney Roles

Attorneys shall be physically present with their clients during all proceedings under the Mental Health Code, even if done via video-conferencing.

RECOMMENDATION 25:

Video-Conferencing

Tele-medicine—the utilization of video technology for the provision of medical services and diversion from jails and emergency rooms—is an increasingly utilized best practice. There is general consensus across the state that utilization of video-conferencing is appropriate for medical evaluations and testimony, but there should be precautions with regard to court hearings under the Code. Two provisions in the current Mental Health Code address video-conferencing and electronically-held hearings, but they are inconsistent.

There is consensus that the patient and the patient's attorney shall be together at the same location for all hearings and that standardized processes are needed with regard to video-conferencing of proceedings under the Mental Health Code.

Suggested modified language is included in *Appendix 6* to this report.

Court Jurisdiction and Transfer

There were suggestions across the state about authority for cross-county jurisdiction for civil commitment proceedings under the Code, but there was not consensus, as there are many systems utilized across the state.

APPENDICES

APPENDIX 1:

Steering Committee Members

Dr. Susan Stone, J.D., M.D., *Chair*

Professor Michael Churgin

UNIVERSITY OF TEXAS SCHOOL OF LAW

Deborah Fowler, *Deputy Director*

TEXAS APPLESEED

Judge Guy Herman

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Beth Mitchell, *Attorney*

DISABILITY RIGHTS TEXAS

Judge Daniel Prashner

PROBATE COURT I
TRAVIS COUNTY, TEXAS

Professor Brian Shannon

TEXAS TECH SCHOOL OF LAW

Dr. James Van Norman, M.D., *Medical Director*

AUSTIN TRAVIS COUNTY INTEGRAL CARE

APPENDIX 2:

Proposed Legislative Language Regarding Confiscation of Lethal Weapons

“Whenever a person who has been taken into custody for examination of his or her mental health condition is found to have in his or her immediate control any firearm or deadly weapon, that deadly weapon shall be secured by any law enforcement officer until it can be safely returned.”

APPENDIX 3:

Proposed Legislative Language Regarding Inpatient Court-Ordered Treatment Criteria:

- (a) The judge may order a proposed patient to receive court-ordered temporary inpatient mental health services only if the judge or jury finds, from clear and convincing evidence, that:
 - (1) the proposed patient is mentally ill; and
 - (2) as a result of that mental illness the proposed patient:
 - (A) is likely to cause serious harm to himself;

- (B) is likely to cause serious harm to others; or
- (C) is gravely disabled.

A proposed patient is “gravely disabled” if the person, as a result of mental illness, is:

- (i) suffering severe and ongoing mental, emotional, or physical distress;
- (ii) in danger of serious physical harm or serious illness due to the proposed patient’s inability to function independently, which is exhibited by the proposed patient’s inability due to mental illness, except for reasons of indigence, to provide for the proposed patient’s basic needs, including food, clothing, shelter, medical care, health, or safety; and
- (iii) unable to make a rational and informed decision as to whether or not to submit to treatment.

APPENDIX 4:

Proposed Legislative Language Regarding Assisted Outpatient Treatment

Judges and Associate Judges with probate jurisdiction should have the ability to order temporary outpatient mental health services if the judge finds that appropriate mental health services are available to the patient.

The person responsible for the services shall submit to the court at the hearing for temporary or extended mental health services a general program of the treatment to be provided. The program shall include services to provide care coordination, and any other treatment or services deemed clinically necessary to treat the person’s mental illness and clinically necessary to assist the patient in functioning safely in the community, including clinically-necessary medication and supported housing. The program must be incorporated into the court order, and the patient must have a right to petition the court for specific enforcement of the court order. The inclusion of clinically-necessary medication in a program and court order under this section, however, does not authorize a person to administer medication to a patient who refuses to take the medication voluntarily, except in cases of emergency, as defined under Title 7, Subchapter C, and emergency treatment shall not include long-acting injectable medications.

Modification of an order for outpatient mental health services to inpatient mental health services may only occur:

- When a person is detained following an order of temporary detention, the detainee will be evaluated—within 24 hours after the person is detained in a facility—to determine whether or not the detainee presents a serious risk of substantial harm to self or others so that a person cannot be at liberty pending the hearing. Substantial risk of serious harm may be demonstrated by the person's behavior, or by evidence of severe emotional distress and deterioration.
- If the evaluation shows that the person does not meet the criteria for continued detention, the facility shall release the person. If the evaluation shows that the person does meet the criteria, the person may be further detained until the probable cause hearing, which must be held within three days of the period of initial detention (excepting weekends, holidays, etc.).
- If the individual is found to present a serious risk of substantial harm to self or others, as defined above, a probable cause hearing will be held within 72 hours excepting weekends, holidays, etc.
- At the probable cause hearing, the question is whether the detainee presents a substantial risk of harm to self or others to the extent that the person cannot be at liberty pending the final hearing, as defined above, which will be held within seven days from the detention.
- A facility must comply with this Section to the extent that the Court and the Local Mental Health Authority determine that the designated mental health services are available.

APPENDIX 5:

Electroconvulsive Therapy

Electroconvulsive Therapy can only be performed without the consent of the individual if a judge determines, based upon two certificates of medical examination, one of which is executed by an individual not involved in the care of the patient and who has experience in the use of ECT for acute catatonia, that:

- 1) the patient is unconscious, unable to communicate or is a minor whose parents or guardians are not available; and
- 2) is suffering from what reasonably appears to be a life-threatening catatonia; and
- 3) immediate treatment is necessary to preserve life or health; and
- 4) there is not sufficient time to obtain a guardianship; and
- 5) all other alternatives have been exhausted; and
- 6) there is no advanced directive or knowledge that the person would refuse ECT.

Court-ordered ECT would be limited to three treatments under the specific court order.

APPENDIX 6:

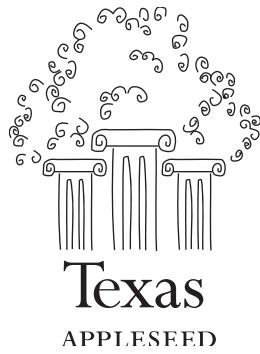
Use of a Secure Electronic Communication Method in Certain Proceedings Under This Chapter

Sec. 574.203.

- (a) A hearing may be conducted with the consent of the court in accordance with this chapter but conducted by secure electronic means, including satellite transmission, closed-circuit television transmission, or any other method of two-way electronic communication that is secure, available to the parties, approved by the court, and capable of visually and audibly recording the proceedings, if:
 - (1) Written consent to the use of a secure electronic communication method for the hearing is filed with the court by:
 - (A) The proposed patient or the attorney representing the proposed patient; and
 - (B) The county or district attorney, as appropriate; and
 - (2) The secure electronic communication method provides for a simultaneous, compressed full-motion video, and interactive communication of image and sound among the judge, associate judge, the county or district attorney, the attorney representing the proposed patient, and the proposed patient; and

- (3) On request of the proposed patient or the attorney representing the proposed patient, the proposed patient and the attorney can communicate privately without being recorded or heard by the judge, associate judge, or by the county or district attorney; and
- (4) The proposed patient and the attorney representing the proposed patient shall be together in the same location for the hearing. If the hearing is within the same county in which the commitment proceeding is pending, the proposed patient and the proposed patient's attorney shall be in the place where the hearing is conducted along with the judge.
- (b) On the motion of the patient or proposed patient, the attorney representing the patient or proposed patient, or the county or district attorney or on the court's own motion, the court may terminate an appearance made through a secure electronic communication method at any time during the appearance and require an appearance by the patient or proposed patient in open court.
- (c) The court shall provide for a recording of the communication to be made and preserved until any appellate proceedings have been concluded. The patient or proposed patient may obtain a copy of the recording on payment of a reasonable amount to cover the costs of reproduction or, if the patient or proposed patient is indigent, the court shall provide a copy on the request of the patient or proposed patient without charging a cost for the copy.





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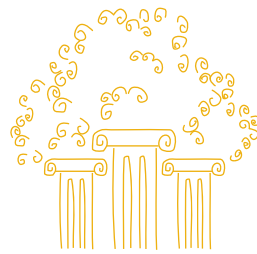
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