OVERVIEW

In the fall of 2009, the Texas Department of State Health Services convened the Continuity of Care 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 pivotal long-term recommendation was a full-scale revision of the Texas Mental Health Code (Subtitle C of the Texas Health and Safety Code.) Minor modifications have been made, but the Code has not been substantially revised since 1985, while the mental health system has changed dramatically. In the fall of 2010, 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, both an attorney and board certified psychiatrist, to facilitate the process.

PROCESS OF DEVELOPING RECOMMENDATIONS

The process began with the formation of a Steering Committee, composed of judges, attorneys, law professors and clinicians. Rather than working exclusively through a Committee, however, we gathered broad input from constituency groups across the state. More than forty-three public meetings with over 5,000 individuals participated in the process to develop these recommendations. Feedback was solicited from consumers, family members, mental health professionals and administrators, hospital administrators, lawyers, advocates and many others. We gave particular attention to the differences between urban and rural jurisdictions.

FUNDAMENTAL ISSUES

Because of the complexities in application of the current mental health code, the Steering Committee recommends wholesale repeal, replacing it with a new structure, outlined below. One exception to this recommendation is that Section 577 of the Code should remain intact, or be imported into another area of the Health and Safety Code. This Section, which deals with hospital regulation, is not consistent with the purpose of the Mental Health Code.

We know that 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 571-578 of the Texas Health and Safety Code.

As we expected at the outset, there was a great deal of interest and a wide array of ideas presented through this process. Gratefully, there was unanimous agreement that change is needed. The current Mental Health 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 difficulties with navigating the civil commitment process.

There are many areas of consensus across the state about changes to the law. As we also expected, however, there are other areas where opinions differ so widely that we cannot make any recommendations. We will document those areas of disagreement, and will articulate the reasoning behind them. While this report is not intended to "draft" legislation, we have arrived at some general recommendations regarding legislative language that have been included as appendices to this report.

ORGANIZATIONAL STRUCTURE

One major point of consensus is that the Code should be reorganized to better reflect the way that individuals move through behavioral health processes in Texas. We recommend the following new 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

Recommendations contained in this report will, to the extent possible, track this new organizational structure. After this draft report is released for comment, we will begin working on a matrix to ensure that all essential language in the current Code is incorporated into the new organizational structure.

DISCUSSION/RECOMMENDATIONS:

I. Title

One question raised through this process was the real need for a "Mental Health Code." With increased appreciation of psychiatric illness as a medical condition, many participants questioned which specific legal protections are needed in statute, rather than in framed in policy and/or training efforts. We were cognizant of this question throughout the development of these recommendations.

- ***Recommendation: No change to the Title of the Texas Mental Health Code.***

II. Purpose

It is generally, but not unanimously, agreed that this section of the Code should include a preamble stating that voluntary interventions are preferred, and that involuntary interventions are only utilized when necessary to protect the health and safety of the proposed patient. We also recommend that the Code makes clear that individuals seeking voluntary services have the opportunity to receive them, whenever possible. This includes individuals who are initially hospitalized under Emergency Detention or Orders of Protective Custody and later decide that they desire voluntary services.

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.

Informed consent and shared decision-making are fundamental concepts in any kind of medical care. While the current Code embodies many of those concepts in Chapter 578, they only apply to Electroconvulsive Therapy. We believe that these concepts are necessary with regard to any form of behavioral health care, and should be included in the Purpose section of the Mental Health Code.

Suggestions were made to add additional language to the Code related to recent Evidence Based Practices promulgated by the National Alliance for Suicide Prevention. The Steering Committee agreed against adding specific language regarding treatment methodologies, in statute, except as noted below.

Recommendations:

- ***Clarify the preference for voluntary services over involuntary interventions, even when the individual was originally hospitalized involuntarily, and later requests voluntary services.***
- ***Move Least Restrictive Alternative provisions to this section of the Code.***
- ***Move Rights of Patients provisions to this section of the Code.***
- ***Incorporate language around informed consent and shared decision-making into the purpose section of the mental health code.***

III. Definitions

Many definitions in the current Mental Health Code are outdated.

Most obviously, reference to the non-existent Texas Department of Mental Health and Mental Retardation Authority and its Board should be removed.

The terms "mental health facility," "inpatient mental health facility," and "mental hospital" are defined and utilized several different ways in the current Code, creating confusion and conflicts across the state. These definitions need to be updated, but we acknowledge that there will be many ramifications to these changes. More work will be needed to craft more consistent terminology, acknowledging the impact on other areas of state law. This work will continue during the additional comment period after the release of this draft report.

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. This work will also be continued during the comment period of this report.

While there were discussions about changing the definition of mental illness under the TMCH to "behavioral health," there is concern that this would increase attempts to "commit" individuals with IDD into long-term hospital settings, which would amplify the current inpatient care capacity crisis. There was not consensus about this recommendation.

The definition of mental illness under the current Code also creates concerns for stakeholders statewide. It was generally acknowledged that references to epilepsy and alcoholism should be removed from the definition, as these are no longer relevant. Similarly, the term "mental deficiency" should be replaced with the term "intellectual disability," in keeping with current statutory and policy language. There was not consensus about the term "senility" used in the current definition, in that modifying it might increase inpatient admissions for individuals with long term care issues. The concern is that precious inpatient bed resources would be utilized for individuals with long term care needs.

Various definitions of "hazardous weather" or "disaster conditions" are scattered inconsistently across the Code. We recommend one definition: "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, " and that this definition be used consistently throughout the Texas Mental Health Code.

In moving forward, careful consideration must be given with regard to definitions, as they can be paramount in treatment and funding decisions, and impact many other sections of Texas law, including insurance payment for treatment services.

Recommendations:

- ***Eliminate references to the Texas Department of Mental Health and Mental Retardation and its Board functions;***
- ***Carefully examine ways to define "community centers," "facility administrator," "general hospital," "inpatient mental health facility," "local mental health authorities," "community centers" and "mental health facilities."***
- ***Consolidate definitions of hazardous weather and disaster conditions into this section, and ensure that the provisions are consistent to all procedures under the Code.***

- ***Revise the definition of Mental Illness under the Mental Health Code to eliminate references to epilepsy and alcoholism. Revise references to "mental deficiency" with the term "intellectual disability."***

IV. Voluntary Mental Health Services

There were three substantive recommendations with regard to voluntary mental health services under the Code. As stated above, it should be made clear that voluntary services are provided whenever possible. Second, the "Rights of Patients" section is redundant. Both of these sections should be consolidated into the Purpose section of the new Code structure.

A more substantive issue, spanning across Texas law, is the ability for adolescents to consent to voluntary mental health treatment. There is statewide consensus that the provisions in the Texas Health and Safety Code and the Texas Family Code are confusing and difficult to navigate. The revised Mental Health Code should clarify that the age of consent for mental health services, both inpatient and outpatient is 16.

Furthermore, the Code should clarify that children under the age of 16 should not be civilly committed under the Mental Health Code unless required by other State law or Texas Department of State Health Services Rules. All other children should have a parent, managing conservator or guardian who can consent to inpatient care. It should also be made explicitly clear that agencies, such as Child Protective Services or non-profits, may not admit a child voluntarily. Children under the supervision of those agencies must be provided with judicial scrutiny over the need for hospitalization.

Recommendations

- ***Consolidate references for request for admission and rights of patients into the purpose section of the new Code structure.***
- ***Clarify that the age of consent for mental health services in Texas is for both inpatient and outpatient mental health services is 16.***
- ***Children under the age of 16 should not be involuntarily committed under the Mental Health Code unless required by other State law or Texas Department of State Health Services Rules.***

V. Emergency Detention

Many law enforcement officers participated actively in the development of these recommendations. Clearly the role of law enforcement has changed since the original Code was enacted.

A. Criteria and Warrants

While most agree that current emergency detention criteria are fairly clear, they are inconsistently applied across the state. Furthermore, while the law allows warrantless detentions, several jurisdictions continue to require warrants, wasting valuable resources. This issue has been further complicated by a recent Attorney General's Opinion suggesting that warrants are required. We recommend that provisions regarding Emergency Detention Warrants be removed from the Code. Furthermore, the Code should clarify that there is no preclusion to the execution of an emergency detention by law enforcement when an individual is admitted to a medical facility, whether emergency room or general medical facility.

We also strongly recommend enhanced training for law enforcement officers to improve statewide consistency in the application of Emergency Detention Criteria. This will be particularly important if provisions around warrants are removed from the Code. This issue would be more fully addressed by the development of standardized forms and training manuals for law enforcement and mental health professionals.

B. Transportation

While legislation was passed during the last legislative session related to transportation of individuals under emergency detention, it has created more confusion than clarity. Many questions remain, including responsibility for transportation, funding, standards and the facilities that accept individuals under emergency detention. This is an issue around which there is such statewide variation that we cannot make substantive recommendations. There is concern, however, that current law suggests that family members are appropriate alternative transportation avenues in situations of emergency detention. While we certainly respect the desire for family member involvement, we believe that these provisions create undue risk.

C. 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 some literature, supporting extension of the evaluation time frame, including the possibility of avoiding a commitment due to stabilization of the psychiatric condition. After extensive discussion, however, we recommend leaving the current time period in place. Our reasoning is that 72 hours can easily become a much longer time period, when weekend, holidays, and emergency situations are added to the consideration.

D. Medical Clearance

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, 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. This should not imply, however, that medical clearance is necessary for transfer from emergency departments or general medical hospitals when proposed patients are placed in those facilities because of lack of service system capacity.

E. Securing Dangerous Weapons

There is general consensus across the state that law enforcement officers involved in emergency detention situations should have statutory authority, and liability protection, for securing dangerous weapons that present a risk of harm to themselves or to the individuals being detained.

Language proposed by the law enforcement community is included as ***Appendix 1*** to this report.

We agree with adding this language to the Mental Health Code to provide additional liability protections for police officers.

Similarly, there should be statutory provisions for disposition/return of those weapons, but we believe that proposed changes to the Code of Criminal Procedure are outside of the scope of this project. We do believe, however, that 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.

F. Emergency Department "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 staff with few options, other than calling law enforcement, when they determine a mental health emergency. There is statewide consensus that the Emergency Detention provisions of the Code should allow for Emergency Departments, General Medical Hospitals 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.

Recommendations:

- ***No change to Emergency Detention Time Periods.***
- ***Implement new training modules and standardized forms around the applicability and implementation of Emergency Detention criteria.***
- ***Develop standardized forms and manuals to clarify the application of emergency detention criteria and processes across the state.***
- ***Clarify that neither warrants nor emergency clearance are required for emergency detention.***
- ***Implement new provisions to the Emergency Detention section of the Mental Health Code related to securing dangerous weapons.***
- ***Include provisions in the Emergency Detention Section of the Mental Health Code to allow a temporary 4 hour hold in an Emergency Department or other Mental Health Facility (prior to admission), to allow activating processes for Emergency Detention or Orders of Protective Custody.***

VI. Court Ordered Mental Health Treatment

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

A. Utilization of Para-Professionals

Psychiatrists are in short supply in Texas. Many participants discussed ways to better utilize para-professionals, such as nurse practitioners, psychologists 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.

B. Inpatient 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 inpatient Court Ordered Mental Health Treatment is included as ***Appendix 2*** to this report.

C. Outpatient Commitment/Assisted Outpatient Treatment/Modification

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 nor within this committee as to the need for modification. 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, and provisions around modification from outpatient to inpatient commitment. Furthermore, we would note that AOT programs have tended to be provide more successful outcomes when there have been increased service system resources to support such commitments.

If changes are to be made to outpatient commitment statutes under the Code, however, we agree that the legislative construct set out in ***Appendix 3*** of this report is most consistent with statewide consensus.

D. 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.

Recommendation: Clarification in statute that involuntary final commitment hearings, and then involuntary medication hearings can be held within 72 hours of emergency detention, with agreement of all parties.

E. ECT

While there have been significant discussions around removing ECT as a specific reference in the Mental Health Code, there are still constituents concerned about its abuse. Concerns by physicians have revolved around the ability to use ECT in life threatening situations. We agreed that there should

be an exception in the current law in these circumstances. Proposed language is included in ***Appendix 4***.

F. Restraint/Seclusion

There were suggestions to include stronger references in the Code regarding restraint and seclusion, but general consensus is that sufficient progress has been made statewide, and that this is not a statutory issue. We heard specific recommendations about eliminating the requirement of physician assessment within four hours of restraint, which is unique to the state of Texas. While this is a striking statistic, we found it outside of the scope of this project, as that requirement is not an element of 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.

A. 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 proposed patient is provided with that information. Nothing in the Code should allow opening of mail outside of the individual's consent and presence.

B. Associate Judges

It should be made clear that Associate Judges have the same authority as Probate Judges under the Mental Health Code.

C. Court Fees

Court costs shall be paid by the applicant except when the proposed patient is receiving services from the Local Mental Health Authority, even if in a private facility.

D. Attorney Roles

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

E. Video-Conferencing

While there is significant interest across the state in the use of video-conferencing for proceedings under the Mental Health Code, there are also concerns about adequate liberty guarantees for proposed patients. Two provisions in the current Mental Health Code address video-conferencing and hearings held electronically, but they are mutually inconsistent. There is not statewide consensus about how video-conferencing should be used under these sorts of proceedings.

F. Court Jurisdiction and Transfer

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

Recommendations:

- ***Citation and Notice provisions under the Mental Health Code should be clarified.***
- ***Associate Judges should be given specific authority under Mental Health Code proceedings.***
- ***Provisions regarding court administrative fees should explicitly exclude individuals being served by Local Mental Health Authorities.***
- ***Clarify that physician testimony via video-conferencing is allowed under the Code.***
- ***Attorneys must be present with the proposed patient in any proceeding under the Code.***
- ***Video-conferencing for proceedings under the Code is only permitted when the proposed patient is in a different county from the court with probate jurisdiction. All parties and the court must agree to a hearing via video-conference.***

Appendix 1: 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 2: 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 abnormal 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 3: 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 within two weeks after the court enters the order 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. 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..

- 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 of others, 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, which will be held within seven days from the detention

Appendix 4: 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.