

Mental Health Law

The Honorable Guy Herman
Travis County Probate Court No. 1
1000 Guadalupe Street
Room 217
Austin, Texas 78701

JUDGE GUY HERMAN
Probate Court No. 1 of Travis County, Texas
County Courthouse, Room 217
Austin, Texas 78701
(512) 854-9258
(512) 854-4418

BIOGRAPHICAL INFORMATION

EDUCATION

University of Texas at Austin, B.A., 1972

University of Delhi, India, 1973

University of Texas at Austin, J.D., 1977

JUDICIAL CAREER

1985-Present Judge, Travis County Probate Court No. 1

-- Appointed on May 17, 1985

-- Reelected in 1986, 1990, 1994, 1998, 2002 and 2006

1980-85 Justice of the Peace, Travis County Precinct 5

LEGAL CAREER

1978 Licensed, May 1978

1978-80 Associate, Practiced with the Law Offices of David R. Richards and Associates
with David Richards and David Van Os

PROFESSIONAL ACTIVITIES

1993-Present President, Texas College of Probate Judges

1998-2001 Presiding Judge, Statutory Probate Judges of Texas

2001-02 Appointed to the Mental Health Service System Task Force upon the
recommendation of the Texas Department of Mental Health and Mental
Retardation

1991-92 Chairperson, the Guardianship Work Group created by the Texas Senate Interim
Committee on Health & Human Services

1991-92 Member of the Citizens' Commission on the Texas Judicial System

1989 Organized the Travis County Mental Health Coordinating Council, providing agencies and
advocacy groups with a forum to address concerns with the involuntary mental health service
system

1986 Instrumental in the conception and formation of the Family Eldercare Guardianship Program, a
volunteer guardianship program

1983 Organized, with three others, the Travis County Dispute Resolution Center, an organization
committed to using mediation when possible to resolve guardianship contests involving family
members

Ongoing Lectures throughout the state on probate, guardianship, and mental health law

PROFESSIONAL MEMBERSHIPS

Member, State Bar of Texas

Member, Travis County Bar Association

Member, National College of Probate Judges

Life Member, Texas Bar Foundation

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I. Introduction

The scope of this article covers the Texas system for the involuntary commitment of persons with mental illness pursuant to the Texas Health & Safety Code. This paper discusses procedures and hearings involving emergency detention, court-ordered mental health services, and protective custody. It is not within the scope of this paper to discuss psychoactive medication hearings, commitments of persons with intellectual disabilities, chemical dependency commitments, or the procedures for involuntary commitments of those needing treatment under criminal court jurisdiction.¹ Further, this paper will not discuss recent legislative changes to mental health law that fall outside the scope of this paper.²

In 2003, the Legislature drastically reorganized the state's agencies, and these changes had a sea-change effect on those entities serving those who need mental health services. Almost all of Texas' stand alone human service agencies were dissolved, with the agencies' functions reorganized into four departments under the umbrella of the Human and Health Services Commission. The four newly created departments are the Department of State Health Services (DSHS), the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), and the Department of Assisted and Rehabilitative Services (DARS). Thus, the Texas Department of Mental Health and Mental Retardation and the Texas Commission on Alcohol and Drug Addiction became extinct. The Legislature split the responsibilities and placed the services for persons with mental illness under the aegis of the Department of State Health Services while placing the services for persons with intellectual disabilities in the Department of Aging and Disability Services. The chemical dependency service function was placed within the Department of State Health Services.

Despite the reorganization at the state level, most of the local mental health authorities will continue to provide services to both persons with mental illness and persons with intellectual disabilities by virtue of

¹ The author recognized that probate courts are involved with psychoactive medication hearings, commitments of persons with intellectual disabilities, and chemical dependency commitments. Because of time constraints, those topics will not be covered in this paper; however, a brief overview of each topic can be found respectively in Appendices A, B, and C.

² In 2005, for example, the Texas Legislature amended the procedure for obtaining a psychoactive-medication Order to include having the probate court issue orders for psychoactive medication for inmates in the county jail or state hospital who are under a criminal commitment or who have been civilly committed as an inpatient within six months of their incarceration in the county jail.

their designation as the local mental health authority (MHA) for a particular area.³ However, although an MHA has the obligation to provide services to persons with intellectual disabilities who reside in the geographic area served, the MHA's authority to refuse services to residents outside the MHA area has been curtailed by the Department of Aging and Disability Services. The result is that counties that have developed more services than others, even with local dollars, will have to serve persons in need of services who reside outside the MHA's normal service area.

II. Involuntary Commitment: Authority

The Texas Constitution Article I, § 15a directs the Legislature to enact laws governing the commitment of persons with mental illness for observation and/or treatment and provides for appeal of such commitments. It prohibits the commitment of a person because of unsound mind, except on competent medical or psychiatric testimony. Article I, § 15 of the Texas Constitution requires there be a jury trial in all involuntary commitments exceeding 90 days; however, a waiver of this mandatory jury is provided for in Article I, § 15a. By statute, the Texas Legislature has mandated jury trials upon request of the proposed patient in involuntary commitments of 90 days or fewer.

Admission, confinement, treatment, and discharge in and from a psychiatric facility, whether voluntarily or involuntarily, are governed by statutory law and not the common law. Most, if not all, of the statutes applicable to voluntary and involuntary psychiatric treatment are contained in the Texas Health and Safety Code. These provisions are set out in Chapters 571 through 578 of the Texas Health and Safety Code, commonly known as the Texas Mental Health Code. The provisions for involuntary commitments of those needing treatment while under criminal court jurisdiction are set forth in Articles 46.02 and 46.03 of the Texas Code of Criminal Procedure.

The commitment and hospitalization of individuals suffering from a mental illness in Texas is civil and not criminal in nature. These proceedings are strictly creatures of statute. Courts may exercise only such authority as has been expressed in the statutes or that may be clearly implied.

There is no common law right to admit or treat a person on a voluntary basis in an inpatient mental health facility. The only authority to treat a person on a voluntary basis in an inpatient facility is by the

³ Subtitle Z, Title 3, Texas Government Code added Chapter 392, effective September 1, 2011, to require the Legislature to eschew such terms as "mentally ill" and "mentally retarded" in favor of "Person First Respectful Language."

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authority of the Texas Mental Health Code. Under the Code, only the person receiving treatment can agree to voluntary treatment.

The involuntary commitment process involves a balance between the state's authority to protect the safety of its citizens and the rights of persons to make decisions about the manner in which they will conduct their lives. Civil commitment potentially constitutes a substantial denial of basic human and constitutional rights without violation of any criminal law. For instance, a person can be detained without bond for up to 30 days pending a final determination of whether the allegations of mental illness in an Order for Protective Custody are true. Thus, the authority of the state to intervene should be permitted only when an illness has so overpowered an individual's ability to make decisions that there is serious danger to self or others. The potential for misuse and abuse⁴ has caused the Legislature to create a statutory scheme for services that, at times, seems onerous, but is easy to follow when one takes the time to understand it.

III. The Texas Mental Health Code

As stated above, the commitment process is civil in nature, and the entire process of entering into a psychiatric facility, court-ordered or voluntary, is governed by the Texas Mental Health Code ("the Code"), which is contained in § 571 et seq. of the Texas Health and Safety Code. (In this paper, all section references are to the appropriate sections of the Texas Health and Safety Code.) This author also recommends reviewing Michael J. Churgin's *An Analysis of the Texas Mental Health Code* (3rd Ed., 2007).

For the most part, the voluntary commitment process does not involve court participation except when the involuntary commitment procedure is instituted while a proposed patient is on a voluntary commitment or when violations of the Code in reference to voluntary patients are brought to the attention of the judge and his role as a magistrate comes into play. Although the Code is a civil statute, there are criminal penalties for violating it under certain circumstances. A magistrate's duties include reporting criminal behavior to the appropriate law enforcement agencies and preventing criminal violations from occurring.

A. Courts with Jurisdiction

With one exception,⁵ statutory probate courts and county courts at law with probate jurisdiction share jurisdiction concurrently with the constitutional county courts in all proceedings for the commitment of persons with mental illness not charged with a criminal offense. Only these courts can make a final determination of whether a person shall be committed under court order to receive psychiatric services. However, a number of other types of courts and entities have some limited jurisdiction at certain stages of the psychiatric detention process. Magistrates (set out in Art. 2.09 of the Texas Code of Criminal Procedure) can sign emergency detention warrants by virtue of being magistrates. They can also sign Orders of Protective Custody if so designated by the judge of the mental health court. In addition, masters, appointed under the authority of the Code to make determinations on probable cause hearings, can enter orders of release or further detention when the judge of the court where an application is pending uses the master system rather than a designated-magistrate system. See § 574.025(c), § 574.026 and § 574.028. Finally, several communities are designating misdemeanor or felony criminal courts to be the criminal "Mental Health Court" for that county. See § 616.001.

B. Important Definitions

The Code gives us certain definitions that guide us in the commitment process. See § 571.003. The most important terms are "mental illness," "inpatient mental health facility," "local mental health authority," and "mental health facility."

The term "**mental illness**" is defined as an illness, disease, or condition that either (1) substantially impairs a person's thought, perception of reality, emotional process, or judgment or (2) grossly impairs behavior as demonstrated by recent disturbed behavior. § 571.003(14). This definition does not include a person suffering from epilepsy, senility, alcoholism, or a mental deficiency. However, a person who suffers from a mental illness along with another condition is still subject to commitment under the Code.

As defined by § 571.003(9), an "**inpatient mental health facility**" is defined as a mental health facility that can provide 24-hour residential and psychiatric services and that

1. is operated by the Texas Department of State Health Services (DSHS);⁶

⁴ For examples of cases upholding convictions for causing the unwarranted commitment of a person to a mental health facility under § 571.20, see *Rent v. State*, 982 S.W.2d 382 (Tex. Crim. App. 1998) and *Shike v. State*, 961 S.W.2d 344 (Tex. App. – Houston, [1st Dist.] 1997, writ ref'd).

⁵ District Courts have jurisdiction to hear civil mental commitments in those counties in which there are no county court at law courts and the county judge is a non-lawyer.

⁶ In this statute, the wording still reads "Texas Department of Health and Mental Retardation" and "Texas Department of Health," depending on the subsection. Presumably, the

Chaz 2008
or 2007 w/out warrant → OPC

No order of
Emergency Det. w/ warrant
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2. is a private mental hospital licensed by DSHS;
3. is a community center, a facility operated by or under contract with a community center, or another entity designated by DSHS to provide mental health services;
4. is a local mental health authority or a facility operated by or under contract with a local mental health authority;
5. is an identifiable part of a general hospital that provides diagnosis, treatment, and care for persons with mental illness and that is licensed by DSHS; or
6. is a hospital operated by a federal agency.

The Code defines “local mental health authority” as an entity to which the Texas Board of Mental Health and Mental Retardation⁷ delegates its authority and responsibility within a specified region for planning, policy development, coordination, including coordination with criminal justice entities, and resource development and allocation for supervising and ensuring the provision of mental health services to persons with mental illness in the most appropriate and available setting to meet the individual needs in one or more local service areas. § 571.003(11).

A “mental health facility” is defined as (1) an inpatient or outpatient mental health facility operated by DSHS, a federal agency, a political subdivision, or any person; (2) a community mental health and mental retardation center, or a facility operated by a community center; or (3) that identifiable part of a general hospital that provides diagnosis, treatment, and care for persons who are mentally ill. § 571.003(12).

C. Representation of the State

The county attorney is responsible for the representation of the state in hearings for court-ordered mental health services. § 571.016. In counties with no county attorney, the district attorney, the criminal district attorney, or a court-ordered special prosecutor shall represent the state. § 571.016. All proceedings for involuntary confinement and/or treatment under this Code are brought in the name of “The State of Texas for the Best Interest and Protection of [the person].”

D. Rights of the Proposed Patient

It must be remembered that an individual who is suffering from a mental condition and subjected to restraint of personal liberty is not deprived of any constitutional rights, benefits, responsibilities, or privileges. The Code specifically enumerates those

rights to which a patient is entitled while receiving mental health services under §§ 572.003, 573.025, 574.004, 576.001, 576.021, and 576.027. Section 571.0167 provides that a petition for a writ of habeas corpus must be filed in the Court of Appeals for the county in which the commitment order is entered. The State shall be made a party in a habeas corpus proceeding and be represented by the county attorney. Any person detained under the emergency-detention provisions, or receiving voluntary or involuntary mental health services under the Mental Health Code, is still presumed to be competent unless a contrary judicial determination has been made under appropriate Texas Probate Code provisions. § 576.002.

E. Three Steps of Involuntary Commitment

Conceptually, the commitment process needs to be broken down into three parts for a clear understanding: (1) emergency detention, (2) protective custody, and (3) commitment. The difficulty in the overall process often arises from misuse of the terms and from use of general terminology when specific terminology is more appropriate. For example, quite often citizens request an Order of Protective Custody (OPC) when what they really want is an emergency detention or a commitment. The term OPC is the most misused phrase in the commitment process, and its overuse gives rise to much confusion.

IV. Emergency Detention

In the vast majority of cases resulting in involuntary commitment, the process is initiated by an emergency detention under § 573.001 or § 573.011. Section 573.001 is the warrantless detention procedure, and § 573.011 is the procedure for emergency detention with a warrant. The criteria for these two sections are the same except that (1) the warrantless provision has the added requirement that the peace officer believe there not be sufficient time to obtain a warrant, and (2) a guardian of a ward may apply for emergency detention without a warrant.

A. Emergency Detention Without a Warrant (Peace Officer) - § 573.001

A warrantless detention is the preferred method of emergency detention because of the very nature of a situation requiring intervention: the Code requires an officer to have sufficient reason to believe (1) that a person is mentally ill and (2) that because of such illness, a substantial risk of harm to self or others exists unless immediate restraint is employed. § 573.001(a). If an officer encounters a person who truly meets the criteria for emergency detention, there should never be time to secure a warrant. A peace officer without a warrant may take into custody any such person

statute will eventually refer to the “Department of State Health Services.”

⁷ The Texas Board of Mental Health and Mental Retardation no longer exists.

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suffering from mental illness, may transport the person to the nearest appropriate inpatient mental health facility – or a mental health facility deemed suitable by the local mental health authority if an appropriate inpatient mental health facility is not available – and may immediately file an application with the facility for the person’s detention. No detention is permitted in a private facility without the consent of the head of such facility.

The officer’s belief that mental illness exists may be based upon (1) the representation of a credible person; (2) the conduct of the person sought to be held; or (3) the circumstances under which such person was found. § 573.001(c). To determine whether an individual is exhibiting substantial risk of harm to self or others, the officer should consider either the person’s behavior, or whether there exists evidence of severe emotional distress and deterioration in the individual’s mental condition to an extent that he or she cannot remain at liberty. § 573.001(b). The officer must also have a reasonable belief that sufficient time does not exist to obtain a warrant. § 573.001(a)(2).

An officer’s Application for Emergency Detention at an inpatient facility must contain adequate statements of the **specific** information and facts that formed the basis for the requested detention. § 573.002. The risk of harm must be specified and described. The specific details of the person’s behavior, acts, attempts, or threats must also be stated. The behavior, overt acts, attempts, or threats of the individual must be recent and either observed by or reliably reported to the officer. Finally, the application must contain the names and relationship to the individual of all persons who reported or observed any recent behavior, acts, attempts, or threats.

Some peace officers have expressed various anxieties about warrantless detention. These concerns range from fear of being sued for some deprivation of constitutional rights in arresting a person without a warrant to an uncomfortable feeling operating in the civil-law arena. The statutory framework for civil detention is not unconstitutional. The authority for these warrantless procedures lies in the police power and general welfare protection role of the government emanating from both the federal and state constitutions and is limited only by due process concepts. The Legislature fully understood this constitutional framework when it enacted the Code. The fact that these detentions occur in non-criminal situations does not necessarily mean that different procedures for detention from those used in criminal law are required. Uneasiness resulting from the fact that these procedures fall under the civil law is misplaced. Any concern should be ameliorated when one considers that these detentions were created not to punish a person for acting with criminal intent but to protect individuals

from self-inflicted harm and to protect society from harm from others as a result of mental illness.

The constitutionality of warrantless detention has not been challenged in court, and there is no Attorney General’s opinion on it. Many jurisdictions within Texas are using the provision successfully, but some areas of the state are not fully using this provision. Some metropolitan areas claim that the warrantless detention provision is unnecessary because of the availability of magistrates twenty-four hours a day to issue warrants. However, investigation shows that, more often than not, the officers are detaining the person without a warrant and later obtaining a warrant. Alternatively, a warrant is obtained after these people are arrested for criminal charges that are subsequently dismissed. This author feels strongly that the proper use of the warrantless detention provision could save a lot of wasted paperwork, jail space, and valuable human resources.

B. Emergency Detention Without a Warrant (Guardian) - § 573.003-4

Since 2003, guardians have had the authority to transport an adult ward (18 or older) to a mental health facility and apply for a “preliminary examination” and emergency detention without a warrant. Section 573.003, which lists the prerequisites for undertaking such action, sets forth the same standard required of peace officers for warrantless apprehension. The contents of the guardian’s application is the same as that required of a peace officer (*see* § 573.002), and the ward’s rights are the same under § 573.025 as that of a person apprehended by a peace officer.⁸

Likewise, Probate Code § 767 (b) gives guardians the power to transport a ward to a mental health facility for the above purpose, “notwithstanding” § 767(4), which excludes consent for inpatient psychiatric commitment as one of the guardian’s powers. It must be noted, however, that the provision allowing a guardian to “check the ward in” for emergency detention does not apply to wards who are minors under the age of 18.

In a similar vein, Probate Code § 770A authorizes the guardian of an adult ward under an Order of Protective Custody to consent to involuntary psychoactive medication. For more psychoactive medication orders, see Appendix A.

⁸ The author is unaware of any guardian using this procedure as of this date.

C. Emergency Detention With a Warrant - § 573.011

1. Application for Emergency Detention - § 573.011

Any adult may file an Application for the Emergency Detention of another. If the application is granted, a warrant is issued. Before issuance of an emergency warrant is approved, there must be adequate and credible information presented so that a reasonable decision may be formulated to protect the rights of the individual against the rights of society in general. The determination of what may be adequate and credible information is very difficult and can be accomplished only on a case-by-case basis. The sole purpose of the issuance of these warrants is to protect the individual or others when a substantial imminent risk of serious harm exists and immediate intervention or restraint is necessary to prevent injury. Thus, both the facts that form the basis for the requested warrant and the person who furnishes these facts must play a key role in the decision-making process. Therefore, the court can require the applicant to appear and be examined in order to attest the adequacy and credibility of the information furnished.

Peace officers are under similar constraints when exercising their authority under the warrantless detention provision contained in the Code. The same can be said of physicians and psychiatrists when performing their duties during preliminary examinations after emergency detention.

The applicant must have reason to believe and must believe all four of the following: (1) the person evidences mental illness; (2) there exists a substantial risk of serious harm to self or others; (3) such risk of harm is imminent unless the person is restrained; and (4) such belief is based on specific recent behavior, overt acts, attempts, or threats. In the application, the applicant must state and describe the following **in detail**: (1) the basis for the risk of harm; (2) the behavior, acts, attempts, or threats that form the basis of the applicant's belief; and (3) the relationship of the applicant to the individual. Any other available relevant information may accompany the application. § 573.011.

2. Issuance of the Warrant - § 573.012

Upon finding that reasonable cause exists, a judge can issue an order for emergency apprehension and detention of a person suffering from mental illness. This warrant should be issued only upon a proper written application of any adult person. Although the Code does not require an applicant to be under oath, it is better practice to require a sworn application. An application may be presented personally to the judge. A physician applicant may transmit an application by email. If the application is approved, the warrant may

be transmitted electronically or by email. The application must provide adequate information and facts upon which the judge can base a decision.

The judge must deny the application unless he or she finds reasonable cause to believe: (1) that the person evidences mental illness; (2) that the person evidences a substantial risk of serious harm to self or others, which harm may be demonstrated either by the person's behavior or by the evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person cannot remain at liberty; (3) that the risk of harm is imminent unless the person is immediately restrained; and (4) that the necessary restraint cannot be accomplished without emergency detention. § 573.012.

If the judge finds that all four criteria for emergency detention exist, the judge shall issue a warrant for the apprehension, transportation, and detention of the person to the nearest appropriate inpatient mental health facility, or a mental health facility deemed suitable by the local mental health authority if an appropriate inpatient mental health facility is not available, for the purpose of having a preliminary examination performed. § 573.012(e). Copies of such warrant must be immediately transmitted to the facility because the warrant serves as the application required by the Code. § 573.012(f).

It bears repeating that an emergency warrant should issue only where the judge is satisfied that a substantial threat of future harm exists. And in making this decision, the judge should look for actual dangerous behavior evidenced by recent past overt acts or threats. If in doubt, the judge may personally interview the applicant instead of relying solely on the application.

D. Emergency Detention & Release - § 573.023

In both a warrantless situation and detention with a warrant, the Code requires that the individual be released and returned to the location of apprehension, place of residence, or suitable place unless a written statement of the examining physician is provided. § 573.023(a). No person may be detained in excess of 48 hours from the time of presentment to the facility unless a written order for further detention is obtained. (It should be noted that until September 1, 2007, the person could only be detained for 24 hours.) Also, in instances when the 48-hour period expires on a Saturday, Sunday or legal holiday or before 4:00 p.m. on the first succeeding business day (the day after the Saturday, Sunday or legal holiday), the person may be held until 4:00 p.m. on the first succeeding business day (the day after the Saturday, Sunday or legal holiday). Note that this does not give an extra day after these days, but gives until 4:00 p.m. on the first

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business day to file even when the 48-hour period would end before noon. § 573.021 (b).

V. Physician's Preliminary Examination after an Emergency Detention

An inpatient facility where the individual has been presented must accept and conduct a preliminary examination by a physician within 12 hours of the person's apprehension pursuant to an emergency detention. § 573.021. (Prior to September 1, 2007, this examination had to be conducted within 24 hours.) If the individual is released, he or she must be returned to the location of apprehension, to his or her residence in the state, or to another suitable place. If the individual is arrested or the individual objects to the return, he or she does not have to be transported.

The Code prohibits the admission of a person to an inpatient mental health facility unless there is a written statement from an examining physician, which statement must be acceptable to the facility. § 573.022. This written statement must express the physician's opinion that (1) the person is mentally ill; (2) the person evidences a substantial risk of serious harm to self or others; (3) the risk of harm is imminent unless immediate restraint is employed; and (4) emergency restraint is the least restrictive means available. The physician's written statement must include (1) a description of the person's disorder; (2) a specific description of the risk of harm the person evidences (which may be demonstrated either by the person's behavior or by evidence of emotional distress and deterioration in his or her mental condition so as not to permit the person to remain at liberty); and (3) the specific detailed information that forms the basis for the physician's opinion. In most cases, this statement will not be available at the time an emergency warrant is requested.

The head of the facility must release the person during the emergency detention period should it be determined that the person no longer meets the conditions found in the physician's written statement. § 573.023(b). It is the responsibility of the county in which the person was apprehended to make arrangements to return the person to the place of apprehension, to his or her residence, or to another suitable place.

VI. Medical Certificates

When an appropriate physician's medical affidavit is generated, an Application for Court-Ordered Mental Health Services can be filed. § 574.001. Before a final hearing on the merits takes place, there must be two medical certificates on file, completed by different physicians. At least one physician must be a psychiatrist if one is available in the county. Both certificates must be based on examinations completed

within 30 days of the final hearing. § 574.009; *In re D.F.R.*, 945 S.W.2d 210, 213 (Tex. App. – San Antonio 1997, n.w.h.).

If the applicant wants the proposed patient detained prior to the final hearing (i.e., by an Order of Protective Custody), the medical certificate must contain allegations that the proposed patient presents a substantial risk of serious harm to self or others and must set out in detail the factual basis for the opinion. § 574.011 et seq. This certificate must be based on an examination of the proposed patient made within three days of the Order of Protective Custody (OPC). § 574.021(d). (Prior to September 1, 2007, this examination had to be made within 5 days of the OPC.) This certificate will be presented to the county attorney for his or her determination of whether the facts warrant the county attorney's office filing a Motion for Protective Custody with the court wherein the application for mental health service is pending. No court or designated magistrate may issue an OPC without an Application for Court Ordered Mental Health Services on file. An OPC cannot be issued when the only application is one for emergency detention. § 574.021(a).

VII. Restriction on Issuance of an OPC

A magistrate is not permitted to sign orders of protective custody unless the judge of the court where an Application for Court-Ordered Mental Health Services is pending has by order designated such judge to sign these orders. Therefore, a magistrate whose court does not have original jurisdiction over mental health proceedings should, in the absence of a special order of appointment, decline to sign any orders of protective custody that may be presented. An OPC is different from an Order for Emergency Detention. Only a judge, or that judge's designated magistrate, of a court of record having mental health jurisdiction can issue an OPC. By contrast, any magistrate in the State of Texas can issue an Order for Emergency Detention.

VIII. Setting Hearings, Giving Notice, & Appointing an Attorney Ad Litem

Immediately upon the filing of an Application for Court-Ordered Mental Health Services, the court or its designated magistrate becomes obligated(1) to appoint an attorney ad litem for the proposed patient; (2) to set a probable cause hearing if an OPC has been or will be issued; (3) to set a final hearing on the merits; and (4) to serve notice on both the proposed patient and the attorney ad litem of all pleadings, attorney appointments, hearing settings, and to provide a written list of attorney ad litem duties. This should be done contemporaneously with the issuance of any OPC. The county clerk is responsible for having the notice served.

A. **Setting & Notice of a Probable Cause Hearing - § 574.025**

The probable cause hearing must be set and heard within 72 hours from the time detention began under the OPC except that if the 72-hour period ends on a Saturday, Sunday, or legal holiday, the hearing can be held the succeeding business day. The probable cause hearing may be postponed each day for an additional period of 24 hours if the judge or designated magistrate declares an extreme emergency based on extremely hazardous weather conditions or the occurrence of a disaster that threatens the patient or other essential parties to the hearing. If an OPC is issued and a hearing does not take place within 72 hours, the facility detaining the proposed patient under the OPC is obligated to discharge the proposed patient. The code provides a form for the Notification of Probable Cause Hearing. See § 574.026(d). Any detention after 72 hours is unlawful unless a waiver of the probable cause hearing signed by the attorney ad litem and the proposed patient is filed, or unless a final hearing is held within the 72-hour period.

B. **Setting the Final Hearing - § 574.005**

The final hearing shall be set at a time that is within 14 days of the date of filing the Application for Court-Ordered Mental Health Services. This 14-day rule is jurisdictional, that is, if the original setting is outside of the 14-day period, all proceedings occurring after 14 days are illegal because the court no longer has jurisdiction over the proposed patient. *In re State for Gill*, 680 S.W.2d 41, 42 (Tex. App. – Amarillo 1984, no writ) (holding that an order for commitment was invalid because the trial court failed to schedule the date for the final hearing within 14 days of the application even though notice of the hearing date was filed within that period).

If the original setting is within the 14-day period, the court, on its own motion or on the motion of the State or the proposed patient's attorney, could continue the as long as the hearing is held and completed within 30 days from the filing of the Application for Court-Ordered Mental Health Services.

C. **Notice of the Final Hearing - § 574.006**

A copy of the Application for Court-Ordered Mental Health Services and written notice of the time and place of the hearing must be sent to the proposed patient and his or her attorney. § 574.006(a). The documents must be delivered in person or sent by certified mail to the following people: (1) the proposed patient's parent, if the patient is a minor; (2) the proposed patient's parent appointed guardian, if the proposed patient is the subject of a guardianship; or (3) each managing and possessory conservator that has been appointed for the proposed patient. § 574.006(b).

Notice may be given to the proposed patient's next of kin if the relative is the applicant, the parent cannot be located, and a guardian or conservator has not been appointed. § 574.006(c).

D. **Appointment of Attorney - § 574.003**

If the proposed patient does not have an attorney, the judge must appoint an attorney to represent a proposed patient within 24 hours after the time an Application for Court-Ordered Mental Health Services is filed. At that time, the judge shall also appoint a language or sign interpreter if necessary to ensure effective communication with the attorney in the proposed patient's primary language. § 574.003(a).

E. **Attorney's Duties - §§ 574.003 & 574.004**

The Code now requires the court to give a copy of the attorney's duties to the attorney in every case in which the attorney is appointed. § 574.003(b). This requirement is a result of several instances where court-appointed lawyers either were not visiting their clients before hearings were held or were conducting group interviews of clients. The publicity surrounding such inappropriate and inadequate representation caused the Legislature to strengthen the rights of patients. § 574.003(b).

The attorney ad litem represents the proposed patient. Thus, the attorney owes his or her duty to the client, not to the client's family. Moreover, it is not the attorney's duty to make the court's life any easier. Duty to the client is paramount, and the Code emphasizes this fact by mandating that the attorney advocate the client's wishes within the bounds of law even when this advocacy of the proposed patient's desires is against the attorney's personal views. § 574.004(c).

The attorney ad litem has to interview the client within a reasonable time before any hearing, thoroughly explain the law and facts to the proposed patient, and conduct his or her representation of the proposed patient according to the mandates of the Code. § 574.004(b). The court that hears mental health cases, in its magisterial capacity, is obligated to make sure no civil or criminal violations of the Code occur.

The attorney ad litem is obligated under law to represent the patient all the way through the appellate process even if the lawyer personally disagrees with the patient as to the efficacy of an appeal. § 574.004(h). Even when a proposed patient wants to represent himself on appeal, the attorney ad litem is obligated to represent the patient until the appellate process is completed.

F. **Disclosure of Information - § 574.007**

If otherwise unattainable, a proposed patient's attorney may request information from the county or

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district attorney regarding the reasons that voluntary outpatient services are not appropriate for the patient, the names of the witnesses who may testify at the hearing, a description of the reasons court ordered mental health services are required, and a list of any acts committed by the proposed patient that will be used as evidence at the hearing. § 574.007(b).

No later than 48 hours before the time set for the hearing on the petition for commitment, the county or district attorney is obligated to inform the proposed patient (through the patient's attorney) whether they will request commitment to inpatient or outpatient services. This requirement may be waived, but the waiver must be done by the proposed patient orally and in the presence of the court or in writing, signed and sworn under oath, by the patient and his attorney. § 574.007(d).

IX. Probable Cause Hearings

A probable cause hearing determines whether a proposed patient may be detained pursuant to the issuance of an OPC. § 574.025. Unless there is probable cause for the detention, the proposed patient is released until the final hearing for court ordered mental health services.

A. Time Limitations- § 574.025(b)

When an OPC has been entered, a probable cause hearing is required within 72 hours of detention unless the proposed patient and his attorney waive the hearing or unless a final hearing is held on the matter within the 72-hour period of detention authorized by the OPC. § 574.025(b). If the waiver or final hearing does not occur, then a probable cause hearing must be conducted. As mentioned earlier, there is a provision for the hearing to be held outside the 72-hour period given weekends and legal holidays. The hearing shall be before a magistrate or a special master appointed by the judge in whose court the case is pending. The master is entitled to reasonable compensation.

B. The Hearing

The Texas Rules of Evidence do not apply to this hearing as they do at a final hearing. § 574.025(e). Therefore, the magistrate or special master may consider hearsay testimony that would be excluded upon appropriate objection at the final hearing. The only issue before the court at a probable cause hearing is whether the patient presents a substantial risk of serious harm to himself or to others. § 574.025(a). It should be noted that the statute governing the probable cause hearing does not authorize the detention of a proposed patient due to his or her "deteriorated" condition. The proposed patient may be detained only if there is a "substantial" risk of harm to the proposed patient or others. This standard is higher than the

standard in the final hearing for court-ordered mental health services. If the magistrate or special master determines that there is no probable cause to believe the patient presents a substantial risk of serious harm to self or others, then the patient is to be released. § 574.028. If the magistrate or special master determines that there is an adequate factual basis for probable cause to believe the proposed patient presents a substantial risk of serious harm to self or others such that he cannot be at liberty pending the final hearing, then the protective custody shall continue. § 574.026. If the protective custody is to continue, the magistrate or special master shall arrange for the patient to return to the mental health facility along with the evidentiary material submitted, and a Notification of Probable Cause Hearing shall be made. The form of the Notification of Probable Cause Hearing is set out in § 574.026(d). Copies of these documents are to be filed in the county clerk records of the court hearing this case.

C. Release by the Head of the Inpatient Facility - § 574.028

If at any time the head of a mental health facility determines that a patient under protective custody no longer meets the criteria, then the proposed patient shall be discharged from the hospital – even after an OPC or Continuation of Protective Custody has been entered.

X. Final Hearing

A. Pre-Hearing

The final hearing is to be heard within 14 days of the filing of the Application for Court-Ordered Mental Health Services. It is possible to continue the matter from its original setting to another hearing date as long as the final hearing is completed within 30 days of the filing of the application. § 574.005. Before the start of the final hearing, there must be two medical certificates on file conducted within the preceding 30 days. § 574.009. If not, the judge shall dismiss the application and immediately dismiss the proposed patient. *Porter v. State*, 703 S.W.2d 840, 843 (Tex. App. – Fort Worth 1986, no writ). Although this requirement of having two medical certificates on file is jurisdictional, defects within the certificates are non-jurisdictional. A trial court will still have jurisdiction to hold a hearing on an application that includes defective certificates, and the proposed patient may waive objections by not timely objecting. *In the Matter of D.T.M.*, 932 S.W.2d 647, 652 (Tex. App. – Fort Worth 1996, no writ).

Granting continuances can be problematic. A continuance may affect whether there are two valid medical certificates made within the 30 days preceding the final hearing due to the interplay between the 3-day

OPC rule and the 30-day final hearing rule. See § 574.005 and § 574.021(d). If both certificates are not filed with the application, the judge or magistrate may appoint a psychiatrist to file the appropriate certificate. § 574.009(b). The judge may order the proposed patient to submit to such examination and may issue a warrant to a peace officer to take the proposed patient into custody for the examination. § 574.009(c).

B. Hearing Rules - § 574.031

At the hearing, the Texas Rules of Evidence shall govern the proceedings, and the hearing shall be on the record. § 574.031(g). A court reporter must take the testimony. § 574.031(g). The hearing can be held anywhere within the county, but shall be at the county courthouse upon the demand of the proposed patient or his attorney. § 574.031(b).

C. Rights of the Proposed Patient

The proposed patient shall have the right to be present at the hearing, but can waive his presence or have his attorney waive his presence so long as the attorney states, on the record, the reason for the proposed patient's absence. § 574.031(c). The hearing shall be public unless the proposed patient or his attorney requests that the hearing be closed, and the court determines there is good cause for the hearing to be closed. § 574.031(d). At a temporary mental health services hearing, the proposed patient has the absolute right to a jury if he so requests. § 574.032(a). A hearing for extended mental health services must be before a jury unless the jury right is waived by the proposed patient or by the proposed patient's attorney. § 574.032(b). Waivers must be sworn to in writing or made orally in the court's presence. At an extended mental health services hearing, the court must have the testimony of a psychiatrist whose testimony cannot be waived even if the proposed patient and his attorney wish to waive it. § 574.035(e).

D. Elements for Commitment

1. Inpatient Mental Health Services

Under §§ 574.034(a) and 574.035(a), the necessary elements for involuntary inpatient commitment are that the proposed patient is mentally ill and, as a result

- (1) the proposed patient is likely to cause serious harm to himself; or
- (2) the proposed patient is likely to cause serious harm to others; or
- (3) the proposed patient *gravely* ^{disabled to the extent they are dangerous} ~~is~~ *standard*
 - (a) is suffering severe and abnormal mental, emotional, or physical distress; and
 - (b) is experiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited

by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health, or safety; and

- (c) is unable to make a rational and informed decision as to whether to submit to treatment.

2. Outpatient Mental Health Services

Before 1997, the Mental Health Code made no distinction between the elements necessary for inpatient and outpatient commitments. Recognizing the differences between the two court-ordered mental health services, the Legislature in 1997 created different elements for outpatient commitment. Where inpatient services can be ordered by the judge after a finding of one or a combination of the three possible commitment criteria, outpatient services can be ordered based upon the following multi-part criteria. Under §§ 574.034(b) and 574.035(b), the court may order a proposed patient to receive temporary or extended outpatient mental health services only if

- (1) the judge finds that appropriate services are available to the patient, and
- (2) the judge or jury finds
 - (a) the proposed patient is mentally ill, and
 - (b) the nature of the mental illness is severe and persistent, and
 - (c) as a result, the proposed patient will, if not treated, suffer severe and abnormal mental, emotional, or physical distress, and will experience deterioration of the ability to function independently to the extent that the patient will be unable to live safely in the community without court-ordered outpatient services; and
 - (d) the proposed patient has an inability to participate in outpatient treatment services effectively and voluntarily.

The application of different criteria for receiving outpatient services allows some patients who would previously have been committed to inpatient services the possibility of receiving structured outpatient services more suitable for the individual's particular mental illness.

3. Specification of the Basis for Inpatient Commitment

In an order for temporary or extended inpatient mental health services, the court must clearly state which of the criteria listed in § 574.034(a)(2) or § 574.035(a)(2) form the basis for the court's decision to order mental health services. See § 574.034(c) and § 574.035(c). There has been a great deal of confusion in the courts on how this standard must be met. Although some lower courts have entered commitment orders where all three criteria were submitted disjunctively in the order, several appellate courts have

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overruled such orders, holding that there were no specific findings since the criteria were not submitted in the conjunctive. *In the Matter of T.L.T.*, 909 S.W.2d 949 (Tex. App. – Eastland 1995, no writ); *In re J.J.*, 900 S.W.2d 353, 356 (Tex. App. – Texarkana 1995, no writ); and *In re J.S.C.*, 812 S.W.2d 92, 96 (Tex. App. – San Antonio 1991, no writ).

Other appellate courts, however, have found that the Code provision that defines the evidentiary standard lists the three elements disjunctively. *E.g.*, *In the Matter of R.S.C.*, 921 S.W.2d 506, 512 (Tex. App. – Fort Worth 1996, no writ). Paradoxically, these courts have found that the standard does not require affirmative findings on each element and that the standard does not prohibit disjunctive findings. *Id.*; see also *Mezick v. State*, 920 S.W.2d 427 (Tex. App. – Houston [1st District] 1996, no writ).

If the commitment order provides sufficient notice as to which criterion formed the basis of the fact-finder's decision to commit, the requirements of § 534.035(b) are met. *L.S. v. State*, 867 S.W.2d 838, 844 (Tex. App. – Austin 1993, no writ). In *L.S. v. State*, the court found that since only two of the three criteria were marked, the order provided sufficient notice as to which of the criteria formed the basis for the decision. *Id.*

One should be wary of any mental health commitment order that leaves itself open to attack in this unsettled area of the law. It is the opinion of this author that any one or any combination of the criteria can form the basis of the commitment, but that a court should specify the exact basis for its decision. The author recommends taking the word "or" out of the order's listed criteria, thus requiring specific findings of the listed criteria, whether one, two, or all three findings apply to the proposed patient; this change should remove the problem of disjunctive interpretation from the order. not used

4. The "Gravely Disabled or ~~Deterioration~~" Standard

As stated earlier, in a petition for involuntary inpatient commitment, the State must prove by clear and convincing evidence that the proposed patient is mentally ill and, as a result

- (1) the proposed patient is likely to cause serious harm to himself; or
- (2) the proposed patient is likely to cause serious harm to others; or
- (3) the proposed patient
 - (a) is suffering severe and abnormal mental, emotional, or physical distress; and
 - (b) is experiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the

proposed patient's basic needs, including food, clothing, health, or safety; and

- (c) is unable to make a rational and informed decision as to whether to submit to treatment.

The third, multi-part element, which is sometimes known as the "gravely disabled standard" or "deterioration criterion," applies to persons with mental illness who do not fit neatly into the "harm to self or others" categories. Underlying the three parts of the "gravely disabled standard" is the concept of "dangerousness." The United States Supreme Court has stated that it is unconstitutional to confine persons with mental illness if "they are dangerous to no one and can live safely in freedom." *O'Connor v. Donaldson*, 422 U.S. 563, 575, 95 S.Ct. 2486, 2494 (1975). Thus, to involuntarily detain a proposed patient, the evidence must show a person who has deteriorated to such a degree that he or she is considered gravely disabled (dangerous to self).

As mentioned earlier, the "deterioration" standard applied in contemplation of outpatient services differs from the criterion applied to the "gravely disabled standard" that is applied in contemplation of inpatient services. Specifically, to meet the "deterioration" criterion for outpatient services, the application must be supported by clear and convincing evidence that the proposed patient, will, if not treated, continue to: (1) suffer severe and abnormal mental, emotional, or physical distress; and (2) experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services. Of course, this "deterioration" criterion must be proved along with the other factors discussed above before the judge may order a proposed patient to receive court-ordered outpatient services. §§ 574.034(b) and 574.035(b).

5. Sufficiency of Evidence

The burden of proof shall be to prove each element of the applicable criterion by "clear and convincing" evidence. §§ 574.034(a) and 574.035(a); see *Addington v. Texas*, 441 U.S. 418 (1979). Clear and convincing evidence is defined as that measure of proof that produces a firm belief or conviction in the mind of the fact-finder as to the truth of the allegations sought to be established. *State v. Addington*, 588 S.W.2d 569, 570 (Tex. 1979). Clear and convincing evidence is an intermediate evidentiary standard that requires more than a preponderance of evidence, but less than a reasonable-doubt standard. *Id.* There is no constitutional requirement that the evidence must be unequivocal or undisputed. *Id.* It is the State's burden to meet the elements for commitment. *In re J.S.C.*, 812 S.W.2d 92, 94 (Tex. App. – San Antonio 1991, no writ).

The clear and convincing evidence necessary for an order for **inpatient** mental health services must include expert testimony and, unless waived, must include evidence of a recent overt act or a continuing pattern of behavior that tends to confirm either (a) the likelihood of serious harm to the proposed patient or others; or (b) the proposed patient's distress and the deterioration of ability to function. §§ 574.034(d) and 574.035(e); *In re Breeden*, 4 S.W.3d 782 (Tex. App. – San Antonio 1999, no pet.). See further discussion in #6 below. In a hearing for temporary mental health services, the evidence of the recent overt act or continuing pattern of behavior may be waived. § 574.034(f).

For **inpatient** mental health services, evidence presented at trial must be factually sufficient to show that a proposed patient is *likely* to harm him or herself or others or meet the deterioration standard. Evidence of the “possibility” or “potential danger” of harm or continued deterioration is insufficient to support a commitment. *Broussard v. State*, 827 S.W.2d 619, 622 (Tex. App. – Corpus Christi 1992, no writ). Psychotic behavior alone does not justify commitment on the ground of deterioration. *Id.* Expert diagnosis alone is insufficient to establish the basis for commitment; expert opinions and recommendations must be supported by a showing of the factual bases on which they are grounded to justify commitment. *In re J.S.C.*, 812 S.W.2d 92, 95 (Tex. App. – San Antonio 1991, no writ); *Goldwait v. State*, 961 S.W.2d 432 (Tex. App. – Houston [1st Dist.] 1997, no writ). It is also important to note that the factual basis is independent of the expert opinion and is subject to hearsay objections.

The clear and convincing evidence necessary for an order for **outpatient** mental health services must include expert testimony and, unless waived, evidence of a recent overt act or continuing behavior pattern that tends to confirm the proposed patient's distress, the deterioration of ability to function independently to the extent that the proposed patient will be unable to live safely in the community, and the proposed patient's inability to participate voluntarily and effectively in outpatient treatment services. §§ 574.034(e) and 574.035(f).

6. Evidence of “Overt Acts or Patterns of Behavior”

The determination of what constitutes a recent overt act or continuing pattern of behavior is highly fact-intensive. The Texas Supreme Court recently clarified the “overt act” requirement in *State v. K.E.W.*, 315 S.W.3d 16, 24 (Tex. 2010):

“In sum, the statute requires evidence of a recent act by the proposed patient, either physical or verbal, that can be objectively perceived and that is to some degree probative of a finding that serious harm to others is

probable if the person is not treated. The overt act itself need not be of such character that it alone would support a finding of probable serious harm to others. See Tex. Health & Safety Code § 573.034(d)(1).”

K.E.W. had argued that an “overt act” could be proven only “by evidence of actual harmful conduct demonstrating a threat of imminent harm to others. The State, on the other hand, urge[d] that the statute does not require evidence of an act that either is actually harmful itself or that demonstrates harm to others is imminent.” *K.E.W.*, 315 S.W.3d at 21. The Texas Supreme Court agreed with the State and held that the statute does not require the act either be actually harmful or demonstrate that harm to others is imminent. *Id.*

Before *K.E.W.*, the courts had not agreed whether speech alone could be an overt act. According to the Supreme Court, speech definitely can be an “act” under the statute.

There has been a relatively recent flurry of cases focused on the question of whether a proposed patient's refusal to take medication is sufficient to meet the requirement of an overt act or continuing pattern of behavior. The majority of courts find that the requirement of “overt acts or patterns of behavior” may **not** be fulfilled merely by citing a patient's refusal of treatment. For example, the First Court of Appeals held in a 2002 case that, although testimony showed insane behavior, no evidence of an overt act or patterns of behavior showed the patient “unable to provide for her own health or safety.” *G.H. v. State*, 96 S.W.3d 629, 632 (Tex. App. – Houston [1st Dist.] 2002, no pet.). The jury in the case had specifically found that the patient was not “likely to cause serious harm to herself or others” but rather met the “deterioration” standard of § 574.034(a)(2)(C). *Id.*

The Fourteenth Court of Appeals explained the rationale for this position eloquently in *In re F.M.*, 183 S.W.3d 489, 494 (Tex. App. – Houston [14th Dist.] 2005, no pet.):

“If we were to adopt the State's position and hold that refusal of medication or medical treatment per se can constitute an overt act or continuing pattern of behavior sufficient to fulfill the clear and convincing standard, the medical and legal determination would become conflated. A person diagnosed with mental illness could be forced to submit to treatment based on nothing more than the very fact that he or she did not wish to be treated.”

Two years later, the Fourteenth Court of Appeals addressed the same question with an added twist. After receiving a pacemaker, the proposed patient in the case deteriorated mentally. *In the Interest of L.M.*,

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Nos. 14-06-00709 & 14-06-00710, 2007 Tex. App. LEXIS 616 (Tex. App. – Houston [14th Dist.], Jan. 30, 2007, not pet.) (not designated for publication). The trial court ordered her committed for temporary inpatient care and authorized involuntary administration of psychoactive medication. In affirming these two orders, the appellate court cited the doctor's testimony that L.M.'s refusal to take her medications rendered her a danger to herself by causing her to neglect to take her health medications resulting in symptoms of congestive heart failure – a life-threatening illness – and frequent hospitalization. This case, noted the court, presents more exigent circumstances than the case where a patient is refusing merely to take psychotropic or cardiac medication. Therefore, the evidence reflected a continuing pattern of behavior or recent overt act tending to confirm the likelihood of serious harm to herself.

7. Expert Testimony

Since the Texas Rules of Evidence apply to final hearings, the testimony of recent overt acts or a continuing pattern of behavior must be from the direct and personal knowledge of a witness unless there is an exception to the hearsay nature of the testimony or the proposed patient makes admissions. The interplay between the evidentiary rules governing hearsay and the rules regarding privileged communications between patients and mental health professionals can have a profound effect on commitment proceedings. When an appropriate hearsay objection is made under Texas Rule of Evidence 801, testimony concerning recent overt acts or patterns of behavior occurring outside the confines of the hospital is inadmissible. In many cases, only one witness, the examining psychiatrist, is brought to the final hearing to provide the necessary testimony on behalf of the State. This can cause a problem, however, especially when the recent overt acts or patterns of behavior occur outside the facility. In that situation, the testifying expert would not have personal knowledge of events occurring outside the hospital. Although the court might still have expert testimony establishing mental illness, there would be no evidence of recent overt acts or a continuing pattern of behavior showing the likelihood of the proposed patient causing serious harm to self or others or of a deterioration in ability to function.

The appellate courts have reversed orders of commitment when a psychiatrist was the only witness in a hearing, and no *factual* basis of harm resulting from the mental illness was established. See, e.g., *T.G. v. State*, 7 S.W.3d 248 (Tex. App. – Dallas 1999, no pet.); *Mezick v. State*, 920 S.W.2d 427, 430 (Tex. App. – Houston [1st Dist.] 1996, no writ); *In re J.S.C.*, 812 S.W.2d 92 (Tex. App. – San Antonio 1991, no writ). An expert's affidavit must go beyond *conclusions* that mirror the statutory criteria but do not include any

factual bases to support the expert opinion. *K.T. v. State*, 68 S.W.3d 887, 893-894 (Tex. App. – Houston [1st Dist.] 2002, no pet.). Although hearsay evidence underlying an expert's opinion may be admissible to show the basis of the expert's opinion that the person is mentally ill and meets one of the criteria, there is still the requirement of the recent overt act or continuing pattern of behavior. See *In re Breeden*, 4 S.W.3d 782 (Tex. App. – San Antonio 1999, no pet.). A proper hearsay objection and a request for limits of use of any hearsay should be made before the expert testifies. Hearsay evidence should not be used to establish the specific factual basis supporting the proposed patient's likelihood of harm or continued deterioration.

8. Admissions and the "Mental Health Miranda"

Admissions by the proposed patient as to recent overt acts or patterns of behavior can resolve the hearsay dilemma under certain circumstances if the patient-mental health professional privilege of confidentiality of communications can be circumvented. The issue of confidentiality in the mental health context is complicated, but not insurmountable. First, it is complicated by the interplay between the Rules of Evidence, the judicial interpretation of the Rules of Evidence as they affect mental health, and the subsequent legislative enactments in the Texas Mental Health Code. The subsequent legislative enactments regarding confidentiality could arguably be interpreted to repeal by implication the Rules of Evidence regarding the disclosure of confidential information in the setting of the mental health commitment process, as well as the case law that has developed under those rules. However, there is a presumption that the Legislature does not intend to repeal statutes by implication and that courts should find such repeal by implication only in a case where the two statutes cannot be reconciled. Therefore, in the author's opinion, Texas Mental Health Code § 611.006 did not repeal the Rules of Evidence governing confidentiality, but rather, allows the confidential testimony into the administrative or judicial proceeding as long as the evidence meets the standards set by the Texas Rules of Evidence. In other words, if the confidential evidence is hearsay that does not fall with any exception under the Rules of Evidence, then it will not be allowed in as evidence in the commitment hearing. In addition, the confidentiality rules differ depending on whether the context is an administrative/judicial proceeding or not.⁹

⁹ For instance, the Texas Supreme Court in *Thapar v. Zezulka*, 994 S.W.2d 635 (Tex. 1999), reaffirmed the Legislature's strong commitment to patient confidentiality by holding that there is no duty for a mental-health professional to disclose threats made by a patient against third parties. To the contrary, while the disclosure is

The issues surrounding confidentiality in the mental health context could fill several papers all on their own; this paper will attempt a brief discussion. The law regarding confidentiality of mental health information is found in Texas Rules of Evidence 510. Rule 510(b) provides the general rule that communications between a patient and a mental health professional are confidential and cannot be disclosed. The exceptions to the general rule are contained in Rule 510(d), and the specific exception that applies to mental health proceedings is contained in Rule 510(d)(4).

This exception allows admission of otherwise privileged communications made in the course of a court-ordered examination in which the patient has been previously informed that communications are not privileged (i.e. has received a "Mental Health Miranda" warning). When the warning is not given, any communications and use of records are prohibited under the privilege unless waived in writing.

On occasion, the State will argue that another exception under Rule 510 allows otherwise confidential communications to be admissible. Rule 510(d)(5) allows admission of otherwise privileged communication relevant to an issue of the physical, mental, or emotional condition of a patient in any proceeding in which any party relies upon the condition as part of the party's claim or defense (the "litigation exception"). The litigation exception applies only to situations in which a party is basing its claims of liability, damages, or defenses upon the mental or emotional condition of the privilege-holder. This rule is primarily intended to cover situations when privileged communication is involved in a proceeding in which there is an attempt to recover damages, and mental condition is relevant. See Steven Goode, et al., *Texas Practice: Guide to the Texas Rules of Evidence*, (3d, 2007). A hearing for court-ordered mental health services does not readily fit this exception. Even though the proposed patient's mental condition is at issue in the hearing, it would be difficult to characterize the commitment hearing as the State's claim against the proposed patient. Furthermore, if the litigation exception were to apply to final hearings, Rule 509(d)(4)'s existence would be unnecessary. Therefore, in the context of court-ordered mental health services, Rule 510(d)(4) is the appropriate exception to the general rule of confidentiality between a patient and a mental health professional. However, as discussed above, this exception applies only if the patient is given the Mental Health Miranda warning. It is not necessary that the examining professional give

optional, a mental-health professional makes such disclosures at his or her own risk. *Id.* That case dealt with a duty to warn third parties of threats; obviously, the context differs from of a commitment proceeding.

this warning; it is sufficient if given by the facility staff. *Jones v. State*, 613 S.W.2d 570 (Tex. Civ. App. – Austin 1981, no writ).

It should be noted that Texas Rules of Evidence 509 creates a privilege very similar Rule 510. Rule 509 creates a privilege between physicians and patients as to communications about the patient's medical condition. Furthermore, under Rule 509 there is an exception to the confidentiality rule in "an involuntary civil commitment proceeding, a proceeding for court-ordered treatment, or a probable cause hearing under the Texas Mental Health Code." Texas Rules of Evidence 509(d)(7). Under this exception, the communications between the physician and patient are not confidential and there is no necessity for a warning of the loss of privilege. However, one court of appeals has held that if a physician makes a diagnosis of a proposed patient for involuntary commitment, Rules 509 and 510 must be read together; therefore, a warning must be made to the patient to defeat the confidentiality of any communications. *In the Interest of R.B.*, 741 S.W.2d 525 (Tex. App. – Tyler 1987, no writ).

E. Least Restrictive Treatment

Upon finding by clear and convincing evidence that the criteria for court-ordered mental health services are met, the court shall determine what the least restrictive treatment placement would be under the circumstances. The least restrictive appropriate setting for the treatment of a patient is the treatment setting that (1) is available; (2) provides the patient with the greatest probability of improvement or cure; and (3) is no more restrictive of the patient's physical or social liberties than is necessary to provide the patient with the most effective treatment and to protect adequately against any danger the patient poses to himself or others. § 571.004.

The local MHA program is obligated under law to file a recommendation for treatment setting forth the most appropriate treatment alternative for the patient. § 574.012. The court is obligated to order mental health services in the least restrictive setting available. § 574.036(d). The court should require the local MHA to ascertain which programs are and which programs are not appropriate for the proposed patient so that the court can make an informed decision about placement in the least restrictive setting.

F. Order for Temporary Mental Health Services - § 574.034

An Order for Temporary Mental Health Services shall state that treatment is authorized for not longer than 90 days. § 574.034(g). The Judge may enter an order committing the person to a mental health facility for inpatient care. See §§ 574.034 and 574.035. Alternatively, the judge may enter an order requiring

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the patient to participate in mental health services in outpatient care, including but not limited to programs of community MHA centers or services by private psychiatrists and psychologists. See §§ 574.034(b), 574.035(b), and 574.037. The period of commitment for inpatient or outpatient services is for a period not to exceed 90 days. The court shall not specify any period shorter than 90 days nor more than 90 days upon an Application for Temporary Mental Health Services.

Under a determination for temporary or extended mental health services, a judge may advise, but may not compel, a proposed patient to participate in counseling, to refrain from the use of alcohol or illicit drugs, or to receive treatment with psychoactive medication, as specified by an outpatient mental health services plan. §§ 574.034(i), 574.035(j). As mentioned earlier, Probate Code § 770A(b) expressly authorizes a guardian to consent to a ward's psychoactive medication even against the ward's will.

G. Order for Extended Mental Health Services – § 574.035

An Order for Extended Mental Health Services shall state that treatment is authorized for not longer than 12 months. § 574.035(h). The court cannot enter an order for extended commitment unless (1) the clear and convincing burden of proof standard is met for all mental illness elements; (2) findings are made that the condition of the patient will last longer than 90 days; and (3) pursuant to the Texas Mental Health Code or the Texas Code of Criminal Procedure, the patient has received either of the following (a) court-ordered inpatient services for a total of at least 60 days in the last 12 months or (b) court-ordered outpatient services during the preceding 60 days. § 574.035(F)(i) & (ii). The court shall not specify any period shorter than twelve months on an extended commitment. "The court cannot make its findings solely from certificates of examination for mental illness but shall 'hear testimony.'" *House v. State*, 222 S.W.3d 497, 500 (Tex. App. – Houston [14th Dist.] 2007, pet. filed).

H. Compilation of Mental Health Commitment Records - § 574.014

The clerk of each court with jurisdiction to order commitment shall provide the Office of Court Administration a monthly report of the number of applications for involuntary mental health services filed with the court and their disposition, including the number of commitment orders for inpatient and outpatient mental health services.

I. Transportation of Patients – § 574.045(a)(1)

Transporting patients between facilities has been an area of much confusion. Section 574.045(a)(1) is amended to provide a priority scheme for patient

transportation. Off-duty mental health deputies are empowered to contract privately with commissioners courts to transport patients.

XI. Voluntary Patients

A. Voluntary Admission of Adults – § 572.001 et seq.

Any individual 18 years of age or older may request to be admitted on a voluntary basis to an inpatient mental health facility. Guardians of adults have no authority to voluntarily admit a person to an inpatient psychiatric facility. A probate court has no authority under the Probate Code to grant a guardian the power to voluntarily commit a ward. Once a person has been voluntarily admitted, no Application for Court-Ordered Mental Health Service may be filed unless a written request for release has been filed with the head of the facility, or it is determined that such individual meets the criteria for court ordered services and (1) is absent without authorization or (2) refuses or is unable to consent to appropriate treatment. § 572.005. Should a voluntary patient request to leave the facility, he or she may still be detained in the facility for a short period before the release. Thus a facility is given time to file an Application for Court-Ordered Mental Health Services and obtain an OPC. There should exist no need to issue an emergency mental health warrant in these situations, and if presented with one, the judge should decline to act.

The amount of time a voluntary patient may be detained after request is limited. See § 572.004. Within 4 hours of the patient's request for discharge, the facility must notify the responsible physician. If the physician has a reasonable cause to believe that the patient might meet the criteria for court-ordered mental health services or emergency detention, the physician must examine the patient within 24 hours of the patient's filed request for discharge. If the physician believes that the patient meets the criteria for detention, the physician should either discharge the patient or file an application for court-ordered mental health service or emergency detention no later than 4:00 p.m. on the succeeding business day after the examination.

B. Voluntary Admission of Minors

A parent, managing conservator, or guardian may consent to the voluntary admission to an inpatient mental health facility of a minor 18 years of age or younger. § 572.001(a). Consequently, a judge should decline to issue an emergency warrant where the individual is younger than 18 years old.

Also, a minor held as a voluntary inpatient pursuant to a request by a parent, managing conservator, or guardian under § 572.002(3)(B) may request a discharge in writing. Upon consultation with the minor's parent, managing conservator, or guardian,

the facility may discharge the minor. However, if the parent, managing conservator, or guardian objects in writing, the facility shall continue treatment of the patient as a voluntary patient. *See also* § 572.004(i).

C. Voluntary Admission and Wards Between 16 and 18 Years of Age

A guardian can voluntarily admit a ward to an inpatient mental health facility when the ward is younger than 18 years. § 572.001(a). *See also* Tex. Prob. Code Ann. § 770(c). However, § 572.002 permits the voluntary admission of a person 16 years or older on his own volition, without the consent of the parent or guardian. In other words, if a person is between 16 and 18, either he or his guardian, acting alone, may admit him for voluntary inpatient services. If such a teenager is admitted by a parent or guardian, the teenager has the right to “be evaluated at regular intervals” to determine the need for continued treatment. § 572.003(e).

XII. Involuntary Commitment and Guardianships

Although matters related to guardianships have been discussed throughout this paper when appropriate, the issues related to involuntary commitments within guardianships is significant enough to warrant reviewing those points in one cohesive section.

First, under § 572.001(a), a guardian may only voluntarily admit a ward if that ward is less than 18 years old. This is consistent with Texas Probate Code § 770(c). However, under Texas Probate Code § 770(b), a guardian of a ward who is 18 or older may not voluntarily admit such “incapacitated person to a public or private inpatient psychiatric facility or to a residential facility or to a residential facility operated by the [Texas Department of State Health Services] for care and treatment.” Furthermore, under Texas Probate Code § 770(a), a “guardian can apply for the residential care and services provided by a public or private facility on behalf of an incapacitated person who has decision-making ability if the person agrees to be placed in the facility.” Tex. Prob. Code Ann. § 770(a). In other words, for a ward over the age of 18, the dispositive factor appears to be whether the ward has decision-making ability (i.e., is partially incapacitated), or does not (i.e., is totally incapacitated). In light of these provisions, it is this author’s position that a guardian of a totally incapacitated ward lacks the authority to do either of the following: (1) enter into an agreed commitment; or (2) waive any procedural rights involving involuntary commitments.

Second, under Texas Probate Code § 770A, the guardian of an adult ward under an Order of Protective

Custody can consent to involuntary psychoactive medication on behalf of the ward.

Third, as of 2003, a guardian may transport an adult ward (18 or older) to a mental health facility and apply for a “preliminary examination” and emergency detention without a warrant. *See* IV, A, *supra* (discussing § 573.003-4). Likewise, Texas Probate Code § 767(b) authorizes the guardian to transport a ward to a mental health facility for the purpose of obtaining a preliminary examination and emergency detention without a warrant. Note that this provision allowing a guardian to “check the ward in” for emergency detention does not apply to minors under the age 18. Furthermore, it is the opinion of this author that the involuntary commitment of a minor is the exclusive prerogative of a parent or guardian (or the subject himself if between 16 and 18); any other person seeking to place the minor in inpatient services against the parents’ will should be required to have the parents’ rights terminated.

XIII. Appeals

The attorney ad litem is required to stay on the case if the patient wishes to appeal a commitment order, even if the ad litem personally agrees with the commitment order. § 574.004(g). These appeals are on an expedited basis, which means that the normal timeframe of a civil appeal to the Texas Court of Appeals does not apply. The clerk and the court reporter must file the transcript and statement of facts within 30 days of the commitment order. The attorney ad litem must to file his or her brief within 30 days of the deadlines for the clerk and court reporter. The county responsible for commitment costs has to pay all costs of appeal of an indigent patient.

It is important to note that the legal concept of mootness generally does not apply to an appeal from an order granting an involuntary commitment for a temporary psychiatric hospitalization. *State v. Lodge*, 608 S.W.2d 910 (Tex. 1980); *In the Matter of R.S.C.*, 921 S.W.2d 506 (Tex. App. – Fort Worth 1996, no writ). The Texas Supreme Court has indicated that it would be “manifestly severe and prejudicially unfair if the commitment is [a situation] that would not stand upon review in an effective appeal.” *Lodge*, 608 S.W.2d at 912. The Court indicates that because of the stigma involved with commitments and the large curtailment of liberty experienced by the person committed, it is unfair to apply the doctrine of mootness, which would deprive the committed person of a chance for legal redress. *Id.* Given that background, it is curious that a 1998 appellate court case held that an appeal from a medication order was moot because the underlying commitment order would likely be expired by its own terms before the appeal time could be perfected. *See In the Interest of E.B.*,

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962 S.W.2d 304 (Tex. App. – Beaumont 1998, no writ).

Most successful appeals are based on a sufficiency of the evidence ruling. However, unlike other civil trials, a person appealing a temporary commitment order is not required to file a motion for new trial as a prerequisite to challenging the factual sufficiency of the evidence. *Johnstone v. State*, 22 S.W.3d 408, 411 (Tex. 2000) (per curiam). Error is preserved if a person files a notice of appeal ten days after the trial court signs the commitment order pursuant to § 574.070. *Id.* An extension of this appeal deadline may be obtained pursuant to Texas Rule of Appellate Procedure 26.3. *In re J.A.*, 53 S.W.3d 869, 871-2(Tex. App.-Dallas 2001, no pet. h.).

XIV. Conclusion

A judge should exercise only that authority which has been conferred upon the judge by the laws of this State. Because of the necessary balancing between an individual's freedom and the protection of society, the rules concerning involuntary commitments must be closely followed. In the area of mental commitments, the judge's power is limited and may not be undertaken outside of these statutes. There is no doubt that a judge will, from time to time, be presented with requests which seek the exercise of authority not in compliance with these statutes and therefore, care should be used to avoid any inappropriate action.

Appendix A: Psychoactive Medication Orders

I. Introduction

In 1993 new procedures regulating the use of psychoactive medications were introduced into the Texas Mental Health Code. The procedures adopted were the result of a compromise to with a number of advocacy groups who initiated litigation against the TDMHMR for unauthorized use of psychotropic medications in the treatment of involuntarily committed mental patients. Now, in order to administer psychoactive medications to persons incapacitated to such a degree that effective consent cannot be obtained, a court hearing must occur. These proceedings are in lieu of the cumbersome guardianship procedures that are normally invoked when a person lacks capacity to consent. The cost provisions of the Mental Health Code apply to these hearings and most occur in the county courts of the catchment-area State Hospitals.

It should be noted that the statutory scheme governing psychoactive medication now addresses the situation where the State seeks involuntary administration of antipsychotic drugs *solely* to render a defendant who is mentally ill competent to stand trial for a crime – that is, where forced medication is warranted by lack of capacity to consent to psychoactive medications or for other considerations such as the defendant’s dangerousness or risk to the defendant’s health. This statutory scheme was enacted in light of the U.S. Supreme Court’s decision in *Sell v. United States*, 539 U.S. 166 (2003). According to *Sell*, the government can involuntarily administer antipsychotic drugs to render a defendant who is mentally ill competent to stand trial on serious criminal charges only if (1) there are important governmental interests at stake, (2) involuntary medication will significantly further those interests, (3) involuntary medication is necessary to further those interests, and (4) the administration of the drugs is medically appropriate.¹⁰

¹⁰ Whether important governmental interests are at stake for purposes of the *Sell* rule depends upon whether the defendant is accused of committing a “serious crime.” Furthermore, a serious crime has been defined as one for which the defendant may be sentenced to imprisonment for more than six months. See *In re F.H.*, 214 S.W.3d 780 (Tex. App. – Tyler, 2007); *In re D.B.*, 214 S.W.3d 209 (Tex. App. – Tyler, 2007); *In re S.A.*, No. 12-06-00286, (Tex. App. – Tyler, 2007).

In determining whether involuntary administration of drugs would significantly further important government interests, one court found that this element of the *Sell* rule was absent because the state had not shown that administration of the drugs was substantially likely to render the defendant competent to stand trial. *In re D.B.*, 214 S.W.3d 209 (Tex. App. – Tyler, 2007).

In determining whether administration of drugs was necessary to further an important state interest, the court in *In re S.A.*, No. 12-06-00286 (Tex. App. – Tyler, 2007) held that this element of the *Sell* rule was absent because there was no testimony

Texas adopted a forced psychoactive regimen in forensic situations in the 2005 Legislative session and has fine tuned the procedure over the last two sessions. Jurisdiction over these forensic psychoactive medications cases is with the mental health court (the Probate Court), and psychoactive medication orders can be ordered for persons subject to Texas Code of Criminal Procedure Chapter 46B. In the 2009 legislative session, the Texas Legislature authorized these proceeding to be had even when the criminal defendant remains in jail awaiting transport to the appropriate State Hospital.

If the persons held under Chapter 46B are a danger to themselves or others, the forensic statute authorizes the forced administration of psychoactive medications even if the person has the capacity to consent.

II. Definitions Related to the Administration of Medication

- A. “Capacity” means a patient’s ability to understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment, and to make a decision whether to undergo the proposed treatment.
- B. “Psychoactive medication” means a medication prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state when treating the symptoms of mental illness.
- C. “Psychoactive medication” includes the following categories when used as described:
 1. antipsychotics or neuroleptics;
 2. antidepressants;
 3. agents for control of mania or depression;
 4. antianxiety agents; sedatives, hypnotics, or other sleep-promoting drugs; and psychomotor stimulants.
- D. “Modification” means a change of a class of medication authorized in the order.

III. Requisites

- A. To administer medication, the patient must be subject to an order for inpatient mental health services under § 574.034 or § 574.035 (temporary

that administration of the drugs was substantially likely to render the defendant competent to stand trial or to what extent the medications could interfere with the defendant’s ability to communicate with counsel.

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or extended commitment) or an order for protective custody under § 574.021.

B. A person may not administer a psychoactive medication to a patient who refuses to take the medication voluntarily unless:

1. the patient is having a medication-related emergency;
2. the patient is younger than 16 years of age and the patient's parent, managing conservator, or guardian consents to the administration on behalf of the patient;
3. the adult patient's guardian, if any, consents;
4. the patient's representative authorized by law to consent on behalf of the patient has consented to the administration; or
5. the patient is under an order issued under Section 574.106 authorizing the administration of the medication regardless of the patient's refusal.

IV. Jurisdiction and Venue

- A. An application by a physician treating a patient may be filed in a probate court or a court with probate jurisdiction or a judge may refer a hearing to a magistrate or court-appointed master who has training regarding psychoactive medications. A trial before the court shall be on the record while a trial in front of a master does not need to be on the record.
- B. A party is entitled to a trial de novo by a judge if an appeal of the magistrate's or master's report is filed with the court within three days after the report is issued.
- C. If a hearing or an appeal of a master's or magistrate's report is to be held in a county court in which the judge is not a licensed attorney, the proposed patient or his/her attorney may request that the proceeding be transferred to a court with a judge who is licensed to practice law in this state.
- D. The county judge shall transfer the case after receiving the request, and the receiving court shall hear the case as if it had been originally filed in that court.

V. Application – Section 574.104

- A. The physician may file an application for an order to authorize the administration of a psychoactive medication regardless of the patient's refusal if:
 1. the physician believes that the patient lacks the capacity to make a decision regarding the administration of the psychoactive medication;
 2. the physician determines that the medication is the proper course of treatment for the patient;

3. the patient is under an order for mental health services; and
4. the patient, verbally or by other indication, refuses to take the medication voluntarily.

B. The application must state:

1. that the physician believes that the patient lacks the capacity to make a decision regarding administration of the psychoactive medication and the reasons for that belief;
2. each medication the physician wants the court to compel the patient to take;
3. whether an application for court-ordered mental health services under §§ 574.034 or 574.035 has been filed;
4. whether a court order for inpatient mental health services for the patient has been issued and, if so, under what authority it was issued;
5. the physician's diagnosis of the patient; and
6. the proposed method for administering the medication and, if the method is not customary, an explanation justifying the departure from the customary methods.

VI. Hearing

- A. The hearing on the application must be held not later than the thirtieth day after the date the application is filed.
- B. The hearing may be held on the date of a hearing on an application for court-ordered mental health services so long as the patient has been committed and there is a separate hearing.
- C. The case may be transferred to a court with jurisdiction where a committed patient is receiving court-ordered services.
- D. The court may grant one continuance on a party's motion and for good cause shown. The court may grant more than one continuance only with the agreement of the parties.

VII. Rights of Patient

The patient has the following rights:

- A. representation by a court-appointed attorney who is knowledgeable about issues to be adjudicated at the hearing;
- B. meet with that attorney as soon as is practicable to prepare for the hearing and to discuss any of the patient's questions or concerns;
- C. receive, immediately after the time of the hearing is set, a copy of the petition and written notice of the time, place, and date of the hearing;
- D. be told, at the time personal notice of the hearing is given, of the patient's right to a hearing and right to the assistance of an attorney to prepare for the hearing and to answer any questions or concerns;

- E. be present at the hearing;
- F. request from the court an independent expert;
- G. oral notification, at the conclusion of the hearing, of the court's determinations of the patient's capacity and best interests; and
- H. as soon as practicable after the conclusion of the hearing, written notification of the court's determinations is to be provided to the patient and the patient's attorney. The notification shall include:
 1. a statement of the evidence on which the court relied, and
 2. the reasons for the court's determinations.

VII. Surrogate Decision Making on Behalf of Incapacitated Jail Inmates

If a patient is an inmate of a city or county jail and is comatose or otherwise incapacitated, a surrogate decision maker as defined by § 313.004(a) Health & Safety Code may not consent to psychotropic medication, involuntary mental health services, or psychiatric services calculated to restore competency to stand trial.

IX. Order – Sections 574.106 and 574.1065

- A. The court may issue an order authorizing the administration of one or more classes of psychoactive medication only to a patient who
 1. is under an court order to receive inpatient mental health services; or
 2. is in custody awaiting trial in a criminal proceeding and was ordered to receive inpatient mental health services in the six months preceding a hearing under this section; or
 3. is subject to a 46B order and is in jail or in a mental hospital.
- B. The court may issue an order under this section only if the court finds by clear and convincing evidence after the hearing that:
 1. the patient lacks the capacity to make a decision regarding the administration of the proposed medication, and treatment with the proposed medication is in the best interest of the patient; or
 2. if the patient was ordered to receive inpatient mental health services by a criminal court with jurisdiction over the patient, that (a) the patient presents a danger to the patient or others in the inpatient mental health facility in which the patient is being treated as a result of a mental disorder or mental defect, and (b) treatment with the proposed medication is in the best interest of the patient.
- C. In making the finding that the treatment with the proposed medication is in the best interest of the patient, the court shall consider:
 1. the patient's expressed preferences regarding treatment with psychoactive medication;
 2. the patient's religious beliefs;
 3. the risks and benefits, from the perspective of the patient, of taking psychoactive medication;
 4. the consequences to the patient if the psychoactive medication is not administered;
 5. the prognosis for the patient if the patient is treated with psychoactive medication;
 6. alternative, less intrusive treatments that are likely to produce the same results as treatment with psychoactive medication; and
 7. less intrusive treatments likely to secure the patient's agreement to take the psychoactive medication.
- D. This section does not apply to a patient who receives services under an order of protective custody under § 574.021.
- E. In making the finding that the patient presents a danger to the patient or others in the inpatient mental health facility in which the patient is being treated because of a mental disorder or mental defect, the court shall consider:
 1. an assessment of the patient's present mental condition;
 2. whether the patient has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm to the patient's self or to another while in the facility; and
 3. whether the patient, in the six months preceding the date the patient was placed in the facility, has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm to another that resulted in the patient being placed in the facility.
- F. An order entered shall:
 1. authorize the administration to a patient, regardless of the patient's refusal, of one or more classes of psychoactive medications specified in the petition and consistent with the patient's diagnosis; and
 2. permit:
 - a. an increase or decrease in medication doses;
 - b. restitution of medication authorized but discontinued for the period the order is valid; or
 - c. the substitution of a medication within the same class.
- G. The classes of psychoactive medications in the order must conform to classes determined in the

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petition. An order issued may be reauthorized or modified on the petition of a party, and the order remains in effect pending action on a petition for reauthorization or modification.

- H. An order is not a determination or adjudication of mental incompetency and does not limit in any other respect that person's rights as a citizen or the person's property rights or legal capacity.
- I. An order expires on the expiration or termination date of the order for temporary or extended mental health services in effect when the order for psychoactive medication is issued.

X. Appeal – Section 574.108

- A. A patient may appeal an order authorizing psychoactive medication in the same manner provided by Section 574.070 for an appeal of an order requiring court-ordered mental health services.
- B. An order authorizing the administration of medication regardless of the refusal of the patient is effective pending an appeal of the order.

Appendix B: Commitments for Persons with Intellectual Disabilities and Residential Commitments

I. Introduction

The "Persons with Mental Retardation Act" is found in Chapter 591 Health and Safety Code. Chapter 592 has been amended in response to abuses of persons with mental disabilities in state-supported living centers. Standing orders for physical restraints are prohibited. Straightjackets are forbidden. A state-supported living center must report to the Executive Commissioner each incident in which a physical or mechanical restraint is administered to a resident of a state-supported living center. § 592.103 et seq. The Court comes into contact with the system in two instances in the mental health area. One is when there is an application for commitment to a residential care facility. The second is when there is the necessity to transfer a patient to a mental hospital for a period in excess of 30 days.

II. Transfer to a Mental Hospital – Section 594.031 et seq.

- A. Director of state mental hospital must request Order of Transfer in the Court that originally committed proposed patient to long-term placement.
- B. Two medical certificates of mental illness must accompany request.
- C. Hearing must be held in not less than 7 days nor more than 30 days from proposed patient's transfer to mental hospital.
- D. Jury trial unless waived by proposed patient, guardian, or parent if a minor.
- E. Two physicians (one of which must be a psychiatrist) must testify at hearing.
- F. Court or Jury must find proposed patient is mentally ill and requires transfer to a state hospital for his own welfare and protection or the protection of others.
- G. No standard proof designated, but must be by clear and convincing evidence.

III. Order of Protective Custody – Section 594.044

- A. Medical certificates that allege a person with intellectual disabilities is likely to cause injury to self or others if not immediately restrained must be filed with Court.
- B. Can be restrained in a residential care facility not longer than 20 days pending order of Court on long-term application.

IV. Commitment to a Residential Care Facility – Section 593.041 et seq.

- A. Proposed patient must be a person with intellectual disabilities.
- B. Proposed patient must represent a substantial risk of physical impairment or injury to self or others, or is unable to provide for and is not providing for his most basic physical needs.
- C. Proposed patient cannot be rehabilitated in a less restrictive setting.
- D. Application must be under oath.
- E. A determination of mental retardation must be filed before hearing takes place. (Court must order one if one is unavailable).
- F. Hearing must be held not less than 10 days nor more than 20 days from filing of application.
- G. Court or jury may hear case (Proposed patient may demand Jury or Court can order jury on its own).
- H. Attorney must be appointed.
- I. Findings for long-term placement must be beyond a reasonable doubt

Appendix C: Chemical Dependency Commitments

I. Introductory definitions

“Chemical dependency” is defined in the Chemical Dependency Act as “the abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance.”

“Controlled substance” means a toxic inhalant or any substance designated as a controlled substance by the Texas Controlled Substances Act (Chapter 481).

“Toxic inhalant” means a gaseous substance inhaled by a person to produce a desired physical or psychological effect that may cause personal injury or illness to the inhaler.

“Treatment Facility” means a public or private hospital, detoxification facility, long-term care facility, outpatient care facility, community mental health center, health maintenance organization, recovery center, halfway house, ambulatory care facility, any other facility that is required to be licensed and approved by the commission, or a facility licensed or operated by the Texas Department of State Health Services (DSHS). The term does not include an educational program for intoxicated drivers or the individual office of a private, licensed health care practitioner who personally renders private individual or group services within the scope of the practitioner’s license and in the practitioner’s office.

II. Voluntary Admission – Section 462.021 et seq.

A. Admission – Sections 462.021 and 462.022

1. An adult, upon request, may be admitted if the treatment facility is licensed by the Texas Commission on Alcohol and Drug Abuse (TCADA) or licensed by or operated by DSHS, and the person’s admission is appropriate under facility’s admission policies.
2. A minor (“an individual younger than 18 years of age for whom the disabilities of minority have not been removed”) may be admitted if facility is licensed by TCADA or licensed by or operated by DSHS, and the person’s admission is appropriate under facility’s admission policies, and
3. Admission is requested by a parent or other authorized person under Section 35.01 of the Family Code, or requested by the minor, without parental consent, under Section 35.03 of the Family Code.

B. Discharge – Sections 462.023 and 462.0235

1. For adults and minors younger than 16 years of age: Upon request in writing from a patient the facility shall release the person within a reasonable time not to exceed 96 hours unless:
 - a. The patient (could be a minor if the minor met the criteria for admission without parental consent under Family Code Section 35.03) withdraws the request in writing;
 - b. An application for court ordered treatment or emergency detention is filed;
 - c. A parent, guardian, or conservator who admitted a minor under the age of 16 objects in writing to the release of the patient after consultation with facility; or
 - d. A person authorized under Section 35.01 of the Family Code who requested the admission withdraws the request of the minor’s discharge.
2. For minors who are 16 or 17 years of age: A facility shall release a minor within a reasonable time not to exceed 96 hours, after the minor requests in writing to be released or, for a minor admitted upon the request of the minor’s parent, managing conservator, or guardian, after the parent, managing conservator, or guardian requests the release in writing.
3. A facility does not have to release a minor who is 16 or 17 years of age within 96 hours if:
 - a. the minor requests his or her release before 15 days have expired since the minor’s admission; or
 - b. the request is filed on or after the 15th day and, not later than 96 hours after the request, the minor files a written withdrawal of the request for release or an examining physician certifies that the minor, if released, is likely to cause serious harm to the minor or others, suffer greatly, deteriorate, or make irrational decisions as to treatment.
4. A 16- or 17-year old minor who is not released initially due to a physician’s certificate must be released on the 15th day after the most recent certificate unless another certificate is filed.
5. A 16- or 17-year old minor who requests his or her release on or after the 60th day after the minor’s admission must be released within 96 hours after the request unless an

application for court-ordered treatment of the minor or for emergency detention of the minor is filed and the minor is detained in accordance with Chapter 462.

III. Emergency Chemical-Dependency Detentions

A. There are two types of chemical-dependency detentions: **warrantless** arrests and arrests **with a warrant** issued by a Magistrate. These detentions are authorized under Sections 462.041 and 462.043 of the code, respectively.

1. The length of time of detention on warrantless arrest is 24 hours unless the person is taken into custody after 12 noon on Friday, or on Saturday, Sunday or a legal holiday (officially designated county holidays are now included along with state-designated holidays).

2. The length of time of detention on arrest with a warrant is 24 hours unless the person is taken into custody after 12 noon on Friday, or on Saturday, Sunday or a legal holiday (officially designated county holidays are now included along with state-designated holidays). However, when extremely hazardous weather conditions exist or a disaster occurs and the presiding judge or magistrate enters a declaration of an emergency, the period of detention may be extended for 24-hour periods so long as there is an emergency or disaster and a daily order entered.

B. Requisites:

1. Peace officer or magistrate must find:

a. the person is chemically dependent; **and**
b. because of that chemical dependency the person presents a substantial and imminent risk of serious harm to self or others if not immediately restrained. (Risk of harm may be demonstrated either by the person's behavior or by evidence of severe emotional distress and deterioration in mental or physical condition.); **and**

c. if detention is without a warrant, the officer believes there is not sufficient time to obtain a warrant before taking person into custody.

2. The person must be released from emergency detention if head of facility determines that any one of the criteria for detention no longer applies.

IV. Court-Ordered Treatment

A. Jurisdiction and Venue

1. The application shall be filed in a constitutional county court, a statutory county court having probate jurisdiction, or a statutory probate court in the county where:

- a. the patient resides;
- b. the patient is found;
- c. the patient is receiving treatment under court order or by virtue of an emergency detention with or without a warrant.

2. It must be sworn and may be filed by the county attorney, district attorney, or any adult with the county clerk. Only the county or district attorney may file an application without an accompanying certificate of medical examination for chemical dependency.

3. On the filing of an application, the court shall set a date for the hearing on the merits that must fall within 14 days of the date on which the application is filed. The hearing may not be held within the first three days after the application is filed if the proposed patient or his attorney objects. One or more continuances of the hearing may be granted on proper motion by either party and for good cause shown or by agreement of the parties as long as the final hearing is held not later than the 30th day after the date on which the original application is filed. Section 462.063

4. The county attorney or the district attorney, if the county does not have a county attorney, shall represent the state and the proposed patient shall have an attorney appointed to represent him upon the initiation of the application for court ordered treatment services. Each application, petition, certificate and other court papers shall be filed with the county clerk and such records are confidential in the same manner as records under the Mental Health Code.

B. Motion for Order of Protective Custody – Section 462.065

1. Only the county attorney, district attorney, or the court may file a Motion for Protective Custody. The motion must be accompanied by a sworn medical certificate alleging chemical dependency and stating the proposed patient presents a substantial risk of serious harm to himself or others if not immediately restrained before the hearing.

2. At least one medical certificate or chemical dependency prepared by a physician who has examined the proposed patient within five

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days of the filing of the motion must accompany the Motion for Protective Custody.

3. The certificate must state the physician's opinion and detailed basis for his opinion of
 - a. whether the proposed patient is a chemically dependent person, and
 - b. whether the proposed patient presents a substantial risk of serious harm to self or others if not immediately restrained before the hearing. Section 462.065

C. Order of Protective Custody

An OPC can only be entered upon Motion accompanied by medical certificate prepared by a physician who has examined the proposed patient within 5 days of the filing of the motion. The judge or magistrate must determine whether the proposed patient is a chemically dependent person who presents a substantial risk of serious harm to himself or others, which can be demonstrated by the proposed patient's behavior or other evidence that the proposed patient cannot remain at liberty. The determination may be made from the information provided on the application and certificate or from other evidence if necessary to make a fair determination of the matter.

D. Probable Cause Hearing – Section 462.066

1. A probable cause must be held within 72 hours of detention under an Order of Protective Custody unless time period ends on Sat., Sun., or legal holiday. This period can be extended each day for an additional 24 hours if the presiding judge or magistrate declares an extreme emergency due to hazardous weather conditions or on the occurrence of a disaster that threatens the safety of the proposed patient or another essential party to the hearing. Section 462.066(b)
2. A judge, a magistrate or a master appointed by the presiding judge conducts the hearing. Section 462.006(b)
3. All evidence offered is admissible even if it would be inadmissible at the commitment hearing. The medical certificate filed with the motion for detention may be the proof necessary for continued detention. Section 462.066(c)
4. The issue is whether there is probable cause to believe the proposed patient presents a substantial risk of serious harm to self or others. Note, however, that this does not allow detention based on deterioration alone as is possible at the commitment hearing – there must be a finding of dangerousness to

self or others at the probable cause stage. Section 462.066(e)

5. A notification of the results of the probable cause hearing and any medical certificates must be sent to the treatment facility so the patient can be released or detained. The statute sets out the notification of probable cause hearing form to be used. Section 462.066(g)

E. Medical Certificates – Section 462.066(g)

1. The court may appoint the necessary physicians to examine the proposed patient and to file the certificates if they are not filed with the application.
2. There must be two medical certificates on file that have resulted from an examination of the proposed patient within 30 days preceding the date on which the final hearing is held.

F. Summary of Requisites for OPC

1. The Motion for an OPC must be filed by county or district attorney or judge in the court where an application for chemical dependency treatment services is pending.
2. An Order issued by judge of that court or designated magistrate.
3. A Judge or magistrate must determine that an examining physician has stated his or her opinion and detailed reasons setting forth that the person is chemically dependent and that the person represents a substantial risk of serious harm to self or others if not immediately restrained.
4. The Application for chemical dependent treatment services must already have been filed.
5. The proposed patient is entitled to an attorney at the probable cause hearing.
6. The-OPC is not to exceed 14 days (30 days if court grants continuances).
7. The proposed patient should be discharged by facility if the OPC expires or if the facility determines such patient no longer meets criteria for OPC.
8. A notification of probable cause hearing form as described in 462.066(G) must be sent to the treatment facility as well as be filed with the clerk.

G. Court-Ordered Chemically Dependent Treatment Services – Section 462.067

1. A hearing for court ordered treatment must be before a jury unless the proposed patient and his attorney waive the right to a jury in writing and under oath.

2. The proposed patient has the right to have a court appointed attorney at all stages of the proceedings.
3. The proposed patient is entitled to have a hearing and to be present at the hearing, but the proposed patient or his attorney may waive either right.
4. A hearing by the court may be held in any suitable place in the county but must be held in the county courthouse if the proposed patient or his attorney demands that location.
5. Texas Rules of Civil Procedure and Texas Rules of Evidence apply to a final hearing held under the act. Proposed patient is entitled to present evidence on his own behalf, cross-examine witnesses who testify on behalf of applicant and view and copy all petitions and reports in the court file.
6. Proposed patient is entitled to elect to have the hearing open or closed to the public.
7. The proposed patient may enter into an agreed judgment of commitment to a treatment facility for a period not to exceed 90 days.
8. The Court or jury must find by clear and convincing evidence that the person is chemically dependent and meets one of the following criteria:
 - a. is likely to cause serious harm to self, or
 - b. is likely to cause serious harm to others, or
 - c. will continue to suffer abnormal mental, emotional or physical distress and to deteriorate in ability to function independently if not treated and is unable to make a rational and informed choice as to whether to submit to treatment.
9. Judge may order inpatient or outpatient services.
10. The head of the facility may discharge from commitment at any time upon determination that person no longer meets criteria for court-ordered treatment or when the court order expires. The administrator shall prepare a certificate of discharge and file it with the court that entered the treatment order. However the administrator, of an inpatient treatment facility shall consider, before discharging the patient, whether the patient should receive additional court ordered care or services as an outpatient on a furlough or on a modified court order.
11. The final hearing must be set not more than 14 days from filing. This hearing must not be held earlier than 3 days of filing of

application if proposed patient or his attorney objects. No hearing can be held past 30 days of filing. With a continuance the original hearing the date can be extended for a period that results in the final hearing occurring no more than 30 days past the filing of the application.

V. Renewal of Court-Ordered Chemical Dependency Treatment Services – Section 462.075

An application for renewal is treated the same as an original application for court ordered treatment except it may be done only if the person is likely to cause serious harm to self or others and must be filed no later than the 14th day before the expiration of the previous order. Two new certificates of medical examination for chemical dependency must be accompany the application. The sworn physicians' certificates must be dated within the last 30 days of the final hearing on the renewal. The provisions of the act relating to notice, hearing procedure, and the patient's rights apply to the renewal application.

VI. Criminal Charged Pending Note – Section 462.062(e)(3)

A person with pending criminal charges may be subject to an emergency detention with or without a warrant under all circumstances. However, a proposed patient cannot be committed at final hearing with pending criminal charges involving an act, attempt, or threat of serious bodily injury to another person (not including a juvenile alleged to be a child engaged in delinquent conduct or conduct indicating a need for supervision as defined in Section 51.03, Family Code). A chemically dependent person with any pending misdemeanor charge may be committed, if the offense is a Class A or B misdemeanor resulting from or related to the defendant's chemical dependency and a treatment facility agrees in writing to admit the defendant. This criminal chemical dependency commitment would include offenses involving an act, attempt, or threat of serious bodily injury to another person.

VII. Modification of Outpatient Order to Inpatient Order – Section 462.070

- A. Upon Court's own motion, the request of the individual responsible for the care or treatment of a proposed patient, or on application of an interested individual, the Court may set a hearing to determine whether to modify the outpatient order.

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- B. The Court must appoint an attorney and give notice of the hearing and of the matters to be considered.
- C. The hearing is held before the Court without a jury under the same procedure as for a hearing for court ordered treatment. The Court may issue an Order of Temporary Detention pending the hearing if the person meets the requirements for a modification on the basis of an affidavit filed by the Director of the outpatient center that:
 - 1. detention is necessary for evaluation for continued care;
 - 2. the proposed patient meets the criteria for court ordered treatment; and,
 - 3. the proposed patient has not complied with the court's order or that the patient's condition has deteriorated to the extent that outpatient care or services are no longer appropriate.
- D. There must be a hearing on the merits within 72 hours of detention if Order of Temporary Detention issues. However, the time exceptions applicable for holding a probable cause hearing for an OPC apply to hearings when an Order for Temporary Detention is entered under this section.
- E. Before modification hearing occurs, there must be a medical certificate filed on examination made within 7 days of the hearing.
- F. Summary of Requisites for Modification of Outpatient to Inpatient: The person meets the criteria for chemical dependency treatment services and
 - 1. the person has not complied with the court's order; or
 - 2. the person's condition has so deteriorated that outpatient chemical dependency treatment services or care are no longer appropriate.
- G. A court that finds the criteria prescribed by the modification section have been met may
 - 1. Refuse to modify the order and may direct the patient to continue to participate in outpatient care of treatment in accordance with the original order;
 - 2. Modify the order to incorporate a revised treatment program and to provide for continued outpatient care or treatment under the modified order.
 - 3. Modify the order to provide for commitment to an approved treatment facility for inpatient care.
- H. A modified court order may not extend beyond the period prescribed for the original order.

VIII. Modification of Inpatient Order to Outpatient Order – Section 462.073

- A. The head of a facility to which a patient is committed may request the court that entered the commitment order to modify the order to require the patient to participate in outpatient care or services.
- B. **Summary of Requisites:**
 - 1. The facility head's request must explain in detail why the facility is making the request.
 - 2. The Request must be accompanied by a certificate of medical examination based on an examination made during the proceeding 7 days.
 - 3. The Patient shall be given notice of the modification request.
 - 4. The Court must hold a hearing on the request if the patient or any other person demands a hearing.
 - 5. If a hearing is held, an attorney shall be appointed to represent the patient.
 - 6. If no hearing is requested the court may consider and make its decision based on the request and the supporting medical certificate.
 - 7. The court shall identify a person responsible for the outpatient care or services and such person must submit a general treatment program to the Court within two weeks after the modification order.
 - 8. A modified order may not extend past the term of the original order.

Appendix D: Prosecutor's Questions for Mental Illness Commitment Hearing Temporary Inpatient Services

A. At this time the State requests a stipulation to the doctor's expert qualifications in psychiatry and a stipulation as to the admissibility of the medical records generated here at the Austin State Hospital (or substitute name of hospital) by persons with personal knowledge of the events they recorded and recorded at or near the time the events occurred. (If stipulation refused, see predicate for qualifying the doctor and also for qualifying the medical records.)

B. Knowledge of Patient

1. Doctor, please state your name for the record.
2. Are you a licensed physician in the State of Texas?
3. Are you board certified or board eligible in psychiatry?
4. Are you familiar with the proposed patient, (Name)?

C. Medical Opinion

1. Have you conducted a psychiatric evaluation of the proposed patient?
2. Do you have an opinion as to whether the proposed patient is mentally ill?
3. What is your opinion?
4. What is your diagnosis?
5. Is your opinion based on your personal knowledge, the patient's history, and the patient's records?

***** *Doctor, I'm about to ask you a series of questions that require either a "yes" or "no" answer. (Do not accept "possibly" as an answer.)*

D. Statutory Justification - TEMPORARY COMMITMENT

1. Harm to Self

- a. As a result of his (or her) mental illness, is the proposed patient **likely to cause serious harm to himself (herself)**?
- b. Does a **recent overt act or continuing pattern of behavior** tend to confirm the likelihood of his (her) causing harm to himself (herself)? **Please describe.** (Question on progress notes.)

2. Harm to Others

- a. As a result of his (or her) mental illness, is the proposed patient **likely to cause serious harm to others**?
- b. Does a **recent overt act or continuing pattern of behavior** tend to confirm the likelihood of his (her) causing harm to others? **Please describe.** (Question on progress notes.)

3. Deterioration

- a. As a result of his (her) mental illness, is the proposed patient suffering severe and abnormal mental, emotional, or physical distress? If so,
- b. As a result of his (her) mental illness, is the proposed patient also experiencing substantial mental or physical deterioration of his (her) ability to function independently? If so,
- c. Is this deterioration exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health or safety? If so,
- d. As a result of his (her) mental illness, is the proposed patient also unable to make a rational and informed decision about whether to submit to treatment? If all of the above are so,
- e. Does a recent overt act or continuing pattern of behavior tend to confirm the proposed patient's distress and the deterioration of the proposed patient's ability to function? **Please describe.** (Can he provide food and shelter for himself? Is he able to provide for his basic needs?)

E. Treatment (FOR MARGINAL CASES ONLY)

1. Is the proposed patient presently on medication? (What medication? What level?)
2. If this patient is committed, what will be your treatment plan for him (her)? (Do you intend to request court-ordered medication?)

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F. Outpatient Feasibility (FOR MARGINAL CASES ONLY)

1. Could the proposed patient be treated successfully as an outpatient at this time?
2. Why not?

G. Least Restrictive Recommendation (ALL CASES)

Is the Austin State Hospital (or substitute name of hospital) the least restrictive appropriate setting available for this patient at this time?

H. Questions for Modification from Outpatient to Inpatient Care

Ask the Court to take judicial notice that the proposed patient is on a temporary (or extended) outpatient treatment order.

1. Doctor, please state your name for the record.
2. Are you familiar with the proposed patient, (name) ?
3. Are you his (her) treating physician? Have you had the opportunity to talk with him (her) since he (she) came back into the hospital?
4. Is the patient mentally ill? What is your diagnosis?
5. Does the proposed patient meet the criteria for court-ordered inpatient commitment at this time? (Refer to Section D for specific criteria.)

NOTE: Response to Hearsay Objection:

1. Not offered for the truth of the matter asserted, but merely to show part of the foundation for the doctor's opinion.
2. Ask the doctor if he (she) has discussed the alleged behaviors with the patient and if so, whether the patient admitted the acts. If you can't get it in this way, call the patient to testify.

I. Predicate for Proving Up Medical Records

1. Does the hospital keep records on each patient?
2. Does the hospital have records for the proposed patient?
3. Do those records contain entries of facts, events, conditions, opinions, or diagnosis of or about the proposed patient?

4. Were the entries made at or near the time the events, conditions, opinions, or diagnosis occurred?
5. Were the entries made by or from information transmitted by a person with personal knowledge of the events or opinions?
6. Are these records made in the regular course of business at the hospital?
7. Is it customary to rely on recorded observations made by staff members (in other words, is it customary for a doctor to rely on recorded observations in preparing his opinion)?
8. Have you reviewed these records?
9. Have you relied on these records in forming your opinion of the mental health of this patient?
10. Do the records confirm or tend to confirm your diagnosis?
11. Please read the entry on (date).

J. Predicate for Proving Up Doctor's Qualifications

1. Please state your name for the record.
2. How are you employed?
3. How long have you been employed at (name of facility) ?
4. What duties do you perform?
5. Please describe your educational background. (College, Medical School, Internship, Medical Residency)
6. Are you licensed as a physician in the State of Texas?
7. Are you experienced in the specialty of psychiatry?
8. How long have you practiced psychiatry?
9. Are you board certified or board eligible in psychiatry?
10. What does board certified (board eligible) mean?
11. At this time we offer Dr. (name) as an expert witness in the field of psychiatry.

Appendix E: Prosecutor's Questions for Mental Illness Commitment Hearing Temporary Outpatient Services

A. At this time the State requests a **stipulation to the doctor's expert qualifications in psychiatry** and a **stipulation as to the admissibility of the medical records** generated here at the Austin State Hospital (or substitute name of hospital) by persons with personal knowledge of the events they recorded and recorded at or near the time the events occurred. (If stipulation refused, see predicate for qualifying the doctor and also for qualifying the medical records.)

B. Knowledge of Patient

1. Doctor, please state your name for the record.
2. Are you a licensed physician in the State of Texas?
3. Are you board certified or board eligible in psychiatry?
4. Are you familiar with the proposed patient, (Name) _____?

C. Medical Opinion

1. Have you conducted a psychiatric evaluation of the proposed patient?
2. Do you have an opinion as to whether the proposed patient is mentally ill?
3. What is your opinion?
4. What is your diagnosis?
5. Is your opinion based on your personal knowledge, the patient's history, and the patient's records?

***** *Doctor, I'm about to ask you a series of questions that require either a "yes" or "no" answer. (Do not accept "possibly" as an answer.)*

D. Statutory Justification - TEMPORARY COMMITMENT

1. Is the nature of the proposed patient's mental illness severe and persistent? If so,
2. As a result of the mental illness, will the proposed patient, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress and experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services? If so,

3. Does the proposed patient have an inability to participate in outpatient treatment services effectively and voluntarily? If so,
4. Is this demonstrated by the proposed patient's actions occurring within the last two years or by specific characteristics of the proposed patient's clinical condition that make it impossible for him (her) to make rational and informed decisions whether to submit to voluntary outpatient treatment? **Please describe.**
5. Does a recent overt act or continuing pattern of behavior tend to confirm the proposed patient's distress, the deterioration of the proposed patient's ability to function independently to the extent that the proposed patient will be unable to live safely in the community, and the proposed patient's inability to participate in outpatient treatment services effectively and voluntarily? **Please describe.**
6. Are appropriate mental health services available for the proposed patient?

E. Least Restrictive Recommendation (ALL CASES)

1. Are the outpatient services of the _____ mental health authority the least restrictive appropriate setting available for this patient at this time?

NOTE: Response to Hearsay Objection:

1. Not offered for the truth of the matter asserted, but merely to show part of the foundation for the doctor's opinion.
2. Ask the doctor if he (she) has discussed the alleged behaviors with the patient and if so, whether the patient admitted the acts. If you can't get it in this way, call the patient to testify.

F. Predicate for Proving Up Medical Records

1. Does the hospital keep records on each patient?
2. Does the hospital have records for the proposed patient?
3. Do those records contain entries of facts, events, conditions, opinions, or diagnosis of or about the proposed patient?
4. Were the entries made at or near the time the events, conditions, opinions, or diagnosis occurred?

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5. Were the entries made by or from information transmitted by a person with personal knowledge of the events or opinions?
6. Are these records made in the regular course of business at the hospital?
7. Is it customary to rely on recorded observations made by staff members (in other words, is it customary for a doctor to rely on recorded observations in preparing his opinion)?
8. Have you reviewed these records?
9. Have you relied on these records in forming your opinion of the mental health of this patient?
10. Do the records confirm or tend to confirm your diagnosis?
11. Please read the entry on (date).

G. Predicate for Proving Up Doctor's Qualifications

1. Please state your name for the record.
2. How are you employed?
3. How long have you been employed at (name of facility) ?
4. What duties do you perform?
5. Please describe your educational background. (College, Medical School, Internship, Medical Residency)
6. Are you licensed as a physician in the State of Texas?
7. Are you experienced in the specialty of psychiatry?
8. How long have you practiced psychiatry?
9. Are you board certified or board eligible in psychiatry?
10. What does board certified (board eligible) mean?
11. At this time we offer Dr. (name) as an expert witness in the field of psychiatry.

Appendix F: Prosecutor's Questions for Mental Illness Commitment Hearing Extended Inpatient Services

A. At this time the State requests a **stipulation to the doctor's expert qualifications in psychiatry** and a **stipulation as to the admissibility of the medical records** generated here at the Austin State Hospital (or substitute name of hospital) by persons with personal knowledge of the events they recorded and recorded at or near the time the events occurred. (If stipulation refused, see predicate for qualifying the doctor and also for qualifying the medical records.)

B. Knowledge of Patient

1. Doctor, please state your name for the record.
2. Are you a licensed physician in the State of Texas?
3. Are you board certified or board eligible in psychiatry?
4. Are you familiar with the proposed patient, (Name) _____?

C. Medical Opinion

1. Have you conducted a psychiatric evaluation of the proposed patient?
2. Do you have an opinion as to whether the proposed patient is mentally ill?
3. What is your opinion?
4. What is your diagnosis?
5. Is your opinion based on your personal knowledge, the patient's history, and the patient's records?

***** *Doctor, I'm about to ask you a series of questions that require either a "yes" or "no" answer. (Do not accept "possibly" as an answer.)*

D. Statutory Justification - EXTENDED COMMITMENT

1. Harm to Self

- a. As a result of his (or her) mental illness, is the proposed patient **likely to cause serious harm to himself (herself)**?
- b. Does a **recent overt act or continuing pattern of behavior** tend to confirm the likelihood of his (her) causing harm to himself (herself)? **Please describe.** (Question on progress notes.)

2. Harm to Others

- a. As a result of his (or her) mental illness, is the proposed patient **likely to cause serious harm to others**?
- b. Does a **recent overt act or continuing pattern of behavior** tend to confirm the likelihood of his (her) causing harm to others? **Please describe.** (Question on progress notes.)

3. Deterioration

- a. As a result of his (her) mental illness, is the proposed patient suffering severe and abnormal mental, emotional, or physical distress? If so,
- b. As a result of his (her) mental illness, is the proposed patient also experiencing substantial mental or physical deterioration of his (her) ability to function independently? If so,
- c. Is this deterioration exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health or safety? If so,
- d. As a result of his (her) mental illness, is the proposed patient also unable to make a rational and informed decision about whether to submit to treatment? If all of the above are so,
- e. Does a recent overt act or continuing pattern of behavior tend to confirm the proposed patient's distress and the deterioration of the proposed patient's ability to function? **Please describe.** (Can he provide food and shelter for himself? Is he able to provide for his basic needs?)

4. Extended Commitment

- a. Do you expect the patient's condition to continue for more than 90 days?
- b. Has the patient received inpatient mental health services under court order pursuant to the Texas Health and Safety Code for at least 60 consecutive days within the last 12 months? (If a jury trial, have the doctor read from the previous or current Order of Commitment).
- c. Has the patient received inpatient mental health services under court order

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pursuant to Section 5, Article 46.02, Code of Criminal Procedure, for at least 60 consecutive days within the last 12 months?

E. Treatment (FOR MARGINAL CASES ONLY)

1. Is the proposed patient presently on medication? (What medication? What level?)
2. If this patient is committed, what will be your treatment plan for him (her)? (Do you intend to request court-ordered medication?)

F. Outpatient Feasibility (FOR MARGINAL CASES ONLY)

1. Could the proposed patient be treated successfully as an outpatient at this time?
2. Why not?

G. Least Restrictive Recommendation (ALL CASES)

Is the Austin State Hospital (or substitute name of hospital) the least restrictive appropriate setting available for this patient at this time?

H. Questions for Modification from Outpatient to Inpatient Care

Ask the Court to take judicial notice that the proposed patient is on a temporary (or extended) outpatient treatment order.

1. Doctor, please state your name for the record.
2. Are you familiar with the proposed patient, (name)?
3. Are you his (her) treating physician? Have you had the opportunity to talk with him (her) since he (she) came back into the hospital?
4. Is the patient mentally ill? What is your diagnosis?
5. Does the proposed patient meet the criteria for court-ordered inpatient commitment at this time? (Refer to Section D for specific criteria.)

NOTE: Response to Hearsay Objection:

1. Not offered for the truth of the matter asserted, but merely to show part of the foundation for the doctor's opinion.
2. Ask the doctor if he (she) has discussed the alleged behaviors with the patient and if so, whether the patient admitted the acts. If you can't get it in this way, call the patient to testify.

I. Predicate for Proving Up Medical Records

1. Does the hospital keep records on each patient?
2. Does the hospital have records for the proposed patient?
3. Do those records contain entries of facts, events, conditions, opinions, or diagnosis of or about the proposed patient?
4. Were the entries made at or near the time the events, conditions, opinions, or diagnosis occurred?
5. Were the entries made by or from information transmitted by a person with personal knowledge of the events or opinions?
6. Are these records made in the regular course of business at the hospital?
7. Is it customary to rely on recorded observations made by staff members (in other words, is it customary for a doctor to rely on recorded observations in preparing his opinion)?
8. Have you reviewed these records?
9. Have you relied on these records in forming your opinion of the mental health of this patient?
10. Do the records confirm or tend to confirm your diagnosis?
11. Please read the entry on (date).

J. Predicate for Proving Up Doctor's Qualifications

1. Please state your name for the record.
2. How are you employed?
3. How long have you been employed at (name of facility)?
4. What duties do you perform?
5. Please describe your educational background. (College, Medical School, Internship, Medical Residency)
6. Are you licensed as a physician in the State of Texas?
7. Are you experienced in the specialty of psychiatry?
8. How long have you practiced psychiatry?
9. Are you board certified or board eligible in psychiatry?
10. What does board certified (board eligible) mean?
11. At this time we offer Dr. (name) as an expert witness in the field of psychiatry.

**Appendix G: Prosecutor's Questions for
Mental Illness Commitment Hearing
Extended Outpatient Services**

A. At this time the State requests a **stipulation to the doctor's expert qualifications in psychiatry** and a **stipulation as to the admissibility of the medical records** generated here at the Austin State Hospital (or substitute name of hospital) by persons with personal knowledge of the events they recorded and recorded at or near the time the events occurred. (If stipulation refused, see predicate for qualifying the doctor and also for qualifying the medical records.)

B. Knowledge of Patient

1. Doctor, please state your name for the record.
2. Are you a licensed physician in the State of Texas?
3. Are you board certified or board eligible in psychiatry?
4. Are you familiar with the proposed patient, (Name) _____?

C. Medical Opinion

1. Have you conducted a psychiatric evaluation of the proposed patient?
2. Do you have an opinion as to whether the proposed patient is mentally ill?
3. What is your opinion?
4. What is your diagnosis?
5. Is your opinion based on your personal knowledge, the patient's history, and the patient's records?

******* Doctor, I'm about to ask you a series of questions that require either a "yes" or "no" answer. (Do not accept "possibly" as an answer.)**

D. Statutory Justification - EXTENDED COMMITMENT

1. Is the nature of the proposed patient's mental illness severe and persistent? If so,
2. As a result of the mental illness, will the proposed patient, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress and experience deterioration of the ability to function independently to the extent that the proposed patient will be unable to live safely in the community without court-ordered outpatient mental health services? If so,

3. Does the proposed patient have an inability to participate in outpatient treatment services effectively and voluntarily? If so,
4. Is this demonstrated by the proposed patient's actions occurring within the last two years or by specific characteristics of the proposed patient's clinical condition that make it impossible for him (her) to make rational and informed decisions whether to submit to voluntary outpatient treatment? **Please describe.**
5. Does a recent overt act or continuing pattern of behavior tend to confirm the proposed patient's distress, the deterioration of the proposed patient's ability to function independently to the extent that the proposed patient will be unable to live safely in the community, and the proposed patient's inability to participate in outpatient treatment services effectively and voluntarily? **Please describe.**
6. Are appropriate mental health services available for the proposed patient?
7. Do you expect the patient's condition to continue for more than 90 days?
8. Has the patient received inpatient mental health services under court order pursuant to the Texas Health and Safety Code for at least 60 consecutive days within the last 12 months? (If a jury trial, have the doctor read from the previous or current Order of Commitment).
9. Has the patient received inpatient mental health services under court order pursuant to Section 5, Article 46.02, Code of Criminal Procedure, for at least 60 consecutive days within the last 12 months?

E. Least Restrictive Recommendation (ALL CASES)

Are the outpatient services of the _____ mental health authority the least restrictive appropriate setting available for this patient at this time?

NOTE: Response to Hearsay Objection:

1. Not offered for the truth of the matter asserted, but merely to show part of the foundation for the doctor's opinion.
2. Ask the doctor if he (she) has discussed the alleged behaviors with the patient and if so, whether the patient admitted the acts. If you can't get it in this way, call the patient to testify.

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F. Predicate for Proving Up Medical Records

1. Does the hospital keep records on each patient?
2. Does the hospital have records for the proposed patient?
3. Do those records contain entries of facts, events, conditions, opinions, or diagnosis of or about the proposed patient?
4. Were the entries made at or near the time the events, conditions, opinions, or diagnosis occurred?
5. Were the entries made by or from information transmitted by a person with personal knowledge of the events or opinions?
6. Are these records made in the regular course of business at the hospital?
7. Is it customary to rely on recorded observations made by staff members (in other words, is it customary for a doctor to rely on recorded observations in preparing his opinion)?
8. Have you reviewed these records?
9. Have you relied on these records in forming your opinion of the mental health of this patient?
10. Do the records confirm or tend to confirm your diagnosis?
11. Please read the entry on (date).

G. Predicate for Proving Up Doctor's Qualifications

1. Please state your name for the record.
2. How are you employed?
3. How long have you been employed at (name of facility) ?
4. What duties do you perform?
5. Please describe your educational background. (College, Medical School, Internship, Medical Residency)
6. Are you licensed as a physician in the State of Texas?
7. Are you experienced in the specialty of psychiatry?
8. How long have you practiced psychiatry?

9. Are you board certified or board eligible in psychiatry?
10. What does board certified (board eligible) mean?
11. At this time we offer Dr. (name) as an expert witness in the field of psychiatry.

Appendix H: Prosecutor's Questions for Psychoactive Medication Administration Hearing

- A. At this time the State requests a **stipulation to the doctor's expert qualifications in psychiatry** and a **stipulation as to the admissibility of the medical records** generated here at the Austin State Hospital (or substitute name of hospital) by persons with personal knowledge of the events they recorded and recorded at or near the time the events occurred. (If stipulation refused, see predicate for qualifying the doctor and also for qualifying the medical records.)
- B. Knowledge of Patient**
1. Doctor, please state your name.
 2. Are you a licensed physician in the State of Texas?
 3. Are you board certified or board eligible in psychiatry?
 4. Are you familiar with the patient, (Name) ?
 5. Is the patient subject to an order for court-ordered inpatient mental health services?
 6. What is the date of the order?
 7. Is the order for a temporary or extended commitment?
 8. Have you conducted a psychiatric evaluation of the patient?
 9. What is your diagnosis of the patient?
- C. Patient's Capacity to Decide**
1. Does the patient have the capacity to make a decision regarding the administration of psychoactive medication?
 2. Why do you believe the patient lacks the capacity to make such a decision? (Is he able to understand the risks and benefits associated with taking the medication?)
 3. If the patient consented to taking the medication at this time, would you allow him (her) to take it? Why not?
- D. Medical Opinion**
1. Have you determined that administration of psychoactive medication is the proper course of treatment for and in the best interest of the patient?
 2. What class or classes of psychoactive medication, in your opinion, should be administered to the patient?
 3. What specific types of medication should be administered to the patient?
 4. What is the patient's prognosis, in your opinion, if he (she) is treated with the class(es) of psychoactive medication you are recommending?
 5. What are the consequences, in your opinion, of not administering the classes of psychoactive medication you are recommending to the patient?
 6. What alternatives have you considered to treat the patient instead of psychoactive medications?
 7. Will these alternatives be as effective as administration of psychoactive medication? Why not?
- E. Predicate for Proving Up Medical Records**
1. Does the hospital keep records on each patient?
 2. Does the hospital have records for the proposed patient?
 3. Do those records contain entries of facts, events, conditions, opinions, or diagnosis of or about the proposed patient?
 4. Were the entries made at or near the time the events, conditions, opinions, or diagnosis occurred?
 5. Were the entries made by or from information transmitted by a person with personal knowledge of the events or opinions?
 6. Are these records made in the regular course of business at the hospital?
 7. Is it customary to rely on recorded observations made by staff members (in other words, is it customary for a doctor to rely on recorded observations in preparing his opinion)?
 8. Have you reviewed these records?
 9. Have you relied on these records in forming your opinion of the mental health of this patient?

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10. Do the records confirm or tend to confirm your diagnosis and opinion regarding the administration of psychoactive medication?
11. Please read the entry on (date).

F. Predicate for Proving Up Doctor's Qualifications

1. Please state your name for the record.
2. How are you employed?
3. How long have you been employed at (name of facility) ?
4. What duties do you perform?
5. Please describe your educational background. (College, Medical School, Internship, Medical Residency)
6. Are you licensed as a physician in the State of Texas?
7. Are you experienced in the specialty of psychiatry?
8. How long have you practiced psychiatry?
9. Are you board certified or board eligible in psychiatry?
10. What does board certified (board eligible) mean?
11. At this time we offer Dr. (name) as an expert witness in the field of psychiatry.

Appendix I: Prosecutor's Questions for Commitment Hearing for Person with Intellectual Disabilities

A. At this time the State requests a **stipulation to the psychologist's expert qualifications** and a **stipulation as to the admissibility of the medical records** generated here at the Austin State Hospital (or substitute name of residential care facility) by persons with personal knowledge of the events they recorded and recorded at or near the time the events occurred. (If stipulation refused, see predicate for qualifying the psychologist and also for qualifying the medical records.)

B. Knowledge of Person

1. Doctor, please state your name for the record.
2. Are you a licensed or certified psychologist in the State of Texas?
3. Are you familiar with the proposed patient, (Name) ?

C. Expert Opinion

1. Do you have an opinion as to whether the proposed resident is mentally retarded?
2. What is your opinion?
(Level of functioning? Mental age?)

D. Statutory Justification

1. Because of the retardation, does the proposed resident represent a substantial risk of physical impairment or injury to himself/herself or others? or
2. Is he/she unable to provide for and not providing for his/her most basic physical needs (food, shelter, security/protecting self)? and
3. Can the proposed resident be adequately and approximately habilitated in an available, less restrictive setting than a residential care facility? and
4. Does the (residential care facility) provide habilitative services, care, training, and treatment appropriate to the proposed resident's needs?
5. Has a comprehensive assessment and evaluation of the proposed resident been completed or updated within six months of the date of this hearing?

Admit assessment & evaluation into evidence.

E. Predicate for Proving Up Medical Records

1. Does the hospital (residential care facility) keep records on each resident?
2. Does the hospital (residential care facility) have records for the proposed resident?
3. Do those records contain entries of facts, events, conditions, opinions, or diagnosis of or about the proposed resident?
4. Were the entries made at or near the time the events, conditions, opinions, or diagnosis occurred?
5. Were the entries made by or from information transmitted by a person with personal knowledge of the events or opinions?
6. Are these records made in the regular course of business at the hospital (residential care facility)?
7. Is it customary to rely on recorded observations made by staff members (in other words, is it customary for a psychologist to rely on recorded observations in preparing his/her opinion)?
8. Have you reviewed these records?
9. Have you relied on these records in forming your opinion of the mental health of this patient?
10. Do the records confirm or tend to confirm your opinion?
11. Please read the entry on (date) .

F. Predicate for Proving Up Psychologist's Qualifications

1. Please state your name for the record.
2. How are you employed?
3. How long have you been employed at (name of facility) ?
4. What duties do you perform?
5. Please describe your educational background. (College, Graduate School, Degrees)
6. Are you licensed or certified as a psychologist in the State of Texas?
7. What does that certification mean?
8. How long have you practiced psychology?
9. At this time we offer Dr. (name) as an expert witness in the field of psychology.

Appendix J: T.G. v. State, 7 S.W.3d 248 (Tex. App. – Dallas 1999, no pet.)

T.G., Appellant v. THE STATE OF TEXAS,
Appellee

No. 05-99-00876-CV
COURT OF APPEALS OF TEXAS, FIFTH
DISTRICT, DALLAS
7 S.W.3d 248; 1999 Tex. App. LEXIS 8346 (no
petition)

November 8, 1999, Opinion Filed

PRIOR HISTORY: [**1] On Appeal from the County Court at Law. Kaufman County, Texas. Trial Court Cause No. 99-127. Trial Judge: Joe Parnell.

DISPOSITION: Trial court's judgment REVERSED, judgment RENDERED denying the State's petition for temporary court-ordered mental health services.

COUNSEL: For APPELLANT: Darla Mcleroy, Attorney at Law, Crandall, TX.

For APPELLEE: Todd Alan Hoodenpyle, Assistant District Attorney, Kaufman County District Attorney, Kaufman, TX.

JUDGES: Before Justices Lagarde, James, and Roach. Opinion By Justice Roach.

OPINION BY: JOHN R. ROACH

[*249] Opinion By Justice Roach

In this case, we must decide whether there is clear and convincing evidence to support T.G.'s court-ordered commitment to Terrell State Hospital for no more [*250] than ninety days. After reviewing the record, we conclude there is not. Accordingly, we reverse and render.¹¹

The court reporter's record of the commitment hearing contains six pages of testimony; of that, three are dedicated to the State's sole witness, Dr. Methner, who was not otherwise identified.¹² [**2] Dr.

¹¹ Although the ninety-day period has expired, the mootness doctrine does not apply to appeals of mental health commitments such as this. *State v. Lodge*, 608 S.W.2d 910, 912 (Tex. 1980).

¹² In her brief, T.G. identifies Dr. Methner as the staff psychiatrist at Terrell State Hospital. Likewise, the clerk's record contains a Physician's Certificate of Dr. John P.

Methner testified he examined T.G. within the last thirty days, found her to be mentally ill, and the diagnosis to be "psychosis NOS." Psychosis NOS is not defined or otherwise explained. In his brief testimony, Dr. Methner stated that he had "concerns about harm to herself" and that she would continue to deteriorate. He further testified: "And she, according to the reports I got, was acting bizarrely. And there was a concern that she was leaving gas burners on the stove on, and not being aware of that. And people had to make sure they were off and there was proper aeration before there was any kind of matches or cigarettes in the area."

Dr. Methner further testified that this was T.G.'s first admission to Terrell State Hospital, although she had a "history of mental [**3] illness going back to '90 or '91 in which she had a similar response." Dr. Methner testified that, when he talked to T.G., she said she was not mentally ill. He said she has a "bizarre history . . . of thinking of a mail carrier as a responsible person for her" and that "she's in the military, and military doctors knew her, and they were the ones that had to be contacted." When asked if there was any verification that T.G. is in fact in the military, Dr. Methner replied, "None that we're able to verify at this time."

Dr. Methner's testimony concluded with the following:

[STATE'S ATTORNEY]: In your opinion, as a result of this mental illness, will this person, if not treated, continue to suffer severe and abnormal mental, emotional or physical distress and continue to experience deterioration of her ability to function independently?

[DR. METHNER]: She will, due to impaired insight, impaired judgment, impaired cognition, fixated thinking around military orientation and denial.

[STATE'S ATTORNEY]: In your opinion, is this person unable to make a rational and informed decision as to whether to submit to treatment?

[DR. METHNER]: She is unable to for the same above-mentioned [**4] reasons.

[STATE'S ATTORNEY]: Other than those already stated, are there any other symptoms or behavior of this person which form the basis of your opinion?

[DR. METHNER]: These are the main ones. When I talked to her, she was still disorganized, hostile. Had no insight, and had no appropriate reason

Methner. Dr. Methner signed the certificate as staff psychiatrist.

why she should be kept at Terrell. Felt she was harassed and was wronged.

[STATE'S ATTORNEY]: What is the least restrictive, appropriate and available setting for treatment for this patient at this time?

[DR. METHNER]: In my clinical opinion, inpatient psychiatric care, Terrell State Hospital for a period not greater than 90 days.

T.G.'s attorney did not cross-examine Dr. Methner, and the State rested after his testimony without presenting any other testimonial or documentary evidence.

T.G. briefly addressed the court and made reference to military service with the United States Air Force and Army. Although her statement is unclear, it appeared that she believed the information given about her was false and said she had [*251] "turned information over to the United States Air Force and the U.S. Embassy." Under cross-examination by the State, T.G. said she enlisted in the army [**5] in July 1987 and entered the air force in 1985. She said she was stationed at Fort Pierce, Colorado, but said she could not give out further military information. She said the proceedings were "an inconvenience" and she had been "brought in here against [her] will."

Immediately after T.G.'s testimony, the trial court determined it was in her best interest to be held at the state hospital for up to ninety days. In the judgment, the court, in accordance with the statute, found: (1) T.G. is mentally ill; (2) as a result of the mental illness, she is likely to cause serious harm to herself or others; or (3) if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress and will continue to experience deterioration of her ability to function independently; and (4) T.G. is unable to make a rational and informed decision as to whether or not to submit to treatment. See *TEX. HEALTH & SAFETY CODE ANN. § 574.034(a)* (Vernon Supp. 1999).

Before a mentally ill patient can be ordered confined to a hospital on a temporary basis, the State must establish by clear and convincing evidence at least one of three criteria set forth [**6] in the mental health statute. See *TEX. HEALTH & SAFETY CODE ANN. § 574.034(a)* (Vernon Supp. 1999). Here, the judge made findings on all three statutory criteria. In three points of error, T.G. complains the evidence is both legally and factually insufficient to support those findings.

To be clear and convincing under the statute, the evidence must include expert testimony and, unless waived, evidence of a recent overt act or a continuing pattern of behavior that tends to confirm either (1) the

likelihood of serious harm to the proposed patient or others or (2) the proposed patient's distress and the deterioration of the proposed patient's ability to function. See *TEX. HEALTH & SAFETY CODE ANN. § 574.034(d)* (Vernon Supp. 1999). Clear and convincing evidence is "that measure or degree of proof which will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established." *State v. Addington, 588 S.W.2d 569, 570 (Tex. 1979)* (per curiam).

In this appeal, T.G. challenges the legal and factual sufficiency of the evidence to support the [**7] trial court's findings that she is likely to cause serious harm to herself or others or that she would continue to experience deterioration of her ability to function independently. In reviewing no evidence complaints in mental health commitments, we must only review the evidence favorable to the court's judgment; in reviewing factual sufficiency complaints, we must review all the evidence to determine if it was sufficient to produce a firm belief or conviction in the fact finder of the allegations pleaded. *Broussard v. State, 827 S.W.2d 619, 620 (Tex. App.-Corpus Christi 1992, no writ)*.

After reviewing the sparse record in this case, we conclude there was no evidence of a recent overt act or continuing pattern of behavior to show T.G. was likely to cause harm to herself or others or to show the deterioration of her ability to function. The only evidence of an "overt act" that we can glean from the record was a reference to T.G. leaving the gas burners on and not being aware of it. With respect to that testimony, Dr. Methner testified only that there was a "concern" that T.G. had done so and, when asked whether the incident in fact occurred, Dr. Methner simply replied [**8] that "it was in the report that she was picked up for that, previous to 4-23-99. So it would have been within that given period of days." From this testimony, we cannot ascertain when or if such an incident even occurred, much less the circumstances. Consequently, we do not consider it any evidence of an overt act.

Further, there is no evidence in the record of any continuing pattern of [*252] behavior to show T.G. was likely to cause harm to herself or others or that her ability to function independently would continue to deteriorate. As is reflected above, Dr. Methner testified T.G. was mentally ill and diagnosed her illness as "psychosis NOS." Dr. Methner neither defined nor explained his diagnosis and was never asked to do so by the State, T.G.'s attorney, or the judge. But expert diagnosis of mental illness alone is not sufficient to confine a patient for compulsory treatment. See *Mezick v. State, 920 S.W.2d 427, 430*

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(Tex. App.-Houston [1st Dist.] 1996, no writ). Expert opinions and recommendations must be supported by a showing of the factual bases on which they are grounded. *Id.* Here, Dr. Methner did little more than testify to the conclusions required by the [**9] statute. For instance, he testified that her ability to function independently would continue to deteriorate “due to impaired insight, impaired judgment, impaired cognition, fixated thinking around military orientation and denial.” Dr. Methner failed to explain these medical conclusions, what facts they were based on, and how they generally affect T.G.’s ability to function on a day-to-day basis without imposing court-ordered mental health services. See *Broussard*, 827 S.W.2d at 622. His testimony that T.G. had some unexplained history of mental illness, thought a mail carrier was responsible for her, and believed she was in the military suffers the same fatal flaw. Perhaps T.G. does suffer mental distress, but evidence which merely reflects that an individual is mentally ill is no evidence that the statutory standard has been met. *Id.* Just as importantly, psychotic behavior alone is insufficient to justify commitment on the grounds of mental distress and the deterioration of the ability to function independently. *Id.* Moreover, it is no evidence of a continuing pattern of behavior that tends to confirm the likelihood of serious harm to herself or others.

Accordingly, [**10] based on a review of the evidence at the commitment hearing, we conclude the trial court could not have properly made the findings it did by clear and convincing evidence because there was no evidence of a recent overt act or continuing pattern of behavior that tended to confirm those findings. See *TEX. HEALTH & SAFETY CODE ANN. § 574.034(d)(1) & (2)* (Vernon Supp. 1999). We

therefore sustain T.G.’s points of error one, two, and three.

In reaching our decision in this case, we are disturbed by the perfunctory manner in which the State prosecuted this involuntary commitment. Just as disturbing is the quantum of evidence determined by the trial court to be clear and convincing so that this woman was deprived of her liberty for up to ninety days. An involuntary commitment to a mental hospital after a finding of probable danger to oneself or others constitutes a significant deprivation of liberty and can also engender adverse social consequences to the person committed. *Addington v. Texas*, 441 U.S. 418, 425-26, 60 L. Ed. 2d 323, 99 S. Ct. 1804 (1979). For these reasons, it is not something our courts and prosecutors should take lightly. [**11] Requiring a standard of proof higher than the usual preponderance-of-the-evidence standard reflects the “value society places on individual liberty.” *Id.* at 425. The higher standard of clear and convincing evidence is intended to allocate the risk of error between litigants and to indicate the relative importance attached to the ultimate decision. *Id.* at 423.

In this case, the system failed, and there is nothing this Court can do to rectify the fact that T.G. was confined against her will on less evidence than is required by statute. Unfortunately, all we can do is reiterate the level of proof required before ordering a person’s involuntary commitment and remind mental health prosecutors and judges that anything less will result in a reversal.

We reverse the trial court’s judgment and render judgment denying the State’s [*253] petition for temporary court-ordered mental health services.

JOHN R. ROACH, JUSTICE

Appendix K: *K.T. v. State*, 68 S.W.3d 887 (Tex. App. – Houston [1st Dist.] 2002, no pet.)

K.T., Appellant v. THE STATE OF TEXAS,
Appellee

NO. 01-00-00618-CV
COURT OF APPEALS OF TEXAS, FIRST
DISTRICT, HOUSTON
68 S.W.3d 887; 2002 Tex. App. LEXIS 1181

February 14, 2002, Opinion Issued

PRIOR HISTORY: [**1] On Appeal from Probate Court No. 3, Harris County, Texas. Trial Court Cause No. 88,581.

DISPOSITION: Reversed and judgment rendered denying the application for temporary mental health services and denying the petition for order to administer psychoactive medication.

COUNSEL: FOR APPELLANT: Michael Ray McLane, Houston, TX.

FOR APPELLEE: Lisa S. Hulseley Rice, Assistant County Attorney, Houston, TX. Jacqueline Lucci, Assistant County Attorney, Houston, TX.

JUDGES: Panel consists of Justices Mirabal, Nuchia, and Price. [The Honorable Frank C. Price, former Justice, Court of Appeals, First District of Texas at Houston, participating by assignment.]

OPINION BY: Margaret Garner Mirabal

[*888] In this case, we must determine whether there is clear and convincing evidence to support K.T.'s court-ordered temporary commitment to Ben Taub Hospital and court-ordered treatment with psychoactive medication.¹³ Because we conclude there is not, we reverse.

[*889] FACTUAL AND PROCEDURAL BACKGROUND

On April 28, 2000, K.T. went to Ben Taub Hospital's emergency room requesting the removal [**2] of vaginal sutures. K.T. told the hospital staff that the sutures were from a gynecological procedure that was performed a few months earlier in Peru. K.T. also told the staff that she was pregnant. An

¹³ See TEX. HEALTH & SAFETY CODE ANN. §§ 574.034, 574.106 (Vernon Supp. 2002).

examination revealed that K.T. was not pregnant and had no vaginal sutures.

After she was informed that no sutures were found, K.T. refused to leave the exam room and became verbally abusive to the staff. A psychiatrist was called for an evaluation and admitted K.T. to Ben Taub's mental health unit.

On May 1, 2000, Sonja Gurule, a hospital social worker, filed an application for court-ordered mental health services seeking to have K.T. involuntarily committed. The trial court issued an order of protective custody ordering that K.T. be kept at Ben Taub's mental health facility pending the hearing on her involuntary commitment. In the order, the court also appointed an attorney to represent K.T.

K.T.'s commitment hearing was held on May 9, 2000. Present at the hearing were K.T.'s court-appointed counsel, the State's counsel, and the trial judge; K.T. did not attend. At the conclusion of the hearing, the trial court ordered K.T. committed for inpatient mental health services for a [**3] period of not more than 90 days.¹⁴ After signing the commitment order, the trial court then held a hearing on a petition to administer psychoactive medication filed by Dr. Danae Georges. At the end of the second hearing, the trial court signed an order to administer psychoactive medication. See TEX. HEALTH & SAFETY CODE ANN. § 574.106 (Vernon Supp. 2002).

[4] BURDEN OF PROOF**

On an application for court-ordered inpatient mental health services, the State is required to prove, *by clear and convincing evidence*, that:

- (1) the proposed patient is mentally ill;
- (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:
 - (i) suffering severe and abnormal mental, emotional, or physical distress;

¹⁴ Although K.T. has already been released from her temporary commitment, her appeal is not moot. See *State v. Lodge*, 608 S.W.2d 910, 911-12 (Tex. 1980). The *Lodge* court held that the doctrine of mootness does not apply to appeals from involuntary commitments for temporary hospitalization. *Id.* This conclusion was based, in part, on the observation that "commitment to a mental hospital can engender adverse social consequences to the individual whether it is labeled a stigma or if it is called something else." *Id.* at 912. This stigma continues even after release is obtained. See *id.*

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- (ii) experiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health, or safety; and
- (iii) unable to make a rational and informed decision as to whether or not to submit to treatment.

TEX. HEALTH & SAFETY CODE ANN. § 574.034(a).

The trial judge must specify which criterion forms the basis for the [*890] decision to grant the State's application. *Id.* § 574.034 (b).

In support of its order to involuntarily hospitalize K.T., the trial court stated in its judgment that [**5] it found by clear and convincing evidence that K.T. was mentally ill and made positive findings under subsections (a)(2)(A),(C)(i),(ii),(iii).¹⁵

STANDARD OF REVIEW

In her first [**6] issue, K.T. contends that the evidence is legally and factually insufficient to support the trial court's findings on which it bases her temporary commitment.

The clear and convincing standard is the degree of proof that will produce in the mind of the trier of fact "a firm belief or conviction" as to the truth of the allegations sought to be proved. *In re K.C.M.*, 4 S.W.3d 392, 395 (Tex. App.--Houston [1st Dist.] 1999, pet. denied); *T.G. v. State*, 7 S.W.3d 248, 251 (Tex. App.--Dallas 1999, no pet). In conducting a legal sufficiency review, we consider only the evidence and inferences tending to support the fact finding, and we disregard all contrary evidence and inferences. *In re K.C.M.*, 4 S.W.3d at 395; *Johnstone v. State*, 961

¹⁵ In its judgment, the trial court stated: The Court . . . finds that all terms and provisions of the Texas Mental Health Code have been complied with; and after considering all the evidence, testimony and Certificates filed herein, the Court finds by clear and convincing evidence that [K.T.] is mentally ill and as indicated below, the result of that mental illness:

- is likely to cause harm to [herself];
-
- (i) is suffering severe and abnormal mental, emotional, or physical distress;
- (ii) is experiencing substantial mental or physical deterioration of [her] ability to function independently, except for reasons of indigence, to provide for [her] basic needs; including food, clothing, health, or safety; and
- (iii) is not able to make a rational informed decision as to whether to submit to treatment.

S.W.2d 385, 388 (Tex. App.--Houston [1st Dist.] 1997, no writ). If any evidence of probative force exists to support the finding, we will uphold the decision. *In re K.C.M.*, 4 S.W.3d at 395. In reviewing factual sufficiency complaints, we review all the evidence to determine if it was sufficient to produce a firm belief or conviction in the fact finder of the allegations [**7] pleaded. *T.G.*, 7 S.W.3d at 251. We will sustain a factual sufficiency challenge only if, after viewing all the evidence, we conclude the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and unjust. *In re K.C.M.*, 4 S.W.3d at 395.

To constitute clear and convincing evidence under Mental Health Code subsection 574.034(a), the evidence "must include expert testimony and, unless waived, evidence of a recent overt act or a continuing pattern of behavior that tends to confirm (1) the likelihood of serious harm to the proposed patient or others; or (2) the proposed patient's distress and the deterioration of the proposed patient's ability to function." TEX. HEALTH & SAFETY CODE ANN. § 574.034(c).

DISCUSSION

As previously noted, K.T. was not present at the commitment hearing. The substance of the commitment hearing constitutes only slightly more than one page in the reporter's record:

THE COURT: Call Cause No. 88581.

[STATE'S COUNSEL]: Yes, Your Honor.

THE COURT: Counsel for the proposed patient ready?

[APPELLANT'S TRIAL COUNSEL]: Ready, Your Honor. And my [**8] client has [*891] refused to appear at the hearing this morning.

THE COURT: All right.

[STATE'S COUNSEL]: The State asks counsel to stipulate to two certificates of medical examination; one from Dr. Georges, and one from Dr. Edythe Harvey, as well as the affidavit of applicant, Sonja Gurule.

All individuals if present and sworn in court today would testify to the contents of these documents.

[APPELLANT'S TRIAL COUNSEL]: So stipulated.

THE COURT: Which criteria?

[STATE'S COUNSEL]: One and three.¹⁶

¹⁶ This apparently references the criteria set out in subsections 574.034(a)(2)(A) and (C); the State did not request, and the trial

THE COURT: You rest?

[STATE'S COUNSEL]: The State rests.

THE COURT: You rest?

[APPELLANT'S TRIAL COUNSEL]: We rest, Your Honor.

THE COURT: All right. I'll sign the order.

The trial court's judgment states that, based on the certificates of medical examination completed by Drs. Georges and Harvey, [**9] and the affidavit of Sonja Gurule, the trial court determined that the State had met its burden under the provisions of section 574.034, and that K.T. should be involuntarily committed.

Dr. Harvey completed her certificate on April 28, 2000—the same day that K.T. came to Ben Taub's emergency room. There is no indication that Dr. Harvey had previously treated K.T. With regard to the bases for her diagnosis, Dr. Harvey explained in her certificate that:

Patient is delusional, paranoid, uncooperative, has been refusing to eat. Demands that sutures be removed from her vagina when none are present. . . . I am of the opinion that the Patient, because of [her] mental illness, presents a substantial risk of serious harm to self or others if not immediately restrained; that the detailed basis for such is as follows: Patient is delusional, paranoid, verbally abusive, uncooperative and is refusing to eat. She was refusing to leave . . . gyn exam rm [sic] after being told she had no sutures in her vagina. . . . Emergency detention is the least restrictive means by which the necessary restraint may be effected, that the facts which form the basis for my medical opinion as to Patient's imminent [**10] risk of harm unless immediately restrained are: Patient does not appear capable of appropriately caring for herself at this time. She is at risk of harm to herself. She is delusional, paranoid and uncooperative. Refusing to eat.

Sonja Gurule, a social worker, signed her affidavit offered in support of the application for court-ordered temporary health services on May 1, 1999 and stated as follows:

[Patient] has tried to elope [leave] twice this morning. She appears paranoid with guarded behavior. [Patient] was admitted after seeing the OB/GYN requesting stitches be removed from her vagina. [Patient] did not have any stitches. She has been going to different hospitals requesting this procedure be done. . . . [Patient] refuses to answer questions unless she has attorney present. . . . [Patient] refuses to eat stating we may be putting medication in her food.

court did not find, that K.T. is likely to cause serious harm to others.

[Patient] has poor insight and judgment and if not treated may continue to decompensate. [Patient] was recently [**892] discharged from Austin St. Hospital.

Dr. Georges's certificate was completed on May 4, 1999. At that time, K.T. had been under her care for six days. In her certificate, Dr. Georges stated as follows:

[**11] [Patient] is delusional, paranoid, and uncooperative. Believes there are sutures in her vagina that must be removed but exams have revealed no sutures evident. Believes she is pregnant, but ultrasound in E.R. showed no fetus and UPT was [negative]. [Patient] eats very little because she believes that hospital food is poisoned. . . . [Patient] suffering from psychotic disorder [with] delusions and paranoia. . . . Condition rapidly deteriorating, [patient] unable to care for herself, at risk of causing harm to herself because of this. . . . [Patient] at imminent risk of decompensation and causing harm. [Patient] lacks insight and judgment as to her need for treatment and is at risk for further continued deterioration.

K.T. contends that this evidence is not legally and factually sufficient to show "a recent overt act" or a "continuing pattern of behavior" that tends to confirm either that K.T. (1) was likely to cause serious harm to herself, or (2) to show the deterioration of K.T.'s ability to function. See *TEX. HEALTH & SAFETY CODE ANN. § 574.034(d)*.

We first address the statements made by Harvey, Georges, and Gurule that K.T. was [**12] mentally ill, "delusional, paranoid, verbally abusive, uncooperative," and had "poor insight and judgment." Texas courts have made it clear that expert diagnosis of mental illness, standing alone, is not sufficient to confine a patient for compulsory treatment. *Mezick v. State*, 920 S.W.2d 427, 430 (Tex. App.—Houston [1st Dist.] 1996, no writ); see also *T.G.*, 7 S.W.3d at 251-52 (finding that physician's diagnosis that appellant suffered from "psychosis NOS" not sufficient to support commitment). Evidence that merely reflects that an individual is mentally ill and in need of hospitalization is no evidence the statutory standard has been met. *Broussard v. State*, 827 S.W.2d 619, 622 (Tex. App.—Corpus Christi 1992, no writ); see also *Johnstone*, 961 S.W.2d at 388; *D.J. v. State*, 59 S.W.3d 352, 357 (Tex. App.—Dallas 2001, no pet) (holding psychotic behavior, such as D.J.'s belief she had experienced a "dehumanizing" process that included undergoing laser surgery by satellite, being implanted with electronics, and being used as a guinea pig by unknown force was not alone sufficient to justify involuntary [**13] commitment under statute).

In *Johnstone*, a temporary commitment case, the State offered psychiatric testimony that Johnstone

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suffered from chronic schizophrenia, auditory hallucinations, paranoid thinking, was irritable, uncooperative, and hostile to the staff, and he refused to take his medication. *Johnstone*, 961 S.W.2d at 387. Based on this evidence, the trial court signed a temporary commitment order. *Id.* at 388. This Court held that the evidence was legally insufficient to show an overt act or continuing pattern of behavior tending to confirm deterioration of the proposed patient's ability to function, and therefore the State had not proven its case by clear and convincing evidence. *Id.* at 389-90.

In *T.G. v. State*, the Dallas Court of Appeals also reversed a temporary commitment order for similar reasons. 7 S.W.3d at 252. In *T.G.*, a doctor testified that T.G. suffered from "psychosis NOS" and that her ability to function would deteriorate, due to impaired insight, judgment and cognition, and fixated thinking that she was in the military, when she was not, and that a mail carrier was a person responsible [**14] [*893] for her. *Id.* at 250. The doctor also testified that T.G. acted "bizarrely" and might harm herself because there was a concern that she sometimes forgot to turn off her stove's gas burners. *Id.* The *T.G.* court noted that the State's doctor did little more than testify to the conclusions required by the Mental Health Code. *Id.* The court reversed the trial court's commitment order finding that there was no evidence of an overt act or pattern of behavior to show that T.G. was likely to cause harm to herself or others, or that her ability to function independently would continue to deteriorate. *Id.*; see also *In re Breeden*, 4 S.W.3d 782, 788-89 (Tex. App.--San Antonio 1999, no pet.) (finding no evidence of overt act or continuing pattern of behavior, even though doctors testified that patient was not eating properly and refusing medication, because medical testimony did not show malnutrition, but did show patient's dietary and medication decisions were based on his concern for animal rights).¹⁷

¹⁷ See also *Broussard v. State*, 827 S.W.2d 619, 622 (Tex. App.--Corpus Christi 1992, no writ) (reversing commitment order on no evidence challenge despite evidence that patient had delusions, had been previously hospitalized for her mental illness, and was described as hostile and provocative); *In re J.S.C.*, 812 S.W.2d 92, 95 (Tex. App.--San Antonio 1991, no writ) (finding insufficient evidence to show that patient could not care for himself outside hospital environment though evidence showed patient suffered from chronic schizophrenia, hallucinations, was catatonic sometimes, delusional and disoriented); but see *Mezick v. State*, 920 S.W.2d 427, 430 (Tex. App.--Houston [1st Dist.] 1996, no writ) (finding evidence sufficient because State showed that patient had history of threatening suicide, refused medication, and lost 30 pounds in three months); *L.S. v. State*, 867 S.W.2d 838, 842-43 (Tex. App.--Austin 1993, no writ) (affirming commitment for patient because evidence showed that patient deliberately gained 10 pounds in one day by drinking excessive water, was attacked by another patient for being intrusive, and habitually walked into traffic without looking).

[**15] Here, the State contends that K.T.'s recurring "delusions" that the staff was putting poison or medication in her food shows her inability to care for herself. However, there was no evidence presented that K.T. was refusing to eat before she was involuntarily hospitalized, or that her refusal resulted in malnutrition or other harm. Further, K.T.'s belief that the staff was trying to put medication in her food may not have been delusional in light of the fact that Dr. Georges filed a petition to administer psychoactive drugs to K.T. on May 4, 2000.

K.T.'s refusal to leave the examination room on one occasion, and the fact that she had been to a number of hospitals complaining about non-existent sutures, does not tend to confirm that K.T. is likely to cause serious harm to herself, nor does it tend to confirm a deterioration of K.T.'s ability to function. Moreover, K.T.'s attempted elopements from Ben Taub demonstrate nothing more than that she did not want treatment and wished to leave the hospital.

K.T. may be mentally ill; however, evidence that tends to establish that an individual is mentally ill is no evidence that the statutory standard has been satisfied. *Broussard*, 827 S.W.2d at 622; [**16] *T.G.*, 7 S.W.3d at 252. We stress that psychotic behavior alone is insufficient to justify involuntary commitment. *T.G.*, 7 S.W.3d at 252.

In the present case, the experts' affidavits stated conclusions that mirrored the requirements of *section 574.034*, but the factual bases for their opinions are lacking. See *Johnstone*, 961 S.W.2d at 388. Based on our review of the evidence presented at the commitment hearing, we conclude that [*894] the trial court could not have properly made the findings required in Mental Health Code subsection 574.034(a) by clear and convincing evidence because there was no evidence of a recent overt act or continuing pattern of behavior that tends to confirm the likelihood of serious harm to K.T. or a substantial deterioration of K.T.'s ability to function independently to provide for her basic needs. See TEX. HEALTH & SAFETY CODE ANN. § 574.034(a),(d)(1),(2).

We need not review the propriety of the order authorizing psychoactive medication. A trial court may not issue an order authorizing the administration of psychoactive medication unless the patient is under an order for temporary [**17] or extended mental health services. See TEX. HEALTH & SAFETY CODE ANN. § 574.106(a)(1); *In re Breeden*, 4 S.W.3d at 790. Because its authorizing order is reversed by this opinion, the order authorizing psychoactive medication cannot stand. *In re Breeden*, 4 S.W.3d at 790.

We sustain K.T.'s first issue. Because of the disposition of issue one, we need not address issues two through six pertaining to K.T.'s contention that her court-appointed counsel was ineffective. *See* TEX. R. APP. P. 47.1.

CONCLUSION

We reverse (1) the trial court's judgment and (2) the order to administer psychoactive medication. We render judgment (1) denying the application for temporary mental health services, and (2) denying the petition for order to administer psychoactive medication.

Margaret Garner Mirabal, Justice