Representing Clients Facing Mental Health Commitment

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I. Introduction. Attorneys representing clients facing inpatient commitment for mental health services are well advised to: 1) realize that psychiatric medicine has advanced substantially in the past sixty years; 2) develop a basic understanding of common psychiatric conditions; 3) review the laws associated with the commitment process; and 4) understand the options available to their clients and the consequences associated with each option.

II. Past Treatment of Persons with Mental Illness—a Snap Shot

A. Majority of U.S. State Institutions Likened to Concentration Camps. In 1946, a year after German forces surrendered, and at a time when the full extent of Nazi atrocities were being reported in the United States, Life Magazine published an expose of two mental hospitals with photos documenting emaciated, naked, and bound patients. The author of the expose, Albert Maisel, likened the "Dungeon," or the Philadelphia State Hospital as it was officially called, to Belsen, a concentration camp located in Northwestern Germany, where there were no ovens, the preferred method of torture and ultimate death being starvation. He blamed public neglect and legislative penny pinching for the overcrowded, dilapidated, and undermanned conditions at the state hospital.[1]

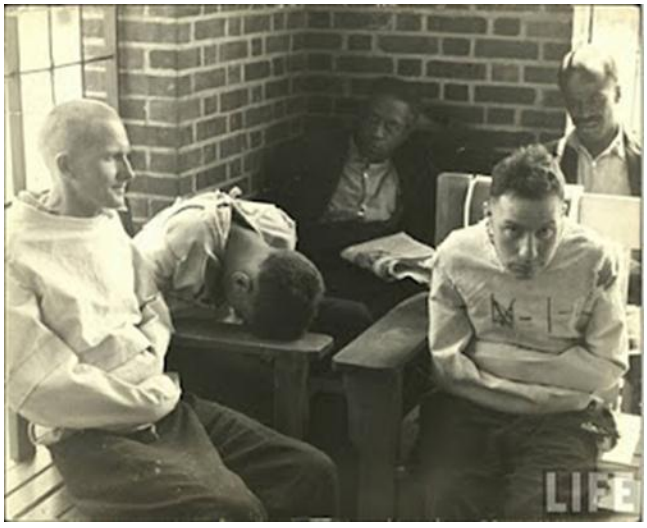

Figure 1 1946 Life Magazine in the "Dungeon"

B. Methods of Restraint Cruel. Patients were provided with shoddy or no clothing and they were often naked and filthy. At the Dungeon, the patients slept on cots packed so tightly into the room that the floor was not visible. In fact, some of the patients slept on blankets or the bare floor. The patients were often bound in thick leather handcuffs, muffs, locks, and straps. Maisel reported that, "hundreds are confined to 'lodges'—bare bedless rooms reeking with filth and feces—by day lit only through half inch holes through steel-plated windows, by night merely black tombs in which the cries of the insane echo unheard from the peeling plaster of the walls."[2] Since state hospitals lacked necessary manpower, patients were managed using seclusion, restraints, and drugs. The record is replete with instances of patient abuse and brutality, which were no doubt precipitated by a system which expected attendants to manage hundreds of patients and work long hours for little pay.[3]

C. Standards of Treatment Hindered Improvement. When Maisel's article was published in 1946, for every 100 patients entering into treatment in the United States, fewer than 12 emerged with improved or restored mental health. Several factors contributed to such discouraging statistics. First, the doctor to patient ratio was very low. For example, a doctor in Rhode Island was responsible for 550 patients at the state hospital and 200 men in prison. Second, in the past, mental hospitals were largely custodial and much less therapeutic, as ECT or electroshock therapy was new on the scene and lithium was not used until the 1950's.[4]

III. The Faces of Mental Illness

A. I See a Red Door and I Want to Paint it Black—Depression

1. Symptoms. The symptoms of depression include long-lasting feelings of hopelessness accompanied by lack of energy and motivation.[5]

2. Treatment. Mild depressive symptoms are alleviated with sleep, exercise, nutrition, social support, and lifestyle changes. However, in more severe cases, depression may be treated with psychotherapy, medication, and perhaps Electroconvulsive Therapy ("ECT").[6]

I see a red door and I want it painted black
No colors anymore I want them to turn black
I see the girls walk by dressed in their summer clothes
I have to turn my head until my darkness goes
. . .
I look inside myself and see my heart is black
I see my red door and it has been painted black
Maybe then I'll fade away and not have to face the facts
It's not easy facing up when your whole world is black
. . .
By Jagger, Mick and Richards, Keith

a. Antidepressants. Antidepressants are used to alleviate the symptoms of depression. The most widely prescribed class of antidepressants is elective serotonin reuptake inhibitors, or SSRIs, and such antidepressants are commonly known by their brand names: Prozac, Zoloft, and Paxil.[7] These antidepressants work by regulating the serotonin levels in the brain.[8] While serotonin affects mood, it also impacts upon other bodily functions including: mental clarity, digestion, sleep, and pain. Consequently, these medications have common side effects which include: nausea, insomnia, anxiety, weight gain, fatigue, decreased sex drive, constipation, diarrhea, and headaches.[9]

b. Psychotherapy. The most common form of psychotherapy used to treat depression is called Cognitive Behavior Therapy ("CBT"). The objective of CBT is to address dysfunctional emotions and destructive behaviors n an effort to reduce the triggers which precipitate depressive episodes.[10] It is thought to be very effective in the treatment of depression.[11]

c. Electroconvulsive Therapy (ECT). Doctors have used ECT to treat patients suffering from depression and bipolar disorder since the 1940's. ECT induces seizures and convulsions by sending electrical waves through the brain of an anesthetized patient. The treatments are safe and considered very effective for depression, mania, and catatonia. In addition, complications associated with ECT are generally mild and temporary.[12]

The most common side effects include short term memory loss and confusion. ECT is considered safe for patients who are pregnant or who have other medical complications such as diabetes; however, ECT is not considered safe for persons with epilepsy or other neurological disorders. The actual ECT treatment lasts only about 15 seconds. ECT is considered more invasive than medication.[13]

A person having authority under a medical power of attorney, and other surrogate decision makers, may not consent the ECT;[14] but a permanent guardian of the person may. The Probate Code gives the guardian of the person power to consent to medical, psychiatric, and surgical treatment other than in-patient psychiatric commitment.[15]

B. I Go to Extremes—Bipolar Disorder

1. Symptoms. Bipolar disorder is characterized my mood swings, vacillating between depression and mania.[16] Each phase of the mood swing can last moments, days, or months. Bipolar disorder affects men and women equally; and people with the disorder tend to display their first symptoms when they are between the ages of fifteen and twenty five.[17] Common triggers which initiate either a manic or depressive episode include: childbirth and other life changes, sleeplessness, recreational drug use, and medications.[18] Generally, there are two types of bipolar disorder, Type I and Type II. People with Type I have periods of depression accompanied by at least one manic episode. Those with Type II also have periods of depression; but they do not experience full blown mania. Rather, they experience periods of impulsiveness and high energy which are less intense as compared to a manic episode.[19]

Call me a joker, call me a fool
Right at this moment I'm totally cool
Clear as a crystal, sharp as a knife
I feel like I'm in the prime of my life
Sometimes it feels like I'm going too fast
I don't know how long this feeling will last
Maybe it's only tonight

Darling I don't know why I go to extremes
Too high or too low there ain't no in-betweens
And if I stand or I fall
It's all or nothing at all
Darling I don't know why I go to extremes

Sometimes I'm tired, sometimes I'm shot
Sometimes I don't know how much more I've got
Maybe I'm headed over the hill
Maybe I've set myself up for the kill
Tell me how much do you think you can take
Until the heart in you is starting to break?
Sometimes it feels like it will
. . .
Out of the darkness, into the light
Leaving the scene of the crime
Either I'm wrong or I'm perfectly right every time
Sometimes I lie awake, night after night
Coming apart at the seams
Eager to please, ready to fight
Why do I go to extremes?
. . .
By Joel, Billy

a. Manic Episodes. Classic hallmarks of manic behavior include: distractedness, recklessness, sleeplessness, poor judgment, hot temper, very elevated mood, increased energy, agitation.[20]

b. Depressive Episodes. Depressive symptoms include: low mood, sadness, over or under eating, fatigue, unusual sleep patterns, hopelessness, isolation, and thoughts of suicide.[21]

2. Treatment. The goals of treatment include enabling the person to: avoid a hospital stay, reduce the number and severity of the episodes, and prevent self-injury.[22]

a. Medications. Mood Stabilizers or anticonvulsants are typically used to treat persons with bipolar disorder.[23] In addition, antipsychotics and antidepressant medications may be used.[24]

i. Mood Stabilizers. Lithium was the first mood stabilizer approved by the FDA and it is still commonly used today. Lithium is designed to remain at therapeutic levels in the patient's system. Common side effects include lethargy and weight gain. In addition, if the lithium levels are too high, the patient can suffer from nausea, diarrhea, and ataxia, a condition which impairs muscular coordination. Depakote is the most widely used mood stabilizer. Depakote's common side effects include tremors, nausea, headaches, drowsiness, and dizziness.[25]

ii. Antidepressants. For a brief discussion regarding antidepressants, refer to paragraph III.A.2.a.

iii. Antipsychotics or Neuroleptics. Antipsychotic medication is divided into two main categories, first generation or typical antipsychotics and atypical or second generation antipsychotics. Haloperidol, having

the trade name Haldol, has been in use since the 1950's and is a typical antipsychotic.[26] Because it can be administered as a long-acting injectable (therapeutic for 2 to 4 weeks), it is widely used to treat patients on an involuntary basis.[27] Antipsychotics and neuroleptics have a tranquilizing effect on patents. Most second generation antipsychotic medicines are available only in pill form, making them appropriate only for compliant patients. Unpleasant and even dangerous side effects cause a majority of patients to stop taking the medications. Common side effects include muscle stiffness, uncontrollable muscle movements, restlessness, tremors, increased heart rate, low blood pressure, lethargy, impotence, and intense nightmares.[28]

b. Psychotherapy. Though psychotherapy may be effective at helping the patient identify and reduce the triggers associated with bipolar episodes, it is often best paired with medication, especially in moderate to severe cases.[29]

c. Electroconvulsive Therapy (ECT). For a brief discussion regarding ECT, refer to paragraph III.A.2.c.

C. I'm Not Crazy I'm Just A Little Unwell—Psychosis and Schizophrenia

1. Symptoms. A person suffering from psychosis or schizophrenia loses touch with reality and they may experience delusions, hallucinations, catatonia, or thought disorder.[30]

a. Delusions. Delusions are strongly held, sustained, and false beliefs that are maintained by the patient despite obvious proof to the contrary. Common delusions involve false beliefs regarding: conspiracy, infidelity, grandiosity, guilt, and religion.[31]

All day staring at the ceiling
Making friends with shadows on my wall
All night hearing voices telling me
That I should get some sleep
Because tomorrow might be good for something

Hold on
Feeling like I'm headed for a breakdown
And I don't know why
. . .
I'm talking to myself in public
Dodging glances on the train
And I know, I know they've all been talking about me
I can hear them whisper
And it makes me think there must be something wrong with me
Out of all the hours thinking
Somehow I've lost my mind
. . .
I've been talking in my sleep
Pretty soon they'll come to get me
Yeah, they're taking me away
. . .
By Thomas, Rob, performed by Matchbox Twenty

b. Hallucinations. While delusions involve strongly held beliefs, hallucinations are defined as sensory perception in the absence of external stimuli.[32] Common hallucinations include auditory hallucinations in which patients, "hear voices." Often times, the voices are derogatory and demanding, causing distress to the patient. Tactile hallucinations are also common, for example, many patients report feeling bugs crawling under their skin. Though auditory and tactile hallucinations are common, hallucinations can involve all five senses.[33]

c. Catatonia. Catatonia presents in two different ways. One presentation of catatonia is called "wavy flexibility," as the patient appears still, quiet, and completely cut off from and unresponsive to external stimuli.[34] If the patient is moved to a different position, the patient maintains the position despite it appearing bizarre or uncomfortable. The second presentation of catatonia involves excessive motor activity without purpose. For example, a patient might run up and down stairs with a high level of internal preoccupation.[35]

d. Thought Disorder. Thought disorder involves a disturbance of the mind as manifested in speech and writing. A patient with thought disorder loses the associations and organization that characterize meaningful verbal communication. In severe cases, patients will use words that have no relation to one another, resulting in meaningless communications sometimes described as "word salad."[36]

2. Treatment.

a. Medications. The medical management of psychosis and schizophrenia often requires a combination of antipsychotic, antidepressant, and antianxiety medication.[37]

b. Psychotherapy. Psychotherapy alone is not generally effective at managing the symptoms of schizophrenia. However, when used with medication, psychotherapy enables the patient to develop behaviors which increase the likelihood that he will use the medications, perform ordinary daily tasks such as grooming, cleaning, and food preparation, and thrive in a social environment.[38]

c. ECT. For a brief discussion regarding ECT, refer to paragraph III.A.2.c.

d. Family Therapy. Family therapy is aimed at enhancing the social support necessary to enable the patient to avoid deterioration, decompensation, and hospitalization. It works by suggesting stress reducing tools to the family members. For example, when faced with a stressful situation, a family meeting to discuss the problem and consider mutually acceptable solutions is suggested. In addition, family members are encouraged to: 1) establish routines; 2) help the patient remain on medication; 3) listen to the patient's fears and concerns; 4) remain patient and calm; and 5) realize that caring for a loved one can be physically and emotionally exhausting and it is important to take time out for yourself and even join a support group if desired.[39]

e. Less Conventional Therapies. Animal assisted therapy has been shown to encourage physical activity, develop social skills, and improve the skills needed for daily living.[40] Music therapy encourages the use of music to improve interpersonal relationship and communication skills. Not only does the patient listen to music, but the patient also creates music.[41] Both animal and music therapy are forms of psychotherapy and they are used in conjunction with medication.

IV. The Involuntary Commitment Process

A. Emergency Detention. There are two types of emergency detention: with and without a warrant.

1. Emergency Detention Without a Warrant. Emergency Detention Without a Warrant may be accomplished by either a peace officer or a guardian of a ward's person.

a. Emergency Detention Without a Warrant by a Peace Officer. As you can imagine, given the nature of an emergency situation, most emergency detentions are without a warrant. According to Section 573.001 of the Texas Mental Health Code, a peace officer, without a warrant, may take a person into custody if the officer has reason to believe and does believe that the person is mentally ill and because of such illness, there is a substantial risk of

serious harm to the person or to others unless the person is immediately restrained.[42] In addition, the officer must believe that there is not sufficient time to obtain a warrant before taking the person into custody. In determining whether the person should be apprehended based upon the above criteria, the officer may rely on representations from a credible person or may form his opinion based upon the conduct of the person or circumstances under which the person is found.[43]

Once the person is apprehended, the peace officer must transport them to the nearest appropriate inpatient mental health facility or suitable mental health facility if an appropriate mental health facility is not available. Only in extreme emergencies will the person be transported to a jail.[44]

Once the person is placed with a facility, the officer must prepare a Peace Officer's Application for Detention. Such Application for Detention must specifically describe: 1) the risk of harm; 2) how the officer's beliefs are derived, either from recent behavior, overt acts, attempts, or threats that were either observed or reliably reported to the officer; 3) a description of the behavior, acts, attempts, or threats; and 4) the name and relationship to the apprehended person who reported or observed such behavior, acts, attempts, or threats. In addition, such Application for Detention must state that the officer has reason to believe and does believe that: 1) the person evidences mental illness; 2) the person evidences substantial risk of serious harm to himself or others; and 3) the risk of harm is imminent unless the person is immediately restrained. [45]

b. Emergency Detention Without a Warrant by a Guardian. A guardian of a ward's person who is at least 18 years of age may transport the ward to an inpatient mental health facility for evaluation if the guardian has reason to believe and does believe that: 1) the ward is mentally ill; 2) because of the mental illness, there is substantial risk of serious harm to the ward or to others unless the ward is immediately restrained.[46]

2. Emergency Detention with a Warrant.

a. Application for Emergency Detention. Any adult may make Application for Emergency Detention if he reasonably believes that a person is mentally ill and that, because of the mental illness, there is substantial risk of harm to the person or others unless the person is immediately restrained.[47] Such Application must provide the same information required of a Peace Officer's Application for Detention.[48]

Applications for Emergency Detention are evaluated by a judge or magistrate to determine the credibility of the person seeking emergency detention and whether the Application meets the criteria. As Judge Herman aptly explains, the rights of the individual must be balanced against the rights of society in general and the decision as to whether to issue a warrant is done on a case by case basis.[49] In fact, the judge or magistrate may interview the applicant; but, such interviews are unusual.

Applications for Emergency Detention containing falsehoods and filed for less than virtuous reasons, though few and far between, represent no surprise to the courts. It should be noted that filing a false report in connection with an official proceeding constitutes aggravated perjury and is a third degree felony.[50]

b. Warrant Issued. If, after review of the Application for Emergency Detention, the judge or magistrate finds that the statements in the Application are credible and there is reasonable cause to believe the person made the subject of the Application meets the criteria, he will issue a warrant for the person's immediate apprehension and placement in the nearest appropriate inpatient mental health facility or a mental health facility deemed suitable by the local mental health authority.[51]

In Harris County, the Precinct One Crisis Intervention Team ("CIT") is specially trained to handle crises involving mental health. Precinct One has the largest mental health warrant division in Texas and serves the entire county. Officers assigned to the Mental Warrant Division are trained in crisis intervention and work in two man teams wearing plain clothes. Unmarked vehicles are used to transport patients due to the sensitive nature of the warrants.

B. Physicians' Examinations. A person may be detained by a mental health facility no longer than 48 hours after such person is presented to the facility. Note the 48 hour period begins when the person is presented to the facility, not examined or admitted to the facility. If the 48 hour period ends on a Saturday, Sunday, legal holiday, or before 4 p.m. on the first succeeding business day, the person may be detained until 4 p.m. on the first succeeding business day. If the 48 hour period ends at a different time, the person may be detained only until 4 p.m. on the day the 48 hour period ends.[52]

A physician shall examine the person as quickly as possible and within 12 hours of the time the person is apprehended by a peace officer or transported to the mental health facility by a guardian.[53]

1. Physician's Preliminary Examination. In order to be admitted to the mental health facility, the physician who conducted the preliminary evaluation must make a written statement providing that it is acceptable to the facility for the patient to be admitted and that in the physician's opinion that: 1) the person is mentally ill; 2) the person evidences a substantial risk of harm to himself or others; 3) the risk of harm is imminent unless the person is restrained; 4) emergency detention is the least restrictive means by which the necessary restraint may be accomplished.[54]

In addition, the statement must include: 1) a description of the nature of the person's mental illness; 2) a specific description of the risk of harm as demonstrated by the person's behavior or evidence of severe emotional distress and deterioration; and 3) specific and detailed information from which the physician formed his opinion that the person was mentally ill, substantial risk of harm existed and was imminent, and that restraint was the least restrictive means to address risk of harm.[55]

If the person is not admitted to a health care facility after the preliminary examination, the person must be released.[56] Upon release, the person may be transported to the location where the person was apprehended, the person's residence, or another suitable location. However, if the person objects to transportation or is arrested, such transportation is not required.[57]

2. Certificate of Medical Examination. Two Certificates of Medical Examination must be on file before an Application for Court Ordered Mental Health

Services may be heard. Such Certificates must be completed by two different physicians, with at least one of them being a psychiatrist if a psychiatrist is available in the county. In addition, the Certificates must be based upon examinations completed no more than 30 days before the hearing.[58] A Certificate of Medical Examination for Mental Illness must be sworn to, dated, and signed by the examining physician and must include: 1) name and address of examining physician; 2) name and address of person examined; 3) date and place of examination; 4) brief diagnosis of person's physical and mental condition; 5) period, if any, during which the person has been under the care of the physician; 6) description of mental health treatment, if any, given by or administered under direction of examining physician; 7) the examining physician's opinion that the person is mentally ill and as a result of such illness he is likely to cause harm to himself or others or is suffering severe, abnormal mental, emotional, or physical distress, experiencing substantial mental or physical deterioration of his ability to provide for his basic needs, and unable to make a rational and informed decision as to whether to consent to treatment.[59]

C. Application for Court Ordered Mental Health Services and Motion for Order of Protective Custody

1. Application Process. Applications for Court Ordered Mental Health Services must be accompanied by a Certificate of Medical Exam, unless the applicant is the district or county attorney. The Application may be filed in the county where the proposed patient resides, is found, or is receiving mental health services under court order.[60] If an Order of Protective Custody ("OPC"), or order requiring the patient be detained until the final hearing, is sought to be obtained by the applicant, the Certificate of Medical Exam must be based upon an examination conducted within 3 days of the OPC.[61]

2. Duties of the Court. Upon the filing of an Application for Court Ordered Mental Health Services and a Motion for Order of Protective Custody, the court must: 1) appoint an attorney ad litem to represent the proposed patient; 2) set a probable cause hearing if an OPC has been or will be issued; 3) set final hearing on the merits; and 4) effect service of notice on both the proposed patient and the attorney ad litem. Notice shall also be given to the parent of the proposed patient if the proposed patient is a minor child, to the appointed guardian provided the proposed patient is under guardianship, and to each managing and possessory conservator that has been appointed for the proposed patient.[62] The notice must include all pleadings, attorney appointments, and hearing settings. In addition, the attorney must receive a list of duties.[63]

D. Probable Cause Hearing. The probable cause hearing must be held no later than 72 hours after the time that the proposed patient was detained under an OPC. If the 72 hour period expires on a Saturday, Sunday, or legal holiday, the hearing may be held on the following day. Probable cause hearings in Harris County are heard on Mondays, Wednesdays, and Fridays. Probable cause hearings may be presided over by magistrates, associate judges, and the judge of a court having jurisdiction over mental health matters.[64] In Harris County, probable cause hearings are generally presided over by a justice of the peace.

1. Presentation of Case. At the probable cause hearing, the proposed patient and

his attorney may appear and present evidence to challenge the allegation that the proposed patient presents a substantial risk of serious harm to himself or others. The rules of evidence are relaxed in that the judge may consider evidence, including letters, affidavits, and other material that may not be admissible in a subsequent commitment hearing. Further, the state may prove its case on the physician's Certificate of Medical Examination filed in support of the initial motion.[65]

2. Order for Continued Detention. After the hearing, if the judge or magistrate determines that an adequate factual background exists for probable cause to believe that the proposed patient presents a substantial risk of harm to himself or others to the extent that he cannot remain at liberty pending the final hearing, such judge or magistrate will enter an Order for Continued Detention.[66]

3. Release. On the other hand, if the judge or magistrate finds the factual background insufficient to support a belief that the proposed patient presents a substantial risk of serious harm, he will release the person.

E. Final Hearing.

1. Setting of Final Hearing. The final hearing is set to be held within 14 days after the date on which the Application for Court Ordered Mental Health Services is filed and such hearing may not be held during the first 3 days after the Application for Court Ordered Mental Health Services is filed if the proposed patient's attorney objects. Though the court may grant one or more continuances, a hearing must be held not later than the 30th day after the date on which the Application was filed.[67]

2. General Guidelines.[68]

a. Though the hearing may be held at any suitable location in the county, the hearing must be held in the county courthouse if requested by the proposed patient or his attorney.

b. The patient is entitled to attend the hearing unless such right is waived by the patient or his attorney. The attorney should state on the record the reason for the proposed patient's absence.

c. The hearing must be open to the public unless the proposed patient or his attorney requests the hearing be closed and the judge finds good cause to close such hearing.

d. The Texas Rules of Evidence apply. Recall, however, that the rules of evidence are relaxed in probable cause hearings.

e. The court may consider the testimony of mental health professionals who are not physicians in addition to medical or psychiatric testimony.

f. The hearing is on the record.

g. The hearing is before the court unless the proposed patient or his attorney requests a jury.

3. 2 Certificates of Medical Examination Required. 2 Certificates of Medical Examination based upon exams conducted within 30 days of the hearing must be filed in the matter before the final hearing or the court must dismiss the Application and release the proposed patient.[69]

4. Elements for Temporary Commitment for Inpatient Mental Health Services. The judge may order a proposed patient to receive court-ordered temporary inpatient mental health services only if the judge or jury find, from clear and convincing evidence, that:

a. The proposed patient is mentally ill; and

b. As a result of that mental illness, the proposed patient is either likely to cause serious harm to himself or others or is suffering severe and abnormal mental, emotional, or physical distress and deterioration such that he is unable to make a rational and informed decision as to treatment and unable to function independently as evidenced by his inability to provide for his basic needs.[70]

V. Petitions for Order to Administer Psychoactive Medication

A. When Appropriate. Even though a patient is committed for the purpose of receiving mental health services, medication to such patient may not be administered against such person's will unless: 1) the patient is having a medication-related emergency; 2) the patient is under an Order Authorizing Psychoactive Medication; or 3) the patient is a ward who is 18 years of age or older and the guardian of the person of the ward consents to the administration of psychoactive medication regardless of the ward's expressed preferences regarding treatment with psychoactive medication.[71]

B. The Application. A physician who is treating a patient may, on behalf of the state, file an Application for an Order to Authorize the Administration of Psychoactive Medication regardless of the patient's refusal if:

1. The physician believes the patient lacks the capacity to make a decision regarding such treatment;

2. The physician determines that the medication is the proper course of treatment for the patient;

3. The patient is under an order for inpatient mental health services; and

4. The patient, verbally or by other indication, refuses to take the medication voluntarily.[72]

The Application must comply with the requirements of the Texas Mental Health Code and state:

1. That the physician believes the patient lacks the capacity to make a decision regarding administration of 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 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;

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.[73]

C. Hearing. Before a hearing on the Petition for an Order to Administer Psychoactive Medication may be heard, the patient must be subject to an order for inpatient mental health services or in custody awaiting a trial in a criminal proceeding and was ordered to receive inpatient mental health services in the six months preceding the hearing. The court may issue an order authorizing the administration of psychoactive medication if the court finds by clear and convincing evidence after a hearing on the matter that 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. In making the finding that treatment with the proposed medications 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.[74]

VI. Representing Your Client

A. Rights of the Patient.

1. Rights of Proposed Patients with Regard to Final Hearing. An attorney must be appointed to represent the proposed patient within 24 hours after the Application for Temporary Mental Health Services is filed.[75] In addition, the proposed patient facing temporary commitment for the purpose of receiving mental health services has the right to be present at the probable cause hearing and the final hearing, unless the proposed patient or his attorney waives his presence. Further, the hearing is to be public unless the proposed patient or his attorney requests the hearing be closed and the judge agrees.[76] Finally, the proposed patient facing temporary commitment or his attorney may request a trial by jury.[77]

2. Other Rights. The Texas Mental Health Code sets out the rights of those persons apprehended, detained, or transported for emergency detention. These rights must be communicated to the patient orally in simple, nontechnical terms, within 24 hours after the time the person is admitted to a facility.[78] In addition, the rights should be provided to the proposed patient in writing and in such patient's primary language, if possible.[79] Such persons have the following rights:

a. To be advised of the location of detention, the reasons for detention, and the fact that the detention could result in a longer period of involuntary commitment;

b. To a reasonable opportunity to communicate with and retain an attorney;

c. To be transported to the location of apprehension, such person's residence, or another suitable location if such person is not admitted for emergency detention unless the person is arrested or objects;

d. To be released from a facility unless such person is either admitted to a facility or such person is admitted, but the facility administrator determines that such person is not mentally ill, does not represent a substantial risk of serious harm to himself or others, any described risk of harm is not imminent unless such person is restrained, or emergency detention is not the least restrictive means by which the necessary restraint may be accomplished.

e. To be advised that communication with a mental health professional may be used in proceedings for further detention; and

f. To be transported with the following accommodations:

i. Medical personnel must accompany patient if it is believed the patient may need medical assistance or medication;

ii. Friends and relatives may accompany patient at their own expense;

iii. Female patient must be accompanied by female attendant unless the patient is accompanied by her father, husband, or adult brother or son;

iv. Unless other means are not available, the patient must be transported in an unmarked police car and accompanied by an ununiformed officer;

v. The patient may not be physically restrained unless the treating physician finds that restraint is necessary to protect the health and safety of the patient or the person traveling with the patient and documents such findings;

vi. The patient must be transported directly to the facility within a reasonable amount of time and without undue delay;

vii. All vehicles used in such transport must be adequately heated in cool weather and ventilated in warm weather;

viii. Special diets or other medical precautions recommended by the patient's physician must be followed; and

ix. The person transporting the patient shall give the patient reasonable opportunities to get food and water and to use a bathroom.[80]

B. A Lawyer's Duty to his Client. The Texas Mental Health Code outlines the duties of the attorney representing the proposed patient.[81] The duties are as follows:

1. Interview the proposed patient within a reasonable time prior to each hearing.

2. Discuss with the proposed patient the facts of the case, the applicable law, and the options available to the proposed patient, including but not limited to the option to hire their own lawyer.

3. While the attorney may advise the proposed patient as to the wisdom associated with either agreeing or resisting efforts to provide mental health services, the proposed patient must make the ultimate decision in such regard.

4. Regardless of the attorney's personal opinion about the case, the attorney must use all reasonable efforts within the bounds of the law to advocate the proposed patient's right to avoid court ordered mental health services or receive lesser restrictive treatment alternatives to temporary inpatient mental health services.

5. Before the hearing, the attorney shall:

a. Review the Application, Certificates of Medical Exam, and the proposed patient's relevant medical records;

b. Interview supporting witnesses who will testify at the hearing; and

c. Explore the least restrictive treatment alternatives to court-ordered inpatient mental health services.

6. The attorney shall advise the proposed patient of his right to attend a hearing or waive the right to attend a hearing; and if the proposed patient will not attend a hearing, explain to the court why a proposed patient is absent from the hearing.

7. The attorney shall discuss with the proposed patient the procedures for appeal, release, and discharge if the court orders inpatient commitment and other rights the patient may have during the period of the court's order.

8. To withdraw from a case after the proposed patient is interviewed, the attorney must file a motion to withdraw with the court; and until the withdrawal is authorized by the court, the attorney represents the proposed patient.

9. The attorney is responsible for the proposed patient's representation until: 1) the Application is dismissed; 2) an appeal from an order directing treatment is taken; 3) the time for giving notice of appeal expires by operation of law; or 4) another attorney assumes responsibility for the case.[82]

C. Impact of Involuntary Commitment

Though court records relating to involuntary commitments are closed[83] and medical records are protected by HIPAA laws,[84] persons involuntarily committed for the purpose of receiving mental health services must reveal if they have been involuntarily committed when seeking certain licenses.

1. Handgun Permit. Under federal law, it is unlawful for any person to sell or otherwise dispose of any firearm or ammunition to any person knowing or having reasonable cause to believe that such person has been adjudicated as a mental defective or has been committed to any mental institution.[85] In addition, in Texas a person is ineligible to carry a concealed weapon if they have been hospitalized for a psychiatric condition.[86]

2. TWIC Eligibility. The impact of mental health commitments on persons seeking to become eligible or seeking recertification for a Transportation Workers Identification Credential ("TWIC") should be considered, especially if the proposed patient is currently in an occupation which requires workers to obtain a TWIC.[87] A TWIC is a common form of identification used by people who require access to secure locations as

they work as truck drivers, long shore workers, port facility employees, and merchant mariners. *Id.*

The TWIC application requires the applicant to disclose whether they have been involuntarily committed to a mental health facility. The Transportation Security Administration ("TSA") determines that an applicant poses a security threat warranting denial of a TWIC, if the applicant has been adjudicated as lacking mental capacity or committed to a mental health facility.[88] However, a waiver may be obtained which outlines procedures for waiver of mental capacity standards.[89] In evaluating the request for waiver, the TSA considers the circumstances surrounding the commitment, court records or official medical release documents indicating that the applicant no longer lacks mental capacity, and other factors that indicate the applicant does not pose a security threat warranting denial of the TWIC.[90]

3. Attorneys. The Texas Board of Law Examiners finds eligible only applicants who possess good moral character and fitness.[91] Rule IV of the Rules Governing Admission to the Bar of Texas provides that "[t]he purpose of requiring an applicant to possess this fitness is to exclude from the practice of law any person having a mental or emotional illness or condition which would be likely to prevent the person from carrying out duties to clients, courts or the profession. A person may be of good moral character, but may be incapacitated from proper discharge of his or her duties as a lawyer by such illness or condition. The fitness required is a present fitness, and prior mental or emotional illness or conditions are relevant only so far as they indicate the existence of a present lack of fitness."[92]

4. Physicians. Physicians and physicians in training (medical students, interns, and residents) must report diagnosis or treatment of a physical, mental or emotional condition, which has impaired or could impair their ability to practice medicine.[93]

In addition, in Texas, a physician's duty to report an impaired colleague is spelled out in the Medical Practice Act. The Act specifies that any physician, medical student, resident, or medical peer review committee shall report relevant information to the Texas Medical Board ("TMB") if, in the opinion of the person or committee, that physician poses a continuing threat to the public welfare through the practice of medicine.[94] If the physician refuses help or the committee believes that the physician poses a continuing threat to the public welfare through the practice of medicine, the law requires the committee to report the physician to the TMB and any known health care entity in which the physician has clinical privileges.[95]

D. Options to Avoid Involuntary Commitment

1. Request Continuance. The final hearing on an Application for Inpatient Commitment for Temporary Mental Health Services must be set within 14 days of the filing of such Application. As discussed above, the court may grant one or more continuances; but a hearing must be held not later than the 30th day after the date on which the Application was filed.[96]

Attorneys should consider requesting a continuance in the following situations and provided there is no petition for an order to administer psychoactive medication on file:

a. The proposed patient is about to be released from the hospital;

b. The proposed patient is cooperative with treatment and is experiencing their first mental breakdown or has a history of managing their illness without court intervention;

c. The proposed patient wants his day in court but is too ill to effectively participate in the proceedings and not ill enough to warrant the attorney's stipulation to the admission of evidence supporting commitment.

2. Suggest the Patient Seek Treatment Voluntarily. Sometimes, particularly cooperative patients will be given the opportunity by their treating physician to convert to receive inpatient mental health services on a voluntary basis, thereby avoiding the commitment process. The patient's attorney may also request that the doctor allow the patient to accept treatment on a voluntary basis. Accepting treatment on a voluntary basis will enable the patient to avoid commitment and the consequences associated with commitment.

3. Proceed with Trial on the Merits. Naturally, if your client is unwilling to wait for a continuance, wants his day in court, and is well enough to participate in the proceedings, you are obligated to mount a defense on behalf of your client. Consider the following before proceeding to trial:

a. The Application for Court-Ordered Mental Health Services and Certificates of Medical Examination should be reviewed for technical defects and inconsistencies.[97]

b. If your client is likely to present well, bring him and call him as a witness. If your client is not likely to present well and does not wish to offer testimony, explain why he is not present and ask that the court excuse his presence.

c. If your client has family or friends who support your client's desire to avoid inpatient commitment, ask them to appear and offer testimony outlining why they support your client's release.

d. Visit with your client and his social worker about plans in the event of release and so that it may be demonstrated, if the patient is in fact mentally ill, that the patient has plans to manage his illness and provide for his basic needs.

e. The rules of evidence apply in the final hearing, so make appropriate objections.

f. As Judge Olsen puts it, "The judge gets paid to look out for the best interests of the proposed patient. The attorney ad litem's job is to be the proposed patient's lawyer."

4. Request Out-Patient Commitment.

a. Why Outpatient Commitment is Uncommon. Generally speaking, outpatient commitment as an alternative to inpatient commitment for temporary mental health services is uncommon for three primary reasons. First, a patient facing involuntary inpatient commitment likely has little insight into the severity of his illness; otherwise, he would have voluntarily sought treatment. Moreover, the statute requires that the patient be unable to submit voluntarily outpatient treatment.[98] Consequently, the likelihood that he will abide by the terms of outpatient commitment is remote unless such patient is fortunate enough to have a

dedicated support network of family, friends, or social workers.

Second, the statute requires that the proposed patient be unable to live safely in the community without court-ordered outpatient services.[99] If the proposed patient cannot live safely in the community without treatment and if the patient lacks the insight necessary to submit to treatment voluntarily, the court would be hard pressed to find that commitment to mental health services as an outpatient would be effective, albeit lesser restrictive.

Third, few mental health treatment facilities offer support for outpatient involuntary commitments.

b. When Appropriate. Though courts in Harris County rarely order temporary outpatient mental health services in lieu of temporary inpatient mental health services, situations exist where such an order may be appropriate. It is likely the court would be more amenable to outpatient commitment if: 1) the proposed patient demonstrated the presence of a committed, experienced, and dedicated support system; 2) the mental health treatment facility serving the proposed patient offered a robust and reliable outpatient program designed to accept outpatient commitments; 3) the proposed patient did not appear to be a danger to himself or others i.e., the agreed opinion of the physicians, as evidenced in the two Certificates of Medical Examination, determined that the proposed patient was suffering from severe distress and deterioration, but that he was not likely to cause serious harm to himself or others; and 4) outpatient commitment would be an effective form of treatment.

c. Statutory Authority. The judge may order a proposed patient to receive court-ordered temporary outpatient mental health services only if appropriate mental health services are available to the patient and the judge finds from clear and convincing evidence that:

i. The proposed patient is mentally ill;

ii. The nature of the mental illness is severe and persistent;

iii. As a result of the mental illness, the proposed patient will, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress and experience deterioration in 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 services; and

iv. The proposed patient has an inability to participate in outpatient treatment effectively and voluntarily as demonstrated by the proposed patient's actions within the two year period immediately preceding the hearing date or specific characteristics of the proposed patient's clinical condition that prevent such patient from making a rational and informed decision as to whether to voluntarily submit to outpatient treatment (lack of insight into the patient's own illness is extremely common among persons suffering from schizophrenia and bipolar disorder).[100]

[1] *See* Maisel, Albert. "Bedlam 1946." Life Magazine 6 May 1946. Print.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] Whitford, Fred W., Baron, Robert A., and Kalsher, Michael J. *Psychology*. 4th ed. Boston: Allyn and Bacon, 1998. Print. Page 224.
[6] Seligman, Linda and Reichenberg, Lourie W. *Selecting Effective Treatments: A Comprehensive, Systematic Guide to Treating Mental Disorders.* 3rd ed. San Francisco: Jossey-Bass, 2007. Print.
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] Segal, Zindel V., Williams, J. Mark G., Teasdale, John D., S., Rachman. *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. New York: Guilford Press, 1997. Print.
[11] *Id.*
[12] Fink, M.D., Max Fink. *Electroconvulsive Therapy: A Guide for Professionals and Their Patients*. New York: Oxford University Press, 2009. Print.
[13] *Id.*
[14] TEX. HEALTH & SAFETY CODE ANN. §313.004 (Vernon 2010).
[15] TEX. PROB. CODE ANN. §767(b) (West 2012) and TEX. HEALTH & SAFETY CODE ANN. §313.003 (Vernon 2010).
[16] Sommers, Michael A. *Everything You Need to Know about Bipolar Disorder and Manic-depressive Illness*. New York: The Rosen Publishing Group, 2003. Print.
[17] *Id*.
[18] White, Ruth C. and Preston, John D. *Bipolar 101: A Practical Guide to Identifying Triggers, Managing Medications, Coping with Symptoms, and More*. Oakland: New Harbinger Publications, Inc., 2009. Print
[19] Ghaemi, Nassir. *Mood Disorders: A Practical Guide*. 2nd ed. Philadelphia: Lippincott, Williams, & Wilkins, 2008. Print.
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id*.
[25] Ketter, Terence A., *Handbook of Diagnosis and Treatment of Bipolar Disorders*. Arlington: American Psychiatric Publishing, Inc., 2010. Print.
[26] Atkins, Charles. *The Bipolar Disorder Answer Book: Answers to More Than 275 of Your Most Pressing Questions*. Naperville: Sourcebooks, Inc., 2007. P. 124.
[27] Desai, Archana and Lee, Mary. *Gibaldi's Drug Delivery Systems in Pharmaceutical Care*. Bethesda: American Society of Health-System Pharmacists, 2007. Print. Page 157.
[28] Dziegielewski, Sophia F. and Leon, Ana. *Social Work Practice and Psychopharmacology*. New York: Springer Publishing Company, Inc., 2001. Print.
[29] Ramirez Basco, Monica and Rush, A. John Rush. Cognitive-Behavioral Therapy for Bipolar Disorder. 2nd ed. New York: The Guilford Press, 2005. Print. Page 7.
[30] Fujii, Daryl and Ahmed, Iqbal. *The Spectrum of Psychotic Disorders: Neurobiology, Etiology & Pathogenesis*. Cambridge: Cambridge University Press, 2007. Print. Page 236.
[31] Weiner, Irving B. and Craighead, W. Edward. "Delusions." *The Corsini Encyclopedia of Psychology*, 2nd vol. 2010. Page 470.
[32] Dirk Blom, Jan. *Dictionary of Hallucinations*. New York: Springer, 2010. Print. Page 23.
[33] *Id.*
[34] Totton, Nick. *New Dimensions in Body Psychotherapy*. New York: Open University Press, 2005. Page 37.
[35] *Id.*
[36] Freudenreich, Oliver. *Psychotic Disorders: A Practical Guide*. Philadelphia: Charles W. Mitchell, 2008. Print. Page 10.
[37] Lieberman, Jeffrey A. *The American Psychiatric Publishing Textbook of Schizophrenia.* Arlington: American Psychiatric Publishing, Inc., 2006. Print. Pages 317-318.
[38] Schatzberg, Alan F. and Nemeroff, Charles B. *The American Psychiatric Publishing Textbook of Psychopharmacology*. Arlington: American Psychiatric Publishing, Inc., 2009. Print. Pages 1141-1145.
[39] *See* Heath, David S. *Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization*. New York: Routledge, 2005. Print.
[40] Wilson, Cindy C. and Turner, Dennis C. *Companion Animals in Human Health*. London: Sage Publications, 1998. Print.
[41] Wigram, Tony and De Backer, Jos. *Clinical Applications of Music Therapy in Psychiatry*. Philadelphia: Jessica Kingsley Publishers, 1999. Print. Pages 24-34.
[42] TEX. HEALTH & SAFETY CODE ANN. §573.001 (Vernon 2010).
[43] *Id.*
[44] TEX. HEALTH & SAFETY CODE ANN. §573.002 (Vernon 2010).
[45] TEX. HEALTH & SAFETY CODE ANN. §573.003 (Vernon 2010).
[46] *See* TEX. HEALTH & SAFETY CODE ANN. §573.003 (Vernon 2010). and TEX. PROB. CODE ANN. §767(b) (West 2012).
[47] *See* TEX. HEALTH & SAFETY CODE ANN. §573.011 (Vernon 2010).
[48] *See id.* as compared to TEX. HEALTH & SAFETY CODE ANN. §573.002 (Vernon 2010).
[49] *See* Herman, Guy, Mental Health Law, Presented at the Annual Meeting of the Texas College of Probate Judges in September of 2012.
[50] *See* TEX. PENAL CODE § 37.03 (Vernon 2010).
[51] TEX. HEALTH & SAFETY CODE ANN. §573.012 (Vernon 2010).
[52] TEX. HEALTH & SAFETY CODE ANN. §573.021 (Vernon 2010).
[53] TEX. HEALTH & SAFETY CODE ANN. §573.022 (Vernon 2010).
[54] *Id.*

[55] *Id.*
[56] TEX. HEALTH & SAFETY CODE ANN. §573.023 (Vernon 2010).
[57] TEX. HEALTH & SAFETY CODE ANN. §573.021 (Vernon 2010).
[58] TEX. HEALTH & SAFETY CODE ANN. §573.009 (Vernon 2010).
[59] TEX. HEALTH & SAFETY CODE ANN. §573.011 (Vernon 2010).
[60] TEX. HEALTH & SAFETY CODE ANN. §574.001 (Vernon 2010).
[61] TEX. HEALTH & SAFETY CODE ANN. §573.021 (Vernon 2010).
[62] TEX. HEALTH & SAFETY CODE ANN. §574.006 (Vernon 2010).
[63] TEX. HEALTH & SAFETY CODE ANN. §574.003 (Vernon 2010).
[64] TEX. HEALTH & SAFETY CODE ANN. §574.026 (Vernon 2010).
[65] *Id.*
[66] *Id.*
[67] TEX. HEALTH & SAFETY CODE ANN. §574.005 (Vernon 2010).
[68] TEX. HEALTH & SAFETY CODE ANN. §§574.025, 574.032 (Vernon 2010).
[69] TEX. HEALTH & SAFETY CODE ANN. §574.009 (Vernon 2010).
[70] TEX. HEALTH & SAFETY CODE ANN. §574.034 (Vernon 2010).
[71] TEX. HEALTH & SAFETY CODE ANN. §574.103 (Vernon 2010).
[72] TEX. HEALTH & SAFETY CODE ANN. §574.104 (Vernon 2010).
[73] *Id.*
[74] TEX. HEALTH & SAFETY CODE ANN. §574.106 (Vernon 2010).
[75] TEX. HEALTH & SAFETY CODE ANN. §573.001 (Vernon 2010).
[76] TEX. HEALTH & SAFETY CODE ANN. §574.031 (Vernon 2010).
[77] TEX. HEALTH & SAFETY CODE ANN. §574.032 (Vernon 2010).
[78] TEX. HEALTH & SAFETY CODE ANN. §573.025 (Vernon 2010).
[79] *Id.*
[80] *Id.*
[81] TEX. HEALTH & SAFETY CODE ANN. §574.004 (Vernon 2010).
[82] *Id.*
[83] TEX. HEALTH & SAFETY CODE ANN. §611.002 (Vernon 2010).
[84] 45 C.F.R. §§ 160, 164 (2009).
[85] 18 U.S.C. § 922(d) (2012).
[86] TEX. GOV'T CODE § 411.172 (Vernon 2010).
[87] *See* Blomstrom, "The Impact of Mental Health Commitments on a Person's TWIC Eligibility or Recertification," Presented at the South Texas College of Law Guardian and Ad Litem Certification Course on September 19, 2012.
[88] 49 C.F.R. § 1572.5 (2009).
[89] 49 C.F.R. § 1515.7 (2009).in accordance with 49 CFR 1515.7
[90] *Id.*
[91] TEX. GOV'T CODE ANN. §82.028 (Vernon 2010).
[92] Rule IV of the Rules Governing Admission to the Bar of Texas, available on the Board of Law Examiner's website located at: http://www.ble.state.tx.us/Rules/_0812_rulebook.pdf.
[93] TEX. OCC. CODE §§160.002, 160.003 (Vernon 2010).
[94] *Id.*
[95] *Id.*
[96] TEX. HEALTH & SAFETY CODE ANN. §574.005 (Vernon 2010).
[97] TEX. HEALTH & SAFETY CODE ANN. §§574.002, 574.011 (Vernon 2010).
[98] TEX. HEALTH & SAFETY CODE ANN. §574.034 (Vernon 2010).
[99] *Id.*
[100] *Id.*