TEXAS ASSISTED OUTPATIENT TREATMENT

PRACTITIONER GUIDE

Date

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FOREWORD

A I would like you to consider two initial observations. First, nothing is more personally transformative to an incumbent judge, than to have lost by twelve votes, in a jurisdiction of over 800,000 registered voters. I don't care what any elected official may say after a loss; it's a gut punch!! Second, early in my judicial career I served as the judge of a Texas County Court at Law. Along with the demands of a growing criminal docket, myself and two other Bexar County judges created and implemented some of Bexar County's first therapeutic drug courts. It was a time when "tough on crime" was the norm. Yet, as rare and unpopular as they seemed back in the day, therapeutic and problem-solving courts are now instead, rather the norm.

At the heart of those two observations you may find, as many of us have, your best and most gripping reason to begin your journey in the realm of assisted outpatient treatment (AOT).

I lost my first bid at reelection years ago, and did I mention it was by *twelve* votes. Determined to show a stiff upper lip through the end of my first term, I sat on the bench watching the clock tick down to zero. As I sat there, one day a young man came through the double doors of the courtroom and loudly asked, "Judge, do you remember me?" As an aside, don't do that. Those words more often than not tend to scare the heck out of a judge. He reached into his coat. My bailiff quickly stood up. I was thinking what a perfect ending to an already horrible year. He then looked at the gallery and said aloud, "You don't remember me and I know your loss must sting, but I was one of your first drug court graduates." He pulled something from his jacket and tossed it to me. He then said, "I've been sober two years now. This court saved my life. I want you to have those." He said thank you and left. It took me a few seconds to realize that I was holding two years' worth of sobriety chips... his chips. I have kept those by my side at every judicial office thereafter.

The time to explore and implement AOT is now! The current waitlist for forensic commitment beds alone is sufficient to eliminate our entire civil commitment capacity. We cannot deny the inescapable truth that our Texas system of mental health care, particularly as it relates to involuntary commitments, is in dire need of alternatives. AOT courts have proven themselves across the nation. Although they are not a magic bullet, they provide an important tool in a court's toolbox, which can bring people to a life of wellness and away from illness. The American Psychiatric Association recently concluded, *"Involuntary outpatient commitment programs have demonstrated their effectiveness when systematically implemented, linked to intensive outpatient services and prescribed for extended periods of time."*

This guide describes the components and operational steps to implement an effective AOT program. If your county does not yet practice AOT, you may find the details overwhelming. We urge you not to be discouraged. While a fully realized AOT program as described in this guide

is our aspiration for every county, we recognize that few if any counties are likely to put every piece in place, especially in the early stages. However, the steps presented here offer some basic principles and concepts to get you off on the right foot. Key partnerships across systems are essential. Details like extensive data collection are likely to come much later. We hope this guide will encourage and inspire you to move your county forward. It can and must be done!

None of this is easy. As public servants, we must choose between being a transitional figure or becoming a transformational force. I actually don't remember much about my first term in office. I do, however, remember those sobriety chips... each and every day.

Hon. Oscar J. Kazen
Judge Presiding
Bexar County Probate Court One

INTRODUCTION

ASSISTED OUTPATIENT TREATMENT (AOT) is the practice of providing community-based mental health treatment under civil court commitment as a means of: (1) motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan; and (2) focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment.

Multiple studies attest to the power of AOT in helping individuals with severe mental illness escape the “revolving doors” of the public mental health and criminal justice systems. Across the United States, communities of all types and sizes have unlocked this promise by establishing AOT *programs:* collaborations between local mental health agencies and civil courts to systematically identify individuals who meet legal criteria for AOT, ensure due process of law, and provide each participant high-quality treatment and services with court oversight.

Texas is home to one of the nation’s pioneering AOT programs (established in Bexar County in 2005), as well as a handful of newer programs established since 2016 in counties such as Harris, Travis, Tarrant, Smith, Johnson, and El Paso. To help more counties follow suit, we are proud to offer this *Texas Assisted Outpatient Treatment Practitioner Guide*. Our aim is to distill what Texans planning to implement and practice AOT in their own communities need to know about the relevant state law and the experience of other programs.

This information is presented in three parts. Part I, itself divided into three chapters, is a step-by-step “how to” guide for effective practice of AOT in accordance with the Texas Health and Safety Code. Part II explains Texas’ unique process for diverting eligible criminal defendants with mental illness out of the criminal justice system and into community-based treatment through AOT. Part III explores the critical yet underappreciated role of families in helping AOT participants engage with treatment and suggests ways to involve families in AOT implementation.

The Appendix of this guide incudes templates for court forms and clinical documents utilized in the practice of AOT in Texas, as well as *Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results* (more commonly known as the “AOT Implementation White Paper”). Published by The Treatment Advocacy Center in collaboration with Northeast Ohio Medical University and the American Psychiatric Association’s SMI Adviser initiative in October 2019, the white paper offers guidance to stakeholders in any US community in building local support for AOT, launching a program, and ensuring its long-term success and sustainability.

Taken as a whole, the content of this guide should equip both clinical and legal practitioners with the basic knowledge they need to plan and launch an AOT program in Texas, and serve as reference worth keeping handy in day-to-day practice. If it leaves any questions unanswered

or if you encounter barriers unaddressed, the Treatment Advocacy Center stands ready to provide you with technical assistance in a variety of forms. We invite you to join our mission to make AOT available in every corner of Texas to those suffering the cruel consequences of untreated severe mental illness.

PART I

STEP-BY-STEP GUIDE TO PRACTICING AOT IN ACCORDANCE WITH TEXAS LAW

Chapter 1: REFERRALS TO AOT

A foundational challenge for any AOT program is establishing a consistent inflow of participants. As a practical matter, program staff cannot be expected to venture into the community searching for individuals who meet AOT criteria. Instead, they must rely upon referrals from the mental health and criminal justice stakeholders who regularly encounter such individuals. This is one of the primary reasons why an AOT program must be conceived as a collaboration among partners rather than as an island unto itself.

Hospitals

For most AOT programs, the most obvious and fruitful sources of referrals are the hospitals within their service area that treat individuals for severe mental illness. This includes the larger public (state) hospitals where those in psychiatric crisis are often sent for long-term care; private hospitals with inpatient psychiatric units; and even hospitals lacking psychiatric units that encounter individuals with mental illness in their emergency rooms and transfer those needing extended care elsewhere. All of these hospitals will be aware of individuals whose need for AOT is made obvious by their frequency of appearance. (The so-called "familiar faces.") Accordingly, these hospitals are essential partners for any AOT program. They must be counted on to inform the program's staff of individuals in their care who they believe will require AOT upon discharge.

Individualized discharge planning for each patient is a basic responsibility of any hospital. For psychiatric patients, that means having staff working in anticipation of release to help the person develop an outpatient treatment plan and identify an appropriate community-based provider for each included service. It should not be difficult to integrate AOT into this existing process. It simply requires hospital staff to build into their routine discharge-preparation procedures the consideration of whether the person meets AOT criteria, and triggering the legal process for those who do by sharing information with AOT program staff. Once that happens, the post-discharge treatment plan that would have been developed in any event becomes the *AOT* treatment plan, to be incorporated into the court order.

With respect to patients being prepared for release from state-run psychiatric hospitals, the responsibility of discharge planning extends as well to the local mental health authority (LMHA). **Tex. Health & Safety Code § 534.0535** requires "joint discharge planning between a department facility and a local mental health authority before a facility discharges a patient," and that the LMHA "shall plan with the department facility and determine the appropriate community services for the patient" and "shall arrange for the provision of the services if department funds are to be used."

The earlier prior to release that a hospital can make the AOT referral, the better. More time makes it easier to coordinate for AOT to start immediately upon release, ideally with the participant meeting the judge for their first AOT court appearance prior to returning home. Obviously, the opportunity for advance planning will be limited for referred patients whose hospital stays are extremely short. In many cases, a lag between hospital release and entry of the AOT order will be inevitable. However, it should be standard practice in all cases to at least make the AOT referral and conduct the necessary medical evaluations while the patient is still under inpatient care.

It should also be noted that hospitals may make AOT referrals not just for patients whom they retain as psychiatric inpatients (both voluntary and involuntary), but also for those whom they do not. Patients who arrive in emergency rooms for evaluation of their need for involuntary inpatient commitment are often released upon a finding that they do not currently meet inpatient criteria. However, many of these individuals *will* currently meet criteria for AOT, based on their history of treatment disengagement. In any jurisdiction with an AOT program, it should be standard practice when conducting psychiatric evaluations to consider the person's eligibility for both inpatient *and* outpatient commitment, and follow up accordingly.

Law Enforcement

Like hospitals, local police are typically all-too-aware of individuals in the community who have difficulty adhering to their mental health treatment, for the simple reason that police respond frequently to 911 calls and public disturbances involving them. Particularly if your local police or sheriff's department has a "Crisis Intervention Team" (CIT) trained unit, you can be virtually certain that law enforcement officers can readily supply the names and addresses (or regular locations) of individuals in need of AOT.

This is just one of the reasons that local law enforcement are essential stakeholders in your AOT program. Most officers do not like having to arrest people who plainly need treatment rather than punishment. They will appreciate having AOT as an alternative course of action.

Community

Another important source of referrals for an AOT program is the community at large. An AOT program should seek maximum visibility in its community and widely publicize the Texas AOT legal criteria along with the program's contact information. The public should be encouraged to refer family members, friends and neighbors if they believe them to meet AOT criteria.

Referrals from the public may describe troubling current behavior, indicating an immediate need for hospitalization and giving AOT program staff sufficient cause to seek emergency detention of the person for clinical evaluation. Other referrals will not rise to this level, but may lead program staff to arrange for a mobile crisis outreach or CIT team to conduct a "wellness check" of the person, assessing them in the community with a potential AOT application in mind. If nothing else, a community referral should allow an AOT program to place an individual "on their radar," such that if and when the person later appears in an emergency room or gets arrested, there will already be some groundwork laid for placing them in AOT.

Local affiliates of the National Alliance on Mental Illness (NAMI) make great partners for raising awareness of the program among families of individuals with severe mental illness. A link to the directory of NAMI Texas affiliates can be found in Part III of this guide.

Criminal Justice System

It is often said that county jails have become our nation's primary providers of psychiatric care. This is no less true in Texas, and there can be no more damning indictment of our collective failure to treat severe mental illness in the community. However, most people sitting in jail cells today will be released within a matter of weeks or months. The high prevalence of mental illness among this population represents an opportunity for AOT programs to identify individuals who meet AOT criteria and help them take control of their own lives. Just as hospitals should evaluate for AOT eligibility each person they prepare for discharge from a psychiatric inpatient stay, so should jails as part of their routine preparations for the release of any inmate who has been receiving treatment for a severe mental illness. This is yet another reason to consider your county sheriff an essential AOT stakeholder.

There is also an opportunity in Texas for AOT to be the vehicle for individuals ensnared in the criminal justice system to be released from detention much sooner than they would be otherwise. As discussed in full detail in Part II of this Guide, Texas law allows a pending criminal case to be suspended or dismissed with simultaneous transfer to the probate court for AOT proceedings. This can be especially useful for individuals stuck in "competency restoration limbo," the generally counter-productive practice of detaining a person who has been found incompetent to stand trial due to symptoms of mental illness for competency restoration efforts (medication and attempts to help the person understand the legal process), despite little or no expectation that competency will be restored within the statutory time limit (60 days for a misdemeanor). This accomplishes little more than to delay dismissal of the charges. It would

be far better for all involved to dismiss the charge upfront and refer the individual into AOT — perhaps after a period of inpatient commitment as warranted.

With any diversion from criminal justice to AOT, the earlier a referral can be made, the better. Ideally, the two systems will develop protocols to enable an AOT referral at the time of booking. This will help avert missed opportunities, such as when a potential AOT candidate is suddenly released on bond and can no longer be easily evaluated.

An LMHA and its corrections partners might also consider developing a basic tracking system for individuals with SMI diagnoses on pre-trial probation, with consistent communication between agencies to support outpatient treatment (including AOT when warranted).

Chapter 2: OBTAINING AN AOT ORDER

AOT Criteria

Understanding Texas' process for AOT begins with understanding the *statutory criteria* for an order of court-ordered outpatient mental health services – i.e., the facts the court must find to establish a legal basis for an AOT court order.[1]

Under Texas law, there are three types of AOT orders:

- "Temporary" AOT, which the court may grant for a period of up to 90 days;
- "Extended" AOT, which the court may grant for a period of up to one year; and
- AOT "By Modification," which the court may grant only for an individual currently subject to inpatient civil commitment, for the period remaining on the extant inpatient commitment order plus up to 60 additional days.

Temporary AOT

Tex. Health & Safety Code § 574.0345(a) provides the criteria for an order of "temporary" AOT (duration of up to 90 days). For this type of order, the judge must find that appropriate mental health services are available to the proposed patient[2] and the judge or jury must find by clear and convincing evidence that:

- The person has a severe and persistent mental illness;
- If the person does not receive treatment for their mental illness, they will consequently suffer deterioration of the ability to function independently, to the extent that they will be unable to live safely in the community;
- The person requires outpatient mental health treatment to prevent a relapse that would be likely to result in serious harm to the person or another; and
- The person is unable to participate in outpatient mental health treatment effectively and voluntarily, as demonstrated by EITHER:
    - Any of the person's actions over the previous two-year period; OR
    - Specific characteristics of the person's clinical condition that significantly impair their ability to make a rational and informed decision about whether to submit to voluntary outpatient treatment.

Extended AOT

Tex. Health & Safety Code § 574.0355(a) and **(b)** provide the criteria for "extended" AOT (duration of up to a year). The evidence must establish **all that is required for "temporary" AOT** plus that:

- The person's condition is expected to continue for longer than 90 days; and
- The person has received any one of the following:
  - Court-ordered inpatient mental health services (i.e., involuntary hospitalization) for a cumulative total of 60 days over the last year;
  - Court-ordered outpatient mental health services (i.e., AOT) during the last 60 days; or
  - A previous order of "extended" court-ordered mental health services (either inpatient or outpatient).

AOT by Modification

Tex. Health & Safety Code § 574.061 addresses the circumstances in which a current inpatient commitment order may be modified to an AOT order. The law allows such modification to be made by the judge upon the detailed recommendation of the facility administrator, the supporting certificate of an examining physician and consultation with the LMHA regarding availability of services. While no specific criteria for this determination are stated or referenced in the statute, it is reasonable to infer that modification is appropriate when the patient is found to: (1) no longer meet criteria for inpatient commitment; and (2) meet the criteria for outpatient commitment as provided in **Tex. Health & Safety Code § 574.0345(a) or § 574.0355.**

We will revisit these criteria again below, in the discussion of what happens at the AOT hearing and what sort of evidence is relevant to the case.

AOT Legal Process

Once an individual referred to an AOT program is clinically found to meet criteria, Texas law guides the process for asking the court to place the person under court order. The basic steps are outlined below. However, a complicating factor in Texas is that there are actually *two distinct AOT processes*: One for a proposed patient with time remaining on a current order of inpatient commitment ("modification to AOT"), and another for everyone else. We will detail each of these processes separately.

Process for AOT by Application ("Temporary" or "Extended")

The process for "temporary" or "extended" AOT can be utilized in a wide range of circumstances. One might be tempted to think of the "modification" process as the natural route for currently hospitalized individuals and the "temporary /extended" AOT process as the natural route for those currently residing in the community or about to be released from jail. However, in fact the modification route can only be taken with a subset of all currently hospitalized individuals – specifically, those currently subject to inpatient commitment, with unused time remaining on the current inpatient court order. That leaves out several categories of current hospital patients,

who can only be placed on AOT by way of a new application for temporary or extended AOT. For example:

- Psychiatric inpatients who are currently hospitalized on a voluntary basis. (This includes many who enter the hospital under involuntary emergency detention for evaluation who are found to require hospitalization but choose to forgo the inpatient commitment process by accepting voluntary admission.)
- Patients under inpatient commitment with no time remaining on their current court order.
- Patients under involuntary emergency detention who have not yet been placed under civil commitment, and who have been determined not to currently meet criteria for inpatient commitment.

For all such potential AOT participants, as well as those currently in the community or nearing release from jail, the process to follow is the "temporary / extended" AOT process described in this section.

Evaluation

The first thing an AOT program must do upon receiving a referral is conduct an assessment of whether the referred individual is indeed appropriate for AOT participation.

The key legal components of that assessment are the two medical evaluations performed by physicians, focused specifically on whether the individual meets Texas' AOT legal criteria as outlined above. However, AOT program staff may have the need to perform their own preliminary analysis before moving forward with medical evaluation. For one thing, program staff may wish to review medical records to see whether they seem to indicate that the individual is likely to be found to meet criteria. Additionally, the program may have their own additional, self-imposed criteria, due to program capacity limitations and/or policy determinations as to whom the program is best able to serve.

This preliminary review will typically require the sharing of treatment records by current or past treatment providers with AOT program staff. Some providers may be reluctant to share records, out of concern for violating the general prohibition in the federal Health Insurance Portability and Accountability Act (HIPAA) on disclosing protected health information (PHI) without patient consent. However, under federal regulation **45 CFR § 164.512(e)(1)(i)**, there is an exception to HIPAA's "Privacy Rule" for a disclosure of PHI made pursuant to a court order. A solution to any provider's HIPAA concern about sharing PHI with AOT staff is for the probate court presiding over your county's AOT program to issue an administrative order permitting disclosures of PHI for the limited purpose of determining whether an individual meets criteria for AOT. Once issued, the order can be shared with any providers from whom treatment records are sought, giving them legal cover to share information without concern of violating HIPAA.

A sample administrative order for the disclosure of PHI, as issued by the probate court in Travis County, is included in this guide as Appendix A.

Once it has been determined that medical evaluation for AOT eligibility is appropriate, Texas law guides the process. **Tex. Health & Safety Code § 574.009(a)** provides:

> ***"(a)*** *A hearing on an application for court-ordered mental health services may not be held unless there are on file with the court at least two certificates of medical examination for mental illness completed by different physicians each of whom has examined the proposed patient during the preceding 30 days. At least one of the physicians must be a psychiatrist if a psychiatrist is available in the county."*

When AOT is sought for a person who is currently detained (whether in a clinical or correctional setting) or who agrees to submit to medical evaluation, the program must arrange for these two medical examinations to be performed and for the certificates of medical examination ("CME"s) to be completed. To support the application, both CMEs must state findings that the individual meets the legal criteria for AOT. These CMEs can then be filed with the application.

It is also possible to apply for AOT in situations where the person is currently in the community, has not been recently evaluated while detained or hospitalized, and refuses to submit voluntarily to medical examination. While most potential AOT applicants are required to submit the two CMEs with their petition, **Tex. Health & Safety Code § 574.001(a)** makes an important exception, providing: *"Only the district or county attorney may file an application that is not accompanied by a certificate of medical examination."* Accordingly, pursuing AOT in circumstances where it is impossible to conduct the medical examination pre-application requires that your district or county attorney serve as the AOT applicant.

Tex. Health & Safety Code § 574.009(b) and (c) provide the procedure for securing the CMEs needed to hold a hearing when an application without them is filed by the district or county attorney:

> ***"(b)*** *If the certificates are not filed with the application, the judge or magistrate ... may appoint the necessary physicians to examine the proposed patient and file the certificates.*
>
> ***(c)*** *The judge or designated magistrate may order the proposed patient to submit to the examination and may issue a warrant authorizing a peace officer to take the proposed patient into custody for the examination."*

Tex. Health & Safety Code § 574.011 provides all of the information that must be stated in the CME.

▶ A template for a CME supporting an application for AOT, conforming in full with the legal requirements, is included in this guide as Appendix B.

Application

Tex. Health & Safety Code § 574.001(a) authorizes any adult to file an application for another person to be committed to AOT, with the important limitation noted above that only a district or county attorney may file an application that is not accompanied by two recent CMEs.

An AOT program must decide in the planning stage who will be responsible for filing applications. In many counties, the obvious choice will be the district or county attorney. One of these agencies is usually responsible for filing applications for *inpatient* civil commitment, making it a natural extension for them to take on outpatient commitments as well. Having the district or county attorney as applicant makes it possible to consider cases where it has not been possible to secure two CMEs in advance.

If it proves impossible to engage the district or county attorney as a program collaborator, the statute's grant of authority to "any adult" means that hope is not lost. For example, an AOT program could be structured with the role of the applicant fulfilled by an officer of the LMHA or the director of the hospital currently holding the proposed patient, with legal representation by the mental health authority's or hospital's own counsel.

Another key policy question an AOT program should resolve in the planning stage is whether to seek "extended" AOT (allowing the court to grant an order of up to one year) when the criteria for it are met, or simply stick with the "temporary" type (order up to 90 days). This will be discussed further in the "Renewal" section below, since it is only upon renewal of an order that most AOT participants will meet the legal criteria for "extended" AOT. Upon an initial application, only those who have spent a total of at least 60 days under inpatient commitment over the prior year will potentially qualify for "extended" AOT.

Ninety days is rarely long enough for *any* AOT participant to develop sustainable habits of treatment engagement – much less for one who has logged so many recent hospital days. This might make the choice to pursue an "extended" AOT seem obvious, and in many cases it will be. However, practical differences between the two options may make an application for "extended" AOT challenging for some programs.

One difference is that **Tex. Health & Safety Code § 574.031(d-1)** allows a proposed patient for "temporary" AOT to waive their right to cross-examine witnesses, which in turn allows the court to admit the CMEs as medical testimony, eliminating the need for an examining physician to appear in court. By contrast, **Tex. Health & Safety Code § 574.031(d-2)** makes clear that an order of "extended" AOT must always rely on medical testimony taken in person at the hearing. This might make the "temporary" route more feasible when the proposed patient is willing to stipulate or waive cross-examination and it is difficult to produce an examining physician for live testimony.

Another difference is that under **Tex. Health & Safety Code § 574.032**, a "temporary" AOT hearing is held with the judge as fact-finder unless the proposed patient requests a jury. This

is reversed for "extended" AOT, with a jury trial provided unless the proposed patient waives their right to it. This could add a layer of complication to the legal process for "extended" AOT if the proposed patient is unwilling to waive the jury requirement.

For these reasons, an AOT program may prefer to avoid the "extended" AOT option altogether and pursue "temporary" AOT even for those who meet "extended" criteria. This is a reasonable choice, so long as the program remains committed to renewing the 90-day order repeatedly. An individual who has spent 60 days of the prior year under inpatient commitment will typically need *at least* a year of AOT to achieve sustainable benefits.

Tex. Health & Safety Code § 574.001(b) provides that the application may be filed with the county clerk in the county where the proposed patient:

- Resides; or
- Is found; or
- Is receiving court-ordered inpatient mental health services.

As a general practice, it makes the most sense to apply for AOT in the county where the proposed patient resides, as that will likely be where your AOT program is operating and is best equipped to provide services. In some situations, it may make sense to conduct the AOT hearing and have the AOT order issued in the county of the state hospital where they are currently detained, and then have the order transferred to their county of residence where your AOT program is operating upon the participant's release and return to home. However, this practice should be undertaken in coordination and agreement with the court where the application is filed, to ensure that the court will actually hear the case. If the proposed patient requests that the application be transferred for hearing to the county of residence, **Tex. Health & Safety Code § 574.001(c)** allows the court to do that for good cause shown.

Tex. Health & Safety Code § 574.002 requires the application to state:

- Whether it seeks "temporary" (up to 90 days) or "extended" (up to one year) AOT. (And, if extended AOT is sought, that the proposed patient has received 60 cumulative days of inpatient commitment over the last year or has received AOT in the last 60 days.)
- The proposed patient's name, address and county of residence;
- That the proposed patient is a person with mental illness and meets the statutory criteria for AOT; and
- Whether the proposed patient is currently charged with a criminal offense.

A template for an AOT application is included in this guide as Appendix C.

Recommendation for Treatment

An additional document that must be filed with the court prior to the hearing is the "Recommendation for Treatment." Once the court receives the application and sets the date for the hearing (as detailed further below), **Tex. Health & Safety Code § 574.012** requires the court to direct the LMHA to file, prior to the scheduled hearing date, its "recommendation for

the proposed patient's treatment" and "a statement as to whether the proposed mental health services are available." The statute further provides that "The hearing on an application may not be held before the recommendation for treatment is filed unless the court determines that an emergency exists."

This section of the law seems to imagine the LMHA in a reactive posture, being pulled into the case at the direction of the judge who has received an AOT application from another party. But of course in an AOT program, the LMHA is a central player. There is thus no reason why the LMHA should not be engaged in developing the Recommendation for Treatment as soon as a decision has been made to seek AOT in a particular case.

The Recommendation for Treatment is essentially a treatment plan to be presented for court review. It need not be as detailed as a treatment plan developed for use in a clinical context, but it should state in broad terms the categories of services that the proposed patient should be court-ordered to receive, and for each category identify a specific community-based provider who is willing and able to provide the services and a source of payment.[3]

A template for a Recommendation for Treatment is included in this guide as Appendix D.

To the extent possible, the treatment plan should be developed not just in consultation with the proposed patient, but it in *collaboration* with them, with a focus on what has worked for the person in the past and on helping the person reach their own articulated life goals. Efforts should be made to also involve in the treatment planning any individual who the proposed patient trusts and wants to have involved. The basic principles of recovery, including that a person is most likely to engage in treatment when they feel personally invested in the development of it, are as true for AOT participants as they are for others. That is not to say that we should defer to unreasonable or unhealthy choices the AOT participant may wish to make for their treatment plan -- only that we should seek to maximize self-direction within the parameters of ensuring that the person receives the care they need.

Identification of Person Responsible

Tex. Health & Safety Code § 574.0125 requires the judge, not later than 3 days before the scheduled AOT hearing date, to "identify the person the judge intends to designate to be responsible" for overseeing AOT services in the event that the application is granted. The simplest way to meet this requirement is to establish an understanding that the court will routinely identify the chief executive of the LMHA as the "person responsible." This authorizes any LMHA staff member, serving as an agent of the chief executive, to fulfill the various statutory functions of the "person responsible" discussed throughout this guide. But it may better suit the needs of some AOT programs for another individual – for example, the chief executive of a community-based provider operating the AOT program under contract with the LMHA – to be so designated. In any event, an AOT program should make known to the court a particular individual who should be identified as the "person responsible" in every case.

Appointment of Attorney

Tex. Health & Safety Code § 574.003 provides that if the proposed patient does not already have an attorney, the court shall appoint an attorney to represent them (along with a language interpreter, if necessary) within 24 hours after the application is filed. The statute further requires that the appointed attorney be informed by the court of their duties in writing, “be furnished with all records and papers in the case,” and “have access to all hospital and physicians’ records.”

An AOT program needs a systematic approach to the appointment of counsel. In larger Texas counties, representation of proposed patients will be the responsibility of the mental health unit of the Public Defender’s Office (PDO). Typically, the PDO will assign a particular mental health defender or two to handle the AOT docket. In smaller counties without a PDO, the best approach is to work with a small pool of attorneys in private practice (potentially even *one* private attorney, if they can manage the caseload) who develops familiarity with AOT and can balance a general support for the program with their duty to vigilantly uphold their clients’ rights. AOT programs should avoid randomly appointing counsel from a long list. Having a “regular” in the defense counsel’s chair will enable proposed patients to get better information about the potential benefits of AOT participation and what to expect, as well as provide the program itself with another stakeholder to participate in ongoing improvement efforts.

Once appointed, the duties of the proposed patient’s attorney are governed by **Tex. Health & Safety Code § 574.004.** These include the duty to “interview the proposed patient within a reasonable time before the date of the hearing,” and to “thoroughly discuss with the proposed patient the law and facts of the case, the proposed patient’s options, and the grounds on which the court-ordered mental health services are being sought.” Ideally, the attorney will be supportive of the AOT program, believe their client meets criteria and would benefit from participation, and advise their client accordingly. Ultimately, of course, the attorney must follow the proposed patient’s wishes in deciding whether to challenge the application at the hearing or agree to AOT by stipulation. **Tex. Health & Safety Code § 574.004(c)** provides:

> ***“(c)*** *The attorney may advise the proposed patient of the wisdom of agreeing to or resisting efforts to provide mental health services, but the proposed patient shall make the decision to agree to or resist the efforts. Regardless of an attorney’s personal opinion, the attorney shall use all reasonable efforts within the bounds of law to advocate the proposed patient’s right to avoid court-ordered mental health services if the proposed patient expresses a desire to avoid the services.”*

Hearing / Disposition

Tex. Health & Safety Code § 574.005 provides that the court must set a date for a hearing within the 14 days following the application date. The court may not set the hearing within the first 3 days of that period if the proposed patient objects. Continuances may be granted for good cause or upon agreement of the parties, but the hearing must be held within 30 days of the application date.

Tex. Health & Safety Code § 574.006 requires that the proposed patient and their attorney receive a copy of the application and written notice of the time and place of the hearing immediately after the date for the hearing is set.

Tex. Health & Safety Code § 574.031(c) provides that the proposed patient may waive their right to attend the hearing. **Tex. Health & Safety Code § 574.031(d)** requires that the hearing be open to the public unless the proposed patient requests that it be closed and the court determines there is good cause to close it.

What takes place at the hearing is largely dependent on the proposed patient's choice whether to "stipulate" to the application (acknowledge the truth of the allegations made in the application, leaving no facts in dispute) or, alternatively, to deny the allegations and hold the AOT applicant to their burden of proving that the legal criteria are met.

A proposed patient who stipulates to an application for "temporary" AOT is also likely to waive their right to cross-examine witnesses under **Tex. Health & Safety Code § 574.031(d-1)**. As mentioned, this allows the judge to accept the CMEs as medical testimony and relieves the examining physician of the need to testify in court. This is not an option with an application for "extended" AOT.

If your AOT program is typical, you will find that most proposed patients *do* stipulate. Your program staff and partners, including defense counsel, can increase the likelihood of this by explaining AOT to proposed patients in conversations prior to the hearing date. When proposed patients understand that AOT participation does not mean they are "in trouble," carries no threat of punishment, will empower them to participate in decisions about their own treatment, is likely to help them avoid the hospital and jail and make progress towards their life goals, and may even allow them to gain release from their current hospitalization a little sooner, they tend to enter the program willingly – sometimes even *eagerly*.

When a proposed patient chooses to stipulate, the judge's role becomes much simpler. With the exception of the universal requirement under **Tex. Health & Safety Code § 574.031(d-2)** of live medical testimony in a hearing for "extended" AOT, the court will not need to hear a full presentation of the applicant's evidence, because there are no factual questions to settle. Instead, the judge will typically walk the proposed patient through the allegations in the application and ask them to stipulate on the record and acknowledge that their decision has been made after consultation with their attorney, with full understanding of the legal implications of civil commitment to AOT, and without undue pressure from anyone. Once satisfied that the choice to stipulate was made knowingly and freely, the judge may issue the AOT order.

Of course, some patients will choose not to stipulate and instead exercise their constitutional right to challenge the application. If the hearing opens with the proposed patient expressing this choice, a presentation of evidence must commence, with the applicant bearing the burden of proving that the legal criteria for AOT are met.

Presentation of Evidence

The primary means of presenting the evidence in support of the application is the testimony of one of the physicians who has examined the proposed patient and completed a CME. Although **Tex. Health & Safety Code § 574.009(a)** generally requires at least one of the physicians completing a CME to be a psychiatrist, Texas law does not require the physician who testifies at the hearing to be a psychiatrist. However, even though not strictly required, having the testimony come from a physician who is a board-certified psychiatrist is essential to ensuring that the fact-finder (judge or jury) will find the testimony persuasive. After establishing the psychiatrist's expert credentials and the basis for their expert opinions (i.e., the examination performed), the attorney for the applicant should have the psychiatrist, state their finding with respect to each of the AOT criteria that must be proven, and the basis for each such finding. In most cases, this should be adequate to establish by clear and convincing evidence that the criteria are met.

Tex. Health & Safety Code § 574.0345(b) and **Tex. Health & Safety Code § 574.0355(c)** add an important element to the evidence that an applicant must present at a hearing for either "temporary" or "extended" AOT. These sections provide that the applicant's case must include evidence of "*a recent overt act or a continuing pattern of behavior*." More specifically:

> ***"(b)*** *To be clear and convincing under Subsection (a)(2), the evidence must include … evidence of a recent overt act or a continuing pattern of behavior that tends to confirm:*
>
> ***(1)*** *the deterioration of ability to function independently to the extent that the proposed patient will be unable to live safely in the community;*
>
> ***(2)*** *the need for outpatient mental health services to prevent a relapse that would likely result in serious harm to the proposed patient or others; and*
>
> ***(3)*** *the proposed patient's inability to participate in outpatient treatment services effectively and voluntarily."*

This evidence may be presented by the psychiatrist in the course of their testimony on their clinical findings. Since individuals tend to be found in need of AOT on the basis of repeated hospitalizations and/or arrests resulting from treatment non-compliance, it should not be difficult to identify a "continuing pattern of behavior" to satisfy this evidentiary requirement. It can be easily accomplished by having the psychiatrist recount the proposed patient's history of poor compliance with prescribed treatment and the harmful consequences that have followed.

If for any reason the applicant's attorney feels the need to buttress the case for AOT with additional expert testimony, **Tex. Health & Safety Code § 574.031(f)** makes clear that "the court may consider the testimony of a non-physician mental health professional in addition to medical or psychiatric testimony."

Of course, the proposed patient must be afforded the opportunity to cross-examine the applicant's witnesses and attempt to expose weaknesses in their findings and conclusions, as well as present their own evidence in rebuttal. The proposed patient may also request that the court order an independent examination pursuant to **Tex. Health & Safety Code § 574.010:**

> *"**(a)** The court may order an independent evaluation of the proposed patient by a psychiatrist chosen by the proposed patient if the court determines that the evaluation will assist the finder of fact. The psychiatrist may testify on behalf of the proposed patient.*
>
> ***(b)** If the court determines that the proposed patient is indigent, the court may authorize reimbursement to the attorney ad litem for court-approved expenses incurred in obtaining expert testimony and may order the proposed patient's county of residence to pay the expenses."*

At the conclusion of the presentation of evidence, the trier of fact (judge or jury) must decide whether the applicant has proven their case by clear and convincing evidence. **Tex. Health & Safety Code § 574.036(e)(2)** provides that if the trier of fact finds that the proposed patient meets the AOT criteria, the judge may issue an AOT order.

Length of the Order

Technically speaking, **Tex. Health & Safety Code § 574.0345(c)** sets the default maximum length for a "temporary" AOT order at 45 days. However, the statute allows an increase to up to 90 days "if the judge finds that the longer period is necessary." Given the available data on the importance of providing a sufficient duration of AOT to achieve sustainable improvements in participant outcomes (see "Tip 5" at page 24 of the AOT Implementation White Paper), an order period of more than 45 days should be considered "necessary" much more often than not. It would be a tragic disservice to AOT participants for programs and judges to interpret the law to allow the 45-day default to be exceeded only under extraordinary circumstances.

Tex. Health & Safety Code § 574.0345(d) sets the maximum length for an order of "extended" AOT at one year.

A sample AOT Order Upon Application and related documents are included in this guide as Appendix E.

Process for AOT By Recommendation (Modification of Inpatient Order)

The legal process for Texas' third type of AOT order is guided by **Tex. Health & Safety Code § 574.061**. This is the process for modifying a current order of inpatient commitment to an outpatient commitment for the period of time remaining. Not only is this process *possible* for current involuntary inpatients, but **Tex. Health & Safety Code § 574.061(a)** actually *requires* the administrator of a facility, no later than the 30th day of an involuntary inpatient's commitment, to "assess the appropriateness" of transferring the patient to AOT. Based on this required assessment, the administrator "may recommend that the court that entered the commitment order modify the order to require the patient to participate in [AOT]."

Tex. Health & Safety Code § 574.061(b) provides that the facility administrator's recommendation "must explain in detail the reason for the recommendation" and must be accompanied by a supporting CME "signed by a physician who examined the patient during the seven days preceding the recommendation."

Although the Texas law does not frame it in such terms explicitly, we can reasonably infer that a modification from inpatient commitment to AOT is appropriate when the examining physician finds that the patient: (1) no longer meets the legal criteria for inpatient commitment under **Tex. Health & Safety Code § 574.034(a)** or **§ 574.035(b)**; and (2) currently meets the criteria for outpatient commitment as provided in **Tex. Health & Safety Code § 574.0345(a)** or **§ 574.0355**.

Findings and conclusions to this effect should be stated in the facility director's recommendation to the court and the accompanying CME.

A sample Recommendation for Modification of Inpatient Commitment is included in this guide as Appendix F.

It is also a good practice to include with the Recommendation for Modification the same Recommendation for Treatment as would be required in a case of AOT by Application. This will aid the court in the execution of its required functions.

Tex. Health & Safety Code § 574.061(c) provides that when a facility director files a modification recommendation with the court, the patient shall be given notice. Under **Tex. Health & Safety Code § 574.061(d)**, a hearing shall be held *if requested* by the patient or "any other interested person."[4] (Another key difference from the AOT application process, in which the hearing is automatic.) If a hearing is held, the court must appoint counsel to represent the patient and "shall consult with the local mental health authority before issuing a decision." Aside from the option of a jury trial, which is precluded, the statute further incorporates by reference all of the procedural rules that apply to hearings on AOT applications under **Tex. Health & Safety Code § 574.031**. To review, these include:

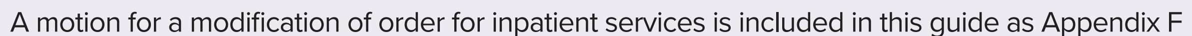
- The patient's prerogative to waive their right to attend the hearing;
- The patient's prerogative to waive their right to cross-examine witnesses, which in turn allows the court to accept the CME as medical evidence and eliminates the need

for live medical testimony;
- The need to make findings by clear and convincing evidence;
- The default to having the hearing open to the public;
- The court's prerogative to "consider the testimony of a non-physician mental health professional" to supplement the medical testimony.

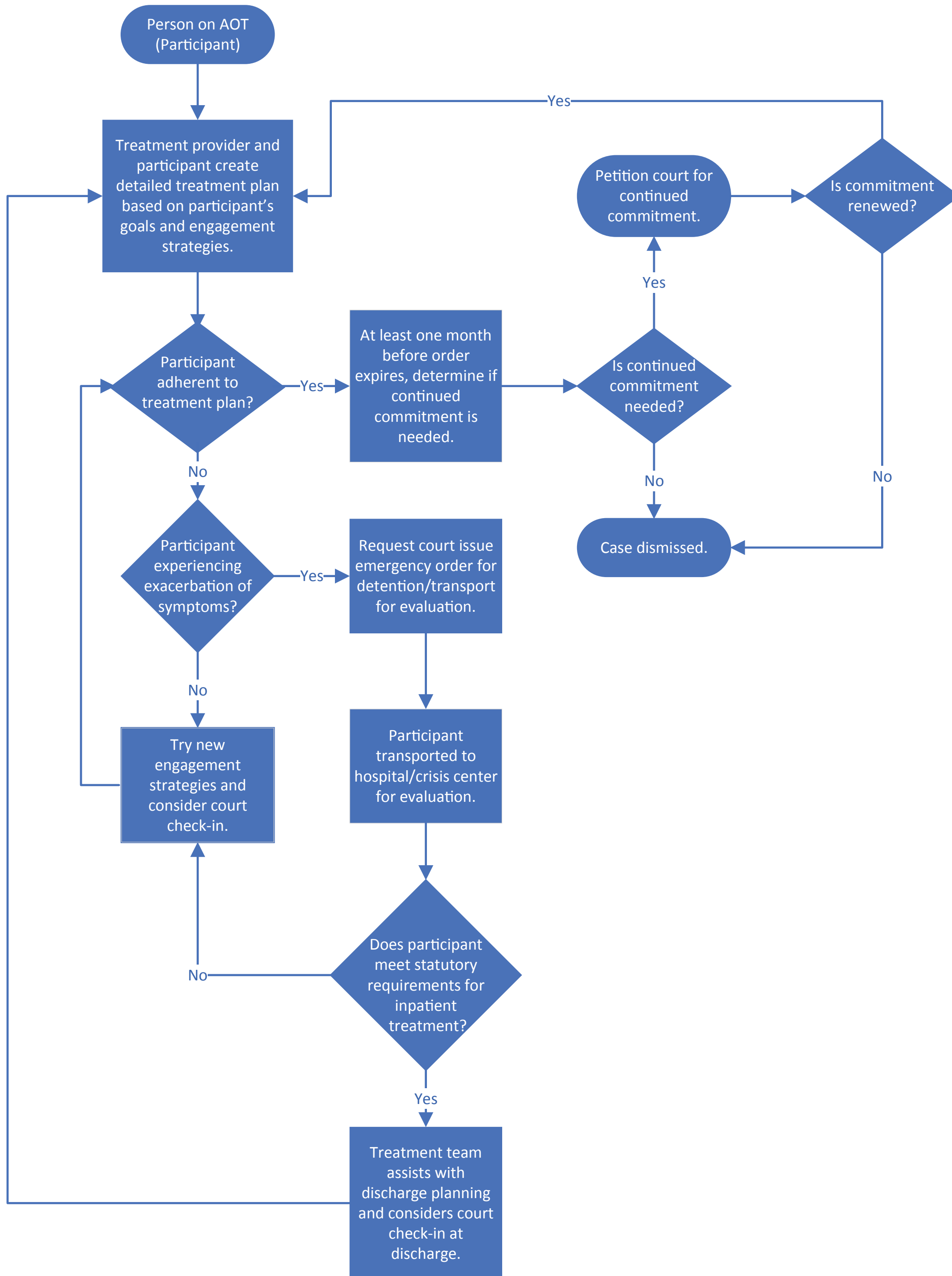
Tex. Health & Safety Code § 574.061(e) provides that if a hearing is not requested, the court shall base its decision upon the facility director's written, detailed recommendation; the supporting CME; and "consultation with the local mental health authority concerning available resources to treat the patient."

With or without a hearing, a court considering a recommendation to modify a current inpatient commitment order to AOT must determine whether the evidence supports a finding that the patient currently meets statutory criteria for outpatient commitment.

If the facility director has met this burden, the court may modify the existing inpatient commitment order to an AOT order. **Tex. Health & Safety Code § 574.061(h)** authorizes the court upon modification to add up to 60 days to the remaining term of the existing order.

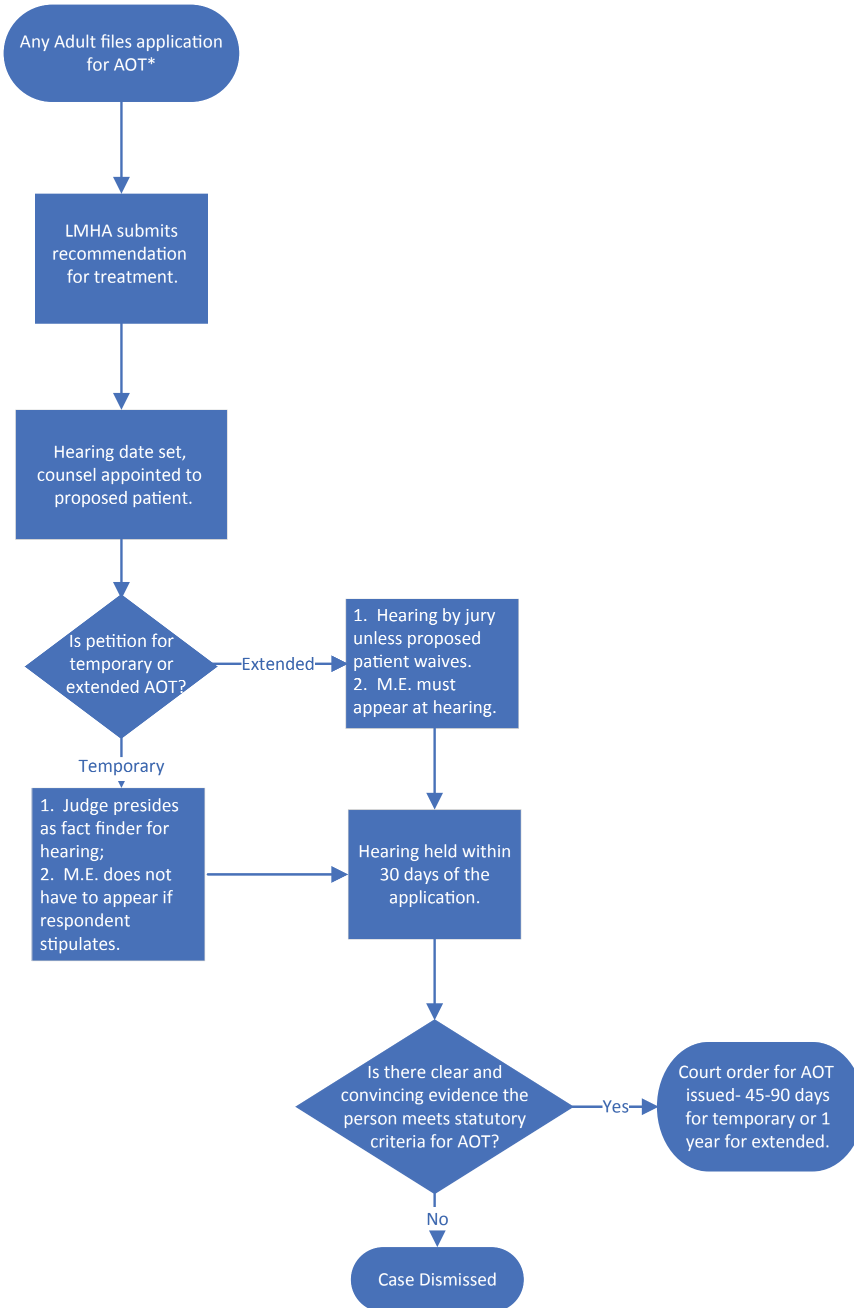


AOT Process



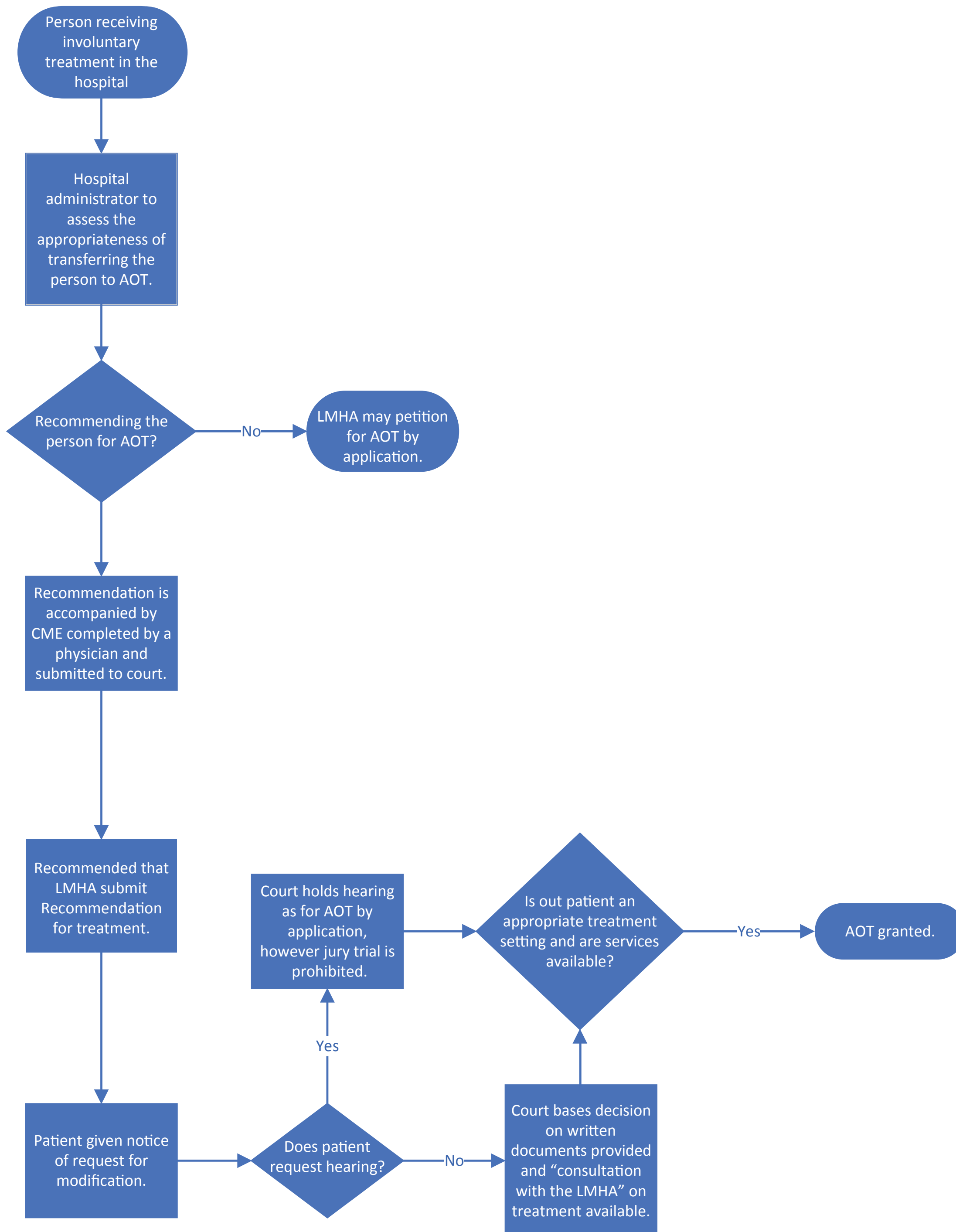
Process for AOT by Application

CME=Certificate of Medical Examination
M.E.=Medical Expert
LMHA=Local Mental Health Authority
* The application must be accpanied by 2 CMEs or filed by a county attorney



Process for AOT by Recommendation

LMHA=Local Mental Health Authority



Chapter 3: AOT TREATMENT AND OVERSIGHT

Once an AOT order has been issued -- regardless of whether it came about through an application for "temporary" AOT, an application for "extended" AOT, or a recommendation for modification of an inpatient order -- Texas law provides a single process for how AOT orders shall be carried out. To make the AOT order more than just a piece of paper, the law speaks to what must happen while it is in effect. This includes the treatment team's duty to provide care and monitoring of the AOT participant; the court's responsibility of oversight over both the participant and the treatment team; the means by which the order may be enforced if either party fails to uphold its responsibility to the other; and the legal process for continuing AOT beyond the term of the current order.

Care and Monitoring of Participant

Several provisions of **Tex. Health & Safety Code § 574.037** are designed to ensure that AOT participants receive the care and monitoring they need to succeed in the program.[5]

Tex. Health & Safety Code § 574.037(a) requires the court to designate in the order itself the "person responsible" for the delivery of services. This should usually be the person identified prior to the hearing as required by **Tex. Health & Safety Code § 574.0125** (see "Application" section above), but the court "may designate a different person if necessary," so long as the person designated is "the facility administrator or an individual involved in providing court-ordered outpatient services." The court is also limited in its ability to draft a "person responsible" without their consent; that can only be done to an administrator of a community center providing mental health services or an administrator of a state facility. Obviously, designation without consent should never be a concern when AOT is being ordered in a county served by an AOT *program*. The program and the court will have an understanding in place as to who should be designated in every case as the "person responsible."

Tex. Health & Safety Code § 574.037(b) directs the designated "person responsible" to submit to the court "a general program of the treatment to be provided." Under **Tex. Health & Safety Code § 574.037(b-2)**, this submission must take place prior to the hearing on the AOT application or inpatient order modification.

These requirements are essentially redundant of the requirement under **Tex. Health & Safety Code § 574.012** for the LMHA to file its "recommendation of the proposed patient's treatment" before the hearing. In the context of an AOT program, the LMHA should be either operating the program itself or working hand-in-glove with the entity that does, such that the practice should be to satisfy both statutes simultaneously by submitting a single treatment plan on behalf of both the LMHA and the proposed "person responsible."

Note, however, that **§ 574.037(b)** is more detailed than **§ 574.012** in terms of what the general program must include. It requires the inclusion of care coordination services in every program.

Beyond that, it offers only the guidance that the plan must include:

> *"any other treatment or services, including medication and supported housing, that are available and considered clinically necessary by a treating physician or the person responsible for the services to assist the patient in functioning safely in the community."*

This should not be read as an absolute mandate that medication or supported housing be included, but rather a strong expression by the legislature that these are type of services AOT programs should look to provide. (And it would certainly be unusual for medication to be omitted.)

Importantly, the statute provides that the treatment plan *"must be incorporated into the court order."* This step may seem at first blush like a procedural formality, but in fact, it has two highly significant implications that should be impressed upon the participant at the AOT hearing: First, it heightens the impact of the AOT order by clarifying the contours of the court's expectations of treatment adherence. Second, it makes the commitment *mutual* by making an outline of the services the court expects to be provided part of the court order itself. In addition to imposing a "black robe effect" upon the treatment team, this provides an opportunity to impart a sense of empowerment upon the participant by informing them of their legal right to the services promised. (This is also part of why it is so important to involve the participant in the development of the plan, as discussed in the "Application" section above.)

Tex. Health & Safety Code § 574.037(b-1) provides that "[i]f the patient is receiving inpatient mental health services at the time the program is being prepared, the person responsible for the services under this section shall seek input from the patient's inpatient treatment providers in preparing the program."

Beyond the AOT-specific requirements that § 574.037 imposes on providers of care, a judge should keep in mind throughout the period of an AOT order the broader responsibilities Texas law imposes on an LMHA to ensure adequate care for community members with severe mental illness. Tex. Health & Safety Code § 533.0354(a) provides:

A local mental health authority shall ensure the provision of ... intensive and comprehensive services using disease management practices for adults with bipolar disorder, schizophrenia, or clinically severe depression[.] The local mental health authority shall ensure that individuals are engaged with treatment services that are:

> ***(1)*** *ongoing and matched to the needs of the individual in type, duration, and intensity;*
>
> ***(2)*** *focused on a process of recovery designed to allow the individual to progress through levels of service;*

> ***(3)*** *guided by evidence-based protocols and a strength-based paradigm of service; and*
>
> ***(4)*** *monitored by a system that holds the local authority accountable for specific outcomes, while allowing flexibility to maximize local resources.*

The allowance in the final requirement for "flexibility" should not be overlooked. It provides the room AOT programs need to tailor their day-to-day operations to the demographics and resource challenges of their service area.

Court Oversight

Two sections of the AOT law speak to the ongoing role of the court during the period that the order is in effect.

Tex. Health & Safety Code § 574.0665 provides that "a court on its own motion may set a status conference with the patient, the patient's attorney, and the person designated to be responsible for the patient's court-ordered outpatient services." This might fairly be regarded as superfluous legislation, since it is *always* within the discretion of a judge to call a status conference on a matter pending before the court. However, it was added to Texas' AOT law for a reason: to signal to AOT programs that an "active court" model is available to them, should they determine that participants would benefit from ongoing interaction with the judge. (For more on the "active court" model, see "Building Block 5" at p.14-15 of the AOT Implementation White Paper.)

With or without status conferences, court oversight during the period of the order is also supported by **Tex. Health & Safety Code § 574.037(c)(2)**, which directs the "person responsible" to inform the court of "any substantial change in the general program of treatment that occurs before the order expires." No guidance is provided as to what constitutes a "substantial" change, but it seems fair to interpret it to mean any change that renders the treatment plan currently incorporated into the order (which should not be overly specific) out of date. One might expect the court to use this information to modify the order to reflect the changed treatment plan. However, this is not possible under **Tex. Health & Safety Code § 574.065**, which only allows modification of the order upon a finding that the participant has come to meet criteria for inpatient commitment. (See "Enforcement of Order" section below.) Unless and until this statute is amended, the court can only take the treatment plan change under advisement while leaving the outdated order in place.

Enforcement of Order: Participant Non-Compliance

An essential function of any state's AOT law is to provide a legal process for responding to the inevitable situations where an AOT participant is not adhering to treatment as required by the court order.

Outside the AOT context, the legal remedy for a court order violation is straightforward and widely understood. A judge is generally empowered to hold a person who violates its order in contempt of court, subjecting them to steep fines and/or incarceration. We tend to think of the specter of contempt as the very reason court orders are taken seriously.

In an AOT program, initiating contempt proceedings against participants who violate their orders would be disastrous. For one thing, it would establish a new pathway into jail cells for people with severe mental illness, turning one of AOT's primary goals on its head. For another, it would misconstrue what actually happens when a participant disengages from treatment. The non-adherent participant is not showing *contempt* for the court -- they are simply evincing their chronic struggle to maintain insight and stability.

In commendable recognition of this, **Tex. Health & Safety Code § 574.037(c-4)** dictates that "[t]he failure of a patient to comply with the program incorporated into a court order is not grounds for punishment for contempt of court[.]"

The law also makes explicit that an AOT order is not enforceable through involuntarily *administered* treatment. **Tex. Health & Safety Code § 574.037(c-3)** draws a critical distinction between "order[ing] the patient to participate in the program," which the court *shall* do, and "compel[ling] performance," which the court *may not* do. This leaves no doubt that if an AOT order directing the participant to take medication is violated, physical restraint and forcible administration of the medication is not a permitted response.

In lieu of these proscribed methods of court order enforcement, the Texas AOT law lays out a process to facilitate the help that the disengaged participant needs to avert a full-blown crisis and get back in sync with the treatment team. This begins with **Tex. Health & Safety Code § 574.037(c)(1),** which provides that the "person responsible for the services shall inform the court of the patient's failure to comply with the court order." This triggers a range of potential court responses, from calling a status conference under **Tex. Health & Safety Code §§ 574.037(c)(2)**, to setting a date for a "modification hearing," and potentially issuing a temporary order of detention of the participant, if requested and deemed appropriate, under **Tex. Health & Safety Code §§ 574.037(c)(2)**. The latter set of responses, intended to address the more serious situations, are further detailed in the sections of the law that follow.

The law treats the participant's non-adherence as an opportunity to re-consider whether AOT and the treatment plan as presently designed continue to meet the participant's evolving needs. There may be a need to *modify* the current order, either by changing the terms of the treatment plan or, if the participant has decompensated to the point of meeting court-ordered inpatient criteria, by converting it to an inpatient order. This is the question to be confronted at the modification hearing.

Tex. Health & Safety Code §§ 574.062 authorizes the court to set a hearing for modification "on its own motion, at the request of the person responsible for the treatment, or at the request of any other interested person." The statute provides that the hearing be held without a jury and

with the patient receiving proper notice and representation by counsel. Reflecting the urgency of the matter, the hearing must be scheduled within 7 days after the motion for modification is filed, with continuances allowed for good cause or upon agreement of the parties but in no event (aside from hazardous weather or disaster) later than 14 days after the motion.

Tex. Health & Safety Code §§ 574.063 covers the order of temporary detention (TDO) which may be necessary if the treatment team believes that allowing the participant to remain at liberty pending the modification hearing would present a substantial risk of serious harm to the participant or others. An application for the TDO may be filed by either the person responsible for treatment or the administrator of an outpatient facility in which the participant receives treatment. The application must state and detail the reasons for the applicant's opinion that the participant presents a substantial risk of serious harm and requires detention "to evaluate the appropriate setting for continued court-ordered services." The court shall issue the TDO if it finds probable cause to believe that the opinions stated in the application are valid. Within 24 hours after detention begins, the court shall provide the participant and their attorney with written notice stating that the participant has been placed under a TDO, the grounds for the TDO, and the date of the modification hearing.

Tex. Health & Safety Code §§ 574.064 adds more detail to the AOT TDO process. The TDO must direct a peace officer or other designated person to take the participant into custody and transport them immediately to "the nearest appropriate inpatient mental health facility," or, if no such facility is available, to a mental health facility deemed suitable by the LMHA (which may not be "a nonmedical facility used to detain persons charged with or convicted of a crime"). A physician must examine the participant as soon as possible and within 24 hours after their arrival at the facility. If the physician determines from the evaluation that the participant does not present a substantial risk of serious harm to self or others, the facility must release the participant and notify the "person responsible" and the court.

If the physician determines that the participant *does* present a substantial risk, that does not necessarily mean the participant may be detained until the modification hearing. Detention of more than 72 hours, extending until the modification hearing takes place, requires a probable cause hearing, at which the judge must find probable cause to believe that the participant presents such a substantial risk of serious harm to self or others that they cannot be at liberty until the hearing, and that continued detention "is necessary to evaluate the appropriate setting for continued court-ordered services." Throughout the period of temporary detention, the person remains subject to the AOT order.

Tex. Health & Safety Code § 574.065 concerns the court's decision at a modification hearing. If the court determines that the participant currently meets the criteria for inpatient commitment, it may modify the AOT order or choose not to. However, *without* finding that the participant currently meets criteria for inpatient commitment, the court has no authority to modify the order. A decision to modify must be supported by a CME from a physician who has examined the participant within the 7 days prior to the hearing. Modification may entail either a conversion to an inpatient commitment order, or continuing AOT while incorporating in the order a revised

treatment plan, provided one was submitted to and accepted by the court. The modification may not extend the term of the current order.

Enforcement of Order: Treatment Provider Non-Compliance

Notably, the Texas AOT law provides the AOT participant with an enforcement mechanism as well. As discussed, the incorporation of the treatment plan into the court order establishes a legal obligation on the part of the providers identified to deliver services as specified. This can be enforced through **Tex. Health & Safety Code § 574.037(c-4)**, which entitles "[a] patient subject to court-ordered outpatient services [to] petition the court for specific enforcement of the court order."

By allowing a participant who does not believe services are being provided as promised to seek redress from the judge, the Texas law gives real substance to the "mutual commitment" underlying the AOT model. While we are unaware of any case where an AOT participant has invoked this right, it seems worth noting that the prohibition against holding a participant in contempt of court for non-compliance does not extend to treatment providers. Presumably a provider's failure to heed the court's command to provide a promised service after the participant has invoked **§ 574.037(c-4)** could subject the provider to a contempt finding. Of course, the court would not be authorized to direct the provider to perform anything more or different from what the provider had agreed to in the treatment plan.

Renewal of AOT Order

The conclusion of the period of an AOT order need not mean the "graduation" of the participant from the AOT program. (Indeed, in the case of a "temporary" AOT order, one term of 90 days should almost never be considered time enough, unless it has been determined that the participant was not appropriate for AOT in the first place.)

As the end of a participant's order period draws near, it is incumbent upon an AOT program to conduct a new clinical evaluation of the participant and determine if their best interests are served by allowing the order to lapse and transitioning them to voluntary care, or by continuing them in AOT for an additional period. If the latter, the program must make a new application to the court for "temporary" or "extended" AOT to commence upon the expiration of the current order. This must be carefully timed and coordinated to ensure a seamless continuation.

"Extended" AOT has been specifically designed to follow from "temporary" or "modified inpatient" AOT. Whereas relatively few will qualify for the "extended" type on their first AOT order (as it requires 60 days hospitalized in the prior year), the very experience of being under a "temporary" or "modified inpatient" AOT order will help qualify the participant for an "extended" order (using the alternative qualification for those who have been under AOT in the prior 60 days) upon expiration of the current order.

While routine transitioning of participants from a first AOT order to an “extended” second should prove convenient for some programs, others may find it easier to employ a series of “temporary” AOT applications rather than a single “extended” one. The reason is the same as what has already been discussed above as the reason a program might reasonably opt for “temporary” AOT even when the proposed patient qualifies for an initial “extended” order. As previously covered, live medical testimony may be waived by the proposed patient under a “temporary” application, but not under “extended.” For programs that find it challenging to arrange for the psychiatrist to appear in court, a series of “temporary” hearings over the year with the proposed patient / AOT participant waiving cross-examination each time may be less of a logistical challenge than a single “extended” hearing with live medical testimony.

Renewal of AOT should never be considered automatic. It requires two fresh CME’s stating findings that the proposed patient continues to meet the statutory criteria. If your program is successful in building rapport and trust, you will find participants willing to stipulate to renewal applications in the great majority of cases. This should even include many of those who challenged their initial applications in court. For those who continue to invoke their right to challenge the application, it will once again be necessary to establish the case for AOT by clear and convincing evidence.

Endnotes

1 The legal mechanism that we call "AOT" throughout this guide (as it has come to be known in general practice across Texas) is referred to in the Texas civil commitment law as "*court-ordered outpatient mental health services.*"

2 The law is ambiguous as to whether availability of appropriate services must be proven by "clear and convincing evidence" like the rest of the criteria, or if the judge may apply the lower "preponderance of the evidence" standard (the default standard in civil cases) to this one criterion. On one hand, Tex. Health & Safety Code § 574.0345(c) sets this criterion apart from the rest in reserving it exclusively for the judge to consider in all cases, and by not applying the "clear and convincing evidence" standard to it as it does to the rest of the criteria. But Tex. Health & Safety Code § 574.031(g) makes no such exception in providing that in any hearing for civil commitment, "the state must prove each element of the applicable criteria by clear and convincing evidence."

3 Since the Recommendation for Treatment should later be incorporated into the court order under Tex. Health & Safety Code § 574.037(b), it should conform to the requirements of that section and be prepared in consultation with any current inpatient care providers as required by Tex. Health & Safety Code § 574.037(b-1). For more, see the section on "Care and Monitoring of Participant" below.

4 "Interested persons" who could request a hearing would presumably include the facility administrator, the LMHA, or any provider of services who would be expected to provide treatment under an AOT order.

5 Cross-references in §§ 574.037 and 574.061 make clear that these requirements apply equally to participants entering AOT by application and those entering by modification of inpatient orders. *See* §§ 574.037(b-2) and 574.061(f),(g).

PART II

PATHWAYS TO AOT FROM THE TEXAS CRIMINAL JUSTICE SYSTEM

In Texas, as in other states, "significant numbers of persons with serious mental illness or intellectual or developmental disabilities (IDD) cycle through our jails and prisons."[1] The Meadows Mental Health Policy Institute has summarized that "Texas jails and emergency rooms are filled with people who have lived with untreated mental illness for years, often cycling in and out of the justice system."[2] Indeed, persons with mental illness or IDD "are greatly overrepresented in the criminal justice system compared to their prevalence in the general population."[3] As the Texas Judicial Commission on Mental Health has noted, "[n]early 25[%] of the inmate population in Texas has a mental health need; adults with untreated mental health conditions are eight times more likely to be incarcerated than the general population."[4] Sadly, "the two largest mental health facilities in Texas are within the Harris County and Dallas County jails."[5]

According to SAMHSA, "[t]he justice system is generally ill-equipped to address the multiple needs of this population, and few specialized treatment programs exist in jails, prisons, or court and community corrections settings ...."[6] For many persons with mental illness, and particularly those who face minor or nonviolent charges, AOT offers an alternative. Indeed, "[s]ome jurisdictions have ... found AOT useful in transitioning individuals with mental illness from the criminal justice system to community-based treatment, to prevent both future hospitalization and [to reduce] criminal recidivism."[7] This part of the Texas AOT Practitioner Guide will describe opportunities under Texas law to make AOT a means of diverting individuals with severe mental illness out of the criminal justice system and into the community-based care and monitoring they truly need.

Pre-Arrest Diversion to AOT

For many non-violent criminal matters involving persons with mental illness, the most efficient and effective pathway to civil mental health proceedings and the potential for AOT arises before and instead of an arrest. "Law enforcement officers have the opportunity to provide the fastest intervention to begin deescalating a [mental health] crisis and obtain the necessary early information to evaluate, stabilize, and safeguard the individual."[8] Moreover, "officers trained in crisis intervention can provide an immediate response with support and access to emergency medical [and mental health] services ...."[9]

Law enforcement officers in Texas who encounter a person in a mental health crisis have significant discretion to utilize warrantless emergency detention as an alternative to arrest. Indeed, in 2017 the Texas Legislature enacted **Article 16.23 of the Texas Code of Criminal Procedure**, to encourage law enforcement agencies to engage in diversion efforts. Specifically, this statute provides that in the case of nonviolent criminal charges arising from a mental health crisis, "[e]ach law enforcement agency shall make a good faith effort to divert a person suffering a mental health crisis or suffering from the effects of substance abuse to a proper treatment center in the agency's jurisdiction …."[10]

The state's civil mental health laws provide a law enforcement officer with significant discretion to make a warrantless apprehension of a person with mental illness when the officer has reason to believe that because of the person's mental illness "there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained."[11] Moreover, and significantly, a "substantial risk of harm" for purposes of this subsection may be demonstrated either by the person's behavior or by "evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person cannot remain at liberty."[12] It is important to recognize that "[a]n emergency detention is not an arrest."[13] Instead, the statute authorizes the officer to transport the person to a mental health facility for an evaluation. "In other words, the officer has the discretion, even in the event of possible criminal activity, to divert the individual for a mental health evaluation and possible services, rather than making an arrest and transporting the individual to jail."[14] In turn, under Texas law, emergency detention is the legal process "by which a person experiencing a severe mental health crisis may be detained for a preliminary examination and crisis stabilization, if appropriate."[15] One potential pathway following an emergency detention is an AOT commitment proceeding.

As more and more law enforcement agencies in communities across the state deploy specially trained Crisis Intervention Team (CIT) officers or comparable mental health deputy units to respond to mental health crises, there will no doubt be greater opportunity for pre-arrest diversion as described above. These officers "have been trained to have special sensitivity to the needs and behaviors of people with mental illness, who make it their business to know those in the community who struggle and help them avoid criminalization."[16] CIT programs also improve safety in these crisis calls both for the responding officers and for the individual in crisis.[17]

Post-Arrest Diversion to AOT

Suppose, however, that at a crime scene involving a person exhibiting evident symptoms of a mental illness, the law enforcement officer does not exercise the officer's considerable discretion to divert the person to a mental health treatment center, but instead arrests the individual and transports the person to the local jail. Of course, this has been the usual approach both in Texas and across the country – even for situations involving relatively minor offenses, and it continues to be the typical path today in many jurisdictions. Nonetheless, there are an array of opportunities for diversion to mental health treatment and AOT post-arrest. The following subsections will describe various diversion options – both pre-booking and post-booking.

Pre-Booking Diversion

Even after arrest, it is also possible to divert persons with mental illness who have been arrested prior to and instead of booking them into jail. For example, Harris County has created a “diversion desk” at their joint processing center where staff from the Harris County Sheriff’s office and staff from the Harris Center (the local mental health authority) work together “to identify people who are appropriate for the Judge Ed Emmett Mental Health Diversion Center before they are booked into the Harris County Jail.”[18] (Their diversion program also allows law enforcement officers to take “persons with mental illness who have been picked up for low-level, non-violent offenses, such as trespass” directly to the Judge Ed Emmett Mental Health Diversion Center.)[19]

This type of diversion, similar to pre-arrest diversion, can serve to direct (or re-direct) non-violent offenders with mental illness into mental health services. If needed, an application for court-ordered mental health services, including outpatient services/AOT, could be pursued when appropriate.

Post-Booking—Mental Health Screening at the Jail

Following a person’s arrest and booking, Texas jails are required to promptly complete a screening form for suicide risks and medical or mental impairments by utilizing a state-mandated template.[20] Jail officials must also conduct a computer query upon intake as to whether the detained individual has previously received services from the state mental health system. In addition, **Article 16.22 of the Texas Code of Criminal Procedure** requires a sheriff or municipal jailer to provide notice to a magistrate within 12 hours of receiving credible information that may establish reasonable cause to believe that a defendant has a mental illness or IDD. Relevant information can include the defendant’s behavior immediately before, during, and after the defendant’s arrest or the results of any previous assessment.

Once the magistrate receives written or electronic notice of this information, the magistrate typically must order that the defendant be interviewed by an appropriate expert to collect information regarding whether the alleged offender has a mental illness or IDD and submit a written report back to the magistrate. This process is unnecessary, however, if the person has been similarly screened and determined to have a mental illness in the prior year or if the defendant is no longer in custody (e.g., released on bail or personal bond).[21] The required screening interview can be conducted by the appropriate expert at the jail, by phone, or via telemedicine.

The Article 16.22 screening is not a full mental health assessment, nor is it a competency examination. Instead, it should serve as an expedited screening for an arrested individual who is evidencing behavior or symptoms associated with mental illness and to recommend treatment.[22] The expert who is appointed to collect the information can be, for example, from the staff of the local mental health authority or from the provider that the jail contracts with to provide mental health services at the jail. The appointed expert’s written report is not detailed,

but is to include findings on three matters:

(1) whether the person has a mental illness (or IDD),
(2) whether the defendant might be incompetent to stand trial and should have a full competency examination, and
(3) any appropriate or recommended treatment or service.[23]

Once the magistrate receives the Article 16.22 report, the magistrate must provide copies to the trial court, counsel, sheriff, and offices that oversee supervised release or personal bond.[24] The statute then gives the trial court several options regarding possible next steps if the report reflects that the defendant has a mental illness. Several of these options create diversion opportunities. For example, the trial court can refer the defendant to a mental health court or another appropriate specialty court. Or, the court can resume criminal proceedings but consider ordering the defendant's release on personal bond (for nonviolent offenses), coupled with court-ordered treatment conditions. In addition, and importantly, as amended in 2019 the statute authorizes one pathway to outpatient civil commitment proceedings, including AOT, which will be discussed in the next subsection.

Referrals under Article 16.22 for AOT – Charges Remain Pending

If a defendant is charged with one of an array of nonviolent offenses, one of the trial court's options upon receiving an Article 16.22 report is to transfer the case to a court with probate jurisdiction for consideration of court-ordered outpatient mental health services, i.e., AOT.[25] Legislation enacted in 2019 added "a roadmap in the Code of Criminal Procedure for prosecutors and trial court judges, once an Article 16.22 report is received, to release the defendant with MI or IDD on bail and transfer the defendant by court order to the appropriate court for court-ordered outpatient mental health services under Chapter 574 of the Health & Safety Code."[26]

Specifically, the court may transfer the case to a civil court with probate jurisdiction for consideration of AOT under subsection (c)(5) "if the offense charged does not involve an act, attempt, or threat of serious bodily injury to another person."[27] The legislature's clear goal was to encourage diversion of persons with mental illness to AOT in cases limited to nonviolent charges.

Interestingly, this authority already existed in the Texas Health and Safety Code prior to the 2019 amendments to the Code of Criminal Procedure. In 1995, the legislature amended the state's civil commitment laws to permit the consideration of civil commitment in criminal matters for a person charged with a criminal offense provided that the charges do not involve an act, attempt, or threat of serious bodily injury to another person. (Under the law prior to 1995, civil commitment was not an option if any charges were pending.)

Unfortunately, however, even though diversion for possible civil commitment – either inpatient or outpatient – has been authorized for persons with mental illness charged with non-violent

offenses for many years, because the authority is located in the Health & Safety Code, and not in the state's criminal statutes, most criminal court judges and prosecutors were unfamiliar with the diversion opportunity. Accordingly, to flag the diversion option for criminal trial courts, the legislature added subsection (c)(5) to Article 16.22 in 2019 to trigger diversion to civil outpatient proceedings. This legislative change should be a catalyst for diverting more offenders with mental illness out of jail and into outpatient civil commitment proceedings, including AOT.

In addition, it is important to note that the AOT diversion opportunity set forth in Article 16.22(c)(5) does not focus on whether the pending charges are for misdemeanors or certain felonies. Instead, the scope for possible diversion extends to cases in which the charges do not involve an act, attempt, or threat of serious bodily injury to another person. This language is more expansive than, for example, focusing solely on nonviolent misdemeanors.

The 2019 legislation also added subsections (c-1), (c-2), and (c-3) to Article 16.22. These subsections prescribe procedural steps if the trial court exercises its discretion to order the defendant's transfer to a court with jurisdiction to consider court-ordered outpatient mental health services, including AOT. Under an Article 16.22(c)(5) referral for consideration of AOT, the criminal charges remain pending. However, under subsection (c-2), should the defendant comply with the AOT treatment order successfully, "the court may dismiss the charges."[28] In the case of noncompliance, however, the state and the trial court may resume the criminal proceedings.[29]

Courts, prosecutors, and defense counsel should take note of the AOT diversion opportunity now specified in Article 16.22(c)(5). For persons with mental illness charged with nonviolent offenses, a diversion to AOT will frequently be a far more appropriate response than criminal prosecution. All too often, the courts move directly to competency proceedings rather than considering alternatives. However, competency restoration is not, per se, mental health treatment. In addition, there is a significant waitlist for forensic inpatient competency restoration services.[30] For persons with mental illness who face only misdemeanors or other nonviolent charges that do not involve an act, attempt, or threat of serious bodily injury, serious consideration should be given to a referral under Article 16.22(c)(5), rather than initiating a competency proceeding per subsection (c)(2).[31]

Article 16.22(c)(5) Diversion for AOT – Two Courts

In many Texas counties, the court presiding over the criminal docket will be different from the court that has probate jurisdiction to oversee civil commitments. Article 16.22(c)(5) does not include many details or specifics regarding diverting a defendant to the probate court to consider an outpatient commitment order. The provision simply states, "if the offense charged does not involve an act, attempt, or threat of serious bodily injury to another person, [the criminal trial court may] release the defendant on bail while charges against the defendant remain pending and enter an order transferring the defendant to the appropriate court for court-ordered outpatient mental health services under Chapter 574, Health and Safety Code."[32] Other details set forth in the outpatient civil commitment statutes such as who completes the

application for court-ordered outpatient mental health services, the need to obtain physician's certificates of mental illness, appointment of an attorney if different from the criminal defense attorney, etc., are missing.[33] Additionally, although the statute permits the criminal trial court to release the defendant on bail pending the outpatient civil commitment proceedings, arguably this does not exclude the possibility of release on personal bond if otherwise permitted.

The statute also does not include any discussion of possible renewals of an AOT order. As discussed extensively in Part I of this guide, an initial order for "temporary" AOT can be for up to 90 days, so long as the judge deems that length of time "necessary" (as should typically be the case.)[34] If at the end of the initial AOT period there is a clinical finding that AOT should be continued, nothing in the Texas code suggests that a case arising from a criminal court referral should be handled differently than any other AOT case. Pursuant to ordinary AOT procedure, a new application may be filed for an additional period of either "temporary" or "extended" AOT, as circumstances warrant. In light of Article 16.22(c)(5)'s broad referral "to the appropriate court for court-ordered outpatient mental health services under Chapter 574, Health and Safety Code," it seems clear that a decision to renew the AOT order is entirely within the purview of the probate court, rather than the criminal court from which the referral came.

Accordingly, for these diversions to proceed successfully there must be broad cooperation between the two courts, the court administrators for the respective courts, the prosecuting attorney's office, and the attorney for the state who oversees civil commitments. Depending on the county, this could involve attorneys from different offices (e.g., the district attorney and the county attorney) or different attorneys from the same office who have differing responsibilities. For example, in many counties although the district attorney's office prosecutes criminal matters, a separate county attorney's office represents the state in mental health commitments.

In contrast, some other counties' district attorney's offices handle both functions for the state (although often through different assigned lawyers). To ensure success, it would be appropriate for the two courts to develop a memorandum of understanding to describe the process and respective responsibilities regarding the diversions from the criminal court to AOT. (If multiple courts with criminal jurisdiction in the county will be ordering diversions under Article 16.22(c)(5) to a court with probate jurisdiction over AOT, the memorandum of understanding should of course include all participating courts.)

As described in more detail in a separate section below, there should also be broad engagement and coordination between the courts (including court staff), the local mental health authority, other community service providers, probation/community supervision staff, the sheriff's office, the police department, district and county attorney offices, and the local defense bar. In addition to having a monitor or monitoring team responsible for oversight of those persons subject to AOT orders, there should also be a person (or persons) designated to serve as a coordinator of the various pathways from criminal justice to AOT.

In executing an Article 16.22 AOT diversion from criminal court to probate court, complications could arise if there is incongruity between the two courts' expectations as to when and how

the criminal court will have the opportunity to revisit the pending criminal charge. As noted above, the statute empowers the court to either dismiss the charge under 16.22(c-2) or resume prosecution under 16.22(c-3), depending upon whether the court determines that the defendant has "complied" or "failed to comply" with AOT. The statute does not specifically say that this decision point is reached upon the defendant's completion of an initial period of "temporary" AOT, nor that the defendant will "graduate" from AOT at such point, but a criminal court might naturally have these expectations when making the AOT referral. This gives rise to two potential concerns.

The first concern is that AOT is designed to be renewable, based solely upon the AOT participant's ongoing clinical needs, without regard to the interest of a prosecutor or criminal judge in reaching a decision point on a pending criminal charge. In a county where an AOT program follows best practices, it is highly likely that AOT will continue well beyond the initial 90-day "temporary" order. A court attempting to determine whether a defendant has succeeded or failed in AOT at that point is likely to encounter a defendant who is still at an early stage of participation in the program.

However, even if the court only seeks to determine the success or failure of the defendant's first 90 days of AOT, a binary choice between "complied" or "failed to comply" is a dubious approach to the task. AOT is not magic. It requires patience and a recognition that stumbles and setbacks are frequently par for the course. Ninety days of real progress could easily be subverted by a court focused squarely on whether the defendant has strictly complied with the terms of the AOT court order.

In light of these concerns, it is essential that in planning a coordinated effort to divert criminal cases into AOT, the two courts agree upfront on a general policy for the resolution of pending criminal charges. Whatever the terms of that agreement, it must recognize the need to continue AOT for as long as the participant continues to meet the legal criteria, and must avoid assessing an individual's success in AOT by a rigid standard of "compliance."

Article 16.22(c)(5) Diversion for AOT – One Court

Notwithstanding the foregoing, in some situations it is possible for the same judge who is presiding over the criminal case to also oversee AOT proceedings. For example, suppose that a person with mental illness is facing nonviolent misdemeanor charges and the case is on a county court at law's docket in a county that does not have a statutory probate court. That court would have both criminal jurisdiction over the misdemeanor case and could exercise probate jurisdiction over an outpatient civil commitment proceeding.[35] The Health & Safety Code provides that proceedings in civil commitment matters must be held in a court that has the jurisdiction of a probate court in matters pertaining to mental illness.[36]

Thus, unless the county has a statutory probate court, a county court at law can oversee both a criminal docket and a probate docket (in addition to civil and family law dockets). Accordingly, upon receipt of an Article 16.22 report, a judge who is presiding over a nonviolent criminal case

brought against an alleged offender with mental illness could enter an order under subsection (c)(5) to divert the defendant to that same court's probate docket for consideration of AOT under the Health & Safety Code. That is, the court with the criminal docket would also be an "appropriate court for court-ordered outpatient mental health services" under Article 16.22(c)(5). In such a case, there would be no need to transfer the matter to a second court.

This structure provides great opportunities for efficiency and judicial oversight in undertaking diversion efforts. To ensure success, in addition to the various participants and stakeholders necessary for a successful AOT program, the judge will also want to encourage cooperation and coordination between the prosecuting attorney's office and the attorney for the state who oversees civil commitments. As described above for diversions involving two different courts, in many counties although the district attorney's office prosecutes criminal matters, a separate county attorney's office represents the state in mental health commitments (and there are other variations in which different attorneys handle prosecutions versus those who handle the civil commitment docket).

Dismissal of Criminal Charges and Diversion for AOT

An alternative option is for the state to dismiss the criminal charges against the defendant and divert the individual to the appropriate court for AOT proceedings. This diversion pathway "would dramatically improve treatment" and reduce recidivism.[37] For example, **Article 46B.004(e) of the Texas Code of Criminal Procedure** allows the court at any point after evidence of incompetency is first raised to dismiss the charges upon the prosecutor's motion. If the court is "of the view that evidence supports a finding of incompetency, the court may (and should) proceed under … Article 46B.151, [which] permits the court to enter an order transferring the defendant to the appropriate court for civil commitment proceedings."[38] Particularly for nonviolent misdemeanors or even certain nonviolent felony charges, the state and the court should strongly consider diverting the defendant. As the Texas Judicial Mental Health Commission has observed, "For individuals charged with any level of misdemeanor, diversion to treatment and services is the best practice."[39] The Commission has added that rather than proceed with costly and time-consuming competency proceedings, "dismissal may be more appropriate" and that the "competency system is not the ideal pathway into behavioral health treatment …."[40]

Similarly, the Hogg Foundation for Mental Health has urged that the state should endeavor to "[d]ivert people with mental illness who commit low-level offenses away from correctional facilities and into community-based treatment settings … [and] improve the state courts' use of civil commitment as a diversionary tool …."[41] For defendants who are deemed to be of low criminogenic risk, are charged with low-severity crimes, and for whom there was a significant contribution from the person's mental illness or a co-occurring substance abuse issue, a pathway from criminal justice to AOT is appropriate.

A dismissal under Article 46B.151 generally requires the criminal court to transfer its responsibilities regarding the defendant to the constitutional county court or other court with

probate jurisdiction for the county. This transfer to a second court would not be necessary, however, if the court presiding over the criminal case also has probate jurisdiction for that county. Further discussion of situations involving two courts versus a single court is included below this section.

A transfer order under Article 46B.151(b) must also state that all criminal charges against the defendant have been dismissed. Following the transfer, the court with probate jurisdiction may proceed with civil commitment proceedings, including outpatient commitment proceedings, under the Health & Safety Code, "just as in any other *civil* case involving the possible imposition of court-ordered mental health services."[42]

In the case of such a diversion, however, there are a few variations from a typical civil commitment worthy of note. First, **Tex. Health & Safety Code § 574.001(e)** provides that an "order transferring a criminal defendant against whom all charges have been dismissed to the appropriate court for a hearing on court-ordered mental health services … serves as an application" for such services under the Health & Safety Code. Thus, no new or separate application is needed.

In addition, if the criminal court orders a defendant's transfer to the court with probate jurisdiction for civil commitment proceedings, Article 46B.151(b) allows the court to order that the defendant be detained in jail or another "suitable place" pending the prompt conducting of the civil commitment proceedings. Because no criminal charges will remain pending in one of these diversions, "the court should endeavor to exercise its considerable discretion to order that the person be detained in a more suitable place, such as a mental health facility designated by the local mental health authority [if available]."[43] Moreover, it should be noted that once the court that oversees civil mental health commitments has jurisdiction, further use of the jail as a holding facility is significantly limited.[44] Thus, "once the criminal court's jurisdiction ends and the civil probate court's jurisdiction begins, the use of the jail should be severely restricted to no more than 2-3 business days …."[45] Accordingly, to move successfully and promptly from dismissal of the criminal case to an AOT proceeding will require coordination and cooperation between the courts and other key stakeholders, as described further below.

Dismissal of Charges and Diversion for AOT – Two Courts

In many Texas counties a dismissal of misdemeanor charges, or even nonviolent felony charges, with a follow-up diversion to AOT proceedings would likely involve two courts. By way of example, the criminal matter might be before a court at law or district court, but the county's probate docket is primarily handled by the constitutional county judge or a statutory probate court. As with the two-court scenario described above for Article 16.22(c)(5) diversions, coordination and cooperation are important. Because the state will have elected to dismiss the criminal charges, however, the person's case will no longer be on the criminal court's docket. Nonetheless, if an office different from the criminal prosecutor's office will represent the state in the outpatient civil commitment proceedings (e.g., a county attorney's office instead of a district attorney's office), coordination for a smooth transition is a key for a timely AOT proceeding. (The same is true if different lawyers from the same office are responsible for the different

state functions in such matters.) In addition, it will be important to recognize and facilitate the likely transition from a public defender or defense attorney in the criminal case to an attorney appointed by the court under the Health & Safety Code to represent the individual in the AOT proceedings (unless the same attorney continues to represent the person).

A planned and coordinated effort will ensure a smooth handoff to the court that will conduct AOT proceedings. It would be unfortunate for the criminal case to be dismissed, but then for a delay to occur prior to the commencement of the civil proceedings. That would present a risk that the individual's mental condition could deteriorate further in the interim.

As with Article 16.22(c)(5) diversions, it would be appropriate for the two courts to develop a memorandum of understanding to describe the process and respective responsibilities regarding the diversions from the criminal court to AOT. Key participants should include not just the judges and court coordinators, but also the local mental health authority, other community service providers, probation/community supervision staff, the sheriff's office, the police department, district and county attorney offices, and the local defense bar. In addition, identifying a coordinator overseeing diversion efforts will be of great value to the process. As described above, that coordinator can assist the court and attorneys in evaluating cases and defendants for possible diversion, monitor the status of persons who have been referred to AOT, and facilitate communications between the various stakeholders.

Dismissal of Charges and Diversion for AOT – One Court

As is the case for diversions under Article 16.22(c)(5) when charges remain pending (as discussed above), in some situations it is possible for the same judge who initially presided over the criminal case to oversee AOT proceedings after dismissal of the criminal charges. This can occur in counties in which a court with criminal jurisdiction also has probate jurisdiction. This model has the potential to permit greater efficiency and judicial involvement in diversion efforts. Of course, after dismissal of the criminal charges, the case will no longer be on the court's criminal docket, but the court could consider the possibility of AOT under the court's probate jurisdiction by adhering to the requirements of Chapter 574 of the Health & Safety Code.

Again, although the criminal prosecutor will no longer be involved after dismissing the criminal charges, coordination and cooperation between the district attorney and county attorney are important to ensure a smooth handoff for this pathway to diversion. (In many counties, these functions will be overseen by different offices or different attorneys representing the state, although in some counties a prosecuting attorney might also handle the mental health docket for the county.) As with the two-court scenario, coordination will also be necessary for transition from a public defender or defense attorney to the attorney appointed by the court under the Health and Safety Code to represent the former defendant in the AOT proceedings (unless the same attorney continues to represent the person).

Possible Diversion to AOT for a Defendant Who is Subject to an Order for Competency Restoration Services but Who Remains in Jail Awaiting a Placement

Suppose that diversion to AOT was not previously considered or was not pursued for a jailed defendant with mental illness who appears to be incompetent to stand trial. Suppose also that after following the process prescribed in Chapter 46B, the court then adjudicates the defendant as being incompetent to stand trial and orders that the defendant receive inpatient competency restoration services.[46] In all likelihood, the defendant will remain in jail for a substantial period before being transferred to a state mental health facility. Indeed, as of mid-2021, there were over 900 people on the state's non-maximum security forensic state hospital bed waiting list, with an average waiting time of just under six months.[47] Accordingly, a person with mental illness who has been adjudicated incompetent to stand trial due to mental illness will remain in the jail and might receive only scant mental health services for an extended period.[48]

As with the diversion pathways from criminal justice described above, and particularly in the case of misdemeanors and other non-violent offenses, there should be consideration of possible dismissal of the charges and diversion to AOT at this point in the process. **Article 46B.004(e) of the Texas Code of Criminal Procedure** authorizes the criminal court to dismiss the charges at any point during Chapter 46B competency proceedings upon the prosecutor's motion, and to "transfer the defendant to the appropriate court for civil commitment proceedings."[49] Also, keep in mind that if the charges are only misdemeanors, there is a great potential for the person's case to "time out" prior to the transfer to a state hospital or shortly after arrival at the state hospital.[50] For example, the maximum period of confinement for a Class B misdemeanor is 180 days, which closely approximates the average waiting list time for an inpatient state hospital placement for a non-maximum security bed.[51]

Accordingly, counties should develop a mechanism to screen defendants who remain in jail awaiting a competency restoration treatment bed who would likely meet AOT commitment criteria. For those defendants who are determined to be appropriate candidates, the prosecutor should then consider moving for dismissal of the criminal case and seek an order to have the case transferred to the appropriate court with probate jurisdiction to consider AOT.

Possible Diversion to AOT if a Defendant is Determined Unlikely to be Restored in the Foreseeable Future or When Charges Remain Pending Following Completion of the Maximum Competency Restoration Period

If a defendant with mental illness is determined to be incompetent to stand trial and not likely to be restored to competency in the foreseeable future, the court has no authority to order competency restoration services.[52] Instead, commitment proceedings under Subchapter E or F of Article 46B must be considered. The same is the case for a defendant who was deemed restorable but who has nonetheless not attained competency following the maximum period for competency restoration services and one 60-day extension.[53] If charges remain pending in either scenario, the criminal court must conduct a civil commitment hearing under Article

46B.102. Importantly, the court has discretion to consider outpatient commitment proceedings for persons who face only non-violent charges.[54] Accordingly, defendants should be screened as to whether they would meet AOT commitment criteria and whether they would be good candidates for AOT, even if charges remain pending.

Alternatively, the state may elect to dismiss charges in these scenarios. Per Article 46B.151(b), upon the state's motion, the criminal court judge must then dismiss the criminal case and transfer the matter to the appropriate court for civil commitment proceedings (assuming that the criminal court does not also have probate jurisdiction). Once again, defendants should be screened for possible AOT proceedings and placement. Because the defendants in these situations have either been deemed unlikely to be restored to competency in the foreseeable future or have not been restored following the maximum allowable period for competency restoration services, it is quite likely that the criminal case might never proceed. Accordingly, it would be worthwhile to consider a dismissal of the charges and diversion to AOT in appropriate cases.

Possible Dismissal of Charges and Diversion to AOT for a Defendant Who is Receiving Outpatient or Jail-Based Competency Restoration Services

Suppose that a defendant has been ordered to receive and then placed in an outpatient competency restoration (OCR) or jail-based competency restoration (JBCR) program. Some individuals with charges pending who are receiving OCR or JBCR services may nonetheless be—or after a period of receiving such services become—appropriate candidates for a dismissal of charges and referral to AOT. As noted above, under **Article 46B.004(e) of the Texas Code of Criminal Procedure**, the criminal court may *at any point* during competency proceedings under Chapter 46B dismiss the charges upon the prosecutor's motion and, per Article 46B.151(b), "transfer the defendant to the appropriate court for civil commitment proceedings." Bexar County has developed a roadmap for possible diversion to AOT in this context.

The goals and objectives of OCR or JBCR and AOT differ. Nonetheless, particularly in the case of misdemeanor and other nonviolent charges, persons who are receiving OCR or JBCR services in the community might benefit from and be appropriate for consideration for diversion to AOT. By way of example, consider a situation involving a defendant with mental illness who faces only nonviolent misdemeanors. Even if the defendant has been determined to be incompetent to stand trial and is ordered to OCR, the competency restoration commitment period is limited to 60 days, with one possible 60-day extension.[55] For Class A misdemeanors, the initial period is up to 120 days for OCR, with one possible 60-day extension.[56] After those maximum periods are reached, if the defendant remains incompetent to stand trial and charges remain pending, the court would need to proceed to Article 46B.102 and consider civil commitment proceedings.[57] A defendant who has just been in an OCR program would likely be a good candidate for consideration of AOT. Utilizing AOT at this point could lead to better treatment outcomes and reduce the risk of recidivism. Alternatively, the defendant might be responding reasonably well to the competency restoration services, but still benefit from consideration of AOT should the

state opt to dismiss the charges rather than continue with the criminal prosecution. OCR or JBCR providers should review and identify appropriate candidates.

Coordination Between and Among Key Stakeholders

A key to successfully traveling the various pathways from criminal justice to AOT is regular engagement and coordination between the various courts involved (including court staff), the LMHA, other community service providers, probation/community supervision staff, the sheriff's office, the police department, district and county attorney offices, and the local defense bar. Texas judges hold significant sway to serve as conveners for meetings of these groups. The group should develop a plan for evaluating cases and defendants to determine when referral to AOT diversion is appropriate. It will also likely be necessary to identify a coordinator to oversee collaboration among the stakeholders, assist the court and attorneys in evaluating cases and defendants for possible diversion, and -- when criminal charges remain pending -- work with the AOT program monitor to keep the criminal court apprised of the status of AOT participants.

Endnotes

1 Brian D. Shannon, *Texas Mental Health Legislative Reform: Significant Achievements with More to Come*, 53 Tex. Tech L. Rev. 99, 100 (2020).

2 Meadows Mental Health Pol'y Inst., Smart Justice, https://www.texasstateofmind.org/focus/smart-justice/ (last visited June 29, 2021).

3 Texas Jud. Comm'n on Mental Health, Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book 3 (3d ed. 2021-22) [hereinafter Bench Book], http://texasjcmh.gov/media/2087/jcmh-adult-bench-book-3rd-ed-final-print.pdf .

4 Id.

5 Brian D. Shannon, *supra* n. 6, at 100. Editorial, The Largest Mental-Health Facility in Texas Shouldn't be a Jail, Dallas Morning News (Feb. 17, 2019), https://www.dallasnews.com/opinion/editorials/2019/02/17/largest-mental-health-facility-texas-shouldnt-jail. For an extended discussion of the large prevalence of persons with mental illness in the criminal justice system in Texas and a summary of some of the reasons why, see Brian D. Shannon & Daniel H. Benson, Texas Criminal Procedure and the Offender with Mental Illness: An Analysis and Guide 7–11 (NAMI-Texas 6th ed. 2019) [hereinafter Shannon Guide], https://3394qh4fg22b3jpwm94480xg-wpengine.netdna-ssl.com/wp-content/uploads/sites/12/2019/10/Shannon-6th-Edition-Oct-2019-for-NAMI-Texas-website.pdf (last visited June 29, 2021).

6 U.S. Dep't of Health & Human Serv., Subst. Abuse & Mental Health Serv. Admin., Screening and Assessment of Co-Occurring Disorders in the Justice System, at 1 (June 2019 ed.), https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf (last visited June 29, 2021).

7 American Psychiatric Assoc., Treatment Advocacy Center & Northeast Ohio Medical University, *Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results*, at 8 (Oct. 2019) [hereinafter AOT *Building Blocks*], https://smiadviser.org/wp-content/uploads/2019/10/White-Paper-FINAL-1.pdf (last visited June 29, 2021), citing Meldrum, M., Kelly, E., Calderon, R., Brekke, J., & Braslow, J., *Psychiatric Services, Implementation Status of Assisted Outpatient Treatment Programs: A National Survey* 630-35 (2016).

8 Bench Book, *supra* note 8, at 82.

9 *Id*.

10 Tex. Code Crim. Proc. Art. 16.23.

11 Tex. Health & Safety Code § 573.001(a)(1)(B).

12 *Id*. § 573.001(b).

13 Bench Book, *supra note* 8, at 80.

14 Shannon Guide, *supra* note 10, at 23. The Houston Police Department has developed a very helpful guide which recognizes that law enforcement personnel typically are the first responders to a person in a mental health crisis. *See Responding to the Mentally Ill: A Guide for Texas Peace Officers* (May 2018), *available at* http://www.houstoncit.org/wp-content/uploads/2018/06/Texas-Peace-Officer-Guide-for-Responding-to-the-Mentally-Ill-May-2018.pdf.

15 Bench Book, *supra* note 8, at 80. The statutory provisions relating to emergency detention are set forth in Chapter 573, Texas Health & Safety Code.

16 AOT *Building Blocks, supra* note 12, at 26.

17 *CIT is More than Just Training ... it's a community program*, http://www.citinternational.org/Learn-About-CIT.

18 Harris Center for Mental Health and IDD, *Harris County Mental Health Jail Diversion Program,* at 2, https://www.theharriscenter.org/Portals/0/Service%20Page%20Docs/Jail%20Diversion/Jail_Diverson_Brochure.pdf.

19 *Id*. Bexar County has also successfully operated a mental health diversion center for many years.

20 *See* http://mmhpi.org/wp-content/uploads/2018/07/New-Jail-Intake-Screening-Form.pdf.

21 The latter exception to screening for defendants no longer in custody was added by Tex. S.B. 49, 87th Leg., Reg. Sess., § 1 (2021), https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB00049F.pdf#navpanes=0, with an effective date of September 1, 2021.

22 For a more detailed discussion of the Article 16.22 requirements and process, see Bench Book, *supra* note 8, at 89-115 and Shannon Guide, *supra* note 10, at 25-34.

23 The Legislature has required that these reports be submitted on a standardized, one-page form. *See* https://www.tdcj.texas.gov/documents/rid/SB_1326.pdf.

24 This list of recipients was expanded in 2021 legislation. *See* Tex. S.B. 49, *supra* note 26, at § 2 (effective September 1, 2021).

25 Tex. Code Crim. Proc. Art. 16.22(c)(5).

26 Tex. Jud. Comm'n on Mental Health, 86th *Texas Legislative Update Spotlight*: SB 362, at 1, http://texasjcmh.gov/media/1647/legislative-summary-_sb-362.pdf (last visited July 1, 2021).

27 Tex. Code Crim. Proc. Art. 16.22(c)(5).

28 Tex. Code Crim. Proc. Art. 16.22(c-2).

29 Tex. Code Crim. Proc. Art. 16.22(c-3).

30 For example, according to information provided by the Forensic Director for the Texas Health and Human Services Commission, at the end of the third quarter of FY 2021, there were 1475 persons on the state waiting lists for inpatient competency restoration services (for both maximum security and non-maximum security beds), including 216 individuals who had only misdemeanor charges pending.

31 In October 2021 the Texas Judicial Commission on Mental Health and the Texas Health and Human Services Commission jointly released a helpful "Toolkit" focused on various alternatives for reducing wait times for competency restoration services. The materials include checklists for prosecutors, defense attorneys, judges, and others that flag diversion alternatives including Article 16.22(c)(5) diversions to AOT. Tex. Judicial Comm'n on Mental Health & Tex. Health & Human Serv. Comm'n, *Eliminate the Wait: The Texas Toolkit for Rightsizing Competency* (2021), https://iemvirtual.com/wp-content/uploads/Eliminate-the-Wait-Toolkit-10.11.21-FINAL.pdf (last visited Oct. 23, 2021).

32 Tex. Code Crim. Proc. Art. 16.22(c)(5).

33 *See*, e.g., Tex. Health & Safety Code §§ 574.001, 574.011, 574.024.

34 Tex. Health & Safety Code §§ 574.0345(c).

35 *See* Tex. Gov't Code Ann. § 25.0003(d)-(f) (providing that except in a county with a statutory probate court, a statutory county court (i.e., a county court at law) has concurrent probate jurisdiction with the constitutional county court).

36 Tex. Health & Safety Code Ann. § 574.008(a).

37 Steven K. Hoge & Richard J. Bonnie, A New Commitment Pathway for Offenders With Serious Mental Illness: Expedited Diversion to Court-Ordered Treatment, Psychiatry Online (Dec. 18, 2020), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000436 (last visited July 6, 2021).

38 Shannon Guide, *supra* note 10, at 51.

39 Bench Book, *supra* note 8, at 140.

40 *Id*. at 141.

41 Hogg Foundation for Mental Health, Texas Dep't of Criminal Justice: Policy Concerns, https://hogg.utexas.edu/texas-department-of-criminal-justice (last visited July 6, 2021).

42 Shannon Guide, *supra* note 10, at 124-25 (emphasis in original).

43 *Id*. at 126.

44 *See* Tex. Health & Safety Code § 574.027(c); Tex. Local Gov't Code § 351.014.

45 Shannon Guide, *supra* note 10, at 126.

46 Some counties also have access to outpatient and jail-based competency restoration programs, but the number of these programs, as well as the program capacity, remains relatively small.

47 According to information provided by the Forensic Director for the Texas Health and Human Services Commission, at the end of the third quarter of FY 2021 (May 31, 2021), there were 924 people on the non-

maximum security forensic state hospital bed waiting list, with an average of 177 days on the waiting list. (In addition, the waiting list for a maximum security bed as of that date included over 500 people with an average waiting time of a year.)

48 In such cases, court-ordered medication proceedings can be considered while the person remains in jail awaiting a placement under the authority of Tex. Health & Safety Code § 574.106 and Tex. Code Crim. Proc. Art. 46B.086.

49 Tex. Code Crim. Proc. Art. 46B.151(b).

50 Tex. Code Crim. Proc. Arts. 46B.009, 46B.0095, 46B.010.

51 For discussion of an illustration of the timing out principle, see Floyd L. Jennings, *Procedural Choke Points in 46B Competency Proceedings*, Voice for the Defense 25, 29 (March 2016).

52 Tex. Code Crim. Proc. Art. 46B.071(b).

53 Tex. Code Crim. Proc. Arts. 46B.084(e)-(f); 46B.085. This also assumes that the defendant has not otherwise "timed out."

54 Tex. Code Crim. Proc. Arts. 46B.106(a)(2); *see also* 46B.104(1)-(2) (cross-referencing other statutes that list violent offenses that would be disqualifying for an outpatient commitment placement).

55 Tex. Code Crim. Proc. Arts. 46B.0711, 46B.079.

56 *Id*. at Arts. 46B.072, 46B.079.

57 *See* Shannon Guide, *supra* note 510, at 57-59 (discussing maximum period and mandatory dismissals).

PART III

ENHANCING AOT THROUGH FAMILY ENGAGEMENT

While there are exceptions to every rule, for most AOT participants the likelihood of success in the program will be enhanced by involving family members to the greatest extent possible.

> "Incorporating the family in a culturally appropriate fashion … improves access to treatment, client participation in care, integration of care, and ultimately, clinical outcomes for populations with serious mental illness (SMI) …."
>
> — Sergio Aguilar-Gaxiola, Professor of Clinical Internal Medicine, University of California, *in testimony before the federal government's Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).*

Family Inclusion in AOT Program Planning, Evaluation, and Improvement

Every AOT program should include at least one family representative in their regular stakeholder meetings to provide input on decisions regarding program planning, evaluation, and improvement. (See "Building Block 6" at page 17 of the AOT Implementation White Paper.) This could be an official representative of the local NAMI Affiliate, and/or a family member of a current or former AOT participant. Family members view the program from a unique perspective and their contribution is often invaluable. Additionally, their presence serves as a constant reminder to the other stakeholders of the important role that AOT plays or can potentially play in the lives of the family and community and sends a strong message that family voice is valued.

Importance of Family Participation in AOT Court Proceedings and Treatment

From the very beginning, family members should be acknowledged as partners on the treatment team and recognized for the valuable role they play in helping their loved one get and stay well. For example, family members should be encouraged to attend the first court hearing to hear the judge explain the program and the roles and responsibilities of the participant. This can be an anxious and confusing time for someone exiting a hospital, jail, or difficult situation in the community. They may not fully grasp or even remember all the court's instructions. Having a loved one there to provide clarification afterwards can be very helpful.

It is equally important for a family member to be consulted in the development of the person-centered treatment plan, as they will often have valuable information about previous experiences with medications and treatment.

Courts should consider allowing family members to speak during status check-ins and continuation hearings. This enables the judge to hear from someone with firsthand knowledge about how the participant is progressing. It is important that the treatment team share communications from the family member with the judge before court so that the judge can congratulate the participant on their achievements or reinforce the need for them adhere to their treatment plan.

Consent for Family Involvement

It should be standard practice in AOT to ask the participant to identify the most important person in their daily life, encourage them to sign a release so you can share information with that person, and then engage that person throughout the AOT period. If at first a participant chooses not to include a family member, consider gently offering them opportunities to change their mind as their mental health improves.

Even if an AOT participant chooses not to sign a release of information, a family member can still play a pivotal role in their loved one's recovery. Since they are often the first to notice when an AOT participant is starting to decompensate, they need to know that the AOT program welcomes them to report any concerns that may arise. Likewise, family members should be equally encouraged to notify the treatment team when they see their loved one making improvement. The absence of a release is never a barrier to the program *receiving* information from family members. However, any interactions in the absence of a release must be handled with great care to avoid divulging unauthorized PHI.

AOT programs must also recognize the limits of HIPAA's general rule against sharing of PHI without a patient's permission. In Part I of this Guide we discussed one important exception to the HIPAA Privacy Rule, for disclosures of PHI authorized by a court order. There are other exceptions under the federal law, and another is especially relevant to the matter of family engagement in AOT. Specifically, if at any time a health care provider has reason to believe that their patient cannot be reached or presently lacks the capacity to make rational decisions about their treatment, *"a health care provider may share the patient's information with family, friends, or others as long as the health care provider determines, based on professional judgment, that it is in the best interest of the patient."* (See U.S Dept. of Health and Human Services, Office of Civil Rights' HIPAA Privacy Rule fact sheet for providers.) While this exception will not generally apply in day-to-day AOT practice, it certainly may in a situation where the participant appears to be in a psychiatric crisis and either cannot be located and/or appears to have lost capacity to make treatment decisions.

Family Education

Once permission to engage with the family has been granted, the next steps are educating the family member about the purpose of the program and establishing a trusting relationship. There are many positives associated with having family members and the AOT program "on the same page." Most importantly, it empowers the family to reinforce the program's messaging with the participant at home, and to communicate concerns about the participant's behavior that could lead to earlier detection of treatment nonadherence. It can also reduce the potential for a well-meaning family member to interfere unintentionally with the goals and objectives of the program.

Just as we recommend providing AOT participants with written materials upon entrance into AOT that clearly spells out their rights and responsibilities while in the program (see "Building Block 7" at page 17 of the AOT Implementation White Paper), we strongly suggest a similar guide for family members. An example on the Treatment Advocacy Center's website may be customized for your program with local family member input. At a minimum, the guide should include a brief explanation of the program, the rights and expectations of family members of program participants, key contacts, and a listing of relevant community resources. The guide should be offered in all languages commonly spoken in your community.

Basic AOT program information should also be provided on the Internet. Family members with loved ones "caught in the revolving door" often search the web for answers. A simple web page explaining how the program operates, who it serves, how an individual is referred, and who to contact for additional information will help your program find the people it is meant to serve.

It is important that families learn to have realistic expectations about AOT. They should be encouraged to understand the program as a tool in the toolbox of courts and mental health systems, working together, to serve a small number of people who struggle to maintain engagement with treatment for severe mental illness. But also, that not everyone who has this struggle is necessarily a good AOT candidate. Other factors must be considered in assessing fitness for the program. (For instance, intellectual disability or severe addiction may interfere with AOT's power to motivate an individual.). Additionally, families must be helped to recognize that while, on the whole, AOT significantly reduces hospitalizations and arrests, not every participant experiences the same level of success. A frustrating or heartbreaking outcome in an individual case should not necessarily be attributed to the AOT team's job performance.

Support for Families

In addition to including family representatives in the stakeholder meetings, there are other opportunities to engage them for the betterment of the overall program. For instance, programs should consider connecting seasoned AOT family members with those coming into the program for the first time. This is an excellent way to support to family members who are likely

exhausted from living in constant crisis mode, fortifying them to prop up their loved one. With AOT participants and their families coming from a variety of cultural and ethnic backgrounds -- with a potential for vastly different understandings and levels of acceptance of mental illness -- it is essential to develop a diverse pool of family supports. Your local NAMI affiliate may be able to assist with these connections.

NAMI Texas

The National Alliance on Mental Illness of Texas (NAMI Texas) is a 501(c)(3) nonprofit organization founded by volunteers in 1984. NAMI Texas is affiliated with the National Alliance on Mental Illness (NAMI). It has 25 local affiliates throughout Texas and nearly 2,000 members, including individuals living with mental illness, family members, friends, and professionals. Its purpose is to help improve the lives of people affected by mental illness through education, support, and advocacy.

NAMI Texas has a variety of education and support programs directed to individuals living with mental illness, family members, friends, professionals, other stakeholders, and the community at large to address the mental health needs of Texans. NAMI Texas works to inform the public about mental illness by distributing information about mental illness through every means of communication.

Opportunities to Give Back

An added bonus of engaging family members at every level of the AOT process is its tendency to produce amazing advocates for the program itself. Grateful family members often want to “give back” by sharing their AOT experience with others (with their loved one’s permission, of course), which in turn raises awareness about the program and helps galvanize stakeholder support. There is simply nothing more effective in winning over policymakers than personal, heartfelt testimonials of your program’s success in transforming lives that had once been dangerously out of control.

“Giving back” looks different from one person to another. Some family members may be comfortable participating in meetings. Others may prefer to provide one-on-one support to other family members. Still others may be eager to share their family’s story of success far and wide. Get to know your participants’ families to unlock the full potential of this invaluable asset.

www.treatmentadvocacycenter.org