Court Ordered Evaluation and Treatment

January 9, 2019

Governing statute: A.R.S. Title 36, Chapter 5

- Who Qualifies?
- Must have a mental disorder, as defined by the statute:
- Substantial disorder of emotional processes, thought, cognition or memory
- Specifically excluded: Disorders primarily due to substance abuse

Disorders primarily due to intellectual disability (previous term: mental retardation).

"Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute"

Disorders caused by a physical health condition

Disorders directly accompanying "impending death"

Must be, as a result of the mental disorder, at least one of the following:

- Dangerous to Self (DTS) – behavior resulting from the mental disorder which constitutes a danger of inflicting serious harm upon oneself or serious illness or, when considered in light of context and prior acts, is substantially supportive of an expectation the threat will be carried out. Does NOT need to be intentional.
- Dangerous to Others (DTO) – behavior resulting from the mental disorder that can reasonably be expected to result in serious physical harm. Does NOT need to be intentional.
- Gravely Disabled (GD) – due to the mental disorder, the person is likely to come to serious physical harm or illness due to an inability to provide for basic physical needs. Implies persistent severe deficits, no just during acute phase of illness.
- Persistently or Acutely Disabled (PAD) – person must be suffering severe and abnormal mental, physical or emotional harm and the disorder must significantly impair judgment, reason, behavior or capacity to recognize reality

PAD, Continued:

- To be PAD, the person must lack the capacity to make an informed decision about treatment
- Also, the disorder causing the person to be PAD must be causing severe harm to the person, and must be likely to improve with treatment.

Final requirement:

- The person must be unable or unwilling to accept treatment voluntarily; the assessment of voluntariness is not solely determined by whether the patient says he/she is willing to cooperate with voluntary treatment; the physician can consider demonstrated history of cooperation with treatment recommendations.

- The person must be willing and able to agree to the minimally necessary treatment which stands a chance of stabilizing his/her psychiatric condition (this is not stated specifically in the law, but is part of what a psychiatrist considers when determining voluntariness for mental health treatment).

COE Process - Emergency Cases

- In Maricopa County, a person who has witnessed the abnormal behavior goes to one of the Crisis Centers (UPC, CPEC, RI) and initiates an application; proposed patient must be considered DTS or DTO
- Crisis Center provider reviews application and sends pick-up order to police to bring the patient there (if deemed non-emergent, default to non-emergent process, which involves time for a pre-petition screening)
- Patient is assessed at the Crisis Center. Provider must decide within 24 working (ie, hours on weekends/holidays do not count) hours to:

Discharge the patient, as not found to be in need of treatment; or, not found to meet criteria for involuntary evaluation and patient refuses offers of voluntary treatment

OR convert to voluntary status (either patient signs voluntary, or has been found to have a guardian with "mental health powers" – i.e., the ability to consent on the ward's behalf to treatment in a psychiatric hospital).

OR, for patients assessed as needing further involuntary evaluation: Petition for COE filed and patient transferred to Desert Vista or Psychiatric Annex – possible to do the COE outpatient, but rarely happens as patient must keep appointments

COE Process – Non-emergent (NOT for patients who are DTS or DTO, only PAD or GD)

- Witness to behavior does application; can initiate process by calling Crisis Line (602-222-9444).
- Contracted provider (in Maricopa County, currently Empact) sends a person out to do a pre-petition screening and prepares report within 48 working hours (if patient already enrolled with an SMI clinic, they would do this part)
- If physician at screening agency agrees COE is needed, petition for COE filed with mental health court. Physician recommends outpatient OR inpatient evaluation
- If inpatient, court issues pick-up order which is good for 14 days. Police pick patient up and bring him/her to one of the crisis centers.
- There, patient is either released, converted to voluntary status, or transferred to DV or Psych Annex to continue COE

Other routes to COE:

- Persons found Not Competent to stand trial and Not Restorable (NCNR) can be referred for COE at time their criminal charges are dismissed; they come directly to MIHS – aka “Rule 11s” – intended for those with a mental disorder, not intellectual disability or dementia alone (they can be referred (by the judge who is finding them incompetent to stand trial) for guardianship instead)
- Jail inmates on whom jail mental health staff do an application for COE, in order to get a COT and force treatment while in jail; come to MIHS for an outpatient or inpatient COE and return to jail – aka “Conditional Releases”
- Prison inmates sent directly to MIHS at completion of their sentence (or jail inmates when released from detention); petition for COE done by jail/prison mental health staff or others
- Persons detained at ASH after being found Guilty Except Insane of a violent crime, on completion of their term under PSRB (Psychiatric Security Review Board) jurisdiction, if PSRB determines COE is indicated
- Hospitalized patients on whom an application for COE is filed, and who have medical needs beyond what can be handled at the crisis centers, come directly to MIHS with admission coordinated by MIHS Assessment Office (480/344-2195)

Standards:

- Danger to Self (DTS) – does not have to be intentional. Imminent risk of serious harm
- Danger to Others (DTO) – does not have to be intentional. Imminent risk of serious harm
- GD (Grave Disability) – inability to care for basic daily needs of food, clothing, shelter, medical care. Chronic even with treatment.
- PAD(persistent or acute disability) – significantly suffering due to untreated mental health disorder; unable to understand advantages vs. disadvantages of various treatment options; likely to benefit from treatment

Not appropriate for COE:

- Children/youth under 18 – can be signed into a psychiatric facility by parent/guardian. There is a separate COE process for juveniles ordered to be evaluated by a juvenile court judge.
- Persons who don't qualify as having a mental disorder as defined by the statute: e.g., behavior is due to acute substance intoxication or withdrawal, antisocial personality disorder, acute medical condition, intellectual disability, sexual disorder, or conditions associated with "impending death"
- Persons who have a guardian with mental health powers (unless they are likely to need police involvement to transport to a crisis center or hospital)
- Gray area: persons with major neurocognitive disorder (dementia). Generally need to have a significant behavioral disturbance with DTS or DTO behavior (ie, likely to benefit from psychiatric treatment), not just need placement) for the application for COE to be accepted.

COE Process: Once at Desert Vista or Psych Annex:

- Patient is evaluated by two physicians (either two psychiatrists, or one psychiatrist and one psychiatric resident supervised by a psychiatrrist), and a social worker, as well as nursing staff and others.
- Possible outcomes: Discharge, as not found to meet criteria for COT

Drop COE but convert to voluntary status for further inpatient treatment.

File petition for COT; must be done within 72 working hours of the petition for COE being filed

Once petition for COT filed, at end of the 72 hour evaluation period, court date is set for 4-6 working days (ie, weekends/holidays don't count) later. Patient may be discharged prior to court and return for the hearing as an outpatient, if appropriate (must have judge's approval; not good option for homeless or those with substance use disorders who might be unreliable to return for their hearing). Also may drop the petition for COT after the filing and before the court hearing, with judge's approval.

COT Process:

- At COT hearing, two “lay witnesses” must testify as to the behavior they directly observed at the time the application for evaluation was filed
- The two physicians who evaluated the patient (“affiants”) and submitted their written affidavits to the court, may be called to testify in person
- The judge must find “clear and convincing” evidence that the person has a mental disorder as defined in Title 36, and is, as a result, DTS, DTO, PAD or GD.
- In order for the judge to include a component of outpatient treatment in the COT (court order for treatment), a community mental health agency must submit a Letter of Intent to Treat, prior to the hearing, indicating they will supervise the COT. THEREFORE, persons who are neither SMI nor on AHCCCS (“Non-Nons”) will only be able to get an inpatient COT, because they won’t have an outpatient agency willing to provide the letter. So, the only purpose to take those patients to court is if they need more inpatient treatment.

Why did this person not get placed on COT?

- Police file an application for COE on a patient they found nude in the middle of a busy street, conducting an imaginary symphony. They took him to an urgent care center and filed an application for COE.
- 3 weeks later they encounter him again, trespassing at a convenience store.
- Reasons a person didn't get placed on COT are many:
- He was found to be intoxicated on methamphetamine and his mental status cleared completely within 24 hours, so no qualifying mental disorder was found
- He accepted voluntary treatment at the urgent care center and was discharged 4 days later, but did not fill his prescription and developed symptoms again
- One of the two required witnesses failed to appear for his COT hearing
- He was not properly served with his COT paperwork
- He improved after two weeks of hospital treatment, but he had no proof of legal residency, so did not get an outpatient COT or a clinic assignment and deteriorated again after discharge

COT Process:

- COT typically lasts 1 year and is renewable
- Maximum inpatient days the patient may be held during that year is specific to what standards were found (DTS – 90 days; DTO &PAD – 180 days; GD – 365 days).
- Patient is discharged once clinically appropriate; after discharge, he/she is followed by outpatient team and, if non-adherent and in need of return to inpatient care, outpatient team files request with court for Amendment of the COT to return patient to inpatient status
- ASH takes very few patients and has a waiting list many months long. Patients are not typically considered for ASH unless their behavior is too violent for MIHS, or they have failed to make progress after at least 3 months of inpatient treatment. In addition, ASH must believe they can benefit from treatment there, and not just because it is a locked setting.

COT, continued:

- Though a residential treatment program can be specified in the treatment plan filed with the court at time of hearing, residential treatment programs will take a patient who is not voluntary for treatment, even if they are on a COT, unless they have a guardian signing them in.
- Court automatically refers patients found GD to the public fiduciary's office to investigate need for a guardian. This is a long and difficult process. Even with a guardian signing him/her into a residential placement, these programs are not locked, and thus the patient can leave if he/she chooses to do so

Statistics:

- Year 2015: 2107 petitions for COE filed, 1372 petitions for COT filed
- Year 2017: 7052 petitions for COE filed, 1908 petitions for COT filed

- In other words, a 235% increase in COE filings and a 39% increase in COT filings

Of patients brought to MIHS for COE:

- 10% are dropped during the COE period (many more or dropped at the crisis centers before being transferred to DV or the Annex)
- 10% are dropped prior to hearing
- 10% are dismissed by the judge at time of hearing

Maricopa County COT Population:

- As of 1/18, Total COT patients in Maricopa County (not counting those on ALTCS) - 2476
- Of these, 189 were on AHCCCS but not SMI. As of 10/1 this population is managed by the AHCCCS Complete Care plans, not Mercy Care (Mercy Care now manages only the patients who are SMI, whether they are on AHCCCS or not).

Problems:

- Patients with self-destructive behaviors due to substance use disorders and not another mental disorder do not qualify for COT
- Large population of demented patients who need supervised living situation; COT does not provide this – need ALTCS, but process very long, even if they qualify financially
- SMI patients with chronic medical conditions but don't qualify for ALTCS (eg, diabetics who won't cooperate with care) – where do they go? Programs for the mentally ill do not provide hands-on medical/nursing care or daily care such as dressing, bathing.
- SMI patients who make too much to qualify for AHCCCS and who need supervised living situations, but have no payor for residential treatment and do not have enough income to pay for the setting they need, or don't want to pay for it.
- Certain conditions don't qualify as SMI (e.g., anorexia nervosa; mood disturbance due to recent traumatic brain injury).
- Undocumented patients have no benefit for treatment after discharge; often in hospital for COE multiple times per year as a result.
- Maricopa County census at ASH limited to 55 patients – hasn't changed in over 30 years

Additional Problems:

- Patients who do well in hospital settings but need supervision in the community and refuse to remain in any setting to which they are discharged, including their own apartment with a staff member present at all times, thus continuously cycling between jail, hospital and the street.
- Patients with comorbid substance use disorders who are not motivated to stop use; often have easily controllable psychiatric symptoms when not using substances, are quickly discharged from the psychiatric hospital, then use substances again and are quickly psychotic and/or dangerous to themselves or others again
- Only consequence to patient for failing to follow treatment plan after discharge (e.g., positive UDS, not taking meds or keeping appointments) is being amended and returned to an urgent care center, but will be quickly discharged if no evidence that psychiatric condition has worsened enough to require inpatient care.

Underlying societal issues:

- No longer the idea that, for individuals with certain very severe psychiatric conditions requiring close supervision, government must step in to provide supervised residential care, even if there is no insurance coverage for it. This has many roots, including past abuse of people with mental illness in large institutional settings, ideals of personal liberty, and cost of such intensive treatment/support.
- Lack of recognition that some individuals have severe illness which is resistant to treatment and thus have chronic, severe symptoms which make it unsafe for them to live independently in the community; if they will not stay in an appropriate setting, they may require a long-term secured setting (ie, which they cannot leave). Right now often the secured setting these patients end up in is prison.
- Tendency to view symptoms arising in the setting of severe substance abuse as easy to distinguish from symptoms caused by a non-substance-related mental illness – often not the case; lots of people have both problems.
- Lack of provision for involuntary treatment for those with the most severe substance use disorders, unless they commit a crime, or have a co-existing mental illness which would allow for COT.

Important to remember:

- Involuntary evaluation and treatment is a tool to be used when absolutely necessary; if the patient is willing and able to have treatment voluntarily, then that is preferred – almost everyone does better when they are affirmatively choosing to have treatment
- Even those receiving involuntary treatment should be given information about reasonable alternatives, allowed to make choices among those reasonable alternatives, and given as much freedom as is consistent with the safety of themselves and others – ie, can't just stick people in hospitals or group homes because that is least expensive or most convenient for others; can't practice "preventive detention" or make a determination about discharge which is not based on current clinical criteria ("this patient assaulted someone so they need to be inpatient for at least a year").
- Getting a COT does not mean a treatment team is not obliged to pay attention to side effects from medications, collaborate as much as possible with the patient, and assist the patient in achieving his/her own goals (not just the team's goals). Patients can escape being on COT by leaving the county or state – don't create more transients.