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- This webinar is being recorded and may be published for others to view at a later date.
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ARIZONA PSYCHIATRIC SOCIETY

Asking Questions of Presenters

- **Please use the Q&A feature on Zoom to ask your questions.**
- **To ensure questions are addressed, our moderators will monitor the Chat and will pose questions of the presenters, time permitting.**
- **If your question is not answered at the end of a session, we will work with the presenters to follow-up with you after the conference.**

ARIZONA PSYCHIATRIC SOCIETY

Faculty

Carol K. Olson, MD, Chair of the Department of Psychiatry, Valleywise Behavioral Health	Josh Mozell, JD, Senior Partner in the Law Firm of Frazer, Ryan, Goldberg & Arnold, L.L.P; Immediate Past Chair, Mental Health America of Arizona; and President, Association for the Chronically Mentally Ill

Civil Commitment in Arizona

Arizona Revised Statutes: Title 36, Chapter 5, Articles 1-7

The good and the bad….

Good:

1) In addition to Danger to Self, Danger to Others and Grave Disability, we have the Persistent or Acute Disability Standard (incapacity + suffering harm + treatability)
2) Combined Inpatient and Outpatient court –ordered treatment the norm
3) Robust Medicaid-funded behavioral health services package compared to other states (residential treatment, ACT teams -regular, forensic, medical- and integrated physical and mental health care)
4) Treatment available (but limited) for those who are SMI, but not eligible for AHCCCS
5) In Maricopa County, three 24 hour/day psychiatric urgent care centers, which serve as “screening agencies” under Title 36. In Mesa, Community Bridges/CPEC; in Phoenix, Connections AZ/UPC; In Peoria, RI International (“RIAZ”, PRC-West are old terms).

The bad….

- Currently no secured settings outside of the hospital or subacute short-term settings.
- Beds at the Arizona State Hospital for Maricopa County residents limited to 55, unchanged since early 1980s
- Standards for acceptance of applications for COE can vary based on training of urgent care center provider
- Delays in bed availability for COE patients with more complicated medical issues requiring “direct admission” to Valleywise (Valleywise Health System has three psychiatric hospitals: VBH-Mesa (“Desert Vista”, 113 adult beds), VBH – Phoenix (“The Annex”, 115 beds, including 22 medpsych beds); VBH-Maryvale (newest location; 168 beds currently, going to 192 beds as of 1/21)
- Limited response when person on COT violates terms of the COT but is not psychiatrically decompensated yet; typically get only brief return to an urgent care center.
- COT does not obligate a patient to go to a supervised placement

Who is appropriate for COE?

Five areas to be considered, in sequence:

1) Does the person already have a court-appointed Title 14 guardian? If inpatient psychiatric care is required, was the guardian awarded "mental health powers"? Children under the age of 18 do not go through the COE/COT process, because their parents/guardians can consent to psychiatric treatment for them.
2) Does the person have a Power of Attorney for mental health care? If so, is the person incapacitated with regard to decision-making for mental health care, at this time? If so, does the POA document authorize the POA to admit the person for inpatient psychiatric treatment?

If no surrogate available to consent to mental health care, must consider whether the person meets criteria for court-ordered psychiatric treatment under Title 36:

1) Does the patient have a "mental disorder", as defined by the statute?
2) Is the person a Danger to Self (DTS), Danger to Others (DTO), Gravely Disabled (GD) or Persistently or Acutely Disabled (PAD) due to the mental disorder?
3) Is the person unwilling or unable to have needed psychiatric treatment on a voluntary basis?

Alternatives to COT:

- If there is a guardian with mental health powers, COE is not necessary, as the guardian can provide needed consents for all forms of mental health treatment.

Exception: If the patient is chronically unstable and requiring frequent involuntary transportation to a hospital or crisis center, having a COT can make the process of involuntary transportation by the police easier.

- A guardian without mental health powers can give consent to psychiatric treatment outside of a psychiatric hospital
- The treatments to which a mental health care POA can consent to, on behalf of an incapacitated person, are often specified in the document.

What is the statutory definition of "mental disorder"?

- *Substantial* disorder of the person's

Emotional process

Mood

Thought

Cognition

OR

Memory

BUT….some exceptions.

Mental Disorder definition, continued

- Cannot be primarily due to substance use disorder or intellectual disability (can have those diagnoses, but must have another diagnosis causing severe impairment)
- Cannot be personality disorders characterized by “lifelong and deeply ingrained antisocial behavior patterns” (ie, ASPD)
- Cannot be a sexual disorder (eg, paraphilia) – there is another civil commitment law used for individuals deemed to be “sexually violent persons”.

- Though not explicit in statute, judges have excluded from COT those whose symptoms are the direct result of a physical health condition (eg, psychosis due to thyrotoxicosis), concluding that such conditions are not *mental* disorders. Neurocognitive disorders generally excluded unless there are treatable psychiatric symptoms causing impairment of sufficient severity to qualify.
- Cannot be primarily due to declining mental abilities accompanying “impending death”.

As a result of the mental disorder, the person must be at least one of the following:

- A Danger to Self – exhibiting behavior as a result of the mental disorder which constitutes a danger of inflicting serous physical harm on oneself. Does not have to be intentional, and can be a judgement call, based on evaluating behavior in the context of prior acts of self-harm.
- A Danger to Others – exhibiting behavior, as a result of the mental disorder, likely to cause serious physical harm to others, and is unable to understand his/her need for treatment.
- Gravely Disabled –As a result of the mental disorder, the person is likely to come to serious physical harm or serious illness due to inability to provide for basic physical needs (food, clothing, shelter, health care, recognition of and response to an emergency).
- Continued…..

Persistent or Acute Disability (PAD)

- As a result of a mental disorder the person:

a. Has a substantial probability, without treatment, to suffer *severe* and *abnormal* mental, emotional or physical harm.

b. The disorder significantly impairs *judgement, reason, behavior, or capacity to recognize reality*

c. The disorder substantially impairs the person's capacity to make an informed decision about treatment (i.e., understand and express an understanding of the advantages vs. disadvantages of various treatment options).

d. The disorder has a reasonable prospect of being *treatable*.

PAD is the most common standard on which cases go to court, and is typically the easiest to prove.

Patients who are being treated by prayer or other spiritual means alone, according to the tenets of a recognized church or religion and by an accredited practitioner of that church or religion, can only be involuntarily evaluated or treated if the court determines they are DTS or DTO due to a mental disorder.

Final assessment: Voluntariness

Patient must be either

a. Unwilling (e.g., refuses treatment needed to improve his/her condition). Does not need to agree on every last detail, but should be in agreement with treatment felt to be minimally necessary

b. Unable (e.g., too confused to give consent; has repeated, documented history of failure to comply once out of a hospital setting; has extreme degree of indecision such that there is no time to act on consent to treatment before mind is changed).

Summary of Requirements:

- Medical workup and/or detox from substances sufficient to exclude a primary physical health condition or intoxication/withdrawal as the cause of the psychiatric symptoms
- Presence of a mental disorder, as defined by the statute
- DTS, DTO, GD or PAD as a result of the mental disorder. The behaviors establishing this cannot have occurred solely while the person was intoxicated or delirious.
- Unwilling or unable to consent to voluntary treatment
- COE/COT is least restrictive option (i.e., can't be handled by existing guardian or MHPOA).

Procedure:

- If patient is hospitalized, hospital SW or crisis agency clinician (typically Terros or CPR) interviews patient after getting informed consent and cautioning about lack of confidentiality.
- If patient is DTS or DTO, they then file application for COE at one of the three urgent care centers. Alternatively, a family member or other witness of recent behavior can do the application.

(If no DTS or DTO behavior, a GD or PAD petition is done. For patients in the community not enrolled with a clinic able to do these petitions, friends/family can contact the Maricopa County Crisis Line, 602/222-9444 and will be referred to Empact-SPC to initiate the process.)

- The urgent care center provider reviews the application and medical records. If they feel capable of managing the medical needs, and believe the allegations support the need for a COE, they issue a detention order directing the police to pick up the patient and bring him/her there. (If the person is considered DTS or DTO. If it is only a PAD or GD petition – considered "non-emergent" - the provider at Empact completes the petition for evaluation – or a Valleywise medical director does, if the patient's medical needs require direct admission to Valleywise - and it is filed with the court; the judge issues the detention order. This process can take several days).
- If the urgent care center provider feels they can't handle the medical needs, they forward the application to Valleywise, which has its medical director review once there is a bed. If medical transportation is needed, police serve the patient with the detention order, but an ambulance transports to Valleywise.

Process, continued:

- Once detained on a DTS or DTO application, the urgent care center has 24 “working hours” to decide whether to file the petition for COE (which is the original application plus the MD/DO/NP statement, called a Form F). Other options to filing for COE: convert to voluntary status, or discharge.
- Once the petition for COE is filed, Valleywise has 72 working hours to file the petition for COT, which sets a date for a COT hearing. The petition for COT must include reports by two physicians (both must be psychiatrists, or at least physicians with “experience in psychiatric matters”; one may be a psychiatric resident, supervised by a psychiatrist) as well as a SW report and recommended treatment plan.
- The psychiatrists’ opinions must be entirely *independent* – ie, can’t collaborate/confer
- The court date must be set for 4- 6 working days after the end of the initial 72 hour evaluation period.

- The entire COE process can be accomplished on an outpatient basis, if the patient is able and willing to keep evaluation appointments and is not a danger to self or others outside of a hospital setting.

Other sources of COE cases:

- Patient is getting voluntary inpatient psychiatric treatment but demands AMA discharge or is refusing other treatment and is considered to meet criteria for involuntary treatment.
- Person in jail who has been found incompetent to stand trial and not able to be restored to competency, due to a mental illness
- Person is in jail and is very psychiatrically ill, needs COT for meds –will be sent for COE on “conditional release” from jail, meaning he/she will return to the jail mental health unit once COT is entered and he/she is felt able to be safely treated there (ie, taking care of basic daily needs okay; not behaving in such a way as to provoke confrontations with correctional officers).
- Person finishing a prison sentence who has a severe mental disorder and is felt to meet the criteria for COT

COT Hearing

- Each Valleywise hospital has a courtroom
- Patient is represented by a public advocate (analogous to a public defender), unless they can afford their own attorney. There job is to protect patients' rights and advocate for their wishes – NOT to advocate for their clients' "best interest"
- Hospital is represented by a deputy county attorney
- Hospital must present two "lay witnesses" –people who have observed the behaviors establishing the presence of a mental disorder and DTS,DTO,PAD or GD and involuntariness. Doctors typically excluded due to presumption of confidentiality during their interaction with the patient.
- Reports (called "affidavits") of the two evaluating doctors typically, but not always, submitted "on the record" without requirement for live testimony.
- Court also gets affidavit from doctor regarding what medications the patient has received in the 72 hours prior to hearing, and attesting that the medications have not affected the patient's ability to participate in the hearing.
- Patient's lawyer can request to have an "independent evaluation" – outside psychiatrist sees the patient

Process, continued:

- Burden of proving the case is on the hospital. Standard of proof at hearing is “Clear and Convincing Evidence” – this is above the standard of proof for most civil cases (“preponderance of the evidence), but below the standard of proof for criminal cases (“beyond a reasonable doubt”)
- Most of the time, the judge orders one year of COT, with a certain maximum number of days of inpatient treatment. Per statute, the maximums are:

For DTS: 90 days

For DTO and PAD: 180 days

For GD: 365 days

Patients found GD are referred to the Maricopa County Public Fiduciary to investigate their need for a guardian. This process takes a few months, and often they will NOT find a need for a guardian.

Patients without a benefit for public mental health treatment (eg, those who cannot prove legal US residency, as well as those who are neither SMI nor AHCCCS enrolled) cannot get an outpatient component to their COT, because there is no public mental health agency available to supervise outpatient treatment. COT is only beneficial for those cases if they still require inpatient treatment at the time of the hearing. *Getting a person on COT does NOT entitle them to any treatment benefits to which they are not otherwise entitled .*

Process, Continued:

- Once a COT is ordered, the treating physician can do a Special Treatment Plan, specifying forced medication or labs in order to accomplish the COT. This must be cosigned by a medical director or deputy medical director. It is NOT used to force medical treatment, unless the medical treatment is crucially necessary in order to safely provide the psychiatric treatment.*In other words, getting the person on COT does not allow us to force medical treatment. Psychiatric patients who are refusing needed medical care at acute care hospitals should be assessed for capacity, and, if deemed incapacitated, needed care should be provided via the hospital's usual policy for incapacitated patients.*
- The patient can be discharged by the Valleywise Attending once he/she concludes the patient is appropriate for outpatient treatment.
- Outpatient care is supervised by an assigned clinic (several different agencies do this). Required to be seen by psychiatrist/psych NP at least monthly and have weekly contact (by phone or in person) with case manager. If on ACT team, goal is for contact with a team member 4 times per week.

COT Requirements:

- Cannot own a firearm; on prohibited possessor list indefinitely
- Barred from using drugs/alcohol
- Must keep outpatient appointments
- Must take medication as prescribed
- Although treatment plan filed with the court may specify a supervised residential treatment setting, all such settings require the patient to agree to treatment there, and none are secured/locked, so the patient can leave at any time. Exception: patient goes to wandering dementia unit – typically requires ALTCS, unless patient is wealthy.
- If patient fails to comply, or seriously deteriorates, outpatient medical director can file an "amendment letter" with the court, detailing the situation and requesting the patient be detained again (they go to one of the urgent care centers).
- COT can be renewed at the end of each year, if patient still meets criteria

Long-term Hospitalization

- Census of Maricopa County residents at ASH capped at 55, dating from the settlement of the Arnold v. Sarn lawsuit in the early 1980s.
- Takes months before application will be considered; often declined if there is significant personality disorder or intellectual disability
- Average LOS at Valleywise around 22 days; much longer for treatment-resistant patients (some stay 6 months or more).
- Pending: secured residential treatment option

What cases are NOT appropriate for COE/COT?

- Patient who does not exhibit severe psychiatric symptoms outside of periods of substance intoxication or withdrawal.
- Patient who has not been “medically cleared” yet, or whose medical/surgical providers are deferring urgently needed care because they think a COT is needed first.
- Patient who needs a decision-maker for physical health care (a COT does not provide this; must use the same process for these patients as for other incapacitated patients)
- Patient who is highly unstable but is capable of informed consent and is generally cooperative with treatment recommendations
- Patient who made a serious suicide attempt, but is agreeable to care currently and does not have a documented history of repeated prior non-adherence
- Patient who is not DTS, DTO or GD and who is not experiencing significant suffering due to his/her symptoms (e.g., higher- functioning psychotic person).
- Patient with major neurocognitive disorder or intellectual disability who needs custodial care but does not have significant psychosis or mood symptoms likely to respond to psychiatric treatment
- Patient who already has a guardian or POA empowered to provide consents to psychiatric treatment

Equity Issues

- Demonstrated tendency of psychiatrists to misdiagnose Black patients with schizophrenia, vs. PTSD or BMD or no diagnosis.
- Based on past and current experiences with authority structures in society, members of some disempowered communities may be suspicious of members of those authority structures, and this can be interpreted as pathology (eg, “paranoia” about police).
- Based on past historical experience with organized medicine, certain racial and ethnic groups may be highly distrustful of treatment recommendations, which may contribute to them entering the involuntary evaluation and treatment process more often. In contrast, this distrust may also make families less likely to initiate the process for their symptomatic family members.
- Poverty affects eligibility for AHCCCS which, in turn, affects eligibility for outpatient court-ordered treatment for non-SMI patients.
- Poverty and attendant lack of stable housing or social supports can make recommendation for COT more likely in borderline cases.

Evaluation and CME or Participation Certificates

At the conclusion of the conference, physician participants will be provided with an opportunity to claim hours of participation and receive an official CME certificate by completing the online CME conference evaluation. Non-physician participants will be able to claim a certificate of participation.

1. Go to **https://education.psychiatry.org/diweb/redeem**
2. Log in with your APA username and password or create a new account
3. Enter the Access code: **LE2834FA834C** and click "Redeem"
4. Click "Access". The activity evaluation will open in a new window.
5. Complete the evaluation and click "Submit Response".
6. On the next page, click "Claim Credits". Select the number of credits from the drop-down menu and click "Claim".
7. Click "Home" to close the course window. From your dashboard, click "My Courses", then select the "My Completed Activities" tab in the middle of the screen. Beneath "How to Get Help for Your Patient Who Doesn't Want it: Process and Law of Involuntary Psychiatric Evaluation and Treatment in Arizona," click "Certificate." Your certificate will open in a new tab. A link to your certificate will also be sent via email.

You must claim your CME credit within 60 days of the education. Certificates will not be issued after March 14, 2021. For customer support, please email apalms@psych.org.

Please note that if you receive an error message when trying to redeem your access code, you may have already redeemed the access code during a previous attempt. Navigate to **education.psychiatry.org and log in using the Sign In button on the top right of the screen. You will then be directed to your dashboard, where you can then navigate to My Courses (top right, under the Sign In button) and locate the activity title listed under My Enrollments.*

For any additional questions or feedback regarding the webinar, please contact the Arizona Psychiatric Society (**admin@azpsych.org**).

ARIZONA PSYCHIATRIC SOCIETY

Promoting the welfare of those with mental illness and fostering principles of psychiatry.

Thank You for your Participation in this webinar and your contributions to care in our community. If you are interested in joining the Society, please contact us at admin@azpsych.org.