Committee on Mental Health and the Justice System
AGENDA

Monday, May 18, 2020
10:00 a.m. – 12:00 p.m.
State Courts Building
REGULAR BUSINESS

10:00 a.m.	**Welcoming Remarks and Roll-Call**	Mr. Kent Batty, *Chair*
10:10 a.m.	**Approval of April 20, 2020 Minutes** ☐ **Formal Action: Vote to Approve**	Kent Batty
10:15 a.m.	**Mental Health Cases: Rule Proposal**	Hon. Jay Polk, Associate Presiding Judge Probate and Mental Health Department Superior Court of Arizona for Maricopa County
10:45 a.m.	**Key Issues Workgroup Recommendations** ☐ **Formal Action: Vote to Approve**	Jim McDougall
11:30 a.m.	**COVID-19 Continuity of Court Operations During a Public Health Emergency Workgroup Best Practice Recommendations**	Stacy Reinstein Theresa Barrett
11:40 a.m.	**Legislative Update**	Liana Garcia
11:50 a.m.	**Committee News/Updates**	Kent Batty All
12:00 a.m.	**Call to the Public**	Kent Batty
12:05 p.m.	**Adjourn**	

Next Meeting:	**2020 Meeting Schedule:**	
July 27	August 24	November 16
	September 21	December 14
	October 19	

NOTICE

The Arizona Supreme Court and Administrative Office of the Courts are taking the necessary steps to protect its employees and partners and help prevent the spread of the Coronavirus in the community. Per the most recent guidelines by the federal government that no more than 10 people should be gathered in a room at the same time, Committee meeting will be held via phone conference. Members of the public who wish to submit comments on any item on the May 18, 2020 Committee on Mental Health and the Justice System agenda, should direct comments to mhjscommitteestaff@courts.az.gov. Additional guidelines for the public are listed on the Committee website at: azcourts.gov/cscommittees/Mental-Health-and-the-Justice-System.

All times are approximate and subject to change. The committee chair reserves the right to set the order of the agenda. For any item on the agenda, the committee may vote to go into executive session as permitted by Arizona Code of Judicial Administration §1-202. Please contact Stacy Reinstein at (602) 452-3255 with any questions. Any person with a disability may request a reasonable accommodation, such as auxiliary aids or materials in alternative formats, by contacting Diana Tovar at (602) 452-3449. Requests should be made as early as possible to allow time to arrange the accommodation.

Monday, April 20, 2020

Virtual meeting
10:00 a.m. – 11:30 a.m.

Present (telephonically): Kent Batty (Chair), Mary Lou Brncik, Amelia Cramer, Shelley Curran, Jim Dunn, Hon. Elizabeth Finn, Hon. Michael Hintze, Josephine Jones, Natalie Jones, Dianna Kalandros, Cynthia Kuhn, Michael Lipscomb, James McDougall, Dr. Carol Olson, Ronald Overholt, Beya Thayer, Proxy for Chief Deputy David Rhodes, J.J. Rico, Dr. Michael Shafer, Hon. Barbara Spencer, Hon. Christopher Staring, Hon. Fanny Steinlage

Absent/Excused: Brad Carlyon, Chief Chris Magnus, Kristin McManus, Paul Thomas

Guests/Presenters: Alex Demyan, Dana Flannery, Tamaria Gammage

Administrative Office of the Courts (AOC) Staff: Theresa Barrett, Don Jacobson, Stacy Reinstein, Diana Tovar

Regular Business

Approval of Minutes

Members were asked to approve minutes from March 23, 2020, noting they were in the meeting packet and provided electronically in advance of the meeting. A motion to approve the minutes was made by Ms. Cramer. The motion was seconded by Judge Staring. Motion was approved unanimously.

National Center for State Courts: Mental Health Update

Ms. Tobias from the National Center for State Courts informed the committee about a new CCJ/COSCA mental health task force which has been created, as a continuation of the work that has been taking place over the last year. Existing priorities underway will continue, along with new areas such as child welfare, family court, and partnerships. The Committee was invited to provide NCSC any priority areas for consideration.

Mental Health/ Justice Training Initiative

Ms. Reinstein shared that the goal of the training initiative is to provide judicial officers and court staff with an increased awareness and understanding of mental health, and of individuals living with mental health conditions in the courtroom setting. Additionally, the initiative will help to provide access to specific resources at the court's disposal which will assist in the delivery of services and improve the administration of justice for people living with mental health conditions.

In the current COVID-19 environment, judicial officers and partners in law enforcement and behavioral health are reporting an uptick in matters involving mental health concerns. These stakeholders project that our justice system will experience an even greater impact once courts are operating at 100 percent, as some mental health conditions are not being addressed through breaks

in continuity of care, service provision, and increases in substance use. As such, the Administrative Office of the Courts (AOC) will be focusing on ensuring judicial officers receive training on mental health as well as trauma-informed courtroom, the impact of secondary trauma, and building leadership capacity of judges in a trauma/high-stress environment.

A "Library of Resources" will also be developed as an accompanying piece of the mental health training modules, featuring bench-specific information and resources that can be adjusted as law, policy, and practice changes.

Competency Practices Workgroup Recommendations

Ms. Kalandros shared the workgroup's recommendation on expanding the use telehealth resources which was provided to committee members in the meeting packet.

Formal Action:

- A motion to move the recommendation on telehealth issues forward was made by Ms. Kalandros.
- The motion was seconded by Dr. Shafer.

Member Discussion:

- What other areas outside of competency are included in the recommendation on telehealth? The recommendation includes in custody, out of custody, pre-screen, and more.
- Use the telehealth recommendation as an opportunity to plug gaps and ensure access to technology resources.
- Expanding current telehealth capacity and improvements.
- Use telehealth as another opportunity to push forward data sharing between courts and all parties managing an individual.
- Maintain confidentiality across all telehealth platforms.
- Will there be reasonable accommodations related to disability? Telehealth contracts would need to follow best practices with respect to confidentiality and reasonable accommodations.

Ms. Kalandros shared the workgroup's recommendation to formulate a university partnership which was provided to committee members in the meeting packet.

Formal Action:

- A motion to move the recommendation forward was made by Judge Hintze.
- The motion was seconded by Mr. McDougall.

Member Discussion:

- Insert caveat regarding funding and cost shifting when appropriate, along with opportunities for peer/family community to provide support without cost. Encourage the AOC and universities to move this forward.
- The University of Arizona just announced furloughs across the board, expect other universities to do so as well. Next academic term may not be the ideal climate to launch the collaborative.

Key Issues Workgroup Update

The Key Issues group has been moving forward with recommendations from the interim report, along with SMI criteria. The workgroup will meet prior to the next committee meeting to prepare and then present to the committee for further discussion and approval.

Committee New/ Updates

Mr. Batty shared that he and staff will put together a few recommendations for the NCSC on priorities, as requested by Patti Tobias during her update. Mr. Batty also mentioned that the committee will continue to move forward and present its recommendations to the standing committees and AJC. He noted that while it is better to be able to convene in person for discussions, the committee will continue to push forward through workgroups and committee discussions through current virtual means. Furthermore, Mr. Batty shared with the committee that the AOC has launched a new mental health website and video. He encouraged committee members to view.

In other news, Judge Hintze communicated that the AZ Court Care website along with the trifold brochure are receiving great feedback to provide to those in need without access to technology. Mr. Dunn from NAMI Arizona shared that August 28-30th there will be a Strengthening Arizona Communities Summit. It will be an intentional partnering approach and opportunity to discuss issues and establish connections.

Good of the Order / Call to the Public

None.

Adjournment

The meeting was adjourned at 11:30 a.m. by order of the chair.

Proposed change to Supreme Court Rule 123

Insert, not replace, new section (d)(3)

(d)(3) Mental Health Records.

(A) All records from mental health proceedings arising under Title 36, Chapter 5, A.R.S. are closed to the public except as stated in this rule.

(B) Complete information**.** All information and records regarding mental health proceedings arising under Title 36, Chapter 5, A.R.S are available to the following:

(i) The Court, Court Administrator, and Clerk of the Court, and their employees.

(ii) The patient.

(iii) The patient's attorney.

(iv) The patient's court-appointed guardian or conservator, or nominated guardian and conservator in pending petition filed under Title 14 Chapter 5, and their counsel.

(v) The Court Investigator and court appointed evaluator appointed pursuant to Title 14 Chapter 5

(vi) The patient's guardian ad litem or representative pursuant to 14-1408, and their counsel.

(vii) The Regional Behavioral Health Agency, inpatient and outpatient providers, and their counsel, treating the patient pursuant to court order.

(viii) The State Department of Corrections in cases where prisoners confined to the state prison are patients in the state hospital on authorized transfers either by voluntary admission or by order of the court.

(ix) Persons authorized by order of the Presiding Judge of the County or her designee.

(C) Limited information.

(i) The State Department of Public Safety is entitled to that information set forth in A.R.S. 36-540 (O), as well as copies of minute entry and order of termination of court-ordered treatment.

(ii) A law enforcement or prosecuting agency that is investigating or prosecuting a prohibited possessor pursuant to A.R.S. 36-540(P) is entitled to a certified copy of the court order for treatment, and any order terminating court-ordered treatment.

(iii) The public is entitled to the following information and records:

a) Appellate court decisions

b) The fact a mental health case exists (or does not exist) for any named individual.

c) The number of that case.

d) The name of the assigned judicial officer.

e) The names of the attorneys of record, if any.

(iv)

(D) For good cause shown, the Court, other than a Justice or municipal court, may order a portion or all of the information and records may be disclosed to any person

Proposed Supreme Court Rule 124: **Confidentiality of Proceedings Pursuant, and Related, to Title 36 Chapter 5, A.R.S**.

(a) **Authority and Scope of Rule**. Pursuant to administrative powers vested in the Supreme Court by Article VI, Section 3, of the Arizona Constitution, and the court's inherent power to administer and supervise court operations, and consistent with A.R.S. section 36-509(C), this rule is adopted to govern public access to all court proceedings relating to matters arising under Title 36, Chapter 5, A.R.S.

(b) **General Rule.** Except as otherwise provided by this rule, court proceedings arising under Title 36 Chapter 5, A.R.S., are confidential and not open to persons other than the parties and witnesses and their respective counsel.

(c) **Exceptions.** Even over the patient's objection, the following persons are entitled to attend a court proceeding relating to matters arising under Title 36, Chapter 5, A.R.S.:

(1) The patient's guardian or conservator or anyone nominated in a then pending petition to serve as the patient's guardian or conservator, and their counsel;

(2) The patient's guardian ad litem, or representative pursuant to A.R.S. 14-1408, and their counsel;

(3) Those persons necessary to ensure the safety and health of the patient and those participating in the proceeding;

(4) Any person entitled to notice of the proceeding pursuant to Title 36, Chapter 5, A.R.S.;

(5) Any person the court determines has a significant nexus to the care, treatment, or maintenance of the patient, including the patient's family members and inpatient and outpatient behavior health care providers; and

(6) Any person agreed to by the parties but only if, after the patient has consulted with counsel, the court determines the patient has knowingly, intelligently, and voluntarily waived his right to a closed proceeding.

Interim Report Recommendations: Title 36 Statutory and System Improvements

Status Update

In its October 2019 Interim Report and Recommendations, the Committee on Mental Health and the Justice System recommended three specific statutory changes to Title 36, including:[1]

- Amend the definition of "mental disorder" in A.R.S. §36-501(25) to include: neurological and psychiatric disorders; substance use disorders which co-occur with mental health conditions; and mental conditions resulting from injury, disease, and cognitive disabilities.
- Create an "enhanced services" order to allow judges to mandate services for certain individuals (A.R.S. §36-540).
- Clarify the definition of persistent or acute disability (PAD) to include a substantial probability of causing harm to others as a possible consequence of the condition not being treated (A.R.S. §36-501). Amend emergency hospitalization standard to include PAD and Gravely Disabled (A.R.S. §§36-524, 36-526).

The Arizona Judicial Council directed the AOC and Committee to spend more time during the next year to understand how the three legislative proposals in the interim report might impact stakeholders in the justice and mental health systems, including on the court, counties, and community. In response, the Committee has conducted research and analysis, and engaged with several stakeholders from across the judicial, legal, behavioral health, mental health advocacy, peer and family support and disability communities. As a result, the committee has begun to build partnerships within the justice and mental health communities dedicated to improving the response of the justice and mental health systems to persons with a mental illness. This partnership building process has been particularly useful, as it has allowed for education between stakeholders and committee members and has fostered critical consensus building on how Arizona can improve the administration of justice for people with mental health conditions who encounter the justice system.

The following are the key highlights of the Committee's position on these three recommendations, followed by discussion and details for consideration.

Recommendations Highlights:

Amend the definition of mental disorder

- Amend the definition of mental disorder to create a clear understanding among screening, evaluation and treatment agencies about the threshold requirement for receiving involuntary mental health treatment and to ensure consistent and universal application of the definition.
- Finalize this discussion by convening a multi-disciplinary team of professionals and stakeholders with expertise in psychiatric disorders, neurological conditions, intellectual disabilities, traumatic brain injuries and substance use disorders, in partnership with a member or members of the legislative and executive branches

[1] See Committee Interim Report, Appendices B-D. LINK

of the government and staff, to finalize the legislative proposal to amend the definition of mental disorder.

Create and authorize a court order for enhanced services

- Enact new statute authorizing the court to order the delivery of defined enhanced services available for individuals who are identified as not historically receiving consistent, sustained or proper treatment for their mental illness and who continue to cycle in and out of the criminal justice, probate, and civil mental health screening, evaluation and treatment systems.
- Enforce A.R.S. §36-540 (C) (2) as written which requires the court to approve a written treatment plan that conforms to the requirements of 36-540.01 (B) and is approved by the medical director of the agency that will supervise the treatment.
- Revise and standardize Outpatient Treatment Plans to be used in all counties pursuant to Title 36.
- Modify existing court orders for treatment in accordance with language noted in B-E in the Enhanced Services section below.
- Recommend the Superior Courts located in each county create a Mental Health Division or designate a single judge within the court to be the designated mental health judge.

Amend the definition of PAD and emergency hospitalization requirements

- Introduce legislation to amend the definition of persistent or acute disability (PAD) in A.R.S. §36-501 to recognize that causing harm to self or others is one of the possible consequences of not getting treatment for a severe mental disorder that substantially impairs judgment, reason, behavior or capacity to recognize reality.
- Amend A.R.S. §§36-524 and 36-526 by adding the PAD and grave disability categories to the statutes which authorize emergency hospitalization for psychiatric treatment.
- Implement adequate and consistent training and education of clinicians, including hospital physicians and mental health clinicians regarding application of the standard to ensure that the right people are getting evaluated as emergent vs. non-emergent.

Recommendations Discussion and Details:

Mental Disorder Definition:

The Committee continues to support the recommendation in the Interim Report to amend the definition of mental disorder. The Committee believes that an amended definition of mental disorder is needed in order to create a clear understanding among screening, evaluation and treatment agencies about the threshold requirement for receiving involuntary mental health treatment and to ensure the consistent and universal application of this definition across these agencies in all counties.

The current definition of "Mental Disorder" in ARS §36-501 is over 40 years old. There is a consensus among stakeholders that this definition is in need of revision, and that any revision will necessitate the difficult task of striking a delicate balance between the need

for treatment, assuring patient's rights and protection of the public. **The Committee believes that the Court and its stakeholders must finalize this discussion and strike a balance that will assure that persons who are living with a mental disorder co-occurring with dementia, TBI and intellectual disability can get needed treatment and protects individuals' rights, and ensure people are not subjected to inappropriate, prolonged and unnecessary inpatient treatment.** These individuals, when properly evaluated and treated, can respond to psychiatric treatment and can also benefit from an inpatient psychiatric treatment. Once properly treated, individuals can safely return to their community, which has a positive impact on their lives, their family, and the community overall.

Throughout the stakeholder engagement process, there was universal agreement that persons with a co-occurring substance use disorder should not be excluded or screened-out of the involuntary mental health treatment system and would benefit from early intervention. Under the current statutory definition of "mental disorder" some screeners and evaluators have taken the position that if the person presents with being intoxicated, the person is screened out of the system because the definition "distinguishes" mental disorders from substance use disorders and the mental health treatment system is not meant to be a system for the involuntary treatment of substance use disorders. Although concern was expressed regarding an increase in costs to the system by mental health treatment providers and court system stakeholders, it was acknowledged that these individuals do in fact end up in the justice system and get passed back to the mental health treatment system; however, they are entering the mental health treatment system later, through the "PAD" process. **The Committee believes that amending the definition of "mental disorder" as proposed will clarify that persons presenting with a substance use disorder are not automatically excluded from consideration of having a mental disorder**, allowing for the mental health intervention to occur at an earlier intercept point and advancing the commitment of the AOC and judicial branch to the Sequential Intercept Model framework, reducing penetration further into the justice system when it is appropriate to do so.

The proposal to amend the definition of mental disorder also seeks to clarify when persons with a co-occurring neurological condition, intellectual disability or traumatic brain injury should be considered for involuntary mental health treatment. The process for the evaluation and treatment of mental disorders must be thoughtful and inclusive, and to ensure that individuals who need court ordered evaluation or treatment for a mental disorder are provided the opportunity to be evaluated and to receive involuntary mental health treatment where appropriate.

At the same time, the Committee recognizes the valid concerns of its partners in the disability advocacy community that the inclusion of persons with certain co-occurring neurological conditions such as dementia or Traumatic Brain Injury, as well as those with an intellectual disability in the definition of mental disorder may result in these persons being inappropriately transferred to and abandoned in the mental health treatment system. A primary concern is that inclusion of persons with these conditions in the definition of mental disorder could unintentionally restrict the rights of people and place them in a treatment setting that is not an appropriate placement or subject them to treatment methods or modalities that are inappropriate for an individual with their co-

occurring conditions. In order to alleviate some of the concerns related to changing the definition of mental disorder related to COE/COT, there should be assurances that people have not been court ordered based solely on a neurological, developmental or intellectual disability, and/or a TBI. The fear is that if the definition of mental disorder is revised as proposed by the Committee, more people with these co-occurring conditions will be added to the involuntary mental health treatment system. If this fear becomes a reality, the result would be a significant unreimbursed cost to the mental health treatment facilities for inpatient care past the date they can be safely discharged to the community and subjecting the person to prolonged unnecessary placement in a facility not equipped to appropriately treat the co-occurring condition.

The Committee believes that these concerns can be alleviated, while still making changes to the decade's old definition through the work of an inclusive, multi-disciplinary team of experts, as noted in the recommendations.

Of note, the Committee has carefully considered the U.S. Supreme Court decision, *Olmstead v. LC*, based on the Americans with Disabilities Act (ADA). In this landmark decision, the U.S. Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community, rather than institutions, when the following three-part test is met:

1. The person's treatment professionals determine that community supports are appropriate;
2. The person does not object to living in the community; and
3. The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.[2]

One factor has significantly hampered the ability of this Committee to address its charge to assess the impact of an amended definition of mental disorder: a lack of data. Appropriate data is not being collected statewide in an accessible and consistent manner to be useful in assessing the impact issue. There exists a significant need to identify appropriate data and to create a system to collect such data at various points in the justice and mental health systems. The identity and collection of appropriate data will provide valid and useful information to all the stakeholders to not only assess current needs but to monitor the effectiveness of any changes made.

After considerable discussion, including with key community stakeholders, **the Committee recommends that a multi-disciplinary team be convened with expertise in psychiatric disorders, neurological conditions, intellectual disabilities, traumatic brain injuries and substance use disorders, in partnership with a member or members of the legislative and executive branches of the government and staff, to finalize the legislative proposal to amend the definition of mental disorder.**

Attention should also be given to ensure an adequate network, statewide, and for individuals and families in rural communities. This may be considered through policy or

[2] For more information and resources about Olmstead, visit olmsteadrights.org.

legislative changes to expand the network of screeners, evaluators, and behavioral health service providers. Persons cannot be compliant with court orders to receive treatment if the network of service providers is not adequate.

A critical component of this discussion – regardless of any statutory changes – must include the following requirements for counties and AHCCCS, who are responsible for funding and oversight of the court ordered evaluation and treatment process:

1. The screening and evaluation forms are reviewed and revised to assure that relevant information is provided for meaningful screening and evaluation and the forms are housed in one place that is accessible to all;
2. AHCCCS and counties collaborate to develop and implement metrics and policy for screeners and evaluators;
3. AHCCCS and counties collaborate to develop a training guide that explains the metrics, policy, evaluation and screening requirements;
4. AHCCCS shall enact rules, policy and procedure to ensure that the screening and evaluation forms are consistently applied statewide (AHCCCS has the authority and is required under A.R.S. §36-502 to do so); and
5. Training is required to be completed every 2 years by any individual and entity administering screening and evaluation, with AHCCCS oversight of the training curriculum and participation.
6. Data collection and analysis must be built into the process in a collaborative manner, to assess current needs, monitor effectiveness, and make recommendations for collaborative change.

Enhanced Services Order:

The Committee continues to support the recommendation in its Interim Report to enact a new statute authorizing the court to order the delivery of defined enhanced services available for individuals who are identified as not historically receiving consistent, sustained or proper treatment for their mental illness and who continue to cycle in and out of the criminal justice, probate, and civil mental health screening, evaluation and treatment systems. While existing Arizona statutes do allow conditional outpatient treatment pursuant to a written outpatient treatment plan, the Committee finds that the current statutes do not go far enough to authorize the court to play a significant role in holding the treatment system – both providers and payors – or the patient accountable. There is little oversight over the outpatient treatment plans or consistency in application of treatment pursuant to such plans to assure continuity of care and a uniform application of fair justice and treatment standards statewide.

Most people who come into the involuntary mental health treatment system are evaluated, ordered to comply with treatment administered by a community treatment provider and, after complying with the treatment provided, stabilize and are able to manage their illnesses without frequent continued contact with the involuntary treatment system. However, there is a small percentage of individuals who are chronically non-compliant with the treatment provided and for whom the treatment providers are unable to prevent non-compliance or to reengage the patient in treatment. These individuals continue to cycle through the justice system and back into the mental health treatment system. It is not hard to see the considerable impact this has to the individual, their family, and the justice and mental health systems. The result is that both systems fail the individual and their family and incur significant unnecessary cost by continuing to do the same thing over and over again and expecting a different outcome. Examples can be seen in the Case Study section of this report.

As with the recommendation to amend the definition of mental disorder, the lack of accessible, relevant and reliable data hampers the Committee's ability to assess how the enactment of the proposal on Enhanced Services might impact stakeholders in the justice and mental health systems if enacted. However, the Committee believes that, when collected, the data will clearly show that continuing the way we are currently practicing has a significant negative impact on individuals, families, communities, and the justice and mental health systems in the form of unnecessary costs.

The Committee acknowledges that implementation of these changes will require additional work, including identifying what the proper continuum of care is or should be, and what the estimated costs will be for each jurisdiction. The Committee believes, however, that this proposal has the potential of reducing many of the unnecessary costs now caused by the "revolving door" and that this cost savings will balance out any costs resulting from the enactment of the proposal.

The committee believes that a significant effort should be made to identify the people who have been failed by the system and are stuck in the "revolving door" between the justice and mental health treatment systems, and, where appropriately identified, the court should be given the authority to order specific appropriate and available services,

and to then exercise significant oversight and accountability for the delivery of such services and compliance. The efficacy and value of a system that does this can be seen in the Mental Health Courts that currently function in some of Arizona's Limited Jurisdiction Courts. The Committee believes that the Superior Courts in Arizona should be able to function in a similar fashion and that the proposed Enhanced Services Order statute would enable that to happen.

Currently, when an individual is found to qualify for a Court Order for Treatment, a written outpatient treatment plan is submitted to the court for approval and the court orders a specific mental health treatment agency to administer and oversee the outpatient treatment of the patient. The information gathered by the Committee, however, indicates that the outpatient treatment plans submitted to the court are often not specific enough to clearly identify the treatment needs of the patient or to meet the statutorily mandated contents of such plans set forth in ARS §36-540.01. No effort appears to have been made to standardize the contents of Outpatient Treatment Plans used by the court in each county. And, because there is no person or agency mandated to monitor the actions of the outpatient mental health treatment agency after the court order is issued, the delivery of appropriate services needed to address the needs of the patient is often inconsistent, untimely and insufficient to help the patient maintain stability and prevent decompensation from non-compliance.

As a result, we often see an individual petitioned for involuntary mental health treatment who has repeatedly entered the system, and for reasons that are not always clear, did not receive appropriate available treatment, or who did not comply with treatment specified by the provider. After the provider loses contact with the patient, the court order is terminated or elapses without enforcing compliance with the treatment plan. What is clear to the Committee is that we must figure out a different way to assist and support individuals who are stuck in this revolving door and failed by the current systems.

The goal of the Committee in recommending the Enhanced Services proposal is to accomplish the following:

1. Provide criteria for the identification of individuals who have shown that they cannot or will not adhere to treatment.
2. For those individuals identified, provide clear authority for the Superior Court to oversee the creation of a detailed specific outpatient treatment plan to address the individual's need for treatment and supervision and mandate the provision of appropriate available services to the patient, and,
3. Provide the Superior Court with clear authority to exercise the degree of oversight necessary that will ensure that the outpatient treatment provider addresses the patient's treatment needs in a timely and effective manner and to closely monitor the patient's adherence to the treatment prescribed in the Treatment Plan.

Although the Committee believes that the Enhanced Services proposal is needed, the Committee understands the resistance to the creation of new statutes. Consequently, the Committee has explored alternative ways to accomplish its goals using the existing statutes.

The following are some of the alternatives using existing statutes considered by the Committee. The Committee recommends these be immediately incorporated into judicial training as well.

A. Enforce A.R.S. §36-540 (C) (2) as written which requires the court to approve a written treatment plan that conforms to the requirements of 36-540.01 (B) and is approved by the medical director of the agency that will supervise the treatment. This statute requires staff familiar with the patient's case history to prepare a written treatment plan and specifies what should be included in the plan. Current treatment plans reviewed by the Committee appear to address the requirements of this statute only on a superficial level. **The Committee recommends that regardless of the approval of the Enhanced Services proposal that the courts and AHCCCS work together to revise and standardize Outpatient Treatment Plans to be used in all counties pursuant to Title 36.**

B. A.R.S. §36-540 (E) (4) states: "The court may order the medical director to provide notice to the court of any noncompliance with the terms of a treatment order." In cases where an individual's case history identifies them as a person needing enhanced court scrutiny, **the court order for treatment should include an order to provide the court with notice of non-compliance with the term of treatment**. With notice of non-compliance the court can take action under ARS §36-540 (E)(5) to set a hearing or, without a hearing, issue an amended order for treatment based upon the record and recommendations of medical professionals familiar with the treatment of the patient.

C. **The court should advise the patient in open court and state specifically in the court order for treatment that: the Treatment Plan approved by the court is part of the Order for Court Ordered Treatment and is enforceable by the court; that the Treatment Plan may, from time to time, be amended by the court; and, that non-compliance with the court's order or the terms and conditions of the Treatment Plan may result in the issuance of an order for the patient to be placed in or return to inpatient treatment and an order for a peace officer to detain the patient for that purpose pursuant to A.R.S. §36-540 E (5) or (6).** If the court amends a Treatment Plan, a new written Amended Treatment Plan should be approved by the court, placed in the patient's medical file and filed with the court. A copy of the Amended Treatment Plan should be given to and discussed with the patient by the agency assigned to administer and supervise the Treatment Plan and the court should order the treatment agency to file with the court an affidavit which verifies that such has been done.

D. The Committee has been advised that many patients who desperately need certain benefits, treatment or services available to them do not receive them because they refuse to agree to the services when offered. For example, when a patient would benefit from assignment to a specific treatment modality such as an ACT team to receive increased supervision and intensive case management, if the patient refuses to agree the ACT team is not assigned. Likewise, if the treatment plan identifies that the patient needs residential placement to assist in the delivery of treatment services and to assure compliance, if the patient refuses, the placement does not occur. The committee believes that this is antithetical to

a system that allows the court to issue an or order for treatment and, as a condition for the issuance of such a court order the court must find that because of their mental disorder the patient is either unwilling or unable to accept voluntary treatment. **Therefore, the committee believes that it is essential that the court orders for treatment in Arizona contain the following:**

> *"Based on the evidence presented, the court has determined that this patient's mental disorder substantially impairs their ability to make an informed decision regarding treatment, to understand the advantages and disadvantages or the alternatives to a particular treatment and therefore, until further order of the court, the patient shall not be allowed to refuse or be required to agree or consent to any particular treatment or service set forth in the Treatment Plan."*

E. It is axiomatic that a court that has the power to issue a court order mandating mental health treatment and appointing an agency to oversee such treatment pursuant to a treatment plan approved by the court, has the power to demand that the agency report to the court about the progress of treatment ordered and the patient's compliance. In Maricopa County, this has been done in the past through an Administrative Order requiring reports to the court 60 days after the order is entered and 60 days prior to expiration of the term of COT. Arizona law does not prevent the Superior Court from requiring in the COT Order that periodic reports be filed with the court and to set status hearings requiring attendance of parties. In fact, during the period of outpatient treatment A.R.S. §36-540(E)(5) allows the court *on its own motion* to determine that a patient is not complying with the terms of the order or that the treatment plan is no longer appropriate and to change the treatment plan. A.R.S. §36-540(E)(5) states (*emphasis added*):

> "During any period of outpatient treatment under subsection A, paragraph 2 of this section, *if the court, on its own motion* or on motion by the medical director of the patient's outpatient mental health treatment facility, *determines that the patient is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate* and the patient needs inpatient treatment, the court, *without a hearing and based on the court record, the patient's medical record, the affidavits and recommendations of the medical director, and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the patient, may enter an order amending its original order*. The amended order may alter the outpatient treatment plan or order the patient to inpatient treatment pursuant to subsection A, paragraph 3 of this section. The amended order shall not increase the total period of commitment originally ordered by the court or, when added to the period of inpatient treatment provided by the original order and any other amended orders, exceed the maximum period allowed for an order for inpatient treatment pursuant to subsection F of this section. *If the patient refuses to comply with an amended order for inpatient treatment, the court, on its own motion* or on the request of the medical director, *may authorize and direct a peace officer to take the patient into protective custody and transport the patient to the agency for inpatient treatment.* Any authorization, directive or order issued to a peace officer to take the

patient into protective custody shall include the patient's criminal history and the name and telephone numbers of the patient's case manager, guardian, spouse, next of kin or significant other, as applicable. When reporting to or being returned to a treatment agency for inpatient treatment pursuant to an amended order, the patient shall be informed of the patient's right to judicial review and the patient's right to consult with counsel pursuant to section A.R.S. §36-546.

Accordingly, in cases needing enhanced court scrutiny the Superior Court should consider doing the following:

a. include a specific order directing the medical director of the outpatient treatment agency to review the condition of the patient and to report to the court about the patient's progress in treatment and any non-compliance with the court approved treatment plan, identifying any real or perceived obstacles to needed treatment and requiring the medical director and the treatment team to consider all reports and information relevant to the patient's treatment or compliance received from any source, including family and friends of the patient.
b. In cases where the patient has a history demonstrating chronic non-compliance with treatment prescribed, recommended or provided, consider requiring the medical director of the outpatient treatment agency, or his designee, and the patient to participate in an 'In-court" case review, at periodic intervals, to review the progress or lack of progress in treatment and the need for amending the Treatment Plan or Court Order. This "in-court" review should allow for the parties to appear through an audio/video conferencing tool from a remote location where needed.

Persistent or Acute Disability and Emergency Hospitalization Standard:

Arizona statutes allow for a person to be hospitalized in an emergency without prior court approval pursuant to A.R.S. §36-524. Emergency hospitalization is permitted where the evaluation agency finds that during the time necessary for pre-petition screening the person is "likely without immediate hospitalization to suffer serious physical harm or serious physical harm or serious illness or is likely to inflict serious physical harm upon another person". However, this emergency hospitalization statute only applies to persons considered to be a danger to self or a danger to others and does not apply to someone considered persistent or acute disability (PAD) or Gravely Disabled. As justification for the exclusion of PAD from the emergency hospitalization statute, some point to the fact that the current definition of PAD does not include a potential danger to others as the result of the deteriorating mental health disorder and therefore should not be subject to immediate hospitalization without prior court approval.

Currently, when someone is applying for court ordered evaluation using the definition of PAD, the person's condition is viewed as "non-emergent" even if there is a clear indication in the person's history that they have a severe, persistent mental disorder which is deteriorating and that without immediate treatment, the person is likely to inflict physical harm on oneself or others. Persons identified as meeting this PAD standard in the screening process are put onto the "non-emergent" track of the system requiring a Petition-and-Pick-up process where a Petition for Involuntary Evaluation, sometimes called a "PAD Petition" is filed with the court and the court issues a Detention Order. This Detention Order is delivered to the sheriff and the sheriff has 14 days to detain the proposed patient and deliver them to an evaluation agency. Because these cases are considered as "non-emergent," the pick-up process is sometimes not given high priority by the Sheriff's Office. It is during this hiatus, between screening and pick up for the court ordered evaluation, that poses the greatest risk of harm to the individual and others. Family members and friends who know the person well can easily identify symptoms of the person's deteriorating persistent illness that, even though they have not yet acted to harm themselves or others, suggests imminent danger if not treated immediately. Yet, Arizona statutes do not currently allow partners such as law enforcement, or the screeners and evaluators to react quickly to seek immediate help for a person considered to have a persistent or acute disability.

The Committee continues to support its recommendation to introduce legislation to amend the definition of persistent or acute disability (PAD) in A.R.S. §36-501 to recognize that causing harm to self or others is one of the possible consequences of not getting treatment for a severe mental disorder that substantially impairs judgment, reason, behavior or capacity to recognize reality. The proposal would also amend A.R.S. §§36-524 and 36-526 by adding the PAD and grave disability categories to the statutes which authorize emergency hospitalization for psychiatric treatment, allowing screeners and evaluators to immediately hospitalize a person if the emergency standard for hospitalization set forth in statute is met, regardless of which category for involuntary treatment a person fits into.

After discussion with key stakeholders and partners, **the Committee also recommends adequate and consistent training and education of clinicians, including hospital physicians and mental health clinicians regarding application of the standard to ensure that the right people are getting evaluated as emergent vs. non-emergent.**

Finally, the issue of a lack of data to assist the Committee to consider the potential impact of the implementation of this recommendation must again be raised. After review and discussion with stakeholders, there appears to be little consistency or ease in accessing data regarding individuals who are turned away at the point of emergency hospitalization because they are considered PAD under the current standard. And yet, when we review the AHCCCS data on the number of people receiving Court Ordered Treatment, persons found to meet the PAD standard are clearly the largest subset of the population under COT. Regardless of the availability of relevant data to support this recommendation however, the Committee has been struck by anecdotal evidence it has received that this problem does indeed exist from the testimonies of numerous family members who have experienced first-hand the inability to get emergency help for a decompensating potentially dangerous mentally ill family member because they are considered only PAD and therefore non-emergent.