TEXAS CRIMINAL PROCEDURE & THE OFFENDER WITH MENTAL ILLNESS

AN ANALYSIS & GUIDE

FOURTH EDITION

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FOR

NAMI – TEXAS
THE NATIONAL ALLIANCE ON MENTAL ILLNESS – TEXAS

THROUGH A GRANT FROM THE
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<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. ACKNOWLEDGMENTS</td>
<td>4</td>
</tr>
<tr>
<td>II. INTRODUCTION &amp; OVERVIEW</td>
<td>7</td>
</tr>
<tr>
<td>III. PROCESS SUBSEQUENT TO ARREST</td>
<td>26</td>
</tr>
<tr>
<td>IV. COMPETENCY TO STAND TRIAL</td>
<td>44</td>
</tr>
<tr>
<td>A. In General</td>
<td>45</td>
</tr>
<tr>
<td>B. Juveniles</td>
<td>133</td>
</tr>
<tr>
<td>C. Death Penalty</td>
<td>160</td>
</tr>
<tr>
<td>V. INSANITY DEFENSE</td>
<td>172</td>
</tr>
<tr>
<td>A. Adult Defendants</td>
<td>172</td>
</tr>
<tr>
<td>B. Juveniles</td>
<td>218</td>
</tr>
<tr>
<td>C. Proposals for Reform</td>
<td>226</td>
</tr>
<tr>
<td>VI. POST-CONVICTION ISSUES</td>
<td>247</td>
</tr>
<tr>
<td>A. Community Supervision</td>
<td>247</td>
</tr>
<tr>
<td>B. Prison or Jail Mental Health Care</td>
<td>256</td>
</tr>
<tr>
<td>C. Completion of the Criminal Sentence</td>
<td>259</td>
</tr>
</tbody>
</table>
I. ACKNOWLEDGMENTS

NAMI – Texas (the National Alliance on Mental Illness of Texas) is a 501(c)(3) volunteer grassroots organization, and is also the Texas affiliate of NAMI (the National Alliance on Mental Illness). The goals of NAMI – Texas include providing support, education, and advocacy to help better the lives of persons affected by serious mental illness and their family members. As part of furthering these goals, in 1993 the organization (then known as the Texas Alliance for the Mentally Ill, or TEXAMI) sought and obtained a generous grant from the Texas Bar Foundation to prepare the first edition of this book as a guide for attorneys, judges, mental health consumers, and family members of persons who have serious mental illness who might encounter the Texas criminal justice system.

The first edition, which was initially printed in March 1994, was widely distributed, free of charge, to county and district court judges, criminal district attorneys, county attorneys, criminal defense attorneys, mental health consumer groups, family members of persons with mental illness, Texas libraries, and many others. Because of the high demand, TEXAMI obtained a grant from the Texas Council of Community Mental Health & Mental Retardation (MHMR) Centers to print an additional 3,000 copies in May 1994.

The publication and distribution of the book regarding Texas criminal law and the offender with mental illness was intended to promote the ends of justice by serving as an important educational tool. Many members of the practicing bench and bar, as well as the public in general, are not well-versed concerning the issues facing
persons diagnosed with mental illness – particularly when those persons are also caught up in the criminal justice system.

Given numerous changes in the law subsequent to the first edition, the Texas Bar Foundation and the Texas Council of Community MHMR Centers again provided generous financial support for the printing and distribution of a second edition of the book in 1999. For that second edition, we also expanded our analysis of the laws to include more information relating to juvenile offenders with mental illness. In addition, NAMI – Texas enlisted the assistance of Assistant Attorney General George Noelke to create a web-based version of the second edition.

Of course, the law does not remain static. Since the 1999 publication of the second edition, the Texas Legislature has enacted substantial changes to many of the laws addressed in the publication. In particular, the legislature completely overhauled the state’s criminal competency statute during the 2003 regular legislative session. One of us was fortunate to participate in the legislative task force efforts that provided the groundwork for the revisions. Those revised provisions became effective on January 1, 2004. The Texas Bar Foundation then provided another grant to allow for the publication and distribution of the third edition of this book in 2004. NAMI-Texas also placed a free version on their website.

Thereafter, the legislature made additional significant changes to the criminal competency statutes in 2005 and 2007, totally overhauled the procedures involved in insanity defense cases in 2005, and enacted further changes to several of the diversion of offenders statutes. Accordingly, the third edition is now out-of-date, and the Texas Bar Foundation has again generously funded a grant to allow for the publication and distribution of this our fourth
edition. This revised volume is intended to update the law and commentary discussed in the first three editions.

We would like, once again, to express our appreciation to the Texas Bar Foundation and NAMI – Texas for enlisting us in this worthwhile project. We also wish to recognize Dean Walter B. Huffman and the Texas Tech University School of Law for encouragement and support. We also remain grateful to our colleague, Charles Bubany, for his careful review of the first edition.

Although we gratefully acknowledge and thank NAMI – Texas, the Texas Bar Foundation, and the Texas Tech University School of Law for their support in this project, we accept full responsibility for any errors or omissions in the ensuing analysis. In addition, we welcome any comments or ideas about our views of the relevant statutes and procedures affecting offenders with mental illness in Texas. We hope you find this to be a useful tool in navigating an often-times challenging area of the law that affects the lives of countless Texans.

Brian D. Shannon
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Lubbock, Texas
July 2008
II. INTRODUCTION & OVERVIEW

There are now far more persons with mental illness in our nation’s jails and prisons than in state mental hospitals. See Michael Winerip, *Bedlam on the Streets*, N.Y. TIMES MAGAZINE (May 23, 1999). A September 2006 Department of Justice report stated that as of mid-2005 “more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 78,800 in Federal prisons, and 479,900 in local jails.” Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice Bureau of Justice Statistics (Sept. 2006). See http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf. In Texas, one study revealed that 30% of state prison jail inmates are also logged in the state’s public mental health database, with approximately 10% of all inmates having a diagnosis of serious mental illness that would be considered in the “priority population” for receipt of public mental health services. See TEX. COUNCIL ON OFFENDERS WITH MENTAL IMPAIRMENTS BIENNIAL REP. 27-28 (2007), http://www.tdcj.state.tx.us/publications/tcomi/Biennial%20Report%202007%20-%20Final.pdf. The rate of incidence of persons with schizophrenia, bipolar disorder (manic depression), and major depression within the jail and prison population is four times that of the general population. See Fox Butterfield, *By Default, Jails Become Mental Institutions*, N.Y. TIMES (March 5, 1998). And, “[o]ne in every 8 State prisoners was receiving some mental health therapy or counseling services at midyear 2000” and close to “10% were receiving psychotropic medications” for treatment of mental illnesses. Allen Beck and Laura Maruschak, *Mental Health Treatment in State Prisons, 2000*, U.S. Department of Justice Bureau of Justice Statistics (July 2001). See http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtsp00.pdf. With our nation now
housing an unprecedented number of people in jail, one would expect the percentage of inmates with mental disorders to correspond with the percentage found in the general population. However, the percentage of jail detainees with mental illness has long been far higher than among the general population. Henry J. Steadman and Bonita M. Veysey, *Providing Services for Jail Inmates with Mental Disorders*, Nat’l Inst. of Justice (April 1997). Indeed, as reported by the Justice Center of the Council of State Government’s Criminal Justice/Mental Health Consensus Project, “People with mental illness are overrepresented in all parts of the criminal justice system – in their contact with law enforcement, in the courts, in jails and prisons, and in parole and probation caseloads across the country.” THE ADVOCACY HANDBOOK 6, http://consensusproject.org/advocacy/pdfs/Handbook_all.pdf.

What accounts for this growth in jail detention of persons with mental impairments? An April 1999 National Institute of Justice report stated the following:

The dramatic growth of the population of jailed mentally ill persons has coincided with the policy of deinstitutionalization that resulted in the release of thousands of mentally ill people from psychiatric facilities to the community. Additional factors, including cuts in public assistance, more stringent civil commitment laws, declines in the availability of low-income housing, and limited availability of mental health care in the community, are thought to have exacerbated conditions for the mentally ill and contributed to their increased involvement in the criminal justice system.

Catherine Conly, *Coordinating Community Services for Mentally Ill Offenders: Maryland’s Community Criminal Justice Treatment Program*, Nat’l Inst. of Justice 3 (April 1999). An earlier and more
blunt analysis suggested that although “[p]risons and jails were not created to be mental hospitals …. because of the failure of public psychiatric services, prisons and jails have become de facto shelters of last resort for psychiatrically ill individuals.” See E. FULLER TORREY ET AL., CARE OF THE SERIOUSLY MENTALLY ILL: A RATING OF STATE PROGRAMS 6 (3d ed. 1990).

The history of the situation in Texas has been similar. One early report theorized the following:

A deinstitutionalization of state psychiatric hospitals and hospitals for the mentally ill and mentally retarded occurred in Texas in the 1980’s. However, community resources did not keep pace with the needs of the deinstitutionalized population, leaving a significant population of mentally impaired clients with unmet residential and service needs. Many of these clients ended up in the criminal justice system because of these unmet needs.

TEXAS CRIMINAL JUSTICE POLICY COUNCIL, MENTALLY RETARDED AND MENTALLY ILL CRIMINAL OFFENDERS: EFFECTIVENESS OF COMMUNITY INTERVENTION PROGRAMS 1 (March 1993). Moreover, information, procedures and protocols were traditionally lacking in Texas jails to deal with detainees with mental illness. As another early 1990’s report observed:

Historically law enforcement, prosecutorial, judicial, and corrections officials have not had adequate information about the signs and symptoms of mental illness, mental retardation and other developmental disabilities. They understand neither appropriate methods of dealing with signs and symptoms nor the needs of these individuals. Consequently, offenders with mental impairments are often
prosecuted, sentenced and incarcerated without consideration of their special needs.

TEXAS COUNCIL ON OFFENDERS WITH MENTAL IMPAIRMENTS, BIENNIAL REPORT TO THE TEXAS LEGISLATURE 5 (1993). This same study stressed further that “[t]hese special populations, with their complex needs, the stigma of disability or illness and their status as offenders, face substantial barriers to service. Even when some services are available, the lack of collaboration and coordination among providers create fragmentation of services.” Id. at 6.

Early in this decade, the Criminal Justice Policy Council provided several reports to the legislature and made issues relating to offenders with mental illness a high priority for the 2001 and ensuing sessions. A report prior to the 2003 session stated the following: “A high proportion of the offender population is mentally ill. Services for mentally ill offenders in the community are limited. Lack of specialized supervision and treatment services impacts [the] success of mentally ill offenders.” TEXAS CRIMINAL JUSTICE POLICY COUNCIL, IMPLEMENTATION EVALUATION OF THE ENHANCED MENTAL HEALTH SERVICES INITIATIVE 7 (Jan. 2003).

Within the prisons and jails in Texas, as well as in the population of individuals under supervision through probation and parole, mental health services have typically been lacking. In 2003, the Texas Council of Offenders with Mental Impairments (now known as the Texas Correctional Office on Offenders with Medical and Mental Impairments) summarized 2001 Criminal Justice Policy Council data to conclude that “the estimated prevalence rate of offenders with mental illnesses involved in the criminal justice system far outweighed the number receiving mental health services. Of the [then] estimated 91,603 offenders with mental illness, approximately 66,041, or 71% were not receiving mental health services.” TEXAS COUNCIL ON OFFENDERS
WITH MENTAL IMPAIRMENTS, BIENNIAL REPORT TO THE TEXAS LEGISLATURE 9 (2003) (emphasis in original). See http://www.tdcj.state.tx.us/publications/tcomi/TCOMI-Biennial-Report-2003.PDF. Jails have all too often become alternative “treatment” facilities within the community. However, adequate treatment is often lacking, and “providing for appropriate treatment for inmates with mental disorders is a task for which most [jail] facilities are ill equipped.” See Henry J. Steadman, supra, at 1.

Who are these individuals with mental illness in our jails? Of course, some persons suffering from mental illness are in jail or prison because they have committed one or more serious offenses. Often, however, the charged offenses may be a lesser offense that is a product of or connected to the offenders’ mental illness. A 1992 survey of the nation’s 3000-plus jails by the National Alliance for the Mentally Ill and Public Citizen’s Health Research Group indicated that the five most common offenses leading to the jailing of mentally ill inmates are assault, theft, disorderly conduct, alcohol or drug-related charges, and trespassing. CRIMINALIZING THE SERIOUSLY MENTALLY ILL 46 (Nat’l Alliance for the Mentally Ill & Pub. Citizen’s Health Research Group 1992). The authors of this nation-wide survey concluded that the vast majority of crimes committed by persons with serious mental illness “are trivial misdemeanors that are often just manifestations of mental illness.” Id. at iv (emphasis in original).

Other factors “cited as causes of people with mental illness being placed in the criminal justice system [include] … lack of community support systems … [and] difficulties in assessing mental health treatment upon release from a previous contact with the criminal justice system.” Marcia Goin, Mental Illness and the Criminal Justice System: Redirecting Resources toward Treatment, Not Containment 3,
http://archive.psych.org/edu/other_res/lib_archives/archives/200401.pdf. (Dr. Goin was the 2004 President of the American Psychiatric Association). Further exacerbating the problem is that the “[m]any mentally ill offenders [who] are charged with relatively minor offenses (e.g., prostitution, shoplifting, vagrancy), . . . are not diagnosed or treated while in jail and are released back into their communities with no plan for treatment or aftercare.” See Conly, supra, at 3. Moreover, even for the small minority of seriously mentally ill persons who are charged with serious crimes, the “perpetrators are frequently individuals whose mental illness has been left untreated.” CRIMINALIZING THE SERIOUSLY MENTALLY ILL, supra, at 46. Nonetheless, individuals with mental illness “not only end up in jail more often than non-mentally ill ones, but they also stay longer” and are “disproportionately arrested for minor crimes.” E. FULLER TORREY, THE INSANITY OFFENSE 131 (2008).*

Some things are definitely changing for the good in Texas, however. Our legislature has been very forward-thinking and has enacted many reforms relating to criminal laws and offenders with mental impairments over the last 15 years. Additional resources have been appropriated to study and begin to address the wide-ranging problem. Efforts have been initiated to better understand and respond to the challenges posed by an ever-increasing number of individuals with mental illness being caught up in the state’s criminal justice system. For example, in 2007 Chief Judge Sharon Keller of the Texas Court of Criminal Appeals created a Mental Health Task Force to address problems involving people with mental illness who are in the criminal justice system. That group

* On this same theme, we would like to urge the reader of this guidebook to also read Crazy: A Father’s Search Through America’s Mental Health Madness (2006). This book, which was a finalist for the 2007 Pulitzer Prize, is an extraordinary chronicle of the challenges faced within the criminal justice system with regard to individuals with mental illness.
held hearings around the state in 2007. See http://www.courts.state.tx.us/tfid/mentalhealth.asp. Additionally, Tarrant, Dallas, and Bexar Counties have been leaders in developing mental health courts. And, on another positive front, in the last few years the Texas Task Force on Indigent Defense has provided funding for the creation of mental health public defender offices in Dallas, El Paso, Limestone, and Travis Counties. See http://www.courts.state.tx.us/tfid/.

Regardless of the precise reasons for the presence of so many offenders with mental illness in the criminal justice system, lawyers, judges, law enforcement, corrections officials, parole and probation officers, mental health experts, family members, and persons suffering from mental illness should endeavor to better understand the interplay between the criminal laws and mental health treatment needs. Texas law provides various mechanisms to divert offenders with mental illness into alternatives to incarceration – particularly with respect to nonviolent offenses. Moreover, even for those offenders with mental illness who must be confined in jail or prison, proper treatment for the offenders’ mental illness should be a priority concern. The availability of legal options are of little value, however, if persons involved in the criminal justice system lack knowledge or adequate understanding regarding the legal issues and special needs of criminal defendants or inmates with mental illness.

Three years prior to the first edition of this book, a 1990 report by the Hogg Foundation for Mental Health emphasized the need for law enforcement personnel such as sheriff’s deputies, judges, and parole officers “to become more knowledgeable and understanding of persons with mental illness.” TECHNOLOGY, TRAINING, COLLABORATION: COMMITTEE REPORTS OF THE COMMISSION ON COMMUNITY CARE OF THE MENTALLY ILL 9 (Hogg Found. for Mental Health 1990). That same report observed further
that “it is also essential for judges and magistrates to be educated, informed, and oriented about basic aspects of mental illness, available resources, and how these factors interface with the legal system.” Id. at 10. That assessment has not changed. Moreover, others within the criminal justice system could similarly benefit from greater knowledge about mental illness and relevant legal provisions regarding offenders with mental impairments. Accordingly, it has been our intent in preparing the various editions of this monograph to provide guidance and information to defense attorneys, prosecutors, judges, law enforcement officials, mental health consumers, family members, and others involved in the criminal justice system. Specifically, we have identified certain key statutes that relate to offenders suffering from mental illness and set forth our analysis of those laws. Because our intended audience is not limited strictly to attorneys and judges, we have endeavored to adopt a narrative style in analyzing the pertinent statutory provisions, and we have consciously chosen to avoid any detailed case analysis.*

What is meant by “mental illness” or “serious mental illness”? Before launching into a discussion of the various statutes covering persons with mental illness who are charged with crimes, it is important to discuss definitions of these terms generally. Recent brain research has revealed and confirmed that major mental illnesses such as schizophrenia, bipolar disorder, clinical depression, and schizoaffective disorder are neurobiological diseases of the brain. Like other organs of the body, the brain can

become ill. Indeed, the medical literature is replete with findings that serious mental illnesses are neurobiological brain diseases. Accordingly, in this monograph the terms “mental illness” and “serious mental illness” will generally refer to neurobiological brain diseases such as schizophrenia, bipolar disorder, schizoaffective disorder, or severe depressive illness. Correspondingly, the terms are generally not intended to include other purely mental, emotional, behavioral, or coping problems that are not neurobiological in nature.

On the other hand, under the state’s civil commitment laws, the Texas Mental Health Code defines “mental illness” somewhat more broadly than a mere listing of identifiable, neurobiological brain disorders. Specifically, Subsection 571.003(14) of the Health & Safety Code provides the following definition:

“Mental illness” means an illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that:
(A) substantially impairs a person’s thought, perception of reality, emotional process, or judgment; or
(B) grossly impairs behavior as demonstrated by recent disturbed behavior.

TEX. HEALTH & SAFETY CODE ANN. § 571.003(14). For our purposes of examining the law relating to criminal offenders with mental illness, this Mental Health Code definition of “mental illness” is often important because many of the pertinent criminal statutes include cross-references to that definition.

The consideration of a bare statutory definition of mental illness, however, is insufficient to gain a full appreciation for this class of diseases. Four of the most common serious mental illnesses are schizophrenia, bipolar disorder, schizoaffective disorder, and major depressive illness. “Schizophrenia” is a brain
disease that affects a person’s thinking and judgment, sensory perception and the ability to interpret and respond to situations appropriately. Symptoms can include poor reasoning, disconnected and confusing language, hallucinations, delusions, and deterioration of appearance and personal hygiene. The NAMI website offers the following definitions:

Schizophrenia is a serious and challenging medical illness, an illness that affects well over 2 million American adults, which is about 1 percent of the population age 18 and older. Although it is often feared and misunderstood, schizophrenia is a treatable medical condition. Schizophrenia often interferes with a person’s ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others. The first signs of schizophrenia typically emerge in the teenage years or early twenties, often later for females. Most people with schizophrenia contend with the illness chronically or episodically throughout their lives, and are often stigmatized by lack of public understanding about the disease. Schizophrenia is not caused by bad parenting or personal weakness. A person with schizophrenia does not have a “split personality,” and almost all people with schizophrenia are not dangerous or violent towards others while they are receiving treatment. The World Health Organization has identified schizophrenia as one of the ten most debilitating diseases affecting human beings.

http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23036&lstid=327. For further definitions and discussion of schizophrenia, see the websites for the Mayo Clinic and the Texas Department of State Health Services:
Another of the more prevalent types of serious mental illness is bipolar disorder, also commonly known as manic depression. In contrast to schizophrenia, persons who suffer from “bipolar disorder” often swing between extremely high and low moods. The NAMI website provides the following definitions:

Bipolar disorder, or manic depression, is a medical illness that causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic and typically vary greatly over the course of a person’s life as well as among individuals. Over 10 million people in America have bipolar disorder, and the illness affects men and women equally. Bipolar disorder is a chronic and generally life-long condition with recurring episodes of mania and depression that can last from days to months that often begin in adolescence or early adulthood, and occasionally even in children. Most people generally require some sort of lifelong treatment. While medication is one key element in successful treatment of bipolar disorder, psychotherapy, support, and education about the illness are also essential components of the treatment process.

For examples of other definitions, consider the websites for the Mayo Clinic and the Texas Department of State Health Services:

“Schizoaffective disorder” represents another “of the more common, chronic, and disabling mental illnesses. As the name implies, it is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder.”

http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23043.

Another prevalent type of serious mental illness is major depressive illness or major depression. Although all humans occasionally feel depressed, depressive illness is much more severe. The NAMI website includes the following information about major depression:

Major depression is a serious medical illness affecting 15 million American adults, or approximately 5 to 8 percent of the adult population in a given year. Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is persistent and can significantly interfere with an individual’s thoughts, behavior, mood, activity, and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed countries.


Persons suffering from the brain disease of major depression may have symptoms such as loss of interest in daily activities, difficulty in sleeping, loss of appetite, recurrent feelings of worthlessness, guilt, hopelessness, and emptiness, and have recurring thoughts of death or suicide. For examples of other definitions, consider the websites for the Mayo Clinic and the Texas Department of State Health Services:

http://www.mayoclinic.com/invoke.cfm?id=DS00175
and
As described above, these mental illnesses are neurobiological in nature. Modern research efforts relating to the causes of mental illness indicate that mental illnesses are the result of neurobiological disease, not of weaknesses in character or poor parenting. Although these diseases are not curable at present, they are treatable. For example, one leading psychiatrist has commented that “[c]ontrary to the popular stereotype, schizophrenia is an eminently treatable disease.” E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A MANUAL FOR FAMILIES, CONSUMERS, & PROVIDERS 156 (4th ed. 2006). He compares the treatment for schizophrenia as being akin to the treatment for diabetes in that “both can usually be well controlled, but not cured, by drugs. Just as we don’t talk of curing diabetes but rather of controlling its symptoms and allowing the person with diabetes to lead a comparatively normal life, so we should also do with schizophrenia.” Id. at 156-57. Moreover, the relatively recent advent of a variety of more effective antipsychotic medications (often called atypical medications) has offered even better treatment outcomes.

Despite recent advances in medical knowledge about the neurobiological bases of serious mental illnesses, many persons still remain ignorant about the true nature of these diseases. Correspondingly, many sufferers of these ailments, as well as their family members, are forced to endure much public stigma. For someone unfamiliar with the true nature of these diseases, symptoms and manifestations such as delusional thinking, hallucinations, and other bizarre behavior can be quite frightening. As current evidence about these illnesses and their treatment becomes better known, however, stigmatization problems resulting from ignorance should lessen. Nonetheless, a person with mental illness who encounters the jail system may face heightened stigma.
not only because of the illness, but also as a consequence of the
arrest and incarceration.

Among the many myths relating to mental illness are misconceptions that all persons with mental illness must be dangerous. As a general matter, this is simply not true. Persons with mental illness in the community who are being treated pose no more a risk of violence than the general population; unfortunately, “if a person is off medication and psychotic, he becomes a greater risk for violence.” See Michael Winerip, supra. The authors of the 1992 survey of the nation’s jails emphatically observed the following: “It should be clearly stated that the vast majority of seriously mentally ill persons who end up in jail are not dangerous.” CRIMINALIZING THE SERIOUSLY MENTALLY ILL, supra, at 85. The authors acknowledged, however, that “it is also clear … that a small number of seriously mentally ill persons, if not treated for their illness, do become dangerous, may commit serious crimes, and usually end up in jail.” Id. (emphasis in original). After highlighting research in this area, the report concluded, “Mentally ill individuals who are being treated are not more dangerous than the general population. It is the failure to treat these individuals that makes them potentially dangerous.” Id. at 86 (emphasis in original). As Dr. Torrey has summarized more recently in discussing persons with schizophrenia, “Studies have made clear that most persons with schizophrenia are not assaultive or violent, but that a small number of them are. The common denominators of those who are assaultive and violent are abuse of alcohol or drugs and/or noncompliance with antipsychotic medication.” E. Fuller Torrey, SURVIVING SCHIZOPHRENIA, supra, at 306. Thus, treatment initiatives should be pursued not only as a response to medical needs, but to avoid the potential for dangerousness. Put simply, treatment works and can lessen the potential for dangerousness or violence.
Treatment and identification have often been scarce in jails, but this is perhaps slowly improving. Prior to early 1997, only limited screening for possible suicide prevention was required by Texas jails. A revised screening requirement was implemented in 1997 to better identify inmates with mental illness or mental retardation. The changed screening requirement has resulted in more offenders with mental illness being referred for psychiatric assessments.


More recently, however, a subsequent study by the Texas Commission on Jail Standards (with the collaboration of the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) in 2005, indicated that the intake process within the jails for mental health screening was unreliable. See _Tex. Council on Offenders with Mental Impairments Biennial Rep._ 29 (2005), [http://www.tdcj.state.tx.us/publications/tcomi/TCOMI-Biennial-Report-2005-final.pdf](http://www.tdcj.state.tx.us/publications/tcomi/TCOMI-Biennial-Report-2005-final.pdf). Based on a random sample of 100 inmates, the local jails identified that 15 (15%) had a mental health diagnosis. However, another 29 of the remaining inmates were found on the CARE (Client Assessment Registry) data system “as current or former clients of MHMR, but no mental health notation was indicated by the jail.” _Id._ at 29. See also [http://www.tcjs.state.tx.us/docs/MH%20Study.pdf](http://www.tcjs.state.tx.us/docs/MH%20Study.pdf) (copy of full report).

Thus, these 29 inmates had gone through the entire criminal process and been convicted and sentenced without the jails having every noted that they either were or had been patients within the state’s public mental health system. The 2005 TCOOMMI report also bleakly concluded that there appeared “to be an inconsistent interaction [around the state] between local jails and the public mental health system.” _Id._ Thereafter, efforts have been undertaken to encourage greater communication and cooperation between
local jails and community mental health authorities. TCOOMMI has worked to establish a better process for local jails and mental health authorities to cross-reference the inmate census with the CARE system. See TEX. COUNCIL ON OFFENDERS WITH MENTAL IMPAIRMENTS BIENNIAL REP. 21 (2007), http://www.tdcj.state.tx.us/publications/tcomi/Biennial%20Report%202007%20-%20Final.pdf.

These improvements in initial screenings and collaboration between jail and public mental health providers are important and should be encouraged throughout the state. Additionally, treatment initiatives, whether at the jail or through diversion programs, must also be encouraged. Indeed, the jails have a legal requirement to provide equitable treatment for mental disabilities – like for other health care needs. For example, in March 1999, the Texas Commission on Jail Standards adopted a rule requiring every jail to comply with the Americans with Disabilities Act (ADA). See 24 Tex. Reg. 1638 (March 5, 1999) (amending 37 Tex. Admin. Code § 269.4). Thus, jails cannot legally discriminate against inmates with mental illness by refusing to provide adequate, appropriate medical care. Additionally, the reader should be aware that over the last several legislative sessions, the Texas Legislature has provided substantial emphasis and funding to focus on issues relating to persons with mental illness in the criminal justice system.

Of course, this book is not intended to be a primer on treatment issues concerning inmates with serious mental illness. Instead, the primary purpose of the book is to set forth and analyze the relevant criminal procedure statutes that apply to persons with mental illness who get caught up in the criminal justice system. The reader should note that many of the statutory provisions discussed below, including those relating to incompetency to stand trial and the insanity defense, also include provisions addressing persons with
mental retardation. Our primary focus, however, is to examine and discuss the laws relating to offenders suffering from mental illness. Thus, we have generally opted to omit discussion of the application of these laws to persons with mental retardation. (By way of background, unlike mental illnesses, which generally strike individuals with normal intelligence after childhood, mental retardation is typically a developmental disability of the brain that often is present from birth and will have been developed prior to a person’s 18th birthday.) Although there are criminal justice issues relating to offenders who have mental retardation, those matters are beyond the scope of this project. Moreover, if an offender suffers from a dual diagnosis of mental illness and mental retardation, counsel should consider pursuing arguments based on the statutory provisions relating to both mental illness and mental retardation.

As the reader will have already observed, there are a myriad of issues surrounding persons with mental illness who are charged with crimes. By and large, however, the public seems to pay little attention to these matters until some notorious crime is committed by a person with mental illness. For example, publicity from two Texas cases in recent years involving Andrea Yates and Deanna Laney provide insight into the types of criminal justice issues and problems relating to offenders with mental illness who commit serious crimes. Ms. Yates, as most people are aware, was initially convicted of capital murder in March 2002 in connection with having systematically killed her five children by drowning in June 2001. In finding Ms. Yates guilty, the Houston jury in the first trial rejected her plea of insanity. As part of the closing arguments in that case, defense lawyer Wendell Odom summarized that “a number of the medical experts who testified said Yates was the sickest patient they had ever seen.” Case of Texas Mother Goes to Jury, CNN.com (March 12, 2002), available at http://www.courttv.com/trials/yates/031202_cnn.html. After a reversal
by the court of appeals, Ms. Yates was found not guilty by reason of insanity in the re-trial. Similarly, in April 2004 a Tyler jury found Ms. Laney not guilty by reason of insanity following her having bludgeoned her three sons with rocks in May 2003, killing two of the boys and causing profound brain damage to the youngest.

Without doubt, these two cases caused substantial debate in the Texas legal and political communities about issues relating to the Texas insanity defense, appropriate treatment, and even the role of capital punishment for offenders with serious mental illness. We will return to a further discussion of the Yates and Laney cases in the chapter on the insanity defense.

Of course, most of the offenses for which persons with mental illness are charged are not as serious as in the Yates or Laney cases. Moreover, the insanity defense is seldom raised and even more seldom successful. Whereas, by way of contrast, competency issues arise daily in our state’s criminal justice system, as do issues relating to the possible diversion of defendants with mental illness charged with non-violent or non-serious crimes. Thus, it is critical that attorneys within the system be familiar with both the nature of the defendant’s illness and the various legal options that can be pursued. Lawyers have a high duty in this regard. Indeed, criminal defense attorneys have been cited for having provided ineffective assistance of counsel for not investigating an alleged offender’s mental illness. For example, in *Bouchillon v. Collins*, 907 F.2d 589 (5th Cir. 1990), the court observed the following:

Where a condition may not be visible to a layman, counsel cannot depend on his or her own evaluation of someone’s sanity once he has reason to believe an investigation is warranted because, where such a condition exists, the
defendant’s attorney is the *sole hope* that it will be brought to the attention of the court.

*Id.* at 597 (emphasis supplied) (footnote omitted).

In *Bouchillon*, the defense attorney declined to pursue any investigation regarding the defendant’s competency despite being told by the defendant that he had mental problems, had been hospitalized previously, and was on medication. *Id.* at 596 (observing that counsel had declined to investigate further because “it was difficult to prove an insanity defense in Lubbock, Texas”). The court held that the attorney’s lack of further investigation after he had notice of the defendant’s “past institutionalization, fell below reasonable professional standards.” *Id.* at 597. As evidenced by cases such as *Bouchillon*, an attorney’s unfamiliarity with mental illness may jeopardize a mentally ill client’s legal rights and medical treatment needs. Moreover, post-conviction attempts to correct errors of counsel will often prove to be inadequate as a substitute for knowledgeable, informed representation.

The presence of both offenders and accused individuals suffering from mental illness in our jails and prisons continues to be a very real and pressing problem facing the Texas criminal justice system. In the ensuing chapters we will examine certain processes that arise subsequent to arrest and prior to trial (with a particular focus on Texas’ diversion of offenders statutes), the criminal competency process (which was completely revamped in 2003), the insanity defense (for which all the relevant procedures were completely re-codified in 2005), and certain post-conviction issues. It is our hope that the analysis set forth in the following chapters regarding the relevant Texas statutes will prove beneficial to judges, prosecutors, defense attorneys, law enforcement officials, parole and probation officers, mental health consumers,
family members, and all others interested in offenders and alleged offenders with mental illness.

III. PROCESS SUBSEQUENT TO ARREST

Prior to 1995, the Texas Mental Health Code precluded a court from issuing a commitment order for either temporary or extended mental health services with respect to a proposed patient who faced charges for any criminal offense. On the other hand, the Mental Health Code did not similarly restrict the imposition of short-term mental health services through either an emergency detention order or an order of protective custody, even when criminal charges were pending. Accordingly, prior to legislation enacted over the last fifteen years, court-ordered mental health services could be initiated under the Mental Health Code, but no final commitment order could be pursued when criminal charges remained pending. Thus, law enforcement officials often found themselves in the difficult position of considering whether to drop criminal charges as a means of assuring that an alleged offender could obtain mental health services pursuant to the Mental Health Code. See generally Michael J. Churgin, An Analysis of the Texas Mental Health Code 129-30 (2nd ed. 1994). Additionally, jail officials are responsible for administering or securing mental health treatment services for alleged offenders with mental illness who remain in jail. Prior to recent years, psychiatric services were traditionally “unavailable or scarce” within the state’s jails. Id. at 24.

Professor Churgin has argued that the former statutory limitations on civil commitments in the Mental Health Code had the undesirable effects of (1) causing alleged offenders with mental illness to receive inadequate mental health care while housed in jail, and (2) forcing law enforcement officials to consider dropping
charges to enable a court to impose mental health services through the commitment process. *Id.* On the other hand, these same limitations have sometimes served to encourage prosecutors and defense counsel, particularly in the case of nonviolent offenses, to “negotiate” the dropping of charges in exchange for the alleged offender’s agreement to obtain mental health services on a quasi-voluntary basis. Indeed, if the individual’s activities that led to the criminal charges stemmed directly from the offender’s mental illness, a release and dropping of criminal charges upon the individual’s agreement to abide by a treatment plan could prove beneficial for all concerned. Of course, if the defendant is unwilling either to seek or consent to mental health treatment on a voluntarily basis, then the Mental Health Code’s former restrictions presented difficulties. (As an aside, an updated version of Professor Churgin’s excellent section-by-section analysis of the Texas Mental Health Code is available online on the Hogg Foundation’s website. See [http://www.hogg.utexas.edu/PDF/Analysis_Texas_Mental_Health_Code.pdf](http://www.hogg.utexas.edu/PDF/Analysis_Texas_Mental_Health_Code.pdf).

Over the last fifteen years, the Texas Legislature has responded in several ways to the Mental Health Code’s previous limitations on court-imposed mental health services (when criminal charges are pending against an alleged offender with mental illness). First, the legislature added two new provisions to the Texas Code of Criminal Procedure in 1993 as part of an extensive package of criminal justice reform. These two statutes first became effective September 1, 1994. Then, in 1995 the legislature took further steps at reform by amending the Mental Health Code to remove, in part, the limits on the use of the commitment process when criminal charges remain pending.

As described in the official analysis of the original version of the 1993 legislation, prior “Texas Law ha[d] no codified procedure for allowing the transfer of suspected mentally ill … defendants
who are in jail. These individuals await[ed] trial without the benefit of any treatment.” HOUSE COMM. ON CRIM. JURISPRUDENCE, BILL ANALYSIS, Tex. H.B. 1605, 73rd Leg. (1993). The bill analysis also declared that there is a

grave injustice that is visited on those who are mentally ill … and who are in need of medical care. Regardless of guilt or innocence, these citizens should be provided appropriate care. The system of justice may proceed with the procedure that is called for; but, the health care issue is to be addressed if we are to act as a civilized society.

Id. This assessment still resonates today. And, thus, the legislature took steps to begin addressing these concerns. The following paragraphs describe the legislature’s ongoing efforts at reform in more detail.

1995 AMENDMENTS TO THE MENTAL HEALTH CODE. The Texas Mental Health Code previously disallowed the imposition of orders for temporary or extended mental health services (90-day or 12-month commitments) for any proposed patient who was charged with a criminal offense. As amended in 1995, however, these prohibitions are now limited to any “proposed patient who is charged with a criminal offense that involves an act, attempt, or threat of serious bodily injury to another person.” TEX. HEALTH & SAFETY CODE §§ 574.034(h), 574.035(i) (amended language in italics). Accordingly, for all other criminal charges, civil commitment proceedings can be undertaken for appropriate individuals despite the presence of pending criminal charges. Thus, civil commitment is an available option for alleged offenders with mental illness who have been charged with most non-violent offenses.
Art. 16.22. Examination and Transfer of Defendant Suspected of Having Mental Illness or Mental Retardation. (a)(1) Not later than 72 hours after receiving evidence or a statement that may establish reasonable cause to believe that a defendant committed to the sheriff's custody has a mental illness or is a person with mental retardation, the sheriff shall notify a magistrate of that fact. A defendant’s behavior or the result of a prior evaluation indicating a need for referral for further mental health or mental retardation assessment must be considered in determining whether reasonable cause exists to believe the defendant has a mental illness or is a person with mental retardation. On a determination that there is reasonable cause to believe that the defendant has a mental illness or is a person with mental retardation, except as provided by Subdivision (2), the magistrate shall order an examination of the defendant by the local mental health or mental retardation authority or another qualified mental health or mental retardation expert to determine whether the defendant has a mental illness as defined by Section 571.003, Health and Safety Code, or is a person with mental retardation as defined by Section 591.003, Health and Safety Code.

(2) The magistrate is not required to order an examination described by Subdivision (1) if the defendant in the year preceding the defendant’s applicable date of arrest has been evaluated and determined to have a mental illness or to be a person with mental retardation by the local mental health or mental retardation authority or another mental health or mental retardation expert described by Subdivision (1). A court that elects to use the results of that evaluation may proceed under Subsection (c).

(3) If the defendant fails or refuses to submit to examination required under Subdivision (1), the magistrate may order the defendant to submit to an examination in a mental health facility determined to be appropriate by the local mental health or mental retardation authority for a reasonable period not to exceed 21 days. The magistrate may order a defendant to a facility operated by the Department of State Health Services or the Department of Aging.
and Disability Services for examination only on request of the local mental health or mental retardation authority and with the consent of the head of the facility. If a defendant who has been ordered to a facility operated by the Department of State Health Services or the Department of Aging and Disability Services for examination remains in the facility for a period exceeding 21 days, the head of that facility shall cause the defendant to be immediately transported to the committing court and placed in the custody of the sheriff of the county in which the committing court is located. That county shall reimburse the facility for the mileage and per diem expenses of the personnel required to transport the defendant calculated in accordance with the state travel regulations in effect at the time.

(b) A written report of the examination shall be submitted to the magistrate not later than the 30th day after the date of any order of examination issued in a felony case and not later than the 10th day after the date of any order of examination issued in a misdemeanor case, and the magistrate shall provide copies of the report to the defense counsel and the prosecuting attorney. The report must include a description of the procedures used in the examination and the examiner’s observations and findings pertaining to:

(1) whether the defendant is a person who has a mental illness or is a person with mental retardation;
(2) whether there is clinical evidence to support a belief that the defendant may be incompetent to stand trial and should undergo a complete competency examination under Subchapter B, Chapter 46B; and
(3) recommended treatment.

(c) After the court receives the examining expert’s report relating to the defendant under Subsection (b) or elects to use the results of an evaluation described by Subsection (a)(2), the court may, as applicable:

(1) resume criminal proceedings against the defendant, including any appropriate proceedings related to the defendant’s release on personal bond under Article 17.032; or
(2) resume or initiate competency proceedings, if required, as provided by Chapter 46B or other proceedings affecting the defendant’s receipt of appropriate court-ordered mental health
or mental retardation services, including proceedings related to the defendant’s receipt of outpatient mental health services under Section 574.034, Health and Safety Code.

(d) Nothing in this article prevents the court from, pending an evaluation of the defendant as described by this article:

(1) releasing a mentally ill or mentally retarded defendant from custody on personal or surety bond; or
(2) ordering an examination regarding the defendant's competency to stand trial.

Since 1994 this statute has authorized jail officials within a sheriff’s office to seek both an initial psychiatric examination and possible transfer of an alleged offender with mental illness from the jail to a mental health treatment facility. This statute represented an initial effort at addressing the Mental Health Code’s former prohibition against imposing temporary or extended mental health services on persons charged with crimes. The legislation allows for proper diagnosis and the initiation of mental health services in an appropriate treatment setting notwithstanding the pending criminal charges. It is also broader than the 1995 changes to the Mental Health Code in that it is not limited to particular types of criminal charges. The legislature has fine-tuned the statute several times over the years to help make it a better tool for identifying and beginning (or resuming) treatment for an alleged offender with mental illness who has been jailed following arrest.

Specifically, Article 16.22 requires a sheriff to provide notice to a magistrate within 72 hours of receiving evidence or a statement that may establish reasonable cause to believe that an alleged offender has a mental illness or is a person with mental retardation. The statute employs the term “shall,” and the 72-hour reporting mandate was added by the legislature in 1997. Amendments added to the statute in 1997 require the magistrate to take the alleged offender’s behavior and any prior mental health
assessments into account in determining whether there is reasonable cause to believe that the defendant has a mental illness. If the evidence or statement establishes reasonable cause to believe that the defendant may indeed suffer from a mental illness, then the magistrate (1) must typically order that the alleged offender submit to a medical examination conducted either by the local mental health authority or some other qualified mental health expert, and (2) may require that the defendant be transferred to an appropriate mental health facility as identified by the local mental health authority for such an examination. Amendments enacted in 2007 added subdivision (a)(2), however, which allow the magistrate to forego ordering a new evaluation if the individual has been evaluated and determined to have a mental illness or to be a person with mental retardation in the year prior to arrest. (County jails and mental health authorities will need to keep records of such evaluations that can be made available to magistrates as they consider whether a new evaluation is needed.)

As originally enacted, this statute required the alleged offender to submit to a medical examination under subsection 3(b) of former Article 46.02, Texas Code of Criminal Procedure. Subsection 3(b) of old Article 46.02 generally related to medical examinations for the purpose of ascertaining a criminal defendant’s competency to stand trial. Traditionally, medical examinations pursuant to that statute were not sought until evidence raising questions about the defendant’s competency to stand trial was presented to the criminal court. In contrast, Article 16.22 was enacted with the specific intent to require the sheriff and magistrate to intervene at an earlier stage in the proceedings – shortly following arrest or after a psychiatric “break” – to have the defendant receive a proper psychiatric examination or be transferred to a more appropriate facility for addressing mental health needs. The clear intent of Article 16.22 is to assure a prompt and proper evaluation and diagnosis for an inmate who is
evidencing behavior associated with mental illness or mental retardation, and to recommend treatment.

Amendments to Article 16.22 enacted in 1997 properly eliminated references to Subsection 3(b) competency exams. Unfortunately, however, as part of some 2001 amendments, a phrase was added to subsection (b) to require the expert’s report not only to include information about whether the defendant has mental illness or is a person with retardation, along with recommended treatment, but also to state “whether the defendant is competent to stand trial.” Given that 16.22 was intended to require a quick, early evaluation and assessment of the defendant suspected of having mental illness or mental retardation, this was a nonsensical addition. The 16.22 evaluation was never intended to include a full “competency” assessment. Happily, this glitch in the statute was corrected by the legislature in 2003. As part of the 2003 enactment of the revised competency statute (Chapter 46B, which is described in detail in a subsequent chapter), the legislature amended article 16.22 to add the language now found in subpart (b)(2). That language requires the expert who has conducted a 16.22 exam to report on “whether there is clinical evidence to support a belief that the defendant may be incompetent to stand trial and should undergo a complete competency examination.” In other words, the expert conducting the 16.22 exam is not to perform a full competency exam, but should include in the report whether a full competency evaluation should be undertaken. This language is more in keeping with the original intent that the 16.22 exam be a type of “screening” exam. It should also be noted, however, that in 2007 subsection (d) was added to make clear that nothing in 16.22 should be construed to preclude the court’s order for a competency exam. That is, a 16.22 examination is not a prerequisite for the ordering of a full competency exam.
Unless there is a report from the past year prior to arrest on file, the appointed examining expert is required to submit a report to the magistrate and all counsel promptly. The 2007 amendments kept the deadline of 30 days from the date of the court’s order for felonies, but shortened the period to 10 days from the court’s order for misdemeanors. This is in keeping with the desire for the 16.22 exam to serve as a means of rapid identification of mental illness or mental retardation. In addition to reporting on whether a full competency exam may be needed, the report must include all observations and findings relating to whether the person has a mental illness or is a person with mental retardation and must include a discussion of recommended treatment. The identification of possible treatment is particularly important given that the examining expert’s report will likely form the basis for the magistrate’s release of the defendant on personal bond (for nonviolent offenses), but conditioned on the defendant’s receipt of mental health services. This personal bond authority is set forth in Article 17.032, Texas Code of Criminal Procedure, and is discussed below. Amendments in 2007 also added subsection (d) which makes clear that the ordering of a 16.22 exam does not preclude the court’s releasing the defendant with mental illness on personal or surety bond.

Although the language in Article 16.22 speaks primarily in terms of authorizing sheriffs to invoke the provisions of the act (through the providing of information about the defendant’s possible mental illness to the magistrate), that limitation should not be read as a bar against other individuals providing pertinent information to a sheriff’s office concerning an alleged offender with mental illness. It may be prudent for a defendant, defense counsel, mental health worker, or a family member or friend to inform law enforcement officials within the sheriff’s office concerning the alleged offender’s mental illness. Such information could prove useful either with respect to invoking these new
statutes or in assuring the provision of mental health services. The information can also be relayed to the prosecuting attorney involved in the case. Additionally, through memoranda of understanding (MOUs) between the sheriff’s office and the local MHMR center, information can also be provided by the MHMR center if the defendant has been the recipient of services from the local center or another state or local MHMR center or facility.

In addition, as a means of augmenting Texas sheriffs’ authority under Article 16.22, other legislation has been enacted to ensure that officials within the sheriff’s office are fully able to appreciate and understand information concerning an alleged offender’s mental illness. In 1993, the Legislature set a “goal” of “establish[ing] at least one special officer for mental health assignment in each county.” TEX. HEALTH & SAFETY CODE ANN. § 531.001(g). These officers will have received specialized training relating to the characteristics and symptoms of mental disabilities. A number of counties have taken advantage of the opportunity to have one or more officers trained as mental health deputies. Since that time, substantial efforts have been undertaken by law enforcement in many parts of the state to provide mental health deputy training and crisis intervention training for law enforcement officers. The Texas Commission on Law Enforcement Officer Standards and Education has developed curricula, and the Commission on Jail Standards and other groups have made law enforcement training a priority.

ARTICLE 17.032, CODE OF CRIMINAL PROCEDURE.

Art. 17.032. RELEASE ON PERSONAL BOND OF CERTAIN MENTALLY ILL DEFENDANTS. (a) In this article, “violent offense” means an offense under the following sections of the Penal Code:
   (1) Section 19.02 (murder);
(2) Section 19.03 (capital murder);
(3) Section 20.03 (kidnapping);
(4) Section 20.04 (aggravated kidnapping);
(5) Section 21.11 (indecency with a child);
(6) Section 22.01(a)(1) (assault);
(7) Section 22.011 (sexual assault);
(8) Section 22.02 (aggravated assault);
(9) Section 22.021 (aggravated sexual assault);
(10) Section 22.04 (injury to a child, elderly individual, or disabled individual);
(11) Section 29.03 (aggravated robbery); or
(12) Section 21.02 (continuous sexual abuse of young child or children).

(b) A magistrate shall release a defendant on personal bond unless good cause is shown otherwise if the:
   (1) defendant is not charged with and has not been previously convicted of a violent offense;
   (2) defendant is examined by the local mental health or mental retardation authority or another mental health expert under Article 16.22 of this code;
   (3) examining expert, in a report submitted to the magistrate under Article 16.22:
       (A) concludes that the defendant has a mental illness or is a person with mental retardation and is nonetheless competent to stand trial; and
       (B) recommends mental health treatment for the defendant; and
   (4) magistrate determines, in consultation with the local mental health or mental retardation authority, that appropriate community-based mental health or mental retardation services for the defendant are available through the Texas Department of Mental Health and Mental Retardation under Section 534.053, Health and Safety Code, or through another mental health or mental retardation services provider.

(c) The magistrate, unless good cause is shown for not requiring treatment, shall require as a condition of release on personal bond
under this article that the defendant submit to outpatient or inpatient mental health or mental retardation treatment as recommended by the local mental health or mental retardation authority if the defendant’s:

(1) mental illness or mental retardation is chronic in nature; or
(2) ability to function independently will continue to deteriorate if the defendant is not treated.

(d) In addition to a condition of release imposed under Subsection (c) of this article, the magistrate may require the defendant to comply with other conditions that are reasonably necessary to protect the community.

(e) In this article, a person is considered to have been convicted of an offense if:

(1) a sentence is imposed;
(2) the person is placed on community supervision or receives deferred adjudication; or
(3) the court defers final disposition of the case.

Another section of the 1993 penal reforms that became effective on September 1, 1994, is Article 17.032 of the Texas Code of Criminal Procedure. Similar to Article 16.22, this statute represented an attempt by the legislature to divert certain alleged offenders with mental illness or mental retardation into a pre-trial treatment facility that is outside the jail environment or into outpatient treatment. In fact, Article 17.032 generally requires magistrates to release certain alleged offenders with mental illness or mental retardation on personal bond pending further criminal proceedings. If a defendant is released on personal bond, there is no requirement for sureties or other security (no bail).

Specifically, the provisions of Article 17.032 direct that a magistrate release a defendant with mental illness on personal bond if (1) the pending charges do not include any of the violent crimes identified in Subsection (a) of the statute, and (2) the
alleged offender has not been previously *convicted* of any such violent crime. In addition, a mental health expert must have examined the defendant pursuant to Article 16.22, Texas Code of Criminal Procedure, as described above. Additional criteria for the defendant’s release under this statute are that the mental health expert’s opinion must include findings that the defendant is mentally ill yet still competent to stand trial and a recommendation that the defendant receive mental health services. Presumably, if the appointed mental health expert is of the view that the defendant is both mentally ill and could be *incompetent* to stand trial, then a full competency exam and competency proceedings should be pursued, and a release on personal bond is not relevant at that time. If the preceding criteria for release on personal bond are met, however, the magistrate still must determine, after consulting with the local mental health authority, that appropriate, community-based mental health services are available through either a state facility or another mental health treatment provider. (The statute continues to refer to the Texas Department of Mental Health and Mental Retardation. That agency no longer exists, but its functions are now handled by the Department of State Health Services.) For obvious reasons, appropriate local mental health services must be available for this statute to be effective. Accordingly, sufficient funding must be made available and dedicated to carry out the legislative intent.

As originally enacted, the release requirements set forth in Article 17.032 were mandatory, provided that the relevant criteria were satisfied. The statute, however, was modified in 1997 to allow a magistrate not to release a defendant with mental illness on personal bond if “good cause is shown otherwise.” This phrase was not further defined in the 1997 amendments, but it does appear to allow the prosecuting attorney to make arguments against release on personal bond in certain cases. Clearly, however, the legislature
was intending “good cause” to apply only in exceptional cases, and not to become the “rule.”

The most important language included in Article 17.032 is set forth in Subsection (c). As a condition of the defendant’s release on personal bond, the magistrate must generally require that the defendant obtain either inpatient or outpatient mental health services, as recommended by the local mental health authority, pending any further criminal proceedings. The magistrate is required to impose such a condition upon finding either that (1) the defendant’s mental illness is chronic in nature, or (2) the defendant’s ability to function independently will continue to deteriorate without the benefit of treatment for the mental illness. As originally enacted, subsection (c) stated only that a magistrate “may” impose such a treatment condition. The legislature modified that language in 1997 by replacing “may” with “shall” (“unless good cause is shown for not requiring treatment”). The 1997 changes reflect a clear legislative intent that alleged offenders suffering from mental illness receive adequate and appropriate mental health services subsequent to arrest. We have long applauded the legislature’s 1997 revision making the treatment condition mandatory. It would be incongruous to identify an alleged offender’s mental illness and need for medical attention, yet release the individual on personal bond with no condition that the person obtain treatment. Exceptions to the treatment condition should be made only in rare circumstances. Also, a lack of funds for treatment should not equate to “good cause’ for not requiring the treatment condition. However, sufficient funding should be appropriated to the local mental health authorities to assure appropriate treatment services are available.

In addition to authorizing the condition that a defendant submit to mental health treatment for release on personal bond, Subsection (d) permits a magistrate to impose other conditions “reasonably
necessary to protect the community.” The statute, however, is otherwise silent with respect to what these “other conditions” might include. To facilitate treatment, added restrictions under this section, if any, should not be overly broad. On the other hand, certain requirements might be both relevant and appropriate. For example, if a magistrate orders as a condition of release on personal bond that a defendant obtain outpatient care at a local mental health facility, that magistrate might also want to include a condition that the defendant or the facility provide regular reports that all appointments are being kept. Similarly, if a magistrate orders that a defendant receive inpatient services, the magistrate might also require reports from the mental health facility as to whether the defendant continues to require inpatient treatment or could be treated satisfactorily on an outpatient basis.

Although Article 17.032 authorizes magistrates to release on personal bond offenders with mental illness who have been charged with nonviolent offenses, the statute is silent about the potential for release on personal bond if the charged offense is for one of the identified “violent crimes.” One may certainly argue from this silence that the legislature must not have intended to authorize any releases on personal bond for those offenses.

We believe, however, that there is an alternative manner in which to analyze the statute. Subsection (b) of Article 17.03, Texas Code of Criminal Procedure, generally authorizes “the court before whom the case is pending” to consider releasing on personal bond a defendant charged with certain violent crimes. The list of violent crimes delineated in Article 17.03(b) is less inclusive than the list set forth in Article 17.032. Moreover, Subsection (a) of Article 17.03 provides general authority for magistrates to consider releasing defendants on personal bond for all charges except those violent offenses left in the hands of the trial judges under Article 17.03(b). Thus, one may argue that even for the violent crimes
identified in Article 17.032, the general grant of authority for releasing defendants on personal bond set forth in Article 17.03 still provides discretion to magistrates (and for certain violent crimes, to trial judges) to consider releasing on personal bond a defendant charged with one of the violent offenses included in Article 17.032. Of course, the magistrate or trial judge, as the case may be, in such a situation has a much greater degree of latitude in deciding whether to release a defendant on personal bond than in the mandatory situations delineated in Article 17.032. Additionally, in cases involving violent offenses, the magistrate or trial judge must give strong consideration to the protection of the public. Finally, if release on personal bond is not granted (or is ultimately determined not to be authorized) in such a situation, there will in all likelihood still exist a substantial need for assuring that the alleged offender with mental illness obtain mental health treatment including appropriate medications within the jail setting (or upon release on bail).

Without doubt, articles 16.22 and 17.032 represent a vast improvement over prior law in attempting to secure the provision of mental health treatment subsequent to arrest for alleged offenders suffering from mental illness. Particularly for nonviolent offenses, Article 17.032 continues to have the potential to provide an innovative mechanism for authorizing and ensuring mental health treatment outside the jail environment pending further criminal proceedings. As an alternative, given the 1995 changes to the Mental Health Code discussed above, civil commitment proceedings can alternatively be pursued with respect to many of the same persons facing charges for nonviolent offenses.

As an additional note, we wish to point out that the existence of these diversion statutes does not preclude the possibility that a prosecutor might opt to drop criminal charges in exchange for an agreed mental health treatment plan, particularly for nonviolent
crimes. That approach may be especially worth pursuing when there is some degree of confidence that the alleged offender will indeed comply with the treatment plan. Defense attorneys should endeavor to develop a prospective treatment plan that can be presented to the prosecution during plea bargaining. Law enforcement officials retain the discretion not to prosecute all matters and may instead turn to the mental health system in appropriate situations.

Additional legislation first enacted in 1999 has been intended to facilitate the prospect that the jails might not be used in appropriate cases in responding to minor offenses by offenders with mental illness. Section 614.017 of the Texas Health & Safety Code allows the exchange of information, notwithstanding other confidentiality requirements, between law enforcement agencies and an array of health and human services agencies with regard to “special needs offenders.” This statute is intended to allow, for example, mental health officials from a community MHMR center to provide treatment or other relevant information to the police, a sheriff’s office, or to jail or community supervision officials. In 1999 the legislation was amended to expand the definition of “special needs offender” from a very narrow category to now include any “individual for whom criminal charges are pending or who after conviction or adjudication is in custody or under any form of criminal justice supervision.” Tex. Health & Safety Code § 614.017(c)(2). The reason for expanding the definition of “special needs offender” was to allow better communication between agencies with respect to individuals with mental disabilities caught up in the criminal justice system. With better communication between agencies, the prospect is greater that alternatives to incarceration might be considered and undertaken, and that workable community diversion programs can be developed and implemented.
As a final comment, we must observe that the legislature has created a viable framework for allowing the pre-trial diversion and treatment of a great many persons with mental illness who face criminal charges. Unfortunately, for a number of years there has not been as much activity within the state to implement diversion programs as would be desirable. Moreover, identification and treatment within the jails for mental illness concerns is still often lacking. For these well-intended diversion initiatives to be successful, judges, prosecutors, and law enforcement officials need to work closely with community and state mental health officials to assure that the legislative intent is carried out. There have been some noble efforts in this regard in communities as diverse as San Antonio, Lubbock, Dallas, Fort Worth, Austin, and Houston. Indeed, Tarrant, Dallas, and Bexar Counties have been leaders in developing mental health courts. And, on another positive front, in the last few years the Texas Task Force on Indigent Defense has provided funding for mental health public defender offices in Dallas, El Paso, Limestone, and Travis Counties. See http://www.courts.state.tx.us/tfid/. These programs involve specialized and trained attorneys who work in tandem with caseworkers or social workers to provide better representation to defendants with mental illness or mental retardation. The Travis County program also helps connect these individuals to available treatment services through the development of pre-trial assessment plans to support conditional release. Notwithstanding these very exciting initiatives, however, we would urge that a much greater effort be undertaken throughout the state.

Since the 2001 session, the legislature has also taken strong steps to expand jail diversion programs. The legislature has appropriated substantial funds to the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) to pursue and implement jail diversion programs across the state. Jail
diversion and coordination of services have truly become legislative priorities. For more information on TCOOMMI, see http://www.tdcj.state.tx.us/tcomi/tcomi-home.htm.

IV. COMPETENCY TO STAND TRIAL

Texas law creates two distinct statutory schemes relating to a criminal defendant’s competency to stand trial depending on whether the alleged offender is an adult or a child. Accordingly, our discussion is divided into a general discussion and an analysis of provisions relating to juveniles. Then, the final subchapter relates to competency issues in death penalty cases.

The relatively recent sagas of the trials of Andrea Yates and Deanna Laney brought issues relating to criminal competency and the insanity defense to the forefront of public discussion. Although these cases will be discussed in more detail in the ensuing chapter on the insanity defense, the cases are also instructive with respect to competency to stand trial. There was little to no dispute among the many experts involved in the Yates case that Ms. Yates’ was suffering from serious mental illness and quite delusional at the time of the horrific killing of her children. Then, in the 2004 trial of Deanna Laney, all five medical experts agreed that Ms. Laney was seriously mentally ill, delusional, and legally “insane” at the time of the stoning of her children. Nonetheless, the legal issues surrounding criminal competency and the insanity defense are not based strictly on medical diagnoses or a defendant’s developmental disabilities. Persons experiencing the symptoms of serious mental illness or who have mental retardation often find themselves caught up in the criminal justice system, particularly given our state’s chronically under-funded public mental health/mental retardation systems. And, although cases involving the insanity
defense often grab the headlines, they are relatively rare. By way of contrast, competency issues arise in every Texas courthouse every week of the year. Accordingly, an understanding of the criminal competency process is important for attorneys who represent individuals accused of crimes who have mental disabilities.

A. IN GENERAL

THE STANDARD FOR INCOMPETENCY TO STAND TRIAL. Under our legal system, a criminal defendant must be able to understand the proceedings that are being conducted against him or her, or the accused may not undergo trial. See Drope v. Missouri, 420 U.S. 162 (1975). Similarly, the defendant should also be in a position to communicate with and assist legal counsel. Indeed, if the defendant cannot understand the proceedings or assist defense counsel, serious questions concerning fundamental fairness arise. This subchapter focuses on the Texas legislative enactments that allow the courts to address issues relating to whether a criminal defendant is competent to stand trial for the charged offense.

Many years ago, a former version of the Texas law on competency to stand trial focused on whether the defendant suffered from “present insanity” at the time of trial. Although no longer a part of the law, this antiquated phrase is useful in understanding that the question of competency relates to a criminal defendant’s mental state, not at the time of the events resulting in the criminal charges, but at the time of trial. Unlike the insanity defense, which is discussed in the next chapter, a finding of incompetency to stand trial is not a defense to the crime charged. In other words, a determination of incompetency does not serve to excuse the offense. Instead, it relates to whether the defendant has the present capacity to stand trial at that time. Moreover, a finding
of incompetency to stand trial differs from and should not be confused with a general finding of incompetency (by a civil court) in which a guardian might be appointed and a person’s rights might be limited.

**RECENT LEGISLATIVE ACTIVITY.** During the 2001 legislative session, concerns were raised regarding (1) inconsistencies in competency evaluations and evaluation reports around the state, and (2) wide variations in the expertise, qualifications, and skills of the evaluators conducting competency exams. Accordingly, the legislature in 2001 passed S.B. 553, which created a 16-member task force to review the competency evaluation process. The task force was led by Senator Robert Duncan and former Representative Patty Gray, and included representatives from the judiciary, medical schools, agencies, prosecutors, defense attorneys, psychologists, psychiatrists, and law schools (including one of the authors of this book). The task force held hearings over the next year and a half and developed a number of recommendations to ensure appropriate and consistent application of criminal competency laws. From the very first hearing, numerous witnesses and experts concurred that the former competency statutes primarily set forth in Article 46.02, Texas Code of Criminal Procedure, were unduly complex, unwieldy, and difficult to interpret and use. A full copy of the report may be accessed at [http://www.tdcj.state.tx.us/publications/tcomi/tcomi-SB553.PDF](http://www.tdcj.state.tx.us/publications/tcomi/tcomi-SB553.PDF).

Among its recommendations, the task force strongly urged the enactment of a revamped, new competency statute to streamline the process and ensure consistent application throughout the state. The task force developed proposed legislation, which was then filed as S.B. 1057 by Senator Duncan during the 2003 legislative session. The bill, which was supported by prosecutors, the defense bar, the judiciary, and organizations of psychiatrists and psychologists, moved rapidly through the legislative process with
little debate or controversy. Governor Perry signed the bill into law, and S.B. 1057 went into effect on January 1, 2004. Much of the credit for the successful overhaul of the competency statute must go to Senator Duncan, who skillfully guided the task force through the process of developing a bill that greatly improved Texas law. In addition, recognition should be given to another key member of the task force, Judge Robert Cheshire, who spent countless hours developing key provisions of the legislation.

As with any lengthy new statute, some refinements were necessary. The legislature returned to the topic of criminal competency in both the 2005 and 2007 regular sessions and enacted a number of fine-tuning amendments. This legislation will be discussed with respect to those sections that were modified.

CHAPTER 46B, CODE OF CRIMINAL PROCEDURE. The remaining portions of this subchapter set forth a section-by-section analysis of Chapter 46B, Texas Code of Criminal Procedure, which initially became effective for all competency proceedings initiated on or after January 1, 2004. We will also highlight significant changes from prior law.

Art. 46B.001. Definitions
In this chapter:
(1) “Department” means the Department of State Health Services.
(2) “Inpatient mental health facility” has the meaning assigned by Section 571.003, Health and Safety Code.
(3) “Local mental health authority” has the meaning assigned by Section 571.003, Health and Safety Code.
(4) “Local mental retardation authority” has the meaning assigned by Section 531.002, Health and Safety Code.
(5) “Mental health facility” has the meaning assigned by Section 571.003, Health and Safety Code.
(6) “Mental illness” has the meaning assigned by Section 571.003, Health and Safety Code.
(7) “Mental retardation” has the meaning assigned by Section 591.003, Health and Safety Code.
(8) “Residential care facility” has the meaning assigned by Section 591.003, Health and Safety Code.
(9) “Electronic broadcast system” means a two-way electronic communication of image and sound between the defendant and the court and includes secure Internet videoconferencing.

Art. 46B.002. Applicability
This chapter applies to a defendant charged with a felony or with a misdemeanor punishable by confinement.

The first two articles set forth in Chapter 46B provide definitions and a statement of general applicability. Regarding the latter, Article 46B.002 makes the chapter applicable to defendants charged with felonies or with misdemeanors in which they may be punished with jail or prison time. Thus, other misdemeanor offenses in which fines are the only punishment are excluded. In addition, as highlighted in the next subchapter, comparable issues involving juvenile offenders are covered by provisions in the Family Code, not Chapter 46B.

As its title suggests, Article 46B.001 sets forth various definitions that apply throughout the overall chapter. Most importantly, the reader should note that the legislature opted to use existing legal definitions as set forth in other areas of Texas law, most notably the Texas Health & Safety Code. For example, with respect to the definition of “mental illness,” the new competency statute has incorporated the Health & Safety Code’s definition, which provides the following broad definition:

“Mental illness” means an illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that:
(A) substantially impairs a person’s thought, perception of reality, emotional process, or judgment; or
(B) grossly impairs behavior as demonstrated by recent disturbed behavior.

That definition, along with further definitions of specific serious mental illnesses, is discussed in detail in Chapter II, *supra*.

**THE STANDARD FOR INCOMPETENCY TO STAND TRIAL HAS NOT CHANGED.** The next article in Chapter 46B identifies the standard for incompetency to stand trial, as well as legal presumptions.

**Art. 46B.003. Incompetency; Presumptions**

(a) A person is incompetent to stand trial if the person does not have:

1. sufficient present ability to consult with the person's lawyer with a reasonable degree of rational understanding; or
2. a rational as well as factual understanding of the proceedings against the person.

(b) A defendant is presumed competent to stand trial and shall be found competent to stand trial unless proved incompetent by a preponderance of the evidence.

In enacting Chapter 46B the legislature did not intend to change the underlying standard for incompetency. These provisions, sometimes called the *Dusky* standards, were established by the United States Supreme Court many years ago in the case of *Dusky v. United States*, 362 U.S. 402 (1960). Thus, as under current law, a person is incompetent to stand trial on criminal charges if that person either (1) cannot communicate with his or her lawyer with a reasonable degree of rational understanding, OR (2) does not have a rational and factual understanding of the ongoing proceedings at that time. Accordingly, under the revised law, the focus remains on whether the criminal defendant possesses sufficient mental competency to stand trial with respect to the charged offense(s). In addition, the defendant has the burden
of proving that he or she lacks competency to stand trial by a preponderance of the evidence. Thus, the defendant must demonstrate with evidence that it is more likely than not that he or she is presently incompetent to stand trial. Otherwise, the defendant is presumed to be competent to stand trial. In addition, mere evidence that the defendant is suffering from a mental illness is legally insufficient to establish that the defendant is incompetent to stand trial. Instead, the evidence must establish either of the two criteria identified in this section.

On a related note, given the general rules regarding competency, a criminal conviction should not stand if indeed the defendant was incompetent to stand trial but was tried nonetheless. See Morales v. State, 587 S.W.2d 418, 421 (Tex. Crim. App. [Panel Op.] 1979). Moreover, if a defendant is incompetent to stand trial, that defendant is also incompetent to plead guilty to an offense. See Ex parte Lewis, 587 S.W.2d 697, 700 (Tex. Crim. App. [Panel Op.] 1979). It is logically inconsistent to suggest that a defendant understands the ramifications of a guilty plea if the defendant is truly incompetent and, accordingly, unable to understand the proceedings against him or her. Although the Supreme Court has held that the general competency standard for pleading guilty is no higher than the standard for standing trial, the Court has acknowledged that a defendant must knowingly and voluntarily enter any guilty plea. Godinez v. Moran, 113 S.Ct. 2680, 2687-88 (1993).

A defendant with mental illness might also be competent to proceed, but still not be viewed as sufficiently competent to be allowed to insist on proceeding without counsel. Consider the 2008 decision of Indiana v. Edwards, 128 S.Ct. 2379 (2008), in which the United States Supreme Court determined that the Constitution does not preclude a state from rejecting a mentally ill defendant’s request for self-representation and requiring that the defendant
proceed to trial with counsel, even when the court viewed the defendant to be otherwise competent to proceed. The Court reasoned that the Drope competency “standards assume representation by counsel and emphasize the importance of counsel,” and that given such a defendant’s uncertain mental state, self-representation “threatens an improper conviction or sentence” and undercuts the prospect of a fair trial.

RAISING THE INCOMPETENCY ISSUE. The incompetency statutes require a separation of the proceedings to determine whether a defendant is incompetent to stand trial from the actual trial on the merits of the case. In general, questions about competency should ordinarily be resolved at the outset of the proceedings, before commencement of the trial on the merits. Of course, it is possible that the issues relating to a defendant’s competency will not manifest themselves until after the criminal trial has begun.

Art. 46B.004. Raising Issue of Incompetency to Stand Trial
(a) Either party may suggest by motion, or the trial court may suggest on its own motion, that the defendant may be incompetent to stand trial. A motion suggesting that the defendant may be incompetent to stand trial may be supported by affidavits setting out the facts on which the suggestion is made.
(b) If evidence suggesting the defendant may be incompetent to stand trial comes to the attention of the court, the court on its own motion shall suggest that the defendant may be incompetent to stand trial.
(c) On suggestion that the defendant may be incompetent to stand trial, the court shall determine by informal inquiry whether there is some evidence from any source that would support a finding that the defendant may be incompetent to stand trial.
(d) If the court determines there is evidence to support a finding of incompetency, the court, except as provided by Subsection (e) and Article 46B.005(d), shall stay all other proceedings in the case.
(e) At any time during the proceedings under this chapter after the issue of the defendant's incompetency to stand trial is first raised, the court on the motion of the attorney representing the state may dismiss all charges pending against the defendant, regardless of whether there is any evidence to support a finding of the defendant's incompetency under Subsection (d) or whether the court has made a finding of incompetency under this chapter. If the court dismisses the charges against the defendant, the court may not continue the proceedings under this chapter, except that, if there is evidence to support a finding of the defendant's incompetency under Subsection (d), the court may proceed under Subchapter F. If the court does not elect to proceed under Subchapter F, the court shall discharge the defendant.

Article 46B.004 includes language to encourage early and prompt court review and evaluations of persons who might lack competency to be tried. With regard to raising the issue of incompetency with the court, Article 46B.004 intentionally uses terms such as “suggest” and “suggestion” with regard to when a court must conduct an informal inquiry to determine whether there is evidence from any source that would support a finding of incompetency to stand trial. This is in contrast to case law interpreting former Art. 46.02 that required a judge to have a “bona fide doubt” prior to conducting such an informal inquiry. Cf. McDaniel v. State, 98 S.W.3d 704 (Tex. Crim. App. 2003). The language used in Article 46B.004 was specifically intended to expand the scope of situations in which the trial court must conduct an informal inquiry to assess whether there is some evidence – from any source – regarding the defendant’s possible incompetency. The revised statute was intended to make it easier than under the old law to raise the incompetency issue before trial. During the S.B. 553 task force process, the members were very intentional in moving away from a limiting standard such as McDaniel’s “bona fide doubt” approach. Accordingly, defense counsel or the prosecution should file a motion with the court to
suggest that the defendant lacks competency to stand trial before
the date set for the trial if there is any indication of the person’s
lack of competency. Article 46B.004 also allows the judge to act
on his or her own motion. This situation would likely occur in a
case in which the judge believes that there are indications of a lack
of competency despite the lack of any written motion to that effect
by defense counsel or the prosecutor. Moreover, subsections (b)
and (c) mandate that the court conduct an informal inquiry if any
evidence suggesting the defendant’s lack of competency comes to
the attention of the judge.

Unfortunately, subsequent to Chapter 46B’s 2004 effective
date, several courts of appeal have failed to note that the legislature
intentionally changed the law in Article 46B.004(a)-(c) away from
the old “bona fide” doubt standard through the use of the new
terms, “suggest” and “suggestion.” See, e.g., Rojas v. State, 228
S.W. 770, 771 (Tex.App.—Amarillo 2007, no pet.); Salahud-din v.
State, 206 S.W.3d 203, 208 (Tex.App.—Corpus Christi 2006, pet.
ref’d); Richardson v. State, 2005 Tex. App. LEXIS 951, at *5
(Tex.App—Houston [1st Dist.] (Feb., 3, 2005, no pet.) (not
designated for publication) (court, without any analysis, simply
stated that because the language in “Chapter 46B is substantively
similar to the requirement set forth in former article 46.02,
McDaniel’s holding remains applicable”). One court of appeals,
however, has correctly construed the clear intent of the legislature
in using the terms “suggest” and “suggestion.” In Greene v. State,
225 S.W.3d 324, 328 n. 3 (Tex.App.—San Antonio 2007, no pet.),
the court reasoned, in part, as follows: “The current statute uses the
terms ‘suggest’ and ‘suggestion’ with regard to when a court must
conduct a competency inquiry, whereas the former version of the
statute did not. We believe the Legislature’s addition of such
language to the statute signifies that the Legislature intended to
depart from the ‘bona fide doubt’ requirement previously
established by case law.” The San Antonio court properly
construed the revised statute. Unfortunately, with scant to nonexistent analysis, the other courts have simply carried forward the prior standard without recognizing that the legislature employed altogether new language. It is to be hoped that the Court of Criminal Appeals will clarify this issue and recognize that the San Antonio court correctly interpreted the revisions in Greene v. State.

Under Article 46B.004, if a suggestion of incompetency has been made through either subsection (a) or (b), subsection (c) requires the court to conduct an informal inquiry to assess whether there is “some evidence from any source” that would support a finding that the defendant may be incompetent. As under prior law, any person can produce evidence of the defendant’s incompetency to stand trial, not just the defendant or defense counsel. Thus, a family member, a sheriff or deputy, a prosecutor, a mental health care worker, or some other interested person may come forward and offer evidence of the defendant’s lack of competency to be tried. Once the judge makes a determination that there is some evidence of incompetency from any source, then all other pending proceedings in the case must be halted — unless, per Article 46B.005(d), the issue has been raised after the trial has begun, or if the prosecutor dismisses the charges per subsection (e). Thus, in the typical case in which incompetency issues are raised prior to the trial on the merits, other proceedings will be halted once evidence of incompetency is determined to exist. In addition, there was no intent to alter the prior law with regard to the requisite evidentiary threshold for establishing that there is “some evidence.” For example, under prior law the court was required to conduct further incompetency proceedings upon the introduction of some probative evidence, more than a scintilla, regarding the defendant’s lack of competency. See Sisco v. State, 599 S.W.2d 607, 613 (Tex. Crim. App. 1980).
Legislation in 2005 added subsection (e), which addresses situations in which the prosecutor elects to dismiss charges after an incompetency issue has been raised. The court may then dismiss the charges regardless of whether evidence supports a finding of the defendant’s incompetency. As a general matter, no further competency proceedings should take place. However, should the court be of the view that evidence exists to support a finding of incompetency, the court may (and should) proceed under Subchapter F of Chapter 46B. That subchapter, which as of 2008 includes only Article 46B.151, the court can enter an order transferring the defendant to the appropriate court for civil commitment proceedings. (Article 46B.151 is discussed in detail, infra.)

WHAT HAPPENS ONCE THE COURT MAKES A DETERMINATION THAT EVIDENCE EXISTS TO SUPPORT A FINDING OF INCOMPETENCY? Prior to 2004, once it was determined that evidence existed to support the possibility of the defendant’s incompetency, the court had to convene a jury trial solely to address the defendant’s possible lack of competency. By way of contrast, Chapter 46B made substantial changes to the procedures that follow this initial determination.

Art. 46B.005. Determining Incompetency to Stand Trial
(a) If after an informal inquiry the court determines that evidence exists to support a finding of incompetency, the court shall order an examination under Subchapter B to determine whether the defendant is incompetent to stand trial in a criminal case.
(b) Except as provided by Subsection (c), the court shall hold a trial under Subchapter C before determining whether the defendant is incompetent to stand trial on the merits.
(c) A trial under this chapter is not required if:
(1) neither party’s counsel requests a trial on the issue of incompetency;
(2) neither party’s counsel opposes a finding of incompetency; and
(3) the court does not, on its own motion, determine that a trial is necessary to determine incompetency.

(d) If the issue of the defendant’s incompetency to stand trial is raised after the trial on the merits begins, the court may determine the issue at any time before the sentence is pronounced. If the determination is delayed until after the return of a verdict, the court shall make the determination as soon as reasonably possible after the return. If a verdict of not guilty is returned, the court may not determine the issue of incompetency.

First, if the court has determined in the informal inquiry that there indeed exists evidence to support a finding of incompetency, the court must order a competency examination. (The legislature intentionally included the word, “shall.”) Moreover, unlike under prior law, there is no longer an absolute requirement for a jury trial to determine incompetency. Indeed, Article 46B.005(c) relieves the court from having to hold a trial – at all – on the question of the defendant’s incompetency if (1) neither party’s counsel requests a trial on the issue, (2) neither party’s counsel opposes a finding of incompetency, and (3) the court does not decide, on its own motion, that a trial on incompetency is necessary. Thus, the parties and court can agree that the defendant lacks competency to stand trial. Moreover, as will be discussed infra, even when a trial on incompetency is undertaken either because a party has opposed the finding of incompetency or the court has ordered an incompetency trial on its own motion, no jury trial is required unless either party affirmatively requests a jury (or on the court’s own motion). Art. 46B.051(a).

These provisions represent a substantial and significant change from prior law. The S.B. 553 task force determined that the issue of incompetency was not being opposed in 80-90% of all cases in which the issue arose. Nonetheless, substantial judicial resources
were being expended to conduct jury trials despite any opposition to the determination of incompetency. In addition, research was provided to the task force that revealed that many counties were improperly utilizing “pick up” juries for the conducting of incompetency hearings (in which courthouse personnel or other citizens were being rounded up to sit as jurors without all the usual procedures for juror identification and selection). In sum, the task force concluded that the former “practice of [utilizing] ‘pick up’ juries or utilizing a jury when all parties agree to the competency issue is not a sound practice.” S.B. 553 Task Force Report, at 10, available at http://www.tdcj.state.tx.us/publications/tcomi/tcomi-SB553.PDF.

Thus, Article 46B.005(c) authorizes the court to forego a trial on the incompetency issue when none is sought, neither party objects, and the court is not of the view that it should order an incompetency trial on its own motion. The defendant’s right to a jury trial on the issue, however, is preserved because the defendant can oppose a finding of incompetency and demand a jury trial on the issue.

ISSUE OF INCOMPETENCY ARISING AFTER BEGINNING OF TRIAL ON THE MERITS. Although the better practice is to resolve incompetency issues prior to the trial on the merits, subsection 46B.005(d) carries forward language from under prior law relating to procedural steps to be employed if the issue of incompetency does not arise until after the trial on the merits has begun. It should not be surprising to those who have knowledge of serious mental illnesses that a situation could arise in which a defendant diagnosed with mental illness might have become stabilized on medication at the outset of trial, but later suffer a relapse of the symptoms of the illness during the proceedings. Given the stresses of a criminal trial, some defendants might decompensate during the course of the process. Accordingly, the statute authorizes the court to consider questions about the defendant’s incompetency even after the trial has begun.
Moreover, the failure to pursue a review of the defendant’s incompetency before the trial on the merits does not waive the opportunity to raise the question at a later stage of the proceedings. Case law interpreting the predecessor statute pointed out that evidence “may come from the trial court’s own observations, known facts, evidence presented, motions, affidavits, or any other claim or credible source.” *Brown v. State*, 960 S.W.2d 772, 774 (Tex.App.—Dallas 1997, pet. ref’d). Subsection (d) allows the court to determine the issue at any time before the sentence is pronounced. Thus, the court can halt the proceedings and undertake a competency determination at the time there is evidence of incompetency or wait until after a verdict is returned. As with a case in which the question is considered prior to the trial on the merits, per subsection (c) no trial on incompetency will be required if the issue is not contested. Moreover, the trial on incompetency can be held before the court unless a jury is sought. It should be noted, however, that if a jury trial is sought on the issue of incompetency, as under prior law the court should conduct the more limited trial on the incompetency issue outside the presence of the jury that is considering the merits.

Per subsection (d), as under the former law, the judge can allow the criminal trial to be completed and undertake incompetency proceedings after the return of a verdict and before pronouncement of sentence. If the judge opts not to conduct the incompetency review immediately upon the raising of the issue, an incompetency trial is not necessary, or even allowed, if the jury acquits the defendant. For purposes of judicial economy, many courts have traditionally pursued this latter approach to avoid suspending ongoing trials. If, however, the incompetency assessment is postponed until post-trial, a finding of guilty will not be allowed to stand if the defendant is found to be incompetent. Additionally, given that the defendant may truly be incompetent to understand the proceedings or assist in his or her own defense, at
some level it is conceptually incongruous to postpone an incompetency proceeding until after the trial on the merits. It would seem that the purposes of assuring that the defendant is able to understand the ongoing proceedings and assist in his or her defense could well be skewed if the judge does not proceed to resolve the incompetency issue at the time it arises.

**NO INTERLOCUTORY APPEAL.** Although taken out of numerical order, it is appropriate to mention Article 46B.011 at this point in our discussion.

**Art. 46B.011. Appeals.** Neither the state nor the defendant is entitled to make an interlocutory appeal relating to a determination or ruling under Article 46B.005.

This provision bars interlocutory appeals of determinations or rulings made by a court pursuant to the foregoing section, Article 46B.005, at the time of such rulings. Any appeal relating to such issues would have to be raised at the conclusion of the ensuing proceedings.

**WHEN TO APPOINT COUNSEL.** One concern that was raised before the S.B. 553 task force was the frequent situation of a defendant being ordered to undergo a competency evaluation prior to the appointment of legal counsel. Under prior law, subsection 4(b) of old Art. 46.02 only required appointment of counsel “prior to the competency hearing.” The law was vague about requiring such an appointment prior to any competency exam. S.B. 1057 provided specific direction as to this issue.

**Art. 46B.006. Appointment of and Representation by Counsel**
(a) A defendant is entitled to representation by counsel before any court-ordered competency evaluation and during any proceeding at
which it is suggested that the defendant may be incompetent to stand trial.
(b) If the defendant is indigent and the court has not appointed counsel to represent the defendant, the court shall appoint counsel as necessary to comply with Subsection (a).

Article 46B.006 requires the court to appoint counsel for an indigent defendant prior to any court-ordered competency evaluation and during any proceeding in which it has been suggested that the defendant might not be competent to stand trial. This, coupled with the provisions of the Indigent Defense Act, should assure that a defendant does not undergo important aspects of a criminal matter – such as an incompetency proceeding or evaluation – prior to the appointment of legal representation. Moreover, given the provisions of Article 46B.005 in which a defendant can waive the right to a jury trial on the question of incompetency or potentially waive the right to a trial on the issue at all, it is important that the individual be represented by counsel – and, preferably, by counsel who is knowledgeable about the revised competency statute.

USE OF STATEMENTS MADE BY A DEFENDANT AT AN EXAM OR HEARING ON INCOMPETENCY.

Art. 46B.007. Admissibility of Statements and Certain Other Evidence. A statement made by a defendant during an examination or trial on the defendant’s incompetency, the testimony of an expert based on that statement, and evidence obtained as a result of that statement may not be admitted in evidence against the defendant in any criminal proceeding, other than at:
(1) a trial on the defendant's incompetency; or
(2) any proceeding at which the defendant first introduces into evidence a statement, testimony, or evidence described by this article.
Article 46B.007 places greater limitations on the use of statements made by a defendant during an examination or at an incompetency trial, or the testimony of an expert based on those statements, than under prior law. Subsection 3(g) of former Art. 46.02 stated, “No statement made by the defendant during the examination or the hearing on his competency to stand trial may be admitted in evidence against the defendant on the issue of guilt in any criminal proceeding.” Thus, although the predecessor statute precluded the later use of statements made by the defendant during an incompetency exam or incompetency trial at the ensuing trial on the merits, the statute did not expressly bar the use of such statements for other purposes, such as during the punishment phase of the criminal proceeding. By way of contrast, Article 46B.007 was intentionally drafted to be much broader in scope. It excludes statements made by the defendant during an incompetency exam or incompetency trial, if any, except at the incompetency trial or in any later criminal proceeding – unless the defense first opens the door by introducing such statements from an exam or the prior incompetency trial.

RULES OF EVIDENCE. Article 46B.008 was included to require that the Rules of Evidence apply to any incompetency trial under the revised statutory scheme regardless of whether it is conducted before the court or in front of a jury.

Art. 46B.008. Rules of Evidence. Notwithstanding Rule 101, Texas Rules of Evidence, the Texas Rules of Evidence apply to a trial under Subchapter C or other proceeding under this chapter whether the proceeding is before a jury or before the court.

CREDIT FOR TIME SERVED. If a person is ultimately convicted of a crime, the court must provide a credit to the person’s sentence for any time that the person has been confined in
a mental health facility, residential care facility, or jail pending trial.

**Art. 46B.009. Time Credits.** A court sentencing a person convicted of a criminal offense shall credit to the term of the person’s sentence the time the person is confined in a mental health facility, residential care facility, or jail pending trial under Subchapter C.

This provision is very similar to section 9 of the old Art. 46.02, and provides quite succinctly that, once a person is sentenced upon conviction, the judge must credit the time spent in incompetency proceedings in a mental health facility, residential care facility, or jail to the term of the sentence. This section has long represented an attempt by the legislature to provide a measure of fairness in the sentencing process. Were the time not credited toward a convicted defendant’s sentence, an individual who has spent time in a mental health facility attaining competency before being convicted could be deprived of his or her liberty for a much longer period than a person convicted of the same offense who remains competent throughout the criminal proceedings.

**CONTINUITY OF CARE.** Although Art. 46B.009 provides a time credit in the event of an ultimate conviction, the section does not, however, address any time credits in other situations. The S.B. 553 task force heard testimony that it is not unheard of for a defendant to spend more time in one or more mental health facilities as a result of incompetency proceedings than would have been spent in jail or prison upon a conviction. In effect, the defendant can be caught in a revolving door between the county jail and the state hospital for years on end. For example, suppose a person is found incompetent and sent for competency restoration treatment. Typically, that treatment will be effective, particularly in the case of treatment for mental illness. The person will become
competent, and then be returned to the county jail to face the pending criminal charges. Unfortunately, however, all too often jails have not continued the treatment begun at the state hospital or the criminal proceedings are delayed. Then, in all too many cases, the person’s mental condition deteriorates and the person is once again incompetent to proceed. Accordingly, it is hardly surprising that defense counsel and defendants with mental illness were traditionally reluctant to raise the competency issue when the potential criminal sentence involved relatively brief jail time.

Given this issue, in prior editions of this book we argued that, as a matter of policy, the legislature should consider amending the act to preclude a person from spending more time in jail awaiting trial and in mental health or residential care facilities as a result of competency proceedings than the person would have faced following an immediate trial or guilty plea. Although the underlying purpose of any criminal or civil commitment differs from the reasons for punishment in jail or prison, the defendant will ultimately have been deprived of his or her liberty for a similar period under either scenario. Alternatively, we urged that until the legislature enacted this type of change to the prior law, prosecutors should consider exercising their considerable discretion to dismiss charges once a defendant spent as much time in a holding pattern between the criminal competency proceedings and mental health facilities as would likely have been spent in jail or prison as a result of a conviction. Following the work of the S.B. 553 task force and in ensuing sessions, the legislature endeavored to address this revolving door problem in several ways.

**Art. 46B.0095. Maximum Period of Facility Commitment or Outpatient Treatment Program Participation Determined by Maximum Term for Offense.** (a) A defendant may not, under this chapter, be committed to a mental hospital or other inpatient or residential facility, ordered to participate in an outpatient
treatment program, or subjected to both inpatient and outpatient treatment for a cumulative period that exceeds the maximum term provided by law for the offense for which the defendant was to be tried, except that if the defendant is charged with a misdemeanor and has been ordered only to participate in an outpatient treatment program under Subchapter D or E, the maximum period of restoration is two years beginning on the date of the initial order for outpatient treatment program participation was entered.

(b) On expiration of the maximum restoration period under Subsection (a), the defendant may be confined for an additional period in a mental hospital or other inpatient or residential facility or ordered to participate for an additional period in an outpatient treatment program, as appropriate, only pursuant to civil commitment proceedings.

This provision was added by S.B. 867 in 2007. It addresses the problem identified above by limiting the amount of time spent involved in incompetency proceedings and related pre-trial transfers to the maximum sentence possible for the pending charges. (Similar language had been added to 46B.009 by S.B. 679 in 2005, but that language was moved to 46B.0095 and modified in 2007.) The one exception is for outpatient competency restoration treatment, for which a maximum cumulative period of two years is authorized (and which might exceed the possible sentencing).

Art. 46B.010. Mandatory Dismissal of Misdemeanor Charges
If a court orders the commitment of or participation in an outpatient treatment program by a defendant who is charged with a misdemeanor punishable by confinement and the defendant is not tried before the date of expiration of the maximum period of restoration under this chapter as described by Article 46B.0095, the court on the motion of the attorney representing the state shall dismiss the charge.

With regard to misdemeanor offenses, Article 46B.010 works in tandem with Article 46B.0095 to require a dismissal of charges.
for misdemeanors punishable by incarceration if the defendant has not been tried within two years of an order for commitment or participation in an outpatient treatment program. This provision further recognizes that substantial time can elapse before trial if a defendant is cycling between competency restoration and any subsequent relapse(s). This statute, along with Article 46B.0095, should serve as encouragement to local prosecutors to proceed to trial promptly upon a person’s return to the county jail after competency restoration.

**LACK OF COMPLIANCE WITH CHAPTER.** Article 46B.012 provides that a lack of appropriate compliance with the provisions of the Chapter will not operate as a basis for the defendant to obtain a dismissal of the charges.

**Art. 46B.012. Compliance with Chapter.** The failure of a person to comply with this chapter does not provide a defendant with a right to dismissal of charges.

**INTERACTIVE VIDEO HEARINGS.** Subchapter A of Chapter 46B concludes with a section that authorizes interactive video hearings. Article 46B.013 was added by S.B. 679 in 2005 primarily to address concerns relating to transfers of individuals serving long-term commitments. Consider, by way of an example, a situation involving a person whose competency has not been restored. As will be described below, should the charges remain pending, eventually that individual’s continued commitment will need to be ordered through civil proceedings for extended hospitalization. It is arguably both more efficient and humane to authorize interactive video hearings between the state hospital and the committing court, rather than transporting the individual back to the county jail to await a further hearing before the committing court, and then transporting that individual back to the state hospital.
Art. 46B.013. Use of Electronic Broadcast System in Certain Proceedings under this Chapter. (a) A hearing may be conducted using an electronic broadcast system as permitted by this chapter and in accordance with the other provisions of this code if:

(1) written consent to the use of an electronic broadcast system is filed with the court by:
    (A) the defendant or the attorney representing the defendant; and
    (B) the attorney representing the state;

(2) the electronic broadcast system provides for a simultaneous, compressed full motion video, and interactive communication of image and sound between the judge, the attorney representing the state, the attorney representing the defendant, and the defendant; and

(3) on request of the defendant or the attorney representing the defendant, the defendant and the attorney representing the defendant are able to communicate privately without being recorded or heard by the judge or the attorney representing the state.

(b) On the motion of the defendant, the attorney representing the defendant, or the attorney representing the state or on the court's own motion, the court may terminate an appearance made through an electronic broadcast system at any time during the appearance and require an appearance by the defendant in open court.

(c) A recording of the communication shall be made and preserved until any appellate proceedings have been concluded. The defendant may obtain a copy of the recording on payment of a reasonable amount to cover the costs of reproduction or, if the defendant is indigent, the court shall provide a copy to the defendant without charging a cost for the copy.

EXPERTS AND EVALUATIONS. Subchapter B of Chapter 46B addresses both the qualifications and appointment of experts and the evaluation process. This portion of S.B. 1057 enacted significant changes from prior law.
Art. 46B.021. Appointment of Experts. (a) On a suggestion that the defendant may be incompetent to stand trial, the court may appoint one or more disinterested experts to:
   (1) examine the defendant and report to the court on the competency or incompetency of the defendant; and
   (2) testify as to the issue of competency or incompetency of the defendant at any trial or hearing involving that issue.
(b) On a determination that evidence exists to support a finding of incompetency to stand trial, the court shall appoint one or more experts to perform the duties described by Subsection (a).
(c) An expert involved in the treatment of the defendant may not be appointed to examine the defendant under this article.
(d) The movant or other party as directed by the court shall provide to experts appointed under this article information relevant to a determination of the defendant's competency, including copies of the indictment or information, any supporting documents used to establish probable cause in the case, and previous mental health evaluation and treatment records.
(e) The court may appoint as experts under this chapter qualified psychiatrists or psychologists employed by the local mental health authority or local mental retardation authority. The local mental health authority or local mental retardation authority is entitled to compensation and reimbursement as provided by Article 46B.027.
(f) If a defendant wishes to be examined by an expert of the defendant's own choice, the court on timely request shall provide the expert with reasonable opportunity to examine the defendant.

APPOINTMENT OF EXPERTS. Art. 46B.021 addresses the appointment of experts. Subparts (a) and (b) relate to the timing of such appointments. Under subsection (a) if there has been a suggestion to the court that the defendant may be incompetent to stand trial, the court may appoint one or more experts at that time to conduct a competency evaluation. Under subsection (b), once there has been a determination that “evidence” exists that supports a finding of incompetency to stand trial, the statute mandates that
the court shall appoint such an expert or experts to conduct the competency evaluation(s). Of course, subsection (b) will not be operative if the court has already exercised discretion to appoint an expert – per subsection (a) – upon a “suggestion” of incompetency. In addition, if a defendant has the resources to obtain an additional psychiatric evaluation, subsection (f) requires the court to provide a reasonable opportunity for such an expert to examine the defendant.

The court is tasked with appointing “disinterested” experts under Art. 46B.021. Accordingly, subsection (c) disallows the appointment of an expert who is involved in the treatment of the defendant. Correspondingly, the statute includes no provisions requiring the court to appoint an expert of the defendant’s or prosecutor’s choosing. In addition, as under prior law, the court may appoint experts who are employed by the local mental health authority – provided that they are not then involved in the defendant’s treatment. (At one time there was concern in certain parts of the state that an employee of a local mental health authority could not be disinterested – even if not involved in the treatment of the defendant. That issue was resolved by 2001 legislation, which was carried forward in subsection (e)). Subsection (e) also requires that the local mental health authority be compensated should one of its employees be appointed as the expert. Also, to assure that the expert has ample information on hand before conducting the evaluation, subsection (d) authorizes the court to direct that relevant documents such as the indictment or information and mental health treatment records be made available to the expert.

A few possible glitches have been raised regarding the repeal of former Article 46.02 and the revamped provisions of Chapter 46B. One relates to the place of evaluation. Subsection 3(b) of former Article 46.02 included language that allowed the defendant
to be transferred to a designated mental health facility (either one operated by a local mental health authority or a state hospital) for an evaluation. That language was inadvertently not carried forward. Nonetheless, there was no intent by the S.B. 553 task force or the legislature to require all competency evaluations to be conducted at the jail. Moreover, there is implicit authority under this section (Article 46B.021), and under Articles 46B.005, 46B.022, and 46B.027(b) for the court to order the transfer of the defendant to a mental health authority or state hospital for an evaluation. Indeed, Article 46B.027(b) specifically refers to reimbursing a facility operated by the state department for expenses connected to the examination.

QUALIFICATIONS OF EXPERTS. One concern regarding experts raised before the S.B. 553 task force related to the former law’s limited statement of qualifications for appointment. The task force identified this as a problem area, and observed the following: “The evaluators’ skill, experience and level of expertise varied from jurisdiction to jurisdiction though the minimum qualifications required in 46.02 appeared to be met in selecting experts. The qualifications, however, appeared to require strengthening to ensure competency of the experts.” S.B. 553 Task Force Report, at 4, available at http://www.tdcj.state.tx.us/publications/tcomi/tcomi-SB553.PDF. S.B. 1057 indeed strengthened the qualifications requirements.

Art. 46B.022. Experts: Qualifications. (a) To qualify for appointment under this subchapter as an expert, a psychiatrist or psychologist must:
   (1) as appropriate, be a physician licensed in this state or be a psychologist licensed in this state who has a doctoral degree in psychology; and
   (2) have the following certification or experience or training:
      (A) as appropriate, certification by:
(i) the American Board of Psychiatry and Neurology with added or special qualifications in forensic psychiatry; or 
(ii) the American Board of Professional Psychology in forensic psychology; or

(B) experience or training consisting of:
   (i) at least 24 hours of specialized forensic training relating to incompetency or insanity evaluations;
   (ii) for an appointment made before January 1, 2005, at least five years of experience before January 1, 2004, in performing criminal forensic evaluations for courts; or
   (iii) for an appointment made on or after January 1, 2005, at least five years of experience before January 1, 2004, in performing criminal forensic evaluations for courts and eight or more hours of continuing education relating to forensic evaluations, completed in the 12 months preceding the appointment and documented with the court.

(b) In addition to meeting qualifications required by Subsection (a), to be appointed as an expert a psychiatrist or psychologist must have completed six hours of required continuing education in courses in forensic psychiatry or psychology, as appropriate, in either of the reporting periods in the 24 months preceding the appointment.

(c) A court may appoint as an expert a psychiatrist or psychologist who does not meet the requirements of Subsections (a) and (b) only if exigent circumstances require the court to base the appointment on professional training or experience of the expert that directly provides the expert with a specialized expertise to examine the defendant that would not ordinarily be possessed by a psychiatrist or psychologist who meets the requirements of Subsections (a) and (b).

Unlike prior law, Article 46B.022 generally limits courts to appoint only physicians and Ph.D.-level psychologists who also meet certain training, experience, and continuing education requirements to serve as experts under the revamped statute. Not surprisingly, the psychiatric examinations authorized by Chapter
46B are extremely significant. It is important that the court and counsel receive a useful evaluation report from a qualified expert or experts. And, although far fewer jury trials are taking place under the revised law, for those cases in which a jury is sought, the expert’s opinion will no doubt continue to play a significant role. Indeed, given the general lack of knowledge and many misconceptions about serious mental illness that predominate in this country, it is quite likely that many prospective jurors will have little or no previous experience with mental illness. Accordingly, the findings, report, and testimony of the medical experts are critical not only for establishing a factual basis for meeting the incompetency criteria, but also in educating the jury about the nature of the mental illness involved.

In addition to limiting the array of eligible experts to physicians or Ph.D.-level psychologists, Article 46B.022 delineates the training, experience, and continuing education requirements necessary for appointment. One method of eligibility is board certification. A physician is qualified under subsection (a)(2)(A)(i) if the doctor has been “board-certified” by “the American Board of Psychiatry and Neurology with added or special qualifications in forensic psychiatry;” that is, if he or she is a “board-certified” forensic psychiatrist. Similarly, a Ph.D.-level psychologist is qualified under subsection (a)(2)(A)(ii) if the expert has been “board-certified” by “the American Board of Professional Psychology in forensic psychology;” that is, if he or she is a “board-certified” forensic psychologist. Alternatively, even if the physician or Ph.D.-level psychologist is not board-certified, such a doctor can qualify through experience and training under either of two alternatives set forth in subsection (a)(2)(B). (The statute actually lists three alternatives, but subsection (a)(2)(B)(ii) related only to appointments made prior to January 1, 2005, and is now moot.) The two current alternatives include either (1) a minimum of 24 hours of specialized forensic training relating to
incompetency or insanity evaluations, or (2) “at least five years of experience before January 1, 2004, in performing criminal forensic evaluations for courts and eight or more hours of continuing education relating to forensic evaluations, completed in the 12 months preceding the appointment and documented with the court.” Thus, since January 1, 2005, the statute has required board certification, substantial training, or historical experience coupled with relatively recent training.

There was confusion by some prospective experts regarding the grammar included in subsection (a)(2)(B). The reader will note that the word “or” appears in the statute following subsection (ii) and before subsection (iii); however, there is no “or” or “and” following subsection (i). Accordingly, some psychiatrists and psychologists (and even a few courts) mistakenly believed that the legislature intended that the doctors adhere to both the training requirement of subsection (i) (24 hours of training) and the experience requirements of subsections (ii) or (iii). That is a misreading of the statute. It is a cardinal rule of construction that the use of the word “or” prior to the end of a series is intended to make all of the options to be alternatives in the series.

In addition to the foregoing requirements, subsection (b) requires all experts to have taken at least “six hours of required continuing education in courses in forensic psychiatry or psychology, as appropriate, in either of the reporting periods in the 24 months preceding the appointment.” Accordingly, there is an ongoing obligation for relatively recent continuing education.

Alternatively, subsection (c) allows a court to appoint as an expert a licensed psychiatrist or psychologist who does not otherwise meet the requirements of Article 46B.022, but only when “exigent circumstances require the court to base the appointment on professional training or experience of the expert.
that directly provides the expert with a specialized expertise to examine the defendant that would not ordinarily be possessed by a psychiatrist or psychologist who meets” the usual requirements of the statute. This was intended to be a very narrow exception and should be reserved for extraordinary situations. For example, the S.B. 553 task force discussed a case arising in the western part of the state in which a defendant not only appeared to lack competency because of either mental illness or mental retardation, but was also profoundly deaf. The court needed an expert psychologist who was primarily knowledgeable about the individual’s hearing disability, but that expert might not have had the usual forensics experience and training typically required by the revised law. Subsection (c) would allow an appointment of such an expert in this type of exceptional case.

Finally, there was discussion during the S.B. 553 task force process of requiring the creation of a registry of qualified experts to be administered by the appropriate state agency licensing board(s). Because of fiscal concerns, however, that concept was not included in the final enactment. Instead, the courts should require prospective experts to provide current, updated information demonstrating their qualifications. Counsel should also raise objections to any prospective expert who does not meet the statute’s requirements.

**CUSTODY STATUS.** The next section, Art. 46B.023, relates to a defendant’s custody or status during an examination.

**Art. 46B.023. Custody Status.** During an examination under this subchapter, except as otherwise ordered by the court, the defendant shall be maintained under the same custody or status as the defendant was maintained under immediately before the examination began.
Under Article 46B.023, the fact of a court’s order for a competency examination does not – standing alone – alter a person’s custody status. Thus, a court can order that the competency examination be conducted in the jail. Of course, as discussed above, the court can also order that the defendant be transported to a local mental health authority facility or to a state hospital for the competency examination. This authority, although perhaps somewhat cryptic, is present in the language, “except as otherwise ordered by the court.” This provides the court with authority, as under prior law, to order a defendant to be transported and examined at a facility outside the jail setting. Correspondingly, if the defendant’s status at the time of the examination order is of a different nature – perhaps the individual is free on bail or without bond per Article 17.032, Texas Code of Criminal Procedure, then that status is not changed absent some other court order.

FACTORS TO BE CONSIDERED DURING THE EXAMINATION. In the years leading up to the creation of the S.B. 553 task force, a number of concerns were raised about the lack of standards under former Art. 46.02 for psychiatrists and psychologists to consider and follow when conducting competency evaluations and in preparing their reports. An entity based in Austin, Capacity for Justice, obtained several federal grants to study and make recommendations concerning competency evaluations in Texas. Those studies revealed inconsistencies around the state in terms of evaluation reports (and in the levels of training and qualifications of experts). Thereafter, the S.B. 553 task force found as a problem area that the “actual evaluations submitted to the courts have been inconsistent in respect to content and compliance to statutorily-required information to be submitted to the courts.” S.B. 553 Task Force Report, at 4, available at http://www.tdcj.state.tx.us/publications/tcomi/tcomi-SB553.PDF. Moreover, former Art. 46.02 had scant language relating either to factors to be evaluated or information to be included in the final examination
Art. 46B.024. Factors Considered in Examination. During an examination under this subchapter and in any report based on that examination, an expert shall consider, in addition to other issues determined relevant by the expert, the following:

(1) the capacity of the defendant during criminal proceedings to:
   (A) rationally understand the charges against the defendant and the potential consequences of the pending criminal proceedings;
   (B) disclose to counsel pertinent facts, events, and states of mind;
   (C) engage in a reasoned choice of legal strategies and options;
   (D) understand the adversarial nature of criminal proceedings;
   (E) exhibit appropriate courtroom behavior; and
   (F) testify;

(2) whether the defendant has a diagnosable mental illness or is a person with mental retardation;

(3) the impact of the mental illness or mental retardation, if existent, on the defendant's capacity to engage with counsel in a reasonable and rational manner; and

(4) if the defendant is taking psychoactive or other medication:
   (A) whether the medication is necessary to maintain the defendant's competency; and
   (B) the effect, if any, of the medication on the defendant's appearance, demeanor, or ability to participate in the proceedings.

Article 46B.024 represented a substantial change and improvement over the prior law. Largely based on a similar enactment in a sister state (Utah), the statute sets forth an array of factors that must be considered in the examination; these primarily relate to functional aspects of the basic competency standards. In addition, Article 46B.025 addresses the information that should be included in the expert’s final report.
issues that relate to the functional aspects of a person’s competency – or incompetency – to face a criminal trial. As noted above, there was no intent to change the underlying Dusky standards relating to the person’s ability to understand the proceedings or ability to consult with counsel. Instead, the statute endeavored to “flesh out” the various components of what is or may comprise the underlying standards. Article 46B.024 was the focus of a great deal of debate during the S.B. 553 task force process and included substantial contributions by representatives from the professional psychiatric and psychological communities. The language was tailored through their assistance to identify the key components comprising the basic framework of what it means to be competent to stand trial. Since the statute’s enactment, this type of information has been particularly helpful to counsel and the courts.

**EVALUATION REPORTS.** For a competency evaluation report to be of value to the courts, it should be thorough in its scope. The S.B. 553 task force received testimony and data that revealed that while many experts in Texas did an excellent job in preparing competency evaluation reports, the quality of the reports was inconsistent around the state, with many being quite conclusory in style. Moreover, the former Art. 46.02 offered little guidance as to the information that should be included in the report. Accordingly, Article 46B.025 is much more specific about the requirements for the reports.

**Art. 46B.025. Expert’s Report.** (a) An expert’s report to the court must state an opinion on a defendant’s competency or incompetency to stand trial or explain why the expert is unable to state such an opinion and must also:

1. identify and address specific issues referred to the expert for evaluation;
2. document that the expert explained to the defendant the purpose of the evaluation, the persons to whom a report on
the evaluation is provided, and the limits on rules of confidentiality applying to the relationship between the expert and the defendant;
(3) in general terms, describe procedures, techniques, and tests used in the examination and the purpose of each procedure, technique, or test; and
(4) state the expert's clinical observations, findings, and opinions on each specific issue referred to the expert by the court, and state specifically any issues on which the expert could not provide an opinion.

(b) If in the opinion of an expert appointed under Article 46B.021 the defendant is incompetent to proceed, the expert shall state in the report:
(1) the exact nature of the deficits resulting from the defendant's mental illness or mental retardation, if any, that impact the factors listed in Article 46B.024, contributing to the defendant's incompetency; and
(2) prospective treatment options, if any, appropriate for the defendant.

(c) An expert's report may not state the expert's opinion on the defendant's sanity at the time of the alleged offense, if in the opinion of the expert the defendant is incompetent to proceed.

(d) The court shall direct an expert to provide the expert's report to the court and the appropriate parties in the form approved by the Texas Correctional Office on Offenders with Medical or Mental Impairments under Section 614.0032(b), Health and Safety Code.

Article 46B.025 requires specific, detailed information in the expert’s report relating to certain delineated matters which are in addition to Article 46B.024’s mandate to report on that section’s array of factors to be considered in the examination. The clear legislative intent was to guard against conclusory reports, and to encourage thorough write-ups. A well-written evaluation report not only assists the courts, but can be an invaluable resource for the hospital treatment team should the defendant be determined to be
incompetent to stand trial. As noted by Shannon Edmonds in his excellent article analyzing S.B. 1057, “What is clear is that the parties and the court will have substantially more information on each defendant than they have under … [the former] law.” Incompetency under New Chapter 46B, Code of Criminal Procedure, THE TEXAS PROSECUTOR 18, 24 (Nov./Dec. 2003). Mr. Edmonds also anticipated that courts and attorneys who are “accustomed to receiving nothing more than a one-page, conclusory memorandum in uncontested competency cases will now have a wealth of new information at their disposal.” Id. (Mr. Edmonds is the Director of Government Relations for the Texas District and County Attorneys Association and participated in the S.B. 553 task force process.)

Subsection (c) of Article 46B.025 represented an important new addition to the state’s competency provisions. Often, a court will appoint the same expert to examine the defendant for both competency and sanity (assuming that the defendant has raised the prospect of pursuing the insanity defense). And, conceptually, there is nothing wrong with such a practice. On the other hand, however, should the expert during the course of the examination conclude that the defendant is incompetent to proceed, any additional information elicited through a further evaluation – at that time – of this incompetent defendant’s sanity would be suspect and likely be of little value. Accordingly, the intent of the S.B. 553 task force in drafting subsection (c) was to guard against that possibility. Thus, under the revised statute, if the expert reaches the conclusion that the defendant is incompetent, that expert should stop the examination and not make an assessment regarding sanity. If, however, the expert is of the view that the defendant is competent, then the expert may proceed and examine for sanity (and thereafter write a separate report relating to the sanity issues). The professional psychiatrists and psychologists on the S.B. 553 task force indicated that subsection (c) also reflected a codification
of their respective ethical requirements. The 2005 enactment of Chapter 46C relating to the insanity defense includes a parallel provision in Article 46C.103, which precludes the expert from examining a defendant for purposes of determining sanity “if in the opinion of the expert the defendant is incompetent to proceed.”

Subsection (d) of Article 46B.025 was added by H.B. 2194 in 2005. It requires courts to direct that the appointed expert’s report comport with a format developed and approved by the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI). That same bill tasked TCOOMMI to develop and make available in electronic format a standardized form for use by experts in reporting competency examination results. TCOOMMI developed such a template following the 2005 legislative session.

As a side note, court decisions have determined that should a competency evaluation reveal that an indigent defendant might have a viable insanity claim, due process requires the court to appoint or give prior approval for the reimbursement of reasonable expenses for the defendant to obtain a competent psychiatrist to assist in the evaluation, preparation, and presentation of the insanity defense. See, e.g., DeFreece v. State, 848 S.W.2d 150, 159 (Tex. Crim. App.), cert. denied, 510 U.S. 905 (1993).

In addition, another section of S.B. 1057 in 2003 amended § 51.20(a), Texas Family Code, to mandate the use of the same requirements for appointment of experts, scope of evaluations, and expert reports for juvenile evaluations relating to the issue of a juvenile’s fitness to proceed.

**TIMELY PREPARATION OF REPORTS.** To be of maximum value to the courts and attorneys, the report from the expert should be submitted in a timely manner.
Art. 46B.026. Report Deadline. (a) Except as provided by Subsection (b), an expert examining the defendant shall provide the report on the defendant's competency or incompetency to stand trial to the court, the attorney representing the state, and the attorney representing the defendant not later than the 30th day after the date on which the expert was ordered to examine the defendant and prepare the report.  
(b) For good cause shown, the court may permit an expert to complete the examination and report and provide the report to the court and attorneys at a date later than the date required by Subsection (a).  
(c) As soon as practicable after the court receives a report under this article, the court shall forward the report to the Texas Correctional Office on Offenders with Medical or Mental Impairments to enable that office to discharge its duties under Section 614.0032(b), Health and Safety Code.

Art. 46B.026 creates a default rule that the expert should have the report completed and submitted within 30 days of the court’s order appointing that expert. Subsection (b) does, however, authorize an extension upon good cause shown. Art. 46B.026 also requires the expert to submit copies of the report to the court, the prosecutor, and the defense counsel. Subsection (c) was added in 2005 by H.B. 2194 to require courts to forward copies of the reports to TCOOMMI, which has the responsibility to review these reports on a state-wide basis and provide information to the legislature about their findings on a periodic basis.

PAYMENT/REIMBURSEMENT FOR EXPENSES. Article 46B.027 carries forward policies from the prior law that require counties to pay the costs for the appointed experts’ services for the competency evaluations. Subsection (a) requires payment directly to the expert or, in the case of a qualified psychiatrist or psychologist who is employed by a local mental health or mental
Art. 46B.027. Compensation of Experts; Reimbursement of Facilities. (a) For any appointment under this chapter, the county in which the indictment was returned or information was filed shall pay for services described by Articles 46B.021(a)(1) and (2). If those services are provided by an expert who is an employee of the local mental health authority or local mental retardation authority, the county shall pay the authority for the services.

(b) The county in which the indictment was returned or information was filed shall reimburse a facility that accepts a defendant for examination under this chapter for expenses incurred that are determined by the department to be reasonably necessary and incidental to the proper examination of the defendant.

THE INCOMPETENCY TRIAL PROCESS. Subchapter C of Chapter 46B addresses the incompetency trial process. This subchapter replaced section 4 of former Art. 46.02. S.B. 679 in 2005 replaced the term “hearing” with “trial” to describe the proceedings.

Art. 46B.051. Trial Before Judge or Jury. (a) If a court holds a trial to determine whether the defendant is incompetent to stand
trial, on the request of either party or the motion of the court, a jury shall make the determination.

(b) The court shall make the determination of incompetency if a jury determination is not required by Subsection (a).

(c) If a jury determination is required by Subsection (a), a jury that has not been selected to determine the guilt or innocence of the defendant must determine the issue of incompetency.

As discussed above, perhaps the most significant change from the former law included in Chapter 46B is the ability to avoid a jury trial on the issue of incompetency unless the prosecutor, the defense, or the court seeks a jury trial. Thus, jury trials are no longer required. Indeed, as provided in Art. 46B.005(b) (discussed above), there is no need for a competency trial at all in an uncontested case unless one is sought by either party or the court. In the event a party contests the issue of competency or a competency trial is otherwise ordered by the court, Article 46B.051 also makes clear that a jury trial is only necessary if sought by a party or directed by the court’s own order. Otherwise, the trial may proceed before the court without a jury.

As under prior law, if a jury trial is sought or otherwise ordered by the court, subsection (c) directs that a jury different from the jury that will determine guilt or innocence must determine the incompetency issue. The requirement of a separate jury for the competency trial permits those jurors to focus exclusively on issues relating to the defendant’s competency to stand trial, uncluttered by evidence or argument relating to the charged offense. Accordingly, these jurors may focus solely on questions relating to the defendant’s present competency.

**JURY DETERMINATIONS.** Should a jury trial be sought, the jury must state in its verdict whether the defendant is incompetent to stand trial or not. In addition, there must be a
unanimous finding by the jury on the question of incompetency to stand trial.

Art. 46B.052. Jury Verdict. (a) If a jury determination of the issue of incompetency to stand trial is required by Article 46B.051(a), the court shall require the jury to state in its verdict whether the defendant is incompetent to stand trial.
(b) The verdict must be concurred in by each juror.

One important aspect of the current law not apparent on the face of Article 46B.052 relates to what is no longer required. Under Section 4 of former Art. 46.02, if the jury found the defendant to be incompetent to stand trial, the jury also had to determine whether the defendant would attain sufficient competency to stand trial in the foreseeable future. Thus, juries not only had to evaluate evidence concerning the defendant’s present capacity to understand or participate in the criminal proceedings, but also make medical predictions about whether the defendant could attain, or regain, sufficient competency in the foreseeable future. The S.B. 553 task force was of the view that this is largely a medical judgment, and that juries are ill-equipped to make such predictions. Accordingly, the 2003 re-write of the statutes dropped that requirement.

WHAT IF THE DEFENDANT IS DETERMINED TO BE COMPETENT? Article 46B.053 addresses the next steps to be taken upon a determination that the defendant is competent to be tried.

Art. 46B.053. Procedure After Finding of Competency. If the court or jury determines that the defendant is competent to stand trial, the court shall continue the trial on the merits. If a jury determines that the defendant is competent and the trial on the merits is to be held before a jury, the court shall continue the trial with another jury selected for that purpose.
If the proceeding results in a determination that the defendant is competent to stand trial, the court may proceed with the trial on the merits after dismissing the jury that determined competency. If there is to be a jury trial on the question of guilt or innocence, a new jury must be impaneled.

WHAT IF THE DEFENDANT IS FOUND TO BE INCOMPETENT TO PROCEED OR THE ISSUE OF INCOMPETENCY IS UNCONTESTED? The final two sections of Subchapter C of Chapter 46B are, in general, cross-reference sections to Subchapter D, which sets forth the procedures to be followed upon an initial determination of incompetency. For ease of reference, we are quoting these final two sections in reverse order.

Art. 46B.055. Procedure After Finding of Incompetency. If the defendant is found incompetent to stand trial, the court shall proceed under Subchapter D.

Art. 46B.054. Uncontested Incompetency. If the court finds that evidence exists to support a finding of incompetency to stand trial and the court and the counsel for each party agree that the defendant is incompetent to stand trial, the court shall proceed in the same manner as if a jury had been impaneled and had found the defendant incompetent to stand trial.

Per Article 46B.055, after a trial on incompetency before either the court or a jury, if the defendant is found to be incompetent to stand trial, the court is directed to follow the procedures set forth in Subchapter D of Chapter 46B. Alternatively, if the court determines that evidence exists that supports a finding of incompetency, and the judge and counsel for both parties agree that the defendant is incompetent, then no trial on incompetency is required. Instead, Article 46B.054 directs that the court proceed as
if a jury had made a finding of incompetence to stand trial. That is, the court should then proceed directly to the process described in Subchapter D, which is discussed immediately below.

**COMMITMENT FOR TREATMENT OR OUTPATIENT TREATMENT.** As noted above, Subchapter D of Chapter 46B sets forth the procedural steps to be followed after an initial finding of incompetency following either a trial on the issue before the court or a jury or if there was an uncontested incompetency determination. Article 46B.071 provides two options: release on bail or a commitment.

**Art. 46B.071. Options on Determination of Incompetency.** On a determination that a defendant is incompetent to stand trial, the court shall:
(1) commit the defendant to a facility under Article 46B.073; or
(2) release the defendant on bail under Article 46B.072.

In turn, Article 46B.072 authorizes or requires release on bail for treatment on an outpatient basis in appropriate cases. A court should weigh this option in any case involving a nonviolent offense or offenses or where the court is of the view that the defendant is not a danger to others. Treatment in the local community is often much more desirable than commitment to a remote institution. Moreover, this approach for nonviolent offenses is quite consistent with the legislative policy reflected by the diversion legislation highlighted in Chapter III above. Indeed, the legislature substantially revamped Article 46B.072 in S.B. 867 in 2007 to require release on bail, with a corresponding outpatient treatment order, for all misdemeanor offenses. The criminal courts should also work with the community mental health and mental retardation authorities to assure that appropriate outpatient treatment programs are available to provide competency restoration services. These 2007 amendments signal a strong
emphasis by the legislature to urge local communities to provide for competency restoration services on a local basis in the case of nonviolent offenders and misdemeanor offenses. But, implicit in the legislation is that the courts and the mental health services providers work closely together to structure and coordinate a workable program.

**Art. 46B.072. Release on Bail.** (a) Subject to conditions reasonably related to assuring public safety and the effectiveness of the defendant’s treatment, if the court determines that a defendant found incompetent to stand trial is not a danger to others and may be safely treated on an outpatient basis with the specific objective of attaining competency to stand trial, and if an appropriate outpatient treatment program is available for the defendant, the court

1. may release on bail a defendant found incompetent to stand trial with respect to a felony or may continue the defendant’s release on bail; and
2. shall release on bail a defendant found incompetent to stand trial with respect to a misdemeanor or shall continue the defendant’s release on bail.

(b) The court shall order a defendant released on bail under Subsection (a) to participate in an outpatient treatment program for a period not to exceed 120 days.

(c) Notwithstanding Subsection (a), the court may order a defendant to participate in an outpatient treatment program under this article only if:

1. the court receives and approves a comprehensive plan that:
   A. provides for the treatment of the defendant for purposes of competency restoration; and
   B. identifies the person who will be responsible for providing that treatment to the defendant; and
2. the court finds that the treatment proposed by the plan will be available to and will be provided to the defendant.

(d) An order issued under this article may require the defendant to participate in:
(1) as appropriate, an outpatient treatment program administered by a community center or an outpatient treatment program administered by any other entity that provides outpatient competency restoration services; and

(2) an appropriate prescribed regimen of medical, psychiatric, or psychological care or treatment, including care or treatment involving the administration of psychoactive medication, including those required under Article 46B.086.

In situations in which release on bail to a local outpatient treatment program is not authorized or such services are not available, the court is instead required to commit the defendant for treatment for the purposes of attaining competency pursuant to the provisions of Article 46B.073.

**Art. 46B.073. Commitment for Restoration to Competency.**

(a) This article applies only to a defendant not released on bail.

(b) The court shall commit a defendant described by Subsection (a) to a mental health facility or residential care facility for a period not to exceed 120 days for further examination and treatment toward the specific objective of attaining competency to stand trial.

(c) If the defendant is charged with an offense listed in Article 17.032(a), other than an offense listed in Article 17.032(a)(6), or the indictment alleges an affirmative finding under Section 3g(a)(2), Article 42.12, the court shall enter an order committing the defendant to the maximum security unit of any facility designated by the department, to an agency of the United States operating a mental hospital, or to a Department of Veterans Affairs hospital.

(d) If the defendant is not charged with an offense described by Subsection (c) and the indictment does not allege an affirmative finding under Section 3g(a)(2), Article 42.12, the court shall enter an order committing the defendant to a mental health facility or residential care facility determined to be appropriate by the local mental health authority or local mental retardation authority.
If there is not a release on bail for outpatient treatment, Article 46B.073 requires the court to commit an incompetent defendant to a treatment facility for up to 120 days for the purpose of providing treatment to allow the defendant to attain competency to be tried. This section supplants the “criminal” commitment process that was formerly set forth in section 5 of old Art. 46.02. One notable difference from the prior law is the duration of this commitment. Under the old law, the section 5 commitment could last up to eighteen (18) months. The S.B. 553 task force received testimony that such a lengthy period does not comport with modern treatment approaches. Indeed, the typical commitment for mental health services in the state hospital system averages less than 30 days, and the experience in public community-based psychiatric hospitals – such as Sunrise Canyon Hospital operated by Lubbock Regional MHMR Center – is in the range of 11-12 days per hospitalization. Thus, under the new statute, the limit for a competency restoration commitment is much shorter: 120 days, with one possible extension of another 60 days as authorized by Article 46B.081 discussed below.

Subsections (c) and (d) identify the appropriate facilities for competency restoration treatment. The type of facility will vary with the nature of the underlying charges. For nonviolent offenses (those not listed in either Art. 17.032 or Section 3g(a)(2), Article 42.12), subsection (d) requires the court to commit the defendant to be committed to the facility deemed appropriate by the local mental health or mental retardation authority. For defendants with mental illness, that could be either the state hospital serving the region or a local public psychiatric facility. For example, Lubbock Regional MHMR operates a competency restoration program for non-violent offenders at its Sunrise Canyon Hospital in Lubbock.

Subsection (c) controls in cases in which the underlying charges are for violent offenses (those that are listed in either Art.
17.032 or Section 3g(a)(2), Article 42.12). For those cases, the commitment for competency restoration treatment will ordinarily be to the maximum security unit of a facility designated by the state department. At present, as it has been for many years, that principal unit is located at the North Texas State Hospital in Vernon. The statute also authorizes a commitment to a V.A. or other federal mental hospital if the defendant qualifies for such services. S.B. 867 in 2007 amended subsection (c) to except out the offense listed at Article 17.032(a)(6). That offense is assault as defined under § 22.01(a)(1), Texas Penal Code. Accordingly, if the defendant is charged with simple assault, he or she can be committed for competency restoration treatment per subsection (d), and need not be committed to a maximum security facility.

**COMPETENT MEDICAL “TESTIMONY.”** Art. 46B.074 permits a criminal commitment under Subchapter D only upon “competent medical or psychiatric testimony” or through a qualifying expert’s report.

**Art. 46B.074. Competent Testimony Required.** (a) A defendant may be committed to a mental health facility or residential care facility under this subchapter only on competent medical or psychiatric testimony provided by an expert qualified under Article 46B.022.

(b) The court may allow an expert to substitute the expert’s report under Article 46B.025 for any testimony by the expert that may be required under this article.

In part, Article 46B.074 carries forward into current law language that was formerly located in subsection 5(b) of former Art. 46.02. As initially enacted in 2003, however, the provision caused some confusion in a few courts with respect to uncontested determinations of incompetency. Obviously, in cases in which there is a trial before the court or a jury on the question of a
defendant’s competency, then the court or jury will hear testimony from the qualified expert(s). After Chapter 46B’s effective date in 2004, however, questions arose as to the role of Article 46B.074 in cases in which the parties waived a competency trial. Some courts were of the view that notwithstanding an agreed finding of incompetency, a hearing was still needed to accept competent medical testimony. In our previous edition of this book, we argued that Article 46B.074 did not apply to an uncontested case. Under a cardinal rule of statutory construction, potentially conflicting provisions of an enactment must be harmonized to the extent possible. We contended that it would be incongruous to construe Article 46B.074 as requiring some type of limited hearing for the sole purpose of eliciting medical or psychiatric testimony when both parties and the court had waived the trial on incompetency as otherwise authorized by the statute. We further posited that albeit not “testimony,” the qualified expert’s report should suffice as sufficient medical or psychiatric evidence for uncontested cases. This uncertainty was clarified by S.B. 679 in 2005, which added subsection (b) to the statute. It is now clear that the expert’s report can be substituted for testimony. This has now become the norm in uncontested cases.

TRANSPORTING THE DEFENDANT TO THE TREATMENT FACILITY. It is the responsibility of the sheriff’s office to transport the defendant to the treatment facility or outpatient facility.

Art. 46B.075. Transfer of Defendant to Facility or Outpatient Treatment Program. An order issued under Article 46B.072 or 46B.073 must place the defendant in the custody of the sheriff for transportation to the facility or outpatient treatment program, as applicable, in which the defendant is to receive treatment for purposes of competency restoration.
With regard to the topic of transportation, although not a part of Chapter 46B, another provision of the Code of Criminal Procedure is worthy of mention. Art. 46.04, Texas Code of Criminal Procedure, provides a listing of certain basic requirements for transportation for any transfers to mental health or mental retardation treatment facilities addressed by the competency statutes, as well as other provisions calling for such transportation in the Code.

Art. 46.04. Transportation to a Mental Health Facility or Residential Care Facility. Sec. 1. (a) A patient transported from a jail or detention facility to a mental health facility or a residential care facility shall be transported by a special officer for mental health assignment certified under Section 1701.404, Occupations Code, or by a sheriff or constable.
(b) The court ordering the transport shall require appropriate medical personnel to accompany the person transporting the patient, at the expense of the county from which the patient is transported, if there is reasonable cause to believe the patient will require medical assistance or will require the administration of medication during the transportation.
(c) A female patient must be accompanied by a female attendant.

Sec. 2. The transportation of a patient from a jail or detention facility to a mental health facility or residential care facility must meet the following requirements:

1) the patient must be transported directly to the facility within a reasonable amount of time and without undue delay;
2) a vehicle used to transport the patient must be adequately heated in cold weather and adequately ventilated in warm weather;
3) a special diet or other medical precautions recommended by the patient's physician must be followed;
4) the person transporting the patient shall give the patient reasonable opportunities to get food and water and to use a bathroom; and
5) the patient may not be transported with a state prisoner.
Article 46.04 was enacted in 1999 after there had been a series of problems regarding the transportation of persons with mental illness from county jails and courts to state mental health facilities. The Bill Analysis accompanying the 1999 enactment stated, “Many of these patients were spending long periods of time on buses making circular routes; being transported in buses without air-conditioning or heating; and being deprived of sufficient bathroom stops.” Moreover, as stated in the Bill Analysis, some of the doctors at the North Texas State Hospital (Vernon) registered complaints that their patients were “suffering severe emotional and mental distress as well as life-threatening physical risks; … in some cases patients have remained shackled for up to twenty-eight hours while being transported; … denied adequate food and drink; and … [transported in vans] with no functional air conditioning and windows closed during periods of extreme heat.” The Bill Analysis concluded that, “[t]hese practices are demeaning, inhumane, and dangerous.”

DOCUMENTATION TO BE PROVIDED TO THE TREATMENT FACILITY. Article 46B.076 identifies an array of information that the court is to order to be provided to the treatment facility.

Art. 46B.076. Court’s Order. (a) If the defendant is found incompetent to stand trial, not later than the date of the order of commitment or of release on bail, as applicable, the court shall send a copy of the order to the facility of the department to which the defendant is committed or the outpatient treatment program to which the defendant is released. The court shall also provide to the facility or outpatient treatment program copies of the following made available to the court during the incompetency trial:

1. reports of each expert;
2. psychiatric, psychological, or social work reports that relate to the mental condition of the defendant;
(3) documents provided by the attorney representing the state or the attorney representing the defendant that relate to the defendant's current or past mental condition;
(4) copies of the indictment or information and any supporting documents used to establish probable cause in the case;
(5) the defendant's criminal history record; and
(6) the addresses of the attorney representing the state and the attorney representing the defendant.

(b) The court shall order that the transcript of all medical testimony received by the jury or court be promptly prepared by the court reporter and forwarded to the proper facility or outpatient treatment program.

Article 46B.076 requires substantially more documentation to be provided to the treatment facility relating to the defendant than under the former law. The S.B. 553 task force received testimony from officials at the North Texas State Hospital in Vernon that frequently their facility would receive only sketchy medical information or documentation about the criminal case when a defendant arrived at the hospital for competency restoration treatment. Accordingly, the task force endeavored to delineate an array of documentation viewed to be beneficial to the treatment team to allow for an expeditious delivery of appropriate services. The list includes not only the qualified expert’s report, but other medical files relating to the person’s mental condition, copies of the charging documents such as the indictment or information, the person’s criminal history record, and – in cases involving a trial – a transcript of the medical testimony. S.B. 867 in 2007 added language requiring similar documentation to be provided in the case of competency restoration at an outpatient treatment facility.

COMPETENCY RESTORATION TREATMENT. Article 46B.077 requires the treating facility or outpatient treatment program to develop and implement an individualized treatment plan with the goal of enabling the defendant to attain competency.
**Art. 46B.077. Individual Treatment Program.** (a) The facility to which the defendant is committed or the outpatient treatment program to which the defendant is released on bail shall:

1. develop an individual program of treatment;
2. assess and evaluate whether the defendant will obtain competency in the foreseeable future; and
3. report to the court and to the local mental health authority or to the local mental retardation authority on the defendant's progress toward achieving competency.

(b) If the defendant is committed to an inpatient mental health facility or to a residential care facility, the facility shall report to the court at least once during the commitment period. If the defendant is released to a treatment program not provided by an inpatient mental health facility or a residential care facility, the treatment program shall report to the court:

1. not later than the 14th day after the date on which the defendant's treatment begins; and
2. until the defendant is no longer released to the treatment program, at least once during each 30-day period following the date of the report required by Subdivision (1).

Article 46B.077(a)(3) also requires the treatment facility or outpatient treatment program to provide a report to the committing court and the local mental health authority regarding the defendant’s progress toward attaining competency. There are additional reporting requirements set forth in subsection (b) in the event the defendant is released to a treatment program other than an inpatient treatment facility.

**DISMISSAL OF CHARGES DURING INCOMPETENCY COMMITMENT.** If the underlying criminal charges pending against the defendant are dismissed during the individual’s commitment for competency restoration, the facility or outpatient treatment program, upon receipt of the court’s order of dismissal, is required to discharge the defendant into the care of the sheriff.
for transportation back to the committing court. A commitment relating to a criminal case cannot stand if the underlying charges are no longer extant. Below we have set forth both the text of Article 46B.078 and a related subsection, Article 46B.082(a), which discusses the requirements relating to transportation after a dismissal.

**Art. 46B.078. Charges Subsequently Dismissed.** If the charges pending against a defendant are dismissed, the court that issued the order under Article 46B.072 or 46B.073 shall send a copy of the order of dismissal to the sheriff of the county in which the court is located and to the head of the facility or the provider of the outpatient treatment program, as appropriate. On receipt of the copy of the order, the facility or outpatient treatment program shall discharge the defendant into the care of the sheriff for transportation in the manner described by Article 46B.082.

**Art. 46B.082. Transportation of Defendant.** (a) On notification from the court under Article 46B.078, the sheriff of the county in which the court is located or the sheriff's designee shall transport the defendant to the court.

**NOTICE AND REPORT TO COURT.** S.B. 867 in 2007 amended and re-ordered the next three sections of this subchapter to make them flow more logically. Article 46B.079 now covers the requirements for the treating entity to provide notice and reports to the court. Much of the substance for this section was formerly located at Article 46B.080.

**Art. 46B.079. Notice and Report to Court.** (a) The head of the facility or the provider of the outpatient treatment program, as appropriate, not later than the 15th day before the date on which a restoration period is to expire, shall notify the applicable court that the restoration period is about to expire.
(b) The head of the facility or outpatient treatment program provider shall promptly notify the court when the head of the facility or outpatient treatment program provider believes that:

1. the defendant has attained competency to stand trial; or
2. the defendant will not attain competency in the foreseeable future.

(c) When the head of the facility or outpatient treatment program provider gives notice to the court under Subsection (a) or (b), the head of the facility or outpatient treatment program provider also shall file a final report with the court stating the reason for the proposed discharge under this chapter and including a list of the types and dosages of medications with which the defendant was treated for mental illness while in the facility or participating in the outpatient treatment program. To enable any objection to the findings of the report to be made in a timely manner under Article 46B.084(a), the court shall provide copies of the report to the attorney representing the defendant and the attorney representing the state.

(d) If the head of the facility or outpatient treatment program provider notifies the court that the initial restoration period is about to expire, the notice may contain a request for an extension of the period for an additional period of 60 days and an explanation for the basis of the request.

Article 46B.079 requires the treatment facility or outpatient treatment program to notify the court: (1) if the defendant has attained competency – subsection (b)(1); (2) if the defendant will not attain competency in the foreseeable future – subsection (b)(2); or (3) not later than the 15th day prior to the date when the restoration treatment period is set to expire – subsection (a). Importantly, if the treatment facility or outpatient program is of the view that the original 120-day restoration period should be extended, the facility or outpatient program should include in the notice a request for an extension for another 60 days of treatment. The request for an extension must include an explanation of the basis for the request. Subsection (c) also requires the facility or
outpatient program to file a report that sets forth the reason for the proposed discharge and include information about the types and dosages of medications with which the defendant had been treated. This should assist with continuity of care.

**EXTENSION OF TREATMENT ORDER.** Chapter 46B authorizes one 60-day extension of the original 120-day treatment order for competency restoration. Article 46B.080 sets forth the grounds for such an extension, and includes provisions that were primarily located at Article 46B.081 prior to the 2007 amendments.

**Art. 46B.080. Extension of Order.** (a) On a request of the head of a facility or a treatment program provider that is made under Article 46B.079(d) and notwithstanding any other provision of this subchapter, the court may enter an order extending the initial restoration period for an additional period of 60 days.

(b) The court may enter an order under Subsection (a) only if the court determines that, on the basis of information provided by the head of the facility or the treatment program provider:

1. the defendant has not attained competency; and
2. an extension of the restoration period will likely enable the facility or program to restore the defendant to competency.

(c) The court may grant only one extension under this article for a period of restoration ordered under this subchapter.

If the treatment facility or outpatient treatment provider submits a proper and timely notice as described by Article 46B.079(d), Article 46B.080 authorizes the court to order a 60-day extension of the original commitment or outpatient treatment order. As per subsection (c), the court can grant only one such extension. Moreover, before an extension may be ordered, the court must determine, based on the information provided by the treating entity, that the extension “will likely enable the facility or
program to restore the defendant to competency.” Article 46B.080(b)(2).

Unlike prior law under section 5 of old Art. 46.02, in which the “criminal” commitment for competency restoration could last for up to 18 months, the maximum duration for treatment under the revamped law is six months – assuming both the original 120 days plus an extension of another 60 days. Any further commitment orders must be entered under the provisions of the civil mental health code (as will be described in more detail infra).

RETURN TO THE COURT FOLLOWING COMPETENCY RESTORATION TREATMENT. Separate from the situation identified in Art. 46B.078 relating to the dismissal of criminal charges and the situation covered by Article 46B.082(b) – discussed below, Article 46B.081 identifies the timing for returning a defendant from a treatment facility or outpatient treatment program. Prior to the 2007 amendments, comparable information was located at Article 46B.079.

Art. 46B.081. Return to Court. Subject to Article 46B.082(b), a defendant committed or released on bail under this subchapter shall be returned to the applicable court as soon as practicable after notice to the court is provided under Article 46B.079, but not later than the date of expiration of the period for restoration specified by the court under Article 46B.072 or 46B.073.

Per Article 46B.081, the defendant is to be returned to the criminal court no later than the date of expiration of the competency restoration period ordered by the court. The return to the court should, of course, come earlier in cases in which the treatment facility or outpatient program has notified the court that the defendant has attained competency in a shorter period of time. This statute should also be read in context with both Article
46B.080, which allows for one 60-day extension of the original 120 day competency restoration order.

ADDITIONAL TRANSPORTATION PROVISIONS. As the reader will have noted, Chapter 46B includes several different provisions regarding transportation. Article 46B.082(b) requires that the treatment facility or outpatient treatment program must cause the defendant to be transported back to the committing court if the person has not been transported “before the 15th day after the date on which the court received” the notice required by Article 46B.079, or if the defendant has not been transported back to the court by the end of the ordered restoration period.

Art. 46B.082. Transportation of Defendant. (b) If before the 15th day after the date on which the court received notification under Article 46B.079 a defendant committed to a facility of the department or ordered to participate in an outpatient treatment program has not been transported to the court that issued the order under Article 46B.072 or 46B.073, as applicable, the head of the facility to which the defendant is committed or the provider of the outpatient treatment program in which the defendant is participating shall cause the defendant to be promptly transported to the court and placed in the custody of the sheriff of the county in which the court is located. The county in which the court is located shall reimburse the department for the mileage and per diem expenses of the personnel required to transport the defendant, calculated in accordance with rates provided in the General Appropriations Act for state employees.

The practical effect of this provision is to require transport of the defendant back to the court by the end of the 120-day treatment restoration period (or 180-day period in cases in which the one-time extension is granted). The provision is intended to make the 120-day treatment period (or 180 days in cases involving extensions) to be the actual limit. The statute puts the burden of
transporting the individual on the treatment facility or program, but also requires the originating county to reimburse the treatment facility or outpatient treatment program if the facility or program has to provide the transportation.

**INFORMATION REGARDING POSSIBLE CIVIL COMMITMENT TO BE PROVIDED BY TREATMENT PROVIDER.** Article 46B.083 requires the facility head or outpatient treatment provider to submit to the court information in support of a possible civil commitment following the competency restoration period.

**Art. 46B.083. Supporting Commitment Information Provided by Facility Head or Outpatient Treatment Program Provider**

(a) If the head of the facility or outpatient treatment provider believes that the defendant is a person with mental illness and meets the criteria for court-ordered mental health services under Subtitle C, Title 7, Health and Safety Code, the head of the facility or the outpatient treatment provider shall have submitted to the court a certificate of medical examination for mental illness.

(b) If the head of the facility or the outpatient treatment provider believes that the defendant is a person with mental retardation, the head of the facility or the outpatient treatment provider shall have submitted to the court an affidavit stating the conclusions reached as a result of the examination.

As under prior law, under Article 46B.083 the head of the treatment facility or the outpatient treatment provider must submit to the court a certificate of medical examination for mental illness if the facility head is of the view that that the defendant is a person with mental illness who meets the criteria for court-ordered inpatient mental health services under the Texas Health & Safety Code. Similarly, Article 46B.083(b) requires a comparable submission of a supporting affidavit in the case of a person with mental retardation.
PROCEDURAL STEPS UPON CONCLUSION OF CRIMINAL COMMITMENT FOR COMPETENCY RESTORATION. Article 46B.084 sets forth the next procedural steps to be followed upon the defendant’s return to the court after the 120-day commitment for competency restoration (or 180 days in a case in which the one-time extension was granted).

Art. 46B.084. Proceedings on Return of Defendant to Court.
(a) On the return of a defendant to the court, the court shall make a determination with regard to the defendant’s competency to stand trial. The court may make the determination based solely on the report filed under Article 46B.079(c), unless any party objects in writing or in open court to the findings of the report not later than the 15th day after the date on which the court received notification under Article 46B.079. The court shall make the determination not later than the 20th day after the date on which the court received notification under Article 46B.079, regardless of whether a party objects to the report as described by this subsection and the issue is set for hearing under Subsection (b).
(b) If a party objects under Subsection (a), the issue shall be set for a hearing. The hearing is before the court, except that on motion by the defendant, the defense counsel, the prosecuting attorney, or the court, the hearing shall be held before a jury.
(b-1) If the hearing is before the court, the hearing may be conducted by means of an electronic broadcast system as provided by Article 46B.013. Notwithstanding any other provision of this chapter, the defendant is not required to be returned to the court with respect to any hearing that is conducted under this article in the manner described by this subsection.
(c) [Repealed in 2007 by S.B. 867]
(d) If the defendant is found competent to stand trial, criminal proceedings against the defendant may be resumed.
(e) If the defendant is found incompetent to stand trial and if all charges pending against the defendant are not dismissed, the court shall proceed under Subchapter E.
(f) If the defendant is found incompetent to stand trial and if all charges pending against the defendant are dismissed, the court shall proceed under Subchapter F.

Subsection (a) requires the court to make a prompt determination regarding the defendant’s competency to stand trial upon the person’s return to the court following the commitment. Assuming that the report from the facility head concludes that the defendant is competent to be tried, subsection (a) authorizes the court to determine and conclude that the defendant is competent based solely on that report. However, if there is an objection to such a finding, subsection (b) requires the court to hold a further competency hearing. Such a hearing is to be conducted before the court unless the defendant, the defense counsel, the prosecutor, or the court seeks a jury trial. Moreover, this hearing is to take place on an expedited basis. The statute requires the subsection (a) determination to be made within 15 days of the court’s receipt of the Article 46B.079 notice from the treatment facility or program. Moreover, even if an objection is made to the court’s relying strictly on the treatment official’s report, the hearing must take place within 20 days of the court’s receipt of the notice. The legislature appears to be very serious about these time deadlines. As part of S.B. 867 in 2007, the legislature repealed former subsection (c), which had previously allowed the hearing to be held within 30 days following an objection, with a continuance allowed for good cause for an additional 30 days. That language is now gone, and the time frame has been significantly shortened. The reason for this short period stems from a very real concern that when a period of time elapses after a defendant is transported back to the county from the treatment facility and prior to a hearing, it is not unusual for the defendant – while once viewed as competent by the treating physicians – to deteriorate in medical condition. And, there is then a risk that the defendant will no longer be competent to proceed. This is particularly true for a defendant with mental
illness who is not continuing to take prescribed medications for the mental illness or being provided with appropriate continuity of care. The county jail should assure that the individualized treatment plan for the defendant is being continued, and the committing court should resume the proceedings promptly as set out in this statute. The criminal courts around the state must implement administrative procedures to assure that the short time periods prescribed by Article 46B.084 are being applied. All too often criminal defendants return to the committing court’s jurisdiction, but languish in jail before the process is resumed. The 2007 legislation, if followed, should help limit the times in which defendants return to an incompetent state having once had their competency restored.

If the court finds the defendant to be competent to be tried, and no objection is lodged, subsection (d) allows for the resumption of the underlying criminal proceedings. Similarly, if there is an objection and after a hearing the court (or jury) concludes that the defendant is competent, the underlying criminal proceedings may resume.

What about the situation, however, in which the head of the treatment facility concludes that the defendant is likely not to attain competency in the foreseeable future? (Although this scenario is far less likely for a person who has a treatable serious mental illness than for a defendant who has mental retardation, it is still possible.) In this type of scenario, the court can make a determination that the defendant is incompetent to be tried based solely on the report. Absent an objection, then the court is to enter a finding of incompetency. Alternatively, if there is an objection – presumably by the prosecutor, there must be a hearing before the court or a jury per subsection (b). And, per subsection (a), that hearing must take place within 20 days of the court’s receipt of the 46B.079 notice. Subsection (b-1), which was added in 2005, is also
relevant in this type of situation. It allows a court to conduct the hearing by means of interactive video. In such a case, the defendant does not have to be returned from the treatment facility to the county with criminal jurisdiction. This approach would seem to be particularly appropriate in a case in which the defendant’s competency has not been restored.

Subsections (e) and (f) come into play if there is a determination by the court, either following a hearing or not, that the defendant remains incompetent to be tried. Subsection (e) directs that the court proceed under Subchapter E of Chapter 46B if the defendant is incompetent to stand trial and the underlying charges against the defendant have not been dismissed. Alternatively, subsection (f) requires the court to proceed under Subchapter F of Chapter 46B if the defendant is incompetent to stand trial and the prosecutor has opted to dismiss the underlying criminal charges.

NO SUBSEQUENT COMMITMENTS OR EXTENSIONS ALLOWED UNDER THE CODE OF CRIMINAL PROCEDURE. Article 46B.085 bars any further court orders for competency restoration treatment under Subchapter D of Chapter 46B following the initial 120-day period and one 60-day extension. That is, there can only be one 120-day commitment (with only one 60-day extension) for competency restoration treatment in connection with the same offense. Any further court orders relating to commitment for treatment must be made in connection with either Subchapter E or Subchapter F, depending on whether the criminal charges remain pending. Under those provisions, which are discussed below, further treatment can only be ordered through use of the Health & Safety Code’s commitment procedures.

Art. 46B.085. Subsequent Restoration Periods and Extensions of those Periods Prohibited. (a) The court may order only one
initial period of restoration and one extension under this subchapter in connection with the same offense.
(b) After an initial restoration period and an extension are ordered as described by Subsection (a), any subsequent court orders for treatment must be issued under Subchapter E or F.

COURT ORDERS FOR ADMINISTRATION OF MEDICATION. Art. 46B.086 authorizes a court, following a due process hearing, to order medications in certain limited situations.

Art. 46B.086. Court-ordered Medications. (a) This article applies only to a defendant:
(1) who is determined under this chapter to be incompetent to stand trial;
(2) for whom an inpatient mental health facility, residential care facility, or outpatient treatment program provider has prepared a continuity of care plan that requires the defendant to take psychoactive medications; and
(3) who, after a hearing held under Section 574.106, Health and Safety Code, has been found not to meet the criteria prescribed by Sections 574.106(a) and (a-1), Health and Safety Code, for court-ordered administration of psychoactive medications; or
(4) who is subject to Article 46B.072.
(b) If a defendant described by Subsection (a) refuses to take psychoactive medications as required by the defendant’s continuity of care plan, the director of the correctional facility or outpatient treatment provider shall notify the court in which the criminal proceedings are pending of that fact not later than the end of the next business day following the refusal. The court shall promptly notify the attorney representing the state and the attorney representing the defendant of the defendant’s refusal. The attorney representing the state may file a written motion to compel medication. The motion to compel medication must be filed not later than the 15th day after the date a judge issues an order stating that the defendant does not meet the criteria for court-ordered administration of psychoactive medications under Section 574.106,
Health and Safety Code. The motion to compel medication for a defendant in an outpatient treatment program may be filed at any time.

(c) The court, after notice and after a hearing held not later than the fifth day after the defendant is returned to the committing court, may authorize the director of a correctional facility or the program provider, as applicable, to have the medication administered to the defendant, by reasonable force if necessary.

(d) The court may issue an order under this article only if the order is supported by the testimony of two physicians, one of whom is the physician at or with the applicable correctional facility or outpatient treatment program who is prescribing the medication as a component of the defendant’s continuity of care plan and another who is not otherwise involved in proceedings against the defendant. The court may require either or both physicians to examine the defendant and report on the examination to the court.

(e) The court may issue an order under this article if the court finds by clear and convincing evidence that:
   (1) the prescribed medication is medically appropriate, is in the best medical interest of the defendant, and does not present side effects that cause harm to the defendant that is greater than the medical benefit to the defendant;
   (2) the state has a clear and compelling interest in the defendant obtaining and maintaining competency to stand trial;
   (3) no other less invasive means of obtaining and maintaining the defendant’s competency exists; and
   (4) the prescribed medication will not unduly prejudice the defendant’s rights or use of defensive theories at trial.

(f) A statement made by a defendant to a physician during an examination under Subsection (d) may not be admitted against the defendant in any criminal proceeding, other than at:
   (1) a hearing on the defendant’s incompetency; or
   (2) any proceeding at which the defendant first introduces into evidence the contents of the statement.

Article 46B.086 was perhaps the one controversial aspect of Chapter 46B during its initial enactment, and it was the subject of
mild debate during the 2003 Senate Jurisprudence Committee hearing on S.B. 1057. There was some adverse testimony and a few questions raised about the section during the committee’s consideration. The provision was also subject to intensive scrutiny and discussions during the S.B. 553 task force process. The article was enacted to address concerns regarding so-called “revolving door” commitments in which a defendant who, after having been restored to competency at the treatment facility, refuses to take medication prescribed as part of the defendant’s individualized treatment/continuity of care plan after returning to the county jail and awaiting further criminal proceedings. Not surprisingly, in many such cases, the person’s mental condition then deteriorates and he or she again becomes incompetent to be tried. To address this type of situation, Article 46B.086 sets forth a due process hearing procedure by which a court can compel a defendant to take medication to maintain his or her competency to be tried. Indeed, this part of the statute was drafted to provide due process protections consistent with and greater than those challenged and upheld in various federal appellate decisions.

Shortly following the 2003 enactment of the statute, however, the U.S. Supreme Court decided Sell v. United States, 123 S.Ct. 2174 (2003). In Sell, the Court observed that earlier cases had determined that the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests. 
Id. at 2184-85. In Sell, however, the Court found impermissible the involuntary medication of a defendant for purposes of trial competency when that defendant was not dangerous, was competent, and the experts had not focused on “the need to bring him to trial.” Id. at 2186-87. We stated the following in the 2004 edition of this book, “The criteria set forth in new Art. 46B.086 for medication hearings appear to square with the standard set forth in Sell; however, Sell likely places some limits on the employment of the new statute – particularly if the defendant is not dangerous to self or others. Indeed, Mr. Sell was a dentist charged with fraud. Thus, before a prosecutor endeavors to seek an order under Art. 46B.086, a close examination of Sell is important.”

Because of concerns regarding Sell, however, in 2005 the legislature enacted S.B. 465, which modified Article 46B.086 to require an additional medication hearing in cases involving inpatient commitments. S.B. 465 added subsection (a)(3), which requires an initial medication hearing under § 574.106 of the Texas Health & Safety Code. As also amended by S.B. 465 in 2005, that § 574.106(a)(2) authorizes the court to issue an order authorizing the administration of medications to a person who “is in custody awaiting trial in a criminal proceeding and [who] was ordered to receive inpatient mental health services in the six months preceding” the hearing under § 574.106. However, § 574.106(a-1) authorizes such an order vis-à-vis the defendant only if:

(A) the patient presents a danger to the patient or others in the inpatient mental health facility in which the patient is being treated as a result of a mental disorder or mental defect as determined under Section 574.1065; and
(B) treatment with the proposed medication is in the best interest of the patient.
§ 574.106(a-1)(2)(A)-(B), Tex. Health & Safety Code. In turn, § 574.1065, also enacted in 2005 as a part of S.B. 465 includes a narrow definition of dangerousness, as part of an effort to conform to Sell. That statute provides:

In making a finding under Section 574.106 (a-1)(2) that the patient presents a danger to the patient or others in the inpatient mental health facility in which the patient is being treated as a result of a mental disorder or mental defect the court shall consider:

1. an assessment of the patient's present mental condition;
2. whether the patient has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm to the patient's self or to another while in the facility; and
3. whether the patient, in the six months preceding the date the patient was placed in the facility, has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm to another that resulted in the patient being placed in the facility.

§ 574.1065, Tex. Health & Safety Code. If the court enters an order for the administration of medication under § 574.106, the order must be reviewed every six months, and it expires upon the date of acquittal, conviction, entry of a guilty plea, or upon a dismissal of the charges. See id. § 574.110.

Should the court determine that the defendant does not meet the criteria for court-ordered medication under Health & Safety Code § 574.106, the state can thereafter seek an order for the administration of medication under Article 46B.086. Per Article 46B.086(b), the motion to compel medication must be filed within 15 days after the date the judge issues an order declining to order medication under § 574.106. The court must then conduct the Article 46B.086 hearing.
Before discussing the hearing process, another enactment should be mentioned. In 2007, as part of emphasizing the possible use of outpatient treatment programs in providing competency restoration, the legislature in S.B. 867 further modified Article 46B.086. That bill added subsection 46B.086(a)(4), which makes the 46B.086 medication hearing process applicable to persons ordered to outpatient treatment for competency restoration per Article 46B.072. For such defendants, the court need not conduct a § 574.106 hearing, but may proceed directly to the Article 46B.086 hearing. Correspondingly, per Article 46B.086(b), the state’s motion to compel medication for a defendant ordered to an outpatient competency restoration program may be filed at any time during the restoration period. This assumes, of course, that such an order has been made necessary by the defendant’s refusal to take prescribed medications.

The due process protections set forth in Art. 46B.086 require that any order under the statute be limited to the administration of those psychoactive medications that have been prescribed by the treatment team and are a part of the defendant’s individualized continuity of care plan. Moreover, before the court may issue an order for administration of the medications, there must be:

- notice and a hearing;
- supporting testimony by two physicians; and
- findings supported by clear and convincing evidence that:
  - the prescribed medication is medically appropriate;
  - the prescribed medication is in the best medical interest of the defendant;
  - the prescribed medication does not present side effects that cause harm to the defendant that is greater than the medical benefits;
the state has a clear and compelling interest in the defendant attaining and maintaining competency to stand trial;
- there is not any less invasive means of attaining and maintaining the defendant’s competency; and
- the prescribed medication will not unduly prejudice the defendant’s rights or use of defensive theories at trial

This quite properly represents a heavy burden for the state. On the other hand, it represents an attempt to avoid or limit the prospect of “revolving-door” commitments and to help assure that competency is attained and maintained.

ADDITIONAL PERIODS OF CIVIL COMMITMENT WHEN CHARGES REMAIN PENDING. As noted above, per Article 46B.084(e), if a person’s competency has not been attained or restored after the commitment process required by Subchapter D of Chapter 46B (re the 120-day restoration period and one possible 60-day extension), Subchapter E must be followed if the underlying criminal charges remain pending. Subchapter E represents the replacement for section 6 of former Art. 46.02 and begins with Article 46B.101.

Art. 46B.101. Applicability. This subchapter applies to a defendant against whom a court is required to proceed under Article 46B.084(e).

CIVIL COMMITMENT HEARING – MENTAL ILLNESS. Like section 6 of old Art. 46.02, if a defendant remains incompetent after the initial 120-day restoration period and ensuing 60-day extension, and the criminal charges remain pending, Article 46B.102 requires the criminal court to conduct a civil commitment hearing.
Art. 46B.102. Civil Commitment Hearing: Mental Illness. (a) If it appears to the court that the defendant may be a person with mental illness, the court shall hold a hearing to determine whether the defendant should be court-ordered to mental health services under Subtitle C, Title 7, Health and Safety Code. (b) Proceedings for commitment of the defendant to court-ordered mental health services are governed by Subtitle C, Title 7, Health and Safety Code, to the extent that Subtitle C applies and does not conflict with this chapter, except that the criminal court shall conduct the proceedings whether or not the criminal court is also the county court. (c) If the court enters an order committing the defendant to a mental health facility, the defendant shall be: (1) treated in conformity with Subtitle C, Title 7, Health and Safety Code, except as otherwise provided by this chapter; and (2) released in conformity with Article 46B.107. (d) In proceedings conducted under this subchapter for a defendant described by Subsection (a): (1) an application for court-ordered temporary or extended mental health services may not be required; (2) the provisions of Subtitle C, Title 7, Health and Safety Code, relating to notice of hearing do not apply; and (3) appeals from the criminal court proceedings are to the court of appeals as in the proceedings for court-ordered inpatient mental health services under Subtitle C, Title 7, Health and Safety Code. Thus, Article 46B.102 directs the judge of the court presiding over the criminal case to make determinations concerning whether the incompetent defendant is experiencing symptoms of a mental illness and requires commitment for treatment at a mental health facility or outpatient treatment program. Specifically, Article 46B.102 requires the “criminal” court to make determinations regarding the defendant’s need for court-ordered mental health services in accordance with provisions of the Texas Health & Safety Code. (As a side note, Subtitle C, Title 7, Health & Safety...
Code, is sometimes referred to as the Texas Mental Health Code.) Accordingly, the judge presiding over the “criminal” court will make those decisions that a county court or other court with probate jurisdiction would normally make in the civil commitment process. (Of course, it is possible that for certain offenses the county court will also be the court that has been presiding over the criminal matters.)

Although Article 46B.102 requires the criminal court to proceed generally in accordance with the provisions of the Texas Health & Safety Code, there are a few differences set forth. For example, unlike the ordinary civil commitment proceeding, Subsection (d)(1) provides that there is generally no need for a formal application for court-ordered mental health services to be on file. Given that the criminal court already has jurisdiction over the matter, such an application would tend to be superfluous. In addition, Subsection (d)(2) eliminates the Health & Safety Code’s notice of hearing provisions. Of course, the defendant will have received ample notice through the ongoing criminal process.

Given that the usual defendant with mental illness who will face a Subchapter E “extended commitment” will have been hospitalized for 120 or 180 days (assuming the one-time 60-day extension), the criminal court will typically be applying the extended, 12-month commitment provisions of the Texas Health & Safety Code, rather than the 90-day commitment rules. Indeed, § 574.035(a)(4), Texas Health & Safety Code, provides that the 12-month commitment provisions apply if “the proposed patient has received court-ordered inpatient mental health services … under Chapter 46B, Code of Criminal Procedure, for at least 60 consecutive days during the preceding 12 months.” It is theoretically possible – albeit very unusual, however – for the mental health treatment provider to return the defendant back to the court – as not likely to attain competency within the
foreseeable future – before the defendant had been hospitalized for 60 days. Then, the Texas Health & Safety Code would require the court to follow the 90-day “temporary” commitment provisions. It will likely be a rare case, however, in which the treatment facility would halt efforts at trying to restore the defendant’s competency during the initial 120-day commitment period prior to the passage of 60 days. We are also aware of unfortunate situations in which defendants have been returned to the committing court, but languished in jail for so many months that § 574.035(a)(4)’s trigger of at least 60 days of hospitalization in the preceding 12 months pursuant to Chapter 46B has lapsed. In such a case, the criminal court would need to conduct civil commitment proceedings under § 574.034, Texas Health & Safety Code, pertaining to court-ordered “temporary” mental health services (a 90-day commitment).

The Health & Safety Code requires a jury for an extended 12-month commitment hearing unless the defendant waives that right. § 574.032(b), Texas Health & Safety Code. This is in contrast to the provisions for the 90-day commitment hearing in which no jury is required unless affirmatively sought by the defendant. Id. § 574.032(a). With regard to the ensuing hearing, if the jury or court finds that the defendant is both mentally ill and meets one or more of the three commitment criteria (likely to cause serious harm to (1) self or (2) others, or (3) will, if not treated, continue to suffer severe mental, emotional, or physical distress and experience deterioration of the ability to function independently), then the court will typically commit the defendant to a mental health treatment facility for inpatient mental health care and treatment for a period of no more than 12 months. However, the statute also authorizes the judge to order extended outpatient mental health services if certain criteria are met. See id. § 574.035(b). In these civil commitment proceedings, the state has the burden of proof,
and the evidentiary standard is proof by “clear and convincing evidence.”

CIVIL COMMITMENT HEARING – MENTAL RETARDATION. Article 46B.103 is a provision that largely parallels Article 46B.102 and governs ensuing civil commitment hearings for persons with mental retardation when charges remain pending and the person remains incompetent to proceed. The legislature amended subsection (d) in 2007 to specifically limit the scope of the provision to pertain solely to commitments for mental retardation services.

Art. 46B.103. Commitment Hearing: Mental Retardation. (a) If it appears to the court that the defendant may be a person with mental retardation, the court shall hold a hearing to determine whether the defendant is a person with mental retardation.
(b) Proceedings for commitment of the defendant to a residential care facility are governed by Subtitle D, Title 7, Health and Safety Code, to the extent that Subtitle D applies and does not conflict with this chapter, except that the criminal court shall conduct the proceedings whether or not the criminal court is also a county court.
(c) If the court enters an order committing the defendant to a residential care facility, the defendant shall be:
   (1) treated and released in accordance with Subtitle D, Title 7, Health and Safety Code, except as otherwise provided by this chapter; and
   (2) released in conformity with Article 46B.107.
(d) In the proceedings conducted under this subchapter for a defendant described by subsection (a):
   (1) an application to have the defendant declared a person with mental retardation may not be required;
   (2) the provisions of Subtitle D, Title 7, Health and Safety Code, relating to notice of hearing do not apply; and
   (3) appeals from the criminal court proceedings are to the court of appeals as in the proceedings for commitment to a
residential care facility under Subtitle D, Title 7, Health and Safety Code.

**PLACEMENT OF THE DEFENDANT FOR A CIVIL COMMITMENT – VIOLENT OFFENSES.** Assuming that the defendant has been found by the jury or court to meet the Texas Mental Health Code’s commitment criteria, the next several statutes in Subchapter E describe the appropriate placement for the defendant. Article 46B.104 governs situations in which the defendant has been charged with any of an array of violent offenses. In such cases, the commitment will be to a maximum security unit of the state department. S.B. 867 in 2007 created an exception to subsection (1) if the charge is limited to simple assault as defined under § 22.01(a)(1), Texas Penal Code.

**Art. 46B.104. Civil Commitment Placement: Finding of Violence.** A defendant committed to a facility as a result of proceedings initiated under this chapter shall be committed to the maximum security unit of any facility designated by the department if:

(1) the defendant is charged with an offense listed in Article 17.032(a), other than an offense listed in Article 17.032(a)(6); or

(2) the indictment charging the offense alleges an affirmative finding under Section 3g(a)(2), Article 42.12.

**STEP-DOWNS FROM THE MAXIMUM SECURITY UNIT.** For a defendant who has been committed to a maximum security unit per Article 46B.104, the next statute, Article 46B.105, provides for the prospect of a “step-down” to a less secure unit or other state facility, or to a local authority. As under prior law, this provision also requires the state department to appoint and maintain a five-member review board to make determinations about whether a defendant committed to a maximum security unit is manifestly dangerous and must remain in the secure facility.
Art. 46B.105. Transfer Following Civil Commitment Placement. (a) Unless a defendant is determined to be manifestly dangerous by a department review board, not later than the 60th day after the date the defendant arrives at the maximum security unit, the defendant shall be transferred to:

(1) a unit of an inpatient mental health facility other than a maximum security unit;
(2) a residential care facility; or
(3) a program designated by a local mental health authority or a local mental retardation authority.

(b) The commissioner of mental health and mental retardation shall appoint a review board of five members, including one psychiatrist licensed to practice medicine in this state and two persons who work directly with persons with mental illness or mental retardation, to determine whether the defendant is manifestly dangerous and, as a result of the danger the defendant presents, requires continued placement in a maximum security unit.

(c) The review board may not make a determination as to the defendant's need for treatment.

(d) A finding that the defendant is not manifestly dangerous is not a medical determination that the defendant no longer meets the criteria for involuntary civil commitment under Subtitle C or D, Title 7, Health and Safety Code.

(e) If the superintendent of the facility at which the maximum security unit is located disagrees with the determination, the matter shall be referred to the commissioner of mental health and mental retardation. The commissioner shall decide whether the defendant is manifestly dangerous.

This statute requires the review board to be comprised of five members, at least one of whom must be a licensed psychiatrist and two who must work directly with persons with mental illness or mental retardation. The review board is not to concern itself with treatment issues, but should decide only whether the persons who come before the board are so dangerous that they must remain in a maximum security unit. Accordingly, the statute specifies that a
review board finding that a patient is not manifestly dangerous does not equate to a determination that the patient no longer meets civil commitment criteria. Instead, such a finding permits the agency to transfer the person to a less restrictive setting for further treatment. Finally, Article 46B.105 includes an “appeal” provision regarding these determinations. If the superintendent of the mental health facility that houses the maximum security unit disagrees with the review board’s findings, the head of the agency must resolve the disagreement.

**PLACE** **MENT OF THE DEFENDANT FOR CIVIL COMMITMENT: NON-VIOLENT OFFENSES.** Assuming that the underlying criminal charges are not for any of the violent offenses set forth in the statutes cross-referenced by Article 46B.104, the next statute, Article 46B.106, requires that the commitment be to a facility designated by the state department or to an outpatient treatment program. The facility or program cannot refuse the placement on grounds that criminal charges remain pending.

_Art. 46B.106. Civil Commitment Placement: No Finding of Violence._ (a) A defendant committed to a facility as a result of the proceedings initiated under this chapter, other than a defendant described by Article 46B.104, shall be committed to:

1. a facility designated by the department; or
2. an outpatient treatment program.

(b) A facility or outpatient treatment program may not refuse to accept a placement ordered under this article on the grounds that criminal charges against the defendant are pending.

**RELEASE OF THE DEFENDANT AFTER THE CIVIL COMMITMENT.** Article 46B.107 sets forth the process to be followed if the treatment facility or program determines that the defendant no longer meets commitment criteria and should be released.

(a) The release from the department, an outpatient treatment program, or a facility of a defendant committed under this chapter is subject to disapproval by the committing court if the court or the attorney representing the state has notified the head of the facility or outpatient treatment provider, as applicable, to which the defendant has been committed that a criminal charge remains pending against the defendant.

(b) If the head of the facility or outpatient treatment provider to which a defendant has been committed under this chapter determines that the defendant should be released from the facility, the head of the facility or outpatient treatment provider shall notify the committing court and the sheriff of the county from which the defendant was committed in writing of the release not later than the 14th day before the date on which the facility or outpatient treatment provider intends to release the defendant.

(c) The head of the facility or outpatient treatment provider shall provide with the notice a written statement that states an opinion as to whether the defendant to be released has attained competency to stand trial.

(d) The court may, on motion of the attorney representing the state or on its own motion, hold a hearing to determine whether release is appropriate under the applicable criteria in Subtitle C or D, Title 7, Health and Safety Code. The court may conduct the hearing:
   (1) at the facility; or
   (2) by means of an electronic broadcast system as provided by Article 46B.013.

(e) If the court determines that release is not appropriate, the court shall enter an order directing the head of the facility or outpatient treatment provider to not release the defendant.

(f) If an order is entered under Subsection (e), any subsequent proceeding to release the defendant is subject to this article.

As with a typical civil commitment ordered by a probate court, once the defendant becomes a patient at a mental health facility or in an outpatient treatment program pursuant to Subchapter E, then
the facility or provider – in general – has the authority to gauge whether the patient may be released earlier than the maximum period set forth in the statute. Under the law governing a civil commitment, if the patient responds well to treatment and the hospital or other treatment provider determines that the commitment criteria are no longer met, the hospital must release the patient at that time. Article 46B.107 sets forth a few variations, however, for a defendant under a civil commitment ordered by the criminal court when charges remain pending. First, subsection (a) makes the release from the facility or outpatient treatment provider subject to the disapproval of the committing court if criminal charges remain pending. Plus, the facility or outpatient treatment provider must give the court and local sheriff at least two weeks’ notice prior to the date when the facility otherwise intends to release the patient. Art. 46B.107(b). Subsection (c) requires the head of the facility or outpatient treatment provider to include with the notice a written opinion as to whether – in the medical judgment of the treatment team – the defendant has attained competency to be tried. Indeed, if the person is doing well enough medically to no longer meet commitment criteria, there is a very good prospect that the treatment will have resulted in the person’s attaining competency to be tried.

Subsection (d) authorizes the court, on a motion by the prosecutor or on its own motion, to hold a further hearing under the Texas Mental Health Code to assess whether release is appropriate under the Mental Health Code’s commitment criteria or whether further commitment is necessary. As amended in 2005, the statute authorizes such hearings to take place at the facility or by interactive video transmission. Alternatively, the court can proceed under the next several articles to consider a re-determination of the defendant’s competency to be tried.
RE-DETERMINATION OF COMPETENCY. Article 46B.108 authorizes the court at any time to determine whether the defendant’s competency has been restored. Although this will likely occur most typically at the time the facility is of the view that the defendant is ready for release, the statute is very open-ended about the timing. Moreover, an inquiry into competency restoration may be made at any time at the request of the treatment provider, the defendant, defense counsel, the prosecutor, or the court.

Art. 46B.108. Redetermination of Competency. (a) If criminal charges against a defendant found incompetent to stand trial have not been dismissed, the trial court at any time may determine whether the defendant has been restored to competency.
(b) An inquiry into restoration of competency under this subchapter may be made at the request of the head of the mental health facility, outpatient treatment provider, or residential care facility to which the defendant has been committed, the defendant, the attorney representing the defendant, or the attorney representing the state, or may be made on the court's own motion.

REQUEST BY THE FACILITY HEAD OR OUTPATIENT TREATMENT PROVIDER. Consistent with the foregoing article, Article 46B.109 authorizes the head of the treatment facility or outpatient treatment provider to request that the court make a determination that the defendant has been restored to competency.

Art. 46B.109. Request by Head of Facility. (a) The head of a facility or outpatient treatment provider to which a defendant has been committed as a result of a finding of incompetency to stand trial may request the court to determine that the defendant has been restored to competency.
(b) The head of the facility or outpatient treatment provider shall provide with the request a written statement that in their opinion the defendant is competent to stand trial.

In this regard, the facility head or outpatient treatment provider must provide a written opinion that the defendant has become competent to stand trial. This is, of course, not a legal conclusion, but the service provider’s opinion based – no doubt – on the medical expertise of the treatment team.

DEFENDANT, DEFENSE COUNSEL, OR PROSECUTOR MAY ASSERT THAT COMPETENCY HAS BEEN RESTORED. Article 46B.110 authorizes the defendant, defense counsel, or the prosecutor to file a motion seeking to have the court determine that the defendant’s competency has been restored. Affidavits may be provided with the motion. 2005 amendments specifically included defense attorneys as having authority to make such motions.

Art. 46B.110. Motion by Defendant, Attorney Representing Defendant, or Attorney Representing State. (a) The defendant, the attorney representing the defendant, or the attorney representing the state may move that the court determine that the defendant has been restored to competency.
(b) A motion for a determination of competency may be accompanied by affidavits supporting the moving party’s assertion that the defendant is competent.

APPOINTMENT OF INDEPENDENT QUALIFIED EXPERTS. Article 46B.111 authorizes the court to appoint qualified experts to examine the defendant upon a request or motion seeking to determine whether the defendant’s competency has been restored. The provisions of Subchapter B of Chapter 46B, discussed supra, govern the qualifications and requirements pertaining to such experts and their reports.
Art. 46B.111. Appointment of Examiners. On the filing of a request or motion to determine that the defendant has been restored to competency or on the court's decision on its own motion to inquire into restoration of competency, the court may appoint disinterested experts to examine the defendant in accordance with Subchapter B.

AGREEMENT THAT THE DEFENDANT HAS ATTAINED COMPETENCY. If the parties and the court all agree that the defendant has attained competency to be tried, the court is required to make such a finding and proceed with any further criminal proceedings.

Art. 46B.112. Determination of Restoration with Agreement. On the filing of a request or motion to determine that the defendant has been restored to competency or on the court's decision on its own motion to inquire into restoration of competency, the court shall find the defendant competent to stand trial and proceed in the same manner as if the defendant had been found restored to competency at a hearing if:
(1) both parties agree that the defendant is competent to stand trial; and
(2) the court concurs.

HEARING TO DETERMINE RESTORATION OR LACK THEREOF. Absent an agreement, Article 46B.113 sets forth the requirements relating to the conducting of a hearing to determine whether the defendant’s competency has been restored.

Art. 46B.113. Determination of Restoration without Agreement. (a) The court shall hold a hearing on a request by the head of a facility or outpatient treatment provider to which a defendant has been committed as a result of a finding of incompetency to stand trial to determine whether the defendant has been restored to competency.
(b) The court may hold a hearing on a motion to determine whether the defendant has been restored to competency or on the court's decision on its own motion to inquire into restoration of competency, and shall hold a hearing if a motion and any supporting material establish good reason to believe the defendant may have been restored to competency.

(c) If a court holds a hearing under this article, on the request of the counsel for either party or the motion of the court a jury shall make the competency determination. If the competency determination will be made by the court rather than a jury, the court may conduct the hearing:

(1) at the facility; or

(2) by means of an electronic broadcast system as provided by Article 46B.013.

(d) If the head of a facility or outpatient treatment provider to which the defendant was committed as a result of a finding of incompetency to stand trial has provided an opinion that the defendant has regained competency, competency is presumed at a hearing under this subchapter and continuing incompetency must be proved by a preponderance of the evidence.

(e) If the head of a facility or outpatient treatment provider has not provided an opinion described by Subsection (d), incompetency is presumed at a hearing under this subchapter and the defendant's competency must be proved by a preponderance of the evidence.

Subsection (a) mandates that the court hold a hearing on the issue of competency restoration upon a request by the facility head or outpatient treatment provider. By way of contrast, subsection (b) permits the court to hold a hearing on the issue of competency restoration if there has been a motion filed by counsel for a party or on the court’s own motion, and requires the court to hold a hearing if the motion and any supporting material “establish good cause to believe” that the defendant has attained competency to be tried. In turn, subsection (c) requires a jury to be impaneled if requested by either party or desired by the court.
Per subsection (d), competency will be presumed at the hearing if the head of the facility or outpatient treatment provider has tendered an opinion that the defendant has regained (or attained) competency. In such a case, *incompetency* must be proven by a preponderance of the evidence. In contrast, if the facility head or outpatient treatment provider has not provided an opinion that the defendant has attained competency, subsection (e) directs that the defendant’s *incompetency* will be presumed at the hearing, and *competency* must be established by a preponderance of the evidence. Thus, the nature of the proof required will vary depending on the opinion of the treatment provider. Amendments in 2005 to subsection (c) allow the hearing (if before the court) to be conducted at the facility or by interactive video.

TRANSPORTATION BACK TO THE COURT. As in other subdivisions of Chapter 46B (and as under prior law), Article 46B.114 places the responsibility for timely transportation of the defendant from the treatment facility to the county of origin on the sheriff of the county in which the committing court is located. Additionally, the county will continue to bear responsibility for the attendant costs. Amendments in 2005 take into account that the hearing might be at the facility or by means of interactive video (thereby avoiding the need for transportation).

**Art. 46B.114. Transportation of Defendant to Court.** If the hearing is not conducted at the facility to which the defendant has been committed under this chapter or conducted by means of an electronic broadcast system as described by this subchapter, an order setting a hearing to determine whether the defendant has been restored to competency shall direct that, as soon as practicable but not earlier than 72 hours before the date the hearing is scheduled, the defendant be placed in the custody of the sheriff of the county in which the committing court is located or the sheriff's designee for transportation to the court. The sheriff or the
sheriff’s designee may not take custody of the defendant under this article until 72 hours before the date the hearing is scheduled.

WHAT IF THE HEARING RESULTS IN A DETERMINATION OF COMPETENCY? For purposes of ease of discussion, the next three sections of Subchapter E are taken out of order. Per Article 46B.116, should the hearing described in the foregoing sections result in a determination that the defendant has become competent to stand trial, not surprisingly the underlying criminal proceedings may be resumed.

Art. 46B.116. Disposition on Determination of Competency
If the defendant is found competent to stand trial, the proceedings on the criminal charge may proceed.

WHAT IF THE HEARING RESULTS IN A DETERMINATION THAT THE DEFENDANT REMAINS INCOMPETENT? Article 46B.117 addresses the disposition of the defendant should the hearing described in the foregoing sections result in a determination that the defendant remains incompetent to stand trial. If the defendant is still under an order of civil commitment, then the defendant must remain at the treatment facility (if the hearing was at the facility or conducted by interactive video), or the sheriff’s office must transport the individual back to the facility or program.

Art. 46B.117. Disposition on Determination of Incompetency
If a defendant under order of commitment to a facility or outpatient treatment program is found to not have been restored to competency to stand trial, the court shall remand the defendant pursuant to that order of commitment, and, if applicable, order the defendant placed in the custody of the sheriff or the sheriff’s designee for transportation back to the facility.
As a side note, should a prosecutor’s office be unsuccessful in a competency restoration hearing as described in the foregoing sections, it is certainly possible that the same official(s) will consider dismissing the underlying charges. This may be particularly true in a situation in which the time spent by the defendant in the competency commitment process is approaching the typical sentence associated with the charged offense(s).

In addition, should the restoration hearing result in a finding of continuing incompetency to be tried, one additional statute set forth in Subchapter E places some limits on when another attempt to determine competency can be undertaken.

### Art. 46B.115. Subsequent Redeterminations of Competency.

(a) If the court has made a determination that a defendant has not been restored to competency under this subchapter, a subsequent request or motion for a redetermination of competency filed before the 91st day after the date of that determination must:

1. explain why the person making the request or motion believes another inquiry into restoration is appropriate; and
2. provide support for the belief.

(b) The court may hold a hearing on a request or motion under this article only if the court first finds reason to believe the defendant’s condition has materially changed since the prior determination that the defendant was not restored to competency.

(c) If the competency determination will be made by the court, the court may conduct the hearing at the facility to which the defendant has been committed under this chapter or may conduct the hearing by means of an electronic broadcast system as provided by Article 46B.013.

Article 46B.115 declares that if there has been a determination that the defendant still has not been restored to competency, then any further request or motion to again re-determine the defendant’s competency filed within 90 days of the prior determination has to provide an explanation of why another inquiry is appropriate and
include support for that belief. Moreover, the court cannot hold a hearing on such a motion filed within this 90-day window unless the court finds a reason to believe that the defendant’s condition has changed materially since the prior hearing. Note that these strictures apply only to the first 90 days following the prior determination. There are no comparable limits for motions or requests made after that period. Amendments in 2005 added subsection (c) to permit hearings at the facility or by interactive video.

ADDITIONAL CIVIL COMMITMENT WHEN CHARGES HAVE BEEN DISMISSED. As noted above, per Article 46B.084(f), if a person’s competency has not been attained or restored after the initial commitment process required by Subchapter D of Chapter 46B, Subchapter F is to be followed if the underlying criminal charges have been dismissed. Subchapter F represents the replacement for section 7 of former Art. 46.02 and includes only one new statute, Article 46B.151. The court may also use this section if permitted by Article 46B.004(e), which is discussed above.

Art. 46B.151. Court Determination Related to Civil Commitment. (a) If a court is required by Article 46B.084(f) or permitted by Article 46B.004(e) to proceed under this subchapter, the court shall determine whether there is evidence to support a finding that the defendant is either a person with mental illness or a person with mental retardation.

(b) If it appears to the court that there is evidence to support a finding of mental illness or mental retardation, the court shall enter an order transferring the defendant to the appropriate court for civil commitment proceedings and stating that all charges pending against the defendant in that court have been dismissed. The court may order the defendant:

(1) detained in jail or any other suitable place pending the prompt initiation and prosecution by the attorney for the state
or other person designated by the court of appropriate civil proceedings to determine whether the defendant will be committed to a mental health facility or residential care facility; or
(2) placed in the care of a responsible person on satisfactory security being given for the defendant’s proper care and protection.

(c) Notwithstanding Subsection (b), a defendant placed in a facility of the department pending civil hearing under this article may be detained in that facility only with the consent of the head of the facility and pursuant to an order of protective custody issued under Subtitle C, Title 7, Health and Safety Code.
(d) If the court does not detain or place the defendant under Subsection (b), the court shall release the defendant.

Like Subchapter E, Subchapter F (Article 46B.151) raises the likely prospect of a civil commitment of the defendant. Unlike Subchapter E, however, Article 46B.151 does not require, nor even permit, the criminal court to conduct all of the commitment proceedings. Instead, once Article 46B.151 becomes applicable after dismissal of the charges, the “criminal” court must make an initial determination regarding whether there is evidence to support a finding that the defendant has a mental illness or is a person with mental retardation. With respect to defendants with mental illness, subsection (b) directs that should the court find there to be evidence indicating mental illness, then the “criminal” court must transfer the defendant to the appropriate court for civil commitment proceedings. Thus, Article 46B.151 generally requires the criminal court to transfer its responsibilities regarding the defendant to the constitutional county court or other court having probate jurisdiction. The transfer order must also inform the appropriate court that all criminal charges against the defendant have been dismissed. Subsequent to such a transfer the defendant must undergo civil commitment proceedings pursuant to the Texas Mental Health Code, just as in any other civil case involving the
If the criminal court does not believe that there is evidence to support findings that the defendant suffers from a mental illness or is a person with mental retardation, subsection (d) requires the court to release the defendant. This situation should arise only in the rarest of instances. For most cases it would be highly unlikely for the court to determine that there is no evidence to support findings of mental illness or mental retardation if there has just been a determination that the defendant remains incompetent to stand trial. If such a case arises, however, presumably such a release would not preclude the prosecutor from later reinstating criminal charges against the defendant unless the initial dismissal was with prejudice (precluding the filing of further charges). The policy choices made in dismissing the charges in the first instance, however, should typically militate against a later re-imposition of those same charges.

If the criminal court orders a defendant’s transfer to the appropriate court for civil commitment proceedings, subsection (b) also permits the court to order that the defendant be held in jail or another “suitable place” pending the prompt conducting of the civil commitment proceeding. As a general proposition, the statute’s continued use of the jail alternative is unfortunate. Given that no criminal charges remain pending in these situations, 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.
Subsection (c) adds, however, that before any such person is
placed in a state mental health treatment facility, the head of the
facility must grant permission, and there must be an order of
protective custody (OPC) entered under the provisions of the
Texas Mental Health Code. This subsection appears to give
authority to the criminal court to issue an OPC in such a situation
as an adjunct to its power to order detention of the defendant in a
suitable place pending the civil commitment proceedings. In
addition, although subsection (c) discusses the need for an OPC for
a state department’s facility, presumably a similar requirement
should apply to an inpatient treatment facility operated by a local
mental health authority. Then, as one additional alternative,
subsection (b)(2) permits the court to release the defendant into the
care of a responsible person pending the civil commitment
proceedings – with satisfactory security having been given.

Unlike the requirements specified for persons committed under
Subchapter E against whom criminal charges remain pending,
Subchapter F does not require the treatment facility to provide
notice regarding the discharge/release of patients who have been
committed under Article 46B.151. Of course, this is not surprising
given that Subchapter F commitments arise only when criminal
charges have been dismissed. If no criminal charges remain
pending, then the court and prosecutor have no need to be apprised
of a patient’s discharge. Because the statute is silent with respect to
whether the dismissal of the criminal charges is with or without
prejudice, however, occasions have arisen in which prosecutors
have otherwise learned of a patient’s discharge and re-instituted
criminal proceedings. Certainly, any such about-face by a
prosecutor is questionable from a policy perspective, particularly
given that the state will have previously made the choice to dismiss
the charges. However, if criminal charges are nonetheless reinstated, defense counsel would again be able to consider raising a competency issue as part of the new proceedings.

ANCILLARY PROVISIONS. Subchapter G of Chapter 46B includes three ancillary provisions that relate to both Subchapter E and Subchapter F proceedings. These are set forth in Article 46B.171. This statute requires the court to order that (1) a transcript be prepared as quickly as possible of all medical testimony from any of the prior hearings, and (2) directs that copies of all the documents delineated in Article 46B.076 (discussed above) accompany the defendant to the treatment facility or outpatient treatment program for the commitments described in Subchapters E and F. This should, of course, also include the transcript of the medical testimony described in subpart (1) of the order. All of this information should be of use to the treating physicians and mental health staff at the facility in preparing an individualized treatment plan. In addition, subsection (b) – which was added in 2005 – requires the facility or treatment provider to provide copies of its records to the defendant’s attorney upon request by either the defendant or the defendant’s counsel.

Art. 46B.171. Transcripts and Other Records. (a) The court shall order that: (1) a transcript of all medical testimony received in both the criminal proceedings and the civil commitment proceedings under Subchapter E or F be prepared as soon as possible by the court reporters; and (2) copies of documents listed in Article 46B.076 accompany the defendant to the mental health facility, outpatient treatment program, or residential care facility.
(b) On the request of the defendant or the attorney representing the defendant, a mental health facility, outpatient treatment program, or a residential care facility shall provide to the defendant or the attorney copies of the facility’s records regarding the defendant.
B. JUVENILES

The Texas Family Code was extensively revised in 1999 with respect to proceedings concerning children with mental illness or mental retardation, and those revisions affect the terminology and the steps in handling the issue of a juvenile defendant’s competency to stand trial.

It should be noted that on September 1, 2004, the Texas Department of Mental Health and Mental Retardation, which was created in 1965, ceased operations. Community mental health services formerly provided by the Texas Department of Mental Health and Mental Retardation are now provided through the Texas Department of State Health Services. Mental retardation services formerly provided by the Texas Department of Mental Health and Mental Retardation are now overseen by the Texas Department of Aging and Disability Services.

As of the date of the writing of this revision, July 2008, some references in the Texas Family Code and other state statutes to the former Texas Department of Mental Health and Mental Retardation have not been amended by the Texas Legislature to refer to the Texas Department of State Health Services or the Texas Department of Aging and Disability Services. Such references to the former Texas Department of Mental Health and Mental Retardation should therefore be understood to mean the new Texas Department of State Health Services or the new Texas Department of Aging and Disability Services, depending upon the context of the particular statute involved.

CROSS REFERENCES TO HEALTH & SAFETY CODE.
The Texas Family Code now has a definition section creating a
cross-reference to the definitions contained in the Health & Safety Code.

Sec. 55.01. MEANING OF “HAVING A MENTAL ILLNESS.” For purposes of this chapter, a child who is described as having a mental illness means a child who suffers from mental illness as defined by Section 571.003, Health and Safety Code.

Mental illness is defined in Section 571.003 of the Health & Safety Code as an illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that: (A) substantially impairs a person’s thought, perception of reality, emotional process, or judgment; or (B) grossly impairs behavior as demonstrated by recent disturbed behavior.

As will be explained below, the Family Code also now contains numerous new references to the Health & Safety Code that incorporate procedural provisions of the Health & Safety Code for the purpose of governing commitment and related procedures involving children who are defendants in juvenile cases.

JURISDICTIONAL MATTERS. Section 55.02 of the Family Code provides broadly for jurisdiction in the juvenile court to initiate proceedings to order mental health or mental retardation services for a child and/or commitment of a child, should those proceedings become necessary in connection with the processing of a juvenile case.

Sec. 55.02. MENTAL HEALTH AND MENTAL RETARDATION JURISDICTION. For the purpose of initiating proceedings to order mental health or mental retardation services for a child or for commitment of a child as provided by this chapter, the juvenile court has jurisdiction of proceedings under Subtitle C or D, Title 7, Health and Safety Code.
The cross-referenced provisions in the Health & Safety Code provide for jurisdiction in proceedings for “court ordered mental health services” (commitment) under Subtitle C, which is the Texas Mental Health Code, and commitment to a residential care facility of persons with mental retardation under Subtitle D, which is the Persons With Mental Retardation Act. Thus, by virtue of Section 55.02 and its cross-reference to the Health & Safety Code, the juvenile court now has such commitment jurisdiction.

THE STANDARD FOR INCOMPETENCY TO STAND TRIAL FOR JUVENILES. Section 55.31 of the Family Code addresses the matter of determining a juvenile defendant’s incompetency, designating it by the terminology “unfitness to proceed”:

Sec. 55.31. UNFITNESS TO PROCEED DETERMINATION; EXAMINATION. (a) A child alleged by petition or found to have engaged in delinquent conduct or conduct indicating a need for supervision who as a result of mental illness or mental retardation lacks capacity to understand the proceedings in juvenile court or to assist in the child’s own defense is unfit to proceed and shall not be subjected to discretionary transfer to criminal court, adjudication, disposition, or modification of disposition as long as such incapacity endures.

Section 55.31(a) of the Family Code thus incorporates for Texas juvenile proceedings the incompetency determination standards of Dusky v. United States, 362 U.S. 402 (1960), Drope v. Missouri, 420 U.S. 162 (1975), and their progeny.

In was in Dusky v. United States, 362 U.S. 402 (1960), that the Supreme Court of the United States restated the historical rule that a person accused of a crime who is incompetent cannot be proceeded against while he or she remains incompetent, and stated
that the trial court must determine (1) whether the defendant has a sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding, and (2) whether he or she has a rational as well as a factual understanding of the proceedings against him or her.

A juvenile defendant, like an adult accused of crime, must be sufficiently competent to understand the proceedings that are being conducted against him or her, and must be able to communicate with and assist legal counsel in his or her defense.

It should be noted, also, that although the matter of a defendant’s competency is ordinarily raised before trial both in criminal and in juvenile cases, that issue can arise during the progress of the trial of the case, as the Supreme Court of the United States cautioned in *Drope v. Missouri*, 420 U.S. 162, at 181 (1975): “Even when a defendant is competent at the commencement of his trial, a trial court must always be alert to circumstances suggesting a change that would render the accused unable to meet the standards of competence to stand trial.”

**RAISING THE INCOMPETENCY ISSUE.** Section 55.31(b) of the Family Code provides:

**Sec. 55.31(b).** On a motion by a party, the juvenile court shall determine whether probable cause exists to believe that a child who is alleged by petition or who is found to have engaged in delinquent conduct or conduct indicating a need for supervision is unfit to proceed as a result of mental illness or mental retardation. In making its determination, the court may: (1) consider the motion, supporting documents, professional statements of counsel, and witness testimony; and (2) make its own observation of the child.
Under Section 55.31(b), a party can raise the issue by motion to the court, and the issue is framed in terms of whether probable cause exists to believe that the child is “unfit to proceed as a result of mental illness or mental retardation.”

DETERMINATION OF THE ISSUE OF INCOMPETENCY. As specified in Section 55.31(b) of the Family Code, in making its probable cause determination on the issue of incompetency, the court has the authority to consider the motion of the party raising the issue, any supporting documents, professional statements of counsel, and witness testimony, and the court’s own observation of the child. Section 55.31(c) of the Code provides:

Sec. 55.31(c). If the court determines that probable cause exists to believe that the child is unfit to proceed, the court shall temporarily stay the juvenile court proceedings and immediately order the child to be examined under Section 51.20. The information obtained from the examination must include expert opinion as to whether the child is unfit to proceed as a result of mental illness or mental retardation.

Section 51.20 of the Family Code, to which Section 55.31(c) refers, provides:

Sec. 51.20. PHYSICAL OR MENTAL EXAMINATION. (a) At any stage of the proceedings under this title, the juvenile court may order a child who is referred to the juvenile court or who is alleged by a petition or found to have engaged in delinquent conduct or conduct indicating a need for supervision to be examined by a disinterested expert, including a physician, psychiatrist, or psychologist, qualified by education and clinical training in mental health or mental retardation and experienced in forensic evaluation, to determine whether the child has a mental illness as defined by Section 571.003, Health and Safety Code, or is
a person with mental retardation as defined by Section 591.003, Health and Safety Code. If the examination is to include a determination of the child’s fitness to proceed, an expert may be appointed to conduct the examination only if the expert is qualified under Subchapter B, Chapter 46B, Code of Criminal Procedure, to examine a defendant in a criminal case, and the examination and the report resulting from an examination under this subsection must comply with the requirements under Subchapter B, Chapter 46B, Code of Criminal Procedure, for the examination and resulting report of a defendant in a criminal case.

(b) If, after conducting an examination of a child ordered under Subsection (a), and reviewing any other relevant information, there is reason to believe that the child has a mental illness or mental retardation, the probation department shall refer the child to the local mental health or mental retardation authority for evaluation and services, unless the prosecuting attorney has filed a petition under Section 53.04.

(c) If, while a child is under deferred prosecution supervision or court-ordered probation, a qualified professional determines that the child has a mental illness or mental retardation and the child is not currently receiving treatment services for the mental illness or mental retardation, the probation department shall refer the child to the local mental health or mental retardation authority for evaluation and services.

(d) A probation department shall report each referral of a child to a local mental health or mental retardation authority made under Subsection (b) or (c) to the Texas Juvenile Probation Commission in a format specified by the commission.

(e) At any stage of the proceedings under this title, the juvenile court may order a child who has been referred to the juvenile court or who is alleged by the petition or found to have engaged in delinquent conduct or conduct indicating a need for supervision to be subjected to a physical examination by a licensed physician.

The legislature in 2003 amended Section 51.20 to require, on and after January 1, 2004, that experts and their reports must meet the qualifications and standards set forth in the new adult competency
statute, Article 46B, Texas Code of Criminal Procedure, which is discussed at length above. In turn, 2005 amendments added subsections (c), (d), and (e) to allow for referrals to the local mental health or mental retardation authority for evaluation and treatment services.

Section 55.31(d) of the Family Code provides the court’s options upon receiving and considering the relevant information pertaining to the child’s fitness or lack of fitness to proceed:

Sec. 55.31(d). After considering all relevant information, including information obtained from an examination under Section 51.20, the court shall: (1) if the court determines that evidence exists to support a finding that the child is unfit to proceed, proceed under Section 55.32; or (2) if the court determines that evidence does not exist to support a finding that the child is unfit to proceed, dissolve the stay and continue the juvenile court proceedings.

HEARING ON FITNESS TO PROCEED. Under the provisions of Section 55.31(d), if the court determines that there is evidence to support a finding that the child is unfit to proceed, then the court must conduct a hearing on that issue, pursuant to the requirements of Section 55.32 of the Family Code, which provides:

Sec. 55.32. HEARING ON ISSUE OF FITNESS TO PROCEED. (a) If the juvenile court determines that evidence exists to support a finding that a child is unfit to proceed as a result of mental illness or mental retardation, the court shall set the case for a hearing on that issue.
(b) The issue of whether the child is unfit to proceed as a result of mental illness or mental retardation shall be determined at a hearing separate from any other hearing.
(c) The court shall determine the issue of whether the child is unfit to proceed unless the child or the attorney for the child demands a jury before the 10th day before the date of the hearing.
(d) Unfitness to proceed as a result of mental illness or mental retardation must be proved by a preponderance of the evidence.

(e) If the court or jury determines that the child is fit to proceed, the juvenile court shall continue with proceedings under this title as though no question of fitness to proceed had been raised.

(f) If the court or jury determines that the child is unfit to proceed as a result of mental illness or mental retardation, the court shall:
   (1) stay the juvenile court proceedings for as long as that incapacity endures; and
   (2) proceed under Section 55.33.

(g) The fact that the child is unfit to proceed as a result of mental illness or mental retardation does not preclude any legal objection to the juvenile court proceedings which is susceptible of fair determination prior to the adjudication hearing and without the personal participation of the child.

It is important to note several significant provisions of Section 55.32 regarding the hearing on the issue of fitness to proceed. First, the hearing on fitness to proceed must be held separate and apart from any other hearing, as required by Section 55.32(b).

Second, the child has a right to a jury trial on the issue of his or unfitness to proceed, although a jury is not automatic and must be demanded by the child or the attorney for the child “before the 10th day before the date of the hearing,” under the provisions of Section 55.32(c). If the child or the child’s attorney does not demand a jury trial, then the issue of unfitness to proceed will be determined by the judge.

Third, the standard of proof is “preponderance of the evidence,” and the burden is on the party asserting the alleged unfitness to proceed, as set forth in Section 55.32(d).

As stated in Section 55.32(e) of the Family Code, if the court or jury determines that the child is competent (“fit to proceed”),
then the juvenile court must continue with the juvenile proceedings “as though no question of fitness to proceed had been raised.”

The unfortunate and inappropriate language about continuing with the juvenile proceedings “as though no question of fitness had been raised” may be simply an instance of redundancy in drafting on the part of the legislature. That is, if the child is found to be competent then the juvenile proceedings will of course continue, and there is no need for the redundant statement “as though no question of fitness had been raised.” But the language of the statute notwithstanding, such proceedings cannot be continued as though the issue of competency had not been raised.

If the legislative intent is that such language be taken literally, and the judge is being commanded to go on with the juvenile trial just as though the judge and all counsel had not been previously alerted in the proceedings to the possibility of incompetence on the part of the defendant, then not only is such a command unrealistic and impossible of execution, but it also seems to ignore the clear warning of the Supreme Court of the United States in *Drope v. Missouri*, 420 U.S. 162, at 181 (1975): “Even when a defendant is competent at the commencement of his trial, a trial court *must always be alert to circumstances suggesting a change that would render the accused unable to meet the standards of competency to stand trial.*” (emphasis added).

The question of a defendant’s competence to stand trial is a continuous, ongoing matter, and is not something that can be finally determined once and for all at a single given moment. Due process considerations dictate that the issue of a defendant’s incompetence to stand trial, whether the defendant is a juvenile or an adult, must be raised, and if necessary revisited, at any stage of a trial in which there are circumstances suggesting that the
defendant is not competent, even if he or she had been initially determined to be competent.

The Family Code provides that if the court or jury determines that the child is incompetent to stand trial ("unfit to proceed as a result of mental illness or mental retardation"), then Section 55.32(f) requires the court to do two things: (1) the court must stay the juvenile court proceedings for as long as that incapacity endures; and (2) the court must "proceed under Section 55.33" of the Family Code.

**PROCEEDINGS FOLLOWING FINDING OF INCOMPETENCY.** The Family Code provides for substantially similar, but procedurally distinct, methods of handling those cases involving a juvenile’s incompetency resulting from mental illness or mental retardation, and those cases involving a juvenile’s incompetency resulting from mental illness alone or mental retardation alone, as will be described below.

Section 55.33 of the Family Code sets forth the basic procedure to be followed by the court after a determination that a child is incompetent to stand trial:

**Sec. 55.33. PROCEEDINGS FOLLOWING FINDING OF UNFITNESS TO PROCEED.** (a) If the juvenile court or jury determines under Section 55.32 that a child is unfit to proceed with the juvenile court proceedings for delinquent conduct, the court shall:

(1) if the unfitness to proceed is a result of mental illness or mental retardation:

(A) provided that the child meets the commitment criteria under Subtitle C or D, Title 7, Health and Safety Code, order the child placed with the Texas Department of Mental health and Mental Retardation [sic] for a period of not more than 90 days, which order may not specify a
shorter period, for placement in a facility designated by the department; or
(B) on application by the child's parent, guardian, or guardian ad litem, order the child placed in a private psychiatric inpatient facility for a period of not more than 90 days, which order may not specify a shorter period, but only if the placement is agreed to in writing by the administrator of the facility; or
(2) if the unfitness to proceed is a result of mental illness and the court determines that the child may be adequately treated in an alternative setting, order the child to receive treatment for mental illness on an outpatient basis for a period of not more than 90 days, which order may not specify a shorter period.

(b) If the court orders a child placed in a private psychiatric inpatient facility under Subsection (a)(1)(B), the state or a political subdivision of the state may be ordered to pay any costs associated with the child's placement, subject to an express appropriation of funds for the purpose.

The court has a variety of options under the foregoing provisions of Section 55.33. Pursuant to Section 55.33(a)(1)(A), if the child’s unfitness to proceed is a result of mental illness or mental retardation, then the court’s first option, provided that the child meets the commitment criteria of Subtitle C (the Texas Mental Health Code) or Subtitle D (the Texas Persons with Mental Retardation Act) of the Texas Health & Safety Code, is to order the child placed with the “Texas Department of Mental Health and Mental Retardation” for a period of 90 days, for placement in a facility designated by that department.*

* As noted at the beginning of this Subchapter B on Juveniles, the former Texas Department of Mental Health and Mental Retardation (TDMHMR) ceased operations on September 1, 2004, and community mental health services formerly provided by TDMHMR are now provided through the Texas Department of State Health Services (DSHS), and mental retardation services formerly provided by TDMHMR are now provided through the Texas Department of Aging and Disability Services (DADS). As of the date of the
In the alternative, pursuant to Section 55.33(a)(1)(B), on application by the child’s parent, guardian, or guardian ad litem, the court can order the child placed in a private psychiatric inpatient facility for 90 days, if such placement is agreed to in writing by the administrator of the private facility. If the court does order a child to be placed in a private psychiatric inpatient facility pursuant to Section 55.33(a)(1)(B), then the state or a political subdivision of the state may be ordered to pay any costs associated with the child’s placement (subject to an express appropriation of funds for the purpose), under the authority of Section 55.33(b).

Under Section 55.33(a)(2), if the child’s unfitness to proceed is a result of mental illness and the court determines that the child may be adequately treated in an alternative setting, then the court can order the child to receive treatment for mental illness on an outpatient basis for a period of 90 days.

TRANSPORTATION TO AND FROM FACILITY. Section 55.34 of the Family Code provides for the appropriate necessary transportation of a child to and from the facility designated in a placement order under Section 55.33(a)(1).

SUBSEQUENT REPORT ON THE CHILD’S COMPETENCY. Section 55.35 of the Family Code provides for the forwarding of relevant information pertaining to the child to the placement facility involved, and for a report on the child’s subsequent condition to be submitted by the placement facility.

writing of this revision, July 2008, the Texas Legislature has not enacted conforming amendments in the Family Code to reflect those changes. References in the Family Code to the former TDMHMR should therefore be understood to mean DSHS or DADS, depending upon the context of the particular statute involved.
back to the court, with a copy of the report being provided to both the prosecuting attorney and the attorney for the child:

Sec. 55.35. INFORMATION REQUIRED TO BE SENT TO FACILITY; REPORT TO COURT. (a) If the juvenile court issues a placement order under Section 55.33(a), the court shall order the probation department to send copies of any information in the possession of the department and relevant to the issue of the child’s mental illness or mental retardation to the public or private facility or outpatient center, as appropriate.
(b) Not later than the 75th day after the date the court issues a placement order under Section 55.33(a), the public or private facility or outpatient center, as appropriate, shall submit to the court a report that: (1) describes the treatment of the child provided by the facility or center; and (2) states the opinion of the director of the facility or center as to whether the child is fit or unfit to proceed.
(c) The court shall provide a copy of the report submitted under Subsection (b) to the prosecuting attorney and the attorney for the child.

PROCEDURES IN RESPONSE TO THE COMPETENCY REPORT FROM THE PLACEMENT FACILITY. Obviously, the placement facility may report either that the child is competent (fit to proceed) or that the child is not competent (fit to proceed). Incompetency may be the result of mental illness, mental retardation, or some combination of mental illness and mental retardation. Different procedures are provided by the Family Code, with respect to each contingency, in Sections 55.36 (report of fitness to proceed, objection, and hearing on objection), in Sections 55.37 through 55.39 (mental illness), and in Sections 55.40 through 42 (mental retardation), respectively.

Sec. 55.36. REPORT THAT CHILD IS FIT TO PROCEED; HEARING ON OBJECTION. (a) If a report submitted under Section 55.35(b) states that the child is fit to proceed, the juvenile
court shall find that the child is fit to proceed unless the child’s attorney objects in writing or in open court not later than the second day after the date the attorney receives a copy of the report under Section 55.35(c).

(b) On objection by the child’s attorney under Subsection (a), the juvenile court shall promptly hold a hearing to determine whether the child is fit to proceed, except that the hearing may be held after the date that the placement order issued under Section 55.33(a) expires. At the hearing, the court shall determine the issue of the fitness of the child to proceed unless the child or the child’s attorney demands in writing a jury before the 10th day before the date of the hearing.

(c) If, after a hearing, the court or jury finds that the child is fit to proceed, the court shall dissolve the stay and continue the juvenile court proceedings as though a question of fitness to proceed had not been raised.

(d) If, after a hearing, the court or jury finds that the child is unfit to proceed, the court shall proceed under Section 55.37.

Under the foregoing provisions of Section 55.36 of the Family Code, if the report submitted by the placement facility states that the child is fit to proceed, the court must enter a finding to that effect unless the child’s attorney makes a timely objection either in writing or in open court. If there is an objection, then the court must promptly conduct a hearing to determine the issue, and the child has a right to a jury trial on the issue of competency if the child or the child’s attorney makes a written demand for a jury before the 10th day before the date of the hearing.

If the result of the hearing is that the court or jury determines that the child is competent (fit to proceed), then the court must dissolve the stay previously entered and continue with the juvenile proceedings, “as though a question of fitness to proceed had not been raised.”
As indicated above in discussing Section 55.32(e), because of due process considerations, the unfortunate and inappropriate language “as though a question of fitness to proceed had not be raised” cannot be taken literally since, as the Supreme Court of the United States cautioned in *Drope v. Missouri*, 420 U.S. 162, at 181 (1975), “Even when a defendant is competent at the commencement of his trial, a trial court must always be alert to circumstances suggesting a change that would render the accused unable to meet the standards of competence to stand trial” (emphasis added). Competence to stand trial is an ongoing matter. An issue of competency having been raised, the trial judge and counsel are certainly on notice about that matter, and should be “alert” to changes in the juvenile’s condition which might render the juvenile incompetent.

If the result of the hearing is that the court or jury determines that the child is not competent (not fit to proceed), then Section 55.36(d) states that “the court must proceed under the provisions of Section 55.37.” Actually, however, Section 55.37 provides the procedures to be followed only if the child’s unfitness to proceed is a result of mental illness. Section 55.40 provides the procedures to be followed if the child’s unfitness to proceed is a result of mental retardation.

Therefore, if the result of the hearing is that the court or jury determines that the child is not competent, then the court must proceed under either Section 55.37 or Section 55.40, as applicable, depending upon whether the incompetence is the result of mental illness or is the result of mental retardation. The statute does not address the procedure to be followed if the incompetence (unfitness to proceed) is the result of a combination both of mental illness and mental retardation.
COMMITMENT PROCEEDINGS FOR CHILDREN WITH MENTAL ILLNESS. The Family Code provides for commitment proceedings for juveniles whose incompetency is the result of mental illness, to be conducted either by the juvenile court or by an appropriate court to which the case can be referred by the juvenile court.

Sec. 55.37. REPORT THAT CHILD IS UNFIT TO PROCEED AS A RESULT OF MENTAL ILLNESS; INITIATION OF COMMITMENT PROCEEDINGS. If a report submitted under Section 55.35(b) states that a child is unfit to proceed as a result of mental illness and that the child meets the commitment criteria for civil commitment under Subtitle C, Title 7, Health and Safety Code, the director of the public or private facility or outpatient center, as appropriate, shall submit to the court two certificates of medical examination for mental illness. On receipt of the certificates, the court shall: (1) initiate proceedings as provided by Section 55.38 in the juvenile court for commitment of the child under Subtitle C, Title 7, Health and Safety Code; or (2) refer the child's case as provided by Section 55.39 to the appropriate court for the initiation of proceedings in that court for commitment of the child under subtitle C, Title 7, Health and Safety Code.

Under the provisions of Section 55.37, the juvenile court has two options in response to a report that the child is still incompetent (unfit to proceed) and that the child meets the commitment criteria for civil commitment under Subtitle C, Title 7, Health & Safety Code, both options resulting in commitment proceedings.

Under the first option, the juvenile court can initiate commitment proceedings under Section 55.38 of the Family Code, and such commitment proceedings will be held in the juvenile court. Under the second option, the juvenile court can refer the
child’s case to an appropriate court under Section 55.39 of the Family Code, and that court to which the case is referred will initiate commitment proceedings.

Subtitle C, Title 7, of the Health & Safety Code is the Texas Mental Health Code, and contains provisions for “court ordered mental health services” (civil commitment) in Section 574.031 and subsequent sections.

COMMITMENT PROCEEDINGS IN JUVENILE COURT FOR CHILDREN WITH MENTAL ILLNESS. Section 55.38 of the Family Code specifies the procedure for commitment proceedings in the juvenile court with respect to a child whose incompetency is the result of mental illness:

Sec. 55.38. COMMITMENT PROCEEDINGS IN JUVENILE COURT FOR MENTAL ILLNESS. (a) If the juvenile court initiates commitment proceedings under Section 55.37(1), the prosecuting attorney may file with the juvenile court an application for court-ordered mental health services under Section 574.001, Health and Safety Code. The juvenile court shall:
   (1) set a date for a hearing and provide notice as required by Sections 574.005 and 574.006, Health and Safety Code; and
   (2) conduct the hearing in accordance with Subchapter C, Chapter 574, Health and Safety Code.
(b) After conducting a hearing under Subsection (a)(2), the juvenile court shall:
   (1) if the criteria under Section 574.034, Health and Safety Code, are satisfied, order temporary mental health services; or
   (2) if the criteria under Section 574.035, Health and Safety Code, are satisfied, order extended mental health services.

The effect of Section 55.38 of the Family code is to require the juvenile court to follow the commitment procedure and the commitment criteria set forth in the cited portions of the Health &
Safety Code. Space limitations prohibit a detailed treatment of those provisions of the Health & Safety Code here, but they, and the cases interpreting them, will govern in juvenile court commitment proceedings under Section 55.38 of the Family Code.

**COMMITMENT PROCEEDINGS IN A COURT TO WHICH THE CASE IS REFERRED BY THE JUVENILE COURT FOR CHILDREN WITH MENTAL ILLNESS.**

Section 55.39 of the Family Code specifies the procedures the juvenile court must follow in referring a child to an appropriate court for commitment proceedings, when the child’s incompetency is the result of mental illness:

Sec. 55.39. REFERRAL FOR COMMITMENT PROCEEDINGS FOR MENTAL ILLNESS. (a) If the juvenile court refers the child's case to an appropriate court for the initiation of commitment proceedings under Section 55.37(2), the juvenile court shall:

1. send all papers relating to the child's unfitness to proceed, including the verdict and judgment of the juvenile court finding the child unfit to proceed, to the clerk of the court to which the case is referred;
2. send to the office of the appropriate county attorney, or if a county attorney is not available, to the office of the appropriate district attorney, copies of all papers sent to the clerk of the court under Subdivision (1); and
3. if the child is in detention:
   (A) order the child released from detention to the child's home or another appropriate place;
   (B) order the child detained in an appropriate place other than a juvenile detention facility; or
   (C) if an appropriate place to release or detain the child as described by Paragraph (A) or (B) is not available, order the child to remain in the juvenile detention facility subject to further detention orders of the court.
(b) The papers sent to a court under Subsection (a)(1) constitute an application for mental health services under Section 574.001, Health and Safety Code.

Section 55.39(a) of the Family Code directs the juvenile court to forward all papers relating to the child’s incompetency (unfitness to proceed) to the clerk of the court to which the case is being referred by the juvenile court, and to the appropriate county or district attorney, as applicable. Section 55.39(a) also directs the referring juvenile court to enter appropriate detention or release from detention orders.

Section 55.39(b) designates the sending of the papers as “an application for mental health services under Section 574.001, Health and Safety Code,” since Section 574.001 of the Health & Safety code provides for the filing of “an application for court-ordered mental health services” as the procedural device for initiating commitment proceedings.

**COMMITMENT PROCEEDINGS FOR CHILDREN WITH MENTAL RETARDATION.** The Family Code provides for commitment proceedings for juveniles whose incompetency is the result of mental retardation, to be conducted either by the juvenile court or by an appropriate court to which the case can be referred by the juvenile court. The provisions are similar to those governing commitment of juveniles whose incompetency is the result of mental illness, in that they incorporate by reference the relevant procedures of applicable portions of the Health & Safety Code pertaining to persons with mental retardation.

**Sec. 55.40. REPORT THAT CHILD IS UNFIT TO PROCEED AS A RESULT OF MENTAL RETARDATION.**

If a report submitted under Section 55.35(b) states that a child is unfit to proceed as a result of mental retardation and that the child
meets the commitment criteria for civil commitment under Subtitle D, Title 7, Health and Safety Code, the director of the residential care facility shall submit to the court an affidavit stating the conclusions reached as a result of the diagnosis. On receipt of the affidavit, the court shall:

(1) initiate proceedings as provided by Section 55.41 in the juvenile court for commitment of the child under Subtitle D, Title 7, Health and Safety Code; or

(2) refer the child’s case as provided by Section 55.42 to the appropriate court for the initiation of proceedings in that court for commitment of the child under Subtitle D, Title 7, Health and Safety Code.

Under Section 55.40, the juvenile court has two options in response to a report that the child is still incompetent (unfit to proceed) and that the child meets the commitment criteria for civil commitment under Subtitle D, Title 7, Health & Safety Code, both options resulting in commitment proceedings.

Under the first option, the juvenile court can initiate commitment proceedings under Section 55.41 of the Family Code, and such proceedings will be held in the juvenile court. Under the second option, the juvenile court can refer the child’s case to an appropriate court under Section 55.42 of the Family Code, and that court to which the case is referred will initiate commitment proceedings.

Subtitle D, Title 7, of the Health & Safety Code is the Persons With Mental Retardation Act, and contains provisions for “placement” (civil commitment) of persons with mental retardation in Section 593.041 and subsequent sections.

**COMMITMENT PROCEEDINGS IN JUVENILE COURT FOR CHILDREN WITH MENTAL RETARDATION.** Section 55.41 of the Family Code specifies the
procedure for commitment proceedings in the juvenile court with respect to a child whose incompetency is the result of mental illness:

Sec. 55.41. COMMITMENT PROCEEDINGS IN JUVENILE COURT FOR MENTAL RETARDATION. (a) If the juvenile court initiates commitment proceedings under Section 55.40(1), the prosecuting attorney may file with the juvenile court an application for placement under Section 593.041, Health and Safety Code. The juvenile court shall:

(1) set a date for a hearing and provide notice as required by sections 593.047 and 593.048, Health and Safety Code; and

(2) conduct the hearing in accordance with Sections 593.049 – 593.056, Health and Safety Code.

(b) After conducting a hearing under Subsection (a)(2), the juvenile court may order commitment of the child to a residential care facility if the commitment criteria under Section 593.052, Health and Safety Code, are satisfied.

(c) On receipt of the court’s order, the Texas Department of Mental Health and Mental Retardation [sic] or the appropriate community center shall admit the child to a residential care facility.

The effect of Section 55.41 of the Family Code is to require the juvenile court to follow the commitment procedure and the commitment criteria set forth in the cited portions of the Health & Safety Code. Space limitations prohibit a detailed treatment of those provisions of the Health & Safety Code here, but they, and the cases interpreting them, will govern in juvenile court commitment proceedings under Section 55.41 of the Family Code.*

* As noted at the beginning of this Subchapter B on Juveniles, the former Texas Department of Mental Health and Mental Retardation (TDMHMR) ceased operations on September 1, 2004, and community mental health services formerly provided by TDMHMR are now provided through the Texas Department of State Health Services (DSHS), and mental retardation services formerly provided by TDMHMR are now provided through the Texas
COMMITMENT PROCEEDINGS IN A COURT TO WHICH THE CASE IS REFERRED BY THE JUVENILE COURT FOR CHILDREN WITH MENTAL RETARDATION. Section 55.42 of the Family Code specifies the procedures the juvenile court must follow in referring a child to an appropriate court for commitment proceedings, when the child’s incompetency is the result of mental retardation:

Sec. 55.42. REFERRAL FOR COMMITMENT PROCEEDINGS FOR MENTAL RETARDATION. (a) If the juvenile court refers the child's case to an appropriate court for the initiation of commitment proceedings under Section 55.40(2), the juvenile court shall:

(1) send all papers relating to the child's mental retardation to the clerk of the court to which the case is referred;

(2) send to the office of the appropriate county attorney or, if a county attorney is not available, to the office of the appropriate district attorney, copies of all papers sent to the clerk of the court under Subdivision (1); and

(3) if the child is in detention:

(A) order the child released from detention to the child’s home or another appropriate place;

(B) order the child detained in an appropriate place other than a juvenile detention facility; or

(C) if an appropriate place to release or detain the child as described by Paragraph (A) or (B) is not available, order the child to remain in the juvenile detention facility subject to further detention orders of the court.

Department of Aging and Disability Services (DADS). As of the date of the writing of this revision, July 2008, the Texas Legislature has not enacted conforming amendments in the Family Code to reflect those changes. References in the Family Code to the former TDMHMR should therefore be understood to mean either DSHS or DADS, depending upon the context of the particular statute involved.
(b) The papers sent to a court under Subsection (a)(1) constitute an application for placement under Section 593.041, Health and Safety Code.

Section 55.42 of the Family Code directs the juvenile court to forward all papers “relating to the child’s mental retardation” to the clerk of the court to which the case is referred. The corresponding provision in Section 55.39(a)(1) pertaining to commitment proceedings for a child with mental illness requires the juvenile court to forward all papers “relating to the child’s unfitness to proceed, including the verdict and judgment of the juvenile court finding the child unfit to proceed” to the clerk of the court to which the case is referred.

Apparently through a legislative drafting oversight, such language about “the child’s unfitness to proceed, including the verdict and judgment of the juvenile court finding the child unfit to proceed” was omitted from Section 55.42(a)(1) directing the forwarding of the applicable papers in a case when mental retardation is the cause of the incompetency (unfitness to proceed).

Presumably in either situation – incompetency because of mental illness or incompetency because of mental retardation – the juvenile court will be expected to send all of the relevant papers in the case to the clerk of the appropriate court to which the case is being referred by the juvenile court.

Section 55.42(a)(2) of the Family Code requires the juvenile court to send copies of all papers sent to the clerk of the court under Subdivision (1) to the office of the appropriate county attorney or district attorney, as applicable.
Section 55.42(a)(3) of the Family Code directs the referring juvenile court to enter appropriate detention or release from detention orders.

Section 55.42(b) designates the sending of the papers as “an application for placement [commitment] under Section 593.041, Health and Safety Code,” since Section 593.041 of the Health & Safety Code provides for the filing of “an application for an interdisciplinary team report and recommendation that the proposed client is in need of long-term placement in a residential care facility,” as the procedural device for initiating “long-term placement” (commitment) proceedings for a person with mental retardation.

The requirement for an interdisciplinary team review, evaluation, and recommendation, referred to in Section 593.041 of the Health & Safety Code, is set forth in Section 593.013 of that Code. The term “interdisciplinary team” is defined as follows in Sec. 591.003(8) of the Health & Safety Code: “‘Interdisciplinary team’ means a group of mental retardation professionals and paraprofessionals who assess the treatment, training, and habitation needs of a person with mental retardation and make recommendations for services for that person.”

RESTORATION OF COMPETENCY. Section 55.43 of the Family Code provides for a restoration of competency hearing with respect to a child who has been previously found incompetent (unfit to proceed) as a result of mental illness or mental retardation, but who was not ordered by a court to receive inpatient mental health services, committed by a court to a residential health care facility, or ordered by a court to receive treatment on an outpatient basis, or is discharged or furloughed from a mental health facility or outpatient center before the child reaches 18 years of age.
Sec. 55.43. RESTORATION HEARING. (a) The prosecuting attorney may file with the juvenile court a motion for a restoration hearing concerning a child if:

1. the child is found unfit to proceed as a result of mental illness or mental retardation; and 
2. the child:
   (A) is not:
      (i) ordered by a court to receive inpatient mental health services;
      (ii) committed by a court to a residential care facility; or
      (iii) ordered by a court to receive treatment on an outpatient basis; or
   (B) is discharged or currently on furlough from a mental health facility or outpatient center before the child reaches 18 years of age.

(b) At the restoration hearing, the court shall determine the issue of whether the child is fit to proceed.

(c) The restoration hearing shall be conducted without a jury.

(d) The issue of fitness to proceed must be proved by a preponderance of the evidence.

(e) If, after a hearing, the court finds that the child is fit to proceed, the court shall continue the juvenile court proceedings.

(f) If, after a hearing, the court finds that the child is unfit to proceed, the court shall dismiss the motion for restoration.

It is to be noted that under Section 55.43(c) of the Family Code, there is no right to a jury at the restoration hearing, and the restoration issue is decided by the juvenile court judge.

TRANSFER TO CRIMINAL COURT ON THE INCOMPETENT CHILD’S 18TH BIRTHDAY. Under the provisions of Section 55.44 of the Family Code, the juvenile court must transfer all pending proceedings from juvenile court to a criminal court, upon the 18th birthday of a child for whom the juvenile court or a court to which the child’s case was referred had
ordered inpatient mental health services or residential care for persons with mental retardation, if the child is not discharged or currently on furlough from such a facility before reaching 18 years of age and the child is alleged to have engaged in delinquent conduct that included a violation of a penal law listed in Section 53.045 of the Family Code and no adjudication concerning the alleged conduct has been made.

Section 53.045 of the Family Code is entitled “Violent or Habitual Offenders,” and cross-references the Texas Penal Code in listing a variety of serious offenses, including capital murder, murder, aggravated sexual assault, sexual assault, aggravated kidnapping, and aggravated robbery, among other offenses.

Section 55.44 of the Family Code pertaining to transfer to a criminal court states as follows:

Sec. 55.44. TRANSFER TO CRIMINAL COURT ON 18TH BIRTHDAY OF CHILD. (a) The juvenile court shall transfer all pending proceedings from the juvenile court to a criminal court on the 18th birthday of a child for whom the juvenile court or a court to which the child’s case is referred has ordered inpatient mental health services or residential care for persons with mental retardation if:

(1) the child is not discharged or currently on furlough from the facility before reaching 18 years of age; and
(2) the child is alleged to have engaged in delinquent conduct that included a violation of a penal law listed in Section 53.045 and no adjudication concerning the alleged conduct has been made.

(b) The juvenile court shall send notification of the transfer of a child under Subsection (a) to the facility. The criminal court shall, before the 91st day after the date of the transfer, institute proceedings under Chapter 46B, Code of Criminal Procedure. If those or any subsequent proceedings result in a determination that

158
the defendant is competent to stand trial, the defendant may not receive a punishment for the delinquent conduct described by Subsection (a)(2) that results in confinement for a period longer than the maximum period of confinement the defendant could have received if the defendant had been adjudicated for the delinquent conduct while still a child and within the jurisdiction of the juvenile court.

Section 55.45 of the Family Code sets forth the statutory standards of care for juveniles who are committed under court orders for mental health services, as well as requirements under certain specified circumstances governing application by administrators of residential care facilities for discharge or release of a child from the facility. With regard to a Constitutional right to treatment if a child is mentally retarded or mentally ill, see Thomas S. Morgan & Harold C. Gaither, Jr., 29 Tex. Prac. Series ¶ 323, *There is a Constitutional Right to Treatment If a Child is Mentally Retarded or Mentally Ill* (1999). The legislature added subsection (c) in 2007. Section 55.45 of the Family Code provides as follows:

**Sec. 55.45. STANDARDS OF CARE; NOTICE OF RELEASE OR FURLOUGH.** (a) If the juvenile court or a court to which the child’s case is referred under Section 55.37(2) orders mental health services for the child, the child shall be cared for, treated, and released in accordance with Subtitle C, Title 7, Health and Safety Code, except that the administrator of a mental health facility shall notify, in writing, by certified mail, return receipt requested, the juvenile court that ordered mental health services or that referred the case to a court that ordered mental health services of the intent to discharge the child on or before the 10th day before the date of discharge.

(b) If the juvenile court or a court to which the child’s case is referred under Section 55.40(2) orders the commitment of the child to a residential care facility, the child shall be cared for, treated, and released in accordance with Subtitle D, Title 7, Health and Safety...
Code, except that the administrator of the residential care facility shall notify, in writing, by certified mail, return receipt requested, the juvenile court that ordered commitment of the child or that referred the case to a court that ordered commitment of the child of the intent to discharge or furlough the child on or before the 20th day before the date of discharge or furlough.

(c) If the referred child, as described in Subsection (b), is alleged to have committed an offense listed in Section 3g, Article 42.12, Code of Criminal Procedure, the administrator of the residential care facility shall apply, in writing, by certified mail, return receipt requested, to the juvenile court that ordered commitment of the child or that referred the case to a court that ordered commitment of the child and show good cause for any release of the child from the facility for more than 48 hours. Notice of this request must be provided to the prosecuting attorney responsible for the case. The prosecuting attorney, the juvenile, or the administrator may apply for a hearing on this application. If no one applies for a hearing, the trial court shall resolve the application on the written submission. The rules of evidence do not apply to this hearing. An appeal of the trial court’s ruling on the application is not allowed. The release of a child described in this subsection without the express approval of the trial court is punishable by contempt.

**APPEAL.** Section 56.01(c) of the Family Code provides that an appeal may be taken by or on behalf of a child from an order entered under Chapter 55 by a juvenile court committing a child to a facility for the mentally ill or mentally retarded.

**C. DEATH PENALTY**

**COMPETENCY TO BE EXECUTED.** The United States Supreme Court has held that the Eighth and Fourteenth Amendments to the Constitution prohibit a state from inflicting the death penalty on a person who is mentally incompetent. *See Ford v. Wainwright,* 477 U.S. 399 (1986). The Court recognized that even at early common law there was a “bar against executing a
prisoner who has lost his sanity.” *Id.* at 406. The Court concluded, “Whether its aim be to protect the condemned from fear and pain without comfort of understanding, or to protect the dignity of society itself from the barbarity of exacting mindless vengeance, the restriction finds enforcement in the Eighth Amendment [proscribing cruel and unusual punishment].” *Id.* at 410.

In a subsequent case, *State v. Perry*, 610 So.2d 746 (La. 1992), the Louisiana Supreme Court held that the State of Louisiana could not forcibly medicate an incompetent death row prisoner against his will with anti-psychotic medications for the sole purpose of making him competent to be executed. In contrast to prisoner cases in which medication can be forcibly administered (after adequate due process) for purposes of *treatment*, the state in *Perry* wanted to medicate only to make the defendant competent enough to be executed. After the case was remanded to Louisiana by the United States Supreme Court for further consideration, the Louisiana court ruled that the state’s proposal to force medication was invalid as well as inhumane. On the other hand, consider *Singleton v. Norris*, 319 F.3d 1018 (8th Cir.), *cert. denied*, 124 S. Ct. 74 (2003), in which the Eighth Circuit rejected a death row defendant’s request to halt an Arkansas prison’s administration of involuntary medication that was apparently keeping him competent to be executed.

Article 46.05, Texas Code of Criminal Procedure, was enacted with the express purpose of codifying the United States Supreme Court’s holding that an inmate must be mentally competent to be executed. Article 46.05 sets forth detailed procedures for assessing and reviewing the inmate’s level of competency. The reader should bear in mind that the statute applies only to inmates who have been sentenced to be executed for committing capital crimes. The text of the statute reads as follows:
Art. 46.05. Competency to be Executed. (a) A person who is incompetent to be executed may not be executed.
(b) The trial court retains jurisdiction over motions filed by or for a defendant under this article.
(c) A motion filed under this article must identify the proceeding in which the defendant was convicted, give the date of the final judgment, set forth the fact that an execution date has been set if the date has been set, and clearly set forth alleged facts in support of the assertion that the defendant is presently incompetent to be executed. The defendant shall attach affidavits, records, or other evidence supporting the defendant’s allegations or shall state why those items are not attached. The defendant shall identify any previous proceedings in which the defendant challenged the defendant’s competency in relation to the conviction and sentence in question, including any challenge to the defendant's competency to be executed, competency to stand trial, or sanity at the time of the offense. The motion must be verified by the oath of some person on the defendant’s behalf.
(d) On receipt of a motion filed under this article, the trial court shall determine whether the defendant has raised a substantial doubt of the defendant's competency to be executed on the basis of:
   (1) the motion, any attached documents, and any responsive pleadings; and
   (2) if applicable, the presumption of competency under Subsection (e).
(e) If a defendant is determined to have previously filed a motion under this article, and has previously been determined to be competent to be executed, the previous adjudication creates a presumption of competency and the defendant is not entitled to a hearing on the subsequent motion filed under this article, unless the defendant makes a prima facie showing of a substantial change in circumstances sufficient to raise a significant question as to the defendant's competency to be executed at the time of filing the subsequent motion under this article.
(f) If the trial court determines that the defendant has made a substantial showing of incompetency, the court shall order at least
two mental health experts to examine the defendant using the standard described by Subsection (h) to determine whether the defendant is incompetent to be executed.

(g) If the trial court does not determine that the defendant has made a substantial showing of incompetency, the court shall deny the motion and may set an execution date as otherwise provided by law.

(h) A defendant is incompetent to be executed if the defendant does not understand:

(1) that he or she is to be executed and that the execution is imminent; and

(2) the reason he or she is being executed.

(i) Mental health experts who examine a defendant under this article shall provide within a time ordered by the trial court copies of their reports to the attorney representing the state, the attorney representing the defendant, and the court.

(j) By filing a motion under this article, the defendant waives any claim of privilege with respect to, and consents to the release of, all mental health and medical records relevant to whether the defendant is incompetent to be executed.

(k) The trial court shall determine whether, on the basis of reports provided under Subsection (i), the motion, any attached documents, and responsive pleadings, and any evidence introduced in the final competency hearing, the defendant has established by a preponderance of the evidence that the defendant is incompetent to be executed. If the court makes a finding that the defendant is not incompetent to be executed, the court may set an execution date as otherwise provided by law.

(l) Following the trial court’s determination under Subsection (k) and on motion of a party, the clerk shall send immediately to the court of criminal appeals in accordance with Section 8(d), Article 11.071, the appropriate documents for that court’s review and entry of a judgment of whether to adopt the trial court’s order, findings, or recommendations issued under Subsection (g) or (k). The court of criminal appeals also shall determine whether any existing execution date should be withdrawn and a stay of
execution issued while that court is conducting its review or, if a stay is not issued during the review, after entry of its judgment.

(l-1) Notwithstanding Subsection (l), the court of criminal appeals may not review any finding of the defendant's competency made by a trial court as a result of a motion filed under this article if the motion is filed on or after the 20th day before the defendant's scheduled execution date.

(m) If a stay of execution is issued by the court of criminal appeals, the trial court periodically shall order that the defendant be reexamined by mental health experts to determine whether the defendant is no longer incompetent to be executed.

(n) If the court of criminal appeals enters a judgment that a defendant is not incompetent to be executed, the court may withdraw any stay of execution issued under Subsection (l), and the trial court may set an execution date as otherwise provided by law.

EXECUTION OF PERSONS WITH MENTAL RETARDATION IS CRUEL AND UNUSUAL PUNISHMENT. In Atkins v. Virginia, 536 U.S. 304 (2002), the Supreme Court of the United States held that the execution of criminals with mental retardation is unconstitutionally cruel and unusual punishment.

In reaching its decision, the Court noted that eighteen states have enacted legislation that prohibits execution of persons with mental retardation. The Court commented, “It is not so much the number of these States that is significant, but the consistency of the direction of change.” Id. at 315. The Court said:

Given the well-known fact that anticrime legislation is far more popular than legislation providing protections for persons guilty of violent crimes, the large number of States prohibiting the execution of mentally retarded persons (and the complete absence of States passing legislation reinstating the power to conduct such executions) provides
powerful evidence that today our society views mentally retarded offenders as categorically less culpable than the average criminal. The evidence carries even greater force when it is noted that the legislatures that have addressed the issue have voted overwhelmingly in favor of the prohibition. Moreover, even in those States that allow the execution of mentally retarded offenders, the practice is uncommon. Id. at 315-16.

The Court concluded that the practice of executing offenders with mental retardation has become truly unusual and that a national consensus has developed against it, commenting further:

This consensus unquestionably reflects widespread judgment about the relative culpability of mentally retarded offenders, and the relationship between mental retardation and the penological purposes served by the death penalty. Additionally, it suggests that some characteristics of mental retardation undermine the strength of the procedural protections that our capital jurisprudence steadfastly guards.

Id. at 317. The Court expanded on the effect mental retardation can have with respect to the procedural protections required in capital cases:

[C]linical definitions of mental retardation require not only subaverage intellectual functioning, but also significant limitations in adaptive skills such as communication, self-care, and self-direction that became manifest before age 18. Mentally retarded persons frequently know the difference between right and wrong and are competent to stand trial. Because of their impairments, however, by definition they have diminished capacities to understand and process
information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others. There is no evidence that they are more likely to engage in criminal conduct than others, but there is abundant evidence that they often act on impulse rather than pursuant to a premeditated plan, and that in group settings they are followers rather than leaders. Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability.

Id. at 318. Finally, the Court concluded:

Our independent evaluation of the issue reveals no reason to disagree with the judgment of “the legislatures that have recently addressed the matter” and concluded that death is not a suitable punishment for a mentally retarded criminal. We are not persuaded that the execution of mentally retarded criminals will measurably advance the deterrent or the retributive purpose of the death penalty. Construing and applying the Eighth Amendment in the light of our “evolving standards of decency,” we therefore conclude that such punishment is excessive and that the Constitution “places a substantive restriction on the State's power to take the life” of a mentally retarded offender. Id. at 321.

NO TEXAS STATUTE TO DATE ON EXECUTION OF PERSONS WITH MENTAL RETARDATION. Even though the Atkins case was decided by the Supreme Court of the United States on June 20, 2002, the Texas Legislature still has not enacted statutory provisions governing the standards and procedures to be followed in capital cases involving mentally retarded defendants, as of the date of the writing of this revision, July 2008. Although
legislation was considered during the 2003 regular session of the Legislature, nothing was enacted.

**JUDICIAL GUIDELINES PROVIDED BY THE TEXAS COURT OF CRIMINAL APPEALS, IN THE ABSENCE OF STATUTORY GUIDELINES.** The Court of Criminal Appeals of Texas acted on February 11, 2004, in a case raising *Atkins* claims, *Ex parte Briseno*, 135 S.W.3d 1 (Tex. Crim. App. 2004), to “provide the bench and bar with temporary judicial guidelines in addressing *Atkins* claims,” and the Court set out the “judicial standards for courts considering those claims under article 11.071 [of the Texas Code of Criminal Procedure].” *Id.* at 5.

The Court commented in *Briseno*:

This Court does not, under normal circumstances, create law. We interpret and apply the law as written by the Texas Legislature or as announced by the United States Supreme Court. In *Atkins* the Supreme Court announced that there is a national consensus that those who suffer from mental retardation should be exempt from the death penalty, but it simultaneously left to the individual states the substantive and procedural mechanisms to implement that decision. The Texas legislature has not yet enacted legislation to carry out the *Atkins* mandate. Nonetheless, this Court must now deal with a significant number of pending habeas corpus applications claiming that the death row inmate suffers from mental retardation and thus is exempt from execution. Recognizing that ‘justice delayed is justice denied’ to the inmate, to the victims and their families, and to society at large, we must act during this legislative interregnum . . . . *Id.* at 4-5.
This was a difficult task for the Court of Criminal Appeals, and more properly the concern of the Texas Legislature. But the Texas Legislature not having acted on this matter, and given the existence of numerous pending cases awaiting resolution on this point, the Court of Criminal Appeals decided that it had to act to fill the gap. The Court stated in *Briseno*:

We … must define that level and degree of mental retardation at which a consensus of Texas citizens would agree that a person should be exempted from the death penalty. Most Texas citizens might agree that Steinbeck’s Lennie [in John Steinbeck, *OF MICE AND MEN* (1937)] should, by virtue of his lack of reasoning ability and adaptive skills, be exempt. But, does a consensus of Texas citizens agree that all persons who might legitimately qualify for assistance under the social services definition of mental retardation be exempt from an otherwise constitutional penalty? Put another way, is there a national or Texas consensus that all of those persons whom the mental health profession might diagnose as meeting the criteria for mental retardation are automatically less morally culpable than those who just barely miss meeting those criteria? Is there, and should there be, a ‘mental retardation’ bright-line exemption from our state’s maximum statutory punishment? As a court dealing with individual cases and litigants, we decline to answer that normative question without significantly greater assistance from the citizenry acting through its Legislature.” *Id.* at 6.

The Court then discussed several bills that had been introduced in the Texas Legislature, one of them even before the *Atkins* decision of the Supreme Court, and noted the various standards contained in those bills, and then stated the standards that it considered appropriate:
This Court has previously employed the definitions of ‘mental retardation’ set out by the American Association on Mental Retardation (AAMR), and that contained in section 591.003(13) of the Texas Health & Safety Code. Under the AAMR definition, mental retardation is a disability characterized by: (1) ‘significantly subaverage’ general intellectual functioning; (2) accompanied by ‘related’ limitations in adaptive functioning; (3) the onset of which occurs prior to the age of 18. As noted above, the definition under the Texas Health & Safety Code is similar: “‘mental retardation’ means significantly subaverage general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.” Id. at 7.

The Court observed that:

Some might question whether the same definition of mental retardation that is used for providing psychological assistance, social services and financial aid is appropriate for use in criminal trials to decide whether execution of a particular person would be constitutional excessive punishment. However, that definitional question is not before us in this case because applicant, the State, and the trial court all used the AAMR definition. Until the Texas Legislature provides an alternate statutory definition of “mental retardation” for use in capital sentencing, we will follow the AAMR or section 591.003(13) criteria in addressing Atkins mental retardation claims. Id. at 8.

In the Briseno case the Applicant contended that he was entitled to a jury determination of mental retardation pursuant to the Supreme Court’s decision in Ring v. Arizona, 536 U.S. 584
(2002), holding that “If a State makes an increase in a defendant’s authorized punishment contingent on the finding of a fact, that fact – no matter who the State labels it – must be found by a jury beyond a reasonable doubt.” Ring v. Arizona, 536 U.S. at 602 (2002). But the Court of Criminal Appeals stated on this issue:

[T]hat case does not establish a constitutional requirement that a jury determine the question of mental retardation. A lack of mental retardation is not an implied element of the crime of capital murder which the State is required to prove before it may impose a sentence above the maximum statutory punishment for that crime. Instead, as the Supreme Court made explicit in Atkins, proof of mental retardation “exempts” one from the death penalty, the maximum statutory punishment for capital murder. There was certainly no indication from the Supreme Court in Atkins that the fact of mental retardation is one that a jury, rather than a judge, must make. Ex parte Briseno, 135 S.W.3d at 10.

The Court noted that “the majority of states which have provided a statutory exemption from capital punishment for the mentally retarded have made the finding of mental retardation a matter for the trial judge as opposed to the jury,” providing citations. Id.

With respect to the burden of proof, the Court of Criminal Appeals asserted in Briseno: “By our count, twelve of the nineteen states with statutes prohibiting the execution of mentally retarded defendants place the burden of proof upon the defendant to show mental retardation by a preponderance of the evidence,” and commented, “The issue of mental retardation is similar to affirmative defenses such as insanity, incompetency to stand trial, or incompetency to be executed, for which the Texas Legislature has allocated the burden of proof upon a defendant to establish by
a preponderance of the evidence.” Id. at 12. And so the Court said: “Therefore, we adopt that allocation of the burden and standard of proof, at least in the context of determining mental retardation in the habeas corpus setting where the inmate traditionally bears the burden of proof.” Id.

The United States District Court for the Southern District of Texas, after reviewing all of the foregoing issues in Briseno, determined that the defendant was not entitled to federal habeas corpus relief, Briseno v. Dretke, 2007 WL 998743 (S.D. Tex. 2007), and the U.S. Court of Appeals for the Fifth Circuit affirmed, Briseno v. Quarterman, 2008 WL 2048360 (5th Cir. 2008).

Given the continuing inaction of the Texas Legislature with regard to providing statutory provisions for implementation of the Supreme Court’s 2002 Atkins decision, the analysis of the Texas Court of Criminal Appeals in the Briseno case sets forth the presently existing judicially declared standards and procedures on the issues involved.

Topics that would need to be addressed in legislation on these issues include: (1) the definition of mental retardation that Texas will apply in capital cases; (2) the procedure for raising the issue of mental retardation in capital cases; (3) psychiatric and other mental retardation evaluations to be ordered in capital cases when the issue of mental retardation has been raised; (4) whether the judge or jury will have the responsibility of deciding the issue of mental retardation; (5) the standard of proof to be applied; and (6) which party has the burden of proof on the issue.

Perhaps the Texas Legislature will one day eventually address these matters, even if a majority of its members fully agree with the Texas Court of Criminal Appeals’ handling of the Briseno case, and enact appropriate legislation to provide statutory
authority for the matters already decided by the Texas Court of Criminal Appeals. And, obviously, if the Legislature disagrees with any of the *Briseno* standards, it is the Legislature’s responsibility to enact corrective legislation.

**V. INSANITY DEFENSE**

Without doubt, the most discussed and most controversial statute involving alleged offenders with mental illness is the insanity defense. In this Chapter we will analyze (1) the existing defense as it currently applies to adult defendants, (2) the different defense for juveniles, and (3) proposals for reform.

**A. ADULT DEFENDANTS**

**TEXAS PENAL CODE.** The insanity defense is set forth in Section 8.01 of the Texas Penal Code:

Sec. 8.01. Insanity. (a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong.

(b) The term “mental disease or defect” does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct.

**HISTORY OF THE INSANITY DEFENSE USED IN TEXAS.** The insanity defense set forth in Section 8.01 of the Texas Penal Code is, in essence, the old M’Naghten test, first promulgated in England in 1843. It is necessary to know something of the history of the M’Naghten test to appreciate how inadequate it is, and to understand why the present Texas insanity defense provided for in Section 8.01 of the Penal Code is inadequate and should be changed.
M=NAGHTEN=S CASE. The name of the test comes from *M’Naghten’s Case*, 8 Eng. Rep. 718 (1843), in which a defendant named Daniel M’Naghten was prosecuted for the murder of the private secretary of Sir Robert Peel, the Prime Minister of England. M’Naghten had intended to kill Peel, but by mistake shot Peel’s private secretary instead. M’Naghten was acquitted on grounds of insanity, and the acquittal caused widespread public outrage. Queen Victoria was also concerned, since she and other members of the English royal family had been the targets of previous assassination attempts. Accordingly, she summoned the House of Lords to “take the opinion of the Judges on the law governing such cases.” *United States v. Freeman*, 357 F.2d 606, 617 (2d Cir. 1966). Responding to the Queen’s summons, the House of Lords conducted a general inquiry into the matter of the insanity defense, and asked the judges of the Queen’s Bench a series of questions regarding the standards that should be employed.

The insanity test that was actually used in the court’s instructions to the jury at M’Naghten’s trial had been influenced by the surprisingly enlightened work of Dr. Isaac Ray, who had been highly critical of the “right-wrong” test in his 1838 book entitled *MEDICAL JURISPRUDENCE OF INSANITY*. But in responding to the questions put to them by the House of Lords, the English judges in effect reversed the approach that had been used in M’Naghten’s trial, and adopted instead what has come to be known as the M’Naghten test. It is still known by that name, even though the “M’Naghten test” (or “M’Naghten rule” as it is sometimes called) announced by the English judges was not the test used in the actual trial of Daniel M’Naghten’s case.

American jurisdictions, including Texas, adopted the M’Naghten test from English law, although for a brief period from
1974 to 1983 Texas used a different, more adequate, insanity test, as will be explained below.

THE “RIGHT-WRONG” TEST AND ITS NARROW EXCLUSIVE FOCUS ON COGNITIVE CAPACITY. The M’Naghten test is sometimes referred to as the “right-wrong” test, because of its exclusive focus on whether the accused person knew the difference between right and wrong at the time of his or her alleged offense.

This exclusive focus on an accused person’s cognitive capacity has been widely criticized by the courts, by psychiatrists and other mental health professionals, and by the legal profession. A serious mental illness may leave an individual’s intellectual understanding and cognitive capacity relatively unimpaired, but can still affect the person’s emotions and reason to such a degree that the individual cannot completely control his or her behavior.

That exclusive focus on cognitive capacity arose from the primitive psychological theories of the nineteenth century and earlier. It was a time in which “psychiatry was literally in the Dark Ages,” when “[p]sychiatrists believed that the human brain was divided into thirty-five separate areas, each with its own peculiar mental function,” and unfortunately “by an accident of history, the rule of M’Naghten’s case froze these concepts into the common law just at a time when they were becoming obsolete.” United States v. Freeman, 357 F.2d 606, 616 (2d Cir. 1966).

As one court put it, “The vast absurdity of the application of the M’Naghten Rules in order to determine the sanity or insanity, the mental health or lack of it, of the defendant by securing the answer to a single question: Did the defendant know the difference between right and wrong, appears clearly when one surveys the array of symptomatology which the skilled psychiatrist employs in
determining the mental condition of an individual.” United States v. Currens, 290 F.2d 751, 766-67 (3d Cir. 1961). To ask merely whether a person knows right from wrong “is to ask a question irrelevant to the nature of his [or her] mental illness or to the degree of his [or her] criminal responsibility.” People v. Drew, 583 P.2d 1318, 1322 (Cal. 1978).

Because the M’Naghten test restricts psychiatric testimony to the narrow area of a defendant’s cognitive capacity, it frequently makes it impossible for expert witnesses to place before the jury a complete picture of a defendant’s mental illness. For this reason, the M’Naghten test fails to aid the criminal justice system in identifying many defendants who may suffer from serious mental illness, and it often provides a defense only for those mentally diseased persons who have cognitive impairment.

ADOPTION BY TEXAS OF THE AMERICAN LAW INSTITUTE TEST. In recognition of these shortcomings of the old narrow M’Naghten test, Texas expanded and modernized its insanity test when it adopted for the Texas Penal Code of 1973 a modified version of the insanity test that had been developed by the American Law Institute (ALI) as a part of the ALI’s 1962 Model Penal Code.

The ALI test had previously been adopted by many other states and by most of the federal circuits. The ALI test takes into account the extent to which a serious mental illness may have impaired an individual’s ability to control his or her behavior.

Accordingly, the 1973 Texas enactment added a “volitional” prong to the Texas insanity defense consistent with the ALI recommendation. The volitional prong of the ALI test derived from courts’ dissatisfaction with the narrow inquiry under the M’Naghten standard and some states’ having developed and
tinkered with the so-called “irresistible impulse” test. Professor Richard Bonnie of the University of Virginia and his colleagues have described the underlying theory supporting the volitional prong as follows:

It rests on the notion … that the conviction of crime expresses a moral judgment about the defendant’s behavior. Moral judgments about people, the argument goes, are premised on the concept of free will. In general, behavior is the product of choice, and people who make bad choices are subject to moral condemnation. In cases where mental disease or defect robs people of the capacity to choose not to engage in criminal behavior, the argument concludes, it is inappropriate to condemn them morally and therefore inappropriate to convict them of a crime.


The 1973 Texas version of the test asked not only about knowledge of right and wrong, but asked also whether the individual, as a result of mental disease or defect, was incapable of conforming his or her conduct to the requirements of the law allegedly violated. Although the 1973 Texas insanity defense revisions were based largely on the ALI test, they differed in one significant respect. The short-lived Texas standard retained the narrow “did not know” language for the M’Naghten prong of the test, as opposed to the ALI’s recommended use of “appreciate the wrongfulness” verbiage. As former Senator Farabee observed, “The use of the term “know” in reference to whether conduct was wrong was … more restrictive.” Ray Farabee & James L. Spearly, The New Insanity Law in Texas: Reliable Testimony and Judicial Review of Release, 24 S. TEX. L. REV. 671, 674 (1983). Thus, even
while including a volitional component in 1973, the Texas Legislature opted not to use the term “appreciate” for the cognitive prong of the test, which could more broadly allow consideration of emotional and affective aspects of serious mental illnesses, as opposed to a more limited focus on cognitive or intellectual mental functioning. *Id.*

**THE HINCKLEY CASE AND REACTION TO IT.** The new Texas test worked well in practice, but in 1982 when John W. Hinckley, Jr., was acquitted on the basis of an insanity defense of shooting and wounding President Ronald Reagan and three other persons, there was a national outcry against the insanity defense similar to that of 1843 in England in response to M’Naghten’s acquittal.

In 1983, responding to calls for “reform,” Texas abandoned the important volitional element of its 1973 insanity test, and went back to the old nineteenth century M’Naghten test, with its narrow, exclusive focus on cognition and its primitive understanding of the human mind. This remains the test for insanity that we have today in Texas for adults, as set forth in Section 8.01 of the Texas Penal Code.

The legislative sponsor of the 1983 Texas revisions, former Senator Ray Farabee, later wrote that over ninety percent of the residents in his senatorial district favored a restriction on the insanity defense in responding to polling following the Hinckley verdict. *Id.* at 671. Ironically, another contemporaneous case that had arisen in Senator Farabee’s district had also influenced the powerful legislator. In a chilling forerunner of the more recent cases of Andrea Yates, Deanna Laney, Dena Schlosser, which will be discussed *infra*, a young mother who had been diagnosed “as having experienced a post-partem [sic] psychosis” had “cut out her young daughter’s heart in an effort to exorcise a devil which she
thought possessed her child.” Id. at 671-72. Following an insanity acquittal, the state hospital released the woman after less than two years of treatment without further required supervision. Id.

Given the 1983 enactment, Texas has jettisoned the volitional component of the 1973 reforms and has instead employed the limited, inadequate “right-wrong” test for the last quarter of a century. It is unfortunate for our state that we have so narrowed our insanity defense to outmoded nineteenth century parameters that we inquire only about a defendant’s knowledge that his or her act was “wrong,” rather than going on to inquire about whether the defendant is capable of conforming his or her conduct to the law.

The extreme narrowness of the Texas test, and its inconsistent results, are illustrated by the recent Texas cases of Andrea Yates, Deanna Laney, and Dena Schlosser, three women who killed or seriously injured their own children and who raised the insanity defense at their trials in Texas state courts.

There was little or no dispute among the experts involved in the Yates case that Ms. Yates was suffering from serious mental illness and quite delusional at the time she killed her children by drowning, yet the jury in her initial trial rejected her insanity defense, and she was convicted and sentenced to prison. That conviction was later reversed and the case remanded for further proceedings. Yates v. State, 171 S.W.3d 215 (Tex. App. – Houston [1st Dist.] 2005, pet. ref’d). In July of 2006, a new jury in the retrial of Ms. Yates returned a verdict of not guilty by reason of insanity.

Similarly, all five of the medical experts in Ms. Laney’s trial agreed that Ms. Laney was seriously mentally ill, delusional, and legally “insane” at the time she killed her children by stoning, and Ms. Laney was acquitted.
Dena Schlosser cut off the arms of her ten-month-old daughter while suffering from psychotic religious ideations. In Ms. Schlosser’s case, a first jury deadlocked 10-2 on the insanity issue, but a second trial before a judge alone, and lasting about five minutes, resulted in a verdict of not guilty by reason of insanity.

It seems clear that all three of these women were clearly in need of custodial hospitalization and long-term psychiatric treatment, but under the initial jury verdicts in the cases only two of them would have received such treatment; one was initially sentenced to prison.

As one of us has noted in a recent law review article:

These tragic cases, involving defendants with severe psychoses, illustrate that the Texas insanity defense bears no relationship to modern understandings of serious mental illness. Contrary to popular myth, the defense is rarely invoked and seldom successful. Notwithstanding the ultimate results in these three cases, the Texas test of insanity is so narrow that it is virtually meaningless. Brian D. Shannon, *The Time is Right to Revise the Texas Insanity Defense: An Essay*, 39 Tex. Tech L. Rev. 67, 69-70 (2006-07).

An analysis of Section 8.01 of the Texas Penal Code will provide some insight into how our courts could reach such radically varying results in the cases of three women plainly suffering from serious mental illness and whose conduct was caused by and attributable to such mental illness. We turn now to that analysis.

**ANALYSIS OF SECTION 8.01, TEXAS PENAL CODE.**

Subsection (a) of Section 8.01 of the Texas Penal Code provides
that it is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his or her conduct was wrong.

**AN AFFIRMATIVE DEFENSE.** As defined by Section 2.04 of the Texas Penal Code, an affirmative defense is one that the defendant must allege and prove by a preponderance of the evidence. Hence, a defendant desiring to use the insanity defense must both raise that issue and present evidence in support of it. The jury is instructed that the terminology “preponderance of the evidence” means the greater weight of the credible evidence.

**“SEVERE” MENTAL ILLNESS.** The term “severe” in Subsection 8.01 is an innovation, never before having been a part of the Texas insanity test, or the M’Naghten test in other jurisdictions. It was added by the Texas Legislature as part of the 1983 “reforms.” Congress also added the term “severe” to the M’Naghten test it enacted in 1984 for all federal courts. The federal insanity test is codified in 18 U.S.C. § 17(a). The term “severe” is not defined in the Texas statute or in the federal statute, but presumably the legislative purpose was to ensure that minor disorders or personality defects will not provide a basis for a successful insanity defense.

The Texas Court of Criminal Appeals has commented that “[i]ntroducing [the term] ‘severe’ seems quite superfluous.” *Pacheco v. State*, 757 S.W. 2d 729, 735 n.7 (Tex. Crim. App. 1988). The Court said “[I]f as a result of mental disease or defect an accused does not know his conduct is wrong when he engages in it, then surely his mental disease or defect is severe.” *Id.*

With respect to the federal insanity test, one federal district court has said that a trial court’s severity analysis “consists of more than locating the magical word ‘severe’ in the diagnosis.” *United
States v. Rezaq, 918 F. Supp. 463, 465 n.6 (D.D.C. 1996). The court continued, “Rather, section 17(a) contemplates a more thoroughgoing approach, in which a court reviews the diagnosis for overall indications of the severity of defendant’s mental disease or defect.” Further eschewing a “magical word” analysis, the court continued: “The mere presence of the word ‘severe’ in a diagnosis that suggests a mild condition will not constitute a defense under section 17(a). Similarly, the absence of the word ‘severe’ will not necessarily mean that the condition diagnosed does not meet the standards of section 17(a).” Id.

Another federal district court explained that: “The legislative history states that the term ‘severe’ was added to the term ‘mental disease or defect’ specifically to exclude antisocial personality ‘tendencies’ from the purview of the insanity defense.” United States v. Henley, 8 F. Supp. 2d 503, 506 (E.D.N.C. 1998). The court added: “The concept of severity was added to emphasize that non-psychotic behavior disorders or neuroses such as an ‘inadequate personality,’ ‘immature personality,’ or a pattern of ‘antisocial tendencies’ do not constitute the defense.” Id. at 506-507.

It is to be expected that there will be further Texas and federal court decisions dealing with the meaning of the term “severe” in the context of the insanity defenses provided by Texas and federal law.

**EXCLUSIVE, NARROW FOCUS ON COGNITION.** As indicated in the discussion above, for the defense to be successful, the jury must be convinced by a preponderance of the evidence that the defendant, because of severe mental disease or defect, did not know that his or her conduct was wrong. Cognition is the narrow exclusive test, regardless of whether a defendant’s mental
illness impairs the ability to control one’s conduct, and no matter how serious the defendant’s mental illness may be.

**LEGAL WRONG.** Although the point is not without some difficulty under the applicable decisions of the Texas courts, the “wrong” referred to in the statute appears to mean *legal* wrong. That is, the question is whether the defendant knew that his or her conduct was legally wrong.

This seems to be the conclusion required by an analysis of the Texas cases addressing this issue, although no case located to date under the current statute states specifically that the “wrong” referred to in the statute means *legal* wrong.

In the case of *Bigby v. State of Texas*, 892 S.W.2d 864, 878 (Tex. Crim. App. 1994), the Court of Criminal Appeals noted that “[s]everal expert witnesses testified appellant knew his conduct was illegal, however, these experts contended that appellant did not know the act was ‘morally’ wrong,” the contention being that “appellant believed that regardless of society’s views about this illegal act and his understanding it was illegal, under his ‘moral’ code it was permissible.” The court then stated:

This focus upon appellant’s morality is misplaced. The question of insanity should focus on whether a defendant understood the nature and quality of his action and whether it was an act he ought to do. *Zimmerman v. State*, 85 Tex. Cr. R. 630, 215 S.W. 101, 105 (1919) (on rehearing). By accepting and acknowledging his action was ‘illegal’ by societal standards, he understood that others believed his conduct was “wrong.” (892 S.W.2d at 878).

It would appear, then, under the court’s language and analysis in *Bigby*, that a defendant who knows that his or her action was
illegal by societal standards – in other words, a defendant who knows that the act is legally wrong, that the act is prohibited by law – will be viewed as having understood that others believed his or her conduct was wrong, and therefore such a defendant knows that his or her conduct is “wrong” within the meaning of Section 8.01(a) of the Texas Penal Code. The *Bigby* case has been cited by the El Paso Court of Appeals as having that meaning. *Reyna v. State of Texas*, 116 S.W. 3d 362, 368 (Tex. App.—El Paso 2003, no pet.).

Other cases have applied the same kind of analysis, examining the evidence of record in order to determine whether the defendant engaged in behavior (such as efforts to avoid detection and arrest, concealing incriminating evidence, attempting to avoid leaving fingerprints, and the like) indicating that he or she knew that his or her conduct was illegal. *Dashield v. State of Texas*, 110 S.W.3d 111, 115 (Tex. App.—Houston [1st Dist.] 2003, pet. ref’d); *Love v. State of Texas*, 909 S.W. 2d 930, 943 (Tex. App.—El Paso 1995, pet. ref’d); *Plough v. State of Texas*, 725 S.W. 2d 494, 500 (Tex. App.—Corpus Christi 1987, no pet.).

The result is that it is almost impossible for a defendant to prevail on an insanity defense in Texas when the issue is contested, given that very few defendants, even those who are seriously mentally ill and unable to control their behavior, are unable to know that their conduct is prohibited by law. And if a defendant knows that his or her conduct is prohibited by law, then he or she is “sane” in Texas criminal law. Consequently, many defendants who are in need of long-term psychiatric treatment are nonetheless convicted and imprisoned, possibly given psychiatric treatment while incarcerated, and eventually released into the community, perhaps to repeat their dangerous conduct for lack of corrective or continuing psychiatric treatment.
It should be noted, of course, that there are indeed occasional exceptions to the general rule about the futility of using the insanity defense in Texas, as illustrated by the Andrea Yates, Deanna Laney, and Dena Schlosser cases that are discussed in detail in Subchapter VI-C, infra. Another case worthy of mention is the unreported decision in *Lopez v. State*, 2007 Tex. App. LEXIS 7183 (Tex. App.—Corpus Christi 2007, pet. ref’d.). In *Lopez*, the Corpus Christi Court of Appeals, in considering testimony by a psychiatrist that the defendant, because of his severe mental illness, did not know that what he was doing was wrong or illegal, decided that the evidence did not support the jury’s rejection of the defendant’s insanity defense. The court accordingly reversed the judgment of conviction. *Id.* at *35, *43-44. The *Lopez* case is a salutary example of a Texas appellate court carefully examining extensive detailed testimony about a defendant’s mental illness, and then reaching a conclusion different from that of the convicting jury, but such a result is very rare. It can also be noted that the court, in *Lopez*, understood the term “wrong” in Section 8.01 as meaning *legal wrong*, and the court cited the *Bigby* case for that proposition.

**ABNORMALITY MANIFESTED BY ANTISOCIAL CONDUCT EXCLUDED.** Subsection 8.01(b) provides that the term “mental disease or defect” does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct. The purpose of Subsection (b) was to “exclude psychopaths from the insanity defense for fear that recidivists would qualify if they could be characterized as psychopaths.” Seth S. Searcy III & James R. Patterson, Practice Commentary, TEX. PENAL CODE ANN. § 8.01, at 179, 181 (Vernon 1974). Of course, as Searcy and Patterson pointed out in their practice commentary, “no psychopath manifests his psychopathy solely by repeated criminal conduct and … [such persons] invariably show some other symptom.” *Id.*
PROCEDURE FOLLOWED IN ADMINISTERING THE INSANITY TEST IN TEXAS. Although Section 8.01 of the Texas Penal Code sets forth the insanity defense for purposes of Texas criminal law, another group of statutes in Chapter 46C of the Texas Code of Criminal Procedure, describe the procedures that are to be observed in cases in which the insanity defense is in issue. These procedural provisions were re-codified in 2005.

It should be noted at the outset that, as Professor Shannon explained in his recent law review article on the Texas insanity defense, the 2005 statute re-codified the procedures, not the substantive standard, for insanity:

During the 2005 legislative session, the Texas Legislature enacted Senate Bill 837, which constituted a substantial overhaul of the procedures relating to the insanity defense in Texas. S.B. 837 repealed former Texas Code of Criminal Procedure Article 46.03 and replaced it with new Chapter 46C. The changes in the law are effective for any offense committed on or after September 1, 2005, the effective date of the Act. S.B. 837 did not include any changes to the substantive test for insanity in Texas but instead focused on procedure. Brian D. Shannon, The Time is Right to Revise the Texas Insanity Defense: An Essay, 39 Tex. Tech L. Rev. 67, 76 (2006-07).

Professor Shannon also pointed out that:

S.B. 837 largely re-codified former Article 46.03 of the Texas Code of Criminal Procedure, yet also made important changes. For example, the new Chapter 46C now includes training and qualification requirements for experts that mirror those mandated for experts who conduct evaluations of a
defendant’s competency to stand trial. Chapter 46C also has changed the deadline by when a defendant must give notice that an insanity defense will be pursued. *Id.* at 79.

We turn now to an analysis of the major provisions of Chapter 46C, Texas Penal Code.

**DEFINITIONS.** Article 46C.001, Texas Code of Criminal Procedure, provides definitions of various terms, including “Department” in Article 46C.001(2), which means the Department of State Health Services. Article 46C.001(3) defines “mental illness” as having “the meaning assigned by Section 571.003, Texas Health & Safety Code, and Article 46C.001(4) defines “mental retardation” as having the meaning assigned by Section 591, Texas Health & Safety Code.

**Art. 46C.001. Definitions.** In this chapter:

1. “Commissioner” means the commissioner of state health services.
2. “Department” means the Department of State Health Services.
3. “Mental illness” has the meaning assigned by Section 571.003, Health and Safety Code.
4. “Mental retardation” has the meaning assigned by Section 591.003, Health and Safety Code.
5. “Residential care facility” has the meaning assigned by Section 591.003, Health and Safety Code.

**SUBMISSION OF THE INSANITY DEFENSE.** The insanity defense will be submitted to the jury only if it is supported by competent evidence. As noted previously, it is the defendant’s obligation to give notice of his or her intent to raise the insanity defense, to raise the issue properly, and support it with adequate evidence at trial.
Article 46C.051 specifically requires notice of intent to raise the insanity defense:

**Art. 46C.051. Notice of Intent to Raise Insanity Defense.** (a) A defendant planning to offer evidence of the insanity defense must file with the court a notice of the defendant's intention to offer that evidence.
(b) The notice must:
   (1) contain a certification that a copy of the notice has been served on the attorney representing the state; and
   (2) be filed at least 20 days before the date the case is set for trial, except as described by Subsection (c).
(c) If before the 20-day period the court sets a pretrial hearing, the defendant shall give notice at the hearing.

Article 46C.051 delineates new rules relating to the timing for the required notice. As Professor Shannon observed in his law review article:

Under former article 46.03, to raise the insanity defense, a defendant had to provide notice of intent at least ten days prior to the date set for trial, at any pretrial hearing set before that ten-day window, or at the time the defendant raised an issue of incompetency to stand trial if the issue was pursued. This latter timing requirement did not make a great deal of sense. An evaluation of a defendant’s competency to stand trial will often take place early in the criminal process. Defense counsel, however, might often be unprepared to form a judgment about whether to pursue an insanity defense until after reviewing experts’ reports of mental health evaluations regarding competency to stand trial or legal insanity. S.B. 837 removed this aspect of the former law and now requires notice either at least twenty days before the date set for trial or at the time of a pretrial
hearing if set earlier than the twenty-day window. Brian D.
Shannon, *supra*, at 79 (citations omitted).

**EFFECT OF FAILURE TO GIVE NOTICE.** Article 46C.052 sets forth the consequences of a defendant’s failure to give proper notice of intent to raise the insanity defense:

Art. 46C.052. Effect of Failure to Give Notice. Unless notice is timely filed under Article 46C.051, evidence on the insanity defense is not admissible unless the court finds that good cause exists for failure to give notice.

**APPOINTMENT OF EXPERTS.** The new Article 46C contains extensive detailed provisions regarding the appointment of experts to examine a defendant, sets forth the qualifications required for such experts, and the requirements pertaining to the written reports of the experts, as well as provisions concerning the examination of the defendant. These were intended to mirror the provisions regarding experts set forth in the 2003 revisions to Chapter 46B pertaining to competency evaluations (discussed in detail in Subchapter IV-A, *supra*).

Art. 46C.101. Appointment of Experts. (a) If notice of intention to raise the insanity defense is filed under Article 46C.051, the court may, on its own motion or motion by the defendant, the defendant’s counsel, or the attorney representing the state, appoint one or more disinterested experts to:

(1) examine the defendant with regard to the insanity defense; and

(2) testify as to the issue of insanity at any trial or hearing involving that issue.

(b) The court shall advise an expert appointed under this article of the facts and circumstances of the offense with which the defendant is charged and the elements of the insanity defense.
Art. 46C.102. Experts: Qualifications. (a) The court may appoint qualified psychiatrists or psychologists as experts under this chapter. To qualify for appointment under this subchapter as an expert, a psychiatrist or psychologist must:

(1) as appropriate, be a physician licensed in this state or be a psychologist licensed in this state who has a doctoral degree in psychology; and

(2) have the following certification or experience or training:

(A) as appropriate, certification by:

(i) the American Board of Psychiatry and Neurology with added or special qualifications in forensic psychiatry; or

(ii) the American Board of Professional Psychology in forensic psychology or

(B) experience or training consisting of:

(i) at least 24 hours of specialized forensic training relating to incompetence or insanity evaluations;

(ii) at least five years of experience in performing criminal forensic evaluations for courts; and

(iii) eight or more hours of continuing education relating to forensic evaluations, completed in the 12 months preceding the appointment and documented with the court.

(b) In addition to meeting qualifications required by Subsection (a), to be appointed as an expert a psychiatrist or psychologist must have completed six hours of required continuing education in courses in forensic psychiatry or psychology, as appropriate, in the 24 months preceding the appointment.

(c) A court may appoint as an expert a psychiatrist or psychologist who does not meet the requirements of Subsections (a) and (b) only if exigent circumstances require the court to base the appointment on professional training or experience of the expert that directly provides the expert with a specialized expertise to examine the defendant that would not ordinarily be possessed by a psychiatrist or psychologist who meets the requirements of Subsections (a) and (b).

Art. 46C.103. Competency to Stand Trial: Concurrent Appointment. (a) An expert appointed under this subchapter to
examine the defendant with regard to the insanity defense also may be appointed by the court to examine the defendant with regard to the defendant's competency to stand trial under Chapter 46B, if the expert files with the court separate written reports concerning the defendant's competency to stand trial and the insanity defense. (b) Notwithstanding Subsection (a), an expert may not examine the defendant for purposes of determining the defendant's sanity and may not file a report regarding the defendant's sanity if in the opinion of the expert the defendant is incompetent to proceed.

Art. 46C.104. Order Compelling Defendant to Submit to Examination. (a) For the purposes described by this chapter, the court may order any defendant to submit to examination, including a defendant who is free on bail. If the defendant fails or refuses to submit to examination, the court may order the defendant to custody for examination for a reasonable period not to exceed 21 days. Custody ordered by the court under this subsection may include custody at a facility operated by the department. (b) If a defendant who has been ordered to a facility operated by the department for examination remains in the facility for a period that exceeds 21 days, the head of that facility shall cause the defendant to be immediately transported to the committing court and placed in the custody of the sheriff of the county in which the committing court is located. That county shall reimburse the facility for the mileage and per diem expenses of the personnel required to transport the defendant, calculated in accordance with the state travel rules in effect at that time. (c) The court may not order a defendant to a facility operated by the department for examination without the consent of the head of that facility.

Art. 46C.105. Reports Submitted by Experts. (a) A written report of the examination shall be submitted to the court not later than the 30th day after the date of the order of examination. The court shall provide copies of the report to the defense counsel and the attorney representing the state.
(b) The report must include a description of the procedures used in the examination and the examiner's observations and findings pertaining to the insanity defense.
(c) The examiner shall submit a separate report stating the examiner’s observations and findings concerning:
   (1) whether the defendant is presently a person with a mental illness and requires court-ordered mental health services under Subtitle C, Title 7, Health and Safety Code; or
   (2) whether the defendant is presently a person with mental retardation.

Art. 46C.106. Compensation of Expert. (a) The appointed experts shall be paid by the county in which the indictment was returned or information was filed.
(b) The county in which the indictment was returned or information was filed shall reimburse a facility operated by the department that accepts a defendant for examination under this subchapter for expenses incurred that are determined by the department to be reasonably necessary and incidental to the proper examination of the defendant.

EXAMINATION BY AN EXPERT OF THE DEFENDANT’S CHOICE. Article 46C.107 provides that if a defendant wants to be examined by his or her own expert, the court must provide the expert with a reasonable opportunity to conduct the examination.

Art. 46C.107. Examination by Expert of Defendant’s Choice. If a defendant wishes to be examined by an expert of the defendant's own choice, the court on timely request shall provide the examiner with reasonable opportunity to examine the defendant.

DETERMINATION OF THE ISSUE OF DEFENDANT’S LEGAL SANITY. The provisions of Article 46C.151 through
46C.153 set forth rules for determination at trial of the issue of a defendant’s sanity:

**Art. 46C.151. Determination of Sanity Issue by Jury.** (a) In a case tried to a jury, the issue of the defendant’s sanity shall be submitted to the jury only if the issue is supported by competent evidence. The jury shall determine the issue.

(b) If the issue of the defendant's sanity is submitted to the jury, the jury shall determine and specify in the verdict whether the defendant is guilty, not guilty, or not guilty by reason of insanity.

**Art. 46C.152. Determination of Sanity Issue by Judge.** (a) If a jury trial is waived and if the issue is supported by competent evidence, the judge as trier of fact shall determine the issue of the defendant’s sanity.

(b) The parties may, with the consent of the judge, agree to have the judge determine the issue of the defendant’s sanity on the basis of introduced or stipulated competent evidence, or both.

(c) If the judge determines the issue of the defendant's sanity, the judge shall enter a finding of guilty, not guilty, or not guilty by reason of insanity.

**Art. 46C.153. General Provisions Relating to Determination of Sanity Issue by Judge or Jury.** (a) The judge or jury shall determine that a defendant is not guilty by reason of insanity if:

1. the prosecution has established beyond a reasonable doubt that the alleged conduct constituting the offense was committed; and

2. the defense has established by a preponderance of the evidence that the defendant was insane at the time of the alleged conduct.

(b) The parties may, with the consent of the judge, agree to both:

1. dismissal of the indictment or information on the ground that the defendant was insane; and

2. entry of a judgment of dismissal due to the defendant’s insanity.
(c) An entry of judgment under Subsection (b)(2) has the same effect as a judgment stating that the defendant has been found not guilty by reason of insanity.

**JURORS PROHIBITED FROM KNOWING CONSEQUENCES OF VERDICT.** Article 46C.154 continues the prior absurd and unjust practice of prohibiting the court and the attorneys from informing a juror or prospective juror of the consequences to the defendant if a verdict of not guilty by reason of insanity is returned:

*Art. 46C.154. Informing Jury Regarding Consequences of Acquittal.* The court, the attorney representing the state, or the attorney for the defendant may not inform a juror or a prospective juror of the consequences to the defendant if a verdict of not guilty by reason of insanity is returned.

The absurdity, and injustice, of this provision is that the jurors will probably not know about the extensive statutory provisions regarding the mandatory procedures to be followed by the court upon the acquittal of a defendant by reason of insanity, including provisions to protect adequately the safety of the community, and may believe that a defendant acquitted by reason of insanity is free to walk out of the courthouse at the end of the trial. That is, jurors may believe, erroneously, that they are confronted by only two options: (1) conviction of the defendant and sentencing him or her to prison in order to protect the community; or, (2) acquittal of the defendant by reason of insanity, in which case – as they often may believe – the defendant will be immediately freed at the conclusion of the trial.

It is perhaps reasonable to conclude that the Texas Legislature intended this result – that Texas jurors are to be required to function in ignorance to this extent – but it is nevertheless an
unjust and unfair result, and it gives an improper advantage to the prosecution in seeking to win verdicts of guilty.

Jurors ought to know and understand that if they acquit a defendant by reason of insanity, the acquitted defendant will be under the control of the court as provided in the applicable statutory provisions requiring further evaluation of the defendant and insuring adequate protection of the community. It has been held, however, that this provision does not deny fundamental fairness to the defendant. *Robison v. State*, 888 S.W. 2d 473, 477 (Tex. Crim. App. 1994), *cert. denied*, 515 U.S. 1162 (1995) (holding that there was no constitutional infirmity and citing *Zwack v. State*, 757 S.W.2d 66, 69 (Tex. App.—Houston [14th Dist.] 1988, pet. ref=d), which held the same).

The constitutionality of Article 46C.154 should be tested in the courts utilizing the authority and reasoning of the United States Supreme Court in *Simmons v. South Carolina*, 512 U.S. 154, 171 (1994) and *Shafer v. North Carolina*, 532 U.S. 36, 51 (2001), in which the Court held that a defendant in a capital case where future dangerousness is an issue has a due process right to have the jury informed that under a life sentence there is no possibility of parole. In our view, the state should not be allowed to set up a “false dilemma” of the kind described by the Supreme Court in the *Simmons* case, in which jurors may believe erroneously that a defendant will be immediately released after a finding of not guilty by reason of insanity, but at the same time the state by statute prevents the jurors from being told that such a thing cannot happen under the applicable law.

**JUDGMENT OPTIONS.** Article 46C.156 provides for the judgment options in a case in which the insanity defense is raised.
Art. 46C.156. Judgment. (a) In each case in which the insanity defense is raised, the judgment must reflect whether the defendant was found guilty, not guilty, or not guilty by reason of insanity.
   (b) If the defendant was found not guilty by reason of insanity, the judgment must specify the offense of which the defendant was found not guilty.
   (c) If the defendant was found not guilty by reason of insanity, the judgment must reflect the finding made under Article 46C.157.

ACQUITTAL THROUGH VERDICT OF NOT GUILTY BY REASON OF INSANITY. Article 46C.155 provides that, except with respect to the expunction of criminal records as governed by Chapter 55 of the Code of Criminal Procedure, a defendant who is found not guilty by reason of insanity stands acquitted of the offense charged and may not be considered a person charged with an offense.

Art. 46C.155. Findings of Not Guilty by Reason of Insanity Considered Acquittal. (a) Except as provided by Subsection (b), a defendant who is found not guilty by reason of insanity stands acquitted of the offense charged and may not be considered a person charged with an offense.
   (b) A defendant who is found not guilty by reason of insanity is not considered to be acquitted for purposes of Chapter 55.

INSANITY DEFENSE UNIQUE; DEFENDANT NOT AUTOMATICALLY RELEASED WHEN ACQUITTED. The insanity defense is unique among the various defenses to crime in that an acquittal by reason of insanity does not necessarily mean that the defendant is immediately set free, and usually that is not the result of such an acquittal.

All jurisdictions, including Texas, have provisions for determining whether a defendant acquitted by reason of insanity is dangerous to others and is in need of psychiatric treatment. And
all jurisdictions allow detention of such an acquitted person, if necessary, to make the necessary determinations and provide the needed treatment. For example, John W. Hinckley, Jr., remains in detention in a public psychiatric hospital in Washington, D.C., notwithstanding his acquittal in 1982 by reason of insanity. In Texas, these matters are governed by the provisions of Article 46C.251 through 46C.270. We turn now to an outline of those provisions.

**DETERMINATION REGARDING DANGEROUS CONDUCT OF AN ACQUITTED PERSON.** One of the most important determinations a court must make in this situation is whether the conduct of the defendant involved an act, attempt, or threat of serious bodily injury to another person. The answer to that critical question determines, in significant part, how the defendant will be handled following his or her acquittal by reason of insanity.

**Art. 46C.157. Determination Regarding Dangerous Conduct of Acquitted Person.** If a defendant is found not guilty by reason of insanity, the court immediately shall determine whether the offense of which the person was acquitted involved conduct that:

1. caused serious bodily injury to another person;
2. placed another person in imminent danger of serious bodily injury; or
3. consisted of a threat of serious bodily injury to another person through the use of a deadly weapon.

**CONTINUING JURISDICTION OF DANGEROUS ACQUITTED PERSON.** This is one of the provisions that jurors should be made aware of prior to their deliberations during the guilt or innocence stage of a trial in which the insanity defense has been raised, so that they will not be victims of a “false dilemma,” as described by the Supreme Court of the United States in *Simmons v. South Carolina*, 512 U.S. 154, 171 (1994), and believe,
erroneously, that the only two options under Texas law are a finding of guilt and prison time for the defendant, or a finding of not guilty by reason of insanity resulting, possibly, in the acquitted defendant’s immediate freedom. But, jurors in Texas may not be told about this matter due to the dubious provisions of Article 46C.154. As described above, this matter should be tested in the courts as a denial of due process of law. In any event, the continuing jurisdiction rules under Article 46C.158 are set forth below. Importantly, the 2005 re-codification provides the court with greater supervisory authority under Chapter 46C over persons acquitted by reason of an NGRI finding than under prior law.

Art. 46C.158. Continuing Jurisdiction of Dangerous Acquitted Person. If the court finds that the offense of which the person was acquitted involved conduct that caused serious bodily injury to another person, placed another person in imminent danger of serious bodily injury, or consisted of a threat of serious bodily injury to another person through the use of a deadly weapon, the court retains jurisdiction over the acquitted person until either:

(1) the court discharges the person and terminates its jurisdiction under Article 46C.268; or

(2) the cumulative total period of institutionalization and outpatient or community-based treatment and supervision under the court's jurisdiction equals the maximum term provided by law for the offense of which the person was acquitted by reason of insanity and the court's jurisdiction is automatically terminated under Article 46C.269.

OPTIONS AVAILABLE REGARDING A NONDANGEROUS ACQUITTED PERSON.

Art. 46C.159. Proceedings Regarding Nondangerous Acquitted Person. If the court finds that the offense of which the person was acquitted did not involve conduct that caused serious bodily injury to another person, placed another person in imminent danger of serious bodily injury, or consisted of a threat of serious
bodily injury to another person through the use of a deadly weapon, the court shall proceed under Subchapter E.

**DETECTION PENDING FURTHER PROCEEDINGS.**

**Art. 46C.160. Detention Pending Further Proceedings.** (a) On a determination by the judge or jury that the defendant is not guilty by reason of insanity, pending further proceedings under this chapter, the court may order the defendant detained in jail or any other suitable place for a period not to exceed 14 days.
(b) The court may order a defendant detained in a facility of the department or a facility of the Department of Aging and Disability Services under this article only with the consent of the head of the facility.

**DETAILS OF PROCEDURE FOLLOWING ACQUITTAL BY REASON OF INSANITY WHEN THERE WAS NO FINDING OF DANGEROUS CONDUCT.** Articles 46C.201 and 46C.202 describe the procedures to be followed when there has been an acquittal by reason of insanity and there was no finding of dangerous conduct.

**Art. 46C.201. Disposition: Nondangerous Conduct.** (a) If the court determines that the offense of which the person was acquitted did not involve conduct that caused serious bodily injury to another person, placed another person in imminent danger of serious bodily injury, or consisted of a threat of serious bodily injury to another person through the use of a deadly weapon, the court shall determine whether there is evidence to support a finding that the person is a person with a mental illness or with mental retardation.
(b) If the court determines that there is evidence to support a finding of mental illness or mental retardation, the court shall enter an order transferring the person to the appropriate court for civil commitment proceedings to determine whether the person should receive court-ordered mental health services under Subtitle C, Title
7, Health and Safety Code, or be committed to a residential care facility to receive mental retardation services under Subtitle D, Title 7, Health and Safety Code. The court may also order the person:

(1) detained in jail or any other suitable place pending the prompt initiation and prosecution of appropriate civil proceedings by the attorney representing the state or other person designated by the court; or

(2) placed in the care of a responsible person on satisfactory security being given for the acquitted person's proper care and protection.

Art. 46C.202. Detention or Release. (a) Notwithstanding Article 46C.201(b), a person placed in a department facility or a facility of the Department of Aging and Disability Services pending civil hearing as described by that subsection may be detained only with the consent of the head of the facility and under an Order of Protective Custody issued under Subtitle C or D, Title 7, Health and Safety Code.

(b) If the court does not detain or place the person under Article 46C.201(b), the court shall release the person.

DETAILS OF PROCEDURE AFTER ACQUITTAL BY REASON OF INSANITY WHERE THERE IS A FINDING OF DANGEROUS CONDUCT. The extensive details of the procedures to be followed after acquittal of a defendant by reason of insanity where there is a finding of dangerous conduct are set forth in Articles 46C.251 through 46C.270. As Professor Shannon observed in his article,

Importantly, the revamped statute provides greater guidance to the court than under prior law with regard to the court’s ability to order mental health treatment for the acquitted individual. The statute gives the court sweeping power to order that the individual obtain inpatient hospitalization in a state facility, community-based
treatment, or outpatient treatment, and the flexibility to order a step-down to an outpatient commitment after a period of inpatient treatment. This type of order would be appropriate once an acquitted person with serious mental illness has been stabilized and is not viewed as posing a threat to society. The statute authorizes the court to require a comprehensive treatment plan and gives the court authority to revoke the outpatient approach if the acquitted person fails to comply with the prescribed treatment regimen. On the whole, the re-codified statute provides substantial direction to the court in overseeing the follow-up treatment and supervision of an individual found NGRI. Brian D. Shannon, supra, at 80 (citations omitted).

Art. 46C.251. Commitment for Evaluation and Treatment; Report. (a) The court shall order the acquitted person to be committed for evaluation of the person's present mental condition and for treatment to the maximum security unit of any facility designated by the department. The period of commitment under this article may not exceed 30 days.

(b) The court shall order that:

(1) a transcript of all medical testimony received in the criminal proceeding be prepared as soon as possible by the court reporter and the transcript be forwarded to the facility to which the acquitted person is committed; and

(2) the following information be forwarded to the facility and, as applicable, to the department or the Department of Aging and Disability Services:

(A) the complete name, race, and gender of the person;

(B) any known identifying number of the person, including social security number, driver's license number, or state identification number;

(C) the person's date of birth; and

(D) the offense of which the person was found not guilty by reason of insanity and a statement of the facts and circumstances surrounding the alleged offense.

200
(c) The court shall order that a report be filed with the court under Article 46C.252.
(d) To determine the proper disposition of the acquitted person, the court shall hold a hearing on disposition not later than the 30th day after the date of acquittal.

Art. 46C.252. Report After Evaluation. (a) The report ordered under Article 46C.251 must be filed with the court as soon as practicable before the hearing on disposition but not later than the fourth day before that hearing.
(b) The report in general terms must describe and explain the procedure, techniques, and tests used in the examination of the person.
(c) The report must address:
   (1) whether the acquitted person has a mental illness or mental retardation and, if so, whether the mental illness or mental retardation is severe;
   (2) whether as a result of any severe mental illness or mental retardation the acquitted person is likely to cause serious harm to another;
   (3) whether as a result of any impairment the acquitted person is subject to commitment under Subtitle C or D, Title 7, Health and Safety Code;
   (4) prospective treatment and supervision options, if any for the acquitted person; and
   (5) whether any required treatment and supervision can be safely and effectively provided as outpatient or community-based treatment and supervision.

Art. 46C.253. Hearing on Disposition. (a) The hearing on disposition shall be conducted in the same manner as a hearing on an application for involuntary commitment under Subtitle C or D, Title 7, Health and Safety Code, except that the use of a jury is governed by Article 46C.255.
(b) At the hearing, the court shall address:
   (1) whether the person acquitted by reason of insanity has a severe mental illness or mental retardation;
whether as a result of any mental illness or mental retardation the person is likely to cause serious harm to another; and

whether appropriate treatment and supervision for any mental illness or mental retardation rendering the person dangerous to another can be safely and effectively provided as outpatient or community-based treatment and supervision.

The court shall order the acquitted person committed for inpatient treatment or residential care under Article 46C.256 if the grounds required for that order are established.

The court shall order the acquitted person to receive outpatient or community-based treatment and supervision under Article 46C.257 if the grounds required for that order are established.

The court shall order the acquitted person transferred to an appropriate court for proceedings under Subtitle C or D, Title 7, Health and Safety Code, if the state fails to establish the grounds required for an order under Article 46C.256 or 46C.257 but the evidence provides a reasonable basis for believing the acquitted person is a proper subject for those proceedings.

The court shall order the acquitted person discharged and immediately released if the evidence fails to establish that disposition under Subsection (c), (d), or (e) is appropriate.

**Art. 46C.254. Effect of Stabilization on Treatment Regimen.** If an acquitted person is stabilized on a treatment regimen, including medication and other treatment modalities, rendering the person no longer likely to cause serious harm to another, inpatient treatment or residential care may be found necessary to protect the safety of others only if:

1. the person would become likely to cause serious harm to another if the person fails to follow the treatment regimen on an Order to Receive Outpatient or Community-Based Treatment and Supervision; and

2. under an Order to Receive Outpatient or Community-Based Treatment and Supervision either:

   A. the person is likely to fail to comply with an available regimen of outpatient or community-based treatment, as
determined by the person’s insight into the need for medication, the number, severity, and controllability of side effects, the availability of support and treatment programs for the person from community members, and other appropriate considerations; or

(B) a regimen of outpatient or community-based treatment will not be available to the person.

**Art. 46C.255. Trial by Jury.** (a) The following proceedings under this chapter must be before the court, and the underlying matter determined by the court, unless the acquitted person or the state requests a jury trial or the court on its own motion sets the matter for jury trial:

1. a hearing under Article 46C.253;
2. a proceeding for renewal of an order under Article 46C.261;
3. a proceeding on a request for modification or revocation of an order under Article 46C.266; and
4. a proceeding seeking discharge of an acquitted person under Article 46C.268.

(b) The following proceedings may not be held before a jury:

1. a proceeding to determine outpatient or community-based treatment and supervision under Article 46C.262; or
2. a proceeding to determine modification or revocation of outpatient or community-based treatment and supervision under Article 46C.267.

(c) If a hearing is held before a jury and the jury determines that the person has a mental illness or mental retardation and is likely to cause serious harm to another, the court shall determine whether inpatient treatment or residential care is necessary to protect the safety of others.

**Art. 46C.256. Order of commitment to Inpatient Treatment or Residential Care.** (a) The court shall order the acquitted person committed to a mental hospital or other appropriate facility for inpatient treatment or residential care if the state establishes by clear and convincing evidence that:

1. the person has a severe mental illness or mental retardation;
(2) the person, as a result of that mental illness or mental retardation, is likely to cause serious bodily injury to another if the person is not provided with treatment and supervision; and

(3) inpatient treatment or residential care is necessary to protect the safety of others.

(b) In determining whether inpatient treatment or residential care has been proved necessary, the court shall consider whether the evidence shows both that:

(1) an adequate regimen of outpatient or community-based treatment will be available to the person; and

(2) the person will follow that regimen.

(c) The order of commitment to inpatient treatment or residential care expires on the 181st day following the date the order is issued but is subject to renewal as provided by Article 46C.261.

Art. 46C.257. Order to Receive Outpatient or Community-Based Treatment and Supervision. (a) The court shall order the acquitted person to receive outpatient or community-based treatment and supervision if:

(1) the state establishes by clear and convincing evidence that the person:

   (A) has a severe mental illness or mental retardation; and

   (B) as a result of that mental illness or mental retardation is likely to cause serious bodily injury to another if the person is not provided with treatment and supervision; and

(2) the state fails to establish by clear and convincing evidence that inpatient treatment or residential care is necessary to protect the safety of others.

(b) The order of commitment to outpatient or community-based treatment and supervision expires on the first anniversary of the date the order is issued but is subject to renewal as provided by Article 46C.261.

Art. 46C.258. Responsibility of Inpatient or Residential Care Facility. (a) The head of the facility to which an acquitted person is committed has, during the commitment period, a continuing responsibility to determine:
(1) whether the acquitted person continues to have a severe mental illness or mental retardation and is likely to cause serious harm to another because of any severe mental illness or mental retardation; and

(2) if so, whether treatment and supervision cannot be safely and effectively provided as outpatient or community-based treatment and supervision.

(b) The head of the facility must notify the committing court and seek modification of the order of commitment if the head of the facility determines that an acquitted person no longer has a severe mental illness or mental retardation, is no longer likely to cause serious harm to another, or that treatment and supervision can be safely and effectively provided as outpatient or community-based treatment and supervision.

(c) Not later than the 60th day before the date of expiration of the order, the head of the facility shall transmit to the committing court a psychological evaluation of the acquitted person, a certificate of medical examination of the person, and any recommendation for further treatment of the person. The committing court shall make the documents available to the attorneys representing the state and the acquitted person.

**Art. 46C.259. Status of Committed Person.** If an acquitted person is committed under this subchapter, the person’s status as a patient or resident is governed by Subtitle C or D, Title 7, Health and Safety Code, except that:

(1) transfer to a nonsecure unit is governed by Article 46C.260;

(2) modification of the order to direct outpatient or community-based treatment and supervision is governed by Article 46C.262; and

(3) discharge is governed by Article 46C.268.

**Art. 46C.260. Transfer of Committed Person to Nonsecure Facility.** (a) A person committed to a facility under this subchapter shall be committed to the maximum security unit of any facility designated by the department.
(b) A person committed under this subchapter shall be transferred to the maximum security unit immediately on the entry of the order of commitment.

(c) Unless the person is determined to be manifestly dangerous by a review board within the department, not later than the 60th day following the date of the person’s arrival at the maximum security unit the person shall be transferred to a nonsecure unit of a facility designated by the department or the Department of Aging and Disability Services, as appropriate.

(d) The commissioner shall appoint a review board of five members, including one psychiatrist licensed to practice medicine in this state and two persons who work directly with persons with mental illnesses or with mental retardation, to determine whether the person is manifestly dangerous and, as a result of the danger the person presents, requires continued placement in a maximum security unit.

(e) If the head of the facility at which the maximum security unit is located disagrees with the determination, then the matter shall be referred to the commissioner. The commissioner shall decide whether the person is manifestly dangerous.

Art. 46C.261. Renewal of Orders for Inpatient Commitment or Outpatient or Community-Based Treatment and Supervision.

(a) A court that orders an acquitted person committed to inpatient treatment or orders outpatient or community-based treatment and supervision annually shall determine whether to renew the order.

(b) Not later than the 30th day before the date an order is scheduled to expire, the institution to which a person is committed, the person responsible for providing outpatient or community-based treatment and supervision, or the attorney representing the state may file a request that the order be renewed. The request must explain in detail the reasons why the person requests renewal under this article. A request to renew an order committing the person to inpatient treatment must also explain in detail why outpatient or community-based treatment and supervision is not appropriate.
(c) The request for renewal must be accompanied by a certificate of medical examination for mental illness signed by a physician who examined the person during the 30-day period preceding the date on which the request is filed.

(d) On the filing of a request for renewal under this article, the court shall:
   
   (1) set the matter for a hearing; and
   
   (2) appoint an attorney to represent the person.

(e) The court shall act on the request for renewal before the order expires.

(f) If a hearing is held, the person may be transferred from the facility to which the acquitted person was committed to a jail for purposes of participating in the hearing only if necessary but not earlier than 72 hours before the hearing begins. If the order is renewed, the person shall be transferred back to the facility immediately on renewal of the order.

(g) If no objection is made, the court may admit into evidence the certificate of medical examination for mental illness. Admitted certificates constitute competent medical or psychiatric testimony, and the court may make its findings solely from the certificate and the detailed request for renewal.

(h) A court shall renew the order only if the court finds that the party who requested the renewal has established by clear and convincing evidence that continued mandatory supervision and treatment are appropriate. A renewed order authorizes continued inpatient commitment or outpatient or community-based treatment and supervision for not more than one year.

(i) The court, on application for renewal of an order for inpatient or residential care services, may modify the order to provide for outpatient or community-based treatment and supervision if the court finds the acquitted person has established by a preponderance of the evidence that treatment and supervision can be safely and effectively provided as outpatient or community-based treatment and supervision.
Art. 46C.262. Court-Ordered Outpatient or Community-Based Treatment and Supervision After Inpatient Commitment.
(a) An acquitted person, the head of the facility to which the acquitted person is committed, or the attorney representing the state may request that the court modify an order for inpatient treatment or residential care to order outpatient or community-based treatment and supervision.
(b) The court shall hold a hearing on a request made by the head of the facility to which the acquitted person is committed. A hearing under this subsection must be held not later than the 14th day after the date of the request.
(c) If a request is made by an acquitted person or the attorney representing the state, the court must act on the request not later than the 14th day after the date of the request. A hearing under this subsection is at the discretion of the court, except that the court shall hold a hearing if the request and any accompanying material provide a basis for believing modification of the order may be appropriate.
(d) If a request is made by an acquitted person not later than the 90th day after the date of a hearing on a previous request, the court is not required to act on the request except on the expiration of the order or on the expiration of the 90-day period following the date of the hearing on the previous request.
(e) The court shall rule on the request during or as soon as practicable after any hearing on the request but not later than the 14th day after the date of the request.
(f) The court shall modify the commitment order to direct outpatient or community-based treatment and supervision if at the hearing the acquitted person establishes by a preponderance of the evidence that treatment and supervision can be safely and effectively provided as outpatient or community-based treatment and supervision.

Art. 46C.263. Court-Ordered Outpatient or Community-Based Treatment and Supervision. (a) The court may order an acquitted person to participate in an outpatient or community-based regimen of treatment and supervision:
(1) as an initial matter under Article 46C.253;
(2) on renewal of an order of commitment under Article 46C.261; or
(3) after a period of inpatient treatment or residential care under Article 46C.262.

(b) An acquitted person may be ordered to participate in an outpatient or community-based regimen of treatment and supervision only if:
   (1) the court receives and approves an outpatient or community-based treatment plan that comprehensively provides for or community-based treatment and supervision; and
   (2) the court finds that the outpatient or community-based treatment and supervision provided for by the plan will be available to and provided to the acquitted person.
(c) The order may require the person to participate in a prescribed regimen of medical, psychiatric, or psychological care or treatment, and the regimen may include treatment with psychoactive medication.
(d) The court may order that supervision of the acquitted person be provided by the appropriate community supervision and corrections department or the facility administrator of a community center that provides mental health or mental retardation services.
(e) The court may order the acquitted person to participate in a supervision program funded by the Texas Correctional Office on Offenders with Medical or Mental Impairments.
(f) An order under this article must identify the person responsible for administering an ordered regimen of outpatient or community-based treatment and supervision.
(g) In determining whether an acquitted person should be ordered to receive outpatient or community-based treatment and supervision rather than inpatient care or residential treatment, the court shall have as its primary concern the protection of society.

Art. 46C.264. Location of Court-Ordered Outpatient or Community-Based Treatment and Supervision. (a) The court may order the outpatient or community-based treatment and
supervision to be provided in any appropriate county where the necessary resources are available.
(b) This article does not supersede any requirement under the other provisions of this subchapter to obtain the consent of a treatment and supervision provider to administer the court-ordered outpatient or community-based treatment and supervision.

Art. 46C.265. Supervisory Responsibility for Outpatient or Community-Based Treatment and Supervision. (a) The person responsible for administering a regimen of outpatient or community-based treatment and supervision shall:
   (1) monitor the condition of the acquitted person; and
   (2) determine whether the acquitted person is complying with the regimen of treatment and supervision.
(b) The person responsible for administering a regimen of outpatient or community-based treatment and supervision shall notify the court ordering that treatment and supervision and the attorney representing the state if the person:
   (1) fails to comply with the regimen; and
   (2) becomes likely to cause serious harm to another.

Art. 46C.266. Modification or Revocation of Order for Outpatient or Community-Based Treatment and Supervision. (a) The court, on its own motion or the motion of any interested person and after notice to the acquitted person and a hearing, may modify or revoke court-ordered outpatient or community-based treatment and supervision.
(b) At the hearing, the court without a jury shall determine whether the state has established clear and convincing evidence that:
   (1) the acquitted person failed to comply with the regimen in a manner or under circumstances indicating the person will become likely to cause serious harm to another if the person is provided continued outpatient or community-based treatment and supervision; or
   (2) the acquitted person has become likely to cause serious harm to another if provided continued outpatient or community-based treatment and supervision.
(c) On a determination under Subsection (b), the court may take any appropriate action, including:

(1) revoking court-ordered outpatient or community-based treatment and supervision and ordering the person committed for inpatient or residential care; or

(2) imposing additional or more stringent terms on continued outpatient or community-based treatment.

(d) An acquitted person who is the subject of a proceeding under this article is entitled to representation by counsel in the proceeding.

(e) The court shall set a date for a hearing under this article that is not later than the seventh day after the applicable motion was filed. The court may grant one or more continuances of the hearing on the motion of a party or of the court and for good cause shown.

Art. 46C.267. Detention Pending Proceedings to Modify or Revoke Order for Outpatient or Community-Based Treatment and Supervision. (a) The state or the head of the facility or other person responsible for administering a regimen of outpatient or community-based treatment and supervision may file a sworn application with the court for the detention of an acquitted person receiving court-ordered outpatient or community-based treatment and supervision. The application must state that the person meets the criteria of Article 46C.266 and provide a detailed explanation of that statement.

(b) If the court determines that the application establishes probable cause to believe the order for outpatient or community-based treatment and supervision should be revoked, the court shall issue an order to an on-duty peace officer authorizing the acquitted person to be taken into custody and brought before the court.

(c) An acquitted person taken into custody under an order of detention shall be brought before the court without unnecessary delay.

(d) When an acquitted person is brought before the court, the court shall determine whether there is probable cause to believe that the order for outpatient or community-based treatment and supervision should be revoked. On a finding that probable cause
for revocation exists, the court shall order the person held in protective custody pending a determination of whether the order should be revoked.

c) An acquitted person may be detained under an order for protective custody for a period not to exceed 72 hours, excluding Saturdays, Sundays, legal holidays, and the period prescribed by Section 574.025(b), Health and Safety Code, for an extreme emergency.

d) This subchapter does not affect the power of a peace officer to take an acquitted person into custody under Section 573.001, Health and Safety Code.

Art. 46C.268. Advance Discharge of Acquitted Person and Termination of Jurisdiction. (a) An acquitted person, the head of the facility to which the acquitted person is committed, the person responsible for providing the outpatient or community-based treatment and supervision, or the state may request that the court discharge an acquitted person from inpatient commitment or outpatient or community-based treatment and supervision.

(b) Not later than the 14th day after the date of the request, the court shall hold a hearing on a request made by the head of the facility to which the acquitted person is committed or the person responsible for providing the outpatient or community-based treatment and supervision.

(c) If a request is made by an acquitted person, the court must act on the request not later than the 14th day after the date of the request. A hearing under this subsection is at the discretion of the court, except that the court shall hold a hearing if the request and any accompanying material indicate that modification of the order may be appropriate.

(d) If a request is made by an acquitted person not later than the 90th day after the date of a hearing on a previous request, the court is not required to act on the request except on the expiration of the order or on the expiration of the 90-day period following the date of the hearing on the previous request.
(e) The court shall rule on the request during or shortly after any hearing that is held and in any case not later than the 14th day after the date of the request.

(f) The court shall discharge the acquitted person from all court-ordered commitment and treatment and supervision and terminate the court’s jurisdiction over the person if the court finds that the acquitted person has established by a preponderance of the evidence that:

(1) the acquitted person does not have a severe mental illness or mental retardation; or

(2) the acquitted person is not likely to cause serious harm to another because of any severe mental illness or mental retardation.

Art. 46C.269. Termination of Court's Jurisdiction. (a) The jurisdiction of the court over a person covered by this subchapter automatically terminates on the date when the cumulative total period of institutionalization and outpatient or community-based treatment and supervision imposed under this subchapter equals the maximum term of imprisonment provided by law for the offense of which the person was acquitted by reason of insanity.

(b) On the termination of the court's jurisdiction under this article, the person must be discharged from any inpatient treatment or residential care or outpatient or community-based treatment and supervision ordered under this subchapter.

(c) An inpatient or residential care facility to which a person has been committed under this subchapter or a person responsible for administering a regimen of outpatient or community-based treatment and supervision under this subchapter must notify the court not later than the 30th day before the court’s jurisdiction over the person ends under this article.

(d) This subchapter does not affect whether a person may be ordered to receive care or treatment under Subtitle C or D, Title 7, Health and Safety Code.

Art. 46C.270. Appeals. (a) An acquitted person may appeal a judgment reflecting an acquittal by reason of insanity on the basis of the following:
(1) a finding that the acquitted person committed the offense; or

(2) a finding that the offense on which the prosecution was based involved conduct that:
   (A) caused serious bodily injury to another person;
   (B) placed another person in imminent danger of serious bodily injury; or
   (C) consisted of a threat of serious bodily injury to another person through the use of a deadly weapon.

(b) Either the acquitted person or the state may appeal from:
   (1) an Order of Commitment to Inpatient Treatment or Residential Care entered under Article 46C.256;
   (2) an Order to Receive Outpatient or Community-Based Treatment and Supervision entered under Article 46C.257 or 46C.262;
   (3) an order renewing or refusing to renew an Order for Inpatient Commitment or Outpatient or Community-Based Treatment and Supervision entered under Article 46C.261;
   (4) an order modifying or revoking an Order for Outpatient or Community-Based Treatment and Supervision entered under Article 46C.266 or refusing a request to modify or revoke that order; or
   (5) an order discharging an acquitted person under Article 46C.268 or denying a request for discharge of an acquitted person.

(c) An appeal under this subchapter may not be considered moot solely due to the expiration of an order on which the appeal is based.

COLLECTION AND MAINTENANCE OF DATA REGARDING PERSONS ACQUITTED BY REASON OF INSANITY. Section 533.0095 of the Texas Health & Safety Code provides for the collection and maintenance of data concerning persons who are acquitted by reason of insanity. This statute was added as part of the 2005 re-codification of Chapter 46C. It also directs the Health and Human Services Commission to provide an
annual report to the legislature that identifies NGRI acquittees and provides information about their civil commitments.

Sec. 533.0095, Texas Health & Safety Code. Collection and Maintenance of Information Regarding Persons Found Not Guilty by Reason of Insanity. (a) The executive commissioner of the Health and Human Services Commission by rule shall require the department to collect information and maintain current records regarding a person found not guilty of an offense by reason of insanity under Chapter 46C, Code of Criminal Procedure, who is:

1. ordered by a court to receive inpatient mental health services under Chapter 574 or under Chapter 46C, Code of Criminal Procedure;

2. committed by a court for long-term placement in a residential care facility under Chapter 593 or under Chapter 46C, Code of Criminal Procedure; or

3. ordered by a court to receive outpatient or community-based treatment and supervision.

(b) Information maintained by the department under this section must include the name and address of any facility to which the person is committed, the length of the person’s commitment to the facility, and any post-release outcome.

(c) The department shall file annually with the presiding officer of each house of the legislature a written report containing the name of each person described by Subsection (a), the name and address of any facility to which the person is committed, the length of the person’s commitment to the facility, and any post-release outcome.

RESTRICTIONS ON THE ADMINISTRATION OF PSYCHOACTIVE MEDICATION. Section 576.025 of the Texas Health & Safety Code sets forth restrictions on administering psychoactive medication to a patient receiving either voluntary or involuntary mental health services who refuses the administration. It cross-references provisions relating to procedures for court-ordered administration of medication which were discussed, supra, in Subchapter IV-A relating to competency.
Sec. 576.025, Texas Health & Safety Code. (a) A person may not administer a psychoactive medication to a patient receiving voluntary or involuntary mental health services who refuses the administration unless:

1. the patient is having a medication-related emergency;
2. the patient is younger than 16 years of age and the patient’s parent, managing conservator, or guardian consents to the administration on behalf of the patient;
3. the refusing patient's representative authorized by law to consent on behalf of the patient has consented to the administration;
4. the administration of the medication regardless of the patient’s refusal is authorized by an order issued under Section 574.106; or
5. the patient is receiving court-ordered mental health services authorized by an order issued under:
   A. Chapter 46B or 46C Code of Criminal Procedure; or
   B. Chapter 55, Family Code.

MAXIMUM PERIOD OF COMMITMENT CANNOT EXCEED MAXIMUM TERM PROVIDED BY LAW FOR CRIME. Article 46C.002 provides that a person acquitted by reason of insanity cannot be committed either to a mental hospital or other inpatient or residential facility under Subchapter F for a cumulative period of time that exceeds the maximum term provided by law for the crime for which the acquitted person was tried. Upon the expiration of that maximum term, the person may be further confined in a mental hospital or other inpatient or residential care facility or ordered to receive outpatient or community-based treatment and supervision only through civil commitment proceedings.

Art. 46C.002. Maximum Period of Commitment Determined by Maximum Term for Offense. (a) A person acquitted by reason of insanity may not be committed to a mental hospital or
other inpatient or residential care facility or ordered to receive outpatient or community-based treatment and supervision under Subchapter F for a cumulative period that exceeds the maximum term provided by law for the offense for which the acquitted person was tried.

(b) On expiration of that maximum term, the acquitted person may be further confined in a mental hospital or other inpatient or residential care facility or ordered to receive outpatient or community-based treatment and supervision only under civil commitment proceedings.

CONCLUSION. The provisions of the applicable law discussed above regarding the insanity defense in Texas are designed to protect both the public and the individual who has been acquitted by reason of insanity by requiring an immediate and appropriate evaluation of the individual following his or her acquittal.

As is clear in those provisions, a distinction is made between those acquitted defendants whose conduct did not involve an act, attempt, or threat of serious bodily injury to another person, and those acquitted defendants whose conduct did involve such an act, attempt, or threat. Appropriate processing is provided for persons in both categories, and the goal is to provide whatever appropriate treatment is needed by the acquitted person, as determined by a careful evaluation of his or her individual condition, and at the same time to protect the general public. Moreover, the 2005 recodification of old Article 46.03 into Chapter 46C provided the courts with much greater supervisory authority over the civil commitments for those few individuals who are determined to be NGRI.
B. JUVENILES

INSANITY DEFENSE FOR JUVENILES. Because different statutory provisions govern alleged criminal offenses committed by juveniles, a review of the insanity defense applicable to juveniles, as set forth in Section 55.51 of the Texas Family Code, is appropriate.

The insanity defense for juveniles in Texas is not designated as an “insanity defense” in the Family Code. Instead, Section 55.51, containing the provisions for the defense, is entitled “Lack of Responsibility for Conduct as a Result of Mental Illness or Mental Retardation,” and Section 55.51 provides not only the elements of the defense itself but also some of the procedural steps to be followed in determining the issues involved.

Sec. 55.51. LACK OF RESPONSIBILITY FOR CONDUCT AS A RESULT OF MENTAL ILLNESS OR MENTAL RETARDATION. (a) A child alleged by petition to have engaged in delinquent conduct or conduct indicating a need for supervision is not responsible for the conduct if at the time of the conduct, as a result of mental illness or mental retardation, the child lacks substantial capacity either to appreciate the wrongfulness of the child’s conduct or to conform the child’s conduct to the requirements of law.

(b) On a motion by a party in which it is alleged that a child may not be responsible as a result of mental illness or mental retardation for the child’s conduct, the court shall order the child to be examined under Section 51.20. The information obtained from the examinations must include expert opinion as to whether the child is not responsible for the child’s conduct as a result of mental illness or mental retardation.

(c) The issue of whether the child is not responsible for the child’s conduct as a result of mental illness or mental retardation shall be tried to the court or jury in the adjudication hearing.
(d) Lack of responsibility for conduct as a result of mental illness or mental retardation must be proved by a preponderance of the evidence.
(e) In its findings or verdict the court or jury must state whether the child is not responsible for the child=s conduct as a result of mental illness or mental retardation.
(f) If the court or jury finds the child is not responsible for the child=s conduct as a result of mental illness or mental retardation, the court shall proceed under Section 55.52.
(g) A child found to be not responsible for the child=s conduct as a result of mental illness or mental retardation shall not be subject to proceedings under this title with respect to such conduct, other than proceedings under Section 55.52.

DIFFERENT FROM THE INSANITY DEFENSE FOR ADULTS IN THE TEXAS PENAL CODE. Section 55.51 of the Texas Family Code makes available to juveniles the kind of insanity defense Texas formerly provided for adults from 1974 to 1983 (when the insanity test was “reformed” by being changed back to the old nineteenth century M’Naghten “right-wrong” test which is narrowly based solely on a defendant’s cognitive capacity).

Basically, the Texas formulation of the juvenile insanity defense is the insanity test developed by the American Law Institute (ALI) in its 1962 Model Penal Code, as slightly modified. Thus, it differs from, and in our view is better than, the inadequate insanity defense for adults provided by Section 8.01 of the Texas Penal Code.

ELEMENTS OF THE TEST. The Family Code insanity test for juveniles in Section 55.51 provides that a child (a person who is ten years of age or older and under 17 years of age) is not responsible for delinquent conduct or conduct indicating a need for supervision if, at the time of the conduct, as a result of mental
illness or mental retardation, he or she lacks substantial capacity either (1) to appreciate the wrongfulness of his or her conduct, or (2) to conform his or her conduct to the requirements of law.

**VOLITIONAL ELEMENT RETAINED; MENTAL RETARDATION INCLUDED.** The volitional element is retained in the Family Code’s insanity defense, unlike in the Texas Penal Code applicable to adults from which it has been eliminated.

Also, under the Family Code insanity test for juveniles, the legislature has amended the statute’s original language to now incorporate the terms, “mental illness” and “mental retardation,” as the bases for a finding of lack of responsibility, unlike under the Texas Penal Code’s insanity test for adults, which still uses the antiquated terms “severe mental disease or defect.”

This contrast between the Texas Family Code and Texas Penal Code results in an anomalous situation in our state – a juvenile defendant will enjoy the benefit of an appropriate, effective, modern insanity test, while an adult defendant will have available only the inadequate old nineteenth century M’Naghten “right-wrong” test with all of its deficiencies that we have discussed previously.

In addition, it appears that a juvenile offender whose case is transferred to a criminal court (under the provisions of Section 54.02 of the Texas Family Code) will lose the substantial protections of the Family Code insanity test and be relegated to the inadequate old nineteenth century M’Naghten test set forth in the Penal Code.

It is fortunate indeed, of course, that the Texas Family Code has retained the better test, but it is to be hoped that the Texas Legislature will one day restore the volitional element of that test
to the Texas Penal Code, so that the adult insanity defense will again be the same one that was originally contained in the 1973 version of the Texas Penal Code. Other possible alternatives are discussed in Subchapter C of this Chapter.

**DISPOSITION FOLLOWING ACQUITTAL BY REASON OF INSANITY (LACK OF RESPONSIBILITY FOR CONDUCT).** As in the case of adult criminal defendants, success in employing the insanity defense does not necessarily mean that the juvenile defendant is immediately set free. The Family Code contains provisions for determining whether a juvenile defendant acquitted by reason of insanity (found to be not responsible for his or her conduct) is in need of psychiatric treatment.

Sec. 55.52. PROCEEDINGS FOLLOWING FINDING OF LACK OF RESPONSIBILITY FOR CONDUCT. (a) If the court or jury finds that a child is not responsible for the child’s conduct under Section 55.51, the court shall:

1. if the lack of responsibility is a result of mental illness or mental retardation:
   1. provided that the child meets the commitment criteria under Subtitle C or D, Title 7, Health and Safety Code, order the child placed with the Texas Department of Mental Health and Mental Retardation [sic] for a period of not more than 90 days, which order may not specify a shorter period, for placement in a facility designated by the department; or
   2. on application by the child’s parent, guardian, or guardian ad litem, order the child placed in a private psychiatric inpatient facility for a period of not more than 90 days, which order may not specify a shorter period, but only if the placement is agreed to in writing by the administrator of the facility; or
2. if the child’s lack of responsibility is a result of mental illness and the court determines that the child may be
adequately treated in an alternative setting, order the child to receive treatment on an outpatient basis for a period of not more than 90 days, which order may not specify a shorter period.

(b) If the court orders a child placed in a private psychiatric inpatient facility under Subsection (a)(1)(B), the state or a political subdivision of the state may be ordered to pay any costs associated with the child's placement, subject to an express appropriation of funds for the purpose.

INFORMATION TO BE PROVIDED TO FACILITY; REPORT TO THE COURT. If the juvenile court issues a placement order under Section 55.52(a), then Section 55.54(a) of the Family Code requires the juvenile court to order the probation department to send copies of any information in the possession of the department and relevant to the issue of the child's mental illness or mental retardation, to the public or private facility or outpatient center, as appropriate.

Section 55.54(b) of the Family Code requires that not later than the 75th day after the date the court issues a placement order under Section 55.52(a), the public or private facility or outpatient center, as appropriate, must submit to the court a report that (1) describes the treatment of the child provided by the facility or center, and (2) states the opinion of the director of the facility or center as to whether the child is mentally ill or mentally retarded. The court must send a copy of the report to the prosecuting attorney and the attorney for the child.

REPORT THAT CHILD IS NOT MENTALLY ILL OR MENTALLY RETARDED. Under the provisions of Section 55.55 of the Family Code, if a report submitted under Section 55.54(b) states that a child does not have a mental illness or mental retardation, then the juvenile court must discharge the child unless: (1) an adjudication hearing was conducted concerning conducted
that included a violation of a penal law listed in Section 53.045(a) of the Family Code and a petition was approved by a grand jury under Section 53.045; and (2) the prosecuting attorney objects in writing not later than the second day after the date the attorney receives a copy of the report under Section 55.54(c).

Section 53.045 of the Family Code, referred to above, is entitled “Violent or Habitual Offenders,” and cross-references the Texas Penal Code in listing a variety of serious offenses, including capital murder, murder, aggravated sexual assault, sexual assault, aggravated kidnapping, and aggravated robbery, among other offenses.

The language about a “petition” being “approved” by a grand jury under Section 53.045, of the Family Code, referred to above, means the procedure by which a petition alleging delinquent conduct can be referred by the prosecuting attorney to the grand jury if the petition alleges that the child engaged in delinquent conduct that constitutes habitual felony conduct or that included violation of any of the offenses listed in Section 53.045. Under the provisions of Section 53.045(b), a grand jury may “approve” such a petition by a vote of nine members of the grand jury, in the same manner that the grand jury votes on the presentment of an indictment.

The significance of “approval” of the petition is that if the court or jury finds that the child engaged in delinquent conduct that included violation of one or more of the offenses listed in Section 53.045, and if the petition was “approved” by the grand jury, then under the provisions of Section 54.04(d)(3), the court may sentence the child to commitment in the Texas Youth Commission with a possible transfer to the Texas Department of Criminal Justice for a term of up to 40 years, depending upon the seriousness of the crimes involved.
OBJECTION OF THE PROSECUTING ATTORNEY TO DISCHARGE; HEARING. On objection to discharge by the prosecuting attorney under Section 55.55(a), the juvenile court is required by Section 55.55(b) to hold a hearing without a jury to determine whether the child has a mental illness or mental retardation and whether the child meets the commitment criteria for civil commitment under Subtitle C (the Mental Health Code) or Subtitle D (the Persons With Mental Retardation Act), Title 7, of the Texas Health & Safety Code. At the hearing, by the provisions of Section 55.55(c) the burden is on the state to prove by clear and convincing evidence that the child has a mental illness or mental retardation and that the child meets the criteria for civil commitment under the Texas Health & Safety Code.

Section 55.55(d) provides that if the court finds the child does not have a mental illness or mental retardation, and that the child does not meet the civil commitment standards of the Health & Safety Code, then the court must discharge the child. But if the court finds that the child does have a mental illness or mental retardation and meets the civil commitment criteria referred to above, then under Section 55.55(e) the court must issue an appropriate commitment order.

REPORT THAT CHILD HAS MENTAL ILLNESS OR MENTAL RETARDATION; PROCEEDINGS FOR COMMITMENT. If the report submitted under Section 55.54(b) of the Family Code states that the child has a mental illness or is mentally retarded, then the juvenile court itself must initiate commitment proceedings under the provisions of Section 55.56 (as to mental illness) or Section 55.59 (as to mental retardation), or must refer the case to an appropriate court for the initiation of commitment proceedings under the provisions of Section 55.58 (as to mental illness) or Section 55.61 (as to mental retardation).
Sections 55.56 through 55.61 contain detailed, specific provisions for conducting the commitment proceedings for mental illness or mental retardation, as applicable, and include cross-references to the applicable commitment criteria and procedural provisions of the Texas Health & Safety Code.

Section 55.02 of the Family Code gives the juvenile court jurisdiction of commitment proceedings under the Texas Health & Safety Code for the purposes of ordering mental health or mental retardation services for a child or for commitment of a child as provided in the Family Code. The juvenile court has the option of conducting such commitment proceedings itself, or referring the case to an appropriate court for commitment proceedings to be conducted under the applicable provisions of the Texas Health & Safety Code.

**APPEAL.** Section 56.01(c) of the Family Code provides that an appeal may be taken by or on behalf of a child from an order entered under Chapter 55 by a juvenile court committing a child to a facility for the mentally ill or mentally retarded. Appeals from commitment orders entered by other appropriate courts than the juvenile court may be taken under the provisions of Section 574.070 of the Texas Health & Safety Code (for cases involving mental illness) and Section 593.056 of the Texas Health & Safety Code (for cases involving mental retardation).

**CONCLUSION.** As with the provisions of the Texas Code of Criminal Procedure regarding adult offenders who are acquitted by reason of insanity, the provisions of the Texas Family Code pertaining to the insanity defense for juvenile offenders are designed to protect both the public and the child who has been acquitted by reason of insanity. Appropriate procedures have been created in order to accomplish the goal of providing whatever
treatment may be needed by the acquitted child, as determined by a thorough evaluation of his or her individual condition, and at the same time to protect the general public.

**C. PROPOSALS FOR REFORM**

The public seems to pay little attention to criminal justice issues involving persons with mental illness until some person with mental illness is charged with committing a notorious crime. Without doubt, three Texas cases in recent years involving Andrea Yates, Deanna Laney, and Dena Schlosser are prime examples. Indeed, more than a quarter of a century after John Hinckley’s insanity acquittal following his attempt to assassinate former President Reagan, these high-profile cases are causing us to re-examine the proper formulation and moral underpinnings of the insanity defense. What is the impact of limiting the insanity test as Texas has done for many years? Andrea Yates, who had a long family history of serious mental illness, had twice previously attempted suicide and had been treated intermittently for her own mental illness. During her first trial in 2002, one psychiatrist identified her as “grossly psychotic” and another as one of the most ill individuals that she had ever treated. Charles Krauthammer, *Not Guilty, Insane*, Washington Post, Mar. 15, 2002, at A23. Through the symptoms and manifestations of her psychosis, Ms. Yates apparently felt compelled to kill her children to “save” them from some delusional belief of overwhelming evil. *Id.* See also *Yates v. State*, 171 S.W.3d 215, 216-18 (Tex. App.—Houston [1st Dist.] 2005, pet. ref’d) (providing a detailed

* Much of this section is excerpted and drawn from an article that one of the authors had published in 2007. *See* Brian D. Shannon, *The Time is Right to Revise the Texas Insanity Defense: An Essay*, 39 Tex. Tech L. Rev. 67 (2006-07). That article was actually an expansion on comparable material that we both prepared and included in a similar subsection in the third edition of this book.
description of Yates’ psychiatric history and long battle with serious mental illness). At the conclusion of the first trial, the jury rejected Yates’ insanity plea. The court of appeals reversed that conviction, however, because the state’s expert witness, Dr. Park Dietz, had provided false testimony that Ms. Yates’ actions in killing her children were “remarkably similar” to the plot of a “Law & Order” television episode, when “there was no ‘Law & Order’ television show with such a plot.” Id. at 221-22. Thereafter, in July 2006 a new jury in the re-trial of Andrea Yates returned a verdict of not guilty by reason of insanity. Unlike with the first jury, which had been “death-qualified” in the initial 2002 capital murder trial, the death penalty was off the table in the re-trial.

In April 2004, after the first Yates trial but before the second trial, a Tyler jury found Deanna Laney not guilty by reason of insanity after her trial that stemmed from her having bludgeoned her three sons with rocks in May 2003, killing two of the boys and causing profound brain damage to the youngest. See Lee Hancock, Driven by a Voice, Dallas Morning News, Apr. 18, 2004, at H1 (Laney claimed to have “beaten her three boys with stones on orders from God.”). Then, in February 2006, a jury deadlocked 10-2 on the issue of insanity after the first trial of Dena Schlosser, who had cut off the arms of her ten-month old daughter while suffering from psychotic religious ideations. Jennifer Emily, Plano Mom’s Trial is Ended; Mistrial Declared After 1 Juror Says He Won’t Change Mind on Guilt, Dallas Morning News, Feb. 26, 2006, at A1. After several months of “religious delusions and hallucinations, … she grabbed the largest knife in the kitchen and severed Maggie’s arms at the shoulders.” Jennifer Emily & Kim Horner, Series of Failures Doomed Baby: It Was No Secret that Dena Schlosser Suffered from Postpartum Psychosis, So Why Wasn’t Maggie Saved?, DALLAS MORNING NEWS, Mar. 19, 2006, at 1A. A second trial, before the judge and lasting approximately five minutes, ended in a verdict of not guilty by reason of insanity.

All three of these women were seriously mentally ill. Both Yates and Laney were “devout home-schooling moms” with substantial delusions about God and religion. *See* Lee Hancock, *supra*. Similarly, Schlosser “experienced religious delusions and hallucinations.” Jennifer Emily & Kim Horner, *supra*. Of course, the legal test for insanity in Texas is very different from and much narrower than a medical diagnosis of a serious mental illness coupled with conduct stemming from delusional beliefs.

Given that all three of these cases eventually ended in findings of not guilty by reason of insanity, the reader might ask whether there really is any need to consider changes to the Texas insanity defense. Perhaps it is indeed working as it is intended. But, consider some of the underlying circumstances in these three cases. In the Andrea Yates case, the verdict of not guilty by reason of insanity was not returned until after two trials and more than five years following the underlying tragic deaths. In the Deanna Laney case, all five of the medical experts – even the State’s witnesses – agreed that Ms. Laney met the Texas test for legal insanity. And, in between the first and second trials of Dena Schlosser, doctors discovered an inoperable brain tumor in addition to her mental illness diagnosis.

These tragic cases involving defendants with severe psychoses have served to illustrate that the Texas insanity defense bears no apparent relationship to modern understandings about serious mental illness. Contrary to popular myth, the defense is rarely invoked and seldom successful. Notwithstanding the ultimate results in these three cases, the Texas test, with its principal focus on the defendant’s knowledge of “right” versus “wrong,” is so narrow that it is often meaningless. Our law’s narrowly structured
focus on an accused person’s cognitive capacity should be reconsidered and revised. Acute symptoms of an untreated serious mental illness may leave an individual’s intellectual understanding and cognitive capacity relatively unimpaired, but can still affect the person’s emotions and reason to such a degree that the individual cannot completely or willfully comprehend the situation or control his or her behavior. Moreover, because the confines of the Texas version of the M’Naghten test can also restrict psychiatric testimony to the narrow area of a defendant’s cognitive capacity, the limited “right-wrong” test frequently makes it difficult or impossible for expert witnesses to place before the jury a complete picture of a defendant’s mental illness. Hence, the M’Naghten test can fail to aid the criminal justice system in identifying many defendants who suffer from acute symptoms of serious mental illness. In this subsection, we will raise and analyze several alternative options that would – if enacted – serve to modernize the Texas insanity defense to make it better comport with modern medical science and be a useful tool in the Texas criminal justice system. Plus, a more modern or appropriate test for insanity would provide meaningful guidance to prosecutors in ascertaining whether to pursue a conviction in a particular case or, instead, be more amenable to agreeing to an insanity finding with the likelihood of long-term, secure hospitalization.

**REPLACING “KNOW” WITH “APPRECIATE.”** There are various ways to reform the Texas insanity test. For example, the legislature could greatly improve current law by simply amending current Section 8.01 by substituting the term “appreciate” for “know” to be more consistent with federal law.¹ A

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¹ Under federal law, it is a defense to a crime if “at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts.” 18 U.S.C. § 17(a).
number of other states take this approach, as well. The term “appreciate” better reflects that the concept of cognition includes various layers of mental recognition beyond simple “knowledge.” Employment of the term has been “construed to permit inquiry into a broader range of mental functions, including perceptual distortion, errors in reasoning, and affective impairments, than were comprehended under the older focus on ‘knowing’ right from wrong.” Paul S. Appelbaum, Almost a Revolution 168 (Oxford 1994). Similarly, the American Psychiatric Association has expressed the view that such a standard “is one which the American Psychiatric Association believes does permit relevant psychiatric testimony to be brought to bear on the great majority of cases where criminal responsibility is at issue.” American Psychiatric Association, The Insanity Defense; Position Statement, at 6 (Dec. 1982). Accordingly, the following sets forth a possible narrow amendment to the current Texas insanity defense for adult offenders to replace the term “know” with “appreciate”:

Sec. 8.01. Insanity. (a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not appreciate know that his conduct was wrong.

Professor George Dix of the University of Texas Law School has advocated a further variation on this approach. He not only recommends replacing “know” with “appreciate,” but also urges that the term “wrong” “be defined as either legally wrong or morally wrong.” George E. Dix, Texas Must Refine Insanity Standard, San Antonio Express-News, Dec. 4, 2005, at 5H. This latter revision of Texas law would serve to trump the prior Texas case law discussed above in which the courts appear to have narrowly held that “wrong” for purposes of Texas law is limited to legal wrongs. As Professor Dix has argued, “This change would not make insanity cases like Yates’ simple ones. But it would tell
juries they must not reject defendants’ claims of insanity simply because the defendants retained some minimal ability to intellectually understand that their conduct was against the law.” *Id.* Such a revision to the statute would also provide prosecutors with greater leeway in making a determination as to whether to push for a conviction or agree that a defendant is legally insane if the facts warrant. For example, prosecutors pursued a conviction for capital murder against Dena Schlosser after she cut the arms off of her infant daughter while having psychotic hallucinations relating to her mental illness. Following the court’s final determination that Dena Schlosser was not guilty by reason of insanity – after the initial trial ended in a hung jury, Professor Dix commented that it was “unfortunate that the law is not clear enough to make Ms. Schlosser’s insanity evident to the state so that a trial would not be needed.” *See* Jennifer Emily, *supra*. Professor Dix further observed, “Had the law made clear that she was insane if – as a result of her impairment – she did not appreciate that cutting off her infant’s arms was morally wrong, I don’t see how a prosecutor could have justified pressing for trial.” *Id.*

A change from “know” to “appreciate” – coupled with the Dix proposal – would represent a substantial improvement over current law. It would recognize that the concept of cognition is not limited to a person’s simple awareness of surrounding circumstances, and that the concept of wrongfulness includes a moral component. In fact, during the 2007 legislative session, a bill would have made these very changes. As passed by the House Committee, H.B. 2795 would have provided the following:

**Sec. 8.01. Insanity.** (a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not appreciate that the actor’s conduct was legally or morally wrong.

231
The bill passed out of committee but died in the final days of the session when much of the focus of the House was on the challenge to the Speaker’s leadership. During the House Criminal Jurisprudence Committee’s hearing on the bill, the committee heard favorable testimony from George Parnham (Andrea Yates’ attorney) and two of the jurors from Yates’ trials. It is expected that this bill will be introduced again during the 2009 legislative session, and legislators should give it strong consideration.

**RESTORING A NARROW VOLITIONAL PRONG TO THE TEXAS TEST FOR ADULT OFFENDERS AND CHANGING THE TERM “KNOW” TO “APPRECIATE.”**

Another possibility is to restore a volitional component for adult offenders as under both former law and the current Texas statute for juveniles. Despite the rush to abandon the volitional prong nationwide following the Hinckley verdict, some concerns were raised along the way. The ABA, for example, acknowledged that its position was not based on empirical investigation, and emphasized that its preference for a narrow insanity test was not based on any findings that there had been any systematic abuse of the ALI standard. AMERICAN BAR ASSOCIATION CRIMINAL JUSTICE MENTAL HEALTH STANDARDS § 7-6.1 cmt. at 342 (1989). Indeed, Professor Perlin has asserted that the volitional prong was abandoned “without any consideration of the empirical studies then widely available as to the impact or wisdom of such a change,” and that the elimination of the volitional prong would most likely exclude defendants with treatable, mental illnesses of biologic origin. MICHAEL L. PERLIN, LAW & MENTAL DISABILITY 574 (1994).

Advocacy groups that support appropriate treatment for persons with mental illness have called for restoration of a two-prong insanity standard to include a volitional component. For
example, at the national level NAMI “supports the retention of the insanity defense and favors the two-prong test that includes volitional as well as the cognitive standard.” NAMI, The Criminalization of People with Mental Illness, available at http://www.nami.org/update/unitedcriminal.html. Similarly, the Mental Health Association in Texas has also urged that changes be made in Texas law so that “[d]eterminations of a defendant’s sanity should not rest solely on whether the defendant knew right from wrong in the legal sense.” Legislative Platform Adopted by the Mental Health Association in Texas, THE MENTAL HEALTH ADVOCATE (Mental Health Assoc. in Texas), Winter 2002, at 6. That organization has further commented “that Texas’ insanity defense should be revised to reflect more accurately the impact and effect of serious mental illnesses.” Id.

Even Professor Bonnie in his influential articulation of grounds for eliminating the volitional prong, observed that “[t]he volitional inquiry probably would be manageable if the insanity defense were permitted only in cases involving psychotic disorders.” Richard J. Bonnie, The Moral Basis of the Insanity Defense, 69 A.B.A. J. 194, 196 (1983). The situations in Yates, Laney, and Schlosser underscore that sentiment. It is time to make the Texas insanity defense more consistent with modern medicine. Psychiatric diagnostics have improved dramatically since the time of the Hinckley trial. Today we know far more about the medical aspects and neurobiological bases of serious mental illnesses and their symptoms and treatment than two or three decades ago. And, diagnostics are only going to improve. Future assessments and diagnoses will likely incorporate biological findings for many of the serious mental illnesses and major psychoses, and functional brain imaging will play an increasingly important role. Thus, the lack of a volitional component, particularly in situations in which the defendant was experiencing acute symptoms of a serious neurobiological mental illness, is inconsistent with and anathema
to the moral foundation of an insanity defense as it pertains to criminal responsibility.

What approach should the Texas Legislature consider adopting? One possibility is simply to amend the Penal Code to track the language of the current insanity defense for juveniles set forth in the Family Code. That would result in a restoration of an ALI standard to include both a cognitive test and a volitional prong. It would also serve to use more modern terms like “mental illness or mental retardation” as opposed to the current employment of the antiquated and stigmatizing language, “mental disease or defect.” A less sweeping alternative would be to enact an approach that adds a volitional alternative, but only for persons with diagnosable serious mental illnesses. This would clearly exclude other types of situations with volitional components such as compulsive gambling or certain sexual offenses. In addition, the legislature could couple these changes with the modifications described in the foregoing subsection. Accordingly, the following sets forth a possible amendment to the current Texas insanity defense for adult offenders to add a narrowly cabined volitional prong and to replace the term “know”:

Sec. 8.01. Insanity. (a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor,
(1) as a result of severe mental disease or defect, did not appreciate that the actor’s conduct was legally or morally wrong, or
(2) lacked substantial capacity to conform the actor’s conduct with the requirements of the law because the actor was experiencing psychotic symptoms of a serious mental illness such as schizophrenia, bi-polar disorder, schizoaffective disorder, or other major psychotic disorder diagnosed through accepted scientific criteria.
(b) The term “mental disease or defect” does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct.
INFORMING JURORS. In addition to the foregoing proposals, other revisions merit consideration. The legislature should amend Texas law to authorize the court to provide a dispositional instruction to jurors regarding the consequences of an insanity verdict. As discussed above, under Texas law the jury may not be informed of the potential consequences of a finding of not guilty by reason of insanity. Specifically, Article 46C.154 of the Texas Code of Criminal Procedure provides the following:

The court, the attorney representing the state, or the attorney for the defendant may not inform a juror or a prospective juror of the consequences to the defendant if a verdict of not guilty by reason of insanity is returned.

Thus, Article 46C.154 prohibits the court and the attorneys from informing jurors or prospective jurors of the consequences to the defendant if they return a verdict of not guilty by reason of insanity. The ostensible purpose of this provision is to prevent the jurors, if possible, from being influenced in their deliberations by the consequences to the defendant of their decision. Although courts have held that this provision does not deny fundamental fairness to the defendant, this provision is extremely troubling. See, e.g., Zwack v. State, 757 S.W.2d 66, 69 (Tex. App.–Houston [14th Dist.] 1988, pet. ref’d); Robison v. State, 888 S.W. 2d 473, 477 (Tex. Crim. App. 1994), cert. denied, 515 U.S. 1162 (1995) (citing Zwack and holding that there was no constitutional infirmity); Shannon v. United States, 512 U.S. 573, 575 (1994) (federal insanity law does not require trial court to instruct the jury on the consequences of an insanity determination). However, if we trust our juries sufficiently to make determinations as serious as making findings to support the imposition of the death penalty, why not trust them with the knowledge that secure hospitalization is the
likely result when a person is found not guilty by reason of insanity?

Even though information regarding the likely consequences of an insanity acquittal is irrelevant to the central question of a person’s mental state at the time of the offense in question, guidance of this nature is necessary for a jury to make a knowledgeable and informed decision about the insanity defense. A typical juror is likely acting under the incorrect impression that a person who is acquitted on the basis of insanity will immediately walk free from the courtroom, as would a person who is otherwise acquitted. No doubt there is a lack of awareness on the part of most jurors that lengthy hospitalization is a likely result in Texas in most cases in which the insanity defense has been invoked. Moreover, despite a tremendous growth in knowledge and awareness over the last ten to fifteen years regarding serious mental illnesses, the range and depth of psychoses, new varieties of successful treatments, and the dangers of non-treatment, there are still many myths about mental illness and a substantial amount of stigma. The Texas Court of Criminal Appeals has observed that “[t]he rationale for providing such an instruction [regarding the consequences of an insanity acquittal] is persuasive, that is, such an instruction prevents confusion by jurors and prevents jurors from finding an individual guilty where the clear weight of the evidence indicates the defendant was insane at the time of the commission of the offense.” Robison v. State, 888 S.W.2d at 477 (emphasis added). In Robison the court rejected a constitutional challenge to the statutory bar on informing jurors of the likely consequences of an

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2 Although the Deanna Laney jury ultimately found Ms. Laney not guilty by reason of insanity, the jurors “wrestled for hours over some jurors’ fears that Ms. Laney ‘was gonna walk’ if they returned an insanity verdict. The jury’s foreman said legislators could help by allowing jurors to ‘know the consequences’ of such a verdict and giving clear definitions to help lay people understand the law.” Lee Hancock, supra.
insanity acquittal determining that it was a “policy decision” that must “be left to the Legislature where they have spoken on such matters.” *Id.*

Advocacy groups have urged that the law should be changed to allow jurors to be better informed. For example, as part of calling for a “sweeping reexamination of the legal standards for insanity and how such cases are handled,” NAMI leaders urged the following:

At the very least, judges should be required to instruct juries … as to what will happen to a defendant found not guilty by reason of insanity: that they will be hospitalized in secure facilities for treatment, and if they ever recover sufficiently to return to the community, they will be subject to continued monitoring.

Statement of Richard Birkel, NAMI Nat’l Director, & Mark Hardwick, President, NAMI Texas, Don’t Kill Andrea Yates: Change the Law Instead (March 14, 2002), available at [http://www.nami.org/pressroom/20020314.html](http://www.nami.org/pressroom/20020314.html). Similarly, the Mental Health Association in Texas has urged that our legislation be revised so that jurors in insanity defense cases will “be told what the implications of a verdict of not guilty by reason of insanity are.” *Legislative Platform, supra* at 6.

The ABA has concluded that a “court should instruct the jury as to the dispositional consequences of a verdict of not guilty by reason of mental nonresponsibility [insanity].” *ABA Standards, supra* at § 7-6.8. Although recognizing the arguments previously made in Texas and other jurisdictions asserting that to inform juries about the consequences of an insanity verdict “may distort the decisionmaking process” and potentially lead to compromise verdicts, the ABA has taken a contrary view. The ABA expressed
concern that “jurors who are not informed about dispositional consequences will speculate about the practical results of a nonresponsibility verdict and, in ignorance of reality, will convict persons who are not criminally responsible in order to protect society.” Id. at 381. The ABA concluded that an instruction was “the most sensible approach given the potential for prejudice otherwise,” and observed the following:

Particularly in cases in which defendants are charged with violent crimes (which is usually the case if the nonresponsibility issue is tried to a jury, as opposed to a judge), juries need to be told about the effect of a finding of mental nonresponsibility [insanity] if the possibility of a serious injustice is to be avoided. The fear of compromise verdicts is misplaced. Jurors frequently are given instructions about lesser-included offenses which theoretically could as easily soften jury decisions but do not seem to do so in practice. Id.

Accordingly, regardless of the nature of any change to the substantive standard for insanity, the Texas Legislature should amend Article 46C.154 in the following manner:

The court shall instruct the jury on the consequences to the defendant if a verdict of not guilty by reason of insanity is returned.

This is a policy matter that is readily susceptible to this simple fix. In fact, during the 2007 legislative session, the same bill that would have changed “know” to “appreciate” – H.B. 2795 – would have enacted this change, as well. The effort should be undertaken once more in the next session. There is no reason to continue the current practice of “hiding the ball.” Why should we continue to
deliberately obfuscate matters for the jury? Jurors should not have to guess or speculate about the potential for treatment or whether the individual will continue to be detained in a secure setting. Even though such information is irrelevant to the central question of a person’s mental state at the time of the offense in question, the information is necessary for a jury to make a knowledgeable and informed decision about the insanity defense. The typical juror is likely acting under the impression that a person who is acquitted on the basis of insanity will immediately walk free from the courtroom, as would a person who is otherwise acquitted. No doubt there is lack of awareness on the part of most jurors that lengthy hospitalization is a likely result in Texas and elsewhere in most cases in which the insanity defense has been invoked.

THE OREGON APPROACH. Another formulation of the insanity defense that merits consideration is the approach that has been codified in Oregon. The Oregon insanity defense is essentially the ALI two-pronged model, with both cognitive and volitional tests, but with a significant twist. Instead of identifying the prospective verdict as “not guilty by reason of insanity,” the Oregon law styles the defense and potential jury verdict as “guilty except for insanity.” Or. Rev. Stat. § 161.295. Specifically, the Oregon statute provides:

(1) A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.
(2) As used in [this statute] …, the terms “mental disease or defect” do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor do they include any abnormality constituting solely a personality disorder.
In turn, Or. Admin. Reg. 859-010-0005, further defines “mental disease” and “mental defect” as follows:

(4) “Mental Disease”. Mental disease is defined as any diagnosis of mental disorder which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning and is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM IV) of the American Psychiatric Association.

(5) “Mental Defect”. Mental defect is defined as mental retardation, brain damage or other biological dysfunction that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning and is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM IV) of the American Psychiatric Association.

There are significant differences between the Oregon statute and a typical insanity defense provision or comparable statute. The most obvious, of course, relates to nomenclature. Given the long history of misinformation and ignorance about both the insanity defense and serious mental illness, there may be a greater willingness on the part of jurors (and legislators) to embrace a verdict that includes the word “guilty” in contrast to “not guilty” for conduct that would ordinarily result in culpability. Moreover, the Oregon statute is not a “guilty but mentally ill” law, which requires incarceration as with any other criminal conviction. Instead, persons who are found “guilty except for insanity” under Oregon law are placed under the jurisdiction of that state’s Psychiatric Security Review Board (PSRB), and generally are placed at the Oregon State Hospital for treatment and later supervised, conditional release. Or. Rev. Stat. § 161.327. See also Mental Health Law in Oregon: A Guide for Consumers and Families – Guilty Except for Insanity (GEI) & Psychiatric Security Review Board (PSRB) Jurisdiction Under Oregon State Law
Accordingly, the statutory structure in Oregon requires long-term treatment and supervision of the affected individuals through a hospital system, and not the state’s prison system. In addition, once a defendant in Oregon has been found “guilty except for insanity,” the person is placed under the jurisdiction of the state’s PSRB for the maximum period for which the individual could have been sentenced upon a finding of “guilty.”

Although the Oregon statutes are somewhat extensive, the Oregon Advocacy Center (Oregon’s version of Advocacy, Inc.) has summarized the PSRB process as follows:

The PSRB was created by the Oregon legislature in 1977 to supervise persons who successfully use the insanity defense. The PSRB has five members including a psychiatrist, a psychologist, a member with a parole or probation background, an attorney with criminal trial experience and a member of the public. PSRB supervision lasts from the day a person is placed under PSRB jurisdiction until the person is discharged or the maximum sentence ends.

A person who is found GEI will usually go to Oregon State Hospital (OSH) in Salem. The person will be in the forensics program at OSH. The forensics program has high and medium security wards and some less restrictive housing for persons close to release.

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After a person goes to OSH, the PSRB must hold a hearing within 90 days to decide if the person should stay in the hospital. After the initial hearing, a person can apply for discharge or conditional release no more than once every six months. The PSRB must hold a hearing within 60 days of the application, except for the first request which does not have to be sooner than 90 days after the initial hearing. … The hospital superintendent also can ask the PSRB to conditionally release or discharge a person. In this case, the PSRB must hold a hearing within 60 days of receiving the application. The PSRB must hold a hearing for each person under its supervision at least every two years, even if no one asks for a hearing.

A person has the right to have an attorney to represent him or her in most PSRB matters. If a person cannot afford an attorney, one will be appointed. …

A person can be conditionally released from the hospital if the PSRB approves a community release plan. A person on conditional release is still under PSRB supervision while in the community and can be returned to the hospital (“revoked”) for breaking any conditions of the release or if the person's mental illness cannot be controlled in the community. PSRB conditions for release often include some or all of the following:

- Mental health treatment and supervision
- An individual who agrees to report to the Board about the person's status and who will notify the PSRB of any violations of the conditions of release
- Housing arrangements
• Other conditions including no alcohol or drugs, random drug screen tests, no use of firearms, and no driving


Over the years, studies have revealed “a low criminal recidivism rate for insanity acquittees on conditional release” under the Oregon PSRB system. See Grant H. Morris, Placed in Purgatory: Conditional Release of Insanity Acquittees, 39 Ariz. L. Rev. 1061, 1071 (1997) (summarizing several studies) (also observing that conditional release was revoked in Oregon “most frequently when patients did not comply with their treatment program or violated some other condition of their conditional release plan, suffered a deterioration in mental condition, or exhibited signs of dangerousness”). Dr. Paul Appelbaum has observed that the Oregon PSRB “is the most extensively studied posttrial [sic] reform model” and that “the close follow-up and the ability to rehospitalize acquittees rapidly that characterize the Oregon system appear to have had a substantial positive effect.” Paul S. Appelbaum, supra, at 186.

As described above, prior to the 2005 legislative session, the Texas Senate Jurisprudence Committee conducted a review of the insanity defense and considered the prospect of a “guilty, but insane” verdict as a possible replacement for the current standard. A number of states have enacted statutes that either replace the “insanity defense” with a GBMI verdict, or add a GBMI alternative. These GBMI statutes, unlike the Oregon approach, function virtually identically to “guilty” verdicts and result in incarceration. An individual found GBMI can be sentenced to life in prison or even to death. Indeed, “GBMI laws have been widely criticized by legal and psychiatric groups ranging from the American Bar Association to the American Psychiatric Association.” Lee Hancock, By Reason of Insanity, DALLAS 243
MORNING NEWS, April 25, 2004, at H1. As Dr. Howard Zonona, a noted psychiatrist from Yale who has headed up the American Academy of Psychiatry and the Law, has observed, “GBMI is a farce in that it is no different from a guilty verdict. It doesn’t offer any specific treatment. It doesn’t offer anything different from going to jail and getting whatever any other prisoner would get.” Id. Thus, a verdict of GBMI is not functionally any different from a “guilty” verdict and does not guarantee any psychiatric treatment. Accordingly, it is good that the Texas Senate committee rejected the use of a GBMI verdict, but unfortunate that the very different Oregon approach drew little attention.

In addition, because the Texas insanity defense is so extremely narrow, for all practical purposes we already have a variation of a GBMI verdict. That is, our defense is so narrow that it borders on being non-existent. Typically, in cases in which the issue is aggressively contested by the prosecution, there is an extremely limited chance of a defendant’s successfully pleading the insanity defense. There are rare exceptions, of course, such as in the Yates, Laney, and Schlosser cases. Yet, in those cases the facts regarding the defendant’s underlying conduct and symptoms of mental illness have tended to be extreme. For example, and as described above, in the Laney case, all five medical experts – even those hired by the prosecution – agreed that she met the standard for legal insanity. Both the Yates and the Schlosser cases, despite their horrific facts, required two trials each. Separate from such rare cases, the typical situation in Texas in which the insanity defense is “successful” is when the prosecution makes a determination not to contest the plea strenuously.

Beginning with a public hearing before the Senate Jurisprudence Committee in the late spring of 2004, NAMI-Texas began advocating the replacement of the insanity defense in Texas with a variation of the current law in Oregon. This effort was then
pursued during the 2005 legislative session. The proposal urged that the name of the Texas defense be changed from “not guilty by reason of insanity” to “guilty except for mental illness.” Similar to Oregon’s statute, this approach, were it to be enacted, would relieve jurors from having to grapple with the intuitively challenging concept of finding a person not guilty for certain bad acts unquestionably committed by that defendant. Moreover, like under current Oregon law, the proposal called for treatment and hospitalization (generally within a secure hospital setting), not incarceration, to follow a jury finding of “guilty except for mental illness.” Plus, similar to Oregon law, under the proposal the state would have retained jurisdiction over an individual found to be “guilty except for mental illness” for the full period of the criminal sentence.

The proposal went nowhere in the 2005 legislative session, and has not been pursued further. However, it is interesting to note that following the verdict in the second Yates trial in late July 2006, USA Today editorialized in favor of the Oregon approach. Yates Verdict Reflects a Healthy Evolution, USA Today, July 28, 2006, at 12A. And, ironically, the jury foreman in the second Andrea Yates trial stated after the verdict that “the group had ‘some emotional difficulty’ in reaching its unanimous verdict and would have had an easier time if they could have found her ‘guilty but insane.’” Yates Committed to North Texas Hospital, Dallas Morning News, July 27, 2006, available at http://www.dallasnews.com/sharedcontent/dws/dn/latestnews/stories/072806dntyates.9aa8de.html.

This type of alternative should merit further study in future legislative sessions. S.B. 837’s enactment of Chapter 46C did an admirable job of establishing clear guidelines and greater authority for courts with regard to the supervision, oversight, treatment, and release of individuals found not guilty by reason of insanity.
Unfortunately, however, given the extraordinarily narrow scope of the underlying standard for insanity, very few individuals will be subject to the enactment’s oversight, supervision, and treatment options. Most others – particularly in cases in which the prosecution contests the insanity defense – will continue to be found guilty and then be sentenced to prison terms (or death), with no guarantee of follow-up mental health treatment. Regardless of which test for insanity is employed, the Oregon approach of converting the name of the defense from “not guilty” to “guilty” – when coupled with the follow-on supervision, oversight, and treatment approaches within the state’s mental health system as recently enacted in S.B. 837 – offers an intriguing alternative that has worked elsewhere and could improve current Texas law.

**SUMMARY.** Regardless of the array of possible reforms discussed above, the Texas Legislature should enact revisions to the Texas insanity defense for adult offenders to better comport our law with the medical understanding of the typical symptoms of untreated serious mental illness. We are not advocating a “get out of jail free” approach, but rather the use of secure hospitalization and treatment alternatives for such defendants following a criminal proceeding that involves appropriate and modern legal standards.

Separate and apart from the issues surrounding the criminal justice aspects of the insanity defense, we must continue to focus on improving our mental health treatment system. Think of the tragedies, including the horrific Yates, Laney, and Schlosser cases, in which serious human consequences might have been avoided had there been proper, timely, adequate, and ongoing treatment. Indeed, we now know that serious mental illnesses are generally treatable, particularly with the array of modern and newer generation medications that are available. We should be striving to make current and appropriate treatments available for such neurobiological diseases and assure continuity of care. If we as a
society continue to neglect, fail to prioritize, and under-fund the needs of our at-risk citizens with serious mental illnesses, however, the criminal justice system will continue to be overburdened with persons who might have been successfully treated in the community prior to any overlap with criminality. Although the insanity defense can be and should be improved, the need for its utilization can be lessened with early diagnoses and appropriate treatment for persons with serious mental illnesses.

VI. POST-CONVICTION ISSUES

As described above, the Texas insanity defense as currently crafted is quite narrow. Moreover, competency proceedings generally merely postpone criminal proceedings, rather than preclude them. Consequently, many thousands of Texans suffering from serious mental illnesses are convicted of crimes and incarcerated. Of course, notwithstanding any criminal conviction, an offender with a mental illness will continue to have a need for proper medical and psychiatric treatment subsequent to the criminal proceedings. In addition, other convicted offenders will be stricken or diagnosed with mental illness for the first time subsequent to their criminal convictions. These offenders will also have treatment needs for their mental illnesses. Several different possibilities exist under Texas law concerning mental health treatment subsequent to conviction for offenders with mental illness.

A. COMMUNITY SUPERVISION

As part of a major overhaul of the state’s criminal justice system, the Texas Legislature amended Article 42.12, Texas Code of Criminal Procedure, in 1993 to create the prospect that the
criminal courts may place certain convicted defendants on “community supervision.” Subsequent to the 1993 amendments, Article 42.12 has defined “community supervision” as follows:

“Community supervision” means the placement of a defendant by a court under a continuum of programs and sanctions, with conditions imposed by the court for a specified period during which:

(A) criminal proceedings are deferred without an adjudication of guilt; or
(B) a sentence of imprisonment or confinement, imprisonment and fine, or confinement and fine, is probated and the imposition of sentence is suspended in whole or in part.

TEX. CODE CRIM. PROC. ANN. Art. 42.12 § 2(2). Prior to this consolidation, the pertinent legislation treated these concepts of deferred adjudication and probation as separate legal matters.

The 1993 amendments to the Texas Code of Criminal Procedure relating to community supervision have special significance for offenders with mental illness. For example, with respect to deferred adjudication, Section 5 of Article 42.12, Texas Code of Criminal Procedure, provides that, except for certain offenses,

when in the judge’s opinion the best interest of society and the defendant will be served, the judge may, after receiving a plea of guilty or plea of nolo contendere, hearing the evidence, and finding that it substantiates the defendant’s guilt, defer further proceedings without entering an adjudication of guilt, and place the defendant on community supervision.

TEX. CODE CRIM. PROC. ANN. Art. 42.12 § 5(a). This aspect of the statute did not represent any substantial change over prior law.
More significantly, however, for offenders with mental illness, since 1993 the amended statute has authorized the judge to require any reasonable conditions of community supervision, including mental health treatment under Section 11(d) of this article, that a judge could impose on a defendant placed on community supervision for a conviction that was probated and suspended, including confinement.

_Id._ (emphasis added). Accordingly, Article 42.12 permits a court to defer an offender’s adjudication of guilt upon a guilty plea or plea of nolo contendere (no contest), yet condition the use of community supervision on the defendant’s obtaining mental health treatment.

If the judge opts to grant a deferral of adjudication, the period of community supervision can be for up to ten years for felonies and a maximum of two years for misdemeanors (although these limits can be extended in certain circumstances). Significantly, at the successful conclusion of the period of community supervision, the judge must dismiss the criminal charges. Additionally, the judge has the discretion to end the period of community supervision and dismiss the charges at an earlier time. Except in certain narrow situations (such as a later conviction for a comparable offense), ultimate dismissals resulting from deferred adjudication and the requisite community supervision are not deemed to be criminal convictions under the law. Accordingly, in most cases the criminal offender’s criminal record is effectively purged upon the successful completion of all community supervision. Thus, the potential advantages stemming from a deferred adjudication should provide a strong incentive for compliance with any specified mental health treatment conditions. Moreover, the courts should take advantage of the specific authorization contained in Section 5 of Article 42.12, Texas Code

249
of Criminal Procedure, allowing them to make mental health treatment a condition of deferred adjudication in appropriate cases. This could result in diverting many mentally ill offenders into appropriate treatment settings. The possibility of mental health treatment conditions should be a key factor in plea negotiations involving offenders with mental illness.

Under the Code of Criminal Procedure, a judge is not limited to granting community supervision only in cases in which adjudication has been deferred following a guilty plea or plea of nolo contendere. Community supervision is also available in connection with the probating or suspending of an offender’s sentence after a conviction, a guilty plea, or a nolo plea. (If a jury has convicted the offender, the jury may also recommend community supervision in lieu of confinement in many situations.) Unlike cases involving a deferral of adjudication, in which the offender’s criminal record can be purged following successful completion of the required period of community supervision, community supervision as part of the suspending or probating of a sentence does not clear the offender’s record. Nonetheless, community supervision will often be a desirable alternative to incarceration. Just as in cases involving deferred adjudication, the Code of Criminal Procedure specifically authorizes judges to require certain offenders with mental illness to submit to outpatient or inpatient mental health treatment as a condition of community supervision stemming from probated or suspended sentences. TEX. CODE CRIM. PROC. ANN. Art. 42.12 § 11(d).

Section 11(d) of the Code of Criminal Procedure was first enacted in 1993 and was modified in 1997 (to extend the section to offenders with mental retardation). The provision, which authorizes a court to impose a mental health treatment condition on the placing of a defendant on community supervision – whether as part of deferring an adjudication or probating a sentence –
represents a significant attempt by the Texas Legislature to divert many offenders with mental illness out of the prison and jail system. To assure that such a treatment condition will be imposed only with respect to appropriate offenders, Section 11(d) of the statute delineates the following parameters:

(d) If the judge places a defendant on community supervision and the defendant is determined to have a mental illness or be a person with mental retardation by an examining expert under Article 16.22 or Chapter 46B of this code or in a psychological evaluation conducted under Section 9(i) of this article, the judge may require the defendant as a condition of community supervision to submit to outpatient or inpatient mental health or mental retardation treatment if the:

1. defendant’s:
   (A) mental impairment is chronic in nature; or
   (B) ability to function independently will continue to deteriorate if the defendant does not receive mental health or mental retardation services; and

2. judge determines, in consultation with a local mental health or mental retardation services provider, that appropriate mental health or mental retardation services for the defendant are available through the Texas Department of Mental Health and Mental Retardation under Section 534.053, Health and Safety Code, or through another mental health or mental retardation services provider.

TEX. CODE CRIM. PROC. ANN. Art. 42.12 § 11(d).

Thus, with regard to persons with mental illness, before a court may impose a mental health treatment condition on the placing of a defendant on community supervision, in general a mental health expert must have examined the offender pursuant to either Article 16.22 or Chapter 46B (described in detail in Chapters III and IV above). Moreover, the court must find either that the defendant’s mental illness is chronic in nature or that his or her ability to
function independently will continue to deteriorate without proper treatment. Finally, the statute requires the judge to take steps to assure that appropriate outpatient or inpatient mental health services are available either through a state facility or through another provider. (An additional section of the 1993 criminal justice reform legislation amended § 534.053(c), Texas Health & Safety Code, to require the state department, to the extent that resources are available, to “ensure that services listed in this section are available for defendants required to submit to mental health treatment under Article 17.032 or Section 5(a) or 11(d), Article 42.12, Code of Criminal Procedure.” TEX. HEALTH & SAFETY CODE ANN. § 534.053(c).

If an offender has a mental illness and the criteria in Subsection 11(d) of Article 42.12 are otherwise met, the court should give strong consideration to exercising its authority to condition the offender’s community supervision on the obtaining of mental health treatment. The primary purposes behind these 1993 amendments were to divert many mentally ill offenders out of the criminal justice system and to place them in more appropriate treatment settings. The legislative intent will be thwarted if courts decline to exercise the authority granted to them.

Subsection 11(d) also grants the court flexibility to require either inpatient or outpatient treatment for the offender’s mental illness. Accordingly, the court should exercise care in ascertaining the proper treatment setting. Moreover, given that other sections of Article 42.12 authorize the court to modify the conditions placed on an offender’s community supervision, the court retains the flexibility to amend the provisions of the mental health treatment conditions. For example, if the court initially mandates an inpatient treatment condition, the symptoms of the offender’s mental illness might improve considerably in a relatively short period of time. Consequently, the court could then modify the earlier order to
require outpatient treatment from that point forward. Treatment results will no doubt vary, and judges should recognize that these statutes afford a great deal of flexibility to tailor appropriate conditions of treatment for offenders with mental illness.

The Code of Criminal Procedure does not authorize a court to grant community supervision for all offenses. As described above, these statutes invest judges with substantial discretion regarding the determination of whether an offender may be placed on community supervision. Accordingly, an offender does not have a “right” to community supervision, and the granting of community supervision is not automatic. In addition, the statutes include other specific limitations on the granting of community supervision. For example, Section 5 of Article 42.12 does not allow a court to defer adjudication and place offenders on community supervision for several crimes in which the offender is intoxicated. TEX. CODE CRIM. PROC. ANN. Art. 42.12 § 5(d)(1)(A). (By way of example, these excluded offenses include driving, boating, and flying when intoxicated, as well as the inflicting of serious bodily injury or death during the course of an offender’s intoxicated driving, boating, or flying. Although community supervision by virtue of deferred adjudication is not available for these intoxication offenses, other provisions of Article 42.12 do permit community supervision with respect to such offenses as part of a probated or suspended sentence.) Other than a handful of statutory exceptions, however, the principal limitation on a judge’s ability to grant community supervision through deferral of adjudication is the judge’s duty to determine that community supervision is in the best interest of society and the defendant. For many offenders suffering from mental illness, both society and the defendant could be well served by the utilization of community supervision conditioned on a mental health treatment requirement.
In contrast to the narrow range of statutory exceptions to the granting of community supervision through deferred adjudication, Article 42.12 sets forth a larger array of exceptions to the employment of community supervision as part of suspending or probating an offender’s sentence. First, Section 3g of Article 42.12 specifically precludes a judge from granting community supervision through the suspension or probation of a sentence for several serious crimes. These offenses include murder, capital murder, indecency with a child, aggravated kidnapping, sexual assault, aggravated sexual assault, aggravated robbery, offenses committed within drug-free zones, and certain other felonies in which the offender either used or exhibited a deadly weapon (although for certain felonies involving firearms, the judge may grant community supervision after an initial incarceration of 60-120 days). TEX. CODE CRIM. PROC. ANN. Art. 42.12 § 3g. It is worth noting that this list of crimes set forth in Section 3g, for which community supervision through a probated or suspended sentence is not available, is actually less inclusive than the list of “violent offenses” delineated in Article 17.032, Texas Code of Criminal Procedure, for which a magistrate may not release an alleged offender with mental illness on a personal bond conditioned on mental health treatment (as described in Chapter III above). Nonetheless, both statutes are consistent in carving out certain offenses as a means of providing a level of protection to the public.

In addition to the specific offenses identified in Section 3g of Article 42.12, Subsection 3(e) of that statute provides that an offender is ineligible for community supervision, as an adjunct to a suspended or probated sentence, if the sentence involved exceeds ten years of imprisonment. TEX. CODE CRIM. PROC. ANN. Art. 42.12 § 3(e)(1). Similarly, Subsection 4(d) of Article 42.12 bars a jury from recommending community supervision if that jury’s

Another section of Article 42.12 – Section 15 – delineates the rules for community supervision for offenders adjudged guilty of state jail felonies. Of significance for offenders with mental illness who have been convicted of state jail felonies, Section 15 permits a judge to “impose any condition of community supervision on a defendant that the judge could impose on a defendant placed on community supervision for” other offenses. Id. § 15(c). Thus, just as for other offenses subject to the 1993 amendments to the Code of Criminal Procedure discussed above, the judge may condition a state jail felony offender’s community supervision on his or her obtaining inpatient or outpatient mental health treatment (provided the offender has a mental illness). Given that community supervision is available for state jail felony offenses, judges should give strong consideration to employing the mental health treatment condition as part of the community supervision for appropriate jail felony offenders suffering from mental illness.

Undoubtedly, the 1993 criminal justice reform legislation (with ensuing modifications) included a bold effort by the legislature to grapple with the difficult issues relating to criminal offenders who have serious mental illness. Now, many years later, courts should generally be willing to place such offenders on community supervision in appropriate cases, particularly given that the law has for over fifteen years authorized the imposition of mental health treatment conditions on the grant of community supervision.

Plea Bargains. As anyone generally familiar with the criminal justice system will acknowledge, the vast majority of criminal convictions are typically the result of bargained-for guilty pleas or pleas of nolo contendere. Legislation enacted and fine-tuned since 1993 that authorizes and encourages courts to divert offenders with
mental illness into inpatient or outpatient mental health treatment should enhance the prospects for negotiated pleas in such cases. One important matter should not be forgotten in cases involving such guilty pleas, however. As part of the general requirement that a defendant be competent to understand the proceedings against him or her, that defendant must also be sufficiently competent to comprehend the import of a guilty plea. If the alleged offender is so mentally ill as not to be presently competent, any guilty plea at that time would be suspect – even if the plea resulted in community supervision with a mental health treatment condition. Thus, for example, if an alleged offender with mental illness opts to plead guilty as part of attempting to secure community supervision through a deferred adjudication, defense counsel, the prosecution, and the court should take steps to assure that the defendant is presently competent. Of course, an offender with mental illness may be sufficiently stable to be competent for purposes of understanding the import of a guilty plea, yet still have ongoing mental health treatment needs. Given that the court must generally require an examination of the offender by a mental health expert before imposing a mental health treatment condition as part of the offender’s community supervision, the mental health expert may well have also evaluated the offender’s competency. Indeed, a typical form of examination authorized by Subsection 11(d) of Article 42.12 as a precursor to the imposition of any mental health treatment condition is an expert’s exam under the provisions of the criminal competency statute (Chapter 46B, Texas Code of Criminal Procedure, which is discussed in Chapter IV above).

B. PRISON OR JAIL MENTAL HEALTH CARE

MENTAL HEALTH TREATMENT IN PRISON OR JAIL. If a convicted offender with mental illness is not granted or does not otherwise qualify for community supervision as described
above, mental health treatment subsequent to conviction is administered through the auspices of the prison system or through programs provided by local jails.

**TEXAS PRISON SYSTEM HEALTH SERVICES POLICY MANUAL.** The Texas prison system, the official name of which is the Correctional Institutions Division of the Texas Department of Criminal Justice, provides mental health care on an inpatient basis under applicable provisions of its Correctional Managed Health Care Policy Manual.

Discussion of the numerous extensive and detailed provisions of the Manual is beyond the scope of this book. Even so, it is important to know that the mental health treatment given by the Texas prison system to convicted offenders is provided in accordance with the provisions of that Manual.

The Manual covers the health services provided to inmates by the Texas prison system, including topics such as initial mental health assessment, initial psychological assessment, psychological testing, and access to the care provided through the prison system’s mental health services.

The Manual deals with the referral of offenders to specialized treatment of various kinds, including psychiatric inpatient or crisis management, and covers consent for admission to inpatient psychiatric care, informed consent to mental health treatment, the right to refuse psychoactive medication for mental illness, release of information regarding mental health services, and forensic information through mental health services.

The treatment provisions of the Manual cover a wide variety of topics, including treatment planning, the prescribing of psychoactive drugs, psychiatric crisis management, use of
restraints with mental health patients, psychiatric inpatient seclusion, mental health evaluation of offenders in disciplinary segregation, and suicide prevention.

Other parts of the Manual cover the topics of discontinuation of outpatient mental health services, referral of mental health patients for consideration of temporary court commitment, inpatient mental health discharge processes, and various matters related to documentation of mental health services provided by the prison system.

**TEXAS CORRECTIONAL OFFICE ON OFFENDERS WITH MEDICAL OR MENTAL IMPAIRMENTS.** Chapter 614 of the Health & Safety Code pertains to the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), formerly known as the Texas Council on Offenders with Mental Impairments. The powers and duties of TCOOMMI are set forth in Section 614.007, Health & Safety Code, and include responsibility for determining the status of offenders with mental impairments in the state criminal justice system, identifying needed services for offenders with mental impairments, related tasks associated with monitoring and assisting with the evaluation and implementation of various aspects of programs, and disseminating information about such programs.

As set forth in the applicable part of these statutes, Section 614.013, Health & Safety Code, gives TCOOMMI the authority and responsibility to coordinate and monitor the development and implementation of a memorandum of understanding establishing the respective responsibilities of the Texas Department of Criminal Justice, the Department of State Health Services (DSHS), the Department of Public Safety, representatives of local mental health or mental retardation authorities appointed by DSHS, and the directors of community supervision and corrections departments,
for instituting a continuity of care and service program for offenders with mental impairments in the criminal justice system.

Some of TCOOMMI’s responsibilities were discussed in several of the foregoing chapters, and the agency is also discussed further in Subsection C of this Chapter, below.

C. COMPLETION OF THE CRIMINAL SENTENCE

Just as a mentally ill offender’s mental health treatment needs do not end upon a conviction, treatment will likely continue to be necessary once the offender completes the requisite prison term or is granted parole. Issues, including legal challenges, have arisen concerning the need for continuity of care for offenders with mental illness upon the conclusion of their incarceration. Similar to the need for proper discharge planning when an individual is released from a state mental hospital to a community setting, offenders with mental illness often require assistance in securing mental health treatment opportunities upon release from the prison system. We have seen a substantial increase in activity in this area of the criminal justice system over the last fifteen years, and a few such initiatives are described below.

Medically Recommended Intensive Supervision. Section 508.146, Texas Government Code, provides the following, in part:

(a) An inmate other than an inmate who is serving a sentence of death or life without parole may be released on medically recommended intensive supervision on a date designated by a parole panel described by Subsection (e), except that an inmate with an instant offense that is an offense described in Section 3g, Article 42.12, Code of Criminal Procedure, or an inmate who has a reportable conviction or adjudication under Chapter 62, Code of Criminal Procedure, may only be considered if a medical condition
of terminal illness or long-term care has been diagnosed by a physician, if:

(1) the Texas Correctional Office on Offenders with Medical or Mental Impairments, in cooperation with the Correctional Managed Health Care Committee, identifies the inmate as being:

   (A) elderly, physically disabled, mentally ill, terminally ill, or mentally retarded or having a condition requiring long-term care, if the inmate is an inmate with an instant offense that is described in Section 3g, Article 42.12, Code of Criminal Procedure; or

   (B) in a persistent vegetative state or being a person with an organic brain syndrome with significant to total mobility impairment, if the inmate is an inmate who has a reportable conviction or adjudication under Chapter 62, Code of Criminal Procedure; and

(2) the parole panel determines that, based on the inmate’s condition and a medical evaluation, the inmate does not constitute a threat to public safety; and

(3) the Texas Correctional Office on Offenders with Medical or Mental Impairments, in cooperation with the pardons and paroles division, has prepared for the inmate a medically recommended intensive supervision plan that requires the inmate to submit to electronic monitoring, places the inmate on super-intensive supervision, or otherwise ensures appropriate supervision of the inmate.

(b) An inmate may be released on medically recommended intensive supervision only if the inmate’s medically recommended intensive supervision plan under Subsection (a)(3) is approved by the Texas Correctional Office on Offenders with Medical or Mental Impairments.

(c) The parole panel shall require as a condition of release under Subsection (a) that the releasee remain under the care of a physician and in a medically suitable placement. At least once each calendar quarter, the Texas Correctional Office on Offenders with Medical or Mental Impairments shall report to the parole panel on the releasee’s medical and placement status. On the basis of the
report, the parole panel may modify conditions of release and impose any condition on the releasee that a panel could impose on a releasee released under Section 508.145, including a condition that the releasee reside in a halfway house or community residential facility.

This statute, which was first enacted in 1991 and subsequently amended in part, authorizes the possibility of an early release from incarceration for many crimes for certain inmates with mental illness (or other medical conditions delineated in the act), but subject to intensive medical supervision. Prior to 2001 amendments, the statute referred to such supervised release as “special needs parole.” Before such an inmate is released with the appropriate medical supervision, the parole panel must determine that the inmate with mental illness is not a threat to public safety. Also, the medical supervision plan must be coordinated with the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI). That agency has traditionally focused its resources toward those with the most serious medical problems. See TEX. COUNCIL ON OFFENDERS WITH MENTAL IMPAIRMENTS BIENNIAL REP. 18 (2007), http://www.tdcj.state.tx.us/publications/tcomi/Biennial%20Report%202007%20-%20Final.pdf.

Parole, in General. In addition to the intensive medical supervision provisions described above, another statute grants authority to parole panels to impose mental health treatment conditions in appropriate cases for offenders with mental illness. Section 508.221, Texas Government Code, provides that “a parole panel may impose as a condition of parole or mandatory supervision any condition that a court may impose on a defendant placed on community supervision under Article 42.12, Code of Criminal Procedure ....” As described in Subchapter VI-A above, Article 42.12 authorizes courts to impose mental health treatment
conditions as part of community supervision for certain offenders with mental impairments. The legislature has granted those same powers to the Board of Pardons and Parole.

**Continuity of Care.** In 1993, the Texas Legislature first enacted legislation relating to the continuity of care for offenders with mental illness (as well as inmates with other special needs) upon release from the prison system. With respect to offenders with mental illness, the legislation directed the Texas Department of Criminal Justice, the Texas Department of MHMR (now the Department of State Health Services), and various community mental health centers to “adopt a memorandum of understanding that establishes their respective responsibilities to institute a continuity of care and service program for offenders with mental impairments in the criminal justice system.” TEX. HEALTH & SAFETY CODE ANN. § 614.013(a). The legislation further requires these agencies to establish methods for (1) identifying offenders with mental impairments in the criminal justice system, (2) developing policies, rules, standards, and procedures for coordinating care for such persons and exchanging information, and (3) identifying necessary services for offenders with mental impairments to return to the community successfully. In addition, a comparable statute calls for a similar memorandum of understanding to be implemented by TCOOMMI, the Commission on Law Enforcement Officer Standards and Education, the Department of Public Safety, and the Commission on Jail Standards. TEX. HEALTH & SAFETY CODE ANN. § 614.016. These memoranda of understanding (MOUs) have been adopted and updated over the years since initial enactment. Similarly, Health & Safety Code § 614.013 requires comparable MOUs relating to continuity of care in local communities and directs the Departments of Criminal Justice, State Health Services, Public Safety, and community mental health authorities and local community supervision and corrections officials to establish and
delineate their respective roles and responsibilities as to offenders with mental impairments.

TCOOMMI has also operated and funded various community-based programs. One of these, which is of particular relevance to this subchapter, is a “continuity of care” program. That program is intended to identify offenders in state jails or prisons with mental illness (or other special needs) who will need post-release aftercare treatment. As one of the agency’s reports to the legislature states, “By identifying offenders who are in need of aftercare treatment prior to their release, the offenders’ chances for a more successful re-entry into the community are improved. This is particularly true for offenders who have a history of non-compliance due to mental health issues.” Tex. Council on Offenders with Mental Impairments Biennial Rep. 20 (2003); http://www.tdcj.state.tx.us/publications/tcomi/TCOMI-Biennial-Report 2003.PDF.

Once these offenders are identified, mental health treatment conditions can be imposed as part of the offender’s parole. The agency, in turn, has endeavored to contract with local mental health authorities for continuity of care services to be provided in the communities upon release. The contracted “workers develop pre-release plans” with services providers in the “community to which the inmate is scheduled to be released.” Id. Texas has been a leader in developing a continuity of care program specifically designed for offenders with special needs. And, the process is continually being re-examined and improved. For example, the agency revamped some of its procedures in 2006 in an effort to reach inmates who are discharged after their prison or state jail terms have expired – with no parole that could have treatment conditions. See Tex. Council on Offenders with Mental Impairments Biennial Rep. 16-17 (2007), http://www.tdcj.state.tx.us/publications/tcomi/Biennial%20Report%202007%20263


Indeed, tremendous strides have been made in the last fifteen years. The state, however, should not lose the initiative and must endeavor to avoid or limit the prospects of future criminal activity by continuing to ensure that these former offenders’ mental health treatment needs are addressed upon discharge or parole from prison or jail.