Emergency Detention in Texas:

Law, Practice, and Cross-System Coordination

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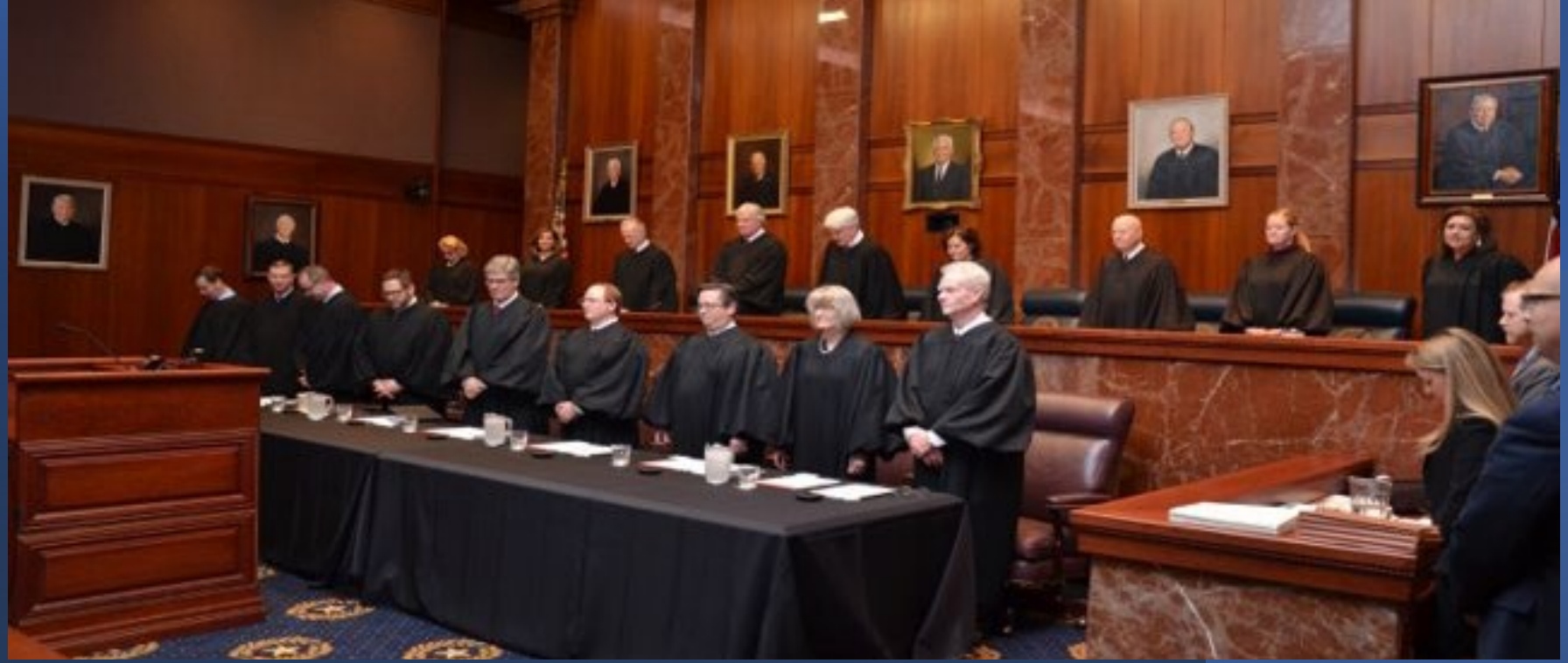
JCMH
Texas Judicial Commission on Mental Health



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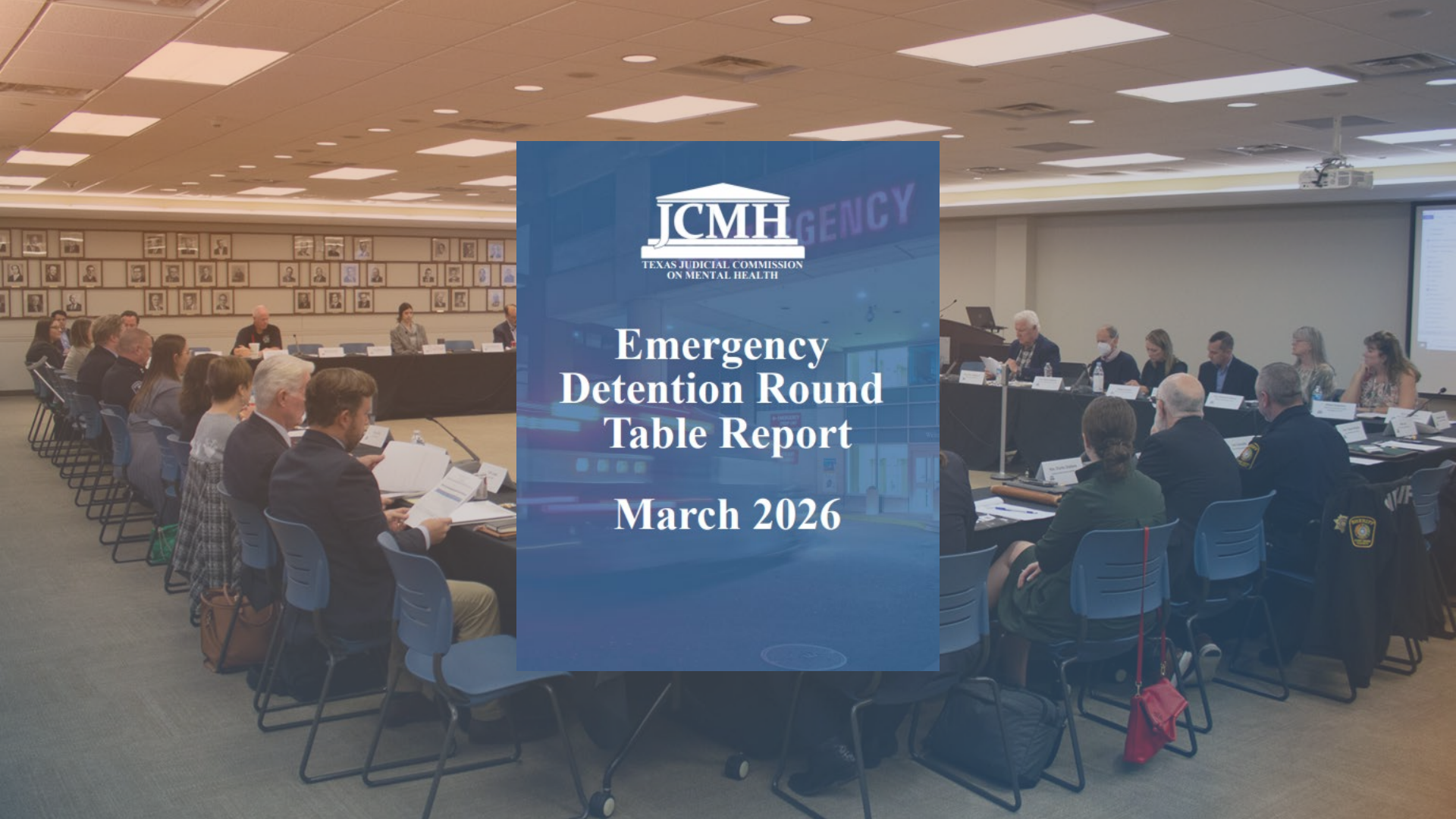

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TEXAS JUDICIAL COMMISSION ON MENTAL HEALTH

Emergency Detention Round Table Report

March 2026

What We'll Cover Today

1. The Root Problem: Resource Constraints Driving Everything
2. Issue: When Does Emergency Detention Begin?
3. Issue: The 12-Hour & 48-Hour Clocks—Running Out of Time
4. Issue: Where Can Law Enforcement Legally Take Someone?
5. Issue: The Handoff—When Can Officers Leave?
6. Issue: "Transport 2"—Who Arranges the Psychiatric Transfer?
7. Solutions That Are Working Now
8. Legislative Ask | Q&A

The Root Problem: It's About Resources

Most operational disputes are not caused by unclear law—they are caused by insufficient capacity.

Civil Psychiatric Bed Shortage

State hospitals are 75–80% forensic (competency restoration). Civil inpatient access depends on LMHA-purchased private beds — often oversubscribed.

Minimal Crisis Infrastructure

Crisis stabilization units, diversion centers, and MCOTs are underfunded and cannot treat complex medical conditions (bleeding, detox), so ERs become the default.

No Medical Exclusion Relief

Facilities have medical exclusionary criteria. When medical needs and psychiatric crisis co-occur, the system has no clear path—everyone gets stuck.

Outpatient Gap for Adults & Children

Insufficient outpatient treatment means crises escalate to emergency detention unnecessarily. Upstream prevention services are underfunded statewide.

IDENTIFIED ISSUES

Recurring problems documented statewide
by law enforcement, LMHAs, hospitals, and courts

Issue 1: When Does Emergency Detention Actually Begin?

Inconsistent answers cause downstream chaos:
wrong clocks, wrong custody assumptions, wrong paperwork.

Scenario 1

Voluntary Transport

Person agrees to go. No ED yet. Clock starts only if the person expresses intent to leave and officer initiates apprehension.

Scenario 2

Unconscious and Unable to Consent

EMS transports for medical care under implied consent. ED consideration begins only after patient is stabilized and criteria are met.

Scenario 3

Refusing / Apprehended

Officer apprehends person—ED begins immediately. All time at the facility, including time in the ER for medical care, counts against the 48-hour clock.

⚠ **Real tension: lengthy medical care can consume most of the 48-hour window before psychiatric evaluation begins.**

Issue 2: Running Out of Time/ The 12-Hour and 48-Hour Clocks

Apprehension
Hour 0

Preliminary Exam Due (12 hrs)
§ 573.021

Transfer to Psych Facility
Best case

48-Hour Deadline
Or OPC needed

What Goes Wrong

- Medical stabilization in the ER consumes hours before the psychiatric clock effectively starts, leaving insufficient time for placement.
- No statutory exception exists for lengthy medical treatment. The 48-hour window runs regardless.
- When time expires, hospitals must release individuals who may immediately repeat 911 calls.
- Order of Protective Custody (OPC) can extend the window, but in some counties, physicians refuse to do CMEs or prosecutors decline to file.
- Jurisdictions inconsistently apply when the 12-hour exam clock starts (at first contact/at formal apprehension).

Issue 3: Where Is Law Enforcement Legally Authorized to Take Someone?

Statutory Options (§ 573.001(d))

- Nearest appropriate inpatient mental health facility
- Mental health facility deemed suitable by the LMHA
- Transfer to EMS under an MOU for transport to above

In practice: state hospitals rarely accept civil Eds (75–80% forensic). LMHA-purchased private beds are often full or can only hold for 7-14 days.

The Emergency Room Debate

Some say ERs qualify:

- All hospitals have an identifiable part providing psych diagnosis & treatment
- Statutory language may be intentionally flexible for rural areas

Others say ERs don't qualify:

- Many ERs lack psychiatrists or residential psych services
- Some hospitals explicitly disclaim Chapter 573 status
- EMTALA stabilization ≠ inpatient psychiatric detention authority

There is no unanimous statewide answer. Local agreements fill this gap.

Issue 4: When Is the Handoff Complete/ When Can Officers Leave?

2023 + 2025

Legislative Amendments:
No Duty to Remain after completed handoff + documentation

What the law intends vs. what still happens:

Law Says	Reality in Many Counties
• Officer delivers person + submits paperwork • Custody accepted by facility • Officer is FREE to leave and return to duty	• Hospitals ask officers to stay for safety and officers often oblige • Some officers believe they must remain until psychiatric admission • Officers return for "Transport 2" to psych facility, sometimes hours or days later • AG Opinion 0877: no express duty to oversee after transport, but confusion persists

Issue 5: "Transport 2"—Who Transports the Person After Medical Stabilization?

Transport 1	Gap Zone	Transport 2
Law enforcement takes person in crisis to ER for medical stabilization. Handoff made; paperwork submitted.	Person medically cleared but no psychiatric bed available. ER holds person. ED clock is ticking. Law enforcement has left.	Hospital contacts law enforcement to return and transport to psychiatric facility. Officers dispute: Is this our job?

Why this is a statewide friction point:

- No clear statutory assignment of Transport 2 responsibility in most counties
- EMTALA: hospitals argue they must arrange transfer—but who provides the ride?
- Where no MOU or protocol exists, law enforcement is asked to fill the gap (often voluntarily but unsustainably)
- Each unnecessary return trip strains patrol coverage and delays response to new calls

SOLUTIONS IN PRACTICE

What is actually working — without waiting for statutory change

The Unified Message to the Legislature

Chapters 571 & 573 provide the framework. But frameworks don't function without resources.

1 Invest in Civil Psychiatric Beds

State hospitals are overwhelmingly forensic. New facilities under construction are a start. Civil beds must keep pace with demand.

2 Fund Crisis Infrastructure

Crisis stabilization units, diversion centers, and Mobile Crisis Outreach Teams need funding to operate at scale and handle co-occurring medical needs.

3 Expand Outpatient Treatment

Adults and children lack access to outpatient mental health treatment that prevents crises from escalating to emergency detention.

4 Targeted Statutory Clarifications

Consider tolling concept for medical emergencies; clarify definitions of inpatient/mental health facility; codify MOU and navigation models.

Local solutions work — but they are not substitutes for adequate statewide investment.

Solution 1: Collaborative Local Protocols, Designations, and MOUs

LMHAs have authority to designate "deemed suitable" facilities — using this proactively resolves the ER destination dispute.

What to Put in a Protocol or MOU

- Which hospitals/facilities are designated as suitable for ED patients
- Distinction: facilities for 48-hour-only hold vs. those accepting OPC+ status
- What constitutes accepted custody (signature, verbal, electronic acknowledgment)
- Who arranges Transport 2 after medical stabilization
- Contact information for LMHA navigator on duty

Why It Works

- Clarifies law enforcement obligations the moment paperwork is accepted
- Reduces officer uncertainty about when they can leave
- Reduces hospital frustration about receiving patients without backup
- Enables faster bed-matching and transfer coordination
- Does not require statutory change — can be implemented now

⚠ **An agreement alone is not enough—it must be operationalized and resourced to make a difference.**

Solution 2: Navigation & Diversion Programs, Two Texas Models

Bexar County and Surrounding Counties

Law Enforcement Navigation Program (STRAC)

- LMHA embedded in the Regional Advisory Council
- Real-time navigation: advises officers on best destination in the moment
- Coordinates with neighboring LMHAs for bed-matching
- Reduces ER boarding and redundant transports
- Requires hospital buy-in and significant dedicated resources

El Paso County

Interfacility Task Force (IFTF)—Rotating Intake System

- Developed after litigation; distributed hospital responsibility
- All local hospitals rotate intake: each takes a turn accepting EDs
- Officers call a dedicated line; operator directs them to the next hospital in rotation
- Geographic flexibility built in so officers return to duty quickly
- Promotes shared accountability and reduces delays

Common thread: both models required significant sustained local investment to build and maintain.

Solution 3: Statewide Training and Communication Gaps to Fix

Turnover in law enforcement and inconsistent training materials sustain confusion even where the law is clear.

Clock Start Rules

When exactly the 12-hr and 48-hr clocks begin; how Scenario 1/2/3 changes the analysis

The New ED Form

SB 1164's more detailed form may increase error rates; officers need training to reduce defective paperwork

"No Duty to Remain"

What constitutes a completed handoff; dispelling belief that officers must stay until psychiatric admission

LMHA Role & Resources

Who the LMHA is, how to reach the navigator line, what the LMHA can arrange

OPC as a Tool

When and how to pursue an Order of Protective Custody to extend the timeline when the 48 hrs will run out

Aligning CIT Materials

Current CIT/HPD training materials emphasize EMTALA in ways that create expectations inconsistent with state law

JCMH resources and existing CIT programs are available—the gap is in reach and consistency, not content.

Questions and Discussion

Suggested discussion questions:

1. What are the biggest pain points in your county right now?
2. Does your LMHA have a navigator program or MOU with local hospitals?
3. Are OPCs being used when 48-hour windows are at risk of expiring?
4. What would the Legislature need to fund to make the biggest practical difference for you?


2026 JUDICIAL SUMMIT ON MENTAL HEALTH
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