



# **ACMI Stakeholder Meeting COE Evaluations in Northern Arizona**

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# Today's Discussion

- Challenges in Northern Arizona
- How patients enter the Title 36 system
- Pre-petition screening and legal timelines
- Due process, counsel, and hearing requirements
- Rule 11 vs Title 36
- Case examples and common system failures
- Restoring structure through court-ordered treatment
- Polara's collaborative approach and outcome data

# Title 36: Legal Foundation

- *O'Connor v. Donaldson (1975)*
  - Ended indefinite confinement without treatment
- *Arizona Mental Health Services Act (1974)*
  - Established due process protections
- Key shifts:
  - No detention in jails pre-hearing
  - Defined timelines for evaluation
  - Required judicial oversight
  - Promoted voluntary treatment
- **Result:**
  - Strong protections for liberty
  - Reduced structural containment

# Rural Arizona Context

- Geographic barriers
- Limited inpatient resources
- Reliance on ER and law enforcement

# Access Challenges



LONG TRANSPORT  
DISTANCES



LIMITED  
EVALUATION SITES



DELAYS IN CARE

# Why This Matters



Repeated  
cycling



Higher acuity



System strain



Worse  
outcomes

# How Patients Enter the System

Community /  
field (family,  
crisis calls)

Emergency  
Department

Jail / law  
enforcement

# Community & Field Presentations

- Family-initiated concerns
- Mobile crisis involvement
- Gradual decompensation



# Emergency Department



ACUTE  
DECOMPENSATION

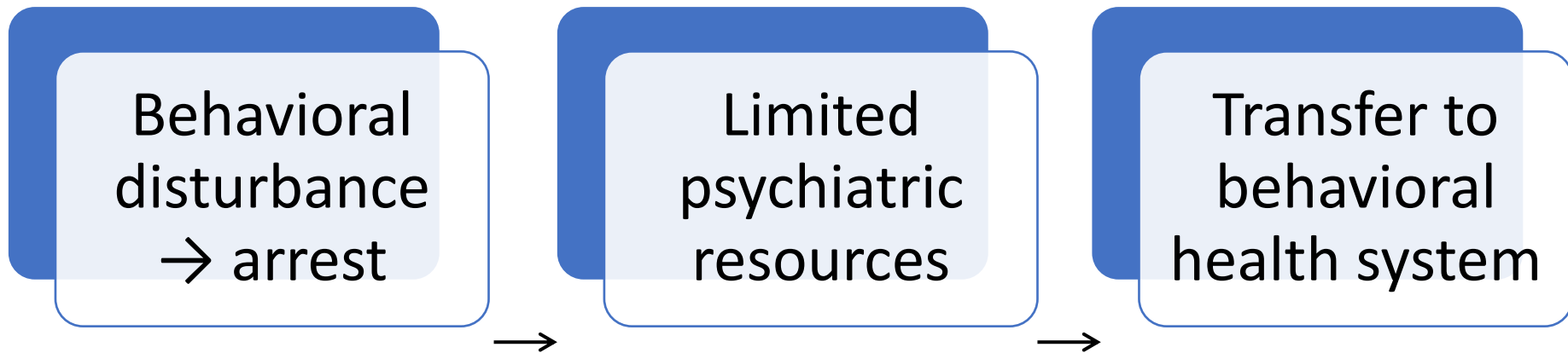


MEDICAL CLEARANCE  
REQUIRED



BOARDING AND  
DELAYS

# Jail & Law Enforcement Pathway



# From Entry Point to Evaluation

1

Transfer to CSU  
/ Connections /  
THP

2

Initial clinical  
assessment

3

Determine  
need for COE

- Key: CSU=Crisis Stabilization Unit;  
Connections (subacute; T36/COE site);  
THP=The Healing Place (Level 1 hospital)

# Pre-Petition Screening

Notarized application submitted

Screening occurs within 24–48 hours

Purpose: determine 'reasonable cause' for evaluation

# Title 36: Legal Triggers & Timeline Activation

- Title 36 admission initiates court process
- **COE must be filed by next court day**
- Judge signs COE → process formally activated
- **72-hour evaluation clock begins at signature**
- Requires evaluation by **two licensed psychiatrists**
- **Public defender assigned at time of judicial order**
- Legal representation begins immediately
- Letters of appointment issued shortly after

# COE / COT Timelines & Legal Flow

Application / Screening  
(~48 hrs)

Petition for COE Filed

Court-Ordered Evaluation  
(≤72 hrs)

Service + Attorney Assigned

Petition for COT → Hearing →  
Order

# Court Documentation & Petition Packet

- Petition for Court-Ordered Treatment (COT)
- Affidavit of Evaluation
- Affidavit Addendum
- Psychiatric Evaluation
- Title 36 Treatment Plan
- Coordinated submission as formal court packet
- Typical exhibit bundle: **~30 pages of documentation**

# Due Process in Practice

- Notice of petition, affidavits, and hearing required
- Right to counsel (appointed)
- Service must occur prior to hearing
- Opportunity for patient participation

- **Bottom line:**

*Due process is not assigning a lawyer — it is meaningful participation.*

# Rule 11 vs Title 36 – Different Lanes

- **Rule 11 (Criminal)**
  - Competency to stand trial
  - Understand proceedings
  - Assist in defense
  
- **Title 36 (Civil)**
  - Involuntary evaluation / treatment
  - Mental disorder + risk / impairment
  - Need for psychiatric intervention
  
- **Bottom line:**  
*Same patient — different legal questions.*

# System Gaps & The Bridge

- Jail ↔ Behavioral health disconnect
- Not competent ≠ clinically stable
- Risk of release without treatment
- Fragmented coordination across systems
- **Our approach:**
- Screen in jail
- Initiate Title 36 before release
- Direct transfer into care

- **Bottom line:**

*Without a bridge, the system doesn't discharge the problem — it transfers the risk.*

# Case 1: Bipolar I Disorder, Manic with Psychotic Features

- 31-year-old female, brought from jail under Title 36
- Severe mania + psychosis: grandiosity, delusions, disorganization
- Threats to self/others, aggressive behavior (feces/urine throwing)
- Persistent denial of illness, refuses mood stabilizers
- Partial stabilization inpatient only (Abilify)
- Explicit plan to stop meds after discharge
- Pattern: stabilize → deny → stop meds → decompensate

## Bottom line:

➔ *Environment-dependent stabilization, no insight, high risk of relapse*

# Case 1: Where Title 36 Falls Short

- Acute stabilization achieved in controlled setting
- Does not address post-discharge adherence
- Insight remains absent
- Patient rejects diagnosis and treatment need
- High likelihood of medication discontinuation
- Recurrent cycle of hospitalization
  
- **Key Point:**
  - ➔ *Stabilization ≠ recovery*

# Case1: Clinical Justification for Court- Ordered Treatment

- Persistently or Acutely Disabled (PAD)
- Severe impairment in judgment and reality testing
- Lacks capacity for informed treatment decisions
- Refuses necessary medications (mood stabilizer)
- Stability dependent on structured setting
- No viable less restrictive alternative

## **Anchor Line:**

 *High risk of rapid decompensation without mandated treatment*

# Case Conclusion

- Illness-driven behavior
- Impaired capacity
- Pattern of relapse

=COT appropriate

# Case 2: Chronic Psychosis + System Misalignment

- Adult male, out of state, transient in Sedona
- Chronic psychosis, disorganized behavior
- Recurrent police contacts, repeated pickups
- Receiving “treatment” at alternative center (non-medical)
- No consistent psychiatric medication
- Family opposed to medications, financially resourced
- Out-of-state guardian (mother) — not functionally applied

## **Bottom line:**

➔ *In the system, but outside effective care and accountability*

# System Failure Points Body:

- “Treatment” without medical oversight
- No medication despite clear psychosis
- Guardian authority not operational across state lines
- Law enforcement cycling without clinical resolution
- No mechanism to transition into appropriate level of care
- **Key Point:**
  - ➔ *Fragmentation between legal authority, clinical care, and geography*


# Case 3: Restoring Structure Through Court Process

- Adult patient with severe depression vs psychotic disorder
- Mutism, immobility, minimal oral intake
- Poor engagement, not disruptive, not aggressive
- Appears “calm” but profoundly impaired
- Unable to advocate for self or accept treatment
- Requires medical + psychiatric intervention (e.g., benzodiazepines, ECT)
- **Bottom line:**
  - ➔ *Severely ill, but easily overlooked*

# Case 3: The Quiet Failure of the System

- No overt dangerousness → may not trigger intervention
- Lacks capacity but cannot express refusal clearly
- High medical risk (malnutrition, dehydration, complications)
- Requires urgent treatment despite lack of resistance
- Easily missed without clinical expertise
- **Key Point:**
  - *Not all high-risk patients are loud*

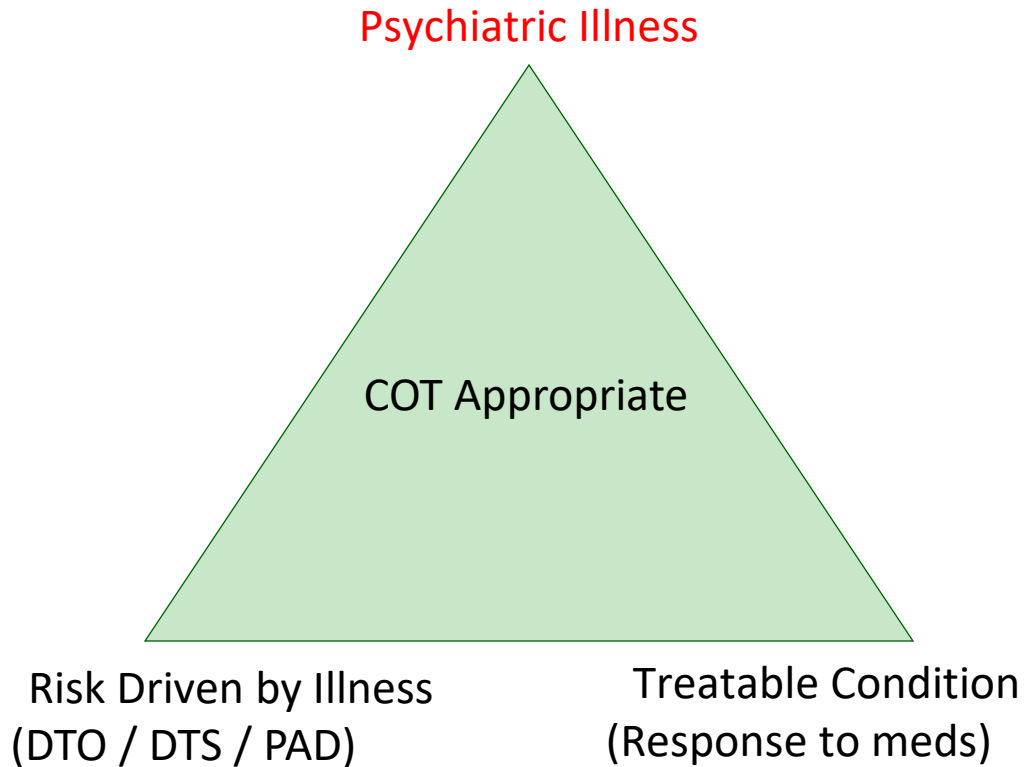
# Case 3: Capacity Without Resistance

- Profound impairment in decision-making capacity
- Inability to engage in voluntary treatment
- Medical and psychiatric risk without intervention
- No reliable self-directed care
- **Anchor Line:**  
 *Incapacity can exist even without objection*

# Restoring Structure Through Court Process

- Untreated psychosis with functional impairment
- Inability to engage in rational treatment decisions
- Ineffective “voluntary” care model
- Guardian not functionally operative
- Recurrent community destabilization
- **Anchor Line:**
  - ➔ *Court involvement becomes the only mechanism to align care, authority, and accountability*

# COT Decision Framework



**If ANY element is missing → NOT appropriate for COT**

# Core Principle

Illness + Risk +  
Treatability

If missing →  
not  
appropriate

# Common Pitfalls

Behavior  $\neq$  psychiatric illness

Police involvement  $\neq$  illness

Always identify underlying illness

# Behavior vs Psychiatric Illness



AGGRESSION ALONE ≠ COT



PSYCHOSIS, MANIA, SEVERE  
DEPRESSION → CONSIDER COT

# Regional Variation



SAME STATUTE, DIFFERENT  
APPLICATION



NORTHERN VS SOUTHERN  
ARIZONA

# Southern Arizona Pattern



Higher threshold



More reliance on  
voluntary care

# Northern Arizona Model



Clinically Anchored  
Pattern-based decisions



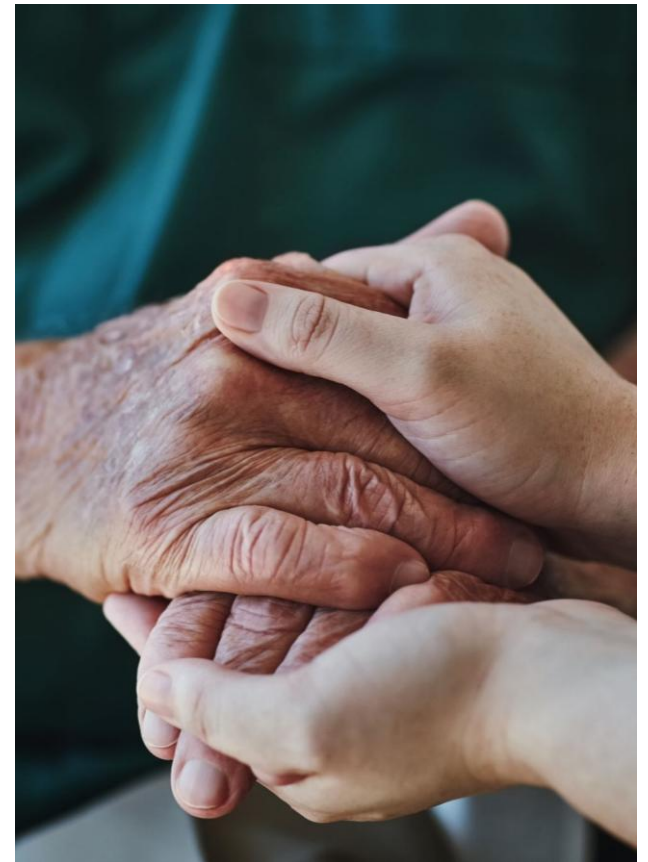
Early Intervention

# Regional Differences: Northern vs Southern Arizona

- No COT amendment mechanism in Northern AZ (Yavapai County)
- Maricopa County uses formal COT amendments for re-hospitalization
- Northern AZ relies on pickup orders under existing COT terms
- Less legal procedural flexibility in Northern AZ
- Mobile crisis capacity significantly higher in Southern AZ
- Maricopa: dedicated teams can actively retrieve patients
- Northern AZ: limited field response resources
- Health Homes model ≠ mobile crisis capability
- Result: delayed intervention, higher risk of decompensation

# Special Populations

- TBI
- Autism / Developmental Disability
- Dementia
- Baseline condition  $\neq$  psychiatric illness



Exception  
Rule

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Co-occurring  
psychiatric disorder

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Symptoms exceed  
baseline

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Treatable condition

Example  
(Appropriate)

Autism + mania

Clear psychiatric  
overlay

COT appropriate

Example  
(Not  
Appropriate)

TBI with aggression

Neurologic behavior

Not COT appropriate

# Clinical Shortcut

Is behavior  
baseline?

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graph TD; A[Is behavior baseline?] --> B[If yes -> not COT]; A --> C[If no -> evaluate psychiatric overlay];
```

If yes → not COT

If no → evaluate  
psychiatric  
overlay

# Capacity Anchor



Impaired by  
psychiatric illness



Drives decision-  
making



Court  
involvement

# Patient Experience

- Lifelong medication is difficult
- Young patients struggle with identity impact
- Side effects: metabolic, sexual, emotional
- Validation is essential

# Polara Approach

Collaborative,  
not coercive

Unconditional  
positive regard

Transparency  
with patients

# What This Looks Like

1

Explain COT  
decisions

2

Educate  
patients

3

Frame as  
support

4

Involve  
patient

# Reframing COT



GUARDRAILS FOR  
STABILITY



ACCESS TO  
SERVICES



SUPPORT BEYOND  
MEDICATION



SHARED  
ACCOUNTABILITY

# Old vs New Model

Old: brief,  
adversarial

New: collaborative,  
informed, engaged

# Polara Data: COE Volume & COT Outcomes

- **COE Volume (Filed Cases)**
- 2024: **84 cases filed**
- 2025: **299 cases filed**
- Significant year-over-year increase in system utilization
- **COT Outcomes**
- 2024: **41 patients ordered to COT**
- 2025: **54 patients ordered to COT**
- Consistently **high court success rates (96%-100%)**
- **Operational Impact**
- Reflects improved coordination and process clarity
- Demonstrates scalable model for SMI care

# Key Takeaway

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COT = illness + risk + treatability

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Avoid behavior-only decisions

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Use structured framework

# Closing

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Commitment to patient-centered care

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Collaboration across systems

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Questions