



Emergency Detention Round Table Report

March 2026



Emergency Detention Round Table III Report

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I. Executive Summary

On September 3, 2025, the Texas Judicial Commission on Mental Health (JCMH) convened a statewide round table to examine the lack of consistency in the implementation of emergency detention under Chapter 573 of the Texas Health and Safety Code. The discussion was prompted by ongoing disputes regarding transportation authority, the role of emergency departments, and whether law enforcement officers are required to remain at hospitals after delivering individuals under emergency detention, particularly following recent legislative amendments intended to reduce prolonged officer presence in medical facilities.

The round table brought together law enforcement, local mental health authorities (LMHAs), hospitals, attorneys, judges, and other state leaders. While participants initially sought a shared statutory interpretation, the discussion revealed that many recurring disputes are not driven primarily by changes in the law, but by longstanding resource constraints, variable local infrastructure, and differing operational assumptions across jurisdictions. As a result, emergency detention practices vary throughout Texas, despite a common statutory framework.

Participants emphasized that limited psychiatric bed capacity is one of the primary underlying drivers of operational challenges. Inpatient psychiatric care is scarce, particularly in rural areas, which is why the Legislature has made substantial investments, and new facilities are currently under construction in urban and rural areas of the state. Complicating access to inpatient psychiatric capacity, state hospitals are now overwhelmingly dedicated to forensic commitments for competency restoration, so the courts can adjudicate criminal offenses. Moreover, because crisis stabilization units, diversion centers, and other alternatives to inpatient care are not equipped to safely treat emergency medical conditions such as internal bleeding or a heart condition, these facilities have medical exclusionary criteria that require a person be medically cleared before the facility can safely admit and begin addressing the mental health crisis. These community-based alternatives also experience demand that exceeds their funded capacity. In this environment, emergency departments function as the default stabilization points for individuals in mental health crisis with urgent medical needs, which creates challenges for these hospitals and tensions between local stakeholders. In the worst-case scenarios, there are prolonged emergency department boarding, expiration of emergency detention timeframes before psychiatric placement can be secured, repeat emergency calls, and significant tensions between law enforcement and local hospitals.

The round table organized its analysis around key operational issues, including when an emergency detention begins, how the statutory 12-hour and 48-hour timelines are triggered and applied when medical care is involved, where individuals may lawfully be transported when both psychiatric and urgent medical needs are present, when a handoff is complete for purposes of law enforcement departure, and who bears responsibility for subsequent transport after medical stabilization. While participants identified areas of emerging consensus and highlighted examples of progress made in certain communities when resources have become available, there was no unanimous agreement

on a single strategy to address these challenges. Stakeholders also highlighted tension between state law, federal requirements (such as the Emergency Medical Treatment and Labor Act and hospital conditions of participation), and law enforcement training materials that shape expectations in practice.

Despite these challenges, the discussion identified a few practical strategies that have helped clarify roles and reduce conflict in certain jurisdictions without waiting for statutory change. These include collaborative local protocols, memoranda of understanding, and other agreements that operationalize the concept of facilities “deemed suitable” by LMHAs; clear delineation of expectations for initial transport and subsequent transport following medical stabilization; and the use of navigation and diversion programs to direct individuals to the most appropriate setting in real time. Participants emphasized that where such structures exist, handoffs are clearer, officer time in facilities is reduced, and outcomes are more consistent for individuals in crisis.

This report reflects a deliberate shift from focusing solely on questions of legal authority to acknowledging the practical constraints faced by communities across Texas. It concludes that while Chapters 571 and 573 provide an essential framework, they cannot function as intended without adequate psychiatric capacity, crisis infrastructure, and shared operational understanding. In the near term, collaborating and creating locally tailored agreements offer the most feasible path forward within existing law. Over the longer term, stakeholders expressed a strong desire for a unified message to the Legislature that meaningful improvements in emergency detention practice will require realization of the investments in civil psychiatric beds, additional investments by the Legislature in crisis services, community supports, navigation models, and targeted statutory clarification where appropriate.

JCMH will continue to convene stakeholders, support education and collaboration, and gather data to inform recommendations for Texas Legislature, with the goal of promoting emergency detention practices that are legally sound, clinically appropriate, and operationally sustainable across Texas.

II. Statutory Framework and Regulatory Context

This section consolidates the statutes, opinions, and federal frameworks that shaped the round table discussion and drove the operational questions described in later sections.

A. Chapter 573 Peace Officer Transportation Duty and Options

Texas Health & Safety Code § 573.001(d)(1)–(2), *Apprehension By a Peace Officer Without Warrant*, requires peace officers to transport people under emergency detention to the nearest appropriate inpatient mental health facility or another mental health facility deemed suitable by the LMHA. Officers may alternatively transfer custody to emergency medical services (EMS) personnel under a Memorandum of Understanding (MOU) for transport. LMHAs can designate suitable mental health facilities when another appropriate inpatient facility is unavailable. The exact statutory language of HSC § 573.001(d):

(1) directs the peace officer to immediately transport the apprehended person to:

(A) the nearest appropriate inpatient mental health facility; or

(B) a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available; or

(2) transfer the apprehended person to emergency medical services personnel of an emergency medical services provider in accordance with a MOU executed under § 573.005 for transport to a facility described by subsection (1)(A) or (B).

B. “No Duty to Remain” Amendments and Legislative Intent

Texas Health & Safety Code § 573.012(d-1) (2023 amendment) clarified that officers executing a magistrate’s emergency detention warrant are not required to remain at the facility once documentation is provided and custody is accepted. Section 573.002(f) (2025 amendment) extended the same language to warrantless emergency detentions for consistency. Stakeholders repeatedly referenced these changes as reflecting legislative intent to allow officers to return promptly to community safety efforts after a completed handoff.

C. Attorney General Opinions Discussed

Attorney General Opinion GA-0753 (2009) concluded that mental health facilities cannot require law enforcement to transport a patient to a medical facility for clearance before admission. Participants emphasized that this opinion remains a key legal marker, while also acknowledging that medical stabilization requirements are common practice, creating ongoing tension between statutory design, clinical realities, and resource limitations.

Attorney General Opinion GA-0877 (2011) advised that Chapter 573 does not place a duty on one law enforcement agency over another to oversee a person subject to an emergency detention order in the facility while awaiting preliminary examination when the facility has not designated an

employee to be responsible for preventing the person from leaving the facility. This opinion arose in discussion about whether officers must remain at hospitals as “security” for patients.

D. 2025 Legislative Changes: S.B. 1164 (as Amended by H.B. 16)

Texas S.B. 1164, 89th Leg., R.S. (2025), as amended by Tex. H.B. 16, 89th Leg., 2d C.S. (2025), improved the law enforcement emergency detention notification form; added a parallel “no duty to remain” rule for a peace officer’s warrantless emergency detention; amended the criteria for emergency detention to include when a person with mental illness evidences an inability to recognize symptoms or appreciate the risks and benefits of treatment; and clarified venue for proceedings for court-ordered services. Stakeholders emphasized that none of these legislative changes amended requirements or duties with respect to transportation. As a result, many disputes described below reflect interpretation and implementation issues rather than direct statutory change.

E. Destination Authority

Texas Health & Safety Code § 571.003(9) defines “Inpatient Mental Health Facility” as a mental health facility that can provide 24-hour residential and psychiatric services and that includes (among other categories) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the department (HHSC). Section 571.003(12) defines “Mental Health Facility” more broadly to include inpatient or outpatient mental health facilities, community centers, identifiable parts of general hospitals providing diagnosis, treatment, and care for persons with mental illness, and reciprocal agreement commitment locations under § 571.0081. The round table discussion highlighted uncertainty about how these definitions apply to emergency departments in practice and whether all emergency rooms that see behavioral health patients should be treated as Chapter 573 destinations.

F. Federal Laws Raised in Relation to Hospital Duties and Constraints

Emergency Medical Treatment and Labor Act (EMTALA) is a 1986 federal law requiring Medicare-participating hospitals with emergency services to provide a medical screening exam to anyone seeking treatment for an emergency medical condition and provide stabilizing treatment for that condition or arrange an appropriate transfer to another hospital. The purpose of EMTALA is to prevent hospitals from refusing to treat patients based on ability to pay, insurance status, or other factors. Stakeholders noted that psychiatric emergencies can qualify as emergency medical conditions under EMTALA.

Participants also discussed hospital Conditions of Participation at 42 CFR § 482.13(f), which strictly regulates the use of restraints and seclusion and prohibit restraint for coercion, discipline, staff convenience, or retaliation. Conditions of Participation impose strict requirements when restraint or seclusion is used, including an order by an authorized practitioner, no standing orders, time-limited orders, continuous monitoring, discontinuation as soon as the emergency ends, and

debriefing within 24 hours. These constraints were raised as part of the practical realities hospitals face when asked to keep emergency detention patients from leaving.

III. Identified Issues

The round table identified several recurring statewide issues. Law enforcement officers are being asked to stay in hospitals in various situations despite S.B. 1164, which specifically allows law enforcement to drop off individuals under emergency detention and return to their work. The discussions during and after the round table revealed uncertainty about the emergency detention laws, inconsistent local practices, prolonged law enforcement presence in emergency departments, and operational challenges for hospitals and LMHAs.

The round table began with questions about transportation authority and whether law enforcement must remain at hospitals when individuals are subject to emergency detention. As discussion progressed, participants consistently returned to an antecedent issue: downstream disputes about destination, custody, and officer presence arise because counties do not consistently understand or apply uniform protocols in situations with (i) urgent medical care where emergency detention has not yet been invoked, and (ii) active Chapter 573 emergency detention where statutory authority and timelines apply. For clarity, the decision points below are organized in the logical order in which they arise operationally. Later authority questions are analyzed assuming emergency detention is active unless otherwise specified.

Initially, the round table participants attempted to resolve the different approaches through a unified understanding of the statutes. However, as the many layers of the issues were discussed it became obvious that limited resources were the root of the problems. The Legislature over the past six years justifiably prioritized investments in inpatient care that takes time to build, and there have not been commensurate investments in community-based crisis services (e.g., diversion centers or Mobile Crisis Outreach Teams) or outpatient treatment for adults and children, which means communities across the state struggle to address these complicated issues. Because there are no one-size-fits-all solutions, Texas needs additional resources, flexibility in the law, and locally tailored solutions.

A. Limited Resources Drive Virtually All Emergency Detention Problems

Across jurisdictions, participants consistently identified resource limitations as the primary factor shaping emergency detention practices. These limitations include shortages of civil inpatient psychiatric beds; the predominance of forensic commitments in state hospitals; and limited availability of crisis services such as crisis stabilization units, extended observation units, respite centers, diversion facilities, and adequately funded mobile crisis outreach teams.

Even when crisis units exist, many are not equipped to manage complex medical conditions such as internal bleeding or detoxification from drugs or alcohol. As a result, medical exclusionary

criteria often prevent admission. Stakeholders emphasized that these constraints frequently leave hospital emergency departments as the only viable stabilization setting.

Consequently, patients may board in emergency rooms while awaiting psychiatric placement. Emergency detention orders may expire before a transfer can be arranged, and individuals may leave before stabilization is complete, contributing to repeating 911 calls. Law enforcement and LMHAs routinely operate within these constraints and with limited available resources.

Many stakeholders expressed a desire to present a unified message to the Legislature: the current statutory framework cannot function as intended without significant investment in psychiatric bed capacity, crisis services, and outpatient treatment for both adults and children. Historically, officers could transport individuals directly to state hospitals for stabilization. Today, state hospitals are approximately 75 to 80 percent forensic and rarely accept patients on emergency detention. Access to civil inpatient care now depends largely on LMHAs purchasing beds from private psychiatric facilities. In many communities, demand exceeds available funding and negotiated reimbursement rates often fail to keep pace with rising healthcare costs.

The consequences are significant:

- i. patients remain in emergency rooms for extended periods while awaiting inpatient psychiatric placement;
- ii. emergency detentions expire, requiring hospitals to release individuals once legal authority ends, which may lead to repeat 911 calls; and
- iii. law enforcement and LMHAs are forced to operate in the gaps between statutory design and available resources.

B. When Does Emergency Detention Begin?

To analyze when an emergency detention started, participants described three common scenarios:

- (1) a person with urgent medical need who is voluntarily willing to go to the hospital;
- (2) a person with an urgent medical need who is unconscious or otherwise unable to consent is transported by EMS to a hospital for medical care with implied consent, and emergency detention is considered once the medical issue is stabilized; and
- (3) a person who is conscious but refusing to consent to go to the hospital and must be taken by emergency detention.

With respect to the question about when emergency detention begins, participants in follow-up discussions felt that there was broad agreement on several points:

- In the first scenario, because it is voluntary, the emergency detention does not begin until the person expresses the intent to leave, and the emergency detention is initiated by a peace officer or a signed Magistrate's warrant.

- In the second scenario, the emergency detention would begin after the patient is stabilized and the person is apprehended because of an ongoing concern that meets criteria. If a person is transported to the hospital solely for medical treatment, which may involve voluntary consent or implied consent if the person is unconscious or incapacitated, the clock for emergency detention has not started yet.
- In the third scenario the emergency detention begins when the person is apprehended by police, meaning when the officer legally holds the person on emergency detention criteria, and the person is presented to the facility with the proper emergency detention paperwork. All time spent in that facility, including time receiving medical care, is part of the 48-hour emergency detention window.
- Once the emergency detention is active, the person is not free to leave, and emergency detention status continues until expiration, discharge, or transition to another legal status such as an order for protective custody.

Even with this consensus, participants expressed discomfort with scenarios where lengthy medical care consumes a substantial portion of the emergency detention period, leaving limited time for psychiatric placement. Some suggested the Legislature may wish to revisit a narrow, carefully drafted tolling concept for limited medical situations.

Timing issues include:

i. The 12-Hour and 48-Hour Clocks and Their Operational Consequences

There was broad agreement that the 12-hour examination clock begins when the person is apprehended, meaning when the officer legally holds the person on emergency detention criteria. There was also broad agreement that the 48-hour detention clock is tied to the person being presented to and accepted by a facility for preliminary examination. However, practice varies on how these rules are applied when medical care is needed before or during emergency detention.

In some jurisdictions, any transport or ride-along initiated because of a mental health crisis is treated as starting the clock at first contact; in others, officers separate medical transport not yet under emergency detention from later emergency detention initiation. Participants emphasized that these differences in law enforcement practices create inconsistent outcomes and influence law enforcement behavior, hospital behavior, and the feasibility of securing psychiatric placement within statutory time limits.

ii. Running Out of Time, Lack of Medical Stabilization Exceptions, and the Role of Order of Protective Custody

Participants described recurring situations where counties run out of time within the 48-hour emergency detention period, particularly when medical stabilization is needed, and the patient waits in the emergency department before preliminary examination. Stakeholders emphasized that

Chapter 573 requires a physician to examine the proposed patient as soon as possible within 12 hours after the person has been apprehended by the peace officer. Once accepted for preliminary examination, the person may be detained in custody for at most 48 hours after the person is presented to the emergency department or other facility unless an Order of Protective Custody (OPC) is obtained; the 48-hour period includes any time the patient spends waiting for medical care before the preliminary examination. The 48-hour period extends to the first succeeding business day if it ends on a weekend or legal holiday and there are currently no statutory exceptions for lengthy medical stabilizations.

Participants recognized that using OPCs can help with the problem of running out of time. When the judge or designated magistrate issues an OPC after considering a physician's opinion that the person is mentally ill and presents a substantial risk of serious harm to self or others if not immediately restrained, the OPC extends the timeline that an individual can be held for treatment and observation. In some jurisdictions, OPCs are not utilized by different system partners; either state attorneys (district or county) are refusing to file them, or doctors are refusing to do Certificates of Medical Examination or testify at hearings. As a result, the statutory framework authorizing protective custody is not fully operational in practice.

C. Where is Law Enforcement Authorized to Take a Person in Mental Health Crisis with Urgent Medical Needs?

When considering the authority question, stakeholders noted fewer authority problems with the first two scenarios because law enforcement is not taking the person into custody at the outset. Under the third scenario, participants described local variations based on the resources available in a particular community. Destination authority is determined by HSC § 573.001(d)(1)–(2) (Apprehension Without Warrant), which requires peace officers to transport people under emergency detention to the nearest appropriate inpatient mental health facility or another mental health facility deemed suitable by the LMHA. Officers may alternatively transfer custody to Emergency Medical Services personnel under a memorandum of understanding for transport.

Texas Health & Safety Code § 571.003(9) defines “Inpatient Mental Health Facility” as a mental health facility that can provide 24-hour residential and psychiatric services and that includes (among other categories) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the department. Texas Health & Safety Code § 571.003(12) defines “Mental Health Facility” more broadly to include inpatient or outpatient mental health facilities, community centers, identifiable parts of general hospitals providing diagnosis, treatment, and care for persons with mental illness, and reciprocal agreement commitment locations under Section 571.0081.

The round table discussion identified disagreement about how these definitions apply to emergency departments and whether all emergency rooms that see behavioral health patients should be treated as Chapter 573 destinations.

i. Competing Interpretations of “Inpatient Mental Health Facility” and “Mental Health Facility”

Some participants read Chapters 571 and 573 to mean that all hospital emergency rooms typically meet the definition of an inpatient mental health facility, because all hospitals have an identifiable part providing diagnosis, treatment, and care for persons with mental illness and 24-hour residential psychiatric services are available. They argued the statutory language may have been left flexible to accommodate the diverse realities of Texas counties, including areas with no stand-alone psychiatric hospitals where emergency rooms must serve as the stabilization sites.

Other participants argued that many emergency rooms do not meet the definition of an inpatient mental health facility because they do not provide 24-hour residential psychiatric services, may lack psychiatrists or specialized mental health teams, and often function as crisis stabilization points rather than ongoing psychiatric diagnosis and treatment settings. Some officers reported that hospitals explicitly state, “we are not an inpatient mental health facility under the statute,” and are reluctant to be treated as such for emergency detention purposes.

Stakeholders repeatedly noted that disputes about destination often arise not solely from statutory ambiguity, but from differences in available resources, how LMHAs exercise their authority to designate facilities, or community stakeholders’ willingness to establish local protocols and agreements. Chapter 573 contemplates that LMHAs will play an active role in identifying facilities that are suitable for emergency detention when an appropriate inpatient mental health facility is not available. In practice, some jurisdictions rely on formal designation, others on written agreements that operationalize consensus on what locations are “deemed suitable,” and others have neither and law enforcement decision-making determines the person’s destination. Participants emphasized that these differences in local resources and practices influence transportation, custody expectations, and law enforcement decision-making with respect to the destination for EDs and whether pressures exist around law enforcement remaining at or leaving the emergency department. Where local agreement has been reached designating emergency departments to receive EDs when no other alternatives exist or written protocols have been developed by local stakeholders, destination decisions by law enforcement are clearer.

ii. Law Enforcement Concerns When ERs are Used as Emergency Detention Destinations Without Clear Agreement

In at least one county represented at the round table, uncertainty about whether an emergency room is a lawful emergency department destination raises several practical concerns: reluctance to transfer custody of a person whose liberty has been restricted to a facility that may not have the capacity or legal authority to hold them; fear that “drop off and go” will lead to liability if persons walk out of the emergency department before stabilization or after the emergency detention order expires; and confusion about whether an emergency room that is willing to provide emergent

medical care but not ongoing psychiatric services can lawfully serve as the emergency detention destination contemplated by § 573.001.

iii. EMTALA as the Primary Counterargument Raised for Emergency Room Involvement

Participants raised EMTALA as a counterpoint to state-law ambiguity regarding transportation and custody authority. Law enforcement representatives noted that psychiatric crises are commonly treated in training as emergency medical conditions under EMTALA, shaping expectations that hospitals will provide stabilization and arrange appropriate transfer when necessary. Some participants cited EMTALA as a reason that hospitals may be expected to accept custody once a person is brought to the emergency department, while hospital representatives cautioned that EMTALA obligations do not resolve broader questions about long-term detention authority, staffing, or capacity. This EMTALA-focused framework was raised as a basis for expecting hospitals that operate emergency departments to accept people on an emergency detention for preliminary examination when no other options are available. In these situations, decisions about who manages transfer and transportation once the person is in the emergency department create challenges for local stakeholders and is an area that could benefit from additional resources. Tensions between federal stabilization requirements and the practical and regulatory limits faced by hospitals remain a challenge and could be mitigated by additional resources. Participants also cited potential civil monetary penalties for EMTALA violations and noted that physicians may face penalties when transfer requirements are misapplied or misrepresented.

Participants emphasized that officer decision-making is shaped by existing training materials, including Texas CIT Association and Houston Police Department Crisis Intervention Team (CIT) guide. Some law enforcement representatives referenced training materials that describe psychiatric crises as emergency medical conditions and explain EMTALA-based hospital obligations, which can influence expectations regarding hospital responsibility for stabilization and transfer. Stakeholders noted that differences between training materials, statutory interpretation, and local practice contribute to ongoing confusion and reinforce the need for consistent statewide education aligned with current law and operational realities.

iv. No Unanimous Agreement and the Practical Reality of “Default Emergency Room Destinations”

Even with robust discussion, there was no unanimous agreement on whether every emergency department that sees behavioral health patients should automatically be treated as a mental health facility or inpatient mental health facility for emergency detention purposes. At the same time, participants acknowledged that in many parts of Texas, law enforcement recognize the emergency department is the only realistic option within a reasonable distance, making it functionally the default stabilization point regardless of any formal designation.

D. When is the Handoff Complete and Can Law Enforcement Leave, Assuming Emergency Detention is Active?

i. Statutory Change Versus Practice Reality

Stakeholders emphasized that the 2023 and 2025 “no duty to remain” amendments were intended to reduce time officers spend waiting in emergency departments after a completed handoff. However, participants described ongoing variation in hospital practice. Some hospitals that operate emergency departments ask law enforcement to remain due to safety concerns. Often law enforcement, being good partners, will provide this assistance, but it creates stress and strain on limited law enforcement resources.

A related interpretive problem emerged concerning when an emergency detention apprehension is considered complete. Some participants reported that in their communities, officers believe they must remain at the hospital or leave and later return because they view the emergency detention as incomplete until the individual is formally admitted to a psychiatric facility. Officers described cases involving alcohol dependence, overdose, or prolonged detoxification requiring extended emergency room stays before psychiatric transfer. Some stakeholders stated they felt obligated to keep the individual in custody until psychiatric admission or believed law enforcement could not leave until the person is medically cleared and transported to an inpatient mental health facility. JCMH noted this was the first time it had encountered this interpretation, and it is unclear how widespread it is. Participants also noted that this reading appears inconsistent with the 88th and 89th Legislatures’ efforts to allow officers to return quickly to community safety efforts. This highlights the need for on-going education efforts.

ii. Areas of Emerging Agreement

Most participants agreed that if a general hospital is deemed a suitable mental health facility either by formal LMHA designation or by local agreement that operationalizes “deemed suitable,” then law enforcement’s obligations are complete when the patient is dropped off and the appropriate paperwork is submitted, assuming custody is accepted. Participants emphasized that confusion increases when hospitals assert that they are not a Chapter 573 destination or when custody acceptance is unclear in practice.

iii. AG Opinion GA-0877 and “Who Oversees the Person”

Participants cited GA-0877 (2011) in connection with hospital requests that officers remain as security. The opinion was discussed as reflecting that Chapter 573 does not expressly assign a duty to a particular law enforcement agency to oversee the person once transported under an emergency detention order, particularly where the facility has not designated an employee to prevent the person from leaving. Stakeholders emphasized that this uncertainty contributes to inconsistent local practice.

E. Who is Responsible for “Transport 2” After Medical Stabilization, Assuming Emergency Detention is Active?

i. Transport 1 Versus Transport 2 as a Recurring Statewide Friction Point

Participants described a two-step dilemma in counties without resources, designations, MOUs, or clear local agreements. Transport 1 involves taking the person to an emergency department for medical stabilization. Transport 2 involves being asked to remain or return later to move the person to a psychiatric facility, despite statutory changes intended to allow officers to leave after Transport 1 when an appropriate handoff occurred. Again, law enforcement acting as good partners do, at times, conduct Transport 2. The challenges that emerge around Transports 1 and 2 could be greatly reduced by additional resources.

ii. How Clarity Changes Expectations

Participants noted that where a general hospital is clearly identified by designation or agreement as a suitable mental health facility for emergency detention, law enforcement obligations are generally understood to be complete once the patient is accepted and documentation is provided. Communities that have successfully addressed these issues have the resources necessary to develop solutions that have mitigated inconsistent practices, officer frustration, facility frustration, and delays that compress the emergency detention statutory timeframe.

iii. EMTALA Arguments Related to Transfer and Transport

Participants raised EMTALA as relevant to whether hospitals must arrange appropriate transfer and the method of transportation when the person cannot be stabilized and requires transfer to another facility with capability and capacity to manage the condition. Stakeholders described this as a central part of the disagreement over whether law enforcement should be responsible for Transport 2 in routine practice versus only in limited circumstances defined by local agreement.

F. Hospital Concerns

i. Emergency Rooms are Not the Ideal Default Destinations for Emergency Detentions

Hospital representatives raised practical and ethical concerns about using emergency rooms as the default destination for emergency detentions. Many ERs lack on-site psychiatrists or dedicated behavioral health staff. Overreliance on ERs can worsen crowding, boarding, and staff burnout. Hospitals may feel they are being asked to hold people under legal constraint without clear statutory authority or capacity to do so. There were concerns that “drop-off and go” practices, absent clear agreements, can place hospitals in untenable positions and expose officers and agencies to liability. At the same time, participants acknowledged that in many rural areas the emergency room is the only realistic option within a reasonable distance, making it functionally the default emergency detention destination whether or not it is formally designated.

ii. Rural Realities

Participants emphasized that many rural counties have limited or no access to inpatient mental health care in any reasonable proximity to their locations. Historically, some officers could transport directly to state hospitals, but state hospitals are now overwhelmingly occupied by forensic commitments. Civil inpatient care is available because the legislature has invested funds for LMHA-purchased private psychiatric beds. Demand for these beds often exceeds available resources in many communities across the state.

iii. High-Volume Urban Realities

Safety-net hospitals reported serving as de facto drop-off points, receiving extremely high emergency detention volumes that far exceed psychiatric bed capacity. Participants in the discussion referenced examples of urban volume on the order of tens of thousands of emergency detention orders annually and noted that this volume makes it unrealistic for inpatient psychiatric bed capacity alone to absorb all emergency detention presentations without emergency room involvement as a stabilization step. Hospitals also raised practical concerns about defective emergency detention paperwork when officers are no longer present to correct errors. One participant voiced concern that the new, more detailed emergency detention notification form may increase error rates without corresponding law enforcement training.

iv. CoPs, Restraints, and the Distinction Between “Detaining” and “Restraining”

Some hospital representatives raised Conditions of Participation concerns, including that CoPs limit restraint use and impose strict rules when restraint or seclusion is used. A counterargument emphasized that detaining patients for stabilization is distinct from restraining them; a two- or four-point restraint to a bed is different from keeping someone from leaving. This perspective argued that detaining a patient may be part of what is required to provide stabilizing treatment in an acute psychiatric emergency. Stakeholders acknowledged that on-the-ground implementation involves staffing constraints, safety considerations, and difficult judgments about risk and intervention which are common in high-intensity medical environments

IV. Solutions Across Jurisdictions (What Helps Clarify Roles Without Waiting for Statutory Change)

Despite differing interpretations and resources, several practical strategies emerged from the discussion.

A. Using Designation, Protocols, and MOUs to Build Consensus Between Stakeholders

Communities that have achieved relative clarity tend to identify appropriate destinations for emergency detention patients (including when medical stabilization is required) through collaborative planning among LMHAs, hospitals, law enforcement, EMS, and county leadership; use MOUs, protocols, or standing agreements to operationalize stakeholder agreements even when there is no formal statutory designation; and distinguish between facilities that can safely receive emergency detention patients for the 48-hour window only and facilities capable of accepting longer-term detention status (order of protective custody and beyond). Under these arrangements, communities can direct emergency detention patients with urgent medical needs to identify hospital emergency departments; direct individuals with primarily psychiatric needs and no apparent urgent medical issue to crisis units or inpatient psychiatric facilities when available; and clarify Transport 2 expectations, including who is responsible for arranging and conducting transport after medical stabilization. As stated previously, these communities often have additional state or local resources to operationalize these agreements. An agreement alone will not solve these challenges.

B. Navigation and Diversion Models

One region (San Antonio, Bexar County and a few surrounding counties) has implemented a Law Enforcement Navigation program through the Southwest Texas Regional Advisory Council (RAC). By agreement of all the local hospitals in San Antonio, the program reduces unnecessary emergency department use when safe and appropriate. The LMHA (Center for Health Care Services) in San Antonio is imbedded in the RAC and provides navigation services and advises officers in real time on appropriate destinations. They also coordinate with neighboring LMHAs to match individuals to available psychiatric beds, reduce emergency room boarding and redundant transports where possible. Participants state this model aligns emergency detention practice and supports more efficient use of limited psychiatric capacity but is dependent on agreement between the hospitals involved and significant resources provided by each hospital to support the program.

As a result of litigation, El Paso developed a local model to distribute responsibility among hospitals for individuals placed under emergency detention. The Interfacility Task Force (IFTF) was created and developed a rotating intake system for all local hospitals. Each facility takes turns accepting patients who are brought in under an emergency detention order. Law enforcement officers contact a dedicated line operated by the contractor that manages the crisis line. That operator directs officers to the hospital whose turn it is in the rotation to receive the patient. There is flexibility in the rotation to accommodate the geographical location of the officer, ensuring that the officer can return to the community quickly and efficiently. Stakeholders report that it has become an effective operational practice that promotes shared accountability among hospitals and reduces delays in transferring individuals in crisis to an appropriate evaluation setting.

V. Emerging Policy Themes and Questions

A. Resource Limitations for Crisis and Outpatient Treatment for Adults and Children as the Underlying Driver

Participants repeatedly emphasized that resource limitations are the primary driver of many challenges: insufficient civil inpatient psychiatric beds; limited crisis units; inadequate funding for upstream services on the continuum of care like outpatient treatment or crisis services that prevent the need for inpatient care or reduce emergency department reliance; and a lack of robust step-down options. Many stakeholders expressed a desire for a unified message to the Legislature that current statutory schemes cannot function as intended without additional investments in psychiatric capacity, crisis services, and outpatient treatment for adults and children.

B. Training and Communication Gaps

Stakeholders also identified training and communication gaps, turnover in law enforcement necessitating continued education about community stakeholders like the LMHAs, local hospitals, and other community-based alternatives to inpatient care. There was broad support for statewide training targeted at law enforcement, hospitals, LMHAs, and judicial officers on both the legal framework and practical pathways.

C. Future Legislative Questions

In addition to operational and interpretive challenges, participants identified several unresolved policy questions that extend beyond local practice and may warrant legislative consideration. These include whether to clarify emergency detention timing when urgent or life-threatening medical care is needed, including whether a narrow tolling concept should be reintroduced; whether to modify the definition of “inpatient mental health facility” and “mental health facility”; and whether to codify or better support through additional resources the use of local protocols, MOUs, and navigation programs as mechanisms for creating locally tailored solutions.

VI. Recommendations

Based on both the statutory framework and the practical realities described, this report offers the following recommendations.

1. **Develop Collaborative Local Protocols.** Encourage LMHAs, hospitals, law enforcement agencies, EMS, and counties to develop written agreements that better identify and align roles and expectations. Local task forces can serve as an effective mechanism for bringing these partners together to develop and formalize these agreements. To build momentum for the local and state investments, it is essential that these agreements are not only established but operationalized through ongoing collaboration and implementation.

2. **Enhance Statewide Training and Communication.** Provide training on the emergency detention statutory framework, including when the 12-hour and 48-hour clocks start; distinctions between voluntary medical care, implied consent, and emergency detention; the new emergency detention form and common errors; and how to contact and collaborate with LMHAs and crisis services. Encourage the use of JCMH resources and existing law enforcement training materials, including those developed by CIT programs.
3. **Support Investment in Navigation and Diversion Programs.** Encourage expansion of innovative programs that better support law enforcement officers and reduce unnecessary emergency department use.
4. **Frame a Unified Legislative Message About Resources.** Work with statewide partners to develop a shared statement to the Legislature emphasizing that existing emergency detention laws depend on adequate psychiatric beds, crisis services, and outpatient treatment capacity for adults and children; crisis stabilization units and other alternatives to inpatient care, and community services are necessary for emergency detention statutes to function as intended; and future statutory changes should be paired with resource commitments.
5. **Study and, if Appropriate, Propose Targeted Statutory Clarifications.** Continue to gather data and feedback on how emergency detention timing interacts with medical emergencies; whether definitions of “mental health facility” and “inpatient mental health facility” should be modified.

VII. Conclusion

Emergency detention law and policy in Texas sit at the intersection of statutory language, clinical realities, and limited resources. The September 3, 2025, round table confirmed that while Texas Health and Safety Code Chapters 571 and 573 provide a framework, they leave important questions open, particularly about the role of emergency rooms, the meaning of “deemed suitable,” and the interaction between emergency detention and urgent medical care. This report reflects a shift from focusing solely on legal authority to acknowledging practical constraints faced by law enforcement, LMHAs, and hospitals. In the near term, local protocols, MOUs, and navigation programs appear effective when resources are available and offer a feasible path forward within existing law. Over the longer term, sustained legislative attention to psychiatric capacity, crisis infrastructure, and outpatient treatment for adults and children is needed. In addition, targeted statutory clarification may be needed to align legal authority with operational practice. JCMH will continue convening stakeholders, gathering data, and refining recommendations for the Texas Legislature, with the goal of promoting emergency detention practices that are legally sound, clinically appropriate, and operationally sustainable across Texas.