UNANNOTATED

CHAPTER 43
Commitment Procedures

ARTICLE 1
Mental Health and Developmental Disabilities

43-1-1. Mental condition of criminal defendants; evaluation; treatment.

A. Whenever a district court finds it necessary to obtain an evaluation of the mental condition of a defendant in a criminal case, the court shall order an evaluation from a qualified professional available to the local facilities of the court or from a qualified professional at a local mental health center designated by the secretary of health, and whenever the court finds it desirable to use state personnel or facilities to assist in making the evaluation, the court shall in its order for an evaluation require service upon the secretary of health of the court's order for evaluation. The secretary of health shall arrange for a qualified professional furnished by the state to visit the defendant in local facilities available to the court or shall designate suitable available facilities. If the secretary of health designates a local mental health center or a state facility for the defendant's evaluation within forty-eight hours of service of the evaluation order, the secretary of health shall notify the court of such designation. The court shall then enter an appropriate transport order which also provides for the return of the defendant to the local facilities of the court. The defendant shall be transported by the county to facilities designated by the secretary of health for the purpose of making an evaluation. Misdemeanor defendants shall be evaluated locally.

B. If the secretary of health elects to have the defendant retained at the district court's local facilities, the qualified professional furnished by the state shall visit the local facilities not later than two weeks from the time of service of the court's evaluation order upon the secretary of health and:

(1) after the evaluation of the defendant is completed, the qualified professional furnished by the state shall be available for deposition to declare his findings. The usual rules of evidence governing the use and admission of the deposition shall prevail; and

(2) if the secretary of health finds that the qualified professional will be unable to initiate the evaluation within two weeks from the time of service of the court's evaluation order upon the secretary of health, the secretary of health shall call upon the county sheriff of the county in which the defendant is incarcerated and have the

defendant transported to facilities designated by the secretary of health for the purpose of conducting the evaluation.

C. If the secretary of health elects to have the defendant transported to the facilities designated by the secretary of health for the purpose of evaluation, the evaluation shall be commenced as soon as possible after the admission of the defendant to the facility, but, in no event, shall the evaluation be commenced later than seventy-two hours after the admission. The defendant, at the conclusion of the evaluation, shall be returned by the county sheriff to the local facilities of the court upon not less than three days' notice. After the evaluation is completed, the qualified professional furnished by the state shall be available for deposition to declare his findings. The usual rules of evidence governing the use and admissibility of the deposition shall prevail.

D. Documents reasonably required by the secretary of health to show the medical and forensic history of the defendant shall be furnished by the court when required.

E. After an evaluation and upon reasonable notice, the district court may commit a dangerous defendant charged with a felony pursuant to Section 31-9-1.2 NMSA 1978 or may dismiss the charges without prejudice and refer the defendant to the district attorney for possible initiation of proceedings under the Mental Health and Developmental Disabilities Code. A defendant so committed under the Mental Health and Developmental Disabilities Code shall be treated as any other patient committed involuntarily. Whenever the secretary of health determines that he does not have the ability to meet the medical needs of a defendant committed pursuant to Sections 31-9-1.2 through 31-9-1.5 NMSA 1978, the secretary or his designee shall serve upon the district court and the parties a written certification of the lack of ability to meet the medical needs of the defendant. The court shall set a hearing upon the certification within ten days of its filing and shall, after the hearing, make a determination regarding disposition of the criminal case. When deemed by the secretary of health to be medically appropriate, a dangerous defendant committed pursuant to Section 31-9-1.2 NMSA 1978 may be returned by the county sheriff to the custody of the court upon not less than three days' notice. The secretary shall provide written notification to the court and parties within three days of the defendant's discharge.

F. All acts to be performed by the secretary of health pursuant to provisions of this section may be performed by the secretary's designee.

History: 1953 Comp., § 34-2-26, enacted by Laws 1976, ch. 43, § 1; 1977, ch. 253, § 45; 1989, ch. 94, § 2; 1989, ch. 128, § 1; 1993, ch. 240, § 7; 1993, ch. 249, § 7; 1999, ch. 149, § 6.

43-1-2. Short title.

Chapter 43, Article 1 NMSA 1978 may be cited as the "Mental Health and Developmental Disabilities Code".

History: 1953 Comp., § 34-2A-1, enacted by Laws 1977, ch. 279, § 1; 1989, ch. 128, § 2.

43-1-3. Definitions.

As used in the Mental Health and Developmental Disabilities Code:

A. "aversive stimuli" means anything that, because it is believed to be unreasonably unpleasant, uncomfortable or distasteful to the client, is administered or done to the client for the purpose of reducing the frequency of a behavior, but does not include verbal therapies, physical restrictions to prevent imminent harm to self or others or psychotropic medications that are not used for purposes of punishment;

B. "client" means a patient who is requesting or receiving mental health services or any person requesting or receiving developmental disabilities services or who is present in a mental health or developmental disabilities facility for the purpose of receiving such services or who has been placed in a mental health or developmental disabilities facility by the person's parent or guardian or by any court order;

C. "code" means the Mental Health and Developmental Disabilities Code;

D. "consistent with the least drastic means principle" means that the habilitation or treatment and the conditions of habilitation or treatment for the client, separately and in combination:

(1) are no more harsh, hazardous or intrusive than necessary to achieve acceptable treatment objectives for the client;

(2) involve no restrictions on physical movement and no requirement for residential care except as reasonably necessary for the administration of treatment or for the protection of the client or others from physical injury; and

(3) are conducted at the suitable available facility close to the client's place of residence;

E. "convulsive treatment" means any form of mental health treatment that depends upon creation of a convulsion by any means, including electroconvulsive treatment and insulin coma treatment;

F. "court" means a district court of New Mexico;

G. "crisis triage center" means a health facility that:

(1) is licensed by the health care authority; and

(2) provides stabilization of behavioral health crises and may include residential and nonresidential stabilization;

H. "department" or "division" means the behavioral health services division of the health care authority;

I. "developmental or intellectual disability" means a severe chronic disability attributable to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, cerebral palsy, autism or neurological dysfunction that requires similar treatment or habilitation;

J. "evaluation facility" means a community mental health or developmental disability program, a crisis triage center or a medical facility that has psychiatric or developmental or intellectual disability services available, including the New Mexico behavioral health institute at Las Vegas, or, if none of those is reasonably available or appropriate, the office of a physician or a certified psychologist that is capable of performing a mental status examination adequate to determine the need for involuntary treatment;

K. "experimental treatment" means any mental health or developmental disabilities treatment that presents significant risk of physical harm, but does not include accepted treatment used in competent practice of medicine and psychology and supported by scientifically acceptable studies;

L. "grave passive neglect" means failure to provide for basic personal or medical needs or for one's own safety to such an extent that it is more likely than not that serious bodily harm will result in the near future;

M. "habilitation" means the process by which professional persons and their staff assist a client with a developmental or an intellectual disability in acquiring and maintaining those skills and behaviors that enable the person to cope more effectively with the demands of the person's self and environment and to raise the level of the person's physical, mental and social efficiency. "Habilitation" includes but is not limited to programs of formal, structured education and treatment;

N. "likelihood of serious harm to oneself" means that it is more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to the person's self by violent or other self-destructive means, including grave passive neglect;

O. "likelihood of serious harm to others" means that it is more likely than not that in the near future a person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense, as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from the person;

P. "mental disorder" means substantial disorder of a person's emotional processes, thought or cognition that grossly impairs judgment, behavior or capacity to recognize reality, but does not mean developmental or intellectual disability;

Q. "mental health or developmental or intellectual disabilities professional" means a physician or other professional who by training or experience is qualified to work with persons with a mental disorder or a developmental or intellectual disability;

R. "physician" or "certified psychologist", when used for the purpose of hospital admittance or discharge, means a physician or certified psychologist who has been granted admitting privileges at a hospital licensed by the health care authority, if such privileges are required;

S. "protected health information" means individually identifiable health information transmitted by or maintained in an electronic form or any other form or media that relates to the:

(1) past, present or future physical or mental health or condition of a person;

(2) provision of health care to a person; or

(3) payment for the provision of health care to a person;

T. "psychosurgery":

(1) means those operations currently referred to as lobotomy, psychiatric surgery and behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of the following:

(a) modification or control of thoughts, feelings, actions or behavior rather than the treatment of a known and diagnosed physical disease of the brain;

(b) treatment of abnormal brain function or normal brain tissue in order to control thoughts, feelings, actions or behavior; or

(c) treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions or behavior when the abnormality is not an established cause for those thoughts, feelings, actions or behavior; and

(2) does not include prefrontal sonic treatment in which there is no destruction of brain tissue;

U. "qualified mental health professional licensed for independent practice" means an independent social worker, a licensed professional clinical mental health counselor, a marriage and family therapist, a certified nurse practitioner, a clinical nurse specialist

with a specialty in mental health or a licensed art therapist, all of whom by training and experience are qualified to work with persons with a mental disorder;

V. "residential treatment or habilitation program" means diagnosis, evaluation, care, treatment or habilitation rendered inside or on the premises of a mental health or developmental disabilities facility, hospital, clinic, institution or supervisory residence or nursing home when the client resides on the premises; and

W. "treatment" means any effort to accomplish a significant change in the mental or emotional condition or behavior of the client.

History: 1953 Comp., § 34-2A-2, enacted by Laws 1977, ch. 279, § 2; 1978, ch. 161, § 1; 1979, ch. 213, § 1; 1979, ch. 396, § 1; 1989, ch. 128, § 3; 1993, ch. 77, § 231; 2005, ch. 313, § 11; 2007, ch. 46, § 42; 2007, ch. 325, § 9; 2013, ch. 39, § 1; 2016, ch. 84, § 15; 2023, ch. 113, § 12; 2023, ch. 117, § 2; 2024, ch. 39, § 124.

43-1-4. Legal representation of clients.

A. Clients shall be represented by counsel at all proceedings under the code and shall be entitled to obtain advice of counsel at any time regarding their status under the code.

B. The court shall appoint counsel to represent a client who has not retained counsel and is unable to do so. When appointing counsel, the court shall give preference to nonprofit organizations offering representation to persons with a mental illness or a developmental disability. A client shall be liable for the cost of legal representation unless the client is indigent.

History: 1953 Comp., § 34-2A-3, enacted by Laws 1977, ch. 279, § 3; 1978, ch. 161, § 2; 2007, ch. 46, § 43.

43-1-5. Competence.

Neither the fact that a person has been accepted at or admitted to a hospital or institutional facility, nor the receiving of mental health or developmental disability treatment services, shall constitute a sufficient basis for a finding of incompetence or the denial of any right or benefit of whatever nature which he would have otherwise.

History: 1953 Comp., § 34-2A-4, enacted by Laws 1977, ch. 279, § 4.

43-1-6. Personal rights of residential clients.

All clients who receive residential treatment or habilitation services shall have the rights provided in this section.

A. Subject to restrictions by a physician for good cause, each resident client has the right to receive visitors of his own choosing daily. Hours during which visitors may be received shall be limited only in the interest of effective treatment and the reasonable efficiency of the supervised residential facility and shall be sufficiently flexible to accommodate the individual needs of the resident client and his visitors. Notwithstanding the above, each resident client has the right to receive visits from his attorney, physician, psychologist, clergyman or social worker in private at any reasonable time, irrespective of visiting hours, provided the visitor shows reasonable cause for visiting at times other than normal visiting hours.

B. Writing material and postage stamps shall be reasonably available for the resident clients' use in writing letters and other communications. Reasonable assistance shall be provided for writing, addressing and posting letters and other documents upon request. The resident client has the right to send and receive sealed and uncensored mail. The resident client has the right to reasonable private access to telephones and, in cases of personal emergencies when other means of communication are not satisfactory, he shall be afforded reasonable use of long distance calls. Provided that for other than mail or telephone calls to a court or an attorney, a physician or certified psychologist may, for good cause, restrict mailing or telephone privileges. A resident client who is indigent shall be furnished such writing, postage and telephone facilities without charge.

C. Each resident client has the right to follow or abstain from the practice of religion. The supervised residential facility shall provide appropriate assistance in this connection including reasonable accommodations for religious worship and transportation to nearby religious services. Clients who do not wish to participate in religious practice shall be free from pressure to do so or to accept religious beliefs.

D. Each resident client has the right to a humane psychological and physical environment. He shall be provided a comfortable bed and adequate changes of linen and reasonable storage space for his personal possessions. Except when curtailed for reason of safety or therapy as documented in his record by his physician, he shall be afforded reasonable privacy in his sleeping and personal hygiene practices.

E. Each resident client shall have reasonable daily opportunities for physical exercise and outdoor exercise and shall have reasonable access to recreational areas and equipment.

F. Each resident client has the right to a nourishing, well-balanced, varied and appetizing diet.

G. Each resident client has the right to prompt and adequate medical attention for any physical ailments and shall receive a complete physical examination upon admission and at least once every twelve months thereafter; provided, however, that clients who have received a complete physical examination within two days prior to the

current admission shall not receive a complete physical examination unless the physician deems it necessary.

H. All resident clients have the right to a clean, safe, comfortable environment in a structure which complies with generally applicable fire safety requirements.

I. All resident clients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a licensed physician or by a verbal order, noted promptly in the patient's medical record and signed by the physician within twenty-four hours. Medication shall be administered only by a licensed physician, registered nurse or licensed practical nurse or by a medical or nursing student under the direct supervision of a licensed physician or registered nurse. The attending physician shall be responsible for all medication given or administered to a resident client. Notation of each individual's medication shall be kept in his medical records and shall include a notation by the physician of the behavioral or symptomatic baseline data upon which the medication order was made. The attending physician shall review on a regular basis the drug regimen of each resident client under his care. All prescriptions for psychotropic medications shall be written with a termination date which shall not exceed thirty days. Medication shall not be used as a punishment, for the convenience of staff, as a substitute for programs or in quantities that interfere with the client's treatment or habilitation program.

History: 1953 Comp., § 34-2A-5, enacted by Laws 1977, ch. 279, § 5; 1978, ch. 161, § 3; 1989, ch. 128, § 4.

43-1-7. Right to treatment.

Each resident client receiving mental health services shall have the right to prompt treatment pursuant to an individualized treatment plan and consistent with the least drastic means principle.

History: 1953 Comp., § 34-2A-6, enacted by Laws 1977, ch. 279, § 6.

43-1-8. Right to habilitation.

Each resident client receiving developmental disabilities services shall have the right to prompt habilitation services pursuant to an individualized habilitation plan and consistent with the least drastic means principle.

History: 1953 Comp., § 34-2A-7, enacted by Laws 1977, ch. 279, § 7.

43-1-9. Individualized treatment or habilitation plans.

A. An individualized treatment or habilitation plan shall be prepared within fourteen days of a client's admission to residential treatment or services.

B. Each client shall, to the maximum extent possible, be involved in the preparation of his own individualized treatment or habilitation plan.

C. Each individualized treatment or habilitation plan shall include:

(1) a statement of the nature of the specific problem and the specific needs of the client;

(2) a statement of the least restrictive conditions necessary to achieve the purposes of treatment or habilitation;

(3) a description of intermediate and long-range goals, with the projected timetable for their attainment;

(4) a statement and rationale for the plan of treatment or habilitation for achieving these intermediate and long-range goals;

(5) specification of staff responsibility and a description of the proposed staff involvement with the client in order to attain these goals; and

(6) criteria for release to less restrictive settings for treatment or habilitation, criteria for discharge and a projected date for discharge.

D. A treatment or habilitation plan for resident clients shall include:

(1) mental status examination;

(2) intellectual function assessment;

(3) psychological assessment, which may include the use of psychological testing;

(4) educational assessment;

(5) vocational assessment;

(6) social assessment;

(7) medication assessment; and

(8) physical assessment.

E. The individualized treatment or habilitation plan shall be available upon request to the following persons: the client; the client's attorney; any mental health or developmental disabilities professional designated by the client; and the client's guardian or treatment guardian if one has been appointed. The client's progress in

attaining the goals and objectives set forth in his individualized treatment or habilitation plan shall be monitored and noted in his records, and revisions in the plan may be made as circumstances require; provided that the persons authorized by this subsection to have access to the individualized plan shall be informed of major changes and shall have the opportunity to participate in such decision. Nothing in this subsection shall require disclosure of information to a client or to his parent when the attending physician or certified psychologist believes that disclosure of that particular information would be damaging to the client and so records in the client's medical record.

History: 1953 Comp., § 34-2A-8, enacted by Laws 1977, ch. 279, § 8; 1989, ch. 128, § 5; 1993, ch. 77, § 232.

43-1-10. Emergency mental health evaluation and care.

A. A peace officer may detain and transport a person for emergency mental health evaluation and care in the absence of a legally valid order from the court only if:

(1) the person is otherwise subject to lawful arrest;

(2) the peace officer has reasonable grounds to believe the person has just attempted suicide;

(3) the peace officer, based upon the peace officer's own observation and investigation, has reasonable grounds to believe that the person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Immediately upon arrival at the evaluation facility, the peace officer shall be interviewed by the admitting physician or the admitting physician's designee; or

(4) a physician, a psychologist or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency has certified that the person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Such certification shall constitute authority to transport the person.

B. An emergency evaluation under this section shall be accomplished upon the request of a peace officer or jail or detention facility administrator or that person's designee or upon the certification of a physician, a psychologist or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency. A court order is not required under this section. If an application is made to a court, the court's power to act in furtherance of an emergency admission shall be limited to ordering that:

(1) the client be seen by a certified psychologist or psychiatrist prior to transport to an evaluation facility; and

(2) a peace officer transport the person to an evaluation facility.

C. An evaluation facility may accept for an emergency-based admission any person when a physician or certified psychologist certifies that such person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Such certification shall constitute authority to transport the person.

D. A person detained under this section shall, whenever possible, be taken immediately to an evaluation facility. Detention facilities shall be used as temporary shelter for such persons only in cases of extreme emergency for protective custody, and no person taken into custody under the provisions of the code shall remain in a detention facility longer than necessary and in no case longer than twenty-four hours. If use of a detention facility is necessary, the proposed client:

(1) shall not be held in a cell with prisoners;

(2) shall not be identified on records used to record custody of prisoners;

(3) shall be provided adequate protection from possible suicide attempts; and

(4) shall be treated with the respect and dignity due every citizen who is neither accused nor convicted of a crime.

E. The admitting physician or certified psychologist shall evaluate whether reasonable grounds exist to detain the proposed client for evaluation and treatment, and, if reasonable grounds are found, the proposed client shall be detained. If the admitting physician or certified psychologist determines that reasonable grounds do not exist to detain the proposed client for evaluation and treatment, the proposed client shall not be detained.

F. Upon arrival at an evaluation facility, the proposed client shall be informed orally and in writing by the evaluation facility of the purpose and possible consequences of the proceedings, the right to a hearing within seven days, the right to counsel and the right to communicate with an attorney and a mental health professional of the proposed client's own choosing and shall have the right to receive necessary and appropriate treatment.

G. A peace officer who transports a proposed client to an evaluation facility under the provisions of this section shall not require a court order to be reimbursed by the referring county.

History: 1953 Comp., § 34-2A-9, enacted by Laws 1977, ch. 279, § 9; 1978, ch. 161, § 4; 1979, ch. 396, § 2; 1989, ch. 128, § 6; 2013, ch. 39, § 2.

43-1-11. Commitment of adults for thirty-day period.

A. Every adult client involuntarily admitted to an evaluation facility pursuant to Section 43-1-10 NMSA 1978 has the right to a hearing within seven days of admission unless waived after consultation with counsel. If a physician or evaluation facility decides to seek commitment of the client for evaluation and treatment, a petition shall be filed with the court within five days of admission requesting the commitment. The petition shall include a description of the specific behavior or symptoms of the client that evidence a likelihood of serious harm to the client or others and shall include an initial screening report by the evaluating physician individually or with the assistance of a mental health professional or, if a physician is not available, by a mental health professional acceptable to the court. The petition shall list the prospective witnesses for commitment and a summary of the matters to which they will testify. Copies of the petition shall be served on the client, the client's guardian, and treatment guardian if one has been appointed, and the client's attorney.

B. At the hearing, the client shall be represented by counsel and shall have the right to present evidence on the client's behalf, including testimony by an independent mental health professional of the client's own choosing, to cross-examine witnesses and to be present at the hearing. The presence of the client may be waived upon a showing to the court that the client knowingly and voluntarily waives the right to be present. A complete record of all proceedings shall be made.

C. A court-appointed guardian for an adult involved in an involuntary commitment proceeding shall have automatic standing to appear at all stages of the proceeding and shall be allowed to testify by telephone or through affidavit if circumstances make live testimony too burdensome.

D. The court shall include in its findings the guardian's opinion regarding the need for involuntary treatment or a statement detailing the efforts made to ascertain the guardian's opinion.

E. Upon completion of the hearing, the court may order a commitment for evaluation and treatment not to exceed thirty days if the court finds by clear and convincing evidence that:

(1) as a result of a mental disorder, the client presents a likelihood of serious harm to the client's own self or others;

(2) the client needs and is likely to benefit from the proposed treatment; and

(3) the proposed commitment is consistent with the treatment needs of the client and with the least drastic means principle.

F. Once the court has made the findings set forth in Subsection E of this section, the court shall hear further evidence as to whether the client is capable of informed consent. If the court determines that the client is incapable of informed consent, the

court shall appoint for the client a treatment guardian who shall have only those powers enumerated in Section 43-1-15 NMSA 1978.

G. An interested person who reasonably believes that an adult is suffering from a mental disorder and presents a likelihood of serious harm to the adult's own self or others, but does not require emergency care, may request the district attorney to investigate and determine whether reasonable grounds exist to commit the adult for a thirty-day period of evaluation and treatment. The applicant may present to the district attorney any medical reports or other evidence immediately available to the applicant, but shall not be required to obtain a medical report or other particular evidence in order to make a petition. The district attorney shall act on the petition within seventy-two hours. If the district attorney determines that reasonable grounds exist to commit the adult, the district attorney may petition the court for a hearing. The court may issue a summons to the proposed client to appear at the time designated for a hearing, which shall be not less than five days from the date the petition is served. If the proposed client is summoned and fails to appear at the proposed time and upon a finding of the court that the proposed client has failed to appear, or appears without having been evaluated, the court may order the proposed client to be detained for evaluation as provided for in Subsection C of Section 43-1-10 NMSA 1978.

H. Any hearing provided for pursuant to Subsection G of this section shall be conducted in conformance with the requirements of Subsection B of this section.

History: 1953 Comp., § 34-2A-10, enacted by Laws 1977, ch. 279, § 10; 1978, ch. 161, § 5; 1979, ch. 396, § 3; 1989, ch. 128, § 7; 2009, ch. 159, § 14.

43-1-12. Extended commitment of adults.

A. A physician or evaluation facility may file a petition for extended commitment within twenty-one days after the beginning of the thirty-day commitment. The petition shall explain the necessity for extended commitment, specify the treatment that has been provided during the evaluation and include an individual treatment plan for the proposed commitment period. The petition shall list the prospective witnesses for commitment and a summary of the matters to which they will testify. Copies of the petition shall be served on the client, the client's guardian, and treatment guardian if one has been appointed, and the client's attorney.

B. A hearing shall be held upon the petition prior to the expiration of the thirty-day commitment period, at which the client shall have all rights granted to the client under Section 43-1-11 NMSA 1978 and in addition shall have a right to a trial by a six-person jury, if requested, and to an expeditious appeal, unless waived.

C. A court-appointed guardian for an adult involved in an involuntary commitment proceeding shall have automatic standing to appear at all stages of the proceeding and shall be allowed to testify by telephone or through affidavit if circumstances make live testimony too burdensome.

D. The court shall include in its findings the guardian's opinion regarding the need for involuntary treatment or a statement detailing the efforts made to ascertain the guardian's opinion.

E. If, at the conclusion of the hearing, the fact-finder determines by clear and convincing evidence that the client presents a likelihood of harm to the client's self or to others, that extended treatment is likely to improve the client's condition and that the proposed extended commitment is consistent with the least drastic means principle, the court shall order commitment of the client for a period not to exceed six months, except that when the client has been committed for two consecutive periods of commitment, any commitment commencing thereafter shall not exceed one year. At the expiration of the commitment order, the client may be detained only after a new commitment hearing, unless waived after consultation with the client's attorney, and entry of a new order for commitment not to exceed six months.

F. A client involuntarily referred for treatment pursuant to this section shall be entitled to a reexamination of the order for the client's involuntary referral for treatment on the client's own petition, or that of the client's legal guardian, parent, spouse, relative or friend, to the district court of the county in which the client resides or is detained. Upon receipt of the petition, the court shall conduct a proceeding in accordance with this section, except that a proceeding shall not be required to be conducted if the petition is filed sooner than sixty days after the issuance of the order for involuntary referral for treatment or sooner than sixty days after the filing of a previous petition under this subsection.

G. Nothing in this section shall limit the right of a client to petition the court for a writ of habeas corpus.

H. Nothing in this code shall prohibit a client from seeking voluntary admission under Section 43-1-14 NMSA 1978.

I. No mental health treatment facility is required to detain, treat or provide services to a client when the client does not require such detention, treatment or services.

History: 1953 Comp., § 34-2A-11, enacted by Laws 1977, ch. 279, § 11; 1978, ch. 161, § 6; 2009, ch. 159, § 15.

43-1-13. Involuntary commitment of developmentally disabled adults to residential care.

A. A guardian appointed pursuant to the Uniform Probate Code [Chapter 45 NMSA 1978] may file an application with an evaluation facility seeking residential habilitation services for the protected person. The application shall set forth the basis for the guardian's belief that residential habilitation is necessary and shall include a copy of pertinent medical and psychological evaluations that have been completed.

B. Upon receipt of an application filed according to Subsection A of this section, an evaluation facility may accept the proposed client for a period of evaluation and treatment not to exceed fourteen days. An evaluation facility shall prepare an individualized habilitation plan that shall be consistent with the least drastic means principle.

C. If the habilitation plan recommends residential services, the evaluation facility shall file with the court a petition for extended residential placement. Upon receipt of the petition, the court shall appoint an attorney to represent the proposed client. Notice of the hearing scheduled on the petition and a copy of the habilitation plan shall be given to the proposed client, the client's attorney and the client's guardian. The petition shall contain a list of the names and addresses of proposed witnesses.

D. At the hearing on the petition, the proposed client shall be represented by counsel and shall have the right to present evidence on the proposed client's behalf, including testimony of a developmental disability professional of the proposed client's choosing; to cross-examine witnesses; to be present at the hearing; and to trial by a six-person jury, if requested. A complete record of the hearing shall be made. There shall be a right to an expeditious appeal.

E. The guardian of an adult involved in a commitment proceeding for extended residential habilitation services shall have automatic standing to appear at all stages of the proceeding and shall be allowed to testify by telephone or through affidavit if circumstances make live testimony too burdensome.

F. The court shall include in its findings the guardian's opinion regarding the need for residential habilitation services or a statement detailing the efforts made to ascertain the guardian's opinion.

G. The court shall order residential placement of the proposed client if it is established by clear and convincing evidence that the proposed client has a developmental disability that creates an imminent likelihood of serious harm to the proposed client's self or to others, or the person is so greatly disabled that residential services would be in the person's best interest and that such residential placement is, in the person's case, the least drastic means. The court's order of residential placement shall be for a period not to exceed six months. At the expiration of the commitment order, the client may be detained only after a new commitment hearing, unless waived after consultation with the client's attorney, and entry of a new order for commitment not to exceed six months.

H. The court shall order placement that is least restrictive to the client and may order attendance and participation as a nonresident in habilitation programs conducted at residential or nonresidential facilities.

I. Any client involuntarily referred for habilitation treatment shall be entitled to a reexamination of the order for the client's involuntary referral for habilitation and

treatment on the client's own petition, or that of the client's legal guardian, parent, spouse, relative or friend, to the district court of the county in which the client resides or is detained. Upon receipt of the petition, the court shall conduct or cause to be conducted by a special commissioner a proceeding in accordance with this section, except that a proceeding shall not be required to be conducted if the petition is filed sooner than sixty days after the issuance of the order for involuntary referral for habilitation and treatment or sooner than sixty days after the filing of a previous petition under this subsection.

J. Nothing in this section shall limit the right of a client to petition the court for a writ of habeas corpus.

K. No developmental disabilities treatment or habilitation facility is required to detain, treat or provide services to a client when the client does not appear to require detention, treatment or habilitation.

History: 1953 Comp., § 34-2A-12, enacted by Laws 1977, ch. 279, § 12; 1978, ch. 161, § 7; 2009, ch. 159, § 16.

43-1-14. Voluntary admission to residential treatment or habilitation.

A. A person may voluntarily seek admission to residential treatment or habilitation.

B. A guardian appointed under the Uniform Probate Code [Chapter 45 NMSA 1978], an agent or surrogate under the Uniform Health-Care Decisions Act [Chapter 24, Article 7A NMSA 1978] or an agent under the Mental Health Care Treatment Decisions Act [Chapter 24, Article 7B NMSA 1978] shall not consent to the admission of an individual to a mental health care facility. If a guardian has full power or limited power that includes medical or mental health treatment or, if the individual's written advance health-care directive or advance directive for mental health treatment expressly permits treatment in a mental health care facility, the guardian, agent or surrogate may present the person to a facility only for evaluation for admission pursuant to Subsection E of Section 43-1-10 NMSA 1978.

C. Nothing in this section shall be construed as depriving voluntary clients of any right given to involuntary clients.

D. A client voluntarily admitted to residential treatment or habilitation has the right to immediate discharge from the residential facility upon request, unless the director of the facility or a physician determines that the client requires continued confinement and meets the criteria for involuntary residential treatment or habilitation under the code. If the director or physician so determines, the director or physician shall, on the first business day following the client's request for release, request the district attorney to initiate commitment proceedings under the code. The client has a right to a hearing on the client's confinement within five days of the client's request for release.

History: 1953 Comp., § 34-2A-13, enacted by Laws 1977, ch. 279, § 13; 1978, ch. 161, § 8; 2009, ch. 159, § 17.

43-1-15. Consent to treatment; adult clients.

A. No psychotropic medication, psychosurgery, convulsive therapy, experimental treatment or behavior modification program involving aversive stimuli or substantial deprivations shall be administered to a client without proper consent. If the client is capable of understanding the proposed nature of treatment and its consequences and is capable of informed consent, the client's consent shall be obtained before the treatment is performed. A client shall not be presumed to be incapable of giving consent for administration of psychotropic medications solely because the client has been involuntarily committed to a treatment facility or is awaiting a hearing on whether the client should be involuntarily committed to a treatment facility.

B. If the mental health or developmental disabilities professional or physician who is proposing this or any other course of treatment or any other interested person believes that the client is incapable of informed consent, the mental health or developmental disabilities professional or physician or other interested person may petition the court for the appointment of a treatment guardian to make a substitute decision for the client.

C. This original petition shall be served on the client and the client's attorney. A hearing on the petition shall be held within three court days. At the hearing, the client shall be represented by counsel and shall have the right to be present, to present witnesses and to cross-examine opposing witnesses.

D. When appointing a treatment guardian for an adult, the court shall give priority to a court-appointed guardian or, if no guardian has been appointed by a court, to an agent designated or nominated by the client when the client had capacity.

E. If after the hearing the court finds by clear convincing evidence that the client is not capable of making the client's own treatment decisions, the court may order the appointment of a treatment guardian.

F. The treatment guardian shall make a decision on behalf of the client whether to accept treatment, depending on whether the treatment appears to be in the client's best interest and is the least drastic means for accomplishing the treatment objective. In making a decision, the treatment guardian shall consult with the client and consider the client's expressed opinions, if any, even if those opinions do not constitute valid consent or rejection of treatment. The treatment guardian shall give consideration to previous decisions made by the client in similar circumstances when the client was able to make treatment decisions.

G. If a client, who is not a resident of a medical facility and for whom a treatment guardian has been appointed, refuses to comply with the decision of the treatment guardian, the treatment guardian may apply to the court for an enforcement order. Such

an order may authorize a peace officer to take the client into custody and to transport the client to an evaluation facility and may authorize the facility forcibly to administer treatment.

H. The treatment guardian shall consult with the physician or other professional who is proposing treatment, the client's attorney and interested friends, relatives or other agents or guardians of the client to the extent reasonably practical in making a decision.

I. If the client, physician or other professional wishes to appeal the decision of the treatment guardian, the client, physician or other professional may do so, filing an appeal with the court within three calendar days of receiving notice of the treatment guardian's decision. In such a decision, the client shall be represented by counsel. The court may overrule the treatment guardian's decision if it finds that decision to be against the best interest of the client.

J. When the court appoints a treatment guardian, it shall specify the length of time during which the treatment guardian may exercise the treatment guardian's powers, up to a maximum period of one year. If at the end of the guardianship period the treatment guardian believes that the client is still incapable of making the client's own treatment decisions, the treatment guardian shall petition the court for reappointment or for appointment of a new treatment guardian. The petition shall be served on the client, the client's attorney and the previously appointed treatment guardian if filed by another party. The guardianship shall be extended or a new guardian shall be appointed only if the court finds the client is, at the time of the hearing, incapable of understanding and expressing an opinion regarding treatment decisions. The client shall be represented by counsel and shall have the right to be present and present evidence at all such hearings.

K. If during a period of a treatment guardian's power, the treatment guardian, the client, the treatment provider, a member of the client's family or the client's attorney or another person believes that the client has regained competence to make the client's own treatment decisions, that person shall petition the court for a termination of the treatment guardianship. If the court finds the client is capable of making the client's own treatment decisions, it shall terminate the power of the treatment guardian and restore to the client the power to make the client's own treatment decisions.

L. A treatment guardian shall only have those powers enumerated in the code, unless the treatment guardian has also been appointed a guardian under the Uniform Probate Code [Chapter 45 NMSA 1978] pursuant to provisions of Section 45-5-303 NMSA 1978. A person carrying out the duties of a treatment guardian as provided in this section shall not be liable in any civil or criminal action so long as the treatment guardian is not acting in bad faith or with malicious purpose.

M. If a licensed physician believes that the administration of psychotropic medication is necessary to protect the client from serious harm that would occur while the provisions of Subsection B of this section are being satisfied, the licensed physician

may administer the medication on an emergency basis. When medication is administered to a client on an emergency basis, the treating physician shall prepare and place in the client's medical records a report explaining the nature of the emergency and the reason that no treatment less drastic than administration of psychotropic medication without proper consent would have protected the client from serious harm. Upon the sworn application of the treating physician, the court may issue an order permitting the treating physician to continue to administer psychotropic medication until a treatment guardian is appointed, if the requirements of Subsection B of this section for appointment of a treatment guardian are in the process of being satisfied in a timely manner.

History: 1953 Comp., § 34-2A-14, enacted by Laws 1977, ch. 279, § 14; 1978, ch. 161, § 9; 1979, ch. 140, § 1; 1989, ch. 128, § 8; 1993, ch. 240, § 8; 1993, ch. 249, § 8; 1999, ch. 239, § 1; 2009, ch. 159, § 18.

43-1-15.1. Crisis triage centers; admission or treatment.

A crisis triage center may accept:

A. voluntary admissions;

B. individuals who are voluntarily seeking treatment;

C. involuntary admissions; and

D. individuals who are not voluntarily seeking treatment.

History: Laws 2023, ch. 117, § 1.

43-1-16 to 43-1-18. Repealed.

43-1-19. Disclosure of information.

A. Except as otherwise provided in the code, no person shall, without the authorization of the client, disclose or transmit any confidential information from which a person well acquainted with the client might recognize the client as the described person, or any code, number or other means that can be used to match the client with confidential information regarding the client.

B. Authorization from the client shall not be required for the disclosure or transmission of confidential information in the following circumstances:

(1) when the request is from a mental health or developmental disabilities professional or from an employee or trainee working with a person with a mental disability or developmental disability, to the extent that the practice, employment or training on behalf of the client requires access to such information is necessary;

(2) when such disclosure is necessary to protect against a clear and substantial risk of imminent serious physical injury or death inflicted by the client on the client's self or another;

(3) when the disclosure is made pursuant to the provisions of the Assisted Outpatient Treatment Act [43-1B-1 to 43-1B-14 NMSA 1978], using reasonable efforts to limit protected health information to that which is minimally necessary to accomplish the intended purpose of the use, disclosure or request;

(4) when the disclosure of such information is to the primary caregiver of the client and the disclosure is only of information necessary for the continuity of the client's treatment in the judgment of the treating physician or certified psychologist who discloses the information;

(5) when such disclosure is to an insurer contractually obligated to pay part or all of the expenses relating to the treatment of the client at the residential facility. The information disclosed shall be limited to data identifying the client, facility and treating or supervising physician and the dates and duration of the residential treatment. It shall not be a defense to an insurer's obligation to pay that the information relating to the residential treatment of the client, apart from information disclosed pursuant to this section, has not been disclosed to the insurer;

(6) when the request is from a physician, a licensed psychologist or a qualified mental health professional licensed for independent practice and responsible for the continuity of care of inmates with a mental or developmental disability who are in a jail or corrections facility, and the disclosure is only of information necessary for the continuity of the client's treatment in the judgment of an equally qualified treating professional who discloses the information;

(7) when such disclosure is by a physician, a licensed psychologist or a qualified mental health professional licensed for independent practice and responsible for the treatment of inmates in a jail or corrections facility to another equally qualified treating professional responsible for the continuation of care of the inmate upon the inmate's release from a jail or corrections facility, and the disclosure is only of information necessary for the continuity of the client's treatment in the judgment of the treating professional who discloses the information; or

(8) for all confidential information in existence on and after July 1, 2024, when the disclosure is made to a governmental agency or its agent or a state educational institution, a duly organized state or county association of licensed physicians or dentists or a licensed health facility or staff committees of such a facility for the purpose of research, subject to the provisions of Section 14-6-1 NMSA 1978 and subject to the review of an institutional review board in compliance with the federal Health Insurance Portability and Accountability Act of 1996 or any succeeding legislation and any federal regulations governing institutional review boards.

C. No authorization given for the transmission or disclosure of confidential information shall be effective unless it:

(1) is in writing and signed; and

(2) contains a statement of the client's right to examine and copy the information to be disclosed, the name or title of the proposed recipient of the information and a description of the use that may be made of the information.

D. The client has a right of access to confidential information and has the right to make copies of any information and to submit clarifying or correcting statements and other documentation of reasonable length for inclusion with the confidential information. The statements and other documentation shall be kept with the relevant confidential information, shall accompany it in the event of disclosure and shall be governed by the provisions of this section to the extent they contain confidential information. Nothing in this subsection shall prohibit the denial of access to such records when a physician or other mental health or developmental disabilities professional believes and notes in the client's medical records that such disclosure would not be in the best interests of the client. In any such case, the client has the right to petition the court for an order granting such access.

E. Where there exists evidence that the client whose consent to disclosure of confidential information is sought is incapable of giving or withholding valid consent and the client does not have a guardian or treatment guardian appointed by a court, the person seeking such authorization shall petition the court for the appointment of a treatment guardian to make a substitute decision for the client, except that if the client is less than fourteen years of age, the client's parent or guardian is authorized to consent to disclosure on behalf of the client.

F. Information concerning a client disclosed under this section shall not be released to any other person, agency or governmental entity or placed in files or computerized data banks accessible to any persons not otherwise authorized to obtain information under this section.

G. Nothing in the code shall limit the confidentiality rights afforded by federal statute or regulation.

H. A person appointed as a treatment guardian in accordance with the Mental Health and Developmental Disabilities Code may act as the client's personal representative pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Sections 1171-1179 of the Social Security Act, 42 U.S.C. Section 1320d, as amended, and applicable federal regulations to obtain access to the client's protected health information, including mental health information and relevant physical health information, and may communicate with the client's health care providers in furtherance of such treatment.

History: 1953 Comp., § 34-2A-8, enacted by Laws 1977, ch. 279, § 18; 1989, ch. 128, § 5; 1993, ch. 77, § 232; 2007, ch. 46, § 44; 2009, ch. 159, § 19; 2016, ch. 84, § 16; 2019, ch. 192, § 4; 2024, ch. 31, § 2.

43-1-20. Special commissioner.

The court may conduct the proceedings required by this code, or may, by general or special order, appoint a special commissioner to do so. The special commissioner must be a licensed attorney. Upon conclusion of the hearing the special commissioner shall file his findings and recommendations with the court promptly.

History: 1953 Comp., § 34-2A-19, enacted by Laws 1977, ch. 279, § 19.

43-1-21. Convalescent status; rehospitalization.

A. The head of a residential facility may release an improved involuntary client on convalescent status when he believes that such release is in the best interests of the client. Release on convalescent status shall include provisions for continuing responsibility to and of the hospital. Prior to the expiration of the client's commitment period, the director of the residential facility shall re-examine the facts relating to the commitment of the client on convalescent status and, if he determines that in view of the condition of the client, commitment is no longer appropriate he shall discharge the client.

B. Prior to such discharge, the director of the residential facility from which the client is given convalescent status may at any time readmit the client. If there is reason to believe that the client requires rehospitalization, the director of the residential facility may issue an order for the immediate return of the client. Such an order, if not voluntarily complied with, shall, upon order by a judge of the district court of the county in which the client is resident or present, authorize any health or police officer to take the client into custody and transport him to the residential facility.

History: 1953 Comp., § 34-2A-20, enacted by Laws 1977, ch. 279, § 21.

43-1-22. Transportation.

Whenever a proposed patient is to be committed to a residential mental health or developmental disability facility, or to be returned to such a facility during commitment, the court ordering the commitment or authorizing the return of the patient may direct the sheriff, the state police or other appropriate persons to furnish suitable transportation in order to effect such commitment or return, contacting the department for directions as to the destination of the patient.

History: 1953 Comp., § 34-2A-21, enacted by Laws 1977, ch. 279, § 22.

43-1-23. Violation of clients' rights.

Any client who believes that his rights, as established by this code or by the constitution of the United States or of New Mexico, have been violated shall have a right to petition the court for redress. The client shall be represented by counsel. The court shall grant relief as is appropriate, subject to the provisions of the Tort Claims Act [41-4-1 to 41-4-27 NMSA 1978].

History: 1953 Comp., § 34-2A-22, enacted by Laws 1977, ch. 279, § 23; 1978, ch. 161, § 13.

43-1-24. Appeals; court of appeals.

Appeals taken pursuant to this code shall be taken to the court of appeals according to the rules of appellate procedure of the supreme court.

History: 1953 Comp., § 34-2A-23, enacted by Laws 1978, ch. 161, § 14.

43-1-25. Cost of care.

Clients who are indigent may receive care and treatment at state-operated facilities without charge. The governing authorities of such facilities may require payment for the cost of care and treatment from all others pursuant to established fee schedules based on ability to pay.

History: 1953 Comp., § 34-2A-24, enacted by Laws 1978, ch. 161, § 15.

ARTICLE 1A
Developmental Disabilities Community Services (Recompiled.)

43-1A-1 to 43-1A-12. Recompiled.

ARTICLE 1B
Assisted Outpatient Treatment

43-1B-1. Short title.

Sections 1 through 14 [43-1B-1 to 43-1B-14 NMSA 1978] of this act may be cited as the "Assisted Outpatient Treatment Act".

History: Laws 2016, ch. 84, § 1.

43-1B-2. Definitions.

As used in the Assisted Outpatient Treatment Act:

A. "advance directive for mental health treatment" means an individual instruction or power of attorney for mental health treatment made pursuant to the Mental Health Care Treatment Decisions Act [Chapter 24, Article 7B NMSA 1978];

B. "agent" means an individual designated in a power of attorney for health care to make a mental health care decision for the individual granting the power;

C. "assertive community treatment" means a team treatment approach designed to provide comprehensive community-based psychiatric treatment, rehabilitation and support to persons with serious and persistent mental disorders;

D. "assisted outpatient treatment" means categories of outpatient services ordered by a district court, including case management services, comprehensive community support services, intensive outpatient services, care coordination or assertive community treatment team services, prescribed to treat a patient's mental disorder and to assist a patient in living and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in harm to the patient or another or the need for hospitalization. Assisted outpatient treatment may include:

(1) medication;

(2) periodic blood tests or urinalysis to determine compliance with prescribed medications;

(3) individual or group therapy;

(4) day or partial-day programming activities;

(5) educational and vocational training or activities;

(6) alcohol and substance abuse treatment and counseling;

(7) periodic blood tests or urinalysis for the presence of alcohol or illegal drugs for a patient with a history of alcohol or substance abuse;

(8) supervision of living arrangements; and

(9) any other services prescribed to treat the patient's mental disorder and to assist the patient in living and functioning in the community, or to attempt to prevent a deterioration of the patient's mental or physical condition;

E. "covered entity" means a health plan, a health care clearinghouse or a health care provider that transmits any health information in electronic form;

F. "guardian" means a judicially appointed guardian having authority to make mental health care decisions for an individual;

G. "least restrictive appropriate alternative" means treatment and conditions that:

(1) are no more harsh, hazardous or intrusive than necessary to achieve acceptable treatment objectives; and

(2) do not restrict physical movement or require residential care, except as reasonably necessary for the administration of treatment or the protection of the patient;

H. "likely to result in serious harm to others" means that it is more likely than not that in the near future a person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense, as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from the person;

I. "likely to result in serious harm to self" means that it is more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to the person's self by violent or other self-destructive means, including grave passive neglect;

J. "mandated service" means a service specified in a court order requiring assisted outpatient treatment;

K. "participating municipality or county" means a municipality or county that has entered into a memorandum of understanding with its respective district court with respect to the funding of such district court's administrative expenses, including legal fees, for proceedings pursuant to the Assisted Outpatient Treatment Act;

L. "patient" means a person receiving assisted outpatient treatment pursuant to a court order;

M. "power of attorney for health care" means the designation of an agent to make health care decisions for the individual granting the power, made while the individual has capacity;

N. "provider" means an individual or organization licensed, certified or otherwise authorized or permitted by law to provide mental or physical health diagnosis or treatment in the ordinary course of business or practice of a profession;

O. "qualified professional" means a physician, licensed psychologist, prescribing psychologist, certified nurse practitioner or clinical nurse specialist with a specialty in mental health, or a physician assistant with a specialty in mental health;

P. "qualified protective order" means, with respect to protected health information, an order of a district court or stipulation of parties to a proceeding under the Assisted Outpatient Treatment Act;

Q. "respondent" means a person who is the subject of a petition or order for assisted outpatient treatment;

R. "surrogate decision-maker" means:

(1) an agent designated by the respondent;

(2) a guardian; or

(3) a treatment guardian; and

S. "treatment guardian" means a person appointed pursuant to Section 43-1-15 NMSA 1978 to make mental health treatment decisions for a person who has been found by clear and convincing evidence to be incapable of making the person's own mental health treatment decisions.

History: Laws 2016, ch. 84, § 2; 2020, ch. 44, § 1.

43-1B-3. Assisted outpatient treatment; criteria.

A person may be ordered to participate in assisted outpatient treatment if the court finds by clear and convincing evidence that the person:

A. is eighteen years of age or older and is a resident of a participating municipality or county;

B. has a primary diagnosis of a mental disorder;

C. has demonstrated a history of lack of compliance with treatment for a mental disorder that has:

(1) at least twice within the last forty-eight months, been a significant factor in necessitating hospitalization or necessitating receipt of services in a forensic or other mental health unit or a jail, prison or detention center; provided that the forty-eight-month period shall be extended by the length of any hospitalization, incarceration or detention of the person that occurred within the forty-eight-month period;

(2) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months; provided that the forty-eight-month period shall be extended by the length of any hospitalization, incarceration or detention of the person that occurred within the forty-eight-month period; or

(3) resulted in the person being hospitalized, incarcerated or detained for six months or more and the person is to be discharged or released within the next thirty days or was discharged or released within the past sixty days;

D. is unwilling or unlikely, as a result of a mental disorder, to participate voluntarily in outpatient treatment that would enable the person to live safely in the community without court supervision;

E. is in need of assisted outpatient treatment as the least restrictive appropriate alternative to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others; and

F. will likely benefit from, and the person's best interests will be served by, receiving assisted outpatient treatment.

History: Laws 2016, ch. 84, § 3.

43-1B-4. Petition to the court.

A. A petition for an order authorizing assisted outpatient treatment may be filed in the district court for the county in which the respondent is present or reasonably believed to be present; provided that such district court is a party to a memorandum of understanding with a participating municipality or county.

B. A petition for an order authorizing assisted outpatient treatment may be filed only by the following persons:

(1) a person eighteen years of age or older who resides with the respondent;

(2) the parent or spouse of the respondent;

(3) the sibling or child of the respondent; provided that the sibling or child is eighteen years of age or older;

(4) the director of a hospital where the respondent is hospitalized;

(5) the director of a public or charitable organization or agency or a home where the respondent resides and that provides mental health services to the respondent;

(6) a qualified professional who either supervises the treatment of or treats the respondent for a mental disorder or has supervised or treated the respondent for a mental disorder within the past forty-eight months; or

(7) a surrogate decision-maker.

C. The petition shall be entitled "In the Matter of _____" and shall include:

(1) each criterion for assisted outpatient treatment as set forth in Section 43-1B-3 NMSA 1978;

(2) facts that support the petitioner's belief that the respondent meets each criterion; provided that the hearing on the petition need not be limited to the stated facts; and

(3) whether the respondent is present or is reasonably believed to be present within the county where the petition is filed.

D. The petition shall be accompanied by an affidavit of a qualified professional that shall state that:

(1) the qualified professional has personally examined the respondent no more than ten days prior to the filing of the petition, that the qualified professional recommends assisted outpatient treatment for the respondent and that the qualified professional is willing and able to testify at the hearing on the petition either in person or by contemporaneous transmission from a different location; or

(2) no more than ten days prior to the filing of the petition, the qualified professional or the qualified professional's designee has unsuccessfully attempted to persuade the respondent to submit to an examination, that the qualified professional has reason to believe that the respondent meets the criteria for assisted outpatient treatment and that the qualified professional is willing and able to examine the respondent and testify at the hearing on the petition either in person or by contemporaneous transmission from a different location.

History: Laws 2016, ch. 84, § 4; 2020, ch. 44, § 2.

43-1B-5. Qualified protective order.

A. A motion seeking a qualified protective order shall accompany each petition for an order authorizing assisted outpatient treatment.

B. In considering the motion, the court shall determine which parties to the proceeding and their attorneys are authorized to receive, subpoena and transmit protected health information pertaining to the respondent for purposes of the proceeding. If the petitioner is a party identified in Paragraph (1), (2) or (3) of

Subsection B of Section 4 [43-1B-4 NMSA 1978] of the Assisted Outpatient Treatment Act, the court may bar or limit the disclosure of the respondent's protected health information.

C. Covered entities shall only disclose protected health information pertaining to the respondent in accordance with the court's order, except as otherwise provided by state and federal health care privacy laws.

D. Parties and their attorneys are only authorized to use the protected health information of the respondent as directed by the court's order.

E. Within forty-five days after the later of the exhaustion of all appeals or the date on which the respondent is no longer receiving assisted outpatient treatment, the parties and their attorneys and any person or entity in possession of protected health information received from a party or the party's attorney in the course of the proceeding shall destroy all copies of protected health information pertaining to the respondent, except that counsel are not required to secure the return or destruction of protected health information submitted to the court.

F. Nothing in the order controls or limits the use of protected health information pertaining to the respondent that comes into the possession of a party or the party's attorney from a source other than a covered entity.

G. Nothing in the court's order shall authorize any party to obtain medical records or information through means other than formal discovery requests, subpoenas, depositions or other lawful process, or pursuant to a patient authorization.

History: Laws 2016, ch. 84, § 5.

43-1B-6. Hearing; examination by a qualified professional.

A. Upon receipt of a petition meeting all requirements of Sections 4 and 5 [43-1B-4, 43-1B-5 NMSA 1978] of the Assisted Outpatient Treatment Act, the court shall fix a date for a hearing:

(1) no sooner than three or later than seven days after the date of service or as stipulated by the parties or, upon a showing of good cause, no later than thirty days after the date of service; or

(2) if the respondent is hospitalized at the time of filing of the petition, before discharge of the respondent and in sufficient time to arrange for a continuous transition from inpatient treatment to assisted outpatient treatment.

B. A copy of the petition and notice of hearing shall be served, in the same manner as a summons, on the petitioner, the respondent, the qualified professional whose

affidavit accompanied the petition, a current provider, if any, and a surrogate decision-maker, if any.

C. If the respondent has a surrogate decision-maker who wishes to provide testimony at the hearing, the court shall afford the surrogate decision-maker an opportunity to testify.

D. The respondent shall be represented by counsel at all stages of the proceedings.

E. If the respondent fails to appear at the hearing after notice, the court may conduct the hearing in the respondent's absence; provided that the respondent's counsel is present.

F. If the respondent has refused to be examined by the qualified professional whose affidavit accompanied the petition, the court may order a mental examination of the respondent as provided by Rule 1-035 (A) NMRA. The examination of the respondent may be performed by the qualified professional whose affidavit accompanied the petition. If the examination is performed by another qualified professional, the examining qualified professional shall be authorized to consult with the qualified professional whose affidavit accompanied the petition.

G. If the respondent has refused to be examined by a qualified professional and the court finds reasonable grounds to believe that the allegations of the petition are true, the court may issue a written order directing a peace officer who has completed crisis intervention training to detain and transport the respondent to a provider for examination by a qualified professional. A respondent detained pursuant to this subsection shall be detained no longer than necessary to complete the examination and in no event longer than twenty-four hours.

H. A qualified professional, who has personally examined the respondent within ten days of the filing of the petition, shall provide testimony in support of the finding that the respondent meets all of the criteria for assisted outpatient treatment and in support of the written proposed treatment plan developed pursuant to Section 7 [43-1B-7 NMSA 1978] of the Assisted Outpatient Treatment Act, including:

(1) the recommended assisted outpatient treatment, the rationale for the recommended assisted outpatient treatment and the facts that establish that such treatment is the least restrictive appropriate alternative;

(2) information regarding the respondent's access to, and the availability of, recommended assisted outpatient treatment in the community or elsewhere; and

(3) if the recommended assisted outpatient treatment includes medication, the types or classes of medication that should be authorized, the beneficial and detrimental physical and mental effects of such medication and whether such medication should be self-administered or administered by a specified provider.

History: Laws 2016, ch. 84, § 6.

43-1B-7. Written proposed treatment plan.

A. No later than the date of the hearing, a qualified professional shall provide a written proposed treatment plan to the court. The plan shall state all treatment services recommended for the respondent and, for each such service, shall specify a provider that has agreed to provide the service.

B. In developing a written proposed treatment plan, the qualified professional shall take into account, if existing, an advance directive for mental health treatment and provide the following persons with an opportunity to participate:

(1) the respondent;

(2) all current treating providers;

(3) upon the request of the respondent, an individual significant to the respondent, including any relative, close friend or individual otherwise concerned with the welfare of the respondent; and

(4) any surrogate decision-maker.

C. The written proposed treatment plan shall include case management services or an assertive community treatment team to provide care coordination and assisted outpatient treatment services recommended by the qualified professional. If the plan includes medication, it shall state whether such medication should be self-administered or administered by a specified provider and shall specify type and dosage range of medication. In no event shall the plan recommend the use of physical force or restraints to administer medication to the respondent.

D. If the written proposed treatment plan includes alcohol or substance abuse counseling and treatment, the plan may include a provision requiring relevant testing for either alcohol or abused substances; provided that the qualified professional's clinical basis for recommending such plan provides sufficient facts for the court to find that:

(1) the respondent has a history of co-occurring alcohol or substance abuse; and

(2) such testing is necessary to prevent a relapse or deterioration that would be likely to result in serious harm to self or likely to result in serious harm to others.

E. If the respondent has executed an advance directive for mental health treatment, the qualified professional shall include a copy of such advance directive with the submission of the proposed treatment plan.

History: Laws 2016, ch. 84, § 7.

43-1B-8. Disposition.

A. After a hearing meeting all requirements of Section 6 [43-1B-6 NMSA 1978] of the Assisted Outpatient Treatment Act, receipt of a proposed treatment plan meeting all requirements of Section 7 [43-1B-7 NMSA 1978] of that act and consideration of all relevant evidence, the court may order the respondent to receive assisted outpatient treatment if it finds by clear and convincing evidence that the respondent meets all criteria set forth in Section 3 [43-1B-3 NMSA 1978] of the Assisted Outpatient Treatment Act.

B. The court's order shall:

(1) provide for a period of outpatient treatment not to exceed one year;

(2) specify the assisted outpatient treatment services that the respondent is to receive; and

(3) direct one or more specified providers to provide or arrange for all assisted outpatient treatment for the patient throughout the period of the order.

C. If the court order includes medication, it shall state the type or types of medication and the dosage range found to be necessary, based on the treatment plan and evidence presented. The court may order the respondent to self-administer medication or accept the administration of such medication by a specified provider. In no event shall the court require or authorize the use of physical force or restraints to administer medication to the respondent.

D. The court may not order treatment that has not been recommended by the qualified professional and included in the written proposed treatment plan, nor direct the participation of a provider that has not been specified in such plan.

E. Nothing in the Assisted Outpatient Treatment Act, nor in the court's order, shall require any of the following to make payment for any services or items not otherwise a covered benefit under the terms of the applicable program or contract of insurance:

(1) a health maintenance organization;

(2) a managed health care plan;

(3) a health insurance company;

(4) a group health plan that provides medical care to employees or their dependents under the federal Employee Retirement Income Security Act of 1974 directly or through insurance, reimbursement or other means; or

(5) the state medicaid program.

F. If the court has received testimony from a surrogate decision-maker or a copy of an advance directive for mental health treatment executed by the respondent, the treatment order shall not conflict with the preferences expressed in such testimony or advance directive without a showing of good cause.

History: Laws 2016, ch. 84, § 8.

43-1B-9. Expeditious appeal.

There shall be a right to an expeditious appeal from a final order in a proceeding under the Assisted Outpatient Treatment Act.

History: Laws 2016, ch. 84, § 9.

43-1B-10. Effect of determination that respondent is in need of assisted outpatient treatment.

An assisted outpatient treatment order shall not be construed as a determination that the respondent is incompetent.

History: Laws 2016, ch. 84, § 10.

43-1B-11. Applications for continued periods of treatment.

A. Prior to the expiration of the period of assisted outpatient treatment, a party or the respondent's surrogate decision-maker may apply to the court for a subsequent order authorizing continued assisted outpatient treatment for a period not to exceed one year. The application shall be served upon those persons required to be served with notice of a petition for an order authorizing assisted outpatient treatment and every specified provider.

B. If the court's disposition of the application does not occur prior to the expiration date of the current order, the current order shall remain in effect until the court's disposition. The disposition of the application shall occur no later than ten calendar days following the filing of the application.

C. A respondent may be ordered to participate in continued assisted outpatient treatment if the court finds by clear and convincing evidence that the respondent:

(1) continues to have a primary diagnosis of a mental disorder;

(2) is unwilling or unlikely, as a result of a mental disorder, to participate voluntarily in outpatient treatment that would enable the respondent to live safely in the community without court supervision;

(3) is in need of continued assisted outpatient treatment as the least restrictive appropriate alternative in order to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others; and

(4) will likely benefit from, and the respondent's best interests will be served by, receiving continued assisted outpatient treatment.

History: Laws 2016, ch. 84, § 11.

43-1B-12. Application to stay, vacate, modify or enforce an order.

A. In addition to any other right or remedy available by law with respect to the court order for assisted outpatient treatment, a party or the respondent's surrogate decision-maker may apply to the court to stay, vacate, modify or enforce the order. The application shall be served upon those persons required to be served with notice of a petition for an order authorizing assisted outpatient treatment and every specified provider. The disposition of the application shall occur no later than ten calendar days following the filing of the application.

B. A specified provider shall apply to the court for approval before instituting a proposed material change in mandated services or assisted outpatient treatment unless such change is contemplated in the order. The application shall be served upon those persons required to be served with notice of a petition for an order authorizing assisted outpatient treatment and every specified provider. The disposition of the application shall occur no later than ten calendar days following the filing of the application. Nonmaterial changes may be instituted by the provider without court approval. For purposes of this subsection, "material change" means an addition or deletion of a category of assisted outpatient treatment and does not include a change in medication or dosage contemplated in the order that, based upon the clinical judgment of the provider, is in the best interest of the patient.

C. A court order requiring periodic blood tests or urinalysis for the presence of alcohol or abused substances shall be subject to review after six months by a qualified professional, who shall be authorized to terminate such blood tests or urinalysis without further action by the court.

History: Laws 2016, ch. 84, § 12.

43-1B-13. Failure to comply with assisted outpatient treatment.

A. If a qualified professional determines that a respondent has materially failed to comply with the assisted outpatient treatment as ordered by the court, such that the

qualified professional believes that the respondent's condition is likely to result in serious harm to self or likely to result in serious harm to others and that immediate detention is necessary to prevent such harm, the qualified professional shall certify the need for detention and transport of the respondent for emergency mental health evaluation and care pursuant to the provisions of Paragraph (4) of Subsection A of Section 43-1-10 NMSA 1978.

B. A respondent's failure to comply with an order of assisted outpatient treatment is not grounds for involuntary civil commitment or a finding of contempt of court, or for the use of physical force or restraints to administer medication to the respondent.

History: Laws 2016, ch. 84, § 13.

43-1B-14. Sequestration and confidentiality of records.

A. All records or information containing protected health information relating to the respondent, including all pleadings and other documents filed in the matter, social records, diagnostic evaluations, psychiatric or psychologic reports, videotapes, transcripts and audio recordings of interviews and examinations, recorded testimony and the assisted outpatient treatment plan that was produced or obtained as part of a proceeding pursuant to the Assisted Outpatient Treatment Act, shall be confidential and closed to the public.

B. The records described in Subsection A of this section may only be disclosed to the parties and:

(1) court personnel;

(2) court-appointed special advocates;

(3) attorneys representing parties to the proceeding;

(4) surrogate decision-makers;

(5) peace officers requested by the court to perform any duties or functions related to the respondent as deemed appropriate by the court;

(6) qualified professionals and providers involved in the evaluation or treatment of the respondent;

(7) public health authorities or entities conducting public health surveillance or research, if authorized by law; and

(8) any other person or entity, by order of the court, having a legitimate interest in the case or the work of the court.

History: Laws 2016, ch. 84, § 14.

ARTICLE 2
Alcoholics and Intoxicated Persons; Detoxification

43-2-1. Repealed.

43-2-1.1. Short title.

Chapter 43, Article 2 NMSA 1978 may be cited as the "Detoxification Reform Act".

History: Laws 2005, ch. 198, § 1.

43-2-2. Definitions.

As used in the Detoxification Reform Act:

A. "alcohol-impaired person" means a person who uses alcoholic beverages to the extent that the person's health and well-being are substantially impaired or endangered;

B. "authorized person" means a physician, public service officer or police officer;

C. "consistent with the least drastic means principle" means that the habilitation, protective custody or treatment and the conditions of habilitation, protective custody or treatment separately and in combination:

(1) are no more harsh, hazardous or intrusive than necessary to achieve acceptable treatment objectives or protection for the person committed; and

(2) involve no restrictions on physical movement except as reasonably necessary for the administration of treatment, for the security of the facility or for the protection of the person committed or another from physical injury;

D. "department" means the department of health;

E. "detention center" means a city, county or other jail, the administration of which agrees to accept intoxicated persons for protective custody; provided, however, that a detention center is authorized to hold a person in protective custody pursuant to Section 43-2-8 NMSA 1978 but is not otherwise subject to the provisions of the Detoxification Reform Act;

F. "drug-impaired person" means a person who uses drugs to the extent that the person's health and well-being are substantially impaired or endangered;

G. "incapacitated person" means a person who, as a result of the use of alcohol or drugs, is unconscious or has the person's judgment otherwise so impaired that the person is incapable of realizing and making rational decisions;

H. "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol or drugs;

I. "likely to inflict serious physical harm on another" means that it is more likely than not that in the near future the person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from that person;

J. "likely to inflict serious physical harm on oneself" means that it is more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to that person's self by violent or passive or other self-destructive means as evidenced by behavior causing, attempting or threatening the infliction of serious bodily harm to that person's self;

K. "protective custody" means confinement of an intoxicated person, for a period not less than twelve hours or more than seventy-two hours in length and under conditions consistent with the least drastic means principle;

L. "public service officer" means a civilian employee within a police department who is authorized by the police department to transport intoxicated or incapacitated persons to a treatment facility or detention center;

M. "treatment" means the broad range of emergency, outpatient, intermediate and inpatient services and care, including protective custody, diagnostic evaluation, medical, psychiatric, psychological and social service care, vocational rehabilitation and career counseling, which may be extended to alcohol-impaired, drug-impaired and intoxicated persons; and

N. "treatment facility" means:

(1) an institution under the supervision of the department and approved by the department for the care and treatment of alcohol-impaired persons or drug-impaired persons;

(2) a public institution approved by the department for the care and treatment of alcohol-impaired persons or drug-impaired persons, but not specifically under the supervision of the department; or

(3) any other facility that provides any of the services specified in the Detoxification Reform Act and is licensed by the department for those services.

History: 1953 Comp., § 46-12-2, enacted by Laws 1977, ch. 374, § 1; 1979, ch. 264, § 1; 1983, ch. 177, § 2; 1989, ch. 47, § 1; 2005, ch. 198, § 2; 2019, ch. 272, § 1.

43-2-3. Policy of state regarding substance abuse.

It is the policy of this state that intoxicated and incapacitated persons may not be subjected to criminal prosecution, but rather should be afforded protection. It is further the policy of this state that alcohol-impaired persons and drug-impaired persons should be afforded treatment in order that they may lead normal lives as productive members of society.

History: 1978 Comp., § 43-2-3, enacted by Laws 1989, ch. 378, § 4; 2005, ch. 198, § 3.

43-2-4. Adoption and enforcement of laws by a politcal [political] subdivision.

A. No county, municipality or other political subdivision may adopt or enforce a local law, ordinance, resolution or rule having the force of law that includes drinking, being a common drunkard or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or a sanction.

B. No county, municipality or other political subdivision may interpret or apply any law of general application to circumvent he [the] provision of Subsection A of this section.

C. Nothing in this section affects any law, ordinance, resolution or rule against driving under the influence of alcohol or drugs or other similar offense involving the operation of a vehicle, aircraft, boat, machinery or other equipment or regarding the sale, purchase, dispensing, possessing or use of alcoholic beverages at stated times and places or by a particular class of persons.

History: 1978 Comp., § 43-2-4, enacted by Laws 1989, ch. 378, § 5.

43-2-5. Duties of the department.

A. The department shall study the problem of alcoholism and drug abuse, including methods and facilities available for the care, custody, detention, treatment, employment and rehabilitation of persons addicted to the intemperate use of spirituous or intoxicating liquors or drugs. The department shall promote meetings for the discussion of problems confronting treatment facilities, clinics and agencies engaged in protective custody, treatment and rehabilitation of alcohol-impaired persons and drug-impaired persons and shall disseminate information on the subject of alcoholism and drug abuse for the assistance and guidance of residents and courts of the state.

B. The department shall make such reasonable rules for treatment facilities concerning physical conditions for protective custody commitments pursuant to Section 43-2-8 NMSA 1978 as it deems necessary, including such rules it deems appropriate for minors.

History: 1941 Comp., § 61-1203, enacted by Laws 1949, ch. 114, § 3; 1953 Comp., § 46-12-3; Laws 1957, ch. 12, § 1; 1976 (S.S.), ch. 9, § 3; 1977, ch. 253, § 51; 1977, ch. 374, § 4; 1983, ch. 177, § 3; 1989, ch. 47, § 3; 2005, ch. 198, § 4.

43-2-6. Gifts.

The bureau may accept or refuse on behalf of and in the name of the state any gift of any valuable thing, however the gift be created, for any purpose connected with the work of the bureau. Any such property so given shall be received and held by the state treasurer, but the division, upon recommendation of the governor and with the approval of the state board of finance, shall have the power to direct the disposition of any property so donated to it for any purpose consistent with the terms and conditions under which such gift was created.

History: 1941 Comp., § 61-1205, enacted by Laws 1949, ch. 114, § 5; 1953 Comp., § 46-12-5; Laws 1957, ch. 12, § 3; 1976 (S.S.), ch. 9, § 4; 1983, ch. 177, § 4.

43-2-7. Repealed.

43-2-8. Protective custody.

A. An intoxicated or incapacitated person may be committed to a treatment facility at the request of an authorized person for protective custody, if the authorized person has probable cause to believe that the person to be committed:

(1) is disorderly in a public place;

(2) is unable to care for the person's own safety;

(3) has threatened, attempted or inflicted physical harm on himself or another;

(4) has threatened, attempted or inflicted damage to the property of another;

(5) is likely to inflict serious physical harm on himself;

(6) is likely to inflict serious physical harm on another; or

(7) is incapacitated by alcohol or drugs.

A refusal to undergo treatment does not constitute conclusive evidence of lack of judgment as to the need for treatment.

B. An authorized person shall make a written application for commitment under this section, directed to the administration of the treatment facility. The application shall state facts in support of the need for protective custody.

C. Upon approval of the form of the application by the administration in charge of the treatment facility, the person shall be retained at the facility to which the person was admitted or transferred to another appropriate treatment facility until discharged under Subsection E of this section.

D. The administration in charge of a treatment facility may refuse an application if the treatment facility is at its relevant capacity or if the person to be committed is deemed too ill, injured, disruptive or dangerous to himself or another to be managed at the treatment facility.

E. An intoxicated person transported to a treatment facility pursuant to this subsection shall not be detained at the facility:

(1) once the person's blood or breath alcohol concentration level is zero, if alcohol-impaired, and there is no probable cause to believe the person remains at risk of physical harm to himself or another; or

(2) for more than seventy-two hours after admission, absent pendency of a petition filed pursuant to Section 43-2-9 NMSA 1978.

F. An intoxicated person held in protective custody pursuant to the Detoxification Reform Act shall not be considered to have been arrested or charged with any crime.

G. A record of protective custody shall not be considered as an arrest or criminal record.

H. A copy of the written application for commitment and a written explanation of the person's right to contact counsel shall be given by the administration to the person as soon as practicable after commitment. The administration of the treatment facility shall arrange translation of the application and explanation of rights for those who are unable to read the same. The administration shall also provide a reasonable opportunity for the person to contact counsel.

History: 1953 Comp., § 46-12-6.1, enacted by Laws 1977, ch. 374, § 5; 1979, ch. 264, § 2; 1985, ch. 182, § 1; 1989, ch. 47, § 4; 2005, ch. 198, § 5.

43-2-8.1. Repealed.

43-2-9. Repealed.

History: 1953 Comp., § 46-12-7, enacted by Laws 1977, ch. 374, § 6; 1979, ch. 264, § 3; 1983, ch. 177, § 5; 1989, ch. 47, § 5; repealed by Laws 2005, ch. 198, § 11.

43-2-10. Repealed.

History: 1941 Comp., § 61-1208, enacted by Laws 1949, ch. 114, § 8; 1953 Comp., § 46-12-8; Laws 1976 (S.S.), ch. 9, § 7; 1977, ch. 253, § 53; 1983, ch. 177, § 6; 1989, ch. 47, § 6; repealed by Laws 2005, ch. 198, § 11.

43-2-11. Voluntary clients.

A. The administration of a treatment facility may receive any intoxicated person, alcohol-impaired person or drug-impaired person who applies to be received as a client into the facility. If the voluntary client is:

(1) intoxicated, the client shall be discharged pursuant to Subsection E of Section 43-2-8 NMSA 1978; or

(2) not intoxicated, the client shall be discharged at the request of the client or, in the absence of such a request, at the discretion of the administration.

B. If a voluntary client leaves a treatment facility with or against the advice of the administration in charge of the facility, the department shall make reasonable provisions for the client's transportation to another facility or to the client's home.

C. A client who voluntarily submits himself for treatment in accordance with the Detoxification Reform Act shall not forfeit or abridge thereby any of the client's rights. The fact that the client has submitted himself for treatment or that the client has been given help or guidance shall not be used against the client in any proceeding in any court. The record of the voluntary commitment shall be confidential and shall not be divulged except on order of the court or upon receipt of a waiver and release duly executed by the client volunteering for commitment.

History: 1941 Comp., § 61-1209, enacted by Laws 1949, ch. 114, § 9; 1953 Comp., § 46-12-9; Laws 1976 (S.S.), ch. 9, § 8; 1977, ch. 253, § 54; 1977, ch. 374, § 7; 1983, ch. 177, § 7; 1989, ch. 47, § 7; 2005, ch. 198, § 6.

43-2-12. Assistance upon request.

The substance abuse bureau of the division shall accept for examination, diagnosis, guidance or treatment at any facility or clinic under its control any person who requests such assistance under regulations as may be prescribed by the division.

History: 1941 Comp., § 61-1210, enacted by Laws 1949, ch. 114, § 10; 1953 Comp., § 46-12-10; Laws 1976 (S.S.), ch. 9, § 9; 1983, ch. 177, § 8; 1989, ch. 47, § 8.

43-2-13. Repealed.

43-2-14. Costs of commitment and support.

The provisions of law with respect to the costs of commitment and the costs of support, including methods of determination of the persons liable for the costs, and all provisions of law enabling the state to secure reimbursement for any such items of cost, applicable to the commitment and support of mentally ill persons in state hospitals shall apply with equal force in respect to each item of expense incurred by the state in connection with the commitment, care, custody and treatment of any person committed to the substance abuse bureau of the division or to any institution maintained by the state. Voluntary patients may be required to pay the cost of their subsistence, care and treatment.

History: 1941 Comp., § 61-1212, enacted by Laws 1949, ch. 114, § 12; 1953 Comp., § 46-12-12; Laws 1967, ch. 78, § 3; 1976 (S.S.), ch. 9, § 11; 1983, ch. 177, § 10; 1989, ch. 47, § 9.

43-2-15. Report.

On or before December 1 in each year, the division shall render a report to the governor and the state legislature of its activities, including recommendations for improvements therein, by legislation or otherwise.

History: 1941 Comp., § 61-1213, enacted by Laws 1949, ch. 114, § 13; 1953 Comp., § 46-12-13; Laws 1976 (S.S.), ch. 9, § 12.

43-2-16. Repealed.

History: 1953 Comp., § 46-14-1, enacted by Laws 1973, ch. 331, § 1; repealed Laws 2005, ch. 198, § 11.

43-2-17. Repealed.

History: 1953 Comp., § 46-14-2, enacted by Laws 1973, ch. 331, § 2; 1977, ch. 374, § 8; repealed Laws 2005, ch. 198, § 11.

43-2-18. Repealed.

History: 1953 Comp., § 46-14-3, enacted by Laws 1973, ch. 331, § 3; repealed Laws 2005, ch. 198, § 15.

43-2-19. Peace officer or public service officer; no liability.

A. A peace officer or public service officer may, if the officer reasonably believes it necessary for the officer's own safety, make a protective search of an intoxicated

person before transporting the person to a residence, treatment facility or detention center.

B. A peace officer or public service officer shall not be held civilly liable for assault, false imprisonment or other alleged torts or crimes on account of reasonable measures taken under the authority of the Detoxification Reform Act, if such measures were, in fact, reasonable and did not involve use of excessive or unnecessary force.

History: 1953 Comp., § 46-14-4, enacted by Laws 1973, ch. 331, § 4; 2005, ch. 198, § 7.

43-2-20. Notification of family.

Whenever an intoxicated person is committed to protective custody, the administration in charge of the treatment facility shall provide the person an opportunity to contact a member of the intoxicated person's family as soon as practicable.

History: 1953 Comp., § 46-14-5, enacted by Laws 1973, ch. 331, § 5; 2005, ch. 198, § 8.

43-2-21. Liability for costs.

Any intoxicated person having transportation, shelter or treatment furnished to the person as an intoxicated person under the Detoxification Reform Act shall be liable to the furnishing city, county or treatment facility for its reasonable costs in providing that transportation, shelter or treatment.

History: 1953 Comp., § 46-14-6, enacted by Laws 1973, ch. 331, § 6; 2005, ch. 198, § 9.

43-2-22. Repealed.

History: 1953 Comp., § 46-14-7, enacted by Laws 1973, ch. 331, § 7; 1977, ch. 319, § 1; 1977, ch. 374, § 9; 1983, ch. 119, § 1; 1993, ch. 66, § 3; repealed Laws 2005, ch. 198, § 16.

43-2-23. Civil liability.

Physicians and treatment facilities and their officers, directors and employees shall not be liable to any person held on account of reasonable measures taken under the authority of the Detoxification Reform Act, absent proof of negligence or intentional misconduct.

History: Laws 2005, ch. 198, § 10.

ARTICLE 3
Community Alcoholism Treatment and Detoxification

43-3-1 to 43-3-6. Repealed.

43-3-7. Repealed.

43-3-8, 43-3-9. Repealed.

43-3-10. Definitions.

As used in Chapter 43, Article 3 NMSA 1978:

A. "board" means the board of county commissioners of a county;

B. "department" means the human services department [health care authority department];

C. "DWI program" means a community program specifically designed to provide treatment, aftercare or prevention of or education regarding driving while under the influence of alcohol or drugs;

D. "incarceration and treatment facility" means a minimum security detention facility that provides a DWI program;

E. "planning council" means a county DWI planning council;

F. "screening program" means a program that provides screening or examination by alcoholism treatment professionals of persons charged with or convicted of driving while intoxicated or other offenses to determine whether the person is:

(1) physically dependent on alcohol and thus suffering from the disease of alcoholism;

(2) an alcohol abuser who has not yet developed the alcoholism disease syndrome but has an entrenched pattern of pathological use of alcohol and social or occupational impairment in function from alcohol abuse; or

(3) neither an alcoholic nor an alcohol abuser such that alcoholism treatment is not necessary; and that provides referral or recommendation of such persons to the most appropriate treatment; and

G. "statewide substance abuse services plan" means the comprehensive plan for a statewide services network developed by the department that documents the extent of

New Mexico's substance abuse problem and statewide needs for prevention, screening, detoxification, short-term and long-term rehabilitation, outpatient programs and DWI programs. The plan shall be based on the continuum of care concept of a comprehensive prevention and treatment system.

History: Laws 1985, ch. 185, § 3; 1989, ch. 146, § 1; 1993, ch. 65, § 10; 1999, ch. 270, § 5; 2007, ch. 325, § 10.

43-3-11. Powers and duties of the department.

A. The department shall adopt rules to provide for:

(1) minimum standards of service for DWI programs that contract for funds pursuant to the department's behavioral health services rules; provided that rules adopted pursuant to this section shall, before adoption, have been presented to all interested parties in a public hearing;

(2) the format and guidelines for county DWI plans and the criteria for evaluating them; and

(3) procedures for reporting of programmatic and financial information necessary to evaluate the effectiveness of programs funded. Evaluation of program effectiveness shall include an analysis of outcome-based measures and the impact of the programs on the incidence of driving while under the influence of intoxicating liquor or drugs and shall be reported to the legislature annually.

B. The department shall provide technical assistance and training to assist each county as needed in developing its DWI plan.

C. The department shall review the impact of the programs on the reduction of the incidence of driving while under the influence of intoxicating liquor or drugs, approve county DWI plans and incorporate these plans into the statewide substance abuse services plan in accordance with Section 43-3-13 NMSA 1978.

D. Any screening programs funded pursuant to the behavioral health services rules shall be established in collaboration with the district, magistrate, metropolitan and municipal courts to be served by the screening program. Whenever feasible, the screening program shall not be provided by an alcoholism treatment program serving the judicial districts involved in order to avoid conflict of interest in recommending that offenders enter treatment.

History: Laws 1985, ch. 185, § 4; 1993, ch. 65, § 11; 1999, ch. 270, § 6.

43-3-12. Repealed.

43-3-13. Statewide substance abuse services plan.

A. The department shall develop and update annually prior to August 30 a statewide substance abuse services plan that documents the extent of New Mexico's substance abuse problem. The plan shall describe the effectiveness of existing services and shall document needs based on a statewide assessment that reflects local planning, concerns and priorities.

B. The department shall annually invite comment and review of the substance abuse services plan for a period of no less than thirty days prior to its publication.

C. The department shall make decisions concerning proposed substance abuse programs consistent with the priorities and service system concepts contained in the current statewide substance abuse services plan.

History: Laws 1985, ch. 185, § 6; 1993, ch. 65, § 12; 1999, ch. 270, § 7.

43-3-14. County DWI planning councils authorized; membership.

A. A board may create a county DWI planning council and appoint the members for terms set by the board. The members of the planning council shall be selected to represent a broad spectrum of interests and may include county officials, DWI program and service providers, law enforcement officers, alcohol counselors and therapists, school administrators and local political leaders.

B. The members of a planning council shall elect from among the membership of the planning council a chairman for a term designated by the board. The planning council shall meet at the call of the chairman.

C. Planning council members shall receive per diem and mileage reimbursement as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978] and shall receive no other compensation, perquisite or allowance.

History: Laws 1993, ch. 65, § 13.

43-3-15. County DWI plans.

A. With the advice of the planning council, the board or its designee shall prepare a county DWI plan. Upon approval of the DWI plan by the board and the planning council, the board shall submit the DWI plan to the department for approval and integration into the statewide alcoholism services plan.

B. Two or more boards may agree to establish a multicounty DWI plan.

C. Each county DWI plan shall include:

(1) a county needs assessment that identifies and quantifies:

(a) the major factors that affect access to and the success or effectiveness of local DWI programs;

(b) the gaps and needs not covered in local DWI programs; and

(c) the extent to which county residents use DWI programs available in other counties;

(2) an inventory of existing public and private DWI providers and programs in the county, including identification of any DWI program duplication, and existing governmental funding and other resources, including county funding, for county DWI programs; and

(3) recommendations and goals for providing, improving and funding DWI programs in the county, based on the needs assessment and inventory, and including proposals to eliminate duplication of programs and services, improve access to programs and services, establish new programs or services, provide additional funding, in-kind contributions and other resources for existing programs and where feasible use DWI programs available in other counties.

D. The county DWI plan shall be updated at the request of the board or the department if the plan as implemented through the statewide alcoholism services plan is not achieving its stated goals, if the needs of the county have changed or if the department determines that the distribution of funds is not having an impact on the incidence of driving while under the influence of intoxicating liquor or drugs.

History: Laws 1993, ch. 65, § 14.