

DEVELOPMENTS IN MENTAL HEALTH LAW

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I. Mental Health Law and Services Reforms in the 2015 Virginia General Assembly

The 2015 Virginia General Assembly session included statutory reforms that supplemented or clarified some of the significant reforms of 2014 regarding the government's response to individuals in mental health crisis. It also substantially changed the criteria for psychiatrically hospitalizing children 14 years of age and older over the minor's objection. The General Assembly approved some of the funding for outpatient and related services for persons with serious mental illness proposed by Virginia Governor McAuliffe as part of his Governor's Access Plan (GAP) initiative, and funding for several community-based mental health services recommended by the Governor's Task Force on Improving Mental Health Services and Crisis Response. Those actions are nicely summarized in a PowerPoint presentation made by Mr. Joe Flores, Deputy Secretary of the Department of Health and Human Services, at the final meeting of the Governor's Task Force on Improving Mental Health Services and Crisis Response, held on March 23, 2015 (and which can be found [here](#) on the Virginia

Department of Behavioral Health and Developmental Services [DBHDS] website [on pages 14 through 27]).

The Governor's Access Plan

Because the General Assembly has declined to adopt Medicaid expansion under the Affordable Care Act as recommended by Governor McAuliffe, the governor submitted a narrower plan, which received waiver approval for federal funding. The proposed "Governor's Access Plan" (GAP) would provide insurance coverage for key outpatient medical services (such as primary care, specialty care, laboratory tests, pharmacy services - including prescription medications - and outpatient behavioral health services) for all uninsured Virginians with a diagnosis of serious mental illness and an income at or below 100% of the federal poverty level (currently \$11,670). It was estimated that GAP could provide coverage for up to 20,000 people. The General Assembly approved funding to provide coverage for those with incomes up to 60% of the federal poverty level.

Implementing Recommendations of the Governor's Task Force on Improving Mental Health Services and Emergency Response

Other behavioral health items included in the Governor's budget amendments (reflecting recommendations from the Task Force) and approved by the General Assembly included:

- 3 million dollars in additional funding to create 3 new PACT (Program of Assertive Community Treatment) Programs (adding to the current total of 20 teams statewide);
- 2.2 million dollars in additional funding to enable Community Services Boards to "purchase" psychiatric beds in local hospitals for the treatment of uninsured individuals needing such hospitalization;
- 2.1 million dollars in additional funding for permanent supportive housing;
- 2 million dollars in additional funding for children's mental health services;
- 1.9 million dollars in additional funds to cover the growth in "special hospitalization costs";
- 1.8 million dollars in additional funding for 6 additional therapeutic assessment "Drop Off" centers (for a total of 24 such centers statewide);
- 800 thousand dollars in additional funding for increased staffing at certain state hospitals.

Other Initiatives

In the appendices to his [presentation](#) (pages 28-35), Mr. Flores noted (and provided additional information on) several important initiatives by the administration to improve healthcare services and outcomes for Virginians:

- encouraging uninsured Virginians who may be eligible for tax credits to purchase health insurance on the federal marketplace (affecting up to 300,000 Virginians);
- providing outreach and education to Virginians about their healthcare coverage options so they can make appropriate choices;

- improving the access to, and quality of, health care provided to veterans (almost 800,000 Virginians);
- improving outcomes for persons with serious mental illness by providing “Medicaid Behavioral Health Homes” that provide coordinated and integrated health, mental health and substance abuse treatment services (presented to but not funded by the 2015 General Assembly);
- establishing a Task Force to address prescription drug and heroin abuse.

Statutory Changes Affecting Behavioral Health Services

The following bills were enacted by the 2015 General Assembly:

SB 773 (McWaters) and SB 779 (McWaters) – **Changing the criteria and certain procedures for psychiatric hospitalization of minors 14 years of age and older over the minor’s objection:**

These bills reflect the recommendations of the Joint Commission on Health Care (JCHC) following a months-long study conducted upon the request of the Senate Committee on Courts of Justice. That committee asked the JCHC to review “the minor consent requirement for voluntary inpatient psychiatric treatment proposed in Senate Bill 184 (McWaters).” Senate Bill 184, which was proposed in the 2014 General Assembly session but was “passed by indefinitely”, would have, among other changes, removed the existing statutory requirement that a minor 14 years of age or older must give consent (in addition to the minor’s parent) before the minor can be admitted to a mental health facility for inpatient treatment (Va. Code §§ 16.1-338 & 339). As set out in detail in the JCHC Report Document No. 459 (found [here](#)), the JCHC conducted a thorough review of key issues regarding the psychiatric hospitalization of older minors and such a minor’s objection to hospitalization. The JCHC recommended, and SB 773 and 779 enacted, these key changes:

- (1) The criteria for a Court to authorize the admission of a minor 14 years of age or older to a psychiatric facility over the minor’s objection were changed to be the *same* as the criteria authorizing a facility (without Court involvement) to admit the child with the child’s consent (Va. Code § 16.1-338(B)) rather than the more stringent criteria previously required.
- (2) If the minor objects to continued hospitalization after initially consenting, the statute will now require the hospital to notify immediately the consenting parent of the minor’s objection and to provide the parent with a summary (prepared by the Office of the Attorney General) of the procedures for requesting the Court to authorize continued inpatient treatment of the minor.

SB 966 (Barker) [identical to HB 1694 (Yost)] – **Clarifying an individual’s custody status while under an ECO/TDO:**

2014 amendments to the involuntary commitment statutes (for both adults and minors) stated (in Sections 16.1-340.1:1 and 37.2-809.1) that an individual for whom a temporary detention order (TDO) had been issued remained “in the custody” of the local community services board (CSB) until transported to a receiving mental health facility. This quoted language conflicts with other, longstanding, Code sections that require that such an

individual remain in the custody of *law enforcement* until custody is transferred to a facility or to an alternative transportation provider. It is the role of the local CSB to conduct an evaluation of the person who is in custody, not to hold the person in custody. SB 966 simply removes the 2014 language that had referred to the individual being in the custody of the CSB instead of law enforcement.

SB 1263 (Deeds) [identical to HB 1693 (Bell, Robert)] – Expanding the discretion to authorize alternative transportation to a facility under an ECO or TDO:

This bill expands the circumstances in which a magistrate can authorize someone other than a law enforcement officer to transport a person to a hospital or other facility for evaluation and/or treatment under an Emergency Custody Order (ECO) or Temporary Detention Order (TDO). Current law allows the magistrate to authorize alternative transportation only if the magistrate finds, in regard to the person in crisis who is to be transported, that “there is no substantial likelihood that the person will cause serious physical harm to himself or others...” This bill removes that required finding, but leaves it in the discretion of the magistrate to determine whether the proposed alternative transportation is safe and appropriate. The bill also provides that a person who provides such alternative transportation will *not* be liable “to the person being transported” for any civil damages for “ordinary negligence” in providing the transportation. Similar liability protection is provided for those who provide alternative transportation for a person to a hospital following a commitment hearing. Similar provisions are included in the commitment of minors legislation in Title 16.1. *Note:* The reduction in the involvement of law enforcement in providing transport in cases of civil commitment has been a key goal for both law enforcement authorities and mental health advocates.

SB 1265 (Deeds) [identical to HB 2118 (Cline/Hope)] – Clarifying the statutory requirement for updating the psychiatric registry:

Concerns were raised over whether the information from each hospital on the statewide “psychiatric bed registry” regarding the availability of a psychiatric bed was being updated with sufficient frequency so that the registry could reflect a “real time” picture of whether and where beds were available. This bill addresses those concerns by requiring each hospital to do the following: (1) make an update whenever there is an actual change in bed availability; and (2) make an update each day even if there is no actual change that day.

SB 1114 (Barker) – Clarifying the timeline and procedure for conducting an evaluation for a TDO of an individual who is under both an ECO and a “medical hold” under Section 37.2-1104:

Virginia Code Section 37.2-1104 already provides that, upon the “advice” of a licensed physician and upon finding “probable cause to believe” that a patient needs testing, observation or treatment for a serious condition but is incapable of giving informed consent to such action, a judge or magistrate may authorize a hospital ER or other facility to hold that person for up to 24 hours to provide the needed medical attention. (This can be extended only through an order, following a hearing, upon the filing of a petition seeking judicial authorization for treatment under Section 37.2-1101.) SB 1114 amends Section 37.2-808, on the issuance of emergency custody orders (ECOs), by providing that

the issuance of an ECO for a person does not preclude the issuance and execution of an order for temporary detention under Section 37.2-1104 for that same person during the same crisis. This bill specifies that, when there is both an ECO and a “medical hold” under 37.2-1104, the window of time for determining whether the person meets TDO criteria is not the 8 hours that an ECO is in effect, but instead is the 24-hour “medical hold” period authorized under Section 37.2-1104.

SB 1264 (Deeds) – Providing information about an individual to law enforcement regarding prior Court commitment(s) and findings of incapacity:

This bill is one piece of a larger discussion about how much information about a person’s diagnosed mental health condition, and about past court determinations about that person’s condition, should be shared with and among law enforcement officers, health care providers and others when a person is in mental health crisis. Current law requires that a report be made to the Central Criminal Records Exchange (CCRE) whenever a person has been involuntarily committed, or has chosen voluntary hospitalization in lieu of involuntary commitment (see Section [37.2-819](#)), and whenever a person is found mentally incapacitated by a court in a guardianship proceeding (see Section [64.2-2014](#)). The CCRE can use that information only to enter onto the person’s record that the person is prohibited from owning or possessing a firearm. The CCRE is not allowed to disseminate to any third party the specific records or findings of mental illness or incapacity upon which the person’s firearms prohibition was based. SB 1264 carves out a specific exception to that limitation. The bill authorizes the CCRE to provide information sent to it pursuant to Sections [37.2-819](#) and [64.2-2014](#) to law enforcement personnel defined in the statute. The purpose behind allowing such dissemination is to enable law enforcement personnel to have what may be important relevant information about the person’s mental health history and capacity when working with that person during a crisis.

The Governor’s Task Force on Improving Mental Health Services and Crisis Response has also addressed information sharing in its recommendations (See Recommendations 14 and 15 in the final report, found [here](#).)

HB 2368 (Garrett) – Directing a plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission:

This bill directs the Commissioner of Behavioral Health and Developmental Services, working with various stakeholders, to develop, by October 1, 2015 a comprehensive plan to “authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission.” That plan, along with recommended legislative changes needed to implement the plan, must be submitted by November 15, 2015 to several committees for consideration by the 2016 General Assembly. HB 2368, as originally presented on January 23, passed with almost no dissenting votes. However, the Governor drafted a proposed revision of HB 2368 for consideration by the General Assembly at its April 15, 2015 “reconvened” session and that version was enacted.

In the Governor’s revised version of HB 2368, found [here](#), the DBHDS Commissioner, with the listed stakeholders, would be directed to:

- (1) “review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission”;
- (2) “identify” in that review “community services boards and catchment areas where significant delays in responding to emergency evaluations are occurring or have occurred in recent years”;
- (3) “develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations”;
- (4) complete the plan and submit it to the Governor and the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century, the House Committee on Health, Welfare and Institutions, and the Senate Committee on Education and Health by November 15, 2015.

The General Assembly passed HB 2368 as revised by the Governor. The bill deserves particular attention because it touches on a pervasive problem in the mental health response system – the increasing pressures on hospital emergency departments presented by those experiencing mental health crises. The editor is devoting a significant portion of this issue of DMHL to this problem.

II. Feature Article: Mental Health Crises and Hospital Emergency Departments

John E. Oliver

While Virginia enacted important reforms in 2014 regarding the state’s response to people experiencing mental health crises, it is still the case that many individuals in mental health crisis may spend long hours (and even days in some states) in a hospital emergency department (ED), medically stable but too psychiatrically ill to be safely discharged, waiting for admission to a psychiatric hospital or other suitable secure placement for mental health treatment. These prolonged waits in EDs are often referred to as “psychiatric boarding,” and they occur with increasing frequency in almost every state. Nationwide, a variety of [studies](#) have documented that the overcrowding of EDs while patients await transfer to another facility results in poorer outcomes for them and for ED patients overall. It has also been documented that psychiatric patients are boarded in the ED longer than any other type of patient. A 2012 [study](#) of one hospital found that the financial loss from boarding psychiatric patients averaged over \$2,200 per patient. The problems in poor patient outcomes and financial losses from psychiatric boarding have reached the point that the American College of Emergency Physicians (ACEP) has made the reform and reduction of psychiatric boarding a major priority for its 2015 agenda. (See [article](#) detailing ACEP president’s initiatives.)

Many factors contribute to psychiatric boarding, including the time required to arrange and conduct emergency psychiatric evaluation in the ED and the legal requirements relating to these evaluations, a shortage of acute care psychiatric hospital beds, and the

gaps in intensive community-based placements as alternatives to hospitalization for individuals experiencing a mental health crisis. The review of the evaluation process for involuntary hospital admission mandated by HB 2368 can address only a part of this complex problem. The Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century has a broader mandate to look at possible innovations in psychiatric emergency treatment as well as emergency evaluations. In the sections that follow, this issue of DMHL will look briefly at some of the possible tensions within the current psychiatric emergency evaluation process, and then provide an overview of some innovative emergency psychiatric service models that might have some application in Virginia to improve interventions and outcomes for people in crisis.

The TDO Process

HB 2368 focuses on the time required to complete an emergency evaluation of a person who is in mental health crisis to determine whether a temporary detention order (TDO) should be issued to psychiatrically hospitalize that person. Virginia Code Section 37.2-809 requires that, before a TDO can be issued, it must be found that the person: (1) has a mental illness; (2) has a “substantial likelihood,” as a result of that illness, of causing serious physical harm to self or others, or suffering serious harm due to incapacity, “in the near future”; (3) needs hospitalization or treatment; (4) is unwilling to volunteer or is incapable of volunteering for hospitalization or treatment; and (5) has an appropriate facility willing to accept the person if a TDO is issued. In Virginia, the emergency evaluation process involves several players, each with their own roles and responsibilities in that process, and each, consequently, with a different perspective on that process.

The CSB evaluator’s role

Community services board (CSB) evaluators are authorized and mandated by law to evaluate individuals in mental health crisis to determine whether a Temporary Detention Order (TDO) should be sought from a magistrate for the temporary psychiatric hospitalization of those individuals (pending an involuntary commitment hearing). Sometimes these individuals are brought to the hospital ED by law enforcement officers under an Emergency Custody Order (ECO), which authorizes holding the individual in custody for up to 8 hours while the evaluation is conducted and a decision about a TDO is made. At other times (particularly in urban and suburban areas, where hospitals are more accessible) people who are in crisis come to the ED on their own or are brought there by others, and ED staff contact the local CSB to request evaluations of these individuals for a TDO. (A 2013 UVA study found that well over half of all CSB evaluations of people for issuance of a TDO occur in the ED setting.)

It is important to highlight that CSB evaluators are trained and expected to seek the least restrictive services and placements appropriate for the individual in crisis, ranging from outpatient and community based services to crisis stabilization or detoxification programs or voluntary admission to a local psychiatric facility, and thus avoid a TDO whenever appropriate. Under Virginia Code Section [37.2-809](#), a magistrate cannot enter a TDO until a CSB evaluator has completed an evaluation of the individual and has submitted

findings and recommendations to the magistrate. Although the magistrate is not required to follow the CSB evaluator's recommendations, in practice the CSB evaluator's recommendation that an individual should be psychiatrically hospitalized through a TDO is followed by the magistrate in the vast majority of cases.¹ If the CSB evaluator does find, and the magistrate agrees, that an individual in crisis meets the criteria for entry of a TDO, that order cannot be entered until the magistrate is able to identify in the order the facility to which that individual will be taken for temporary detention. A final part of the CSB evaluator's role, then, is to find an appropriate psychiatric facility that will accept the person.

The challenge of finding psychiatric beds for people in crisis

Prior to the 2014 General Assembly amendments to Section 37.2-809, there was no state statutory requirement that private or public psychiatric facilities accept the placement of a person under a TDO. Once an ECO expired, the individual could no longer be held against his or her will unless a TDO had been issued; such a TDO could *not* be entered unless and until the psychiatric hospital in which the person would be detained could be identified in the TDO itself. The limited and decreasing number of psychiatric hospital beds in Virginia, coupled with the behavioral challenges sometimes posed by individuals experiencing mental health crisis, has made CSB evaluators' task of finding psychiatric facilities willing and able to accept individuals under a TDO increasingly difficult. Sometimes finding beds for voluntary hospitalization is also difficult. On infrequent but recurring occasions, the ECO expired before a bed could be found for people who met the TDO criteria. If they were unwilling to remain in the ED (or other location where the evaluation was conducted) or to agree to a crisis service plan, they could slip through the safety net and put themselves and others at risk.

In 2014, SB [260](#) amended Section 37.2-809 and other statutes regarding involuntary commitment. A key change was a new requirement: if an individual in custody under an ECO is found to meet the criteria for a TDO, a state mental health facility *must* accept that person for admission under a TDO at the expiration of the ECO if another facility has not been found for that person. Significantly, the 2014 General Assembly did not provide any similar guarantee for individuals who are *not* being held under an ECO but who are in mental health crisis and meet criteria for a TDO.

The ED physician's perspective

ED physicians' concerns about the Virginia TDO evaluation process, even after the 2014 General Assembly reforms, were highlighted last year in the Governor's Task Force Work Group meetings. At the May 21, 2014 meeting of the "Crisis Response" work group of the Task Force, Dr. Bruce Lo, Chief of Emergency Medicine at Sentara Norfolk General Hospital, submitted a statement asking that the work group also "focus on persons who are not necessarily under an ECO but whose situation may lead to a TDO or

¹ No systemic study has been conducted regarding the frequency of cases in which the CSB evaluator does not find that the TDO criteria are met while other clinicians believe that they are met.

possibly a voluntary admission and their need for timely disposition just as for those in custody of law enforcement.”

In that same May 21 meeting, Dr. Douglas Knittel, an emergency psychiatrist at the Naval Medical Center in Portsmouth, Virginia, expressed the view that the existing evaluation process of having a CSB evaluator determine whether a TDO should be issued for a person in crisis is “redundant and wasteful.” His view was that a physician or licensed psychologist should be able to conduct the screening evaluation currently performed by the CSB evaluator.

Discussions during that May 21 meeting, as captured in the meeting minutes, responded in part to the concerns raised by Dr. Lo and Dr. Knittel. Mr. Lawrence “Buzz” Barnett, the (now-retired) director of Emergency Services for Region 10, noted that “individuals under ECOs or TDOs are only a small percentage of the much larger group of individuals who seek voluntary care during a psychiatric crisis.” Dr. Knittel’s proposal for physician-conducted TDO evaluations brought two responses. The first was that physicians are not as familiar with less restrictive community based treatments to which people in crisis could be diverted. As noted above, CSB evaluators are trained to seek least restrictive services, yet ED physicians normally do not interact with such treatment facilities and programs, which may limit the ability of the ED physician to adequately assess the possible treatment options of the individual outside the ED and/or psychiatric inpatient units. The second response to Dr. Knittel was that sometimes “there is some benefit to not making the decision to TDO too rapidly,” as the pre-screening process with the CSB evaluator itself sometimes can be a “therapeutic” process for a person in crisis that helps that person achieve more stability and choose a different treatment path than hospitalization. (See pp. 30-37 of the meeting minutes [here](#).)

These comments in the Crisis Response Work Group minutes provide a brief and incomplete glimpse into the differences in perspective that can develop between ED physicians and CSB evaluators regarding the best ways to respond to persons in the ED who are in mental health crisis. They also highlight important questions that remain about the proper role of the ED in managing such crises. For example, what should be done if the ED provider believes that the patient warrants (and that EMTALA mandates) admission but CSB does not believe the criteria are met? The DBHDS Commissioner’s HB 2368 stakeholders’ group will be exploring these issues and others, including challenges in achieving consensus on medical clearance, and whether the magistrate may consider the ED provider's opinion in determining whether to issue a TDO even if CSB does not recommend it.

However these issues about the TDO process are resolved by the DBHDS study group and, eventually, by the General Assembly, they will have only a marginal impact on the pressures being faced by EDs in trying to respond to increasing numbers of patients experiencing mental health crises. In order to address these problems, it is necessary to address the underlying causes of the “psychiatric boarding” and to envision service models that can provide better targeted services for evaluation, stabilization and treatment. In the remainder of this article, DMHL will review models that have

developed in other parts of the country for providing psychiatric emergency evaluations and services to people in crisis. Perhaps this review will help to inform the upcoming discussions of both the DBHDS Commissioner's HB 2368 stakeholders' group and the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century.

Models for Mental Health Crisis Response

In a June 1, 2010 article entitled "Treatment of Psychiatric Patients in Emergency Settings", published in *Primary Psychiatry* (available [here](#)), Dr. Scott Zeller, the Chief of Psychiatric Emergency Services at the John George Psychiatric Hospital in San Leandro, California, notes that the steadily increasing percentage of hospital ED visits nationwide that involve mental health issues and require psychiatric emergency services (now estimated to be between 6% and 9% of all ED visits), has led to the development of "psychiatric emergency services" as a medical sub-specialty. Dr. Zeller identifies three primary models of emergency delivery of psychiatric services (with various hybrid versions of each of these models having also developed in various states): (1) the psychiatric consultant in the ED; (2) the dedicated mental health wing in an ED; (3) the free-standing Psychiatric Emergency Services (PES) unit. Below is a summary of Dr. Zeller's discussion of those models.

Psychiatric consultant in the medical ED

Many hospital EDs employ a mental health services consultant, who often is not a psychiatrist, and in many cases may be a nurse practitioner, LCSW, or other licensed therapist. The advantages of this model: (1) it is "the lowest cost and easiest to implement"; (2) the patients all receive a medical screening so that organic causes for the person's psychiatric symptoms can be ruled out; (3) these patients are treated together with all other ED patients, so there is "less opportunity for stigma and delays in treatment than segregation might cause."

The disadvantages: (1) it may be hours before the mental health consultant can arrive, resulting in the patient going for a long period with "little or no treatment"; (2) "the consultant's decision is usually restricted to the choice either to admit for psychiatric hospitalization or to discharge, with little chance to observe a patient sufficiently to see if improvement or decline in status might change the disposition"; (3) the ER setting is not designed or intended for "extended psychiatric treatment"; (4) the high activity levels and serious patient health emergencies normally found in an ED work against the effort to calm a person in mental health crisis; (5) the ED can be unsafe because of the medical instruments and machinery found there; (6) staff may view mental health patients as inappropriate for that setting, and treat such patients poorly; (7) when understaffed, the ED may resort to using restraints to keep a mental health patient safe; (8) if the consultant is not a psychiatrist, the ED physicians may not respect that person's findings; (9) when the consultation is provided by psychiatrists from an area inpatient psychiatric facility, impartiality may be a concern.

Dedicated mental health wing of ED

Dr. Zeller notes that this model (1) provides a more nurturing environment; (2) provides more skilled treatment staff; (3) still ensures that there is a medical screening and history; (4) may allow “more time for medications and interventions to have effect prior to disposition decisions.”

The disadvantages: (1) the potential stigma for patients referred to this unit as being “different” or “crazy”; (2) the potential for overflow of medical ED patients into the unit during times of high ED use; (3) the potential evolution of these units into “holding areas” or “dumping grounds”, used primarily to get these individuals out of the ED, with little actual treatment until they are “placed.”

A stand-alone psychiatric emergency services unit: The “Alameda Model”

The John George Psychiatric Hospital, in Alameda County, California, is home to a stand-alone PES unit that has garnered attention and come to be known as the Alameda Model. The model, described in an article by Dr. Zeller, and his colleagues (available [here](#)), makes a significant claim: Dedicating sufficiently intensive services in an appropriate psychiatric emergency services (PES) setting to treat persons experiencing mental health crisis can bring sufficient stability to most of these individuals within 24 hours. Thus, people are able to return home or to a community-based program from the PES unit, so that (1) the disruptions to these people’s lives are minimized while their treatment needs are met in the least restrictive treatment setting, (2) psychiatric boarding in hospital emergency departments is ended, and (3) unnecessary psychiatric hospitalizations are prevented.

Dr. Zeller describes the PES unit as “typically a stand-alone program dedicated solely to the treatment of individuals in mental health crisis.” It can be locked, unlocked, or a combination; community-based or in-hospital. Normally it would be staffed with psychiatric nurses and other mental health professionals on a 24-hour basis, with psychiatrists either on-site or readily available. Set up and staffed this way, the PES unit can assess and treat people right away, “with the potential for patients to stabilize quickly.” The PES unit operates as an outpatient facility. The timeline for treating and discharging patients at the PES unit is 23 hours and 59 minutes.

As described in more detail in a February 15, 2015 article on the Alameda Model published by [AHC Media](#) (entitled, “Intriguing model significantly reduces boarding of psychiatric patients, need for inpatient hospitalization”, and found [here](#)), when a patient first arrives at the PES unit, a triage nurse conducts an initial evaluation for medical stability and then [if appropriate] sends the patient to a triage psychiatrist, stationed by the ambulance bay, who again assesses and makes “a quick determination if some immediate medicines are needed prior to full evaluation”. Once cleared through that process, the patient goes to “a large waiting-room type area where people can sit in chairs or lie down with a pillow or a blanket”. Patients do not have individual rooms because it is an outpatient service. Intensive supportive services are provided over the next several

hours. Within 24 hours of a patient's admission, a decision must be made on whether the patient needs hospitalization or can return home or go to a placement less restrictive than an ED.

According to Dr. Zeller and his colleagues, the first two models described above tend to follow a "triage" approach in dealing with patients in mental health crisis, focusing on "rapid evaluation, containment and referral." In contrast, the PES model follows a "treatment" approach, with the goal of treating the person "to the point of stabilization onsite." This is possible because "many PESs have extended observation capability, allowing them to treat patients for up to 24 hours or even longer. This can often be sufficient time for many patients to stabilize and thus avoid inpatient hospitalization." (As noted above in the discussions of the Crisis Response work group of the Governor's Task Force, this process is consistent with the practice and goals of the CSB evaluator, who is seeking the least restrictive appropriate treatment to resolve a person's mental health crisis, but it is different from the practice and goals of the standard hospital ED, which needs to move a medically stable but psychiatrically distressed patient to another setting as quickly as possible.)

Evidence of improved outcomes in the Alameda Model

Dr. Zeller and colleagues have reported on the model's efficacy (found [here](#)) and a recent article from [AHC Media](#) (found [here](#)) has updated Dr. Zeller's earlier findings. Those findings include the following:

Reducing law enforcement involvement in psychiatric emergencies: California law ([WIC 5150-5155](#)) gives police, as well as designated doctors, clinicians and facilities the authority to detain, transport, and involuntarily hold an individual in acute mental health crisis for up to 72 hours. A police officer who places an individual under such a "5150 hold" will bring that person to a county ED, where ED staff must evaluate and stabilize the person and find an appropriate placement for that person. Many of these individuals end up being "psychiatrically boarded" in the EDs because there are no available psychiatric hospital beds.

Under the Alameda Model, the police make a "5150 hold", but then contact an EMS ambulance service, and transfer custody of the person to the ambulance crew, who perform a "field screening" of the person, "looking only for medical stability issues". If the person is deemed medically stable, the ambulance will bring the person directly to the Psychiatric Emergency Services (PES) unit. Roughly two-thirds of persons placed on "psychiatric holds" in the Alameda County program go directly from the community to the PES unit in this manner for evaluation and treatment. Police officers are able to return to their work more quickly.

Reducing ED involvement in psychiatric emergencies: When ambulance crews find that a person in crisis is medically unstable and needs further evaluation and "medical clearance", then the person is taken to one of the county's 11 EDs. A "streamlined process", in which no specific laboratory tests (including alcohol level screening) are required, is in place (developed jointly by the area EDs and the PES unit at John George Psychiatric Hospital) to facilitate transfer of these individuals to the PES unit as soon as

they are medically cleared. Dr. Zeller relates that experience has shown that time-consuming laboratory testing seldom identifies conditions that preclude safe transfer to the PES unit. In addition, an onsite psychiatric consult in the ED regarding these patients is not necessary, as the attending ED physician consults by phone with a psychiatrist at the PES unit. If the doctors agree that transfer is appropriate, the patient is accepted by the PES unit without regard to the person's psychiatric diagnosis or history, and without regard to whether the person has medical insurance or has access to a psychiatric hospital bed if hospitalization is ultimately found to be needed. The PES unit, as a "high acuity site", is set up for people deemed "psychiatric emergencies" under EMTALA (the federal Emergency Medical Treatment and Labor Act). The PES unit is available for these patient transfers from the county EDs on a 24-hour-a-day basis. Patients may also "self-present" at the PES for care.

Improved outcomes for patients and hospitals: Dr. Zeller reports that the Alameda Model has effectively eliminated psychiatric boarding because, in his words, "The only boarding in our county is the length of time it takes for emergency providers to arrange transport from their facility to our facility, and two-thirds of the patients aren't even stopping at an ED anyway." (See AHC article [here](#))

In addition, Dr. Zeller and colleagues' 2013 study (found [here](#)) made the following key findings:

- a. County hospital EDs participating in the study had an average psychiatric "boarding time" of 1 hour and 48 minutes (a reduction of over 80% in the average length of boarding times statewide in California during that period).
- b. Only 24.8 percent of the patients experiencing psychiatric emergency in the referring EDs were admitted for inpatient psychiatric hospitalization from the PES.

A year later, the AHC Media article (found [here](#)) indicates that those outcomes have continued: only 22% of the patients treated in the PES unit ultimately need to be hospitalized; the other 78% are able to go home or to a community-based program (e.g. detox, crisis residential housing, or "a board and care arrangement").

(Note: Neither Dr. Zeller's published study nor the follow-up AHC article included any data on readmission rates; that is, there is no information on whether and/or how frequently individuals are re-admitted to the PES unit within specified periods of time.)

Financial considerations and replication of the Alameda Model

Dr. Zeller reports that the Alameda Model produces "overall" cost savings in terms of reduced time of patients in emergency departments and the stabilization and diversion of patients from psychiatric hospital placements. The Alameda Model benefits from having a supportive funding situation through California Medicaid, which has a "unique facility-based billing code for "Crisis Stabilization" that allows for sustainability in a locality with "a high enough census." In most states, however, the cost savings cited by Dr. Zeller do not automatically translate into an income stream that can sustain the

operational costs of a PES unit. Dr. Zeller has proposed that “[i]nstituting a national billing code [especially for Medicare and Medicaid] for crisis stabilization might facilitate development of more programs such as the Alameda Model.” (See the conclusion of his article [here](#)) Others have expressed support for the idea, including Kimberly Nordstrom, MD, JD, the president of the American Association for Emergency Psychiatry and director of a Denver, CO-based model similar to the Alameda model. In the AHC article noted above (found [here](#)), Dr. Nordstrom reports that her program, while able to discharge 76% of its patients despite seeing only those in acute mental health crisis, is reimbursed “on an outpatient level” of service despite its high (and costly) level of care, so that the program “barely squeaks by” financially, making it doubtful that this kind of program will be replicated across the nation until the billing issue is resolved.

Suggestions for psychiatric emergency services in non-urban settings

In his writings, Dr. Zeller agrees that the financial viability of a PES unit depends upon a demand for services that exists only in urban and some suburban communities. In his October 6, 2014 article for *Psychiatry Advisor*, entitled “New Strategies to Reduce Psychiatric Boarding in ERs” (found [here](#)), Dr. Zeller writes that, even in areas where there is not sufficient population to support a PES unit like the one in Alameda County, there are other available strategies for providing quality psychiatric emergency services to individuals in crisis to help them to find stability and avoid psychiatric boarding on the one hand and psychiatric hospitalization on the other. Those strategies include:

“Commencement of Care Algorithms”: Dr. Zeller argues that many “straightforward treatments” can be started by ED physicians for persons in psychiatric distress “using standard protocols created in concert with their psychiatric consultant.” This can alleviate pain and stress for the patient in the ED, and even enable sufficient improvement to make diversion from hospitalization a viable option when the psychiatric consultant does arrive.

“On-Demand Emergency Telepsychiatry”: Dr. Zeller cites in particular the success of a telepsychiatry consultation program for EDs in South Carolina, with “improved patient outcomes and rapid stabilization of psychiatric crises.” (An article on the success of the telepsychiatry program, which is operating under grant funding in South Carolina and in North Carolina, can be found [here](#). A separate article on the North Carolina program, published in the *North Carolina Medical Journal*, can be found [here](#).)

“Crisis Stabilization Units” & “Crisis Residential/Acute Diversion Units”: In his article Dr. Zeller describes “crisis stabilization units” as being “like psychiatric emergency rooms”, as they “will attempt to resolve psychiatric crises in less than 24 hours.” That does not appear to be the current model for CSUs in Virginia, where the average length of stay (in a 2010 [study](#)) was over 8 days. Virginia CSUs appear to more closely resemble “crisis residential/acute diversion units”, which Dr. Zeller describes as “longer-term programs” (3-14 days). However, while Dr. Zeller describes the focus of these programs as being on “subacute mental health patients in need of a period of stabilization,” it is the case that a number of Virginia CSUs clearly include people in

acute crisis (with some accepting individuals under TDOs). Studies and surveys of CSUs in Virginia in recent years indicate that they are viewed as effective in helping people in crisis avoid psychiatric hospitalization, yet considerable differences remain among the various CSUs across the Commonwealth. Dr. Lo at the Sentara Norfolk General ED notes that there are ongoing challenges for EDs in understanding the differing criteria among CSUs in accepting or not accepting patients.

Best Practices in all Models

In his Primary Psychiatry article (available [here](#)) Dr. Zeller describes best practices for psychiatric services in *all* emergency settings. He sets out and then describes the “treatment goals of emergency psychiatry”: “exclude medical etiologies for symptoms”; “rapid stabilization of acute crisis”; “avoid coercion”; “treat in the least restrictive setting”; “form a therapeutic alliance”; and “appropriate disposition and aftercare plan.”

What is particularly noteworthy is Dr. Zeller’s emphasis on establishing and maintaining a “therapeutic alliance” with the patient in the emergency setting. Dr. Zeller describes the therapeutic alliance as “a collaborative relationship between a patient and a clinician”, which, in practice, means, among other things, “avoiding coercion, which is the use of force or threats to make patients do things against their will. In emergency psychiatry, this includes the use of oral medications with informed consent as opposed to forcible injections; verbal de-escalation of agitated individuals instead of physical restraints; and little or no infringement on a patient’s rights when possible. Treating in the least restrictive level of care is another means of avoiding coercion.”

Innovative Psychiatric Emergency Services in Virginia: Developments and Proposals

Crisis Intervention Teams (CIT), Therapeutic Assessment “Drop Off” Centers, Crisis Stabilization Centers (CSU), Mobile Crisis Units, and Triage Centers

Different programs in different parts of Virginia operate a number of different services, including CIT programs, Therapeutic Assessment Drop Off Centers, CSUs and Triage Centers, that respond to individuals experiencing mental health crises in the community and resolve them in the least restrictive manner possible. Their expansion, strengthening and coordination have been recommended by the Governor’s Task Force, and many received additional funding support from the Governor and the 2015 General Assembly. From the perspective of the physician in the hospital ED, where psychiatric patients and psychiatric boarding remain difficult issues, navigating these options and finding willing placements for psychiatric patients among these options remains a challenge. As noted above, the different standards across programs for “medical clearance” of these individuals before they will be accepted from the ED can result in confusion and delay. In addition, none of these existing services appears to provide the model of service intended in the PES unit described by Dr. Zeller, either in terms of intensity of treatment or length of stay. The CSU’s for example, have an average patient stay of several days, and the Triage Center concept is focused less on providing intensive coordinated psychiatric treatment and stabilization than on providing a safe place where the police can leave a

person in crisis and return to the street while the CIT officer provides coverage and CSB staff provide an evaluation for possible issuance of a TDO.

A proposal for “regional psychiatric emergency centers”

On June 17, 2014, a member of the Governor’s Task Force on Improving Mental Health Services and Crisis Response sent an email to Mr. Jim Martinez of DBHDS proposing regional psychiatric emergency centers. (That email can be found [here](#), on page 38.) The Task Force member, Mr. Ted Stryker, observed that, “in all of the recommendations of the various workgroups of the Task Force, it is striking to me there is relatively little said about reforming the delivery system of care for the purposes of strengthening the integration of services; reducing unnecessary hand-offs; and increasing accountability. Some of the workgroups have kind of mentioned it (Ongoing Treatment talks about an ‘integrated community system of care – public/private partnership’ and Public Safety talks about creating ‘functional CIT Assessment Centers’), but, he noted, no “bold delivery system changes” had been proposed. Mr. Stryker went on to suggest discussion of regional psychiatric emergency centers that could “effectively combine four separate, fragmented levels of care”: “Crisis Screening Centers operated by CSB’s; Crisis Stabilization Centers; CIT Secure Assessment Centers; & Hospital ED’s. A unified system of psychiatric care under one roof,” he wrote, would improve coordination of care (single point of access; unified and common clinical electronic record; single point of accountability; and reduced system hand-offs) to create a high reliability system of care for people seeking care when they are in psychiatric crisis.”

Concluding Observations

The best solution for reducing the current pressure on Virginia’s mental health crisis response system is adequately funded community-based care that enables people to avoid crises through effective treatment, advance care planning, and early intervention services. That solution remains a goal, but even in an ideal system crises will regularly occur and must be resolved appropriately. While Virginia has been developing innovative practices and programs to improve the system’s response to mental health crises, with the Governor’s Task Force recommending the spread and strengthening of many of them, it’s appropriate to ask whether we currently have, or can develop, a consensus on an overarching model of psychiatric emergency care into which these various innovative practices and program can fit. The program in Alameda, California, as noted above, submits this significant claim for an overarching model: that with the delivery of intensive emergency psychiatric services in a dedicated PES unit at the time of mental health crisis, most people in such crisis can achieve stability and return to the community within 24 hours. If that claim is sound, and the model described by Dr. Zeller works, more people can return to their lives more quickly, fewer of them will experience unnecessary psychiatric hospitalization, and psychiatric boarding in many hospital EDs will be dramatically reduced. In addition, even in those rural communities where a PES unit cannot be maintained, improved protocols for psychiatric care in the ED setting, and both consultation with, and treatment by psychiatrists through tele-psychiatry, can improve outcomes and reduce the pressures on EDs.

The 2014 reforms to Virginia law have helped to ensure that those who experience a mental health crisis and are evaluated while being held under an Emergency Custody Order (ECO) will receive psychiatric hospital care if they meet the criteria for a Temporary Detention Order (TDO). The law now mandates that the state psychiatric hospital system accept these individuals if no one else will do so before their 8-hour ECO period expires, so that they do not slip out of the “safety net” of care while still in crisis. However, those very reforms place additional pressures on the system to make quick decisions to hospitalize when other dispositions might better serve some of these individuals, and they place additional pressures on hospitals that must treat more patients without having more beds for them. Moreover, those reforms do not address the root causes of the problem. Nor do they address the needs of many others who also experience a serious mental health crisis but who, for various reasons, are not being held under an ECO, and who are finding that they are in hospital EDs that do not meet their mental health needs and are unable to enter facilities or services that could meet those needs. As studies have shown, the extended stay of these individuals in the hospital ED can result not only in poorer outcomes for them, but also in poorer outcomes for other patients who are in the hospital ED for other kinds of care.

The search for a more comprehensive response to mental health crisis needs to continue.

III. Case Law Developments

Supreme Court Round-Up

ADA: Application of “accommodation” requirement to emergency police encounters with persons with mental illness

Sheehan v. City & Cnty. of San Francisco, 743 F.3d 1211 (9th Cir.) cert. granted sub nom. *City & Cnty. of San Francisco, Cal. v. Sheehan*, 135 S. Ct. 702 (2014).

Lower Court Opinions:

Plaintiff, Teresa Sheehan, filed suit under 42 U.S.C. 1983 against police officers and the city after the officers entered her home without a warrant and shot her five or six times when she reacted violently to the officers' presence, grabbing a knife and threatening to kill the officers. Plaintiff, a woman in her mid-50s suffering from a mental illness, told the officers that she did not want to be taken to a mental health facility. The United States District Court for the Northern District of California granted summary judgment in favor of the defendants finding that the officers (1) were justified in entering Sheehan's home, (2) did not use excessive force when they shot Sheehan, and (3) could not bring against the individual officers or the city under the Americans with Disabilities Act. The district

court relied on language from a 5th Circuit case in reaching this third conclusion: “section 12132 does not permit a cause of action based on an “officer's on-the-street responses to reported disturbances or other similar incidents, whether or not those calls involve subjects with mental disabilities, prior to the officer's securing the scene and ensuring that there is no threat to human life.”

The 9th Circuit affirmed in part, holding that the officers were justified in entering plaintiff's home initially under the emergency aid exception because they had an objectively reasonable basis to believe that she was in need of emergency medical assistance and they conducted the search or seizure in a reasonable manner up to that point. The court held that there were triable issues of fact as to whether the second entry violated the Fourth Amendment where a jury could find that the officers acted unreasonably by forcing the second entry and provoking a near-fatal confrontation. The court further held that there were triable issues of fact as to whether the officers used excessive force by resorting to deadly force and shooting plaintiff. Finally, the court held that the district court properly rejected claims of municipal liability; the court joined the majority of circuits that have addressed the issue and held that Title II of the Americans with Disabilities Act, 42 U.S.C. 12132, applied to arrests; on the facts presented here, there was a triable issue as to whether the officers failed to reasonably accommodate plaintiff's disability; and the court vacated summary judgment on plaintiff's state law claims and remanded for further proceedings.

Briefs of Petitioners and Respondent:

On appeal to the Supreme Court, both parties raised two questions in their original briefs. First, whether the accommodation requirement of Title II of the Americans with Disabilities Act requires law enforcement officers to provide accommodations during the course of bringing an armed and mentally ill suspect into custody. Second, for the purpose of determining whether officers were entitled to qualified immunity, whether it was clearly established that even if an exception to the warrant requirement applied, entry into a residence may be unreasonable under the Fourth Amendment when officers enter the home of an armed and mentally disturbed individual.

According to petitioners (City and County of San Francisco), Sheehan was not entitled to accommodations during her arrest process because she was not “qualified...to invoke a public entity's duty to modify its activities” because she posed “a direct threat or significant risk to the safety of others” at the time of her arrest. Petitioners contended that, because the determination of threat or risk is to be based on the reasonable judgment of the person from whom the accommodation is demanded, and the officers made an objectively reasonable judgment based on the information they had at the time, Sheehan was not entitled to an accommodation during her arrest. In regard to the Fourth Amendment warrant-exception issue, the petitioners contended that the rule articulated in the case below—that absent an immediate need police officers are prevented from entering the residence of an armed, violent, and mentally ill person and even in the case of an immediate need to enter the officers are prevented from using force to defend

themselves against even a provoked attack—both contradicted Supreme Court precedent and was not clearly established by 9th Circuit precedent.

In response, the brief for Teresa Sheehan argued at the outset that it did not make “legal” sense to apply an exception to Title II’s reasonable accommodation requirement when an individual’s mental illness is the reason for the police’s interaction with that person. Further, the brief for the respondent contended that, as a factual matter, Sheehan could not have been considered a reasonable direct threat for the purpose of the exception because (1) she was alone in the residence and the officers were on the outside of the door, (2) Sheehan was not a flight risk, and (3) Sheehan had only ever threatened individuals who entered her room without permission. In response to the petitioners’ claim that delay would have been an unreasonable accommodation, respondent contended that the proposed modifications put forward were “consistent with applicable training materials and universally accepted police practices designed to minimize the risk of a violent confrontation with a mentally ill individual.” Finally, Sheehan contended that the officers should not be entitled to qualified immunity in respect to their actions because forcibly reopening the door to Sheehan’s room and shooting her multiple times without taking her mental illness into account or identifying a countervailing need to enter was objectively unreasonable.

Reply Brief of Petitioners:

In their reply brief, the petitions began by identifying that while Title II of the ADA “does not permit police officers to assume that erratic conduct caused by mental illness is dangerous” it also does not “require officers to ignore dangerous conduct because it may be caused by mental illness.” The reply brief emphasized that arrest situations—especially ones involving mentally ill persons who are armed, acting erratically, and potentially violent—involve split-second judgments that should not be assessed “[w]ith the benefit of hindsight and calm deliberation.” Thus, the risk determination should be assessed in the closed universe of the facts of the situation as available to the officers at the time of the arrest. The reply brief also took issue with the temporal focus on the respondent’s brief (i.e. solely focusing on the “second” entry when the officers entered Sheehan’s closed-off bedroom). Instead, petitioners argued that the second entry could not be considered in isolation, but must be analyzed in the context of the entire encounter up to that point: “[W]hen the officers decided to reenter Sheehan’s room, they knew beyond question that Sheehan was violent and intended harm.”

Briefs of Selected Amici Curiae:

American Psychological Association (et alia): The American Psychological Association filed a brief in conjunction with several other amici. The complete list of joint amici included the American Psychiatric Association, American Psychological Association, Delaware, Illinois, New Mexico, Ohio, and Vermont Psychological Associations, National Council on Disability, National Alliance on Mental Illness, and Judge David L. Bazelon Center for Mental Health Law. The joint brief took the position that the question of whether an individual is “qualified” within the meaning of the ADA should be

determined by analyzing the *entire* encounter between law enforcement and the mentally ill individual. Further, the brief argued that it is precisely the situation in which failure to provide accommodation is the partial cause of threatening or violent behavior that the statute's protection is important. Finally, the APA brief took the position that an obligation to provide reasonable accommodations when interacting with mentally ill individuals at the time of arrest would not impose any undue burden on law enforcement or other public entities.

Policy Council on Law Enforcement and the Mentally Ill ("Policy Council"): The Policy Council filed a brief in strong support of respondent Teresa Sheehan, opening their argument with the proposition that it is "critical to the safety and well-being of those suffering from mental illness, as well as their loved ones, that the Americans with Disabilities Act (ADA) apply vigorously to police encounters" because they are "acutely vulnerable." The Policy Council's brief highlighted the public policy concerns that support the enforcement of the ADA's accommodation requirement: namely, "the importance of encouraging people who need help to seek it." The brief also took the position that in "barricade situations involving mentally ill individuals, there should rarely be a question as to the [ADA]'s applicability." Finally, the Policy Council argued that "fairness and equity suggest that the ADA accommodation requirement should apply when officers are present for the sole purpose of assisting" mentally ill persons.

United States: The amicus brief of the United States of America supported vacatur in part and reversal in part. As to the ADA claim, the United States agreed that "[b]y its plain terms, the provision...extends to arrests." The government did, however, also argue that when "police officers arrest an individual with a disability who is armed and violent, any deviation from ordinary law enforcement tactics will generally present very real safety risks." Still, while of the mind that in the ordinary run of cases no modifications to the ADA will be required, the government espoused the position that a plaintiff should still "remain free to show that special circumstances rendered a modification reasonable" given the facts of any particular case." Given the facts of the instant case, the government argued that Sheehan's being armed and violent put the burden on her to show that an accommodation would not have presented safety concerns for the officers involved.

National League of Cities: The National League of Cities, filing in support of the petitioners, began by arguing that the holdings of the 9th Circuit below ignored the "practical reality faced by police officers who must routinely confront seriously mentally ill suspects who are armed and violent." Taking a position quite different from the other amici curiae, the National League of Cities, while acknowledging that some cities have adopted special procedures for responding to incidents with mentally ill individuals, claims that "there is no conclusive evidence that these specialized approaches reduce the rate or severity of injuries suffered during police encounters with mentally ill suspects." Further, the National League of Cities argued that requiring police officers to "undertake special procedures to accommodate an armed and violent suspect's mental disability during an emergency situation" would have serious consequences for the safety of

officers and the public because it would encourage them to “hesitate or delay in confronting an armed and violent suspect who displays any sign of a mental illness.”

Argument Analysis:

[*from* Lyle Denniston, *Argument Analysis: Can a Really Rough Start be Overcome?*, SCOTUSBLOG.COM, (Mar. 23, 2015, 3:07 PM),

<http://www.scotusblog.com/2015/03/argument-analysis-can-a-really-rough-start-be-overcome/>]

In the opening moments of the oral arguments, Justice Scalia expressed concern (and thinly veiled annoyance) at his perception that the case “may have changed markedly once it got on the Court’s docket.” Justice Scalia questioned Christine Van Aiken, deputy city attorney for San Francisco, on the apparent discrepancies between the question on which the Court granted certiorari and the arguments raised in the city’s merits brief. According to Justice Scalia, the Court had taken the case to decide whether the ADA should apply at all in the context of an arrest (the position taken in the city’s lower court briefs), but the briefs filed by the city with the Supreme Court couched the question in terms of *when* the ADA’s protections kick in during an arrest. The city’s articulated position in its merits brief (as read out from petitioners’ filings by Justice Scalia and also remarked upon by Justice Sonia Sotomayor) was that the ADA’s protections only apply once “a threat [posed by a disabled person] has been eliminated.” Justice Samuel Alito also introduced another complicating factor—although no one had addressed the issue in a brief— by articulating the opinion that the definition of discrimination in the context of police activity could be a threshold matter.

By the time Van Aiken’s time had expired, the Court had only spent a little time on the merits of the case. Ian H. Gershengorn, Deputy Solicitor General, spoke next, advancing the view espoused in the federal government’s brief that the protection of the ADA “definitely does, and should, apply to police arrests.” He received some pushback from the Justices, but held strongly to his argument even under fire on the topic of the questions that might arise in the “tense situations” when officers confront a potentially violent and mentally ill individual.

Soon after Leonard Feldman, Sheehan’s lawyer, began his arguments, the Justices seemed to be “developing some skepticism about how police could actually try to calm a situation when an armed and violent person came at them with a knife and with a threat to kill them.” Specifically, Chief Justice John Roberts raised the issue of whether Sheehan might have been a suicide risk—suggesting that a reasonable fear of an individual posing a risk of self-harm might be enough to trigger exceptions to the ADA and the Fourth Amendment warrant requirement.

Ultimately, the court seemed confused (or at the least to have serious lingering questions) about (1) which standard each party was advocating for the Court to apply in interpreting the ADA’s applicability to arrests, and (2) the factual specifics of whether Sheehan did actually pose a “direct threat” to the officers.

Virginia and the Fourth Circuit

NGI: trial court complied with statutory criteria for ordering inpatient hospitalization vs. conditional release of NGI acquittee

Bates v. Com., 287 Va. 58, 752 S.E.2d 846 (2014).

After being found not guilty by reason of insanity on a charge of arson pursuant to Va. Code Ann. § 18.2-77, Tanisha Bates was remanded to the temporary custody of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services (the “Commissioner”) in order to evaluate options for her treatment or release. The clinical psychologist who performed the evaluation recommended inpatient hospitalization whereas the psychiatrist recommended conditional release coupled with outpatient treatment. The Northern Virginia Mental Health Institute (“NVMHI”) then prepared a court-ordered conditional release plan in advance of hearing “to determine the appropriate disposition of the acquittee” in accordance with Va. Code Ann. §§ 19.2–182.3 and 19.2–182.7. At the request of the Commissioner, the Forensic Review Panel also submitted a report, concluding that “Bates’ continued delusions, risk of suicide, lack of substantial response to treatment, and history of deadly and dangerous behavior” all supported a recommendation that Bates should remain committed to inpatient hospitalization. The circuit court followed that recommendation and entered an order committing Bates to the custody of the Commissioner.

Bates appealed the order, contending that the circuit court misapplied the relevant Virginia Code sections in reaching the decision that she required inpatient hospitalization. The Virginia Supreme Court affirmed the commitment order of the court below, holding that it had correctly applied the statutory criteria. Although the court below had acknowledged that the NVMHI report stated that Bates was “ready to leave” inpatient treatment, the finding that there was “no means for controlling her on an outpatient basis” was enough to warrant an order committing Bates to inpatient hospitalization. Further, the Supreme Court held that the provisions in Va. Code Ann. § 19.2–182.7 do not require lower courts to “fashion an appropriate plan for [] outpatient treatment and supervision when it [has] already determined that [a defendant] [is] not eligible for conditional release, and that she require[s] inpatient hospitalization.”

Competency to Stand Trial: no error in trial court’s determination of defendant’s “present” ability to understand the proceedings and assist counsel, including denial of motion for a second hearing based on “new evidence”

Dang v. Com., 287 Va. 132, 752 S.E.2d 885 cert. denied sub nom. *Dang v. Virginia*, 135 S. Ct. 130, 190 L. Ed. 2d 99 (2014).

On appeal from his conviction for murder and violation of a protective order, petitioner Lam Dang argued that the circuit court erred in failing to order a second competency

evaluation after his counsel uncovered new evidence concerning head trauma he suffered as a child. In his first competency evaluation, Dang was found competent to stand trial and seemed particularly focused on providing “his side of the story” and repeatedly had to be constantly redirected to the question posed. Dang’s evaluator noted that he exhibited a high degree of situational anxiety, but that it was not indicative of a mental illness relevant to competency but was “consistent with most defendants who face legal charges.”

Four days prior to his trial, Dang’s counsel moved for a second competency evaluation based on evidence he had recently uncovered that, beginning at age six and continuing until sixth or seventh grade, Dang had been subject to repeated physical assaults that included being pelted in the head with rocks. The circuit court denied the motion, finding no probable cause that Dang “lack[ed] substantial capacity to understand the proceedings against him or to assist his attorney in his own defense.”

The Supreme Court of Virginia upheld the Court of Appeals’ denial of Dang’s petition. The Supreme Court found that the circuit court had given adequate weight to the new information acquired by defense counsel and had focused on the proper issue at hand—Dang’s “*present* ability to understand the proceedings and assist his counsel.” Given the first evaluator’s opinion that Dang’s shifting focus was representative of “situational anxiety” and the “wide latitude” offered to circuit courts in light of their “first-hand interactions with, and observations of, the defendant and the attorneys at bar” the Supreme Court of Virginia found that the circuit court did not abuse its discretion in denying the request for a second evaluation.

Sexually Violent Predators: burden of proof on Commonwealth to prove in annual review hearing that continued involuntary confinement necessary

***Gibson v. Com.*, 287 Va. 311, 756 S.E.2d 460 (2014).**

Overruling *Commonwealth v. Bell*, 282 Va. 308, 714 S.E.2d 562 (2011), the Supreme Court of Virginia held that the Commonwealth is the party who bears the burden of proving that no suitable, less restrictive alternative to involuntary inpatient treatment exists for someone declared to be a sexually violent predator. After a jury found that the defendant, Donald Gibson, was a sexually violent predator within the meaning of Va. Code Ann. § 37.2-900, the circuit court continued the trial in order to hear additional evidence related to Gibson’s suitability for conditional release as an alternative to involuntary commitment.

In moving forward, Gibson argued that the burden was on the Commonwealth to prove “by clear and convincing evidence” that the elements of Va. Code Ann. § 37.2-912 were not satisfied, whereas the Commonwealth, relying on *Commonwealth v. Bell*, argued that burden was on Gibson to prove “by a preponderance of the evidence that he meets the criteria for conditional release.”

The Virginia Supreme Court noted that statements in *Commonwealth v. Bell* seemed to conflict with the earlier decision *McCloud v. Com.*, 269 Va. 242, 261, 609 S.E.2d 16, 26 (2005) which held that “the burden of proving that there is no suitable less restrictive alternative to involuntary confinement rests with the Commonwealth, and that burden cannot be shifted to the [respondent].” Finding no reason “to draw a distinction between an initial sexually violent predator trial and an annual review hearing in terms of which party bears the burden of proof on the issue whether there are no suitable less restrictive alternatives to involuntary confinement,” the Supreme Court of Virginia overruled *Bell* and returned to the rule in *McCloud* instead of reconciling the two by drawing such a distinction.

Sexually Dangerous Offenders: period in confinement pending civil commitment determination not applicable as “credit” toward time served for criminal sentence

***United States v. Hass*, 575 Fed. Appx. 139 (4th Cir. 2014) (unpublished per curiam opinion).**

In appealing the district court’s judgment revoking his supervised release and sentencing him to eighteen months in prison followed by an additional thirty months of supervised release, defendant Johnny Hass argued that the district court erred in fashioning his sentence by refusing to factor in time he spent in Bureau of Prisons (“BOP”) custody awaiting civil commitment proceedings. After the Government certified that Hass qualified as a sexually dangerous person under the Adam Walsh Child Protection and Child Safety Act of 2006, the court stayed his release pending the outcome of a hearing to determine whether Hass was sexually dangerous. After his supervised release was revoked and a new prison sentence imposed by the district court, Hass argued on appeal to the Fourth Circuit that he should have been granted credit for time served equal to the time he spent in BOP custody awaiting his civil commitment hearing.

Given the deference due to the district court, the Fourth Circuit stated it would only reverse if the sentence imposed was “plainly unreasonable.” A sentence can be either procedurally or substantively unreasonable. Procedural reasonability is determined by examining the district court’s consideration of “applicable 18 U.S.C. § 3553(a) (2012) factors and the policy statements contained in Chapter Seven of the Guidelines.” Substantive reasonability is determined by examining whether the district court stated a “proper basis for concluding that the defendant should receive the sentence imposed.”

The Fourth Circuit rejected Hass’ claim that failing to give him credit for his prior time spent in BOP custody was a basis for plain error, stating that “it is unthinkable to lend support to any judicial decision which permits the establishment of a line of credit for future crimes.” Because Hass “was being sentenced for violating the terms of his supervised release” and cited “no precedent to support his claim that over-service of a prior sentence is even a proper consideration for a court when imposing a revocation sentence,” the Fourth Circuit affirmed the sentence imposed by the district court.

NGI: delay in commitment proceedings justified by acquittee's misconduct

United States v. Conrad, 776 F.3d 253 (4th Cir. 2015).

Defendant-appellant Samuel Robert Conrad III, currently serving an eight-year term of imprisonment, appealed both the district court's denial of his motion to dismiss commitment proceedings arising from a 2007 insanity acquittal (arising from a separate set of offenses) and the district court's order to delay those commitment proceedings until he is released from prison. At issue for the Fourth Circuit on Appeal was 18 U.S.C. § 4243, which provides the "procedural framework for the evaluation and commitment of defendants adjudicated NGI."

Initially, Conrad's § 4243 hearing following the 2007 acquittal resulted in the district court's imposition of a conditional release, which was subsequently revoked when Conrad was charged by the Commonwealth of Virginia for the murder of his sister-in-law. Conrad appealed the revocation of his conditional release, and the order originally granting it was vacated by the Fourth Circuit in 2010 based on that court's determination that the language of § 4243 "allows only two forms of disposition--unconditional release or indefinite commitment; it does not authorize conditional release." A new hearing was thus required under § 4243(e), but never actually took place because in 2013 Conrad was charged with possession of a firearm by a convicted felon and conspiracy to distribute controlled substances—charges which lead to his current incarceration. When Conrad moved to dismiss the pending § 4243 commitment proceedings arising from the prior case (arguing that § 4243 was no longer applicable to him because he could not pose a threat to public safety while incarcerated), the district court denied his motion, ordering instead that a delay of the proceedings until Conrad completes his current term of imprisonment would best serve the statute's purposes."

The Fourth Circuit affirmed the denial of Conrad's motion to dismiss as well as the order delaying the § 4243 proceedings. In affirming the denial of the motion to dismiss, the Fourth Circuit held that § 4243 "applies on its face to NGI acquittees" and "unambiguously requires a hearing to determine commitment or release," and so in the absence of any "provision permitting nullification of the statute's applicability through subsequent commission of crime and incarceration," the district court was within its discretion to refuse dismissal of the § 4243 hearing. Further, the Fourth Circuit held that the delay ordered by the district court was permissible, confronting the timing requirement of § 4243(c) which "requires a hearing within 40 days of the NGI verdict, which, under a separate provision, may be extended only by 30 days, and only by the director of the facility to which the acquittee has been committed." The Fourth Circuit stated that both parties agreed that there is at least one implicit exception to the 40-day requirement of § 4243(c) and cited to other opinions in which a delay greater than 40 days was allowed and found to be justified due to "circumstances outside of the acquittee's control--such as a commitment facility's inadequate resources to promptly conduct the evaluation." Given this precedent, the Fourth Circuit stated that a delay would "would seem even more fitting" in circumstances *within* the acquittee's control and held that because Conrad "has been the principal architect of the delay he faces, and

such delay is reasonable under the statute when the acquittee is serving a term of incarceration” the district court did not err in delaying the proceeding.

Sexually Dangerous Offender: establishing personal jurisdiction over defendant for civil commitment hearing does not require service of summons under Rule 4

United States v. Perez, 752 F.3d 398 (4th Cir. 2014).

Jose De La Luz Perez appealed the determination of the district court that he was a "sexually dangerous person" under the Adam Walsh Child Protection and Safety Act of 2006 (the "Act"). On appeal, Perez asked the Fourth Circuit to vacate the civil commitment order, contending that the district court lacked personal jurisdiction because the government failed to serve him with a summons pursuant to Rule 4 of the Federal Rules of Civil Procedure. The Fourth Circuit affirmed the order, holding that although the Federal Rules of Civil Procedure are broadly applicable in civil commitment proceedings, that does not mean that they "cannot be displaced by specific procedural provisions included in the Act." The central question on appeal was whether the Act required the government "to serve a summons pursuant to Rule 4 [of the Federal Rules of Civil Procedure] upon a respondent in federal custody despite the obvious differences between the initiation of civil commitment proceedings under § 4248 and a typical civil action."

The Fourth Circuit pointed to a "streamlined procedure for initiating commitment proceedings against individuals in BOP custody" contained in the statutory language that served to supplant the usual summons requirements of Rule 4. Apart from the view that the text of the statute is sufficient to displace the summons requirement of Rule 4, the Fourth Circuit pointed out that while "physical custody is no longer necessary to endow a civil court with personal jurisdiction over a defendant, it is clearly sufficient to do so," and so the fact that the government "has physical custody over the respondent in § 4248 civil commitment proceedings obviates the need for a summons."

Treatment of Mentally Ill Individuals in Custodial Settings

Eighth Amendment: Failure to follow national suicide screening prevention standards with prisoner who later commits suicide presents colorable eighth amendment claim that survives summary judgment motion

Barkes v. First Corr. Med., Inc., 766 F.3d 307 (3d Cir. 2014).

After Christopher Barkes committed suicide while being held at a correctional facility in Delaware, his wife and children brought a § 1983 suit against the commissioner of the state department of corrections ("DOC"), the warden, and the private company with whom the DOC contracted to provide medical services to the prison ("FCM") alleging violations of the Eighth Amendment of the federal Constitution.

When Barkes was arrested in November, 2004, he underwent a medical intake screening procedure conducted by a licensed nurse employed by LCM, the private contractor hired to provide medical services to the prison. The procedure involved (1) a self-report intake form that included questions about suicidal ideation, (2) screening for seventeen suicide risk factors, and (3) a standard medical intake form with questions about “altered mental status ... or abnormal conduct.” Barkes indicated that he had attempted suicide in 2003, but made no mention of three other attempts (one in 1997 and two in 2004) and checked only two of the seventeen suicide screening factors (eight were required to initiate suicide prevention measures). Finally, the licensed practical nurse who conducted the evaluation reported that Barkes showed no signs of either altered mental status or abnormal conduct. Barkes did, however, place a call to his wife that evening and express his intention to kill himself, but his wife did not inform the DOC. The next morning, Barkes was observed lying on his bed in his cell at 10:45, 10:50, and 11:00 a.m. When an officer came to deliver his lunch at 11:35 a.m., Barkes had hanged himself with a bed sheet.

The Third Circuit held (1) for purposes of determining whether the warden and DOC commissioner were entitled to qualified immunity, Barkes’ constitutional right to “proper implementation of adequate suicide prevention tools” was clearly established at the time of his suicide; (2) that summary judgment was inappropriate given evidence that “FCM's policies and procedures in place at the time of Barkes's suicide created an unreasonable risk of a constitutional deprivation;” and (3) that a reasonable jury could have found that Barkes’ suicide was caused by the DOC’s failure to supervise FCM. The second holding was based on evidence of the DOC’s awareness that “FCM's suicide prevention screening practices were not in compliance with [National Commission on Correctional Health Care] standards, as required by their contract with the DOC.” The Third Circuit reached its third holding despite the fact that Barkes did not self-report any suicidal ideation or exhibit any suicidal behavior because, in the court’s view, “had Appellants properly supervised FCM and ensured compliance with the contract, Barkes's answers during his screening would have resulted in additional preventive measures being taken.”

Custodial Interrogation: Police conduct with 18-year-old with Intellectual Disability is coercive under “totality of the circumstances”, rendering confession inadmissible

***United States v. Preston*, 751 F.3d 1008, 1010 (9th Cir. 2014).**

The 9th Circuit, sitting en banc, held that under the totality of the circumstances, including the eighteen-year-old defendant's intellectual disability, a confession that resulted from police questioning was involuntarily given and should not have been admitted at trial. In reaching this decision, the court overruled *Derrick v. Peterson*, 924 F.2d 813 (9th Cir.1991) as well as subsequent cases relying on it, which had held that individual characteristics are “relevant to our due process inquiry *only if* we first conclude that the police's conduct was coercive.”

The court divided its initial inquiry into two categories—defendant’s reduced mental capacity and the techniques used during the interrogation. As to the first category, the

court found that the intellectually impaired have a demonstrated increased vulnerability to coercion. The court also relied on scholarly assessment of common traits of intellectually disabled persons that may make them more susceptible to coercive interrogation techniques and then used those traits to inform their analysis of the techniques used to question the defendant, noting that “[A]s interrogators have turned to more subtle forms of psychological persuasion, and away from physical coercion, courts have found the mental condition of the defendant a more significant factor in the ‘voluntariness’ calculus.”

The court based its totality of the circumstances inquiry into the coercive nature of the interrogation on several factors: (1) defendant's severe intellectual impairment, (2) repetitive questioning and the threats that questioning would continue without end, (3) pressure placed on the defendant to adopt certain responses, (4) the use of alternative questions that assumed defendant's culpability, (5) the officers' multiple deceptions about how the statement would be used, (6) suggestive questioning that provided details of the alleged crime, and (7) false promises of leniency and confidentiality.

Liberty Interest Deprivation and Eighth Amendment: Claim of prisoner with mental illness that liberty deprivations from facility's Behavior Action Plans were imposed without due process and resulted in Eighth Amendment violations raises genuine issues of fact and survives motion for summary judgment

***Townsend v. Cooper*, 759 F.3d 678 (7th Cir. 2014).**

Townsend, a prisoner at the Green Bay Correctional Institution (GBCI), sued GBCI officials for civil rights violations. Townsend suffered from significant mental illness and engaged in disruptive behavior, including suicide attempts and fighting. Townsend was repeatedly subjected to observation placements and Behavioral Action Plans (BAPs). Vacating the judgment below, the Seventh Circuit held that Townsend had raised genuine issues of material fact regarding whether the imposition of the BAP violated his due process rights by imposing an atypical and significant hardship compared to the ordinary incidents of prison life, without appropriate notice and an opportunity to be heard and whether the BAP imposed conditions of confinement that denied Townsend the minimal civilized measures of life's necessities.

To succeed on his Fourteenth Amendment due process claim, Townsend was required to “establish that he ha[d] a liberty interest in not being placed in the [BAP]—as it was administered to him—without procedural protections,” noting that it was “undisputed that he received no procedural due process, so the claim turns on whether he can establish a liberty interest.” Prisoners have a liberty interest, guaranteed by the Fourteenth Amendment, in “avoiding transfer to more restrictive prison conditions if those conditions result in an *atypical and significant hardship* when compared to the *ordinary incidents of prison life*.” In order to succeed on an Eighth Amendment claim, a prisoner must show that the BAP “imposed conditions that denied him the minimal civilized

measure of life's necessities” and that defendants “acted in disregard of a substantial risk of serious harm to him.”

Other Cases

Mental Condition as Mitigating Evidence in Criminal Sentencing: voluntary intoxication instruction upheld

***Sprouse v. Stephens*, 748 F.3d 609 (5th Cir.) cert. denied, 135 S. Ct. 477, 190 L. Ed. 2d 362 (2014).**

After being convicted of capital murder of a police officer, petitioner Sprouse was sentenced to death. On state habeas review, Sprouse challenged jury instructions that “effectively precluded the jury from considering voluntary intoxication as mitigating evidence.” Raising the issue again on federal habeas review, Sprouse contended that the state court “unreasonably applied” *Penry v. Lynaugh* (“*Penry I*”), 492 U.S. 302, 109 S.Ct. 2934, 106 L.Ed.2d 256 (1989), *Boyde v. California*, 494 U.S. 370, 110 S.Ct. 1190, 108 L.Ed.2d 316 (1990), and *Penry v. Johnson* (“*Penry II*”), 532 U.S. 782, 121 S.Ct. 1910, 150 L.Ed.2d 9 (2001). The Fifth Circuit affirmed the federal district court’s denial of Sprouse’s habeas petition.

At the close of the punishment phase of the trial, the jury received three general instructions regarding the proper treatment of mitigating evidence. First, what constituted mitigating evidence, second that “neither intoxication nor temporary insanity of mind caused by intoxication constitute [*sic*] a defense to the commission of a crime,” and a final instruction on temporary insanity. On appeal to the Fifth Circuit, Sprouse argued that the voluntary-intoxication instruction (instruction two) “unconstitutionally limited the jury's ability to consider mitigating evidence.” The Fifth Circuit affirmed the district court’s denial of Sprouse’s federal habeas petition, holding that neither the state court nor the federal district court were unreasonable in their application of Supreme Court precedent. Further, the Fifth Circuit stated that “the fact that Sprouse perceives a negative inference in one sentence of his jury charge does not demonstrate that his jury was confused about, and precluded from following, the comprehensive and catch-all affirmative command to the jury to consider mitigation circumstances.”

In November 2014, the United States Supreme Court denied certiorari.

Involuntary Psychiatric Hospitalization of Minor: Parents’ claim that doctors’ “medical hold” keeping child in hospital over their objection violated their right to familial association survives motion to dismiss.

***Thomas v. Kaven*, 765 F.3d 1183 (10th Cir. 2014).**

Legina and Todd Thomas, parents of M.T., a twelve-year-old girl at the time of the events at issue in this case, placed M.T. in the University of New Mexico Children's

Psychiatric Center after she revealed suicidal tendencies during a police investigation of a potential sexual assault. She was diagnosed as exhibiting several serious psychiatric problems and her doctors recommended a prescription of psychotropic drugs. The Thomases resisted both the diagnoses and the doctors' recommendations. M.T. was evaluated for several weeks until Mrs. Thomas decided to remove her from the hospital. Concerned about her safety, M.T.'s doctors and therapist placed her on a medical hold and initiated an involuntary residential treatment petition in state court. After a seven-day hold, M.T. was released before the involuntary commitment proceedings began.

The Thomases claimed that when doctors and the hospital placed a medical hold on M.T. and filed a petition for involuntary residential treatment they violated (1) their constitutional right to direct M.T.'s medical care and (2) their right to familial association. The defendants moved to dismiss, asserting absolute and qualified immunity. The district court granted the motion on qualified immunity grounds, and the Thomases appealed. The Court of Appeals for the 10th Circuit affirmed the decision of the district court with regard to the alleged violation of the right to direct M.T.'s medical care. In regard to the violation of the right to familial association, however, the Court held that the Thomases *had* stated a claim eligible for relief and remanded the case for further proceedings. As the case had come up as an appeal of a motion to dismiss (not a motion for summary judgment), the decision was made on the basis of the pleadings alone, and the defendants could not "establish as a matter of law at this point in the proceedings that the relevant state interests outweighed the Thomases' interest in their right to familial association."

Competency to Stand Trial/Restoration of Competency: *Sell* criteria for involuntary treatment to restore competency apply to sentencing phase

***United States v. Cruz*, 757 F.3d 372 (3d Cir. 2014) cert. denied, No. 14-7512, 2015 WL 133477 (U.S. Jan. 12, 2015).**

Cruz was arrested and convicted on two counts of threatening a federal law enforcement officer. After the court received the pre-sentence investigation report, the prosecution successfully moved for a determination of competency. A Federal Bureau of Prisons forensic psychologist concluded that Cruz was mentally incompetent and suffered from schizophrenic disorder, bipolar type. After a hearing, the court concluded that Cruz was incompetent and found that he could not proceed with sentencing.

A second report concurred with the diagnosis, noted Cruz's ongoing refusal to take anti-psychotic medication recommended by BOP personnel, concluded that without medication Cruz would remain incompetent, and stated that "there is a substantial probability that [his] competency can be restored with a period of forced medication." The prosecution obtained an order authorizing the BOP to medicate Cruz against his will.

On appeal, the issue was whether "the Government, pursuant to the Supreme Court's decision in *Sell v. United States*, 539 U.S. 166, 123 S.Ct. 2174, 156 L.Ed.2d 197 (2003),

can have a sufficiently important interest in forcibly medicating a defendant to restore his mental competency and render him fit to proceed with sentencing.” In affirming the decision of the federal district court, the Third Circuit held that the government *could* have a sufficiently important interest in sentencing a defendant for serious crimes to justify involuntary medication. Relying on the stated concern in *Sell* that “memories may fade or evidence may be lost,” the Third Circuit held the same concern applies with equal force in the sentencing context (the guilt phase was at issue in *Sell*) because it means that it may be “difficult or impossible to *sentence* a defendant who regains competence after years of commitment.” Additionally, while it may be cognizable that some crimes are not “serious” enough to justify forcible medication at the sentencing stage, Cruz’s offense was certainly “serious” enough.

The United States Supreme Court denied certiorari in January 2015.

Sexually Violent Person: No due process violation in delay of over two years (due to prison sentence in unrelated matters) between finding that defendant is a sexually violent person and the start of his confinement based on that finding

***Gilbert v. McCullough*, 776 F.3d 487 (7th Cir. 2015).**

Carl C. Gilbert, Jr. had his parole revoked twice after he violated the conditions of his parole. These violations occurred while a civil commitment petition was pending against him, but because Gilbert was sentenced to prison after his second parole revocation, he served that sentence before being transferred to a Wisconsin Department of Health Services ("DHS") facility as a civilly committed person (a jury having found that he qualified as a sexually violent person). Gilbert argued on habeas review that his commitment was contrary to the Supreme Court's decision in *Foucha v. Louisiana*, 504 U.S. 71 (1992) because the interposition of his prison term caused a delay between his commitment verdict and his entry in DHS care, meaning that there was no "current" determination that he was a sexually violent person when he entered DHS care. After the Supreme Court of Wisconsin rejected Gilbert’s due process argument, both the federal district court for the Eastern District of Wisconsin and the Court of Appeals for the Seventh Circuit expressed concern regarding the delay, but ultimately held that the decision to reject Gilbert’s due process claim did not qualify as “contrary to or an unreasonable application of clearly established United States Supreme Court precedent.”

Although the Seventh Circuit acknowledged that “[w]ere the question presented to us as an initial question of federal constitutional law, we might reach a different result” and that the “two-and-a-half year delay between the order of commitment and Gilbert's entry into DHS care is certainly a concern for us,” they found themselves “constrained...by the narrow scope of habeas review.” In distinguishing *Foucha*, the Seventh Circuit found that, unlike in that case, there was “no suggestion that Gilbert no longer suffers from a mental disorder.” Further, there was no ruling or even intimation that “Gilbert could be committed, or that his commitment could continue, if he no longer had a mental disorder,” which *would* have been a holding contrary to *Foucha*.

Fourth Amendment Liberty Interest During Mental Health Crisis: exigent circumstances exception allows warrantless entry and seizures when officers have reasonable basis to believe person poses imminent danger of harm to self

Sutterfield v. City of Milwaukee, 751 F.3d 542 (7th Cir. 2014).

Krysta Sutterfield sued the City of Milwaukee and several of its police officers after officers forcibly entered her home to effectuate an emergency detention for purposes of a mental health evaluation, opened a locked container, and seized for safekeeping the gun and concealed-carry licenses they found inside. Sutterfield contended that the officers in question violated her rights under the Second, Fourth, and Fourteenth Amendments. On appeal from the federal district court for the Eastern District of Wisconsin, the Seventh Circuit held that the warrantless entry into Sutterfield's home was justified under the exigent circumstances exception to the Fourth Amendment's warrant requirement, as the officers had a reasonable basis to believe that Sutterfield posed an imminent danger of harm to herself. The Seventh Circuit ultimately affirmed the lower court's grant of summary judgment to the defendants on the basis of qualified immunity, even assuming that the search of a closed container for a gun, and the ensuing seizure of that gun, violated Sutterfield's Fourth Amendment rights.

On appeal, only the liability of the individual officers was at issue. Sutterfield argued that the police officers' warrantless entry into her home, the seizure of her person, the search of the locked compact disc case, and the seizure of the revolver and the concealed carry licenses discovered therein all violated her rights under the Fourth and Fourteenth Amendments, and that the seizure of the gun and licenses also violated her rights under the Second Amendment. She further contended that because these rights were clearly established (in her view), the officers did not enjoy qualified immunity from suit. The two primary competing interests at stake in the case were Sutterfield's privacy—specifically the right to be left alone in her home—and the important role police play in safeguarding individuals from dangers posed to themselves and others.

The Seventh Circuit noted that the Milwaukee police had been contacted by Sutterfield's physician with a concern that she might harm herself, and that Wisconsin law set forth an emergency detention procedure to deal with that sort of situation. Pursuant to section 51.15, a statement authorizing Sutterfield's emergency detention was prepared, and police executed that statement when they entered Sutterfield's home and took her into their custody. There was no suggestion that the officers acted for any reason other than to protect Sutterfield from harm. The Seventh Circuit also noted that their task was made more complicated by (1) the lack of information presented by the parties as to alternatives other than emergency detention, and (2) a lack of clarity in Fourth Amendment law as to the appropriate framework for examining warrantless intrusions motivated by purposes other than law-enforcement and evidence-gathering. Ultimately, however, the Seventh Circuit held that warrantless entry into appellant's home could not be sustained on the basis of the community caretaker doctrine, but was justified under the exigent

circumstances exception to the Fourth Amendment's warrant requirement, as the officers had a reasonable basis to believe that appellant posed an imminent danger of harm to herself.

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