DEVELOPMENTS IN MENTAL HEALTH LAW
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Commission Endorses Legislative Proposals for 2012 General Assembly Session

The Commonwealth of Virginia's Mental Health Law Reform Commission held its final meeting on June 24, 2011. In addition to reviewing the current statistical report on mental health proceedings, the proposed Rules of Court for Civil Commitment Proceedings (see below), and implementation of new legislation on Advance Directives in Virginia, the Commission endorsed in concept two legislative proposals provided draft language can be agreed upon.

Amended TDO for Back-up Facility

The first proposal is a "housekeeping" matter that will seek to clarify that magistrates may designate a back-up facility in addition to the facility of temporary detention on the temporary detention order ("TDO"). Section 37.2-809 requires the community services board ("CSB") to determine the facility of temporary detention and that it be "indicated" on the TDO. The General Assembly has recently funded the establishment of crisis stabilization units ("CSU") throughout the Commonwealth designed to rapidly stabilize individuals in crisis and return them to their home or community setting before they are removed for longer periods of time through involuntary civil commitment. The Department of Behavioral Health and Developmental Services is encouraging CSUs to accept persons under TDOs or those who are involuntary committed when their security, medical and behavioral needs can be met in that setting.

Due to the emergency nature of the TDO and commitment process, CSUs may not always receive sufficient information and assessment of an individual's condition before they are admitted under a TDO, or their medical or behavioral needs may escalate for a number of reasons. If a CSU or other TDO does not provide the level of care needed to address the safety, medical or behavioral needs of the person, that person, other residents and staff are put at risk, and if the person is an escape risk, the public safety may be jeopardized. As a routine matter, CSUs are developing transfer or back-up agreements with other facilities, primarily hospitals with medical and/or psychiatric services that can address issues that are beyond the capacity of the CSU to handle. Some magistrates in the Commonwealth are relying on Attorney General's Opinions that provide that a TDO cannot be extended and that a TDO is fully executed upon delivery of the person to the TDO facility. They believe the TDO cannot therefore be amended once executed.

In order to address this issue, the Commission proposes to amend Virginia Code § 37.2-809 as follows:

1. To permit a magistrate to include on the original TDO a back-up facility in addition to the original TDO facility. If the CSB advises the magistrate that the originally-designated facility has entered into an agreement with a back-up facility to accept the person if the original facility does not have adequate space to accommodate the person, or is unable to meet the person's security, medical or behavioral heath care needs, that facility may also be indicated on the order without the need for further amendment.
2. To permit the magistrate to amend the original TDO to substitute another facility based upon reliable information provided by the CSB, the original TDO facility, or the proposed facility that the original facility does not have adequate space to accommodate the person or is unable to meet the security, medical or behavioral health care needs of the person.
3. Transportation to the second facility will be provided by law enforcement if alternative transportation is not available.
4. The duration of an amended TDO will be measured from the time of execution of the original TDO, and not the amended TDO.

The Commission will be forming a small work group to develop this proposal to include participation from law enforcement.

Judicial Authorization for Treatment

If an adult person in the Commonwealth lacks capacity to consent to treatment, several different mechanisms exist for obtaining substitute consent for that person. The person may have previously executed an advance directive under the Health Care Decisions Act, § 54.1-2981 *et seq*., appointing a health care agent or indicating his or her instructions concerning the proposed treatment. If a person has not executed an advance directive, a physician may rely on the consent of a guardian or the person's next-of-kin in descending order of priority under § 54.1-2986, or a guardian may be appointed under § 37.2-1000 *et seq*. For persons receiving services from providers operated, licensed or

funded by the Virginia Department of Behavioral Health and Developmental Services, program directors may appoint authorized representatives to act on behalf of the individual, subject to review by local human rights committees under Virginia Code § 37.2-400 and its supporting regulations 12VAC35-115-10 *et seq*.

If a person has not executed an advance directive and someone is not available to provide substitute consent, a provider may seek a court order authorizing treatment for the incapacitated person under § 37.2-1100 *et seq*. Prior to authorizing treatment under this provision, the court must first find, among other things, "[t]hat there is no legally authorized representative available to give consent." § 37.2-1101(G)(1).

Questions have arisen in the past as to the meaning of "available." Some courts have been unwilling to enter an order if the person has a relative but the relative is unwilling to serve. Similarly, if the relative is out of the country, out-of-state, ill or hospitalized, courts have been unwilling to enter such an order. More importantly there have been times when an incapacitated person's closest relative also has a mental illness and is not well-suited to make decisions on behalf of his or her incapacitated relative, or most critically is refusing all proposed treatment for the relative without a rational basis and the lack of any such treatment is leading to the serious deterioration and potential death of the incapacitated person. The Commission is therefore proposing legislation that would clarify when a legally authorized representative is considered "unavailable."

Language under consideration to be added to § 37.2-1101(G)(1) includes the following: "A person who otherwise would have legal authority to authorize or refuse the proposed treatment shall be deemed unavailable if the person is unable or unwilling to serve as the legally authorized representative of the incapacitated person, or if the person's proposed decision is contrary to the basic values or preferences previously expressed by the incapacitated person."

Language is proposed to be added in a new subsection (G)(5) that would also clarify changes made in the Health Care Decisions Act in 2009 and 2010 that permit individuals to execute advance directives to include all health care decisions, including mental health treatment, and not just end-of-life decisions,. Language would be added to clarify that a judicial order may not be entered over the person's protest unless the treatment is consistent with an advance directive executed in accordance with the Health Care Decisions Act. Language would also clarify that treatment may be provided over a person's objection in an emergency.

Section 37.2-1102 also prohibits a court from entering an order for specific types of treatment, such as non-therapeutic sterilization, abortion, or psychosurgery, admission to a hospital or training center, or administration of antipsychotic medication or electroconvulsive therapy except under certain conditions. Subsection 4 prohibits any orders for restraint or transportation of a person unless necessary for the administration of an authorized treatment for a *physical* disorder. The Commission proposes clarifying this subsection to permit restraint or transportation for a mental disorder if the person has been previously involuntarily civilly committed under provisions of Title 37.2, is under a

criminal charge and ordered treated for restoration to sanity or to receive treatment in a hospital or jail, or has been committed after having been found not guilty by reason of insanity.

The Commission will be working on these proposals and language to present during the 2012 Session of the General Assembly. If you have comments on these proposals, contact Joanne Rome at the Virginia Supreme Court at (804) 786-3756 or jrome@courts.state.va.us.

Proposed Rules of Court Governing Involuntary Commitment Proceedings

The Commonwealth of Virginia's Commission on Mental Health Law Reform established a task force in the fall of 2010 to draft proposed Rules of Court designed to:

"(a) Promote uniformity in the application of the laws governing the involuntary civil commitment process in the General District Courts and Circuit Courts of the Commonwealth;

(b) Assure a full and fair adjudication of involuntary civil commitment proceedings, and to enable mental health professionals to carry out their statutory and professional duties to the fullest extent;

(c) Respect the rights, needs and interests of persons subject to these proceedings, and to ensure that the timing, location and conduct of such proceedings are not detrimental to the best interests of the respondent."

Proposed Draft Rule 9:2.

The draft Rules were presented to the Advisory Committee on Rules of Court for the Judicial Council of the Virginia Supreme Court at its meeting in May. Upon review, the Advisory Committee has decided to seek comment from the citizens of the Commonwealth. The Proposed Draft Part Nine of the Rules of Court Governing Involuntary Commitment Proceedings may be viewed at http://www.courts.state.va.us/courts/scv/2011_0821_part_9_for_publication.pdf.

Comments on these proposed draft Rules should be sent by **August 26, 2011** to:

Advisory Committee on Rules of Court
c/o Steven Dalle Mura
Office of the Executive Secretary
Supreme Court of Virginia
100 North Ninth St.
Richmond, VA 23219
OR via email with the subject line: "comment on proposed Part 9" to:
proposedrules@courts.state.va.us

Comments provided to the Committee should reflect not only concerns about specific Rules or the Rules in general, but also whether the Rules as a whole or individually will be helpful to the process. Upon receipt of comments, the Advisory Committee will make a recommendation to the Judicial Council. If approved by the Judicial Council, the draft Rules will then be presented to the Justices of the Supreme Court, and if approved by the Justices, will be posted on the Supreme Court's website for 60 days for comment. Upon receipt of comment and revisions, the Justices of the Supreme Court may adopt the Rules by late fall or early winter.

Written in a clear, concise and straightforward format, the draft Rules are designed to be an easy reference for those participating in the commitment process, including individuals subject to involuntary commitment and their families. For the most part, the draft Rules recite existing law but in simple and comprehensible sentences unlike the complex legal drafting found in the current statutes. Many other states have Rules of Court for involuntary commitment proceedings. Minnesota, New Jersey, Iowa and Washington were considered as models. A summary of the proposed Rules may be found in Issue 2 of *Developments in Mental Health Law.*

Inspector General Equates OAG Advice Involving Use of Restraints to Abuse and Neglect

In his Semiannual Report to the Governor and the General Assembly (October 1, 2010-March 31, 2011) issued May 11, 2011, the Inspector General for Behavioral Health and Developmental Services ("IG") described the results of a complaint investigation conducted by his office into the failure of a Department of Behavioral Health and Developmental Services ("DBHDS") facility to provide therapeutic treatment to a patient. This failure was based upon the advice of the Office of the Virginia Attorney General ("OAG") that the use of a manual hold on a patient when administering medically necessary treatment with the consent of the guardian violates the Centers for Medicare and Medicaid Services' ("CMS") restraint and seclusion regulation, 42 CFR § 482.13(e). The Report relates that the court-appointed guardian for her seriously mentally ill adult child complained that she had consented to medically necessary antipsychotic medication prescribed by the attending psychiatrist that had been effective in the past in treating the patient's severe mental illness. The guardian was concerned that without this drug, her daughter was sinking further into a psychotic state and prolonged psychosis could cause permanent damage, and the treatment team agreed. The Report may be accessed at: http://www.oig.virginia.gov/documents/SAR-10-1-10-03-31-11.pdf.

According to the IG, the OAG had advised that "the use of a brief restraint to administer medically necessary palliative treatment that would restore a delusional person to a baseline of competency, except to ensure 'the immediate physical safety of the patient, a staff member or others' violates 42 CFR § 482.13(e)." The IG reported that a nonviolent psychotic patient could therefore only be medicated if he or she agreed to the

restraint, even though he or she had been found to lack the capacity to make such decisions. The patient could therefore only be restrained to be medicated when "the immediate physical safety to self or others threshold has been crossed."

The IG believes that this interpretation does not comport with the overall intent of 42 CFR Part 482 which is designed to provide important safeguards to "ensure minimum protections of each patient's physical and emotional health and safety," including the right to participate in decision making, the right to be free from abuse and neglect, and the right to be free from medically unnecessary restraint. The IG then implies that "the refusal to provide treatment deemed medically necessary by an attending physician for the health, safety or welfare of the patient, with the express consent of the guardian, satisfies the definition of neglect and abuse as described by [in § 37.2-100 of] the Code of Virginia." The IG reports that the Attorney General has declined to change his advice unless otherwise advised by CMS.

AG Response

The Attorney General responded to the IG Report through an advice letter to Governor Robert F. McDonnell dated July 1, 2011 in which he writes that the IG "materially misrepresents that advice, and reports erroneous conclusions based upon his misinterpretation of the law." The Attorney General notes that in order to receive federal Medicaid and Medicare funds, state hospitals providing mental health treatment must be certified by CMS and in order to do so, must comply with federal conditions of participation adopted by the United States Department of Health and Human Services. The AG writes that the regulation is plain on its face and requires no interpretation, providing: "Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time." 42 CRF § 482.13(e). The Attorney General points out that under federal regulations a patient has the right to consent to or refuse treatment with medication and if the patient lacks the capacity to consent, such consent may be obtained from the patient's representative as provided under state law. 42 CFR § 482.13(b)(2).

Relying upon the State Operations Manual, which is a set of interpretive guidelines issued by CMS that surveyors are required to use when determining a hospital's compliance with the federal conditions of participation, the Attorney General finds that there is a distinction between the right to consent to or refuse medication and the right to be free from restraint. State Operations Manual, Appendix A, Tag A-0161. In fact, CMS explicitly states that a court order providing substitute consent "only removes the patient's right to refuse medication." Id. "The application of force to physically hold a patient against the patient's wishes is considered restraint." The Attorney General concludes that unless CMS changes the language of the regulations or issues guidance pertaining to this issue, the law is clear that restraint may only be used to ensure the immediate physical safety of the patient, a staff member, or others."

Contrary to the IG's assertion, the Attorney General does not conclude that the agreement or consent of the patient to restraint is required before medication may be administered. The Attorney General writes:

> In the vast majority of cases where a patient lacks capacity and substitute consent for medication is provided by an authorized representative or the court, even where the patient disagrees, as long as the medication can be administered without the use of restraint, it can be done. It is only in cases where the patient needs to be held down in order to inject the mediation that the restraint regulation will be triggered. In those cases, it must be determined that the restraint is necessary to ensure the immediate physical safety of the patient, a staff member or others."

The Attorney General goes on to recognize and validate the professional judgment of treatment providers in making this determination: "the determination of when a restraint is necessary to ensure immediate physical safety is one solely to be made by treating professionals in the exercise of professional judgment. This Office has advised that the treating clinicians have broad discretion to make such determinations.

Recently Decided Cases

Arkansas Court Rules against US Department of Justice in CRIPA/ADA/IDEA Lawsuit Brought Against State of Arkansas

Following a six-week trial from September 8 through October 15, 2010, the United States District Court for the Eastern District of Arkansas has found that the United States Department of Justice ("DOJ") did not meets its burden of proving as alleged under the Civil Rights of Institutionalized Persons Act ("CRIPA") that the State of Arkansas and Arkansas state officials were failing to provide reasonably safe conditions and habilitation and training services necessary to protect the residents' liberty interests, at Conway Human Development Center, a training center for 509 persons with developmental disabilities. *United States v. State of Arkansas, et al.*, 2011 U.S.Dist. LEXIS 61347 (June 8, 2011). The Court also held that DOJ failed to prove that Conway Development Center violated the integration mandate of the Americans with Disabilities Act as alleged by failing to provide services in the most integrated, least restrictive setting appropriate to the needs of qualified individuals with disabilities. The Court did find that Conway Development Center failed to comply with all the requirements of the IDEA, but because Congress provided for a state educational agency to enforce compliance with that Act and because evidence established that the state agency was enforcing the Act and the Center had submitted a corrective action plan, no injunction was appropriate.

The Court began its opinion noting how unusual it was for the US Department of Justice's Civil Rights Division to be enforcing the rights of individuals with disabilities when most of the residents of Conway Development Center had parents or guardians to enforce those rights. Most of the parents or residents were fully satisfied with the services provided and opposed the DOJ claims. Six members of the Conway Human Development Center Parents' Association, an association comprised of parents and guardians concerned about the Center, its residents and staff, testified at trial regarding the services. The Court noted that two of the witnesses were nurses themselves. Many of the same parents were also members of Families and Friends of Care Facility Residents, a statewide umbrella organization for all of the parent and guardian groups of the human development centers.

Conditions of Care

DOJ alleged that the policies and practices at Conway Development Center departed from generally accepted professional standards and residents were subjected to abuse and neglect, unconstitutional use of restraints, and unprofessional levels of psychological and medical services. DOJ also alleged that the Center's procedures used to prevent choking, aspiration pneumonia, fractures, decubitis ulcers and other injuries were subpar, and that residents died prematurely. The Court reviewed in detail the testimony of the experts, Center staff and parents on each of the allegations and concluded that the DOJ experts were holding Center staff to a "best practices" standard as opposed to the standard in *Youngberg v. Romeo*, 57 U.S. 307 (1982) that requires proof of a departure from generally accepted professional standards. The Court specifically noted that the Center was certified by the Centers for Medicare and Medicaid Services ("CMS") and complied with all CMS standards. DOJ's experts had testified that professional standards in each of the disciplines were constantly changing and one DOJ expert testified that the CMS standards were outdated. The Court therefore found that the DOJ experts had presented *no* standards with which the Conway staff could be expected to comply, nor did the experts present any benchmarks to compare the Center's alleged deviations involving, for example, the numbers of abuse or neglect complaints, choking incidents or aspiration pneumonia with other comparable facilities. In fact, the Court found that one of DOJ's experts "had no formal education in any field relevant to her testimony," Opinion at 28, and that another expert "presented no evidence that convinced the Court that she was qualified to testify as an expert in any area other than occupational therapy." Opinion at 83. Applying the *Youngberg* standards to this case, the Court held that "[e]ven if the professional judgment of some or all of the plaintiff's experts were better than the professional judgment of some or all of the professionals at Conway Human Development Center, the evidence does not prove that decisions of the latter represent such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that professional judgment was not actually exercised." Opinion at 133-134.

Americans with Disabilities Act

DOJ also alleged that Conway Developmental Center was violating the integration mandate of the Americans with Disabilities Act by failing to provide services, programs and activities in the most integrated, least restrictive setting appropriate to the needs of qualified individuals with disabilities as upheld in *Olmstead v. Zimring*, 527 U.S. 581 (1999). DOJ also alleged that the Center's staff failed to provide parents and guardians with adequate information about other services that DOJ considered more integrated, and that staff did not exercise professional judgment in determining the most integrated setting appropriate for residents.

The evidence established that Arkansas participates in and serves 4083 individuals in the Home and Community Based Waiver program, or four times the number of individuals served in its training centers. In 2007, there were approximately 700 persons on its waiver waiting list, and as of April 2010, that number had risen to 1400. By the time of trial, the waiting list included 1600-1700 people. The evidence revealed that if a parent or guardian of a resident in a developmental center sought a waiver placement, that resident went to the top of the waiting list. The superintendent of Conway Development Center testified that many or all of the Center's residents could be served under the waiver with the proper supports and if resources were sufficient. The evidence also demonstrated though that from June 2007 to July 2009, only 18 residents were discharged.

After considering all of the evidence, the Court held that the terms "restrictive" and "integrated" in the ADA refer to the level of interaction disabled individuals have with nondisabled persons. It then found that the Center provided a significant number of opportunities for individuals to interact with people in the community, sponsoring 305 off-campus activities, including some work opportunities, attendance at movies, eating out, bowling, shopping, fishing, going to parks, going to the state fair, going to the library, attending athletic events, attending church, and participating in the Special Olympics. The Court also heard evidence that nondisabled volunteers visited and worked with residents in about 592 on-campus activities held the previous year, in addition to unrestricted visits permitted from families and friends. The Court also found that individuals in community settings, including those residing in individual apartments had no more contact with nondisabled individuals than did those residing at the Conway Developmental Center. The Court stated, "just as it is an error to assume that because Conway Human Development Center is an institution, its residents have no interaction with nondisabled person, so too is it an error to assume that a community placement *ipso facto* precludes the possibility of isolation or automatically provides more interaction with nondisabled persons than an institutional setting." Opinion at 109. The Court noted that no evidence was presented that the Center refused to discharge a resident when requested by the parent or guardian.

Before each annual interdisciplinary team meeting, the Center sent the parent or guardian a brochure explaining services available under the waiver program with a list with contact information of waiver providers in the state and in the county where the resident's family resided. The Center also sent the parent or guardian a choice of services form on which the parent or guardian indicated whether they wanted to receive services

through the waiver program or at the Center. In addition, the Center invited providers to attend meetings of the Friends and Families of Care Facilities and whenever there was a vacancy in a home in a resident's community, the Center notified the family. The Court thus found that the Center adequately informed parents and guardians of the nature and scope of the home and community based waiver program and provided them with a comprehensive list of waiver providers.

The Court also found that the interdisciplinary team discussed whether the Center was the least restrictive most integrated placement at each annual team meeting and made sure the parent or guardian had received the brochure and list of waiver providers. The Court therefore found staff members at the Center made professional judgments in determining the least restrictive placement appropriate for each resident, even though staff and families agreed that the professionals often did not recommend placement with a waiver provider unless requested to do so by the parents or guardians.

Impact on Virginia

DOJ notified Virginia on February 10, 2011 of the results of its investigation finding that Virginia and Central Virginia Training Center are also violating the integration mandate in Americans with Disabilities Act, making most of the same allegations it made in its losing case against Arkansas: http://www.justice.gov/crt/about/spl/documents/cvtc_findlet_02-10-2011.pdf. With DOJ having lost the Arkansas case, Virginia may now have greater leverage in its negotiations with DOJ that it seemed to have lost when the State of Georgia agreed in October 2010 when faced with a similar federal court complaint to close all of its facilities for individuals with intellectual disabilities rather than go to trial.

DOJ had also previously launched a CRIPA investigation in 2008 at Central Virginia Training Center alleging it had probable cause to believe that CVTC was not protecting residents there from harm and was providing professionally inadequate psychological and psychiatric services. It expanded its investigation in 2009 to investigate CVTC's nutrition services and occupational therapy and physical therapy programs, alleging many of the same violations at issue in the Arkansas lawsuit. After three on-site visits in 2008 and 2009, DOJ has yet to issue a "findings" letter detailing the results of that investigation.

Most DOJ investigations result in settlement agreements with the state that are filed with the court either before the original complaint is filed or before going to trial. Settlements are reached because of the extraordinary expense involved in month-long trials involving prior document-intensive discovery, the hiring of experts in every discipline under attack and the prolonged diversion of staff time and resources away from the delivery of care to individuals. Whether Virginia will be able to significantly increase its waiver program and switch from an institutionally-based system of care to a community-based system under a reasonable settlement agreement and or will decide to litigate remains to be seen as DOJ and Virginia continue their negotiations.

Delaware Settles with DOJ Following ADA Investigation

In an investigation under the Americans with Disabilities Act similar to that involving Arkansas and Virginia described above, the United States Department of Justice ("DOJ") announced its settlement with the State of Delaware on July 6, 2011 involving the Delaware Psychiatric Center, the State's one psychiatric hospital. DOJ initiated its investigation in November 2007, completed on-site inspections of the hospital and community placements in May 2008 and August 2010, and issued its "findings" letter notifying the State of its violations in November 2010. The Settlement Agreement may be accessed at: http://www.ada.gov/delaware.htm.

Under the Settlement Agreement, Delaware agrees to develop an extensive array of community crisis intervention, treatment and support services for persons with serious and persistent mental illness who are at the highest risk of unnecessary institutionalization. Services include implementation of a clinically staffed crisis hotline 24 hours per day, 7 days per week; development of mobile crisis teams, crisis walk-in centers, crisis stabilization teams, crisis apartments, assertive community treatment teams, intensive case management services, case management services, supported housing, supported employment and family and peer support services. Development of all services must be accomplished on a strict timeline, leading to July 1, 2016 when Delaware must substantially comply with all of the terms of the Settlement Agreement. One service - supportive housing - includes the provision of housing vouchers or subsidies and bridge funding for all who need it by July 1, 2016. In addition, transition planning to return individuals to the community must initiated for all persons being admitted to the hospital or an IMD within five days of admission and for all current patients within 30 days. Delaware must meet the transition planning deadlines for 95% of all such individuals by July 1, 2016.

Delaware must also maintain a quality assurance and performance improvement system "with a goal to ensure that all mental health services funded by the state are of good quality and are sufficient to help individuals achieve positive outcomes, including increased integration and independence, and self-determination in all life domains." It must also maintain a risk management system that proactively identifies and addresses risks of harm and complete all root cause analyses when significant incidents occur within 10 days and develop a corrective action plan.

The Settlement Agreement also designates Robert Bernstein, formerly a DOJ expert in CRIPA investigations involving the Northern Virginia Mental Health Institute and Western State Hospital in Virginia, as monitor. The State must pay all the expenses of the monitor who may hire staff and consultants to monitor Delaware's compliance with the Settlement Agreement and submit bi-annual public reports concerning its progress. Delaware must immediately deposit $100,000 to the Settlement Fund to pay the monitor's expenses and maintain that balance throughout the duration of the Settlement Agreement. The monitor will have unlimited and confidential access to all

facilities, staff, and individuals being served, records and data collected. In any future court proceedings in which DOJ does not agree that Delaware has substantially complied with the Settlement Agreement, the burden of proof rests on Delaware to prove its compliance.

Prior Determination That Defendant Not a Mentally Disordered Sex Offender Not Bar to Later Civil Commitment as Sex Offender

The Nebraska Supreme Court held on May 20, 2011 that a 1991 determination at the time of a defendant's conviction and sentence that he was not a "mentally disordered sex offender" under Nebraska's sex offender law then in effect was not *res judicata* barring commitment proceedings in 2010 under Nebraska's current Sex Offender Commitment Act. *In re Interest of D.H.*, 281 Neb. 554, 797 N.W.2d 263 (Neb. 2011). In so deciding, the Court followed a similar California case that found that a 1982 determination that the defendant was not a sex offender did not preclude a civil commitment proceeding 10 years later because the issue was the mental health of the defendant as he approached release, not as it existed at the time of his conviction. *People v. Carmony*, 99 Cal.App. 4th 317, 120 Cal.Rptr.2d 896 (2002). The Nebraska Court held that the Act provides for assessment of the defendant's mental health, risk of recidivism and threat to public safety as he approaches release. Based upon the changeable nature of mental health and dangerous determinations, the assessment is not *res judicata* because the issue presented is not the same as that litigated at the time of his 1991 sentencing.

Ninth Circuit Declines to Find Ineffective Assistance of Counsel for Attorney's Strategic Decision Not to Seek Third Neurological Exam in Capital Case Even Though Exam Recommended

The Ninth Circuit Court of Appeals reversed the decision of the Idaho federal district court that had granted a new sentencing hearing to a defendant sentenced to death on the grounds of ineffective assistance of counsel in this *habeas corpus* case. *Leavitt v. Arave*, 2011 U.S. App. LEXIS 9944 (9th Cir. May 17, 2011). The Court found that the defendant's attorney made a reasonable strategic decision at the sentencing phase not to seek another neurological examination. The defendant was convicted of a gruesome stabbing murder in which he removed the victim's sex organs. The expert who examined the defendant diagnosed him with antisocial personality disorder and intermittent explosive disorder, but recommended a follow-up MRI following an inconclusive neurologic examination to rule out an organic disorder. The trial judge who was deciding the sentence demonstrated hostility toward hearing any further psychiatric evidence, stating that such evidence tended to hurt more than help the defendant. The judge intimated that the evidence indicated an inclination on the part of the defendant to commit further violent acts. The Court held that the defendant's counsel made the strategic decision to try to convince the judge that his client was a "good guy" even though he was aware of the possibility of brain damage as mitigating evidence. He was

therefore not ineffective, as the district court had found, for failure to thoroughly investigate the defendant's mental health condition.

California Supreme Court Finds No Denial of Due Process in Requiring Convicted Defendant to Prove Incompetence to Stand Trial

The California Supreme Court has determined that a defendant is not denied due process of law when he is required to carry the burden of proving that he was incompetent to stand trial at a retrospective hearing to determine his competency. *People v. Ary*, 120 Cal. Rptr.3d 431, 246 P.3d 322 (2011). The defendant in this case was charged with murder and other related felonies. At trial, the defendant moved to suppress his confession and presented psychiatric evidence that he was mildly mentally retarded. The trial court found that he had voluntarily waived his Miranda rights, but found that the confession was coerced and suppressed it. The jury convicted the defendant of murder but was unable to decide upon whether to recommend the death penalty. The court then declared a mistrial on the sentencing issue and sentenced him to life in prison.

On appeal, the Intermediate Court of Appeals determined that the trial judge had erred in failing to evaluate whether the defendant was competent to stand trial and remanded the case for such a determination first as to whether sufficient evidence existed to determine whether the defendant had been competent to stand trial and, if so, to conduct a competency hearing. The trial court found upon remand that evidence of the defendant's mental condition was still available and it was feasible to retrospectively determine his competency at the time of the original trial, and proceeded to conduct the competency hearing. Over the defendant's objection that the prosecution should prove beyond a reasonable doubt that he was competent to stand trial, the judge placed the burden on the defendant to prove by a preponderance of the evidence that he was mentally incompetent when tried. After a retrospective hearing, the trial court found the defendant competent.

On appeal, the Intermediate Court of Appeals concluded that, in contrast to the burden of proof allocation at competency hearings held before or during trial, at a retrospective competency hearing federal due process principles require the prosecution to bear the burden of proving by a preponderance of the evidence that the defendant is competent to stand trial. The Attorney General's Office appealed to the California Supreme Court which reversed finding that the trial court appropriately placed the burden on the defendant. The California Supreme Court noted that a defendant is presumed competent and that the United States Supreme Court had previously upheld California's imposition of the burden at the pretrial stage on the defendant to prove incompetence by a preponderance of the evidence. *Medina v. California*, 505 U.S. 437 (1992). It was therefore appropriate in retrospective hearings to also place the burden on the defendant. In order to impose such a burden post-trial and for the court to consider such an issue, however, the Court held that there must be sufficient evidence available to reliably determine defendant's mental competence after the fact.

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