DEVELOPMENTS IN MENTAL HEALTH LAW

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Articles and information on the following topics appear below:

National Healthcare Decisions Day

Remember National Healthcare Decisions Day on Saturday, April 16, 2011. Be sure to complete your Advance Directive, or if you have already done so, review your directive to make sure it is up to date and accurately reflects your wishes. For information and forms on Virginia Law check out Advance Directive websites at: http://www.advancedirectivesva.com/Virginia_Advance_Directives/Welcome.html and http://www.advancedirective.org/.

Behavioral Health and Criminal Justice Transformation – Update and Review of Three Key Initiatives: Cross Systems Mapping, Crisis Intervention Teams and Jail Diversion

By Victoria Cochran, JD
State Coordinator for Behavioral Health and Criminal Justice Initiatives
Department of Behavioral Health and Developmental Services

Over the past several years the Commonwealth of Virginia has, through multiple initiatives, made great strides in identifying and addressing the challenges encountered when individuals with behavioral health issues become entangled with the criminal justice system. Beginning with its Systems Transformation initiative in 2001, the Department of Behavioral Health and Developmental Services (DBHDS) focused significant attention on criminal justice issues within the behavioral health system through the work of its Forensic Special Populations Workgroup. The Department of Criminal Justice Services (DCJS) developed a white paper on Mental Health Issues in Jails and Detention Centers as part of its 'Blueprints for Change' series (http://www.dcjs.virginia.gov/blueprints/mentalhealthissues.pdf). In October, 2006, when the late Chief Justice Leroy Hassell established the Commonwealth of Virginia Commission on Mental Health Law Reform, he specified the inclusion a Criminal Justice Workgroup with broad criminal justice and behavioral health stakeholder participation (http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/tf_criminal.pdf) to develop recommendations for improving the criminal justice and behavioral health

interface. In response to initial recommendations in the Commission's Preliminary Report (http://www.courts.state.va.us/programs/cmh/2007_0221_preliminary_report.pdf), in 2008, the Commonwealth Consortium for Mental Health and Criminal Justice Transformation (Commonwealth Consortium) was created to bring together state agencies, as well as statewide advocacy and constituency organizations representing affected stakeholders to develop and support policy and training to improve systems interoperability and identify training needs and options. In 2010, Governor McDonnell created the Virginia Prisoner and Juvenile Reentry Council, which includes a mental health and substance abuse issues workgroup to focus on the behavioral health needs of those reentering society after incarceration (http://www.governor.virginia.gov/issues/ExecutiveOrders/2010/EO-11.cfm). Concurrently, sometimes informing these processes and sometimes resulting from them, localities and regions throughout Virginia have also been developing local and regional programs and systems responses intended to improve behavioral health and criminal justice collaboration, systems' response and individual outcomes for justice involved individuals and those at risk for becoming involved in the criminal justice system.

There has been a wealth of history, study and action taken as a result not just of the foregoing, but many other initiatives, as well. A full treatise could be devoted to a comprehensive review and analysis of Virginia's criminal justice and behavioral health transformation process. However, the following brief summary highlights three of the significant programmatic activities underway in the Commonwealth and provides information concerning preliminary successes and outcomes. Each of these three benefits from strong partnership among the Department of Behavioral Health and Developmental Services, the Department of Criminal Justice Services, local courts and criminal justice agencies, behavioral health services providers, consumers and family members. Each additionally boasts a significant and informative developmental history, which would be edifying, but is beyond the scope of this short article. What they have in common is that each has been undertaken as a direct result of or been supported by the Commonwealth Consortium for Mental Health and Criminal Justice Transformation, each is making a difference in communities across the Commonwealth, and each benefits from the Commonwealth's adoption of the Sequential Intercept Model as the framework for creating a common means to identify, understand and respond to the challenges presented at the criminal justice and behavioral health interface (see, *Use of the Sequential Intercept Model as An Approach to Decriminalization of People with Mental Illness, Griffin and Munetz and Griffin (2006)*, at http://psychservices.psychiatryonline.org/cgi/content/full/57/4/544).

The Sequential Intercept Model provides a framework for understanding the correlative processes of the behavioral health and criminal justice systems by identifying 5 discrete points of intersection between the systems. These five 'intercept points' represent the most effective opportunities for identifying individuals with behavioral health disorders, intervening in the criminal justice process and impacting the way the systems respond to them. They are:

1. Law Enforcement and Emergency Services
2. Initial Detention/Initial Court Hearings
3. Jails and Courts
4. Re-entry
5. Community Supervision/Community Support

CROSS SYSTEMS MAPPING - Building the Foundation for Successful Regional and Local Transformation

Cross Systems Mapping is a 1.5 day, professionally facilitated community workshop that brings together local criminal justice and behavioral health stakeholders to examine and improve the criminal justice/mental health interface. The Cross Systems Mapping process helps communities develop a common language, process and knowledge base for understanding their local criminal justice/behavioral health systems. Each Cross Systems Mapping group generates a local "Map" of the five sequential intercepts, depicting how individuals with mental illness flow through their local criminal justice system. Service and process gaps and resources are identified. A highly structured and specific Local Action Plan identifying 5 or 6 key consensus based priority areas and 'low cost/no cost' strategies for improving system interface and client outcomes in each area is developed by the group. Facilitators then create and disseminate a Final Report that serves as process documentation.

Since its beginnings at the Governor's transformation conference in May, 2008, the following significant goals have been accomplished:

- 40 community criminal justice and behavioral health leaders across Virginia have completed the two day certified training to become Cross Systems Mapping facilitators.

- Since January 2009, 20 Cross System Mapping workshops have been provided to communities

- Over 600 criminal justice/mental health stakeholders representing 43 of Virginia's 134 localities have participated in a Cross Systems Mapping Workshop.

- The most frequently reported priority areas on the Local Action Plan include:
    - The need for comprehensive treatment in advance of release and improved discharge planning from jails and prisons.
    - Additional Crisis Intervention Teams (CIT) and training for law enforcement and/or drop-off centers.
    - Additional community-based MH/SA services and the full range of continuity of care, including housing, mobile emergency services, crisis stabilization, social detoxification centers, temporary shelters, medication, restoration of benefits, etc.

- Nearly 50 additional localities have expressed an interest in bringing a Cross Systems Mapping Workshop to their area. Two workshops are currently scheduled and nine are in the planning stage.

CRISIS INTERVENTION TEAM PROGRAMS – Intercept 1: Reducing Incarceration

Crisis Intervention Team programs (CIT) provide an enhanced local law enforcement based capability to respond to situations involving individuals with symptomatic behavioral health issues. CIT brings together local stakeholders, including law enforcement, emergency dispatchers, mental health treatment providers, consumers of mental health services and others (such as hospitals, emergency medical care facilities, non-law enforcement first responders, and family advocates), in order to improve multi-systems' response to persons experiencing behavioral health crises who come into contact with law enforcement first responders. Such individuals may come to the attention of law enforcement and other first responders or corrections and jail personnel due to exhibiting symptoms or behaviors that are misinterpreted as criminal in nature, inappropriate, dangerous or violent. Additionally, law enforcement officers routinely interact with individuals with behavioral health disorders as a result of the statutory structure of Virginia's civil commitment process. In many of these situations, it is necessary to help such persons access mental health treatment, or place such persons in custody and seek either mental health treatment referral or incarceration for criminal acts.

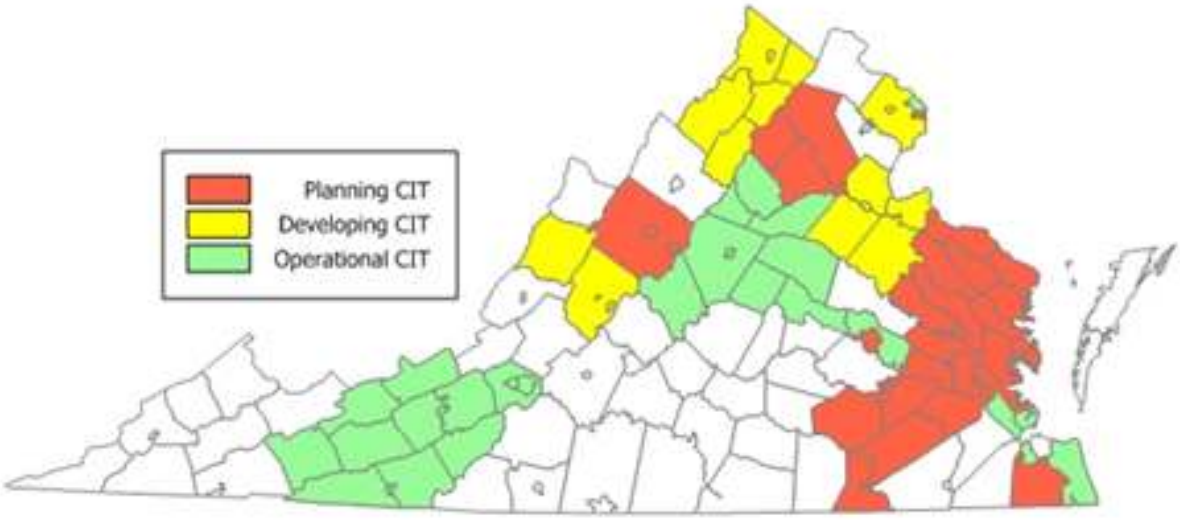
CIT programs enhance community collaboration, develop effective infrastructure and provide outstanding training to improve criminal justice and mental health system response to individuals with mental health issues. In response to a growing grass roots development of programs in Virginia throughout the early 2000's, in 2009 the Virginia General Assembly, amended sections 9.1-102, -187, -188, -189 and -190 of the *Code of Virginia* to direct the Department of Criminal Justice Services in conjunction with the Department of Behavioral Health and Developmental Services to "…support the establishment of crisis intervention team programs in areas throughout the Commonwealth." This legislation established numerous goals and criteria for the departments to use in implementing its provisions and establishing CIT programs in the Commonwealth, and directed that a status report be submitted in November 2009 to the Joint Commission on Health Care, and further, that a report assessing the effectiveness of Crisis Intervention Team programs be submitted to the Joint Commission on Health Care in November 2009, 2010, and 2011. The full 2010 report can be found at http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/1cf9d7d74e2382f1852576900071514f?OpenDocument . Pursuant to Code and in practice across the Commonwealth, the goals of the crisis intervention team programs shall be:

1. Providing immediate response by specially trained law enforcement officers;
2. Reducing the amount of time officers spend out of service awaiting assessment and disposition;

3. Affording persons with mental illness, substance abuse problems, or both, a sense of dignity in crisis situations;
4. Reducing the likelihood of physical confrontation;
5. Decreasing arrests and use of force;
6. Identifying underserved populations with mental illness, substance abuse problems, or both, and linking them to appropriate care;
7. Providing support and assistance for mental health treatment professionals;
8. Decreasing the use of arrest and detention of persons experiencing mental health and/or substance abuse crises by providing better access to timely treatment;
9. Providing a therapeutic location or protocol for officers to bring individuals in crisis for assessment that is not a law-enforcement or jail facility;
10. Increasing public recognition and appreciation for the mental health needs of a community;
11. Decreasing injuries to law-enforcement officers during crisis events;
12. Reducing inappropriate arrests of individuals with mental illness in crisis situations;
13. Decreasing the need for mental health treatment in jail.

At its core, CIT provides 1) law enforcement-based crisis intervention training for assisting individuals with a mental illness; 2) a forum to promote effective problem solving regarding interaction between the criminal justice and mental health care system; and, 3) improved community-based solutions to enhance access to services for individuals with a mental illness. Successful CIT programs improve officer and consumer safety, and appropriately redirect individuals with mental illness from the criminal justice system to the health care system.

In the 10 years since development of the first successfully sustained Crisis Intervention Team program in Virginia, a rural multi-jurisdictional program located in the New River Valley comprised of 14 law enforcement agencies and covering four counties and one city, 22 other communities across the state have begun working on CIT initiatives or have created CIT programs. As of November, 2010, this map represents the breakdown of programs by locality and status.



Program breakdown numbers are as of November 2010 and status is defined as follows:

Operational (8): Programs that have a stakeholder taskforce which meets regularly and provides program oversight and educational outreach, has a CIT coordinator in place, has trained the number of CIT officers necessary to provide 24/7 CIT response capability, has an established therapeutic assessment location or protocol in place and has begun collecting data to assess the efficacy of the program.

Developing (7): Programs that have a well established stakeholder taskforce with a CIT coordinator in place or dedicated leadership, have a significant number of trained local CIT officers and CIT faculty and are working toward the implementation of a therapeutic assessment location or establishing protocols to enhance linkage to services in lieu of incarceration.

Planning (8): Programs that are establishing a stakeholder taskforce, studying the CIT model, providing initial officer and mental health provider training and developing partnerships to address options for implementing assessment locations or establishing protocols to enhance linkage to services.

The following data provides an overview of CIT activities in the Commonwealth:

- Through FY2010, there are 23 CIT initiatives in the Commonwealth
- Through FY2010, 95 dispatchers received 2 – 6 hours of training to enhance CIT response capacity
- To date, nearly 100 40-hour trainings have been held
- To date, over 2,000 law enforcement, other first responders, corrections officers, mental health providers and consumers have completed the 40-hour Core CIT curriculum

VIRGINIA'S JAIL DIVERSION COHORT PROGRAMS – Intercepts 2 – 5: Identifying, Intervening and Impacting Clients and Services Across the Intercepts

Many Community Services Boards (CSBs) throughout Virginia provide a variety of effective services and programs benefitting justice involved individuals. However, since 2008, the General Assembly has designated specific funds appropriated through the Department of Behavioral Health and Developmental Services (DBHDS) to support the development of jail diversion and jail treatment programs for individuals with behavioral health disorders. As a result of this funding, beginning in 2009, DBHDS has worked with 10 CSBs to create a cohort of jail diversion and jail treatment initiatives. The common thread of these 'cohort' programs is in the unique system developed for measuring both criminal justice and clinical outcomes.

The ten cohort CSBs and the jails in their services areas are:

1. **Alexandria** (Alexandria Detention Center)
2. **Arlington** (Arlington Detention Center)
3. **Chesterfield** (Chesterfield County Jail, Riverside Regional Jail)
4. **Fairfax County** (Fairfax ADC)
5. **Hampton/Newport News** (Hampton City Jail, Hampton Jail Annex, Newport News City Jail)
6. **Middle Peninsula** (Middle Peninsula and Northern Neck Regional Jails)
7. **New River Valley** (Montgomery County Jail, New River and Western Va Regional Jails)
8. **Portsmouth** (Portsmouth City Jail, Hampton Roads Regional Jail)
9. **Rappahannock Area** (Rappahannock Regional Jail)
10. **Virginia Beach** (Virginia Beach Correctional Center)

In FY10, the first full year in which data was available, the following outcomes were obtained:

- 3,666 individuals were screened for clinical and criminal justice program eligibility and 730 individuals were enrolled into existing services or specialized programs. The breakdown by intercept is as follows:

FY2010	**Intercept 2**	**Intercept 3**	**Intercept 4**	**Intercept 5**	**TOTAL**
Screenings	2,630	944	39	53	3,666
Enrollments	236	381	89	24	730

- Of those 730 enrolled in services and programs, the following represents the breakdown of services received:

Programs and Services	**Intercept 2**	**Intercept 3**	**Intercept 4**	**Intercept 5**	**TOTAL**
Linked to Existing Services	64	170	83	38	**355**
Specialized CJ-MH Program	171	220	108	44	**543**
Need Housing	26	28	31	9	**94**
Linked to Housing	17	15	19	4	**55**
Linked to Entitlements	55	3	16	6	**80**
TOTAL	**333**	**436**	**257**	**101**	**1,127**

Programmatic activity provided at these sites ranges from the New River Valley's Intercept 2 program "The Bridge", which identifies, screens and makes referrals within 48 hours of booking and then provides comprehensive treatment, case management utilizing a forensic and trauma informed service program to an Alexandria based Intercept 5 state Probation and Parole based jail initiative which provides a mental health and substance abuse trained probation officer carrying a behavioral health client case load and working in direct collaboration with the services and supports available through the CSB.

Outcomes seen in these specific initiatives include the following, as set forth in a report from the Alexandria CSB:

- During FY10, the Alexandria Jail Diversion Program screened a total of 64 individuals and enrolled 29 into services
- 34% of the target arrests were misdemeanors and 66% were felonies
- A total of 9 prior arrests were reported in the 12 months prior to intervention; In the 12 months post intervention, a total of 2 arrests were reported
  - This represents a 78% reduction in arrests
- Clinical Outcomes:
  - 14 individuals linked to entitlements
  - 2 individuals linked to housing
- Of 31 enrolled into the Alexandria Jail Diversion Initiative
  - 13 under supervision through Alexandria Probation & Parole and assigned to Mental Health Probation Officer
- The average number of days incarcerated for the 12 months prior to intervention was 145 days. The average number of days incarcerated for the 12 months post intervention was 49 days.
  - This represents a 66% reduction in jail days or an average of 96 days per consumer.

- 7 of the 13 returned to jail in the post intervention year. 2 individuals received new charges and the remaining 5 individuals returned for felony probation violations

As reported by the New River Valley Bridge Program:

- During FY10, the Bridge Program screened a total of 359 individuals and enrolled 55 into services
- 31% of the target arrests were misdemeanors and 69% were felonies
- A total of 84 prior arrests were reported in the 12 months prior to intervention; In the 12 months post intervention, a total of 16 arrests were reported
  - This represents a 81% reduction in arrests
- Clinical Outcomes:
  - 2 individuals linked to entitlements
- Improved Identification and Enrollment
  - From March, 2007 through June, 2009, the Bridge screened 584 individuals and kept 106 clients out of jail and in the community a total of 16,892 client days
- Reduction in Days Spent in Jail
  - Based on a sample of 152 program referrals, individuals who were eligible and enrolled in the Bridge Program spent on average 10 days less in jail than individuals who were eligible and not enrolled
- Reduction in Post Enrollment Charges
  - Based on the sample of 38 clients where a full two years of data could be captured, there was a 72% *decrease* in charges accrued post-enrollment (12-months following the point of diversion)

These three programmatic areas, Cross Systems Mapping, Crisis Intervention Teams and Jail Diversion Cohort programs are emblematic of the improved focus, breadth and impact of behavioral health and criminal justice transformation across the Commonwealth of Virginia.

2011 Virginia General Assembly Session

After three years of enacting significant legislation related to the civil commitment of individuals with mental illness, the General Assembly focused on other issues in this short session, enacting only one minor bill related to emergency custody orders described below. Unless otherwise noted, the bills summarized below have all been signed by the Governor and become effective July 1, 2011. Links to each of the bills is provided at the end of each summary.

Persons with Intellectual Disabilities – Training Centers

Trust Fund Bill - HB 2533 (Cox)/SB1486 (Northam): By far the most significant bills enacted this session were these two duplicate bills that amend Virginia Code § 37.2-319, requested for introduction by the Governor on February 16, 2011, after receipt of the Department of Justice's findings that Virginia is violating the Americans with Disabilities Act by failing to provide adequate community-based services for persons with intellectual disabilities (*see* Volume 30, Issue 2 of *Developments in Mental Health Law*). In addition, the General Assembly appropriated $30 Million additional dollars for deposit to the Behavioral Health and Developmental Services Trust Fund (Trust Fund) to transition individuals from state training centers to community-based settings (Item 305.W: http://lis.virginia.gov/cgi-bin/legp604.exe?111+bud+21-305), and added 275 additional Medicaid waiver slots to the Intellectual Disabilities waiver effective July 1, 2011 (Item 297.ZZ.4: http://lis.virginia.gov/cgi-bin/legp604.exe?111+bud+21-297).

The current law focuses on the use of funds from the sale of DBHDS-operated hospitals and training centers for the generalized purpose of providing "mental health, mental retardation and substance abuse services to enhance and ensure the quality of care and treatment provided." These bills were amended at every stage of the House and Senate review. As passed and signed by the Governor, the law will contain more guidance as to how the funds can be used. It is clear now, if not previously, that trust funds can be used "to facilitate transition of individuals with mental retardation from state training centers to community-based services." Beginning this fiscal year, any funds deposited into the Trust Fund pursuant to the general appropriation" (as opposed to those deposited as a result of the sale of state-owned property) must be used to finance "(i) a broad array of community-based services including but not limited to Intellectual Disability Home and Community Based Waivers or (ii) appropriate community housing, for the purpose of transitioning individuals with mental retardation from state training centers to community-based care."

From a public-policy perspective, the Trust Fund now becomes the mechanism to fund transition of the intellectual disability services system to a community-based system. Although the statute can again be amended in future years, funds appropriated to the Trust Funds are theoretically "locked-in" and unspent funds plus interest unspent from year-to-year will not revert to the general fund. Passage of this legislation also highlights the General Assembly's public policy shift away from institutional care in favor of community-based care. Although the statute also permits expenditure of trust funds for mental health services, the specificity of the language in these two bills relating almost exclusively to services for individuals with intellectual disabilities leads one to believe that if any funds are appropriated for deposit in the Trust Fund in the future for services for persons with mental illness, the General Assembly should again amend this statute to clearly so provide or at the least insert very specific language in any future Appropriation Act.

The General Assembly also added two additional enactment clauses. The first requires the Secretary of Health and Human Resources to develop a plan to transition individuals with intellectual disabilities from state training centers to community-based settings, including provisions to reduce the number of individuals currently residing in training centers, and to submit that plan to the General Assembly by November 1, 2011. The plan must also include facility specific objectives and timeframes to implement the changes, and must be developed with input from individuals receiving training center services and their families, community services boards, private providers and the Department of Medical Assistance Services. The Secretary must submit reports on the development and implementation of the plan to the Governor and Chairmen of the General Assembly money committees by July 1 and December 1 of each year beginning July 1, 2011.

The third enactment clause provides that any funds directed to be deposited to the Trust Fund beginning July 1, 2011 pursuant to the general appropriation shall be used to finance "a broad array of community-based services, including up to 600 Intellectual Disability Home and Community Based Waiver slots, one-time transition costs for community placements, appropriate community housing, and other identified community services that may not be covered through the waiver program, for the purpose of transitioning individuals with mental retardation from state training centers to community-based settings." http://lis.virginia.gov/cgi-bin/legp604.exe?111+ful+HB2533ER+pdf.

Consent for Discharge - HB 1790 (Tata): Currently, § 37.2-837 permits any person with an intellectual disability, or his or her legally authorized representative if the person lacks capacity to make such decisions, to "choose" whether or not to be discharged from a training center. This bill would permit the person's discharge only upon his or her "consent," or the "consent" of his or her legally authorized representative, and only after "disclosure of information regarding the actual availability and accessibility of services sufficient to meet the needs of the consumer in the community." **This bill must be reenacted by the 2012 Session of the General Assembly before becoming effective**. It is not clear whether this "informed consent" requirement, if reenacted, will stymie efforts to downsize and replace Southeastern Virginia Training Center or discharges from the other training centers, especially Central Virginia Training Center under DOJ investigation. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB1790ER+pdf

Emergency Custody Orders

HB 2090 (Herring): This bill amends § 16.1-340 and § 37.2-808 extending the timeframe during which an emergency custody order must be executed before the order becomes void from four to six hours of issuance. The timeline applying to the effectiveness of the order in this instance is measured from the time of issuance of the ECO to the time the person is taken into custody. The timeframe will now correspond to the total length of time a person may be held under a 4-hour emergency custody order when extended by the magistrate to 6 hours. The two timeframes, however, are unrelated

and serve different purposes. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+CHAP0249+pdf

Sexually Violent Predators

Qualifications of Expert - HB 2227 (O'Bannon): This bill eliminates the requirement that the licensed psychiatrist or psychologist who serves on the Commitment Review Committee, or who conducts mental health examinations of or provides expert assistance to alleged sexually violent predators for purposes of civil commitment proceedings be skilled in the "treatment" of sex offenders. Instead the professional need only be "knowledgeable about the treatment of sex offenders." This amendment is designed to expand the pool of psychiatrists and psychologists qualified to perform these functions since there are few mental health professionals in the Commonwealth actually experienced in the treatment of sex offenders. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+CHAP0042+pdf

Rescission of Refusal to Cooperate - HB 1698 (Athey)/SB 1275 (Obenshain): As reported in last month's issue of *Developments in Mental Health Law*, these bills establish procedures surrounding the ability of a respondent in a civil commitment proceeding who is alleged to be a sexually violent predator to rescind any refusal to cooperate with the State's mental health examination. These bills address the November 4, 2010 Virginia Supreme Court decision issued on November 4, 2010 holding that the failure of the court to permit a prisoner to rescind his refusal to cooperate with the Commonwealth's mental health expert violated the respondent's procedural due process rights. *Hood v. Commonwealth*, 280 Va. 526, 701 S.E.2d 421 (2010), found at http://www.courts.state.va.us/opinions/opnscvwp/1092402.pdf.

Under these bills, the respondent may rescind his refusal to cooperate and elect to cooperate with the mental health examination within 21 days of retention or appointment of counsel. Counsel for the respondent must provide written notice of the respondent's election to cooperate to the court and the attorney for the Commonwealth within 30 days of the appointment or retention of counsel. The probable cause hearing is then postponed until 30 days after receipt of the mental health examiner's report. If the respondent thereafter refuses to cooperate with the mental health examination, the court is *required* to admit evidence of such failure or refusal and to bar the respondent from introducing his own expert evidence. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB1698H1+pdf

Community Services Boards and Behavioral Health Providers

Privileged Communications – HB2373 (Peace)/SB 1469 (Saslaw): The provisions of these bills have been debated since the Virginia Supreme Court decision in *Riverside Hospital, Inc. v. Johnson*, 636 S.E.2d 416 (Va. 2006) found at http://www.courts.state.va.us/opinions/opnscvwp/1060392.pdf, that defined a medical record to include any document containing information about a patient and making incident reports and other information previously viewed as privileged by health care

providers under § 8.01-581.17 available to plaintiffs and their attorneys in discovery proceedings. This long-negotiated legislation makes it clear that all factual information related to a patient is available, including patient incident reports in whatever format. However, all analysis, findings, conclusions, recommendations and the deliberative process of any medical staff committee or entity specified in § 8.01-581.16, including its proceedings, minutes, records and reports – especially those of experts for such entities – are privileged in their entirety, and do not constitute "medical records." Information known by a witness with knowledge of the facts or a treating health care professional will be available unless that witness obtained the information solely by virtue of his involvement in the quality assurance, peer review or credentialing process.
http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+CHAP0015+pdf

Medical Malpractice Cap – HB 1459(Albo)/SB 771(Saslaw): The General Assembly overrode Governor McDonnell's veto of the increase to Virginia's medical malpractice cap. The total amount recoverable against a health care provider in a lawsuit brought as a result of the death of or injury to a patient has been capped at $ 2 Million since July 1, 2008. Beginning July 1, 2012 and every year thereafter the cap will increase by $50,000 until July 1, 2031 at which point it will be set at $ 3 Million. The annual increase will apply to acts of malpractice occurring on or after the effective date of the increase each year and not the year in which the judgment is rendered.
http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+SB771ER+pdf

P&T Committee - HB 2013 (Pogge): This bill amends § 37.2-304 to authorize the Commissioner of Behavioral Health and Developmental Services to establish a pharmaceutical and therapeutics committee to develop a drug formulary for use at all community services boards, state operated facilities and providers licensed by DBHDS. Members of the committee must include representatives of the Department of Medical Assistance Services, state facilities operated by DBHDS, community services boards, and at least one health insurance plan and one consumer. The bill's second enactment clause *requires* DBHDS to establish the P&T Committee no later than July 1, 2011.
http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB2013ER+pdf

Autism Coverage – HB 2467(Greason)/SB 1062(Howell): For the first time Virginia will mandate health insurance carriers and health maintenance organizations to provide coverage for the diagnosis and medically necessary treatment of autism spectrum disorders for children ages 2 through 6, subject to a $35,000 annual cap for the cost of applied behavioral analysis, **beginning January 1, 2012**. This mandate will also apply to health coverage offered to all state and local employees, but will exclude coverage provided by employers with 50 or less employees and small group plans. The Act will also not apply to insurers if the costs exceed one percent of premiums charged over each year. The Governor did not sign this legislation, but returned it to the General Assembly recommending 5 amendments for consideration at the veto session on April 6, 2011. The General Assembly agreed to the first four recommendations: 1) requiring applied behavior analysts to be licensed by the Board of Medicine and 2) be independent of the prescribing provider; 3) providing for an independent review of treatment plans; and 4) permitting requirements for prior authorization for services. The General Assembly

rejected the Governor's recommendation and the Governor concurred that the whole Act would be invalidated if the $35,000 annual cap was invalidated by state or federal law or a court of competent jurisdiction. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+SB1062ER2+pdf

Criminal Background Checks - HB 1729 (Carrico): This bill amends § 37.2-416 and § 37.2-506 to permit community services boards and licensed providers to hire applicants for positions at adult substance abuse treatment facilities who have been convicted of one offense of assault and battery of a law-enforcement officer if (i) the person has been granted a simple pardon; (ii) more than 10 years have elapsed since the conviction; and (iii) the provider determines based upon a screening assessment that the behavior was substantially related to the applicant's substance abuse and he or she has been successfully rehabilitated and is not a risk to consumers based on his criminal history background and substance abuse history. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB1729ER+pdf

Restoration of Firearm Rights

HB 1699 (Athey): This bill amends §§ 18.2-308.1:1, 18.2-308.1:2 and 18.2-308.1:3 making the process for petitions for restoration of firearms rights uniform for persons who have been found not guilty by reason of insanity, adjudicated incapacitated or involuntarily admitted to a mental health facility or ordered to mandatory outpatient treatment.. The bill clarifies that the court may consider evidence concerning the person's reputation as developed through character witness statements, testimony or other character evidence. The bill also defines "treatment record" to include copies of health records detailing the petitioner's psychiatric history and the records pertaining to the court proceeding through which the petitioner lost his or her right to purchase, possess or transport a firearm. Most significantly, the legislation that passed required the person who petitions the general district court to have an audio recording of any hearing made that would be retained in a confidential file with the clerk of the general district court for at least three years. The Governor did not sign this bill but returned it to the General Assembly with the recommendation that this provision be removed. The General Assembly approved this deletion on a split vote at its veto session on April 6, 2011. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB1699ER2+pdf

Guardianship

SB 750 (Howell): The Uniform Adult Guardianship and Protective Proceedings Act creates a new Chapter 10.1 in Title 37.2 and will establish a mechanism for resolving jurisdictional disputes in adult guardianship and conservatorship (protective) proceedings. This Act has been adopted in 19 states and the District of Columbia. Procedures are provided for determining which jurisdiction is the "home state" having primary jurisdiction when a person has a significant relationship in more than one state, transferring a guardianship or conservatorship to another state, registering orders entered in other states in Virginia, and addressing emergency situations. Questions have frequently been raised as to when and under what circumstances an out-of-state

guardianship order can be recognized in Virginia. This Act will be very helpful in clarifying this situation, although the process will continue to remain relatively expensive for family members of persons with intellectual disabilities and mental illness. http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+CHAP0518+pdf

Inspector General for Behavioral Health

HB 2076 (Landes)/SB 1477 (Stosch): The General Assembly has merged the powers and duties of the Inspector General for Behavioral Health and Developmental Services into the newly created Office of Inspector General **effective July 1, 2012**. The new State Inspector General will be appointed by the Governor and confirmed by the General Assembly for a four-year term, and must have at least five years of demonstrated experience or expertise in accounting, public administration or audit investigations as a certified public accountant or a certified internal auditor, but not expertise as a mental health professional. His or her primary responsibility will be to investigate the management and operations of state agencies and non-state agencies (defined as a public or private foundation, authority, institute, museum, corporation or similar organization wholly or principally supported by state funds but not a unit of state or local government) to determine whether acts of fraud, waste, abuse or corruption have been committed by their officers or employees. In addition to DBHDS and providers it licenses, the State Inspector General will also have specific responsibilities related to inspections of the Departments of Corrections, Juvenile Justice and Transportation, as well as the Tobacco Indemnification and Community Revitalization Commission.

Beginning July 1, 2011, the Governor must begin development of a plan, to be completed by December 31, 2011, for the coordination and oversight of the various internal audit programs operated by state agencies and determine whether transfer of those programs to the State Inspector General may be necessary or whether a dual reporting structure is more practical. How this new structure will impact the work and priorities of the Inspector General for Behavioral Health and Developmental Services remains to be seen.

The bills also amend Virginia Code § 2.2-3705.6(7) of the Virginia Freedom of Information Act to carve out a specific exclusion for investigations conducted by the Office of the Inspector General. Under this provision (effective July 1, 2012), investigative notes, correspondence and information furnished in confidence and records otherwise exempted by any Virginia statute and provided to the Office of the State Inspector General will not be available to the public under FOIA. Records of all completed investigations will, however, be available to the public in a form that does not reveal the identity of the complainants or persons supplying information to investigators. Records that must be disclosed include the name of the agency involved, the identity of the person who is the subject of the complaint, the nature of the complaint, and the actions taken to resolve the complaint.

Currently the DBHDS Inspector General posts routine inspection reports on his website, but relies on the governor's working papers exclusion under FOIA to protect

investigations involving deaths, serious incidents and other specific complaints. These reports may now become available to the public. Because the Office of Inspector General must maintain the confidentiality of any information obtained during the course of an investigation that the entity maintaining the information is required to keep confidential in accordance with applicable state and federal law, protected health information related to individuals receiving services will not be disclosed. It is unclear, however, the extent to which privileged information created under Virginia Code § 8.01-581.17 related to the quality of services provided by state operated agencies will be protected. The BHDS Inspector General will continue to have authority under Virginia Code § 2.2-316 to access such information kept by state agencies, but not by licensed providers. Presumably privileged information will be furnished to the Inspector General in confidence and will thus be unavailable to the public, but the Inspector General's final report based on that information will be public. The Governor returned these bills to the General Assembly recommending technical amendments, which the House and Senate adopted at the veto session on April 6, 2011. http://leg1.state.va.us/cgi-bin/legp504.exe?ses=111&typ=bil&val=sb1477

Pending and Recently Decided Cases

Class Action Filed Alleging Texas Violates ADA in Failing to Provide Community-based Services

Six named individuals residing in nursing facilities in Texas, the Arc of Texas, and the Coalition of Texans with Disabilities filed suit in December 2010 against the Governor, the Executive Commissioner of Health and Human Services and the Commissioner of the Department of Aging and Disability Services alleging that Texas is violating the Americans with Disabilities Act, § 504 of the Rehabilitation Act, Title XIX of the Social Security Act and the Nursing Home Reform Amendments. *Steward v. Perry*, No. 5:10-cv-01025 (W.D. Tex.).

The plaintiffs are alleging that each of the named individuals with a combination of intellectual disabilities and other conditions, such as cerebral palsy, epilepsy, or head injury, all qualify for community-based services and supports and are seeking class action certification for the 4500 others in Texas nursing facilities and the thousands more at risk of institutionalization. They are alleging that 45,756 individuals are on Texas' waiting list for Home and Community-Based Services Waiver with Texas ranking 49th out of the 50 states in providing community-based care. They further allege that Texas has failed to provide PASARR Level II screenings to the plaintiffs or to provide "specialized services" required by Medicaid. Ironically, the plaintiffs argue that individuals residing in Texas' 13 state-operated supported living centers under DOJ consent decree receive active treatment and better services than they do, noting that their scope of specialized services is limited to physical, occupational and speech therapy. The plaintiffs Arc and Coalition of Texans with Disabilities are suing on their own behalf and on behalf of their members.

The defendants filed a Motion to Dismiss on March 8, 2011 arguing, among other things, that the plaintiffs lack standing to bring this action, that a portion of their complaint is time barred and that the Acts they allege the defendants are violating convey no private right of action upon the plaintiffs.

Government Fails to Carry Burden to Forcibly Medicate Incompetent Defendant

The Ninth Circuit Court of Appeals has reversed the decision of the trial court and found that the Government did not meet its burden of establishing by clear and convincing evidence the *Sell* factors authorizing treatment of a defendant over his objection. *United States v. Ruiz-Gaxiola*, 623 F.3d 684 (9th Cir. 2010).

The defendant in this case, a Mexican citizen with an extensive criminal history of drug offenses, was charged with illegal reentry into the United States. Diagnosed with a delusional disorder, grandiose type, he was found incompetent to stand trial and sent to Butner Correctional Institution in North Carolina for treatment. At an administrative hearing, the defendant was found not to be a danger to himself or others in the institutional setting and did not suffer from a grave disability justifying involuntary medication. Thus the sole issue before the court was whether the defendant could be medicated over objection for the purpose of restoring his competency to stand trial.

Under *Sell v. United States*, 539 U.S. 166 (2003), the government must prove by clear and convincing evidence each of the factors enunciated by the United States Supreme Court: 1) that important governmental interests are at stake; 2) involuntary medication will significantly further that interest, i.e. it is *substantially likely* to restore defendant to competency and *substantially unlikely* to cause side effects that would impair significantly his ability to assist in his defense; 3) involuntary medication is necessary to further those governmental interests; and 4) treatment with medication is medically appropriate.

The magistrate judge considered the evidence and concluded that the government had proved its case. The Court of Appeals reversed finding that this case does not present one of those rare circumstances permitting medication over objection to render the defendant competent to stand trial and the government had not met its burden under *Sell's* second and fourth prong. Although the defendant had never been treated with antipsychotic medications, the Court held that the government must prove what the medication will do, not what it is designed to do. The appellate court discounted the testimony of the government's experts and relied on the testimony of the defendant's expert who testified that the medication was likely to worsen his rare and difficult to treat mental disorder and increase his delusional thinking, especially based upon his inferiority feelings and hypersensitivity to powerlessness. It found that treatment with haldol would also unduly subject him to the risk of tardive dyskinesia. The court therefore found that treatment with medication was medically inappropriate.

SVP Petition Cannot Be Filed in New York When Respondent Not in Custody for Sex Offense

The New York Court of Appeals has upheld the decision of the appellate court dismissing the Attorney General's petition to commit this respondent under its Sex Offender Management and Treatment Act. *In the Matter of the State of New York v. Rashid*, 16 N.Y.3d 1, 2010 NY LEXIS 3339 (November 23, 2010). Although the respondent had pled guilty to sodomy in 1991, he was incarcerated for robbery at the time the interagency notice was sent by the Department of Corrections that Rashid may be a sex offender. At the time the respondent received notice of the petition, he was in jail for petit larceny. Because the respondent was not subject to state custody or supervision, he was not a detained sex offender at the time the petition was filed for purposes of the Act. The Court also held that the proceedings commenced at the time the Attorney General filed the petition, not at the time notice was provided by the Department of Corrections.

Hospital Not Liable for Counselor's Sexual Harassment of Patients

The Eleventh Circuit Court of Appeals has held that Grady Memorial Hospital is not liable for one of its counselor's sexual misconduct with three patients in its methadone treatment clinic. *Doe v. Fulton-DeKalb Hospital Authority*, 628 F.3d 1325 (11th Cir. 2010). The plaintiffs alleged that the counselor made inappropriate sexual advances during drug counseling sessions, and that Grady failed to conduct an adequate background investigation prior to hiring the counselor and to adequately supervise the counselor. The Court found that under Georgia law an employer cannot be found liable for the sexual misconduct of an employee under the doctrine of *respondeat superior*. In addition, the Court upheld the finding of the district court that the hospital exercised ordinary care in the hiring process. While its screening protocols were less than ideal, the hospital had no actual notice of prior misconduct by this employee; he passed criminal background checks and a drug test; and he provided dishonest information during the application and interview process as to why he left his previous jobs. The fact that the hospital failed to comply with Georgia regulation requiring it obtain a five-year employment history on all applicants posed licensing problems only and did not impost tort liability on the hospital.

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Developments is edited by Jane D. Hickey. Please send comments concerning its contents to jhickey080@gmail.com.