

DEVELOPMENTS IN MENTAL HEALTH LAW

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I. Article

SJ 47 Joint Subcommittee: Mental Health Initiatives at the 2018 General Assembly Session

While the biggest headlines on health care delivery and coverage in the 2018 General Assembly session went to Medicaid expansion (which was supported by key members of

the SJ 47 Joint Subcommittee), the biennium budget passed by the General Assembly and signed by the Governor also included major mental health initiatives recommended and supported by the SJ 47 Joint Subcommittee. Those initiatives included continuing the mental health service system change that the Joint Subcommittee first endorsed in the fall of 2016 (covered in the winter 2016 issue of DMHL, found [here](#)).

The final recommendations of the SJ 47 Joint Subcommittee for the 2018 session, agreed upon at the Subcommittee's December 2017 meeting, are summarized in a 3-page document developed by the Division of Legislative Services (DLS) and now posted on the DLS website (available [here](#)). Most of those recommendations, along with background information and updates from the 2018 General Assembly session, are set out below.

1. System Change

A. STEP-VA (System Transformation, Excellence, and Performance in Virginia)

Action: The Joint Subcommittee endorsed the provisions in the Governor's proposed budget that include: (1) a total of \$17.2 million in general funds to expand access to same-day mental health screening and evaluation to every Community Services Board (CSB) and complete implementation of same day access; (2) \$11.2 million to support outpatient clinics for primary health care screenings at CSBs (part of the effort to integrate primary health care and mental health care).

Background: The Joint Subcommittee in 2016 endorsed the DBHDS Commissioner's proposal for public mental health system reform known as STEP-VA, which calls for the development of a community based public mental health system that includes nine core services and integration of those services in the system of care. Initial funding for the implementation of STEP-VA was provided by the 2017 General Assembly, at the urging of the Joint Subcommittee, and the 2017 General Assembly approved, without yet funding, the core service model of STEP-VA. The plan, as reflected in the additional appropriations recommended in the Governor's budget, is to implement STEP-VA over several years.

Update: The biennium budget passed by the 2018 General Assembly included the following provisions specifically for the continuing implementation of STEP-VA:

- a. (Item 312(DD)) - \$10,795,651 the first year and \$10,795,651 the second year from general funds to the Community Service Boards to implement "same day access" for community behavioral health services (with an annual DBHDS report on the effectiveness and outcomes of this service).
- b. (Item 312(HH)) - \$3,720,000 the first year and \$7,440,000 the second year from general funds to enable primary care outpatient screening services at Community Services Boards.

c. (Item 312(II)) - \$15,000,000 in the second year of the biennium from general funds to start expansion of outpatient mental health and substance abuse services at Community Services Boards as envisioned by STEP-VA.

d. (Item 312(JJ)) - \$2,000,000 the second year from general funds to begin phasing in an expansion of detoxification services at Community Services Boards as envisioned by STEP-VA.

Note: A power point presentation by former DBHDS Commissioner Barber, found [here](#), explains some of the key concepts of STEP-VA (such as “same day access”) and how they are seen as improving access to services and the quality of mental health care.

B. Plan for financial realignment

Action: The Joint Subcommittee endorsed the continued financial realignment of the Commonwealth’s behavioral health system through the Health and Human Resources Secretariat, as directed by the 2017 General Assembly, with the goal of that realignment being to move the monies currently disproportionately devoted to state hospital care to local CSBs for community-based behavioral health services, and to provide “bridge funding” to support that movement. The realignment plan will include financial and other incentives for CSBs to effectively use those transferred funds to serve individuals in their communities without resorting to state hospital care.

Background: As noted to the Joint Subcommittee by former DBHDS Commissioner Barber in a presentation given November 27, 2017 (available [here](#)), Virginia’s state psychiatric hospitals require more than 50% of the state budget for public mental health services but serve only 2% of the total number of people served by the public mental health system. Dr. Barber noted his desire to move state funds from the hospitals to the communities, with the goal of dramatically reducing the use—and therefore the size—of the state hospitals. However, the hope of achieving that goal was (and continues to be) threatened by an ongoing and unprecedented demand for state hospital beds, coupled with the hospitals finding increasing difficulties in discharging patients committed to their care because the conditions and/or behavioral histories of those patients make it difficult to find a suitable community placement for them. Currently, localities do not have to return to the state any of the state general funds they receive for providing local mental health services to individuals, even if those individuals have to be placed in state psychiatric hospitals for care. Financial realignment, in Dr. Barber’s vision, would change that by requiring that localities pay for all or part of the care of their local residents in state psychiatric hospitals, thereby creating a financial incentive for developing local, and presumably less expensive, alternatives to state hospital care. Dr. Barber recognized that this change required that the localities first be able to develop the capacity to provide these local alternative services, and he proposed “bridge funding” to develop local capacities before full financial realignment was implemented.

Because the success of mental health treatment is best reflected in the success of consumers in managing their lives, Dr. Barber also supported, as part of the financial

realignment process, a change in the DBHDS “performance contracts” under which the state compensates CSBs for community mental health services to individuals who lack insurance coverage. Currently, CSBs are compensated on the basis of documented services rendered to individuals. Financial realignment would include a change to payments based upon “outcome” measures—including outcomes relating to how well each CSB consumer is able to maintain stability in the community. By the end of Dr. Barber’s tenure in early 2018, DBHDS and the CSBs had agreed that the **DLA-20** (an **assessment of consumer functioning across 20 identified domains of “Daily Living Activities,”** developed by **MTM**) provides a sound “outcomes measures” framework for assessing the level of functioning of CSB consumers. They had also agreed in principle that the DLA-20 data would be entered into a web-based management tool known as **SPQM (Service Process Quality Management)** to help generate cost/outcome reports for assessing CSBs’ performance under their performance contracts.

Update: DBHDS has a new Commissioner and the Health and Human Resources Secretariat has a new Secretary. The new administration has been engaged in a top-to-bottom review of all activities within the Department.

C. System funding options

Action: The Joint Subcommittee directed the System Structure and Finance Expert Panel to study options for additional funding for behavioral health services, including options available under the Affordable Care Act.

Background: A report from the System Structure and Finance Expert Panel (available [here](#)) recommended full implementation of STEP-VA as presented by DBHDS, the continuing effort at financial realignment, the additional pursuit of alignment between DBHDS and DMAS in regard to outcome measures for compensating mental health service providers, and both maintaining and strengthening the existing public mental health service system. The Group’s report also recommended other, more focused and immediate reform measures, which are described in the following sections below.

Update: The Expert Panel is continuing to study available funding options for behavioral health services.

2. Emergency Services – Task Force to Facilitate Effective Emergency Intervention and Reduce TDO Admissions to State Hospitals

Action: In response to a proposal (available [here](#)) submitted by Professor Richard J. Bonnie, Director of the Institute of Law, Psychiatry, and Public Policy at UVA and adviser to the Joint Subcommittee, the Joint Subcommittee members directed the convening of a Task Force, made up of a variety of mental health provider and advocacy stakeholders, to address the current crisis caused by the continuing increase in Temporary Detention Orders (TDOs) for psychiatric hospitalization and the even greater increase in the proportion of those TDOs resulting in admissions to state hospitals. The Task Force is asked to do the following: (i) identify the causes of the TDO increase; (ii) determine

the impact of this increase on both private and state hospitals; (iii) evaluate the role of private hospitals in the treatment of patients under a TDO; (iv) identify the factors that are preventing private hospitals from playing a greater role and consider actions that could affect those factors; and (v) investigate and make recommendations regarding other emergency mental health service models (e.g., psychiatric emergency centers) that might reduce the number of TDOs and emergency inpatient hospitalizations. As set out in a January 12, 2018 letter from Senator Deeds to Professor Bonnie, this Task Force is to provide an interim report to the Joint Subcommittee by November 1, 2018 and a final report by August 1, 2019.

Background: Since its formation in the spring of 2016, the Emergency Services Expert Advisory Panel has supported the development of psychiatric emergency centers (PECs) as an alternative to both the increasing resort to psychiatric hospitalization for individuals in mental health crisis and the continuing “psychiatric boarding” of many individuals in hospital emergency rooms when psychiatric beds are not available. The challenge, as noted in various reports (to the Joint Subcommittee on June 12, 2017, found [here](#), and on November 27, found [here](#), and in a proposal made to the Eastern Virginia Medical School Mental Health Summit in the spring of 2017, found [here](#)) has been in finding a viable model for PECs. During 2017 the Panel actively looked at whether existing Crisis Intervention Team Assessment Centers (CITACs, discussed in the referenced reports and in the criminal justice diversion materials below) might be “upgraded” to include active treatment capacities that would enable them to function like a PEC. That effort has not resulted in a candidate site for a PEC. The Task Force directed by the Joint Subcommittee will look at the PEC model and other alternatives as part of its mandate.

Update: As set out in more detail in a June 5 report to the SJ 47 Joint Subcommittee (found [here](#)), regional stakeholder meetings are being scheduled or discussed in each of the five Health Planning Regions. In Region 4, which held a region-wide stakeholders meeting in late March, the challenges identified by the stakeholders included the following: (i) *collecting key data*, including (a) information about the numbers of voluntary psychiatric hospital patients in the region’s private facilities and their length of stay, and the number of patients in private hospitals coming from outside the region, and (b) more in-depth data from the pre-admission screening forms used by CSB evaluators with individuals in crisis, to obtain a better picture of the presenting challenges and needs of individuals who are in mental health crisis; (ii) *developing non-hospital treatment options for individuals experiencing mental health crisis*, including Psychiatric Emergency Centers, Crisis Triage Centers, peer-operated Recovery Centers, and more robust use of Crisis Stabilization Units (CSUs); (iii) *reviewing the current statutory requirements regarding ECOs and the 8-hour ECO decision-making period for issuing a TDO*, with particular attention to those individuals whose crisis might be resolved without the need for hospitalization if more time were available to obtain a clearer clinical picture of their crisis and their treatment needs; (iv) *developing local capacity to serve “special populations” whose treatment needs are outside “standard” mental health treatment interventions*, including individuals with ID/DD, those with aggressive behaviors, those with complex medical needs, those who are homeless, and those with dementia; (v) *ensuring the continuity of services following hospital discharge to lessen*

dangers of re-hospitalization, including improvements in pre-discharge planning and improved communication and coordination between hospitals and community providers; (vi) identifying the non-emergency services that produce the greatest benefit in preventing mental health crises, and obtaining both DBHDS and Medicaid Managed Care support for those services, with particular attention to reducing barriers to reimbursement for services that have demonstrated efficacy in helping people remain stable in their communities.

Preliminary discussions with leadership from the CSBs in other regions have identified similar challenges across the state, and they are part of the agendas for upcoming stakeholder sessions statewide.

One goal is for each regional stakeholders group to produce action plans and proposals for improving and expanding local capacity to meet the needs of individuals experiencing mental health crisis, and to have those plans and proposals reviewed and supported by the statewide TDO Task Force and the SJ 47 Joint Subcommittee by the fall of 2018.

3. Telemental Health Services – The Appalachian Telemental Health Network Initiative

Action: The Joint Subcommittee endorsed a proposed Appalachian Telemental Health Network Initiative for the underserved western portion of Virginia, and voted to introduce a budget amendment of \$1.1 million per year for the next biennium for that initiative.

Background: This initiative, developed by a work group on telemental health services led by Dr. Katharine Wibberly at UVA, consists of four projects that together would help to provide significant strengthening of the telemental health infrastructure and improve access to it, resulting in more mental health patients being effectively served, either through direct services from a mental health services provider via teleconferencing or through consultative services via teleconferencing between mental health experts and primary care physicians and other providers in the community. The four proposed projects are: (i) creation and maintenance of a telemental health services directory; (ii) development and provision of online telemental health training by the Southside Telemental Health Training Academy and Resource Center; (iii) telemental health network development and support through the Healthy Appalachia Institute at UVa-Wise; and (iv) support of Project ECHO to sustain and expand telehealth consulting services to include mental health services.

These four projects, which are described in more detail in Dr. Wibberly's proposal to the Joint Subcommittee (found [here](#), along with a budget projection, found [here](#), and background information on the origins of telemental health services to the under-served Appalachia region, found [here](#)), are part of a larger set of recommendations to strengthen telemental health services in Virginia that were made in 2016 by the work group that Dr. Wibberly chaired. As a result of action by the 2017 General Assembly, that larger set of recommendations is currently being reviewed by the Joint Commission on Health Care

(JCHC). Paula Margolis, Ph.D., is the key JCHC staff person leading that review. Dr. Margolis' interim report, "Options for Increasing the Use of Telemental Health in the Commonwealth," is available on the JCHC website, which is linked [here](#).

The Telemental Health work group was part of the Emergency Services Expert Advisory Panel, and two research staff from the Institute of Law, Psychiatry, and Public Policy working with the panel (Ashleigh Allen and Kathy Faris) conducted a review of the use by Community Services Boards (CSBs) of telemental health services in the emergency setting. Their report (found [here](#)) shows a variety of ways in which CSBs in rural, urban and suburban communities have utilized telemental health technology to improve emergency services response. The potential for telemental health services in the emergency setting will continue to be explored.

Update: The 2018 General Assembly approved full funding for this request:

- a. (Item 312(OO)) - \$1,100,000 for both biennium years were appropriated from general funds for the Appalachian Telemental Health Initiative.

Dr. Margolis and the JCHC are continuing their review of the recommendations in Dr. Wibberly's 2016 report, and will be issuing their final report this fall.

4. Alternative Transportation – Non-Law Enforcement Transport of Individuals under a Temporary Detention Order

Action: The Joint Subcommittee voted to support the recommendations of the Alternative Transportation Task Force (formed **at the direction of the 2017 General Assembly** upon the recommendation of the Joint Subcommittee) for statewide implementation of a system of transportation by trained non-law enforcement providers for individuals being taken to a psychiatric hospital under a Temporary Detention Order (TDO). The Joint Subcommittee went beyond the Task Force's recommendation, which focused on adults, by specifying that such non-law enforcement transport would also be provided for children. The members endorsed a budget amendment to provide \$10.2 million per year to implement the alternative transportation system.

Background: The growing concerns over the state's reliance on TDO transport by law enforcement officers have included (i) the evidence of added trauma to individuals due to this "criminalization" of their mental health crisis as they are placed in handcuffs and transported in a law enforcement vehicle, and (ii) the negative impact on local law enforcement agencies, particularly small ones in rural jurisdictions, from having officers taken from their normal duties for TDO transports that are increasingly requiring many hours and long distances.

The Task Force report, a PowerPoint version of which can be found [here](#), confirmed these concerns and urged the adoption of a statewide system of non-law enforcement transport by private contractors with experience in secure transport. The Task Force recommended that DBHDS be the agency responsible for managing the implementation

of the alternative system, which the Task Force estimated would provide transportation for approximately half of all TDO transports. (Law enforcement would provide transport in cases in which the magistrate determined that safety concerns required law enforcement involvement.)

Update: The 2018 General Assembly appropriated \$2,500,000 in the first year and \$4,500,000 in the second year from general funds for DBHDS to provide alternative transportation for adults and children who are under a TDO, with DBHDS instructed to phase in the alternative transportation services over the course of three years, and to be statewide by the third year (Item 311(E)). An annual fall report is to be made to the General Assembly and the Governor on the effectiveness and outcomes of the program.

5. Permanent Supportive Housing

Action: The Joint Subcommittee expressed its support for expanding access to permanent supportive housing for individuals with serious and persistent mental illness, noting with approval the inclusion in the Governor's budget of \$4.6 million to expand permanent supportive housing activities. The members also voted to introduce a budget amendment to increase funding for the Virginia Housing Trust Fund by \$4.5 million to enable expansion of Permanent Supportive Housing through capital investment, allowing the Department of Housing and Community Development and the Virginia Housing Development Authority to continue serving individuals with serious mental illness.

Background: The Joint Subcommittee has supported the expansion of Permanent Supportive Housing as an effective service that significantly improves the stability of the lives of individuals with serious mental illness and thereby reduces their resort to emergency health care and emergency mental health services and lessens their rate of incarceration. The Joint Subcommittee successfully supported a \$10 million dollar increase in the state budget for Permanent Supportive Housing in the 2017 General Assembly session. At its November 28, 2017 meeting, the Joint Subcommittee received an update on the statewide Permanent Supportive Housing program (available [here](#)), received information about an innovative housing initiative by the Norfolk CSB (available [here](#)), and heard a presentation from the Virginia Department of Housing and Community Development on the strategies it is developing with other key statewide stakeholders, as directed by the 2017 General Assembly, for expanding housing opportunities for people with serious mental illness. (The PowerPoint for that presentation is available [here](#).)

Update: Several budget items in the 2018 General Assembly session allow for implementation of these supportive housing initiatives:

- a. (Item 311(D)) - \$1,750,000 the first year and \$1,750,000 the second year from general funds for the development or acquisition of clinically appropriate housing options to provide comprehensive community-based care for individuals in state hospitals who have complex and resource-intensive needs and who have been clinically determined to be able to move from a hospital to a more integrated setting.

In addition, \$250,000 the second year from the general fund is provided for a community support team to assist housing providers in addressing the complex needs of residents who have been discharged from state facilities or individuals who are at risk of institutionalization.

b. (Item 312(C)) - Funds are provided to Community Services Boards “in an amount sufficient to reimburse the Virginia Housing Development Authority for principal and interest payments on residential projects for the mentally disabled financed by the Housing Authority.”

c. (Item 312(Z)) - \$10,496,105 the first year and \$12,021,210 the second year from general funds are provided for “programs for permanent or transitional housing for individuals with serious mental illness,” with most going to “permanent supportive housing to support rental subsidies and services to be administered by community services boards or private entities to provide stable, supportive housing for persons with serious mental illness” and the rest for “transitional” housing supports for individuals being discharged from state mental health facilities and for expansion of permanent supportive housing.

d. (Item 312(KK)) - \$826,200 the first year and \$1,652,400 the second year from general funds for permanent supportive housing to pregnant or parenting women with substance use disorders.

6. Expansion of Criminal Justice Diversion Capacity in Rural Communities

The Joint Subcommittee endorsed two proposals from its Criminal Justice Diversion Work Group:

- i. Provide funding for the development, implementation, and maintenance of Crisis Intervention Team (CIT) activities in up to six rural communities. The funding would enable: (a) training for law enforcement officers and mental health staff in CIT concepts (which provide understanding of the experience of a person in mental health crisis and techniques for engaging individuals who are in crisis in a positive way that de-escalates tensions); (b) hiring a CIT coordinator in each community; and (c) establishing a CIT assessment site in each community;
- ii. Provide funding to enable the creation of diversion programs at “Intercept 2” (initial detention/initial court appearance) in up to six rural communities, including staffing (clinical team lead, case manager, criminal justice liaison) and access to treatment.

The members voted to introduce budget amendments providing funds for DBHDS to award grants to up to six rural communities for (i) CIT training (\$657,648 each year), and (ii) CIT Assessment Centers (\$1,925,400), and funds to DBHDS to award grants to up to three rural communities to establish “Intercept 2” diversion programs ((\$1,417,326).

Background: As explained in detail in the report by the Criminal Justice Diversion Expert Advisory Panel (found [here](#)), Crisis Intervention Team (CIT) programs involve training

for law enforcement officers and mental health clinicians in safely engaging with individuals in the community who are in mental health crisis and, where appropriate, diverting these individuals from incarceration to treatment. The CIT model of intervention has been adopted by most jurisdictions in Virginia over the past 15 years. Currently, 36 of Virginia's 40 CSBs have developed active CIT programs, and 33 have CIT Assessment Centers (CITACs), where officers can bring an individual who is in mental health crisis for evaluation by a CSB evaluator, and can leave the individual in the custody of an officer who is on site at the CITAC and return to normal duties, instead of having to remain with the individual until a CSB evaluation can be completed.

Despite the program's overall success, there are still some rural communities in western, southwestern and central Virginia that have not yet adopted CIT, in most cases because they do not have the financial resources to cover the costs of training for officers and clinicians, the hiring of a CIT coordinator, and the development of a site for a CIT Assessment Center. The requested funding would enable DBHDS to offer grants to communities that want a CIT program and have the other key elements in place but lack the financial resources to fully implement the program.

CIT is related to the larger concept of "Sequential Intercept" for identifying and addressing the needs of individuals with serious mental illness who become involved in the criminal justice system. The Sequential Intercept Model identifies 5 stages in a person's encounter with the criminal justice system: (1) initial law enforcement encounter, (2) initial detention/court appearance, (3) court trial and case disposition, (4) completion of incarceration and re-entry into the community, and (5) community probation, parole and support services. The additional funding recommended by the Panel would be used in up to six rural communities to develop programs at the Intercept 2 stage. More discussion of the Sequential Intercept Model and the Panel's Step 2 proposal is included in the Panel's main report, cited above, and in the Virginia Sequential Intercept Overview developed by the Panel (available [here](#)).

Update: The following budget items in the 2018 General Assembly session enable the implementation of the recommended proposals:

- a. (Item 312(T.2)) - \$900,000 the first year and \$1,800,000 the second year from general funds for grants to establish Crisis Intervention Assessment Centers in up to 3 currently un-served rural communities.
- b. (Item 312(T.3)) - \$657,648 the first year and \$657,648 the second year from general funds for grants to establish CIT training programs in up to 3 rural communities.
- c. (Item 312(NN)) - \$708,663 the first year and \$708,663 the second year from general funds to establish an Intercept 2 program in up to three rural communities.

7. Forensic Discharge Planning

Action: The Joint Subcommittee endorsed funding to make forensic discharge planning available for persons with serious mental illness upon their release from jails, with the goal being to connect these individuals to mental health and related support services that could reduce the danger that these individuals would again become involved in criminal conduct. The members approved the introduction of a budget amendment (totaling \$4,109,900) to pay for staff positions in the CSBs to provide forensic discharge planning at jails as recommended by DBHDS.

Background: The DBHDS report to the Joint Subcommittee (summarized in a presentation by Michael Schaefer, Ph.D., Assistant DBHDS Commissioner for Forensic Services, and available [here](#)) was the result of a study conducted with key statewide stakeholders, **as directed by the General Assembly** upon the recommendation of the SJ 47 Joint Subcommittee. The report describes the potential value of discharge planning services and related community supports for jail inmates with serious mental illness, identifies the widespread lack of such services in Virginia's jails, and recommends the implementation of a model of forensic discharge services known as the APIC Model (for "Assess, Plan, Identify, and Coordinate"). DBHDS recommended that the discharge planning services be provided through the local CSBs and be coordinated with STEP-VA services. While noting that a comprehensive program for all Virginia's jails would cost just over \$12 million a year, Dr. Schaefer also laid out an alternative plan for phased implementation of these discharge services, with the annual cost of serving the five jails with the highest percentage of serious mental illness (SMI), accounting for a third of all inmates statewide with SMI, being a little over \$4 million per year.

This proposed initiative is one of a number of projects aimed at better identifying and addressing the mental health needs of individuals in the criminal justice system. As noted in the Criminal Justice Diversion Work Group recommendations (available [here](#)), the Governor's budget already includes a million dollars to expand mental health dockets in Virginia, and the Compensation Board is currently reviewing staff training and other needs for implementation of the General Assembly's mandate (coming from a recommendation of the SJ 47 Joint Subcommittee) for mental health screening of all inmates upon entering jail, using an instrument designated by the DBHDS Commissioner. (The Compensation Board provided an update to the Joint Subcommittee on its work in November. A presentation from that report is available [here](#).) The Panel also noted that pilot programs overseen by DCJS for mental health services in the jails were continuing in six jails through funding already provided by the General Assembly.

The Joint Subcommittee also received an interim report at its November 28, 2017 meeting from Stephen Weiss, Senior Health Policy Analyst for the Joint Commission on Health Care, on the JCHC's two-year study of the quality of health care services in Virginia jails and prisons and the impact of requiring CSBs to provide mental health services in jail. That report can be found [here](#).

Update: The 2018 General Assembly provided the following budget support for limited implementation of mental health discharge planning from jails.

- a. (Item 312(MM)) - \$1,600,000 the first year and \$1,600,000 the second year from general funds for discharge planning at jails for individuals with serious mental illness. “Funding shall be used to create staff positions in Community Services Boards and will be implemented at two jails with a high percentage of inmates with serious mental illness.”

In addition, as set out in the June 5, 2018 report (available [here](#)) by the SJ 47 expert panel on Criminal Justice, Dr. Michael Schaefer, DBHDS Assistant Commissioner of Forensic Services, has been leading a Mental Health Standards Workgroup that is developing mental health standards for the identification, care and management of inmates with mental illness in Virginia’s local and regional jails. That Workgroup will also provide cost estimates for meeting those standards.

II. Update

Mental Health Related Bills Introduced in the 2018 General Assembly Session

A number of bills regarding mental health and substance abuse issues were introduced in the 2018 General Assembly session. Below is a listing of the bills that have been passed by the General Assembly and signed by the Governor. Following that list is a short list of bills that have been “carried over” to the 2019 General Assembly session. Finally, there is a listing of a few of the bills that did not make it, but may be of interest. (The lists are largely comprehensive but may not include every bill related to mental health and/or substance abuse. House bills are listed first, then the Senate bills, in numerical order.)

Each bill below is hyperlinked to the page on the Legislative Information Service (LIS) website on which the bill can be found.

Some acronyms to note:

CSB: Community Services Board

DBHDS: Department of Behavioral Health and Developmental Services

DCJS: Department of Criminal Justice Services

DOC: Department of Corrections

ECO: Emergency Custody Order

EMS: Emergency Medical Services

JCHC: Joint Commission on Health Care

MOT: Mandatory Outpatient Treatment

TDO: Temporary Detention Order

Bills Related to Mental Health That Have Survived

HB52 (Hope) - *Competency and sanity evaluations; location of evaluation.* This bill as originally drafted would have amended Sections 19.2-169.1 through 169.5 to require competency and sanity evaluations to be conducted on an outpatient basis at a mental health facility or in jails. Currently these Code sections provide that such evaluations are to be conducted on an outpatient basis, but that a court may order that a person be hospitalized instead if the court finds the services necessary to conduct an outpatient evaluation are not available, or if the results of the outpatient evaluation indicate that it is necessary to hospitalize the person for further evaluation. This amendment would have entirely removed the court's authority to order hospital-based evaluations.

The House Courts of Justice Subcommittee #2 approved an amended version of this bill. The amended version still stated that competency and sanity evaluations "shall" be performed on an outpatient basis at a mental health facility or in jail, but provided an exception to this requirement when the defendant was in the custody of DBHDS as a result of an involuntary commitment to hospital care.

An amended HB52 passed the House and Senate as **HB52ER**, which directs that competency and sanity evaluations of criminal defendants will be performed on an outpatient basis at a mental health facility or in jail unless (1) the outpatient evaluation finds that a hospital-based evaluation is needed "to reliably reach an opinion," or (2) the defendant is already in the custody of DBHDS through an involuntary commitment order. This version of the bill was submitted to and signed by the Governor. The final version, effective July 1, 2018, is available [here](#).

HB53 (Hope) - *Persons acquitted by reason of insanity; evaluation.* This bill would have amended Va. Code Section 19.2-182.2 to authorize the DBHDS commissioner to determine whether the evaluation of an insanity acquittee will be conducted on an outpatient basis or in a hospital setting. Currently, there is no option for outpatient evaluation of an insanity acquittee.

The House of Delegates passed an amendment in the nature of a substitute to HB53, available [here](#), that gives the trial court the discretion to authorize that the evaluation of an insanity acquittee be conducted on an outpatient basis. If the court authorizes an outpatient evaluation, the DBHDS Commissioner can determine, based on available information, whether an outpatient or inpatient evaluation will be conducted. If outpatient is chosen, and the acquittee fails to cooperate in the evaluation, the Commissioner has the authority to petition the Court to order inpatient hospitalization. The bill also provides that, where an evaluation recommends release of a hospitalized acquittee, the conditional release or discharge plan is to be jointly prepared by the appropriate CSB and DBHDS. The current law provides specifically that staff at the hospital where the acquittee is confined must prepare the plan with the local CSB.

The Senate passed the House version of the bill and the Governor signed it. The final version, effective July 1, 2018, is available [here](#).

HB301 (Watts) - *Disclosure of health records; state and local correctional facilities*. This bill would have amended Virginia Code Section 32.1-127.1:03 by providing in subsection C that the standard requirements for disclosing health records shall *not* apply to the release of health records to a state correctional facility (which is governed instead by Section 53.1-40-10) or to a local or regional correctional facility (which is governed instead by Section 53.1-133.03).

The House Committee on Militia, Police and Public Safety approved an amendment in the nature of a **substitute**, which included the provisions in HB301 but also added amendments to Virginia Code Sections 53.1-40.10 and 53.1-133.03 that specifically provide that whenever a person is committed to one of these facilities, the person in charge of the facility (or a designee) is entitled to obtain medical records concerning the person from a health care provider.

The Senate approved the House's amended version of the bill, and the Governor signed it. The final version, effective July 1, 2018, is available [here](#).

HB322 (Bourne) – *Possession and administration of naloxone*. Passed by the General Assembly and signed by the Governor as originally introduced, this bill amends Va. Code Section 54.1-3408 to add Department of Corrections employees designated as probation and parole officers or as correctional officers to the list of those who may possess and administer naloxone in accordance with protocols developed by the Board of Pharmacy, after they have completed a training program. The signed version of the bill, effective July 1, 2018, is available [here](#).

HB364 (Rush) – *Execution of temporary detention orders; inmates in local correctional facilities*. This bill amends Va. Code Section 19.2-169.6 to provide that, when a Temporary Detention Order (TDO) is issued by a magistrate for an inmate at a local correctional facility, a deputy sheriff or jail officer employed by that facility can be authorized to serve the TDO on that inmate.

This bill was passed by both chambers without opposition and was signed by the Governor. The final version, effective July 1, 2018, is available [here](#).

HB569 (Gooditis) - *Department of Behavioral Health and Developmental Services; report on suicide prevention activities*. This bill amends Va. Code Section 37.2-312.1, which already makes DBHDS the “lead agency” for suicide prevention across the lifespan in Virginia, by requiring the DBHDS Commissioner to report annually by December 1 to the Governor and the General Assembly on the Department's activities related to suicide prevention across the lifespan.

This bill passed the Senate and the House of Delegates with little opposition and was signed by the Governor. The final version of the bill, effective July 1, 2018, is available [here](#).

HB842 (LaRock) - *Possession or distribution of controlled paraphernalia; hypodermic needles and syringes; naloxone.* The bill amends Va. Code Sections 54.1-3466 and 54.1-3467 to enhance the delivery of naloxone to those experiencing an opioid overdose in the following way: Virginia Code 54.1-3408 already authorizes certain licensed medical professionals, as well as individuals certified by DBHDS, to possess naloxone and to both administer it to individuals experiencing overdose and to dispense it to other individuals who have completed specified training in administering naloxone to individuals who are in opioid overdose. This bill would have authorized these individuals to *also* possess hypodermic needles and syringes and to (i) use them to administer naloxone to individuals in opioid overdoses, and (ii) dispense them to individuals who have completed training in administering naloxone. The needles and syringes can be used *solely* for the purpose of administering naloxone to a person who is in opioid overdose.

The House of Delegates approved an amended version of the bill, available [here](#), which added language to make it clearer that the authorized distribution of needles and syringes is solely for injecting naloxone. The House version of the bill passed the Senate without opposition, and was signed by the Governor. The bill's final version, which is effective immediately, is available [here](#).

HB886 (Stolle) - *Admissions for mental health treatment; toxicology.* This bill as introduced would have amended Va. Code Section 32.1-127 by requiring the Board of Health to include in its regulations a requirement that every hospital providing inpatient psychiatric services must establish a protocol for cases in which the hospital refuses to admit a patient on the grounds that the patient's toxicology report raises a question of medical stability or medical appropriateness for admission, with the on-call physician in the psychiatric unit being required to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or certified poison specialist, to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists.

The House amended the bill to provide that the conversation with the toxicologist must occur only if the referring physician requests it. The version that passed the House (**HB886E**) was approved by the Senate and signed by the Governor. The final version of the bill, effective July 1, 2018, is available [here](#).

HB1088 (Boysko) - *Hospitals; security and emergency department staff; mental health training.* This bill as introduced would have amended Virginia Code Section 321-127(B) to require that regulations of the Virginia Department of Health include a requirement that licensed hospitals ensure that their security staff and ED staff receive

training in identifying and safely addressing situations involving patients and others experiencing a mental health crisis.

An amended version of the bill, **HB1088ER**, was approved by both houses. The Senate amendments provided that the training be based upon a trauma-informed approach and that it address patient behaviors arising out of substance abuse in addition to mental illness. The Governor has signed the bill, which takes effect July 1, 2018. The final version of the bill is available **here**.

HB1173 (Pillion) - *Limits on prescription of controlled substances containing opioids*. This bill amends Va. Code Section 54.1-2522.1 by *eliminating* a current exception to the requirement in Section 54.1-2522.1 that a prescriber must request certain information from the Prescription Monitoring Program (PMP) when initiating a new course of treatment that includes prescribing opioids for a human patient for more than 7 days. Under the current exception in 54.1-2522.1, a prescriber is *not* required to request that information from the PMP for opioid prescriptions of up to 14 days to a patient as part of treatment for a surgical or invasive procedure. The bill's elimination of this exception would expire on July 1, 2022.

The bill was passed unanimously in both chambers and was signed by the Governor. The final version of the bill, effective July 1, 2018, is available **here**.

HB1193 (Bell) - *Persons acquitted by reason of insanity; commitment; sentencing*. This bill as introduced would have amended Va. Code Sections 19.2-169.6, 19.2-182.3 and 53.1-40.2 to provide that if a person is convicted of an offense and acquitted by reason of insanity for another offense in the same proceeding *and* the court finds that the person is in need of inpatient psychiatric hospitalization, the court "shall" order the person's commitment to inpatient hospitalization. Such person could not be released or discharged from such inpatient hospitalization except into the custody of the correctional facility where the person will serve the sentence. The time the person is committed would *not* be deducted from the length of the sentence. The bill also provided that the person in charge of a correctional facility must file a petition for the hospitalization of any person incarcerated in such facility if a court determines that such person requires inpatient hospitalization after being acquitted by reason of insanity for an offense.

Subcommittee #1 of the House Courts of Justice Committee approved an amendment in the nature of a substitute for the original bill, found **here**, which essentially reversed the mandate of the original bill. The substitute specifies that, if a person is convicted and sentenced for a criminal offense and in the same or subsequent proceeding is acquitted of another offense by reason of insanity, that person *shall* be ordered to serve the criminal sentence before being transferred to DBHDS. In addition, the substitute bill requires that, if a person has already been committed to DBHDS following a finding of NGRI and is later sentenced to prison for a separate offense, the person must be transferred from DBHDS to Corrections to serve the criminal sentence.

The substitute bill was eventually passed by both houses and signed by the Governor. The final version, effective July 1, is available [here](#).

HB1194 (Garrett) - *Schedule I controlled substances*. This bill amends Va. Code Section 54.1-3446 by adding a number of drugs to the list of Schedule I controlled substances.

This bill was passed by both houses and signed by the Governor. The final version, effective July 1, is available [here](#).

HB1355 (Hope) - *Designating an alternative facility for placement of a minor under a temporary detention order*. This bill amends Virginia Code Sections 16.1-340.1 and 16.1-340.2 to establish in regard to minors the same discretion and procedure as now exists in regard to adults for magistrates to order the transfer of an individual who is the subject of a temporary detention order from one facility to another facility.

The bill passed both houses and was signed by the Governor. The final version, effective July 1, is available [here](#).

HB1375 (Tyler) - *Definition of qualified mental health professional*. This bill amends Va. Code Sections 54.1-2400.1 and 54.1-3500 by broadening the definition of "qualified mental health professional" to include employees and independent contractors of the Department of Corrections who by education and experience are professionally qualified and registered by the Board of Counseling to provide collaborative mental health services.

The bill was passed by the House and Senate and signed by the Governor. The bill's final version, effective July 1, is available [here](#)

HB1604 (Bell) *Health instruction; mental health*. This bill amends Virginia Code Section 22.1-207 by adding to the existing requirement that public schools provide physical and health instruction as part of educational program through all school grades, the further requirement that such health instruction incorporate standards that recognize the multiple dimensions of health by including mental health and the relationship of physical and mental health so as to enhance student understanding, attitudes, and behavior that promote health, well-being, and human dignity. The bill also directs the Board of Education to review and update the health Standards of Learning for students in grades nine and 10 to include mental health.

This bill was passed by both the House and the Senate, and was signed by the Governor. The final version of the bill, which takes effect July 1, is available [here](#).
(Identical Senate Bill: **SB953** (Deeds))

SB120 (Favola) *Alcoholic beverage control; substance abuse prevention; Virginia Institutions of Higher Education Substance Use Advisory Committee established*. The bill as introduced would have amended Virginia Code Section 4.1-103.02 to direct the

Virginia Alcoholic Beverage Control Authority Board to establish and appoint members to the Virginia Institutions of Higher Education Substance Use Advisory Committee, which would develop and update a statewide strategic plan for substance use education, prevention, and intervention at Virginia's public and private institutions of higher education.

The Senate passed an amendment in the nature of a **substitute** that directs the ABC Board to establish the same advisory committee, but with the more specific task of advising the Board regarding the Higher Education Alcohol Drug Strategic United Prevention (HEADS UP) program to ensure that the program utilizes best practices, collects meaningful data, and assists institutions of higher learning with their strategic plans. The Advisory Committee, which shall include representatives of public and private institutions of higher learning, students, directors of student health and others, must report to the Governor and General Assembly by December 1 of each year.

The bill went through further revision in the House, and **SB120ER**, which was passed by both houses, broadens the Advisory Committee's role, giving it a goal of developing a comprehensive strategic plan for substance abuse education, prevention and intervention at Virginia's institutions of higher learning. The Governor has signed the bill, which becomes effective July 1. The final version is available **here**.

SB267 (Howell) - *Sexually violent predators; assessment protocol*. The bill as introduced would have amended Va. Code Section 37.2-903 by requiring the Director of the DOC to review each month a database of prisoners convicted of sexually violent offenses who are scheduled for release within 24 months of that review and, using an assessment protocol approved by the Director and the Commissioner of DBHDS, identify those prisoners who appear to meet the definition of a sexually violent predator. Current law specifies that the Director review prisoners who are within 10 months of release, and use the Static-99 assessment protocol or a comparable, scientifically validated instrument designated by the Commissioner.

The Senate passed an amended version of the bill, available **here**, with the amendment providing that the assessment protocol be "evidence based."

The House approved the bill after amending it with language (found **here**) that requires the DBHDS Commissioner to report annually to the key House and Senate Committee chairs on the protocol adopted to identify violent sexual predators and the numbers of prisoners so identified, with comparisons to findings in previous years.

The Governor recommended several changes to the bill, including language requiring that the DOC Director's review include "defendants" as well as "prisoners" in DOC custody. Both houses approved the Governor's recommended changes, and the final bill, effective July 1, was passed and signed by the Governor. The bill's final version is available **here**.

SB329 (Dunnavant) *Clinics for the treatment of opioid addiction; location.* This bill as introduced would have amended Va. Code Section 37.2-406 to provide the following limited *exception* to the statutory prohibition on locating clinics for the treatment of persons with opiate addiction through the use of methadone or opioid replacements within one-half mile of a public or private licensed day care center or a public or private K-12 school: licensure may be available for an applicant to operate in its current location or to relocate an existing facility when the facility is currently located within one-half mile of a public or private licensed day care center or a public or private K-12 school in the City of Richmond, and when the clinic has been licensed and operated as a facility to provide treatment for persons with opiate addiction through the use of methadone or other opioid replacements by another provider immediately prior to submission of the application for a license, and, upon issuance of the license, will be operated by a behavioral health authority.

The Senate passed an amendment in the nature of a **substitute** to this bill, with the substitute bill allowing an existing opioid clinic in both Richmond and Henrico County to continue operating in its current location despite being within a half-mile of a school or daycare facility. A similar bill, **SB455**, was incorporated into this bill.

The House approved the bill (**SB329ER**) and sent it to the Governor, who signed it. The final version of the bill, which becomes effective July 1, is available **here**.

SB392 (Barker) *Involuntary commitment of a juvenile; notification of parents.* The bill as introduced would have amended Virginia Code Section 16.1-341 to provide that a petition for the involuntary commitment of a minor shall not be dismissed for failure to immediately serve both parents with a copy of the petition and notice of the hearing if one parent is present at the hearing and the judge determines that a reasonable effort was made to notify the other parent.

The Senate passed an amendment in the nature of a **substitute**, which provides that the court may proceed with the hearing in instances where both parents cannot be notified if, at the hearing, the court makes a determination that a reasonable effort was made to serve the petition and notice of the hearing on both parents.

The House approved a substitute of the Senate version of the bill. That substitute, **SB392H1**, provides that the hearing can proceed if the court finds that one parent was served with copy of the petition and notice of the hearing and that reasonable efforts were made to serve both parents. The Senate later approved the House-passed version of the bill, and sent it to the Governor, who signed it. The final version, which takes effect July 1, is available **here**.

SB555 (Mason) - *Barrier crimes; adult substance abuse and mental health treatment providers.* This bill as introduced would have amended Va. Code Sections 37.2-416 to provide that a substance abuse or mental health treatment provider licensed by DBHDS may employ as an adult substance abuse or mental health treatment program a person who was convicted of burglary (a violation of Virginia Code Section 18.2-89), *if the*

hiring provider determines, after assessment, that the criminal behavior was substantially related to the applicant's substance abuse or mental illness and that the person has been successfully rehabilitated and is not a risk to individuals receiving services based on criminal history background and substance abuse or mental illness history.

The Senate passed an amendment in the nature of a substitute, which added the same amendment to Virginia Code 37.2-506, so that it would also apply to hiring by local CSBs. The Senate version of the bill was passed by the House and sent to the Governor, who signed it. The final version of the bill, which takes effect July 1, is available here.

SB669 (Deeds) - *Involuntary mental health treatment; minors; access to firearms.* The bill as introduced would amend Virginia Code Sections 16.1-337, 16.1-344 and 18.2-308.1:3 and would add Section 16.1-337.1, to provide that, *if* a minor 14 years of age or older is ordered to involuntary admission to a mental health facility or to mandatory outpatient treatment, or was subject to a temporary detention order (TDO) and then agreed to voluntary admission, it is unlawful (Class 1 misdemeanor) for that person, as both a minor and an adult, to possess, purchase, or transport a firearm. The person may utilize the current statutory procedure for petitioning for the restoration of such person's firearms rights. The bill also requires that, prior to a involuntary commitment hearing, or prior to consent to voluntary admission following temporary detention, the minor is advised of the revocation of firearms rights if the minor is involuntarily admitted or consents to admission. The bill set out procedures for the submission by the court clerk to the CCRE of such involuntary admission orders and consents to admission following temporary detention.

The Senate passed the bill as introduced. The House passed essentially the same bill, but with an amendment that corrected an unintended wording error, and the Senate then passed the House version. The Governor recommended that the bill be made effective upon the Governor's signing, instead of taking effect on July 1, and both houses agreed. The final version of the bill, which is now in effect, is available here.

SB 670 (Deeds) – *Mental health awareness training; firefighters and emergency medical services personnel.* This bill would add Sections 9.1-203.1 and 32.1-115.1 to the Virginia Code to require fire departments and emergency medical services agencies to develop curricula for mental health awareness training for their personnel, with such training qualifying for continuing education credits.

This bill, which is identical to HB 1412, passed the Senate and the House, and was signed by the Governor. The final version of the bill, which takes effect July 1, is available here.

SB673 (Deeds) - *Emergency custody; time period.* This bill as introduced would have repealed the enactment that put a June 30, 2018 “sunset” on a subsection in Virginia Code Sections 37.2-808(O) and 16.1-340. That subsection provides that where a person is being held under an emergency custody order (ECO), the local CSB and the state hospital to which the person would otherwise be placed under a temporary detention

order (TDO) may continue to attempt to identify a facility other than a state hospital that is able and willing to accept the individual, for up to 4 hours after the 8-hour period of the ECO has run.

The Senate passed an amendment in the nature of a **substitute** that accomplishes the same thing—that is, keeps in effect the statutory provision allowing the additional 4-hour search for an alternative to state hospital placement—but does so through amendments to Virginia Code Sections 16.1-340 and 37.2-808. The House passed the Senate version of the bill, and the Governor signed it. The final version of the bill, which takes effect July 1, is available **here**.

SB719 (Dunnavant) - *Data sharing; substance abuse data.* This bill as introduced would have added Section 2.2-213.6 to the Virginia Code to establish a Substance Abuse Data Sharing and Analytics Clearinghouse, administered by the Secretary of Health and Human Resources in consultation with the Substance Abuse Data Sharing and Analytics Advisory Committee that would also be created by the bill. The purpose of the Clearinghouse would be to share or disseminate among and between involved agencies data related to substance abuse, with a focus on opioid addiction and abuse, in order to, among other things, conduct research and apply data analytics to identify the most efficient and efficacious treatments and to streamline administrative processes and reduce burdens on persons being served. The Secretary of Health and Human Resources would also have the authority enter into agreements with private entities and public institutions of higher education to further the goals of the Clearinghouse. The bill required the Secretary to report annually to the Governor and the General Assembly regarding the results achieved through the use of the Clearinghouse, including cost savings and policy recommendations. The bill also amended Va. Code Sections 2.2-213.6 and 2.2-213.7 (in the Government Data Collection and Dissemination Practices Act) to specify that data sharing among state and local agencies in certain circumstances was a proper use of personal data.

The Senate Committee on General Laws and Technology incorporated this bill (and three others) into **SB580** (Hanger), a much broader bill that amends the Government Data Collection and Dissemination Practices Act (§ 2.2-3800 et seq.) to facilitate the sharing of data among agencies of the Commonwealth and between the Commonwealth and political subdivisions. It creates the position of Chief Data Officer of the Commonwealth (CDO) in the office of the Secretary of Administration, to develop guidelines and oversee improved practices on data management and data sharing among agencies to improve service delivery of services. It also creates a temporary Data Sharing and Analytics Advisory Committee to advise the CDO, and directs the CDO and the Advisory Committee to work first on developing a project for the sharing, analysis, and dissemination of data at all levels related to substance abuse, with a focus on opioid addiction, abuse, and overdose.

The amended bill, **SB580S2**, passed the Senate and the House and was signed by the Governor. The final version of the bill, which takes effect on July 1, is available **here**.

SB728 (Dunnavant) - *Prescription Monitoring Program; prescriber and dispenser patterns.* This bill as introduced would have amended Virginia Code Section 54.1-2523.1 by adding a subsection C that requires the Director of the Department of Health Professions to annually review controlled substance prescribing and dispensing patterns. The bill required the Director to conduct such review in consultation with an advisory panel consisting of representatives from the relevant health regulatory boards, the Department of Health, the Department of Medical Assistance Services, and the Department of Behavioral Health and Developmental Services. The bill required the Director to make any necessary changes to the criteria for unusual patterns of prescribing and dispensing and report any findings and recommendations for best practices to the Joint Commission on Health Care by November 1 of each year.

The Senate passed an amendment in the nature of a **substitute** that implements essentially the same requirements, but through amending the existing subsection A of Section 54.1-2523.1 instead of adding subsection C. The House approved the Senate version and sent it to the Governor, who signed it. The final version of the bill, which becomes effective on July 1, is available **here**.

SB762 (Barker) - *Board of Behavioral Health and Developmental Services; definition of "licensed mental health professional."* This bill (a "Section 1" bill) would direct the State Board of Behavioral Health and Developmental Services to amend regulations governing licensure of providers of behavioral health services to include (i) behavior analysts and (ii) assistant behavior analysts in the definition of "licensed mental health professional."

The Senate passed an amended version of the bill, which deletes the inclusion in the original bill of the position of "assistant behavior analyst." **SB762ER** was passed by both houses and signed by the Governor. The final version of the bill, which takes effect July 1, is available **here**.

SB804 (Carrico) - *Reporting, collection, analysis and dissemination of controlled substance overdose data.* This bill as introduced would have added Sections 2.2-213.6, 15.2-1723.1, 32.1-111.15:1, 32.1-279.1, 52-8.7 and amend Section 32.1-127 to require the Office of the Chief Medical Examiner, state and local law-enforcement agencies, emergency medical services agencies, and hospitals to report information about overdoses of controlled substances within 120 hours of receiving such information to the Office of the Secretary of Health and Human Resources, and for the Secretary to establish a system to collect and analyze such data and to make such information available to public health, law-enforcement, and emergency medical service agencies and fire departments and companies within 120 hours of receiving the information. The Secretary was required to report this information quarterly to the Governor and make the report available to all public health, law-enforcement, and emergency medical services agencies in the Commonwealth. Protection from civil or criminal penalty was provided to any person who reports or receives such information "in good faith." The bill was a recommendation of the Joint Commission on Health.

The Senate Finance Committee incorporated this bill into SB580 (Hanger), which is discussed above in regard to SB719 (Dunnavant).

Bills Carried Over to the 2019 Session

HB541 (Freitas) - *Alternative treatment options for certain veterans.* This bill would have added Section 2.2-2001.1:1 to the Virginia Code, directing the Virginia Department of Veterans Services (VDVA) to enter into contracts with one or more providers to provide “alternative treatment options” for veterans certified by the U.S. Department of Veterans Affairs or any branch of the United States Armed Forces as having a traumatic brain injury or posttraumatic stress disorder. The bill defines “alternative treatment” as (i) not part of the standard of medical care established by the U.S. Department of Veterans Affairs for treating these conditions *but* shown by at least one scientific or medical peer-reviewed study to have “some positive effect” on these conditions, and (ii) provided at the direction and under the supervision of an individual licensed by the Board of Medicine, Nursing, Counseling, Psychology, or Social Work.

The House Health, Welfare and Institutions Committee significantly amended the bill, so that it now directs the VDVA to “consider the efficacy” of alternative treatments for these conditions and report its findings and conclusions to the Chairman of the House Committee on Health, Welfare and Institutions by November 1, 2018. The Senate Committee on Education and Health continued consideration of the bill to the 2019 session.

HB1606 (Orrock) *Certificate of public need; psychiatric beds and services.* The bill would have amended Virginia Code Section 32.1-102.1 by removing the following from that section’s definition of “medical facility” (with a proposed “medical facility” being subject to review and approval by the Department of Health for a “certificate of public need” before it can be constructed): mental hospitals, psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric, or psychological treatment and rehabilitation of individuals with substance abuse.

The House Committee on Health, Welfare and Institutions approved the bill with an amendment, available [here](#), that adds the requirement that “the Department of Health shall develop a plan for an expedited permitting process for psychiatric beds consistent with the State Medical Facilities Plan by July 1, 2019.” The Senate Committee on Education and Health continued the bill to the 2019 session.

SB436 (Wexton) - *Schedule I drugs; classification for fentanyl derivatives.* This bill would have amended Va. Code Section 541-3446 by adding fentanyl derivatives, and any substances containing fentanyl derivatives (unless they are FDA approved products or otherwise excepted) as Schedule I drugs.

The Senate Finance Committee continued the bill to the 2019 session.

Bills Related to Mental Health That Did Not Survive

HB374 (Yancey) - *Exposure to controlled substances; bodily injury to law-enforcement officers, etc.; penalty.* This bill would have (i) amended Va. Code Section 18.2-51.1 to provide that, if a law-enforcement officer, firefighter, search and rescue personnel, or emergency medical services personnel are exposed to a controlled substance while performing official duties and such exposure causes bodily injury, the person who knowingly or intentionally possessed such controlled substance is guilty of a Class 6 felony, and (ii) amended Va. Code Section 18.2-144.1 to create a similar Class 6 felony when a police animal performing its lawful duties or being kept in a kennel, pen, or stable while off duty is exposed to a controlled substance and injured as a result.

This bill was left in the House Courts of Justice Committee.

HB479 (McQuinn) - *Barrier crimes; adult substance abuse and mental health treatment providers.* This bill would have amended Va. Code Sections 37.2-416 and 37.2-506 by authorizing community services boards and providers licensed by DBHDS to hire for compensated employment at an adult substance abuse or mental health treatment program a person who was convicted of *any* “barrier crime” listed in Section 19.2-392.02, *if* they find that the person’s criminal behavior was substantially related to the person's substance abuse or mental illness and the person has been successfully rehabilitated and is not a risk to individuals receiving services. Under current law, this exception applies only to a subset of the “barrier crimes.”

This bill failed to make it out of House Health, Welfare and Institutions Subcommittee #2.

HB595 (Carr) - *Safe reporting of overdoses.* This bill would have added Section 18.2-251.04 to the Virginia Code, providing to a person experiencing a drug-related or alcohol-related overdose an affirmative defense to charges of (i) simple possession of a controlled substance, marijuana, or controlled paraphernalia; (ii) intoxication in public; or (iii) the unlawful purchase, possession, or consumption of alcohol, *if* another individual, in good faith, seeks emergency medical attention for that person *and* both the person and the individual making the report cooperate with authorities in specified ways. Current law only provides protection for a person calling for him/herself.

This bill failed to make it out of the House Courts of Justice Subcommittee #1.

HB 607 (Carr) - *Department of Behavioral Health and Developmental Services; recovery community organization pilot program.* This “Section 1” bill would have required the DBHDS Commissioner to implement a pilot program to evaluate the recovery community model of substance abuse treatment, and report annually on December 1 to the Governor and General Assembly regarding development and implementation of the pilot.

The House Committee on Health, Welfare and Institutions approved a substitute bill (available [here](#)) that is consistent with the nature and intent of the original bill but

provides more detail and direction. However, the bill was later left in the House Appropriations Committee.

HB758 (Leftwich) - ***Death penalty; severe mental illness.*** This bill would have added Sections 19.2-264.3:1.4 and 19.2-264.3:1.5 to the Virginia Code, and would have amended Sections 19.2-264.3:1.3, 19.2-264.3:3, and 19.2-264.4, to provide that a defendant in a capital case, with proper notice (as set out in the bill) may present evidence of severe mental illness (defined in the bill) at the time of the offense. If the defendant, though found guilty of the capital offense, proves severe mental illness at the time of the offense by a preponderance of the evidence, the sentence shall be life imprisonment rather than death. The bill establishes procedures for determining whether a defendant had a severe mental illness at the time of the offense and provides for the appointment of expert evaluators.

This bill was left in the House Courts of Justice Committee.

HB795 (Hope) - This bill would have added Section 53.1-39.1 to the Virginia Code, prohibiting the placement of an inmate who is a member of a “vulnerable population” (defined in the bill) in “isolated confinement” (also defined in the bill), or placing any inmate in isolated confinement for more than 15 consecutive days or 20 days in a 60-day period, unless (i) there is a facility-wide lockdown, (ii) isolated confinement is necessary because of a risk of harm to the inmate or others, (iii) the inmate is placed in medical isolation, or (iv) the inmate is placed in voluntary protective custody. The bill would have required the Department of Corrections to implement policies and procedures regarding the use of isolated confinement, including training standards for its personnel, and to report to the Governor and the General Assembly on a semiannual basis on the use of isolated confinement. The bill also would have directed the Joint Subcommittee to study Mental Health Services in the Commonwealth in the Twenty-First Century to study the prevalence of mental illness in jails, and submit its finding and recommendations to the Governor and the General Assembly by December 1, 2019.

This bill was left in the Committee on Militia, Police and Public Safety.

HB815 (Levine) - ***Rights of individuals receiving services; unmonitored communication and access to 911.*** This bill would have amended Virginia Code Section 37.2-400(A), which provides for the rights of individuals receiving services in facilities and programs operated or licensed by DBHDS, to include the right to: (i) unmonitored mail, (ii) a weekly unmonitored telephone call; and (iii) unlimited access to place a 911 emergency call in emergency situations.

This bill was left in the House Health, Welfare and Institutions Subcommittee #2.

HB884 (Stolle) - ***Treatment pursuant to judicial order; when provider not liable.*** This bill would have added Section 37.2-804.3 to the Virginia Code to provide the following: (i) that no health care professional or licensed hospital providing treatment, testing or detention pursuant to an order for a person’s emergency custody, temporary detention or

involuntary treatment is liable for any claim by the person that he or she lacked the capacity to consent to such care; and (ii) no health care professional or licensed hospital that provides treatment to an individual *with* that individual's consent shall be liable for any cause of action claiming the individual lacked capacity to consent to such treatment if a judge or special justice has denied a petition for emergency custody, temporary detention or involuntary commitment of that individual on the grounds that the individual did not meet the criteria for such action.

This bill did not make it out of the House Courts of Justice Subcommittee #2.

HB933 (Hope) - ***Mandatory outpatient treatment; time period.*** This bill would have amended Va. Code Sections 16.1-345.2, 16.1-345.5 and 37.2-817 by extending the maximum time period of an order for mandatory outpatient treatment for adults and juveniles from the current 90 days to 180 days.

This bill did not make it out of House Courts of Justice Subcommittee #2.

HB934 (Hope) - ***Medical and mental health treatment of prisoners incapable of giving consent.*** This bill would have amended Va. Code Sections 17.1-406, 17.1-410 and 37.2-803 and would have added Section 53.1-133.04, enabling the sheriff or administrator in charge of a local or regional correctional facility to petition a court to authorize medical or mental health treatment for a prisoner in that facility who is incapable of giving informed consent for such treatment. The process for obtaining such an order paralleled the existing process for the Director of the Department of Corrections for its inmates (Va. Code Section 53.1-40.1). The bill provided that the treatment ordered may be provided within a local or regional correctional facility if such facility is licensed to provide such treatment.

*The House approved an amended version of the bill. An apparently identical bill, **HB1133** (Rasoul) did not make it out of the House Courts of Justice Subcommittee #2. The Senate Finance Committee later recommended a substitute version of the House-passed bill, which kept intact all the major provisions of the bill. That version, **HB934S1**, was passed by the Senate, but was then rejected by the House. The two chambers were unable to reach agreement, and the bill failed to advance.*

HB935 (Hope) - ***Mandatory outpatient treatment (MOT); consent.*** This bill would have (i) amended Va. Code Section 16.1-345.2 by eliminating the current requirements for an MOT order in the juvenile setting that the child be at least 14 years of age, have sufficient capacity to understand the proposed outpatient treatment, consent to the treatment and be capable of complying with it; instead, only parental capacity and consent would be required; and (ii) amended Va. Code Section 37.2-817 (the parallel section concerning adults) by eliminating the requirement that the individual agree to the treatment plan and be found capable of complying with it.

The bill did not make it out of Subcommittee #2 of the House Courts of Justice Committee.

HB1034 (Price) - *Biased policing; training standards.* This bill would have amended Virginia Code Section 9.1-102 to add to the powers and duties of DCJS the requirement that, in its training standards and model policies for law enforcement, the training on “sensitivity to and awareness of cultural diversity and the potential for biased policing” (already required by subsections 37(c) and 38) *include* “recognizing implicit biases in interacting with persons who have a mental illness, substance abuse disorder, or developmental disability.”

This bill did not make it out of House Courts of Justice Subcommittee #2.

HB1100 (Levine) - *Appeal of involuntary admission order; possession of firearms.* This bill would have amended Va. Code Section 37.2-821 to provide that once an order of involuntary commitment or mandatory outpatient treatment (MOT) is entered in regard to an individual pursuant to Section 37.2-817, that individual loses the right to purchase, possess, or transport a firearm until that right is restored by court order following petition by the person for restoration, with the outcome of any appeal of the original commitment or MOT order having no effect on the loss of this right.

This bill was left in the House Courts of Justice Committee.

HB1115 (VanValkenburg) - *Disposition alternatives when juvenile court adjudges that a minor committed a delinquent act but did not act intentionally or willfully.* This bill would amend Virginia Code Section 16.1-274.2 to provide that if the juvenile court adjudges that a minor committed a delinquent act as charged but was not responsible because the minor did not act intentionally or willfully, the court, in final disposition, may (i) enter an order of disposition or commitment authorized for children in need of services, (ii) if the juvenile has reached the age of 18 years, enter an emergency custody order (ECO) under Virginia Code Section 37.2-800, or (iii) dismiss the petition. The bill would also amend Section 37.2-800 to authorize a juvenile court to enter an ECO. This bill was a recommendation of the Virginia Criminal Justice Conference.

This bill was left in the House Courts of Justice Committee.

HB1487 (Stolle) - *Mental health services in local and regional correctional facilities.* This bill would have amended Virginia Code Sections 37.2-500 and 53.1-68, to include as a core service of CSBs the provision of mental health services to inmates in local and regional correctional facilities who are residents of the jurisdictions the CSBs serve, with such services to continue following the inmates’ return to the community, and to require the Board of Corrections (BOC), with guidance from the DBHDS Commissioner, to establish standards for mental health services within local correctional facilities. Those standards would include a requirement that the sheriffs/superintendents of those facilities enter into agreements with the local CSBs for delivery of mental health and substance abuse treatment services in the facilities.

In its path through the House, the bill received amendments providing that the CSBs' delivery of such services would be dependent upon the specific request of the sheriff/superintendent of the correctional facility. Ultimately, the bill was left in the House Appropriations Committee.

HB1507 (Adams) - ***Patient-Centered Medical Home Advisory Council; opioid addiction treatment pilot.*** This bill would have added Sections 2.2-214.2 and 2.2-214.3 to the Virginia Code to establish the Patient-Centered Medical Home Advisory Council to advise the Secretary of Health and Human Services and the agencies within that Secretariat on using a “patient-centered medical home system” to improve treatment and recovery services for opioid addiction and opioid-related disorders. Additionally, the bill would add Section 37.2-310.1 to the Virginia Code to mandate a “pilot” program for opioid addiction treatment and recovery services in Planning District 12 through a partnership between DBHDS, local CSBs, a licensed hospital in Virginia, and telemedicine networks and collaboration with the Patient-Centered Medical Home Advisory Council to develop the pilot program.

The House Health, Welfare and Institutions Subcommittee #3 approved amendments and substitutes to the bill and voted to refer the bill as amended and substituted to the Committee on Appropriations. The bill was left in the House Appropriations Committee.

HJ109 (Gooditis) - ***Study; Department of Medical Assistance Services; transportation for individuals with disabilities, mental illness, and substance abuse problems; report.*** This bill, citing the current problems faced by people with mental illness, substance abuse problems and other disabilities have in obtaining adequate transportation to services, would have asked DMAS to conduct a comprehensive study of the transportation needs of these populations and the barriers to their securing needed transport, and with relevant stakeholders develop recommendations for strategies, policies, or programs that would better meet the transportation needs of these individuals, including establishing partnerships with ride-sharing companies.

This resolution was stricken from the docket of the House Rules Committee.

SB225 (Stanley) - ***Patient-Centered Medical Home Advisory Council; opioid addiction treatment pilot.*** This bill would have amended the Virginia Code in a manner identical to **HB1507** (Adams).

The Senate passed a substitute version of this bill, which added the additional requirement that DBHDS establish a work group of interested stakeholders, including several named physician and nursing organizations, the Virginia Association of Community Services Boards, and the Virginia Hospital and Healthcare Authority, to collaborate with DBHDS in the development of this program. The substitute bill went on to identify the sources of funding for this pilot, and specified that the bill would not become effective unless the general appropriation needed for the pilot was made by the 2018 General Assembly. While the bill passed the Senate, it did not get out of the House Appropriations Committee.

SB296 (Edwards) – *Prisoners; medical and mental health treatment of those incapable of giving consent.* This bill would have amended the Virginia Code in a manner similar to **HB934** (Hope).

This bill was initially passed by indefinitely in the Committee on Rehabilitation and Social Services. It was later reconsidered and stricken at the request of the Committee on Rehabilitation and Social Services.

SB641 (Stuart) - *Purchase, possession, or transportation of firearms by persons voluntarily admitted to an inpatient mental health facility; penalty.* This bill would have amended Va. Code Sections 18.2-308.09, 18.2-308.013, 18.2-308.2:1, 18.2-308.2:2, 19.2-386.28 and 37.2-805 and add Sections 18.2-308,1:6 and 37.2-431.1, to make it unlawful (Class 1 misdemeanor) for a person voluntarily admitted to a public or private mental health facility for inpatient treatment to purchase, possess, or transport a firearm while in the facility *and* for two weeks following discharge. The facility must (i) notify the person of this provision, (ii) receive from the person, prior to admission, written consent to (a) the temporary revocation of firearms rights and (b) disclosure of information regarding the person's admission and future discharge to the State Police for entry in the Central Criminal Records Exchange, and (iii) provide such information to the State Police.

The bill was stricken at the request of the patron in the Courts of Justice Committee.

SB757 (Sturdevant) - *Certificate of public need; psychiatric beds and services.* The bill would have amended Virginia Code in a manner identical to **HB1606** (Orrock).

This bill was reported out of the Senate Committee on Education and Health, but was defeated by a vote on the floor of the Senate.

SB801 (Favola) - *Study; behavioral health in state correctional facilities; report.* This bill would have requested that the Department of Corrections, in collaboration with the DBHDS, study the provision of patient-centered behavioral health services in state correctional facilities, including a review of the use and impact of solitary confinement, with strategies for successfully transferring more prisoners from solitary confinement to the general prison population. A report to the Governor and General Assembly would be due on November 30, 2018.

This bill was left in the Senate Rehabilitation and Social Services Committee.

SB802 (Favola) - *Death penalty; severe mental illness.* This bill would have amended the Virginia Code in a manner identical to **HB758** (Leftwich).

This bill was passed by indefinitely in the Senate Courts of Justice Committee.

SB878 (Dunnavant) - *Mental health services in local and regional correctional facilities.* This bill would have amended Virginia Code in a manner identical to **HB1487**

(Stolle). An amended version of this bill was approved by the Senate Rehabilitation and Social Services Committee, with that amendment providing that payment by the sheriff or superintendent of the correctional facility shall be “pursuant to Section 53.1-126.”

An amended version of this bill passed the Senate, but the Subcommittee on Health and Human Resources of the House Appropriations Committee voted in favor of “laying” the bill “on the table,” thereby killing it.

SJ14 (Edwards) - ***Study; alternative models of emergency custody and temporary detention; report.*** Noting that other states enable various health and mental health care professionals to authorize taking into emergency custody individuals who are in mental health crisis (Virginia authorizes only law enforcement officers and magistrates to effect such emergency custody), the resolution would have directed the SJ 47 Joint Subcommittee to study alternative models of emergency custody and temporary detention, and specifically to identify alternative models, “including Florida's Baker Act,” and to evaluate them and their potential costs and benefits and make recommendations for changes to Virginia’s current model to improve outcomes for individuals in need of emergency custody and temporary detention and to improve public safety.

This resolution was passed by indefinitely by the Senate Committee on Rules.

III. ILPPP Data Corner

Incidence and Characteristics of TDOs in Psychiatric Admissions to UVA Hospital in 2015

Anja Miller
M.D. Candidate, Class of 2020
University of Virginia School of Medicine

The following Data Corner was adapted from a summer 2017 study prepared for the ILPPP by Anja Miller, an M.D. candidate at the University of Virginia (UVA) School of Medicine, as part of the UVA Medical Student Summer Research Program. Her work was supervised by Tanya Wanchek, J.D., Ph.D., Assistant Professor with the UVA Department of Public Health Sciences.

Background

Temporary Detention Orders (TDOs)¹ have increased in the state of Virginia over the years of 2013-2017 (1). This fact is concerning in terms of a loss of patient autonomy and

¹ Virginia Code § 37.2-808 *et seq.* detail the involuntary civil commitment process, which may include up to three actions: Emergency Custody Order (ECO), Temporary Detention Order (TDO), and Commitment Hearing. A TDO is a motion issued by a magistrate that enables an individual to be taken into custody and

a lack of hospital capacity, each posing direct threats to the overall quality of patient care. As it stands, there is not a standardized, easily accessible, and/or dependable manner to identify which patients in Emergency Departments or on psychiatric units have had TDOs, which impedes our understanding of TDOs and their complex effects on Virginia's mental health system. This investigation's purpose is to evaluate the incidence of TDOs of psychiatric inpatients at the UVA Health System in a given calendar year to have a more accurate picture of TDO patterns and to better understand their influence in our communities.

Method

Institutional Review Board-Health Sciences Research approval was obtained for the study. Identifiable data and medical charts were reviewed by only Ms. Miller.

A catalog of 2015 psychiatric inpatients was obtained from the UVA Clinical Data Repository (CDR) that included the patients' Medical Record Number (MRN), sex, age, date of admission, date of discharge, race, ethnicity, and disposition at discharge. The charts of the provided MRN numbers were reviewed in the electronic medical record (EMR). Data reviewed includes their history of the present illness (HPI) at the time of admission to psychiatry, progress notes throughout their admission, discharge summaries, pre-screener evaluations², and demographic information to determine:

1. Whether or not a patient was issued an Emergency Custody Order (ECO)
2. Whether or not a patient was issued a TDO
3. Whether a patient had insurance (and if so, what type)
4. Whether a patient was issued other TDOs in 2015
5. How many TDOs were issued for this patient (as documented in the UVA Health System) in the years 2010-2015
6. Whether a patient was issued a TDO in 2016
7. If a patient was issued a TDO, did they have any known outpatient treatment at the time of admission?
8. If a patient was issued a TDO, did they have any previous inpatient treatment?
9. If a patient was issued a TDO, were they ever treated in a state facility?

Information on a patient's legal status was obtained primarily by either (i) a note at the time of admission to psychiatry or (ii) progress notes throughout their admission. Their status was then verified by cross-checking it in Region 10³ evaluations. In some cases, the Region 10 evaluation was missing; in these scenarios, whether or not a patient was issued a TDO relied solely on the information specifically written in their progress notes. Information on previous psychiatric outpatient treatment, inpatient treatment, and

transported to a proper medical facility for up to 72 hours when there is probable cause to believe that a patient meets commitment criteria (2).

² Per Virginia Code, individuals taken into custody under an ECO and individuals who are not under an ECO but for whom a petition for a TDO has been made, must be evaluated by an emergency services employee from the local community services board, commonly referred to as a "pre-screener."

³ Region 10 is the local Community Services Board (CSB) serving the area in which UVA hospital is located.

previous state hospitalizations were obtained from the Region 10 evaluations, and coded as dichotomous variables. TDO and non-TDO admissions were then stratified based on sex, the issuance of ECOs, payer source, and previous psychiatric treatment.

Results

Table 1: Total number of 2015 admissions that entailed an ECO, a TDO, and both an ECO and TDO, stratified by sex.

| | All Admissions | ECO | TDO | ECO + TDO |
|------------|----------------|-----|-----|-----------|
| Females | 635 | 106 | 209 | 86 |
| Males | 549 | 122 | 206 | 96 |
| Both sexes | 769 | 228 | 415 | 182 |

- Out of the individual patients that were placed under a TDO in 2015 ($N = 364$ because some individuals had multiple TDOs issued), 41 were also TDO'd at least once in 2016.
- Out of the 364 individual patients that were placed under a TDO in 2015, 127 patients had previous records of multiple (2 or more) TDOs within the previous 5 years (2010-2015).

Table 2: Absolute number and proportion of payer source for TDO admissions and absolute number and proportion of payer source for total admissions.

| Payer source | # TDO admissions | % TDO admissions | # all admissions | % all admissions |
|---------------------|------------------|------------------|------------------|------------------|
| Private | 91 | 21.9% | 269 | 22.7% |
| Medicaid | 88 | 21.2% | 270 | 22.8% |
| Medicare | 60 | 14.5% | 135 | 11.4% |
| None | 105 | 25.3% | 327 | 27.6% |
| Medicare & Medicaid | 38 | 9.2% | 105 | 8.87% |
| Medicare & Private | 31 | 7.5% | 73 | 6.17% |
| VA or Medicare, VA | 2 | 0.48% | 5 | 0.42% |
| Total | 415 | 100% | 1184 | 100% |

Table 3: Number and proportion of TDO patients ($N = 364$) that had current/previous outpatient treatment, inpatient treatment, and previous state hospital admissions

| | Previous outpatient treatment | Previous inpatient treatment | Previous state hospitalization |
|---------|-------------------------------|------------------------------|--------------------------------|
| Yes | 121 (33.2%) | 201 (55.2%) | 58 (15.9%) |
| No | 167 (45.9%) | 94 (25.8%) | 215 (59.1%) |
| Unknown | 76 (20.9%) | 69 (18.9%) | 91 (25.0%) |

Discussion

Since July 2014, Virginia state psychiatric facilities have been required to admit individuals who meet TDO criteria, unless an alternative facility agrees to accept the individual (2). TDO admissions to state hospitals increased by 60% during the years of 2015-2016 (1). Input from psychiatrists and registered nurses working on the psychiatric wards also provided additional insight into the potential clinical consequences of an increased issuance of TDOs. For example, two nurses described a bottlenecking effect as a seeming consequence of this increase. The general understanding by practitioners is as follows: because the state hospitals are flooded with TDO patients, the acute care psychiatric centers are functioning more like chronic care facilities. That is to say, acute psychiatric care facilities, such as the one at UVA, are providing long-term inpatient treatment to some patients instead of transitioning them to flooded chronic treatment centers. They noted that this trend sometimes extends to the Emergency Department, where patients needing admission for psychiatric care experience an increased stay in the ED.

We found that 35.1% of inpatient admissions to the UVA psychiatric floor were issued a TDO at some point just preceding (typically in the ED) or during their admission. Of those issued during admission, patients' legal status changed for a variety of reasons; for example, initially a patient could be admitted on a voluntary basis, and based on their clinical condition or potentially a refusal of necessary care, were later issued a TDO. There were 86 more females than males admitted, but a slightly lesser proportion of females were issued TDOs than their male counterparts. Over one third of individual patients that were issued a TDO in 2015 had been issued TDOs in the previous five years. This percentage may be an underestimate because of the lack of standardization of TDO documentation. Nevertheless, the percentage as it stands represents the grave need for easily accessible mental health care in our community—these individuals had their autonomy restricted for the sake of their wellbeing not just once but multiple times over a period of five years.

Nearly 60% of inpatients at UVA psychiatry had Medicaid, lacked insurance entirely, or had a combination of Medicare/Medicaid. Similarly, 55.7% of patients that were issued TDOs lacked health insurance, were enrolled in Medicaid, or were in enrolled in both Medicaid and Medicare. These results suggest that the patient population served includes a majority of individuals from a lower socioeconomic status, potentially without the means to afford preventative and less invasive mental health care⁴.

When accounting for multiple admissions, there were 364 patients on UVA's psychiatric unit that were issued a TDO during 2015. Of these individuals, only 33.2% had previous or current outpatient treatment, 45.9% had no current or previous outpatient treatment,

⁴ Note that as one of Virginia's major safety net hospitals, UVA serves a higher proportion of uninsured and underinsured patients than most other hospitals. If we were to replicate this study at another facility, we could anticipate different findings regarding insurance status. This could also potentially impact the relationship between insurance status and TDO status.

and 20.9% had an unknown status of previous outpatient treatment (i.e., the pre-screen evaluation was missing or the data fields were left blank). Interestingly, 55.2% had had previous inpatient treatment. This could potentially further point to a lack of accessible outpatient care as individuals sought help when their symptoms were bad enough to require hospitalization.

References

1. Larocco, S. A. (2017, May). *Factors Influencing the Rise in TDOs in Virginia* (pp. 1-14, Rep.).
2. Tysinger, A. K. (2014, July). *Virginia's Civil Commitment Laws* [PDF]. Richmond: Office of the Attorney General.

Note from the editor:

Ms. Miller's findings are important for several reasons. Virginia policymakers and policy researchers lack consistent, system-wide information about psychiatric hospitalizations. Virginia Health Information (VHI) keeps a rich database of all licensed Virginia hospital discharges, which includes information about patient demographics as well as administrative, clinical, and financial information on every discharge that occurs. Records are *not* kept, however, regarding whether a patient was admitted voluntarily or involuntarily, which creates a significant blind spot for undertakings such as the TDO Study (described in the first article of this issue). The study that Ms. Miller conducted demonstrates that it *is* feasible and useful to determine the TDO status of psychiatric inpatients via chart review. One limitation of this study is that we were unable to obtain records for patients who were seen in the ED and underwent a psychiatric evaluation but who were not admitted to UVA. ILPPP staff are currently collaborating with UVA Health System staff to explore the possibility of obtaining these data.

IV. Case Law Developments

United States Supreme Court

Death Penalty, Ineffective Assistance, Intellectual Disability: The Supreme Court of the United States denied certiorari to hear a case involving ineffective assistance of counsel based on not obtaining psychological evaluation for intellectual disability. Of relevance here is the opinion of the dissenting Justices, who found that the Alabama Court of Criminal Appeals incorrectly imposed a rule requiring trial counsel to testify in order for a petitioner to succeed on a federal constitutional ineffective-assistance-of-counsel claim.

Reeves v. Alabama, 138 S. Ct. 22 (2017).

Background: Matthew Reeves was convicted of capital murder and sentenced to death. He sought post-conviction relief on several claims of ineffective assistance of trial and appellate counsel, including that his trial counsel was ineffective for failing to hire an expert to evaluate him for intellectual disability, despite having sought and obtained

funding and an appointment order for a specific neuropsychologist. His post-conviction counsel later hired that neuropsychologist, who concluded that Reeves was intellectually disabled. Reeves contended that this and other evidence could have been used during the penalty phase of his trial to establish mitigation. The Alabama Criminal Court of Appeals concluded that Reeves failed to call his counsel as witnesses and that the record was thus silent as to why trial counsel failed to present the mitigating testimony from experts. The Alabama Supreme Court denied review, and Reeves appealed to the Supreme Court of the United States contending that the state appellate court incorrectly required that he present his counsel's testimony to establish ineffective assistance of counsel.

Holding: The Supreme Court denied the petition for writ of certiorari. Justices Sotomayor, Ginsburg, and Kagan dissented.

Dissent: The dissenting Justices argued that the Alabama Criminal Court of Appeals wrongly made the success of Reeves' claim of ineffective assistance of counsel contingent upon his former counsel testifying at the post-conviction hearing. The Alabama Criminal Court of Appeals had stated that their decision was based on the totality of the evidence. The dissenting Justices, however, referred to language by the Alabama Criminal Court of Appeals that effectively required questioning of trial counsel to overcome the strong presumption of effectiveness. The dissenting Justices found such a requirement to be inconsistent with Supreme Court precedent and concluded that sufficient evidence has been presented by Reeves to demonstrate that his counsel were constitutionally deficient.

Federal Circuit Courts of Appeal Decisions

Qualified Immunity, Duty of Care, Jails and Prisons: Sixth Circuit ruled that there is a clearly established Fourteenth Amendment right to sufficient treatment for a serious medical problem and upheld a district court's denial of qualified immunity to a jail nurse where there was evidence that the nurse acted with deliberate indifference to an inmate's serious mental illness.

Bays v. Montmorency Cty., 874 F.3d 264 (6th Cir. 2017).

Background: Shane Bays, a 28-year-old man, was arrested for driving on a suspended license. While awaiting trial, Shane was at Montgomery County Jail. At the jail he described symptoms of mental illness to the jail nurse, Donna Sigler. Sigler interviewed Shane as a part of the jail's inmate health screening. Shane complained of severe psychological conditions, and Sigler recommended referral for emergency treatment by circling "YES" on the screener but added "on discharge" as a note. Later the same day, Shane returned expressing severe paranoia, anxiety, restlessness, and rage. Upon hearing this, Sigler informed a registered nurse via telephone that Shane was "having some issues with anxiety;" the registered nurse recommended Benadryl, which Sigler administered. Two days later, Sigler scheduled an appointment for Bays at the mental health center for the next month. Approximately a week later, Bays saw Sigler again reporting further

deterioration. Sigler noted that Bays denied self-harm; she attempted to schedule an earlier meeting with the RN but was unable to reach her. Sigler did not seek emergency help or place him on a watch list, despite both options being available. Shane committed suicide a few days later. Shane's parents sued Sigler for violating Shane's right to receive care for a serious medical need and sued Montgomery County on a failure-to-train claim. The district court dismissed the claim against Montgomery County on qualified immunity grounds but denied Sigler qualified immunity.

Holding: The Sixth Circuit affirmed the district court's denial of qualified immunity to Sigler on grounds of Sigler violating Shane's Fourteenth Amendment right to have a serious psychological illness treated seriously. The Sixth Circuit affirmed the dismissal of the failure-to-train claim.

Discussion: The Sixth Circuit determined that Shane had a clear, established right to treatment for serious medical needs, and that a jury could have determined that Sigler was subjectively reckless because she was aware of Shane's serious illness but took insufficient action. The court clarified that it was not basing the deliberate indifference analysis on a right to have suicidality recognized and treated but on a right to have a serious mental illness recognized and treated. The court noted that Shane's mental illness was objectively serious based upon his expressed need to have his psychological illness treated. The Sixth Circuit noted that liability attaches only when treatment is "so cursory as to amount to a conscious disregard." Yet the court found that Sigler's actions met the "admittedly low bar" because her actions, such as circling "YES" and attempting to schedule an earlier appointment, showed her knowledge of the seriousness of Shane's condition and that her failure to take further actions, like placing him on a watch list, were deficient in light of that knowledge. The Sixth Circuit simultaneously determined that Sigler's violation of Shane's constitutional right to treatment was not inextricably intertwined with the claim against Montgomery County. Sigler's deliberate indifference to Shane's medical needs did not establish that the County failed to train its employees or had a policy that violated this constitutional right.

Qualified Immunity, Excessive Force, Law Enforcement: Eighth Circuit held that deploying a Taser against a person in a public area who was refusing law enforcement commands to drop a knife did not violate a clearly established right and the officers were eligible for qualified immunity.

Frederick v. Motsinger, 873 F.3d 641 (8th Cir. 2017).

Background: Fallon Fredrick entered a convenience store mid-morning with a four-inch folding knife, demanding that the store clerk call 911 because Frederick was being followed. A police sergeant nearby arrived first. Frederick asked for the officer's badge number, then "excitedly announced" that she had a knife, at which point the sergeant drew his firearm. Frederick stated that she believed he was not a police officer. A second officer arrived, and Frederick asked for his badge number. The sergeant directed the officer to use his Taser because Frederick was near the bathroom doors and the officers were concerned she might harm a customer if there was a customer in one or

more of the bathrooms. Frederick was holding the knife in a “stabbing position” and told the officers that she was “a paranoid schizophrenic.” The officers commanded Frederick to drop the knife or they would have to deploy the Taser. Officer Motsinger arrived as the second officer was deploying the Taser. The probe was blocked by her purse and she then charged toward the second officer with a raised knife. Officer Motsinger shot Frederick three times. Frederick’s estate brought suit claiming that the tasing was objectively unreasonable, after conceding that it was not unreasonable to use deadly force against a suspect who was charging an officer with a knife in a stabbing position. The district court held that the Fourth Amendment objective reasonableness standard was met given the reasonableness of the particular use of force in the face of imminent harm.

Holding: The Eight Circuit affirmed the district court’s holding, thereby upholding the officers’ qualified immunity.

Discussion: The Eight Circuit affirmed that the officers’ decision to use non-lethal force in an attempt to disarm Frederick after she disregarded and refused warnings to drop the four-inch knife was objectively reasonable. It was reasonable to use non-lethal force because it was reasonable to assume she was ready to use her knife against them and others in the store. The court cited the officers’ statements that they believed Frederick was under the influence of methamphetamine based on her behavior and that they were concerned for the safety of others as support for finding there was an “actual and imminent threat of harm.” Given the imminent threat, actual harm in the form of an attack did not have to proceed before the police officers deployed non-lethal means. Regarding the presence of mental illness, the court noted that “the relevant inquiry is whether she posed a threat, not what prompted her threatening conduct.” The court found there was no precedent that “clearly established that tasing a person standing in a public area who refused several commands to drop a knife would violate that person’s constitutional rights.” The officers were therefore entitled to qualified immunity.

Qualified Immunity, Law Enforcement, Excessive Force: Ninth Circuit held that (1) **disputation about the reasonableness of deputy’s actions did not preclude granting qualified immunity, and (2) deputy was entitled to qualified immunity for the tasing and fatal shooting of the decedent because the decedent held no clearly established right not to be shot in circumstances in which he was larger than two officers, was not incapacitated by the taser, and was “winning” in hand-to-hand combat with the officers.**

Isayeva v. Sacramento Sheriff's Dep't, 872 F.3d 938 (9th Cir. 2017).

Background: Two family disturbance calls were received by the Sacramento County Sheriff’s office, one from the decedent’s brother-in-law and one from Tereschenko (the decedent), concerning a family dispute about his moving out of his brother-in-law’s home. The brother-in-law noted that Tereschenko suffered from mental health issues, including hearing voices. Two deputies were dispatched to the home, where they met some family members outside who again mentioned mental illness and added that they thought Tereschenko might be under the influence of methamphetamine. The deputies

spoke with Tereschenko for 7 to 10 minutes, during which time he told them he was “schizophrenic,” and ultimately determined that they should take him into emergency custody for a mental health evaluation. Tereschenko failed to fully comply with their requests that he turn around (presumably so that he could be handcuffed), and one of the officers grabbed his arm as Tereschenko moved it as if to grab something. The second officer grabbed his other arm, and a fight ensued, with the physically larger Tereschenko succeeding in throwing off one officer and punching the other repeatedly. During the initial struggle when the officers grabbed his arms, one officer attempted to stun Tereschenko with a Taser, but Tereschenko only became agitated and aggressive. Finally, as Tereschenko appeared to advance toward the officer whom he had punched and who was losing consciousness, that officer shot him three times. Tereschenko’s wife, Isayeva, brought suit, and the district court denied qualified immunity to the officers because there were genuine disputes of material facts (including differences between the two officers’ descriptions of the incident).

Holding: The Ninth Circuit held that Tereschenko did not have a clearly established right not to be tased or to be shot and, thus, qualified immunity was available to the officers despite the existence of disputed facts.

Discussion: The Ninth Circuit held that a dispute about material facts does not preclude granting qualified immunity because the qualified immunity analysis focuses on (1) whether a constitutional right was violated, and (2) whether that right was clearly established. The court reviewed the various relevant standards applied to excessive force cases, such as *Graham v. Connor*, 490 U.S. 386 (1989), but noted that such considerations are “only a starting point” and that the “dispositive question is ‘whether the violative nature of *particular* conduct is clearly established.’” (quoting *Mullenix v. Luna*, 136 S.Ct. 305 (2015)). The court reviewed the facts in favor of Isayeva as the non-moving party and found that it was nonetheless apparent that there was no clearly established right in the particular circumstances presented. Analyzing the use of a taser (including reviewing three Ninth Circuit cases that held Taser use as unreasonable) and then the use of a firearm, the court found that in circumstances where a large, actively fighting person, who was possibly on methamphetamine, was succeeding in overpowering two officers, it was not unreasonable to use either of the methods of force.

Combined summaries

Mental Health, Sentencing: The following three cases each involved defendant challenges to the imposition of mental health treatment as part of their sentencing. The cases are presented here in brief because of their relatively similar, short opinions that do not present notable fact patterns or developments in jurisprudence.

United States v. Carlin, 712 F. App’x 365, (5th Cir. 2017); *United States v. Stephens*, 699 F. App’x 343 (5th Cir. 2017).

Both *Carlin* and *Stephens* essentially concerned a misstatement of a condition of sentencing. In both cases, the court ordered that the defendant “participate in a mental

health program as deemed necessary and approved by the probation officer,” thus impermissibly delegating sentencing authority to the probation officer. In both cases, the Fifth Circuit affirmed a modified sentence that imposed mental health treatment, with details of the treatment to be supervised by the probation officer.

United States v. Wesberry, 709 F. App’x 895 (10th Cir. 2017).

In *Wesberry*, the defendant challenged the imposition of mental health treatment as part of his sentence under the U.S. Sentencing Guidelines, arguing that the condition was unreasonable because it bore no relation to the goals of the guidelines. The Tenth Circuit reviewed his claim for plain error because he had not challenged the condition in district court. The court found that there was no “well-settled” law supporting his challenge, thus there was no clear error to be found in the lower court’s sentencing decision. In addition, the court noted that the Guidelines’ policy statement recommends requiring participation in a mental health program if a court has reason, based on particularized findings, to believe the defendant is in need of psychological or psychiatric treatment; the court noted the district court’s reliance on presentence reports documenting Wesberry’s diagnoses and medications as meeting the requirement of particularized findings.

Off-label Drug Prescriptions: The following two cases both involved off-label drug prescriptions and improper promotion practices.

United States ex rel. Ibanez v. Bristol-Myers Squibb Co., 874 F.3d 905 (6th Cir. 2017).

Two former sales representatives of Bristol-Myers Squibb Co. (BMS) filed a qui tam action alleging improper promotion of Abilify. The district court had dismissed the complaint in part and denied the relators’ motion to amend. On review, the Sixth Circuit noted the long chain of causal links the relators alleged “reveals just what an awkward vehicle the [False Claims Act] is for punishing off-label promotion schemes,” but ultimately upheld the lower court’s rulings because the relators could not adequately amend the complaint to meet the requirements of the FCA (such as providing a representative claim). Judge Stranch concurred with one part of the court’s holding but dissented regarding many of its other findings about the relators’ claim sufficiency, noting the importance of combating health care fraud.

Sidney Hillman Health Ctr. of Rochester v. Abbott Labs., 873 F.3d 574 (7th Cir. 2017).

In 2012, Abbott Laboratories pleaded guilty to unlawful promotion and paid \$1.6 billion for undercover promotion activities that encouraged off-label use of Depakote. In 2013, two welfare-benefit plans (Payors) filed suit seeking damages under the Racketeer Influenced and Corrupt Organizations (RICO) Act. As relevant here, a district judge dismissed the complaint, ruling that Payors could not hope to show proximate causation as required under RICO. On appeal, Payors claimed that Abbott’s activities directly injured them, but the Seventh Circuit noted that it was “not at all clear that they are the initially injured parties, let alone the sole injured parties.” The court noted that patients suffer most directly and expressed skepticism in Payors’ claimed ability to show damages

using statistical and other means to identify how Abbott's practices led to specific instances of Payors spending money on off-label Depakote prescriptions.

State Court Decisions

Competence to Stand Trial, Prosecutor: The Supreme Court of California found that the prosecution was permitted to dismiss prior charges and refile identical charges where the defendant had been committed for the duration of the statutory period while being evaluated for competence to stand trial; provided, however, that if found still incompetent to stand trial, the defendant could not be re-committed for another statutory period.

Jackson v. Superior Court, 406 P.3d 782 (Cal. 2017).

Background: Jackson was charged with sexual misconduct and the trial court found that he was not competent to stand trial. Jackson spent three years at a hospital for restoration of competency and further evaluation. At the end of the three years, the court declared he was still not competent to stand trial and had to release him as three years was the duration of the statutory period. Three days after he was released, the Riverside County District Attorney obtained a grand jury indictment against him for identical charges and re-arrested him. The court declared doubt as to his competence to stand trial and suspended the proceedings. Jackson moved for his release, claiming that the prosecution could not initiate a new competency proceeding by filing a new charge after the maximum period for commitment provided for under the law had elapsed.

Holding: The Supreme Court of California held that Jackson could be rearrested on the identical refiled charges, but if the trial court determines he is not competent to stand trial, it cannot re-commit him for another statutory period.

Discussion: The Supreme Court of California found that the prosecution is allowed to refile felony charges after dismissal once and only once under the "two-dismissal rule" provided for in California statute. The court elected not to adopt a "good cause" standard for why the initial charges were dismissed, finding it unnecessary as the prosecution will be barred if the defendant can show actual prejudice as a result of the delay in refiled charges. The court also found that if the defendant is again found incompetent to stand trial, he may only be further committed for evaluation for any balance of time remaining in the three-year commitment period.

Death Penalty, Ineffective Assistance: The Supreme Court of Florida vacated a death sentence and granted a new penalty phase to the defendant because his counsel did not provide effective assistance at trial and the non-unanimous jury verdict regarding the sentence may have violated the Sixth Amendment.

Ellerbee v. State, 232 So.3d 909 (Fla. 2017).

Background: Ellerbee admitted to killing a man and was thereafter convicted of first-degree murder and sentenced to death. He appealed his conviction on the grounds that, among other claims, he received ineffective counsel at trial and was prejudiced as a result. He alleged that counsel failed to discover information about his childhood abuse and present testimony about his resulting mental health conditions at the penalty phase. Ellerbee also petitioned for a writ of habeas corpus on the ground that the jury verdict to impose the death sentence was non-unanimous and thus the sentence was unconstitutional under the Sixth Amendment.

Holding: The Supreme Court of Florida vacated the sentence of death and granted a new penalty phase because the jury was not unanimous regarding the sentence and Ellerbee's counsel failed to provide him with effective assistance in the penalty phase, creating a reasonable probability that a jury would have come to a different conclusion regarding sentencing had assistance been reasonable.

Discussion: The Supreme Court of Florida found that the failure to require a unanimous verdict on the death sentence was not necessarily harmless in light of *Hurst v. State*, 202 So. 3d 40 (Fla. 2016) and *Mosley v. State*, 209 So. 3d 1248 (Fla. 2016), and therefore Ellerbee's sentence may not have been constitutional under the Sixth Amendment. Alternatively, it found grounds to vacate the sentence and grant a new penalty phase because counsel failed to provide Ellerbee with effective assistance. The court noted that normally it would decline to reach the penalty phase complaint after finding that Ellerbee was entitled to a new penalty phase but stated that "we feel compelled to address this issue because of the egregious nature of Ellerbee's upbringing, counsel's failure to discover it, and the prejudice Ellerbee suffered as a result." Counsel did not discover his history of childhood abuse, including his mother beating him and starving him before leaving when he was just seven years old and then his father beating him, leaving him malnourished, failing to provide him with basic needs, and exposing him to danger throughout his childhood. Counsel additionally did not provide testimony at the penalty phase about the impacts of this abuse as well as Ellerbee's long history of drug use on his mental development, including his resulting difficulties with emotion regulation and impulse control. The court found that these errors fell below the objective standard of reasonable professional norms under the circumstances and there was a reasonable probability that the jury would have arrived at a different conclusion regarding sentencing had this testimony been presented.

Death Penalty, Ineffective Assistance, Intellectual Disability: The Supreme Court of Florida denied a new evidentiary hearing for intellectual disability, granted a new penalty phase where counsel was ineffective in its penalty phase investigation, and withheld a new guilt phase because counsel was not ineffective in its guilt phase investigation.

State v. Morrison, 236 So.3d 204 (Fla. 2017).

Background: Morrison was convicted of first degree murder and sentenced to death. The post-conviction court granted Morrison a new guilt phase and a new penalty phase based on claims regarding ineffective assistance of counsel. Both Morrison and the State appealed the decision. The State appealed the decision that Morrison was prejudiced because his counsel was ineffective when he failed to challenge the voluntariness and reliability of Morrison's written statement to the police, failed to adequately investigate various defenses, and failed to adequately investigate and prepare for the penalty phase, specifically with regard to undiscovered information about his mental health and social background. On appeal, Morrison claimed that he should have prevailed on a claim of intellectual disability, among other claims not reviewed here.

Holding: The Supreme Court of Florida vacated Morrison's death sentence and granted a new penalty phase because it found he received ineffective assistance from counsel regarding the investigation conducted prior to the penalty phase but denied him (1) a new guilt phase, because he did not receive ineffective assistance regarding his written statement to the police or the guilt phase investigation, and (2) a new evidentiary hearing on intellectual disability.

Discussion: The Supreme Court of Florida granted a new penalty phase on the grounds of ineffective assistance. Morrison was originally to be represented by a public defender, but his case was later transferred to trial counsel, causing a miscommunication regarding the state of the investigation. The court found that the investigation constituted ineffective assistance because it included almost no information about Morrison's mental health and social background and caused unfair prejudice. However, the court did not grant a new guilt phase because Morrison was not unfairly prejudiced by counsel's failure to investigate various alternative defenses or its failure to challenge the reliability of Morrison's written statement to the police because the evidence that the statement was voluntary prevented any prejudice in the guilt phase. Further, the court denied a new evidentiary hearing on intellectual disability because there was not sufficient evidence to show that the disability presented before age 18, a required element of the claim.

Dissent: Judge Pariente argued in dissent that Morrison should be entitled to a new evidentiary hearing on his intellectual disability claim because evidence showed Morrison's intellectual disability presented before age 18 (based on his academic failures and trouble performing simple tasks from a young age). Judge Pariente criticized the lower courts' heavy reliance on an IQ score obtained when Morrison was 8 years old despite evidence of significant deficits, which the post-conviction court specifically cited before disregarding Morrison's deficits.

Mental Health Experts, Jury Instructions, Not Guilty by Reason of Insanity: The Massachusetts Supreme Judicial Court upheld a conviction of first-degree murder because the judge correctly excluded expert testimony about a hearsay conversation not admitted into evidence, the Commonwealth's expert witness testimony was proper, and the judge accurately instructed the jury with the appropriate model instructions at the time of the trial.

Commonwealth v. Piantedosi, 87 N.E.3d 549 (Mass. 2017).

Background: Defendant was convicted of first-degree murder for fatally stabbing his girlfriend. At trial, he admitted to killing his girlfriend but argued he lacked criminal responsibility by reason of involuntary intoxication and insanity. Dr. Meyers, a forensic psychologist, opined that the defendant had bipolar disorder and, as a result of the combination of Prozac and Trazodone he had been prescribed, was not able to appreciate the wrongfulness of his conduct at the time of the incident. In contrast, the Commonwealth's expert witness, Dr. Fife, testified that anger, sadness, and rage—not a mental disease—"drove" the defendant's behavior at the time of the incident. The defendant appealed his conviction, challenging the judge's refusal to permit Dr. Meyers to testify to hearsay statements made by the defendant, the admission of Dr. Fife's testimony, and the judge's instructions to the jury on the consequences of a not guilty by lack of criminal responsibility verdict.

Holding: The Supreme Judicial Court affirmed the conviction, finding that the judge did not err in refusing hearsay testimony, allowing the Commonwealth's expert witness's testimony, or instructing the jury as she did.

Discussion: The Supreme Judicial Court held that the judge did not err in not allowing testimony by the medical expert concerning a conversation that he had with the defendant during a forensic interview, because an expert can formulate an opinion based on data not admitted to evidence but he cannot testify to the substance or contents of that information, as it would allow hearsay evidence into trial. The court also held that the testimony by the Commonwealth's expert witness was proper because experts are allowed to provide an opinion of the defendant's motivation as long as it does not offer an opinion on responsibility. Finally, the court held that although the Massachusetts standard for jury instructions now included mentioning the possibility of lifetime commitment with a verdict of not guilty by lack of criminal responsibility, the instructions the judge gave the jury were in accordance with the model standard at the time.

Intellectual Disability, Death penalty: The Supreme Court of Mississippi found that the trial court was incorrect in denying a State motion to evaluate a defendant on his claim of intellectual disability when considering the death penalty because testing completed for a previous charge was insufficient for State expert to form opinion.

State v. Russell, 238 So.3d 1105 (Miss. 2017).

Background: Russell was sentenced to death for the murder of a correctional officer. He claimed he was intellectually disabled and thus could not be sentenced to death under *Atkins*. The trial court refused to grant an additional evaluation of his intellectual disability, instead relying on a psychological evaluation from 2006 that originally served the purpose of determining if he was competent to stand trial for a different charge. This assessment did not evaluate him on the specific criteria of intellectual disability. The

State expert on intellectual disability testified that he would need more testing data to arrive at an opinion; however, a state hospital doctor who had assessed Russell for the competency evaluation had provided an unsolicited opinion about Russell intellectual disability status based on the 2006 competence evaluation. The trial court relied on the state hospital doctor's assessment to deny the State's motion for evaluation. The court subsequently vacated Russell's death sentence after hearing from three defense witnesses at the *Atkins* hearing and no State witnesses. The State appealed, contending that additional assessment was necessary and the trial court erred in denying its motion to evaluate Russell further.

Holding: The Supreme Court of Mississippi found that the trial court erred by not sustaining the State's motion to further evaluate Russell for intellectual disability as required under *Atkins* and remanded the case to the trial court for additional assessment prior to the sentencing determination.

Discussion: The Supreme Court of Mississippi determined that the 2006 assessment of Russell was not sufficient to evaluate him for intellectual disability under *Atkins*. The court relied heavily on the testimony of a medical expert, Dr. Macvaugh, who believed he did not have enough information to form an opinion on Russell's claim without further assessment. The court also found that the State and Russell had an understanding in 2006 that the evaluation in question would not also serve to satisfy requirements for his *Atkins* claim. The court decided that, as a result, the trial court should have sustained the State's motion and subjected Russell to further assessment.

Dissent: In dissent, Chief Justice Waller argued that no additional psychological testing was required. He first asserted that Russell and the State did indeed believe this evaluation would be used to satisfy *Atkins* in 2006, and the statement the majority relied on was simply an acknowledgement that other sources of evidence beyond an evaluation would be required to satisfy *Atkins*. The Chief Justice argued that the evaluation completed in 2006 tested adequately for intellectual functioning as Russell was not entitled to be evaluated under the most recent version of the WAIS test, and the State had access to other information necessary to evaluate adaptive functioning, including academic records, employment records, and other individuals who knew Russell prior to age 18.

Civil Commitment, Rights Waiver: The Supreme Court of Montana upheld a statute preventing defendants from being able to waive their right to counsel in civil commitment proceedings, finding it does not violate the Sixth or Fourteenth Amendments to the Constitution.

Matter of S.M., 403 P.3d 324 (Mont. 2017).

Background: The State petitioned to involuntarily commit S.M. after he told a friend of his plan to commit suicide and refused inpatient treatment. At the initial hearing, S.M. requested that he represent himself. His request was granted and he was appointed standby counsel only. The standby counsel filed a notice that the right to counsel may not

be waived in involuntary commitment proceedings according to a Montana statute. In response, the court appointed counsel. Collectively, S.M., his attorney, and the State agreed that he required mental health assistance and the least restrictive alternative was placement in a community outpatient treatment facility. S.M. later appealed the treatment order and asserted that the Montana statute preventing him from being able to waive his right to counsel in a civil commitment proceeding violates the Sixth and Fourteenth Amendments.

Holding: The Supreme Court of Montana found that the Montana statute that prevents the defendant from being able to waive the right to counsel in involuntary commitment proceedings is constitutional because the Sixth Amendment applies only to criminal proceedings. Further, it does not violate the Fourteenth Amendment because the right to self-representation in these proceedings is not a fundamental right and the statute is based on sound public policy.

Discussion: The Supreme Court of Montana found that the Montana statute does not violate the Sixth Amendment because the amendment applies to criminal prosecutions, not to involuntary civil commitment. It also found that the statute does not violate the due process requirement of the Fourteenth Amendment because the right to self-representation in an involuntary civil commitment proceeding is not a fundamental right. The court held that the right is not fundamental because formal proceedings for involuntary civil commitment are relatively modern developments and compelling representation by counsel in this instance serves the State's strong interest that these proceedings lead to fair and accurate outcomes. As the right was not fundamental, a rational basis review applied to the restriction. The court found that the statute was based on the sound public policy concern about preserving fairness, integrity, and accuracy, and although S.M. could not waive his counsel, he was able to participate in a manner that protected his personal autonomy.

Mental Health Providers, Privilege: The Supreme Court of Nevada ruled that psychologist-patient privilege applied and was not waived where counseling records concerned only treatment and no substantial part was shared with anyone, treatment was not substantively at issue in any claim or defense, and neither state law, due process, nor the right to confrontation required disclosure.

Bradley v. Eighth Judicial Dist. Court of Nev., 405 P.3d 668 (Nev. 2017).

Background: Based on statements J.A., a minor arrested for soliciting prostitution, made to the police, the State charged Dontae Hudson with first-degree kidnapping, sex trafficking of a child under the age of 16, living from the earnings of a prostitute, and child abuse, neglect, or endangerment. Hudson filed a motion for discovery requesting all of J.A.'s juvenile and delinquency records, including records concerning her court-ordered counseling, for *in camera* review, arguing that the records were relevant to determining J.A.'s competency and credibility. J.A.'s counselor, Dr. Bradley, sought to vacate the order, arguing that the counseling records were protected by psychologist-

patient privilege. The trial court denied the motion but allowed Dr. Bradley to file a petition for a writ of mandamus or prohibition with the Supreme Court of Nevada.

Holding: The Supreme Court of Nevada held that the psychologist-patient privilege applied and was not waived, and therefore the treatment records did not need to be produced for *in camera* review.

Discussion: The Supreme Court of Nevada held that the communications were privileged unless an exception applied or the privilege was waived. The court treated the issue of treatment and psychologist-patient privilege as it had medical conditions and doctor-patient privilege; it found that an exception to privilege applied only if the treatment was an *element* of a claim or defense, but not if the treatment was merely *relevant* for certain purposes (like questioning witness credibility). Disclosure was not otherwise required because (1) no state law requiring disclosure applied, (2) any due process requirement to produce evidence may only be reviewed retroactively under *Brady v. Maryland*, 373 U.S. 83 (1963), and (3) the right to confrontation was not applicable to pre-trial discovery. Finally, the court held that the privilege was not waived although Dr. Bradley shared information about J.A.'s compliance with therapy and others were present at Dr. Bradley's office, because there was no evidence that any significant parts of the *confidential* communications were shared with anyone.

Ineffective Assistance, Rights Waiver: The Supreme Court of South Dakota upheld a sentence because the defendant waived his Fifth Amendment right against self-incrimination and he did not receive ineffective counsel either by failure to warn the defendant of his Fifth Amendment right prior to a psychological evaluation or by failure to request a hearing to determine if institutionalization may be appropriate.

Iannarelli v. Young, 904 N.W.2d 82 (S.D. 2017).

Background: Iannarelli pleaded guilty but mentally ill to charges of first-degree manslaughter for the death of his disabled wife and the second degree-rape of his 14-year-old stepdaughter in exchange for the State not seeking the death penalty. The court requested a psychological evaluation, including a psychosexual evaluation, to assist with sentencing. Dr. Woldt conducted the evaluation and found that Iannarelli posed a high risk to the community and that rehabilitation efforts would be lengthy and difficult. This report was used to support the court's imposition of the maximum possible sentence: 130 years for first degree manslaughter and 45 years for second degree rape. On appeal, Iannarelli claimed that his Fifth Amendment rights were violated because he was not specifically informed of his right against self-incrimination prior to Dr. Woldt's evaluation and his Sixth Amendment rights were violated (i.e., he received ineffective assistance of counsel) when his attorney did not request a hearing to determine if he should receive institutionalization prior to incarceration in a penitentiary.

Holding: The Supreme Court of South Dakota affirmed the trial court on the grounds that the defendant waived his Fifth Amendment right against self-incrimination and therefore did not receive ineffective assistance when he was not specifically warned of his right to

remain silent and his counsel was not ineffective when it failed to request a hearing regarding provisional institutionalization.

Discussion: The Supreme Court of South Dakota held that Iannarelli waived his Fifth Amendment right against self-incrimination because he specifically placed his mental status at issue when he pled guilty but mentally ill and he knew that the statements he made during Dr. Woldt's examination would be used by the court in imposing a sentence. Further, he did not receive ineffective assistance when his counsel failed to request an institutionalization hearing because this motion would have only been appropriate had he been found guilty of an offense. Guilty but mentally ill is a distinct finding with distinct procedures that were correctly followed by counsel and the court regarding the sentencing.

IV. Institute Programs

Please visit the Institute's website at

<http://www.ilppp.virginia.edu/OREM/TrainingAndSymposia>

The Institute will start announcing its offerings for the program year August 2018 through June 2019 in late July. Please visit and re-visit the Institute's website to see new and updated announcements. The Institute appreciates support for its programs. Please share this edition of *DMHL* and share announcements of programs that may interest your professional, workplace, and community colleagues.

Planned programs (to be announced at website during Summer 2018):

Basic Forensic Evaluation: Principles and Practice

September 24-28 2018, Charlottesville VA : This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation. Content includes clinical, legal, ethical, practical and other aspects of forensic mental health evaluation with adults. The format combines lectures, clinical case material, and practice case examples for evaluation of adults. Day five incorporates a report writing exercise required for qualification to evaluate adults in Virginia.

Assessing Risk for Violence in Clinical Practice

Fall 2018: Topics of this one-day program include overview of risk assessment (history, process, ethical considerations), empirically supported risk factors, structured risk assessment instruments, risk communications and report writing. The HCR:20 instrument is presented including an exercise using a case example. Faculty will also discuss proceeding from risk assessment to risk management. This program meets one of the training requirements for clinicians who conduct VA DBHDS Commissioner evaluations for NGRI acquittees.

Evaluating Individuals Found Not Guilty by Reason of Insanity

Fall 2018: This one-day program addresses assessment of persons who have been found Not Guilty by Reason of Insanity (NGRI) in criminal cases and therefore require forensic evaluation regarding commitment or conditional release. Please note that this program is most relevant for VA DBHDS staff involved in evaluation and supervision of NGRI acquittees. This program meets the training requirements for clinicians who conduct VA DBHDS Commissioner-appointed evaluations of NGRI acquittees.

Assessing Risk for Violence with Juveniles

Early 2019: This one-day program trains mental health professionals, juvenile and criminal justice professionals, social and juvenile services agencies, educators, and others to apply current research pertaining to risk assessment with juveniles. Along with theoretical foundations the program includes review of legal parameters, impact of online behavior, and student threats.

Assessing Individuals Charged with Sexual Crimes

Early 2019: This two-day program focuses on the assessment and evaluation of individuals charged with sexual crimes in Virginia. The program provides legal background relevant to assessment involving sexual offenses, overview of paraphilias and base rates of re-offending, and discussion of a well-researched sexual offender risk assessment instrument. This program may meet needs of providers for renewal of SOTP (Sex Offender Treatment Provider) certification in Virginia.

Juvenile Forensic Evaluation: Principles and Practice

Spring 2019: This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation with juveniles. Content includes clinical, legal, ethical, practical and other aspects of forensic evaluation with juveniles. The format combines lectures, clinical case material, and practice case examples for evaluation of juveniles. Day five incorporates a report writing exercise required for qualifications to evaluate juveniles in Virginia.

Evaluation Update: Applying Forensic Skills with Juveniles

Spring 2019: This program is especially for experienced adult forensic evaluators - who have already completed the five-day “Basic Forensic Evaluation” program (regarding evaluation of adults) and accomplished all relevant qualifications for performing adult forensic evaluation - and wish now to complete relevant qualifications to perform juvenile forensic evaluations.

Questions about ILPPP programs or about *DMHL*?: please contact els2e@virginia.edu

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The Editor may be contacted at jeogal@gmail.com

Editor

John E. Oliver, J.D.

Co-Editor

Heather Zelle, J.D., Ph.D.

Managing Editor

Edward Strickler, Jr., M.A., M.A., M.P.H., CHES

ILPPP Research Assistants

Hanaa Khan, Mary Seraj

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