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Articles and information on the following topics appear below:

Alternative Transportation Orders Effectively Utilized Throughout Virginia for Individuals Subject to ECOs and TDOs

By Amy Liao Askew and Jane D. Hickey

During its 2009 Session, the Virginia General Assembly passed landmark legislation, proposed by the Commonwealth of Virginia's Commission on Mental Health Law Reform and its Alternative Transportation Workgroup, authorizing for the first time transportation of individuals under emergency custody ("ECO") and temporary detention ("TDO") orders by someone other than a law-enforcement officer, http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-808; http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-810. The goal of the legislation introduced by then Senator Kenneth T. Cuccinelli and Delegate John O'Bannon was to develop a civil commitment transportation plan that would: (1) "decriminalize" transportation and reduce stigma through lessening Virginia's over-reliance on law-enforcement agencies and the use of restraints in transporting individuals in the civil commitment process, while at the same time ensuring the safety of the person, the transporter and the public, and (2) promote the recovery of the individual by enabling the provision of voluntary

services in the least restrictive manner and setting. At least 27 other states permit transport by someone other than law enforcement, including family, friends, mental health professionals, ambulances and public and private transportation companies, although most, as does Virginia, continue to rely upon law enforcement for a majority of their transports. (Commonwealth of Virginia's Commission on Mental Health Law Reform 2008 Progress Report at 36, found at http://www.courts.state.va.us/programs/cmh/2008_1222_progress_report.pdf.)

Since the legislation went into effect July 1, 2009, the Executive Secretary's Office has been collecting data on magistrates' issuance of alternative transportation orders ("ATOs") for ECOs and TDOs through its *e-Magistrate* database. From July 1, 2009 through December 31, 2010, the last date for which data for this analysis were available, magistrates have issued 241 alternative transportation orders. The number of ATOs increased steadily each quarter in FY10 and in the 1st quarter of FY11. The largest increase occurred from the 1st quarter to the 2nd quarter in FY10 – a 40% increase. The majority of ATOs – 83% - were issued for adults under TDOs. To date, no adverse events have been reported as a result of transportation by people or entities other than law enforcement.

Table 1. Frequency of Alternative Transportation Orders During FY10 in eMagistrate

	eMagistrate: Number of ATOs			
	ECO	**Adult TDO**	**Juvenile TDO**	**Total**
July	1	7	0	8
August	1	1	0	2
September	0	15	3	18
1st Quarter Total	**2**	**23**	**3**	**28**
October	2	6	1	9
November	0	9	0	9
December	1	19	1	21
2nd Quarter Total	**3**	**34**	**2**	**39**
January	0	13	5	18
February	0	9	4	13
March	3	7	1	11
3rd Quarter Total	**3**	**29**	**10**	**42**
April	0	11	4	15
May	1	15	1	17
June	0	15	1	16
4th Quarter Total	**1**	**41**	**6**	**48**
FY10 Total	**9**	**127**	**21**	**157**

Table 2. Frequency of Alternative Transportation Orders During FY11 in eMagistrate

	eMagistrate: Number of ATOs			
	ECO	**Adult TDO**	**Juvenile TDO**	**Total**
July	1	14	1	16
August	0	16	2	18
September	0	15	1	16
1st Quarter Total	**1**	**45**	**4**	**50**
October	2	11	0	13
November	1	4	2	7
December	0	13	1	14
2nd Quarter Total	**3**	**28**	**3**	**34**
FY11 Total	**4**	**73**	**7**	**84**

The most common provider type for ATOs are family members, with 55% providing transportation, followed by medical transport, usually Emergency Medical Services (EMS), at 23%. Finally healthcare providers, including community services boards, have provided 8% of the transportation. The goal of the Mental Health Law Reform Commission is to increase the provision of psychiatric transportation in routine, urgent and emergency situations by both public and private healthcare providers. To do so, a reliable and adequate funding stream must be identified to encourage the development of this service. The downturn in the economy has prevented this goal from being realized.

Law enforcement continues to provide the bulk of transportation services. The Virginia Association of Chiefs of Police conducted a survey in 2008, prior to enactment of this legislation, to ascertain the frequency with which local police agencies, sheriffs' departments, EMS agencies, or others provide transportation for ECOs and TDOs (the "Police Survey"). The Police Survey determined that local police provide transportation for ECOs and TDOs approximately 75% of the time and sheriffs' departments provide transportation the remainder of the time. In addition, sheriffs provide transportation following the commitment hearing. Given that there are at least 20,000 civil commitment hearings in Virginia annually, this represents a significant demand on sheriffs' resources. To better understand this demand, the Sheriffs' Association completed a staffing study during the spring of 2008 (the "Sheriff's Study") finding that 26.3 additional full time equivalent (FTE) positions are needed for Sheriffs' Departments statewide to provide necessary services related to Virginia's involuntary civil commitment process. Even with enactment of the ATO legislation, the division of labor between local police and sheriffs remains about the same and the burden on local law enforcement remains. (*Id*. at 35-36)

Neither police departments nor sheriffs departments receive specific funding either for executing ECOS, TDOS or providing transportation following a commitment hearing. Law-enforcement officers continue to spend up to four hours, and often much longer, in hospital emergency departments waiting for completion of medical assessments and CSB evaluations, and for the CSB to locate a temporary detention bed.

Thereafter, due to a shortage of psychiatric beds in some localities, even longer hours may be spent transporting individuals outside the jurisdiction to other parts of the state, necessitating taking two officers and a vehicle off of the street and away from other law enforcement duties needed in that locality. Overtime expenses are often incurred in transporting individuals to mental health facilities. (*Id.* at 35.)

Table 3. Alternative Transportation Order Provider Type During FY10 in *eMagistrate*

	ATO Provider Type						
	Family	**Friend**	**Medical Transport**	**Law Enforcement**	**Healthcare Provider**	**Not Recorded**	**Total**
July	4	1	3	0	0	0	8
August	1	0	0	1	0	0	2
September	10	0	5	2	1	0	18
1st Quarter Total	**15**	**1**	**8**	**3**	**1**	**0**	**28**
October	4	1	2	1	1	0	9
November	3	0	3	1	2	0	9
December	10	1	6	0	4	0	21
2nd Quarter Total	**17**	**2**	**11**	**2**	**7**	**0**	**39**
January	10	1	4	1	2	0	18
February	6	0	4	0	2	1	13
March	5	2	3	0	1	0	11
3rd Quarter Total	**21**	**3**	**11**	**1**	**5**	**1**	**42**
April	10	1	2	0	2	0	15
May	11	0	1	2	2	1	17
June	13	0	3	0	0	0	16
4th Quarter Total	**34**	**1**	**6**	**2**	**4**	**1**	**48**
FY10 Total	**87**	**7**	**36**	**8**	**17**	**2**	**157**

Table 4. Alternative Transportation Order Provider Type During FY11 in *eMagistrate*

	ATO Provider Type						
	Family	**Friend**	**Medical Transport**	**Law Enforcement**	**Healthcare Provider**	**Not Recorded**	**Total**
July	10	3	1	1	0	1	16
August	8	1	5	1	2	1	18
September	9	0	5	2	0	0	16
1st Quarter Total	**27**	**4**	**11**	**4**	**2**	**2**	**50**
October	6	0	5	1	0	1	13
November	5	0	0	1	1	0	7
December	7	1	4	0	0	2	14
2nd Quarter Total	**18**	**1**	**9**	**2**	**1**	**3**	**34**
FY11 Total	**45**	**5**	**20**	**6**	**3**	**5**	**84**

A key complaint leading to the establishment of the Commission on Mental Health Law Reform forcefully presented by members of the Senior Lawyers Conference of the Virginia State Bar was that elderly people in nursing homes in need of psychiatric care were being forced to be transported by law enforcement in patrol cars and in restraints to psychiatric facilities, resulting in increased trauma and often bad outcomes for them. The Police Survey referenced above also found that use of restraints for persons being transported in the civil commitment process is mandatory policy for 61%

of police personnel providing transportation and is at the officer's discretion in approximately 29% of police departments. In those jurisdictions where an officer has discretion concerning the use of restraints, specific policy guidance for use of the officer's discretion was lacking and it was unclear how often that discretion is used to forgo restraints. (*Id*. at 35.) Moreover, the coercive nature of law enforcement transportation, including the use of restraints, has been found to impede individuals' recovery. (Swanson et al. "Psychiatric advance directives and reduction of coercive crisis interventions," *Journal of Mental Health,* 17:3, 225-267, June 2008.)

Although just over 50% of ATOs have been issued for adults between the ages of 19-64, the data for FY10 indicate that 30.8% of the individuals for whom an alternative transportation order was issued were age 65 and older. During the first half of FY11, 32.1% of individuals were over age 65. Stories also emerged of children as young as 10 being transported handcuffed in the back of police cars, often without parents or family riding with them. In FY10, 14.7% of ATOs were issued for minors, and 8.3% in the first half of FY11. Passage of the ATO legislation has therefore been effective in providing a safe transportation alternative for these vulnerable people.

Table 5. Alternative Transportation Orders by Age Group during FY10 in *eMagistrate*

Age Group for FY10

	Frequency (n)	Percent (%)
18 and under	23	14.7
19-64	85	54.5
65 and over	48	30.8
Total	156	100.0

Table 6. Alternative Transportation Orders by Age Group during FY11 in *eMagistrate*

Age Group for FY11

	Frequency (n)	Percent (%)
18 and under	7	8.3
19-64	47	56.0
65 and over	27	32.1
Total	81	100.0

Importantly, ATOs are being issued in every region in the Commonwealth with no adverse events being reported. Southwest Virginia, and especially Wise County, lead the way with 11.5% of the ATOs issued in Wise County in FY10 and 8.3% in the first half of FY2011 alone. Following Wise County in FY10 was Henrico County and the Cities of Lynchburg, Newport News and Portsmouth, with 4.5% each. In the first half of FY11, the Cities of Suffolk and Virginia Beach followed Wise County issuing 6% of the total each, followed by Henrico County at 4.8%. The Commission has speculated that in rural Southwest Virginia with its significant transportation challenges, people are already

inclined to help friends and family with transportation problems, and also know each other better. They are therefore better able to predict someone's behavior and proclivity for violence (of lack thereof) and are thus more willing to take a risk. Nonetheless, the data reveals that in urban areas, such as Lynchburg, Newport News and Portsmouth, and suburban areas, such as Henrico County, the safe use of alternative transportation is also possible.

Table 7. ATO Issuance by Locality in FY10 in *eMagistrate*

	Frequency (n)	Percent (%)
Accomack	1	.6
Albemarle	1	.6
Alleghany	1	.6
Arlington	3	1.9
Bath	1	.6
Bedford County	1	.6
Buchanan	2	1.3
Caroline	1	.6
Carroll	1	.6
Chesterfield	1	.6
Culpeper	3	1.9
Dickenson	4	2.5
Fairfax County	3	1.9
Franklin County	2	1.3
Gloucester	4	2.5
Hanover	6	3.8
Henrico	7	4.5
Henry	1	.6
Isle of Wight	1	.6
King William	2	1.3
Lee	3	1.9
Loudoun	1	.6
Mecklenburg	1	.6
Montgomery	5	3.2
Patrick	1	.6
Prince Edward	3	1.9
Prince George	1	.6
Prince William	2	1.3
Rockingham	3	1.9
Russell	1	.6
Scott	1	.6

Stafford	1	.6
Tazewell	2	1.3
Washington	5	3.2
Wise	18	11.5
York	6	3.8
Alexandria	4	2.5
Buena Vista	1	.6
Chesapeake	5	3.2
Emporia	1	.6
Hampton	3	1.9
Harrisonburg	2	1.3
Hopewell	1	.6
Lynchburg	7	4.5
Newport News	7	4.5
Petersburg	4	2.5
Portsmouth	7	4.5
Richmond	2	1.3
Richmond	1	.6
Roanoke	2	1.3
Salem	1	.6
Staunton	1	.6
Suffolk	1	.6
Virginia Beach	3	1.9
Williamsburg	4	2.5
Total	157	100.0

Table 8. ATO Issuance by Locality in FY11(first half) in eMagistrate

	Frequency	Percent
Accomack	3	3.6
Alexandria	1	1.2
Bland	1	1.2
Botetourt	1	1.2
Buchanan	3	3.6
Buckingham	1	1.2
Charlottesville	1	1.2
Chesapeake	3	3.6
Chesterfield	3	3.6
Culpeper	1	1.2

Dickenson	1	1.2
Essex	1	1.2
Fairfax	1	1.2
Gloucester	2	2.4
Halifax	2	2.4
Hampton	3	3.6
Hanover	1	1.2
Henrico	4	4.8
Henry	1	1.2
Isle of Wight	1	1.2
Lancaster	2	2.4
Louisa	1	1.2
Lynchburg	2	2.4
Mathews	1	1.2
Middlesex	1	1.2
Montgomery	2	2.4
Newport News	1	1.2
Pulaski	1	1.2
Radford	1	1.2
Richmond County	1	1.2
Russell	1	1.2
Scott	2	2.4
Shenandoah	1	1.2
Smyth	1	1.2
Suffolk	5	6.0
Tazewell	3	3.6
Virginia Beach	5	6.0
Warren	1	1.2
Washington	1	1.2
Westmoreland	2	2.4
Williamsburg	1	1.2
Winchester	2	2.4
Wise	7	8.3
Wythe	1	1.2
York	3	3.6
Total	84	100.0

The above data demonstrates that individuals may be transported safely by providers other than law enforcement. Developing a targeted funding stream to provide

effective and efficient routine, urgent and emergency transportation for individuals to obtain psychiatric care would greatly reduce the enormous burden on law enforcement, reduce the stigma associated with mental illness, reduce the trauma associated with law enforcement transport and assist individuals in their recovery.

Please provide any comments you may have or any anecdotal information about the use of Alternative Transportation Orders to jhickey080@gmail.com.

Use of Advance Directives by People with Serious Mental Illness under Virginia's Health Care Decisions Act: Implementation of a Major Public Health Reform
Project Overview: December 31, 2010

By Richard J. Bonnie, Harrison Foundation Professor of Law and Medicine, University of Virginia School of Law

In 2009, the Virginia General Assembly enacted major amendments to the Commonwealth's Health Care Decisions Act (HCDA). The revisions were based on recommendations of the Supreme Court's Commission on Mental Health Law Reform, which had solicited extensive input from and involvement of a broad spectrum of stakeholder groups during a two-year period of deliberation and drafting (Bonnie et al., 2009). Because of the statutory revisions enacted in 2009 and 2010, the HCDA now provides a legal mechanism for persons with chronic health conditions, including serious mental illness (SMI), to document, while competent, their treatment instructions and preferences, and to authorize a healthcare agent to make treatment decisions for them during periods of incapacity, http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2981. These advance directives may also contain individualized, patient-centered plans to prevent crises, as well as to manage and recover from them.

Legal advance directives for mental health treatment represent an innovative and promising approach for promoting treatment engagement and continuity of care for people with serious mental health conditions and could play a significant role in improving long-term health and safety outcomes for this population (Swanson et al., 2006; 2008; Wilder et al., 2007; 2010). A major goal of these directives is to empower psychiatric patients to control their own care and, in so doing, to reduce the need for coercive interventions during mental health crises (Swanson et al., 2000, Scheyett et al., 2007).

With strong support from policymakers and stakeholders alike, Virginia is undertaking an unprecedented effort to effectuate the goals of the HCDA. Beginning in January, 2010, the key stakeholder groups have initiated a multi-pronged consensus-based strategy to promote use of advance directives by mental health consumers and to assist them in completing and executing these legal instruments. This effort was coordinated and overseen during 2010 by the Commission on Mental Health Law

Reform, and is now coordinated and overseen by a Coordinating Committee for Promoting Use of Advance Directives by People with Mental Illness. The Coordinating Committee comprises representatives from key private organizations and public agencies and its work is administered by an Executive Committee.

Activities undertaken by the Coordinating Committee include the following:

- The Department of Behavioral Health and Developmental Services is supporting initiatives by public mental health service providers to incorporate advance directive facilitation into routine clinical care. Community mental health services agencies in four localities are serving as "vanguard sites" for these initiatives, which began in the summer and fall of 2010.
- Advocacy organizations, including NAMI, VOCAL, the Mental Health America, and VOPA, are taking steps to facilitate the use of advance directives by members of their organizations and the people they serve.
- Standardized advance directive forms have been developed under the auspices of the Virginia Hospital and Healthcare Association.
- Health law experts, including the Office of the Attorney General, are undertaking coordinated activities to clarify the legal aspects of executing and enforcing advance directives.
- Training workshops have been organized to help disseminate more information about the law to advocates and health care providers.
- New administrative data elements are being added to electronic health records to document facilitation and execution of advance directives.
- A web site has been established to provide ready access to resources regarding advance directives for persons with mental illness and to provide information and guidance regarding the legal effect of executing an advance directive under Virginia law: www.advancedirectivesva.com.

Successful implementation of Virginia's Health Care Decisions Act may hold valuable lessons for other states seeking more cost-effective, ethical, and person-centered means to address the serious public health problem posed by untreated mental illness in the community. However, the scope and effect of these facilitation efforts on practice and clinical outcomes is still unknown. Consequently, a research study is being conducted by a team of investigators from the University of Virginia and Duke University to assess the effects of those efforts on a continuing basis.

The first component of the research was completed during the first half of 2010. Taking advantage of initial dissemination and training activities, the goal of this portion of the study was to collect baseline data on knowledge, attitudes and experience regarding the new HCDA statute. Key stakeholders including hospital and community service board (CSB) administrators, clinicians, and other stakeholders (including mental health service users, family members, and advocates of those vested in the care of individuals with diagnosed mental illness) were surveyed to assess their knowledge of

and attitudes about the HCDA. A total of 485 respondents across all sampled stakeholder groups completed the online survey. Data analyses are underway.

The second component of the study, initiated in the fall of 2010, examines the process of facilitating and completing advance directives for persons with SMI in two of the "vanguard" CSBs; it will feature focus group sessions with facilitators and interviews with a sample of individuals who execute these documents after facilitation. Initial follow-up interviews will ascertain whether consumers are satisfied with the process of completing advance directives and are finding those documents beneficial to their health care and recovery. Subsequent follow-up interviews will seek to ascertain the effect of executing advance directives on treatment engagement, the occurrence of mental health crises and on the use of coercive interventions. Ultimately, this information will yield recommendations for improving the process of facilitating advance directives, which, in turn, can increase the number of people with SMI who execute advance directives.

The third component of the research will measure the number and content of advance directives executed by the target population in the four vanguard sites and will examine de-identified data from electronic health records in these three sites to compare clients who have executed advance directives and those who have not on a number of clinical and service parameters.

The study's findings will be used to develop specific recommendations to improve implementation of the HCDA in Virginia and will also be disseminated nationally to inform policymaking in other states.

The research project is being supported by grants from the Robert Wood Johnson Foundation Public Health Law Research Program, the John D. and Catherine T. MacArthur Foundation Research Network on Mandated Community Treatment, the University of Virginia Law School Foundation, and the Virginia Department of Behavioral Health and Developmental Services in cooperation with the SAMHSA Center for Mental Health Services and the David L. Bazelon Center for Mental Health Law.

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Advance Directive Websites Available to Provide Information and Forms for Those Interested in Executing Advance Directives

As referenced above an Advance Directive website created under the auspices of John Oliver, retired Chesapeake Deputy City Attorney and volunteer, is now available providing access to resources regarding advance directives for persons with mental illness as well as guidance concerning the legal effects of executing advance directives under Virginia law: www.advancedirectivesva.com. **John Oliver invites you to visit the website and send him your reactions and recommendations at** jeo99@hotmail.com.

In addition, Mental Health of America Virginia is currently developing a more advanced and user-friendly site at www.advancedirective.org. **Curt White also invites people to visit this site and provide him with your reactions and recommendations at** curt.white@mhav.org.

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Recently Decided and Pending Cases

Georgia Enters Precedent-Setting Settlement Agreement with Department of Justice

In order to settle the United States Department of Justice lawsuit brought against it under the Americans with Disabilities Act, the State of Georgia agreed on October 19, 2010 to substantially change its service delivery system for both persons with intellectual disabilities and mental illness by emphasizing community-based care over institutional settings. *United States v. Georgia*, N.D. Ga No. 1:10-cv-249-CAP, http://www.justice.gov/crt/about/spl/documents/georgia/US_v_Georgia_ADAsettle_10-19-10.pdf. The Settlement Agreement is remarkable in its commitment to institute sweeping changes to the entire developmental disability and mental health service delivery system. Key portions of the agreement include:

For persons with developmental disabilities,

- stop all admissions to its facilities for persons with intellectual disabilities by July 1, 2011
- transition its residents with intellectual disabilities to community settings by July 1, 2015
- apply for 1150 home and community based waivers by July 1, 2015; 750 for those transitioning from state hospitals; 400 to help prevent institutionalization for those currently in the community
- provide family supports to 2350 families by July 1, 2015
- establish 6 mobile crisis teams by July 1, 2012
- establish 12 crisis respite homes by July 1, 2014 to provide respite services to persons with developmental disabilities and their families

For persons with mental illness,

- serve 9,000 people with serious mental illness in community settings by July 1, 2015. The target population consists of people currently served in state hospitals with frequent readmissions or seen in emergency rooms, including those who are chronically homeless or in and out of jail
- establish 22 PACT teams by July 1, 2013
- establish 8 community support teams by July 1, 2014 to provide services to people in their own home and ensure community resources for those who remain in their own home
- establish 14 intensive case management teams by July 1, 2015
- hire 10 full-time case managers that will coordinate treatment and support services and assist individuals with accessing community resources
- develop 45 case management service providers by July 1, 2015 to coordinate treatment and support services and help maintain services and supports already in place
- establish 6 crisis service centers by July 1, 2015 to provide walk-in psychiatric and counseling services that are clinically staffed 24 hours per day/7 days per week to serve individuals in crises
- add 3 crisis stabilization programs by July 1, 2014
- add 35 community based psychiatric hospital beds in non-state community hospitals
- establish a toll free telephone access system for people to obtain information about community resources
- establish mobile crisis teams in every county by July 1, 2015
- establish 18 crisis apartments by July 1, 2015 as an alternative to crisis stabilization programs and psychiatric hospitalization
- provide supportive housing to 9000 people with serious and persistent mental illness by July 1, 2015
- provide housing supports to 2000 people ineligible for benefits by July 1, 2015
- provide bridge funding to 540 people by July 1, 2014 to support their transition to supported housing
- provide 550 people with supported employment by July 1, 2015

- provide peer support services to PACT and CST services by July 1, 2014 for an additional 835 people
- hire one case manager and one transition specialist per state hospital by July 1, 2010

Georgia will also develop an annual network analysis to assess availability of community supports by July 1, 2012 and develop a quality management system by July 1, 2012 to perform annual quality service reviews of community services under the agreement. Georgia will also fund an independent reviewer to assess the state's compliance with the Agreement.

Supreme Court Hears Arguments Whether Protection and Advocacy Agency May Sue State Officials to Access Peer Review Records

The United States Supreme Court heard oral argument on December 1, 2010 in *Virginia Office for Protection and Advocacy v. Stewart,* 568 F.3d 110 (4th Cir. 2009) *pet. for cert*. granted (U.S. No. 09-529, June 21, 2010), as to whether one independent state agency, the Virginia Office for Protection and Advocacy, may sue other state officials, namely the Commissioner of the Department of Behavioral Health and Developmental Services and the directors of two state facilities, to enforce the requirements of the Protection and Advocacy for Individuals with Mental Illness Act or 1986 ("PAIMI"), 42 U.S.C §§ 10801-10851 and the Developmental Disabilities Assistance and Bill of Rights Act ("DD Act"), 42 U.S.C. §§ 15001-15115. The 4th Circuit had reversed the decision of the federal district court, refusing to allow VOPA to sue the Commissioner and directors of Central State Hospital and Central Virginia Training Center to obtain peer review records related to the deaths of two individuals and the severe injury of a third. The 4th Circuit refused to apply the *Ex parte Young* doctrine which permits law suits by private parties to enforce federal law and obtain injunctive relief, but not monetary damages, from individual state officials in federal court. The court found that the lawsuit could otherwise be brought in state court.

Indiana is also seeking Supreme Court review in a similar case in which the 7th Circuit *en banc* held that the Indiana Protection and Advocacy agency could sue. *Indiana Family and Social Services Administration v. Indiana Protection and Advocacy Services*, 603 F.3d 365 (7th Cir. 2010) *en banc, pet. for cert.* filed, (No. 10-131, July 21, 2010). In addition to the *Ex parte Young* arguments heard in the Virginia case, Indiana is also arguing that PAIMI does not create a private right of action and peer review documents are protected against disclosure under state law.

Should the Supreme Court rule in the DBHDS Commissioner's favor in VOPA v. Stewart, VOPA would need to file a new lawsuit in state court to seek access to peer review records. If the Supreme Court rules in VOPA's favor, the case will be remanded back to the United States District Court in Richmond for a determination of the case on the merits. Four other federal circuits have already ruled that the state's protection and advocacy agency has access to peer review records. *Pennsylvania Protection and*

Advocacy, Inc. v. Houstoun, 228 F.3d 423 (3rd Cir. 2000); *Center for Legal Advocacy v. Hammons*, 323 F.3d 1262 (10th Cir. 2003); *Missouri Protection & Advocacy Services v. Missouri Department of Mental Health*, 447 F.3d 1021 (8th Cir. 2006). *Protection and Advocacy for Persons with Disabilities v. Mental Health and Addiction Services*, 448 F.3d 119 (2nd Cir. 2006).

Sixth Circuit Refuses to Vacate Tennessee Consent Decree Involving Conditions in Arlington Development Center

The 6th Circuit Court of Appeals has refused to vacate a consent decree and court orders entered in the 1993 lawsuit concerning conditions at the Arlington Development Center. *United States v. Tennessee*, 615 F.3d 646 (6th Cir. 2010). In the lawsuit originally brought by the Department of Justice under the Civil Rights of Institutionalized Persons Act, the trial court had found that the Tennessee Department of Mental Health and Developmental Disabilities had failed to provide individuals residing in ADC with medical care, and keep them free from abuse and neglect and undue bodily restraint. Tennessee sought to have the consent decree vacated on the grounds that there was a change in the law between the time the federal trial court approved the consent decree and entered orders enforcing its terms. Tennessee argued that "state control" changed the standard for determining when a resident is voluntarily confined as opposed to a person being placed involuntarily in a state-operated facility.

The Court stated that even though there was a split in the courts as to whether the state owes an affirmative constitutional duty of care and protection to voluntarily admitted residents as it owes to involuntarily committed individuals under *Youngberg v. Romeo*, the 6th Circuit had not ruled on the issue. It also noted that although individuals with intellectual disabilities are considered "voluntary" residents in Tennessee and are free to leave the facility at any time they wish, they are admitted with the consent of their parents or guardians and are at their mercy as to whether they will remain placed at the facility. The Court also recognized the comprehensive involvement of the state in every facet of a resident's daily life, including provision of their food, transportation, shelter, medical care and protection, and that they generally remain in the state's care for years. The Court therefore held that there had been no change in the law since entry of the consent decree and subsequent orders that would warrant vacation of the consent decree.

Fourth Circuit holds Government Cannot Forcibly Medicate Incompetent Defendant Due to Special Circumstances.

In *United States v. White*, 620 F.3d 401 (4th Cir. 2010), the 4th Circuit Court of Appeals determined that the government's usually strong interest in prosecuting someone charged with six felony offenses was too diminished in this case by "special circumstances" to make it constitutional to involuntarily medicate the defendant with antipsychotic drugs to restore her competency to stand trial. The defendant, charged with conspiracy, credit card fraud and identity theft, had already spent 41 months locked up

and the estimate was that it would take another ten months before she would be competent to stand trial if treated with medication.

Prior to involuntarily medicating a defendant to restore his competency to stand trial, the United States Supreme Court held in *Sell v. United States*, 539 U.S. 166 (2003), that the government must establish that the treatment must 1) serve an important government interest, 2) be substantially likely to succeed without significant side effects, 3) be necessary in light of alternatives, and 4) be "medically appropriate." Applying the *Sell* standard, the 4th Circuit found in *United States v. Bush*, 585 F.3d 806 (4th Cir. 2009) that the government must establish the *Sell* requirements by clear and convincing evidence. It also held that the government must establish not only that it has an important interest in involuntarily medicating the defendant, but also that this interest is not mitigated by special circumstances in a particular case.

Courts have generally found that a ten year maximum sentence constitutes a sufficiently serious crime to establish an important governmental interest. In this case, the defendant's sentence if found guilty would likely range from 42-51 months; she had already been confined for 41 months; and the estimate was that it would take another ten months to render her competent. In addition, the crime charged was nonviolent; she was not a danger to herself or the public; her conviction met requirements for the federal ban on possession of firearms; and there was considerable ambiguity as to the side effects and effectiveness of antipsychotic medication because she suffered from a "rare form of delusional disorder." Of note, Judge Barbara Milano Keenan added a concurring opinion stating that this case was not one of those exceptional cases contemplated by *Sell* and that a contrary ruling would come "perilously close to a forcible medication regime best described…as routine." The Court therefore refused to authorize the government to forcibly medicate the defendant to restore her competency to stand trial.

Mentally Incompetent Defendant Has No Due Process Right Against Being Tried, Committed and Treated as Sexually Violent Predator

Overturning the decision of the California Court of Appeals, the California Supreme Court in a split decision has ruled that a mentally incompetent defendant has no due process right to avoid being tried and committed as a sexually violent predator. *Moore v. Superior Court of Los Angeles County, California*, 237 P.3d 530 (2010). The court held that due process does not require mental competence on the part of someone undergoing a commitment or recommitment trial, which is a civil proceeding under the California Sexually Violent Predators Act. The strong governmental interest in protecting the public through the proper confinement and treatment of SVP's would be substantially thwarted by recognizing an SVP's right to delay or avoid confinement and treatment for a sexually violent mental disorder because his problems render him incompetent to stand trial. Recognition of such a due process right could prevent an SVP determination from being made at all. Such a scenario could often recur and would undermine the purpose and operation of the Act. The court found that public safety could suffer as a result.

Frequently Asked Questions Related to Virginia's Commitment Process

The Institute of Law, Psychiatry and Public Policy plans to include answers in ***Developments*** to frequently asked questions that significantly impact implementation of the commitment process in Virginia. Answers will be a product of consensus developed to the extent possible among the Executive Secretary's Office of the Virginia Supreme Court, the Virginia Department of Behavioral Health and Developmental Services and the Virginia Office of the Attorney General. Some questions are currently under review by these entities and will be included in future issues. **If you have questions that impact the commitment process, please submit them with clarifying information and your contact information for follow-up to** jhickey080@gmail.com.