DEVELOPMENTS IN MENTAL HEALTH LAW

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Reducing Mental Health Civil Commitments through Longer Temporary Detention Periods

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When an individual experiences a mental health crisis, Virginia law permits that individual to be detained up to 48-hours plus weekends and holidays for evaluation and emergency treatment under a temporary detention order (TDO). After 48-hours, authorities must hold a civil commitment hearing. The four possible hearing outcomes are dismissal of the commitment petition, mandatory outpatient treatment (MOT), voluntary hospitalization, and involuntary hospitalization. Currently, Virginia is one of only three states that require a commitment hearing be held within 48 hours of initial detention. At the other extreme, three states allow up to 30 days for a hearing. Most states, however, require a hearing within four to eight days. Not only is Virginia's 48-hour TDO period among the shortest in the nation, but often commitment hearings occur less than 24-hours from the start of the detention (Barclay, 2007). The drawback of a short detention period is that it may not allow sufficient time to stabilize and evaluate individuals. Virginia is currently considering extending the 48-hour limit to 72-hours (Commission on Mental Health Law Reform, Progress Report, 2009), a scaled-back version of a recommendation to extend it to four or five days (Commission on Mental Health Law Reform, Preliminary Report, 2007). The longer time period is expected to allow time for adequate evaluation and crisis stabilization, thereby leading to lower rates of involuntary commitment (Commission Progress Report, 2009).

To determine whether longer TDO periods could be effective at reducing the need for involuntary commitment and its associated stigma and trauma, we utilized the natural variation in TDO length in Virginia. While Virginia requires a hearing within 48-hours when possible, the length of the TDO period can in fact extend up to five days if the detention falls during a holiday weekend. This natural variation provides an opportunity to compare the effect of different TDO lengths on hearing outcomes and subsequent hospitalization. A new Court Management Systems (CMS) database began tracking TDOs and hearing outcomes across the state in 2008. We combined CMS data with Medicaid data on hospitalization claims, which allowed us to match the length of a TDO

and hearing outcome with the length of the subsequent hospital stay for a sample of Medicaid recipients.

Due to lack of data there has been relatively little research into the effect of temporary detention on subsequent commitment outcomes. Virginia's Commission on Mental Health Law Reform studied commitment hearings during May 2007, which assessed over 1500 civil commitment hearings in Virginia (Commission Hearing Study, 2008). The study found that most (80%) civil commitment hearings resulted in inpatient hospitalization, whether voluntary or involuntary. The study also found a significant variation in TDO length across Virginia. It appeared that the variation was a result of differences in the types of information and personnel involved in the hearings and differing scheduling practices. However, there was insufficient data on subsequent hospitalization to identify a link between TDOs and hospitalization length.

Barclay (2007) reviewed data from Virginia, Colorado, Massachusetts and Pennsylvania on lengths of stay in inpatient facilities before and after commitment hearings. She concluded that Virginia's short TDO period was generally considered inadequate for a thorough assessment of the individual. The TDO period allows patients to stabilize and, if necessary, detoxify and enables clinicians to make more accurate assessments. The result is to increase the likelihood that a case will be dismissed at the hearing or that the patient will agree to voluntary hospitalization in lieu of commitment. TDOs that are too short may also increase the probability of an error in the decision-making process leading up to the commitment hearing.

In the investigation of the April 16, 2007 shooting at Virginia Tech, the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services found that the mental health examinations performed in connection with commitment hearings are often very brief and fail to capture potentially important information about the individual in question. The study found that the short time period from detention to commitment hearing "makes it very difficult, if not impossible, to collect and consider additional collateral information about the individual. This also makes it difficult to complete the physical exam and psychiatric evaluation, assessment and treatment plan before the commitment hearing is held." These findings have led some policymakers to consider the costs and benefits of extending the TDO period.

Methods

Data were obtained by combining the new CMS database on commitment hearings with Virginia's Medicaid claims files. There were a total of 2,780 records from the CMS database that contain both a start date of the TDO, the date of the commitment hearing, and the hearing result (involuntary, voluntary, dismissal, and MOT) over a three quarter period from July 1, 2008 through March 31, 2009. These records were matched to Virginia's Medicaid claims file. The Medicaid claims file provided information on the length of the hospitalization, if any, that immediately followed the commitment hearing, as well as information on the age, race, sex and primary diagnosis of the Medicaid recipients.

After excluding entries with incomplete records or data entry errors, and removing outliers that had a hospital stay of more than 21 days, or two standard deviations from the mean, our dataset included 500 observations. Of the observations, 102 cases were dismissed (N=99) or resulted in mandatory outpatient treatment (MOT) orders (N=3), 153 agreed to voluntary hospital commitments, and 245 were involuntarily committed.

Although the dataset is only a small subset of the total number of individuals who had a TDO, to the extent that sample of data is random the statistical analysis is valid. One potential source of bias is the number of observations from each CSB. The Commission's Hearing Study (2008) found significant variation in TDO practice across the CSBs. Our dataset contained a disproportionally large number of observations from the Blue Ridge Behavioral Healthcare CSB, which had 188 observations or 27 percent of the total. If outcomes at this CSB are systematically different from those at the average CSB, then the results may be biased. A t-test was used to compare the means for post-TDO hospitalization days and TDO length from the Blue Ridge Behavioral Healthcare CSB with the mean from the entire sample. The Blue Ridge Behavioral Healthcare CSB did not have a statistically different number of post-TDO hospitalization days, with a mean of 4.21±0.35 relative to a mean of 4.39±0.26 for the sample. Clients did have shorter average TDO periods (1.38±0.06) than the sample mean (1.63±0.05). However, the Blue Ridge Behavioral Healthcare CSB had a wide range of TDO lengths, from 19 observations having less than 24-hour TDOs, 103 observations with 1-day TDOs, 41 observations with 2-day TDOs, and 25 observations with 3-day TDOs. The wide range suggests that the lengths are not skewed toward a specific TDO length and may still be representative of the range of TDOs in Virginia.

Analysis

The first part of our analysis investigated the relationship between length of TDO and TDO hearing outcome. The data reflect a positive correlation between TDO length and the likelihood of dismissal. Individuals with a TDO length of less than 24 hours end up involuntarily committed 69 percent of the time and dismissed only 9 percent of the time. After a 3-day TDO, the percent of dismissed, voluntary and involuntary commitments were approximately equal and after a TDO of 4 days 59 percent were dismissed.

The second part of the analysis focused on how the length of the TDO relates to the length of the subsequent hospitalization using multivariate regression analysis. Longer TDO days are expected to be associated with shorter post-TDO hospitalizations. We tested this hypothesis by looking at the relationship between hospitalizations and TDO length, where dismissals/MOTs signify zero hospital days. The dependent variable, hospitalization days, is the number of continuous days that an individual was hospitalized following the commitment hearing, from 0 through 21 days. Individuals with more than 21 days of hospitalization (N=8) were excluded from the study. Many of these extended

stays are individuals who are hospitalized indefinitely and only go to the commitment hearing to have their stays renewed.

One concern is that individuals with more severe mental illnesses may have consistently longer or shorter TDO periods and longer hospital stays. However, the length of the TDO and the timing of the commitment hearing is a function of the administrative structure of the local jurisdiction, rather than a response to the health or mental state of the individual (CSB Emergency Evaluation 2008). Therefore, the severity of illness does not appear to be a third variable that affects *both* TDO length and hospitalization length.

In both the logistic and multivariate regressions, we controlled for the CSB where the TDO was located, as well as sex, age, and race. We also controlled for the primary diagnosis from the Medicaid claims file, based on ICD-9 codes, which are the codes used by Medicaid for classifying diseases and health related problems. By controlling for individual characteristics and diagnosis we were able to rule out those differences as the reason for the correlation between TDO and hospitalization length.

Results

Results from the logistic regressions showed that longer TDO periods were correlated with a lower probability of hospitalization and, when hospitalization did occur, a lower probability of involuntary hospitalization, even after taking into account individual and community characteristics. In looking at dismissal/MOTs versus hospitalization, TDO days was negatively correlated with the TDO hearing result. The negative odds ratio of 0.66 (95% CI 0.52-0.82), means that longer TDO periods decreased the probability that an individual was hospitalized and increased the probability that an individual's case was dismissed. Furthermore, being male, non-white, and older increased the probability of an individual being hospitalized at any given TDO length. The CSB region was also significant in predicting whether an individual would be dismissed or hospitalized following the TDO period. This suggests that the correlation between TDO length and hospitalization also is influenced by individual and community characteristics. However, further research is needed to fully understand why those relationships arise and what the policy implications may be.

In addition to hospitalizations, we also examined whether longer TDO periods were positively correlated with voluntary rather than involuntary hospitalization. We analyzed voluntary versus involuntary hospitalization using a logistic model where dismissal/MOTs were excluded from the sample. Looking exclusively at hospitalized individuals, TDO days again had an odds ratio of less than one (OR 0.73; 95% CI 0.59-0.90). In other words, more TDO days decreased the probability of an involuntary hospitalization and increased the probability of a voluntary hospitalization.

Based on the logistic regression coefficients we also calculated the expected probability of hospitalization. With all other variables held constant at their means, the probability of hospitalization for TDOs occurring the same day was 0.921, while the probability of hospitalization for TDOs lasting 3 days was 0.765. If the TDO period was

extended from 2 to 3 days (48 to 72 hours), as is being proposed in Virginia, then the probability that an individual is hospitalized after the TDO period would be reduced by 0.068 or 6.8 percent.

When an individual was held less than 24 hours, there was a 72.7 percent chance of involuntary hospitalization. The probability dropped to a 43.3 percent chance after a 4 day TDO. The results were consistent with the proposed increase in TDO length from 2 to 3 days leading to an increase of 7.7 percent in the probability of a voluntary rather than involuntary hospitalization.

The second part of our analysis focused on how TDO days relate to the length of hospitalization for those who are voluntarily admitted or involuntarily committed. We examined both the full sample and only individuals who were hospitalized. Using a multivariate regression model, we found that fewer TDO days were correlated with longer post-TDO hospitalizations. However, the total hospitalization time, including both the TDO period plus post-TDO commitment, generally increased as TDO length increased.

We looked at the effect of different TDO lengths on hospitalization by treating the TDO length as a categorical or dummy variable, rather than a continuous variable. The result should be interpreted as the importance of the specified number of TDO days relative to a TDO of 0 days (i.e. less than 24 hours). For the full sample, increasing the TDO length from 0 to 2 days was correlated with a reduction in the post-TDO hospital stay by 1.211 days. Similarly, increasing the TDO length from 0 to 3 days was correlated with an increase in the expected post-TDO hospital stay by 2.004 days. This suggests that increasing the TDO length from 2 to 3 days, as is currently being proposed, would be correlated with a reduction in post-TDO hospital stays by 0.8 days. The only net reduction in total care time (TDO plus post-TDO days) occurred when the TDO length increased from 0 to 1 day, which reduced the post-TDO length by more than one day (1.347 days).

Impact on the State

Finally, to estimate the impact on the Commonwealth of Virginia, we used the results of this study to extrapolate the effect of changing TDO law from its current maximum of 48 hours to 72 hours of detention prior to a commitment hearing. To estimate the effect on overall detention and hospital days, we first estimated the expected increase in TDO days that individuals are held under the longer TDO period. The second step was to determine the expected reduction in days of post-TDO hospitalizations attributable to the lengthier TDO periods. The reduced hospitalization included both 1) a reduction in hospital days among those who continue to be hospitalized and 2) a reduction in the number of individuals who are being hospitalized under the longer TDO period. Finally, based on extrapolation, we estimated the total number of additional detention days for FY 2010 if the longer TDO period had been in effect during that year.

Based on the e-Magistrate database maintained by the Supreme Court, there were 20,927 adult TDOs issued in FY2010. If the 72-hour TDO period had been in effect, we would expect an increase of 26,288 TDO days and a decrease of 24,506 hospitalization days, resulting in a net increase of 1,782 treatment days. The impact on the state's budget will depend on the differences in costs and funding sources between TDO detention days and hospitalization days that are covered by public funds rather than by private insurance, as well as on indirect costs related to public health and safety.

Discussion

Involuntary commitment can result in both stigma and trauma to individuals suffering from mental illness. Therefore, an important policy goal is to reduce involuntary hospital commitments. The findings of this study are consistent with extending TDO length as a means to this goal. This study found that extending TDOs beyond the 48 hours required under current law in Virginia could reduce the level of coercion needed to restrain and treat people experiencing mental health crises. In our sample of Medicaid recipients, longer TDO lengths were positively correlated with increased rates of dismissal. When hospitalization did occur, the hospital stay was more likely to be voluntary rather than involuntary. Furthermore, longer TDO lengths were correlated with shorter post-TDO hospitalization commitment periods.

While improving health outcomes is in itself an important goal, policymakers must also consider the costs of proposed changes. This study suggests that a 1-day increase in TDO detention is correlated with a reduction in a post-TDO hospital stay of 0.8 days. Thus, for those individuals whose detention changes from 48 to 72 hours, the net time in the hospital may increase slightly. Extrapolating these results to the total number and length of TDOs in Virginia, we find that there would likely be an increase in TDO detention days. However, there are also a number of individuals whose commitment hearings occur less than 24 hours from the start of their TDO. To the extent that the state can encourage or require a minimum TDO length beyond 24 hours, then we can expect a *reduction* in the cost of care for these individuals. Increasing TDO length from less than one day to one day would reduce the post-TDO commitment time by 1.4 days, which more than offsets the increased TDO length. It is possible that simply increasing the TDO length to 3 days would reduce the number of TDOs that are less than 24 hours. More research is needed to determine how jurisdictions would respond to the change in law and individuals would be affected under the proposed change.

In sum, this study is the first to clearly identify the relationship between TDO length and both commitment hearing result and subsequent hospitalization outcomes. While more research is needed to determine the costs, the findings are consistent with using longer TDO periods as a means to improve health outcomes of individuals suffering mental health crises.

Acknowledgements

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Key Findings from the Virginia College Mental Health Survey[1]

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Almost half a million students attend Virginia's colleges and universities. About 45% attend one of the 15 four-year public colleges, 17% attend one of the 25 four-year private colleges, and 38% attend one of the 24 public two-year colleges.
Last October, the Joint Commission on Health Care agreed to undertake a study of mental health issues in the Commonwealth's colleges and universities. The study is being conducted by two task forces – one to assess students' access to mental health services and the other to analyze legal issues surrounding colleges' responses to students' mental

[1] These findings were reported to the Joint Commission on Health Care on September 7, 2010.

health needs. In the spring of 2010, the Joint Commission, in coordination with the Commission on Mental Health Law Reform, conducted a survey of Virginia's public and private colleges to collect relevant data bearing on these issues. Data was requested for the 2008-09 academic year.. The survey response rate was a remarkable 98%. The study's task forces are now reviewing and analyzing the data and will report their conclusions and recommendations to the Joint Commission next spring. However, key findings of the survey are summarized in this article.

Access to Services

The survey indicates that counseling centers in the private colleges have about 70% more staff capacity than counseling centers in the 4-year public colleges. Similarly, about 70% more students are served by counseling centers in the private colleges than in the 4-year public colleges. While these findings may not be surprising, they highlight the challenge of addressing mental health needs of students in the 4-year public universities. One of the most important issues being considered in our deliberations concerns the mental health needs of students enrolled in the Commonwealth's 23 community colleges. While access to on-campus mental health services may seem less important in non-residential colleges than in residential ones, students attending community colleges often face mental and emotional challenges equivalent to those faced by students in traditional 4-year colleges, and may be even less able to cope with them without professional assistance. Nonetheless, Virginia's community colleges are prevented by official policy from providing mental health services on their campuses.

Health insurance, including adequate behavioral health benefits, is an important part of the equation for assuring adequate access to mental health services for college students. Although the proportion of students covered by insurance could not be ascertained in this survey, most private colleges (about 60%) and about one-quarter of 4-year public colleges require all of their students to have health insurance. As a result, counseling centers at the 4-year colleges customarily refer their students to private providers when they are unable to meet the students' mental health needs. By contrast, none of the community colleges requires its students to have health insurance; instead, community colleges rely heavily on the services provided by the Commonwealth's community services boards (CSBs) to assist troubled students.

Frequency of Hospitalization and Withdrawal for Mental Health Problems

The survey data indicate that four-year colleges rarely initiated either an Emergency Custody Order ("ECO") or a Temporary Detention Order ("TDO") to detain students for emergency mental health evaluation in 2008-09, doing so for only 2 out of every 10,000 students. However, the initiation of involuntary commitment proceedings is meant to be a last resort. Better indications of the frequency of severe distress experienced by Virginia's college students are the rates of medical withdrawal for mental health reasons and psychiatric hospitalization. An average of 56 students per 4-year public college and 6 students per private college withdrew from school in 2008-09 for mental health reasons. The average number of students admitted to a psychiatric hospital

in 2008-09, regardless of legal status, was about 10 per 4-year public college and 3 per private college.[2] Overall rates of medical withdrawal and psychiatric hospitalizations in Virginia's 4-year colleges in 2008-09 were 35 per 10,000 students and 12 per 10,000 students respectively.

Student Suicides and Attempts

During 2008-09, at least 11 Virginia college students committed suicide[3] and at least 86 more attempted suicide. One-third of all public colleges experienced a student suicide, and about three-quarters experienced a student suicide attempt. The numbers of suicide attempts were lower at private colleges (an average of 1 attempt per college) than at public colleges (an average of 6 attempts per college) because of the smaller average size of the private colleges. All public 4-year colleges, 80% of private colleges, and almost 40% of community colleges, have guidelines for identifying and addressing the needs of students exhibiting suicidal ideation or behavior. This is an example of how policies and practices required for public 4-year colleges by law,[4] have been embraced by private colleges and even by community colleges.

Parental Notification

The perceived legal impediments to parental notification described in the Virginia Tech Panel's report in 2007 appear to have been lessened by clarification of federal law and changes in the Code of Virginia. Public colleges notified a student's parents because they were concerned about the student's becoming harmful to him or herself or others a total of 68 times in 2008-09.[5] Private colleges did so 70 times, and community colleges 6 times. Public colleges notified a student's parents because they were concerned about the student's mental health more broadly, even without a concern that the student would harm him or herself or others, a total of 4 times in 2008-09. Private colleges did so 80 times, and community colleges once.

Threat Assessment Teams

All public colleges, as well as three-fourths of private colleges and community colleges, have established threat assessment teams charged with assessing individuals

[2] The survey data indicate that an average of 4 students per community college withdrew for mental health reasons and about one person per community college required psychiatric hospitalization. However, most of the colleges were unable to provide the requested data and these figures are probably not reliable indicators of the prevalence of substantial mental health distress among community college students.

[3] Only 2 colleges reported that one of their students was arrested for killing someone else during 2008-09 (in one of these case the victim was another student).

[4] See Virginia Code § 23-9.2:8: "The governing boards of each public institution of higher education shall develop and implement policies that advise students, faculty, and staff, including residence hall staff, of the proper procedures for identifying and addressing the needs of students exhibiting suicidal tendencies or behavior."

[5] This was the first academic year following the 2008 General Assembly's adoption of Virginia Code § 23-9.2:3.C, which requires Virginia public institutions to notify parents of tax-dependent students whenever students who receive mental health treatment at the institution's student health or counseling center meet state commitment criteria.

whose behavior may pose a threat to campus safety and to recommend appropriate interventions. The average number of active cases considered by threat assessment teams in 2008-09[6] was about 20 at public colleges, 9 at private colleges, and 5 at community colleges. Mental health issues were believed to be a significant factor in most of these cases.

College Requests for Mental Health Information

One issue raised in the wake of the tragic shootings at Virginia Tech was whether colleges should seek, and have access to, information about the mental health histories of students prior to or after enrollment. The General Assembly authorized Virginia's colleges to require admitted or enrolled students to provide mental health records from the originating school. This authority has been used by only eight colleges (four 4-year public colleges, two private colleges, and two community colleges), who indicated that they sometimes request information about selected students. In addition, about half of the 4-year colleges administer health surveys to enrolled students that include questions regarding mental health and share the information with the counseling center. The legal issues task force is attempting to ascertain why the authority to seek school records is not being used more often.

Cooperation by Colleges, CSBs and Hospitals in Emergencies

Working agreements with local CSBs have been established by two-thirds of public 4-year colleges, about half of private colleges, and about 70% of community colleges. In addition, working agreements with local psychiatric hospitals have been established by about half of public 4-year colleges and one-third of private colleges.[7] Our study task forces have identified a number of major concerns about the sharing of information between colleges, CSBs and hospitals about students needing or receiving acute mental health services. For example, most colleges report that they are not notified when a commitment proceeding involving a student is initiated by someone other than the college or when their students are admitted to or discharged from a hospital. The task forces are attempting to identify solutions to allow for improved communication in these situations.

Recently Decided Cases

US Supreme Court Orders California to Reduce Prison Population for Failure to Provide Constitutionally Adequate Treatment for Inmates with Serious Mental Illness

[6] This was the first academic year following the 2008 General Assembly's adoption of Virginia Code § 23-9.2:10, which requires Virginia public institutions to establish threat assessment teams to include members of law enforcement, mental health professionals, representatives of student affairs and human resources, and, if applicable, college or university counsel.

[7] Only one community college reported having such an agreement.

In a 5-4 decision written by Justice Kennedy, the United States Supreme Court upheld the decision of a three-judge panel entered under the Prison Litigation Reform Act of 1995 ("PLRA") ordering California to reduce its prison population by 137.5% of its original design capacity, or by 46,000 prisoners, within two years in order to address severe and unconstitutional conditions related to the delivery of mental health and medical care to California's 156,000 inmates. *Brown, Governor of California, et al. v. Plata, et al*., No. 09-1233, decided May 23, 2011. Slip opinion found at: http://www.supremecourt.gov/opinions/10pdf/09-1233.pdf

This decision is the result of two consolidated federal class action suits challenging the mental health and medical conditions in California's prisons. The first, *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Calf. 1995), was filed in 1990 alleging that deplorable mental health care constituted cruel and unusual punishment under the Eighth Amendment. After a 39-day trial, the court found the prisons severely and chronically understaffed with no method for ensuring competence of staff. The prisons failed to implement necessary suicide precautions due to severe understaffing and mentally ill inmates languished for months and years without access to care, suffering severe hallucinations and decompensating to catatonic states. After 12 years, a Special Master appointed to oversee remedial efforts reported that after slow improvement, the status of mental health care was again deteriorating. A rise in the prison population had led to greater demand for care, and existing program space and staffing levels were inadequate to keep pace. In 2006, at the time of trial before the three-judge panel, the suicide rate was approaching one per week with the suicide rate nearly 80% higher than the national average for prison populations. Suicidal inmates were held for prolonged periods in telephone booth-size cages without toilets. Slip Opn. at 11. According to the Special Master, 72.1% of suicides involved "some measure of inadequate assessment, treatment, or intervention, and were therefore most probably foreseeable and/or preventable." Slip Opn. at 12. In 2007, the rate had risen to 82% and by 2010 there had been no improvement.

A second class action, *Plata v. Brown*, was filed in 2001, in which California conceded that deficiencies in prison medical care violated the Eighth Amendment. When the State had not complied with the remedial injunction issued, the Court appointed a Receiver to oversee the remedial efforts. Three years later, the Receiver described equally deplorable continuing deficiencies in medical care. In one prison, up to 50 sick inmates were held together in one 12 foot x 20 foot cage up to five hours awaiting treatment. The *Coleman* and *Plata* plaintiffs thereupon requested their respective district courts to convene a three-judge panel to order reductions in the prison population.

The Supreme Court held that if a prison deprives inmates of their basic needs for sustenance, including adequate mental health and medical care, courts have a responsibility to remedy the Eighth Amendment violations. Under the PLRA, only a three-judge panel may enter an order imposing a population limit and only after a district court has entered an order for less intrusive relief that has failed after the state has been given reasonable time for compliance. Before doing so, that court must also first consider a range of options, and then find by clear and convincing evidence that crowding is the

primary cause of the violations, no other relief will remedy the situation and the relief is narrowly drawn and the least intrusive means to correct the violations. The court must also consider any adverse impact such a population limit will have on public safety and the operation of the criminal justice system. The Supreme Court thus held that the three judge-panel had properly heard evidence of then-current conditions and that no other relief short of imposing a population limit would remedy the situation. California indicates that it is proceeding to implement measures to reduce its prison population, but with the State's severe budget crisis, it remains to be seen how effective its efforts will be.

Justice Scalia filed a dissenting opinion in which Justice Thomas joined. Justice Alito also filed a dissenting opinion in which Chief Justice Roberts joined.

Ninth Circuit Finds NGRI Acquittee May Appeal Rulings Made in Criminal Proceeding

Unlike the Arkansas Supreme Court in *Hughes v. State of Arkansas*, 2011 Ark. 147; 2011 Ark. LEXIS 134 (April 7, 2011) and reported in Issue 4 of *Developments in Mental Health Law*, the Ninth Circuit Court of Appeals found that federal courts have statutory authority to hear the appeal of a defendant in a criminal case who was found not guilty by reason of insanity. *United States v. Vela*, 624 F.2d 1148 (9th Cir. 2010). In the Ninth Circuit case, a defendant found NGRI attempted to appeal the trial court's ruling refusing to dismiss the indictment against him and another ruling prohibiting him from presenting a diminished capacity defense. The defendant had been charged with assault of a federal officer, having stabbed a customs and border protection chief in the chest with a knife. He argued that the indictment should have been dismissed for failure to contain an element of specific intent and the verdict reversed for the trial court's failure to instruct the jury on a defense of diminished capacity. The defendant also raised the insanity defense and presented expert testimony in support of that defense and the jury returned a NGRI verdict. He argued, however, that the trial court denied him the opportunity for an outright acquittal. The government argued that a verdict of not guilty by reason of insanity does not result in a judgment of conviction subject to appeal. It also argued that there was no final decision from which to appeal a NGRI verdict because the verdict did not result in a sentence.

The Ninth Circuit recognized that the right of appeal is purely statutory, but found that 28 U.S.C. § 1291 affords jurisdiction to review all final decisions of district courts. The Court noted that the final decision in a criminal case is not triggered until there is a conviction and imposition of a sentence. But here the Court found that the lack of a sentence does not preclude finality because the criminal case has terminated. The Court further found that the defendant's ability to appeal his civil commitment does not provide an adequate substitute for an appeal of the issues raised in his criminal trial and indeed the defendant might be precluded from raising those issues in a civil commitment appeal.

As you may recall from Issue 4 of Developments in Mental Health Law, the Arkansas Supreme Court held by contrast that a defendant who was acquitted of a

criminal offense as a result of mental disease or defect and committed to a mental health facility could not appeal his acquittal because the Court only had jurisdiction to hear appeals of criminal "convictions." The defendant had appealed on the grounds that the court erred by finding he committed the offense of terroristic threatening and by compelling him to use the affirmative defense of mental disease or defect, thereby depriving him of his constitutional right of trial by jury. Similarly, Virginia does not recognize a right of appeal unless such a right is specifically provided by statute. It is doubtful therefore whether the Virginia Court of Appeals or Virginia Supreme Court would entertain such an appeal in a similar case absent a clear statutory provision authorizing that appeal.

Ninth Circuit Sets Out Test for Determining When Mental Impairment Tolls Statute of Limitations for Filing Federal Habeas

The Ninth Circuit Court of Appeals has established a 2-part test to determine when a prisoner's mental impairment tolls the one-year statute of limitations for filing a federal *habeas corpus* petition under the Antiterrorism and Effective Death Penalty Act of 1996. *Bills v. Clark*, 628 F.3d 1092 (9th Cir. 2010). The United States Supreme Court had previously upheld Eleventh Circuit determinations finding that the one-year statute of limitations must be tolled if equitable circumstances exist beyond a prisoner's control preventing him from filing on time. The prisoner must establish that 1) he has been pursuing his rights diligently, and 2) some extraordinary circumstance stood in his way. *Holland v. Florida*, 560 U.S. __, 130 S.Ct. 2549, 177 L.Ed.2d 130 (2010). In determining whether a mental disability constitutes such an extraordinary circumstance, a petitioner must show that the disability severely impaired his ability to meet the filing deadline despite diligent efforts to do so.

In this case, while serving a sentence for other charges, the prisoner was charged with possession of a sharp instrument by a state prisoner and was sentenced to 25 years to life. The prisoner appealed his conviction and after the time expired for a petition for *certiorari* to the United States Supreme Court, he pursued state *habeas* proceedings. Thereafter, he filed a late *habeas* petition in federal court alleging ineffective assistance of counsel. Noting the unusually long sentence, the court appointed counsel to represent him. Counsel argued that the petition should not be dismissed as untimely filed due to the prisoner's inability to read and write, neurological deficits, borderline to mild mental retardation, concurrent psychosis and lack of assistance available to him. The prisoner's expert psychologist testified that he had been diagnosed as bipolar with a variety of behavioral and cognitive disorders, and that he could not understand his legal rights sufficiently to make rational choices. The record reflected, however, that the prisoner had prepared a number of administrative and judicial filings, including a *pro se habeas* petition in 2000 and an administrative complaint regarding medical care in 2001. He had also represented himself *pro se* at his trial on this charge. The district court denied the late filing finding that his mental capacity was not sufficiently severe to impede his filing of a timely petition based on his second grade reading level and its finding that a jail house lawyer had been available to help with the filing of the petition.

In setting out the standard for review, the Ninth Circuit stated that there must be a causal connection between the petitioner's mental disability and the ability to file the petition. The Court determined that the relevant question is whether the mental impairment caused the untimely filing and set out the following two-part test:

1. The petitioner must show that the mental impairment was an extraordinary circumstance beyond his control demonstrating an impairment so severe that either
    a. The petitioner was unable to rationally or factually personally understand the need to timely file, or
    b. The petitioner's mental state rendered him unable to personally prepare a *habeas* petition and effectuate its filing.
2. The petitioner must show diligence in pursing claims to the extent he could understand them, but that the mental impairment made it impossible to meet the filing deadline under the totality of the circumstances, including whether there was reasonably available access to assistance.

The Court found that this standard "flows naturally" from the Supreme Court's rulings concerning competency to stand trial in *Dusky v. United States*, 362 U.S. 402 (1969); competency to plead in *Godinez v. Moran*, 509 U.S. 389 (1993);and competency to represent oneself in *Indiana v. Edwards*, 554 U.S. 164 (2008). In other words, the court must determine whether the petitioner is competent to do what the law requires. In examining the totality of the circumstances, the court:

1. must find that the petitioner has made a non-frivolous showing that he had a severe mental impairment during the filing period that would entitle him to an evidentiary hearing;
2. determine after considering the record whether the petitioner satisfied his burden that he was in fact mentally impaired;
3. determine whether the petitioner's mental impairment made it impossible to timely file on his own; and
4. consider whether circumstances demonstrate the petitioner was otherwise diligent in attempting to comply with the filing requirements.

The Ninth Circuit remanded the case for the district court to apply the facts of the case to the standard articulated in its decision.

Tennessee Supreme Court Rules Experts Can Testify to Reflect Capital Defendant's Actual Cognitive Abilities in Addition to Consideration of IQ Scores

The Tennessee Supreme Court has held that under Tennessee law a defendant can present expert testimony to show that his test scores do not accurately reflect his actual cognitive abilities for purposes of raising a defense of intellectual disability to a sentence of death. *Coleman v. State*, 2011 Tenn. LEXIS 319 (April 11, 2011). The defendant in this case had been convicted of first degree murder and sentenced to death over 30 years ago. Following the decision in *Atkins v. Virginia*, 536 U.S. 304 (2001), prohibiting

imposition of the death penalty for persons with mental retardation, the inmate filed a *habeas* petition alleging that he suffered from an intellectual disability. The evidence presented at his *habeas* hearing indicated, among other things, that his mother had an intellectual disability and history of mental illness, that his home was violent, chaotic and overcrowded, that his mother drank, engaged in prostitution and abused him, and that his father had spent most of his life in prison and had little-to-no involvement in his life. The petitioner had failed 1st, 2nd, 3rd and 7th grade and was only "socially promoted" to higher grade levels, and that he was teased by his fellow classmates. He was lonely and stigmatized as a child and intellectually and socially behind his peers. He was viewed as "dull" by police officers with whom he had many encounters as a juvenile.

Even though eight other state statutes limit the assessment of intellectual disability to scores on IQ tests, the Tennessee Supreme Court found that Tennessee law does not limit the evidence to test scores. The Tennessee statute requires a "functional" intelligence quotient of 70 or below, not just a test score of 70 or below. The Court therefore concluded that its General Assembly wanted courts to make fact-intensive and complex decisions with assistance from experts in the field because "functional" IQ cannot limited to raw IQ scores. Trial courts may therefore receive and consider any relevant and admissible evidence as to whether the defendant's IQ is 70 or below. It noted that under the Flynn effect recognized by mental health experts, IQ test scores tend to increase over time. Clinical judgment is therefore important in diagnosing and assessing intellectual disability in borderline cases, especially since the standard of error measurement is generally 3-5 points. The Court therefore remanded the case to the trial court to consider expert testimony in determining the petitioner's functional IQ.

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