

# ***DEVELOPMENTS IN MENTAL HEALTH LAW***

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## **College Mental Health Study Measures Student Access to Mental Health Services Four Years after Virginia Tech Tragedy**

**Virginia College Mental Health Study**

**Prepared for the Joint Commission on Health Care**

**General Assembly of the Commonwealth of Virginia**

**Executive Summary**

**By Richard J. Bonnie**

**November, 2011**

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 (including the 23 community colleges). It is well known that young adulthood is the period of onset for major mental disorders and is often characterized by intensive use of alcohol and other drugs. Based on national data as well as the data available in Virginia, it is likely that at least 46,000 of Virginia's college students are experiencing significant mental health concerns and are in need of psychological assistance at any given time. According to the Virginia College Mental Health Survey (VCMHS), at least 11 Virginia college students committed suicide and at least 86 more attempted suicide during 2008-09. However, based on national data, we estimate that there were

approximately 2300 attempted suicides and approximately 30 completed suicides among college students during that year.

### **Prevention**

Each college and university that has not already done so should establish a planning group for involving and guiding students in clinically, culturally, ethically and legally appropriate roles in campus-based mental health awareness and suicide prevention.

### **Access to Services in Residential Colleges**

The best way of preventing mental health crises is to assure that people experiencing mental or emotional stresses or disturbances have expeditious access to mental health services before events spiral out of control. This challenge is no less important in a college environment than it is in the community at large. Research shows that participation in college counseling services increases student retention and graduation rates.

All of the 15 four-year public colleges and 22 of the 25 private colleges offered mental health counseling services to enrolled students (generally full-time students). Using the International Association of Counseling Services standards as a guide, the majority of private colleges in Virginia meet the minimum requirement of one counselor per 1,500 students while the majority of counseling centers in the public colleges do not meet the requirement. Most counseling center directors report that they lack adequate psychiatric coverage. The percentage of the student body served by Virginia's college counseling centers parallels the staffing pattern. In the public colleges and universities, 6.3% of the student body utilized services in the counseling center during academic year 2008-09, compared with 11.1% of the student body in the private colleges and universities.

### **Health Insurance**

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 the VCMHS, 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 four-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 mainly on the services provided by the Commonwealth's community services boards (CSBs) to assist troubled students.

### **Access to Services for Community College Students**

One of the most important issues considered in our deliberations concerned the mental health needs of students enrolled in the Commonwealth's 23 community colleges. National survey data suggest that at least a quarter of all the country's community colleges offer full or part-time services by clinically trained providers. However, according to official policy,

Virginia's community colleges do not currently provide mental health counseling services. Moreover, it appears that very few community colleges in Virginia have clinically trained counselors on their staff.

Unfortunately, there is reason to believe that a significant portion of community college students do not have access to off-campus mental health services because they are more likely than students in the 4-year colleges to be uninsured or under-insured and because most community services boards lack capacity to provide timely counseling and psychiatric assistance to college students. Task force members regard the current gap in accessible mental health services to community college students as a serious problem. Failure to respond to this problem aggravates the already substantial disparities in educational achievement among people of color.

Although community colleges do not currently offer mental health counseling services, their governing policy does require them to develop "proper procedures for addressing the needs of a student who may pose a threat to him/herself or to others." However, task force members believe that capacity to prevent and respond successfully to mental health crises depends on timely access to clinically trained professionals who are able to screen and refer troubled students and to facilitate adequate crisis response. In our judgment, current capacity to do this among the community colleges is uneven at best.

The Task Forces recommend that the Commonwealth embark on a sequential plan, as resources permit, to assure that every community college has the capacity to provide brief screening and referral services for students who appear in need of mental health intervention; to maintain fully staffed threat assessment teams; to conduct risk assessment screenings in cases that may pose a risk of harm to campus safety; and to coordinate with CSBs, law enforcement agencies and families to carry out emergency interventions and other types of crisis response when necessary.

This recommendation is meant to declare a goal without prescribing a one-size-fits-all approach for achieving it. It envisions flexible responses in what services are provided and in the staffing needed to deliver them, depending on the size, financial capacity, and location of the particular community college. The immediate aim of this recommendation is to establish a minimum capacity for screening and referral in every community college

It is not necessary for every community college to provide direct counseling services. However, community colleges that are able to provide direct counseling services should be encouraged to do so (and should not be precluded from doing so as a matter of policy).

For the foreseeable future, CSBs will likely be the primary providers of safety net services for uninsured college students. It is hoped, however, that economic recovery will eventually allow the Commonwealth to fund CSB services at a sufficient level to increase their capacity to provide timely outpatient services.

## **Review of 2008 Legislation in Operation**

The Task Force on Legal Issues was charged with ascertaining how the legislation enacted in 2008 in the wake of the Virginia Tech tragedy has been operating in practice. Although most of the new policies and procedures have had positive effects, the Task Force concluded that several clarifications and adjustments would be helpful.

### **Sharing of Information in Admission/Enrollment Process**

Virginia Code § [23-2.1:3](#) permits colleges to seek mental health records of applicants or admitted students from originating schools. The survey data indicated that no institution in Virginia currently requests mental health records for all its incoming students and that only a handful of colleges have requested such records. Although the task force proposes no significant legislative change, it recommends clarification of the meaning of “originating school” to ensure it includes transferring institutions of higher education, and not only high schools.

### **Interventions for Suicidal Students**

All of Virginia’s four-year public institutions have developed and implemented policies for identifying and addressing the needs of suicidal students as required by the first sentence of Va. Code § [23-9.2:8](#). This is a welcome mandate as these policies are a critically important aspect of protecting the mental and emotional well-being of Virginia college students. However, only 38.1 percent of community colleges reported in the survey that they have such policies, reflecting the current reality that community colleges do not provide mental health services to their students and that most of them do not have the expertise to implement suicide prevention policies. Until these circumstances change, the Task Force recommends revising the first sentence of Va. Code § [23-9.2:8](#) to release community colleges from this legislative mandate.

In addition, the Task Force recommends legislative clarification or repeal of the two remaining sentences in the provision because they are contradictory, simultaneously directing colleges not to penalize students for being suicidal while also permitting them to deal “appropriately” with students who pose a danger to themselves or others. If the intention was to protect students with disabilities, federal law (ADA and Rehabilitation Act) already provides this protection. In terms of clarity, it would be best to leave this to federal disability discrimination standards. The added sentences to state law, while well intentioned, create added confusion for student affairs officials in these complicated cases.

### **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 by Va. Code § 23-9.2:3.C, which requires colleges to establish policies and practices regarding notification of parents of dependent students when the student receives mental health treatment at the student health or counseling center and certain criteria are met. Although an exception is provided if the treating physician or clinical psychologist believes notification would be harmful, there is some lingering concern that this notification requirement could deter students from

accessing care at the campus counseling center and uncertainty whether the General Assembly intended for community colleges to be subject to this notification requirement. It may be advisable to amend the statute to make it clear that the provision is permissive, not mandatory, for community colleges. Also many smaller schools do not have a physician or clinical psychologist on staff. Accordingly, Va. Code § 23-9.2:3.C should be amended to permit any available school health professional to authorize the exception not to notify a parent. This can be accomplished by changing the phrase “physician or treating clinical psychologist” to “health care professional.”

### **Threat Assessment Teams**

Virginia Code § [23-9.2:10](#) provides a good framework for establishing and operating threat assessment teams. It does not dictate how schools should run their teams. It gives them flexibility to design their own mission statement and operations. In 2010, the General Assembly authorized threat assessment teams to receive health and criminal history records of students for the purposes of assessment and intervention, and largely exempted records of threat assessment teams from the Freedom of Information Act.

Virginia’s public four-year institutions have all implemented threat assessment teams on their campuses. Despite the absence of a statutory mandate, the majority of Virginia private institutions have also done so. Implementation of the requirements of § [23-9.2:10](#) among community colleges appears to be uneven, however, largely due to the lack of clinically trained staff and other personnel needed for a fully staffed team. It seems likely that the General Assembly was focusing primarily on four-year colleges when it enacted § [23-9.2:10](#). The Task Force recommends that the staffing requirements prescribed by § [23-9.2:10](#) be loosened to take account of the wide variation in staffing capabilities among community colleges. However, the Task Force hopes it will be possible within a few years for all colleges, including community colleges, to employ or retain the necessary clinically trained personnel to maintain a fully staffed threat assessment team and carry out risk assessments in appropriate cases.

### **Cooperation by Colleges, CSBs and Hospitals in Emergencies**

Working agreements with local CSBs have been established by two-thirds of public four-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 four-year colleges, one-third of private colleges and one community college. The task forces identified a number of major concerns about the sharing of information between colleges, CSBs and hospitals regarding students needing or receiving acute mental health services. For example, most colleges reported that they were not notified when a commitment proceeding involving a student was initiated by someone other than the college or when their students were admitted to or discharged from a hospital. The Task Forces recommended solutions to allow for improved communication in these situations.

The Task Force identified significant information gaps between college and university officials, CSBs, and psychiatric hospitals during the processes of emergency evaluation (Emergency Custody and Temporary Detention Orders) and commitment of students. This issue

requires priority attention. Colleges and universities are key stakeholders whenever their students are subject to these state processes. They often have significant mental health and behavioral information that would aid state officials involved in these proceedings. Residential colleges are also the homes to which many discharged students return. Accordingly, colleges and universities should be notified and involved in these proceedings to ensure community safety and appropriate continuity of care when a discharged student returns to campus.

The Task Force recognized that CSBs have limited resources at their disposal and limited time to act during the ECO and TDO stages. Colleges and universities do not wish to burden CSBs with additional responsibilities. On the contrary, the Task Force believes that colleges and universities could become a helpful partner to CSBs throughout these proceedings. To that end, the Task Force recommends pursuing each of the steps below :

- Each college should establish a written memorandum of understanding with its respective CSB to ensure both parties have the same understanding of the scope and terms of their operational relationship.
- Each college should establish a written memorandum of understanding for use with local psychiatric hospitals to assure inclusion of colleges, where appropriate, in the post-discharge planning of student patients, whether admitted voluntarily or involuntarily.
- Working together with the colleges in their catchment areas, Virginia's CSBs should establish a reliable system for assuring that a designated contact person at each Virginia institution is notified whenever one of its students is the subject of commitment proceedings and for assuring exchange of information among institutions, providers and the legal system in a timely fashion.
- The Office of the Executive Secretary of the Supreme Court, the Department of Behavioral Health and Developmental Services, the Virginia Association of Community Services Boards, the Office of the Attorney General and Virginia's colleges and universities should conduct collaborative training activities to assure that all participants in commitment proceedings are familiar with special issues arising in cases involving college and university students.

The Full Study may be accessed on the Joint Commission on Health Care website at: [http://services.dlas.virginia.gov/User\\_db/frmView.aspx?ViewId=2742](http://services.dlas.virginia.gov/User_db/frmView.aspx?ViewId=2742).

## **CMS Administrator Responds to IG on Use of Restraints to Medicate over Objection**

Donald M. Berwick, M.D., former Administrator for the Centers for Medicare and Medicaid Services,<sup>i</sup> responded on July 21, 2011 to Virginia's Inspector General for Behavioral Health and Developmental Services ("IG") clarifying when restraint may be used to involuntarily medicate an incapacitated individual without his or her agreement. He writes that the restraint requirements found in 42 CFR § 482.13(e)<sup>ii</sup> "do not prohibit the use of restraints in hospitals." The regulation instead "establishes the patient's right to be free from inappropriate restraint or seclusion, and lays out the basic protections in the event that these interventions are needed."

In the last issue of *Developments in Mental Health Law* (Vol. 30, Issue 6), we reported that the IG questioned the advice provided by the Virginia Attorney General in his Semiannual Report to the Governor and General Assembly (October 2010-March 2011) issued May 11, 2011.<sup>iii</sup> The IG challenged the Attorney General's advice that under the CMS regulation a person who lacks the capacity to consent to treatment could not be restrained in order to be treated with medication deemed medically necessary and consented to by his or her legally authorized representative without his or her agreement unless necessary to ensure the immediate physical safety of the patient, staff, or others. In his May 11, 2011 letter to the CMS Administrator, the IG wrote:

Notwithstanding the foregoing discussion, the refusal to provide treatment deemed medically necessary by an attending physician for the health, safety, or welfare of the patient, with the express consent of the individual's legal guardian, satisfies the definition of neglect and abuse as described by the *Code of Virginia* at § 37.2-100:

"Neglect" means failure by an individual or a program or facility operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, **treatment**, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse.

"Abuse" means any act **or failure to act** by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, **and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, mental retardation, or substance abuse.** (Emphasis added by IG.)

The Attorney General responded to the IG's Report in a letter to Governor Robert F. McDonnell dated July 1, 2011, stating that "as long as medication can be administered without the use of restraint, it can be done. It is only in cases where a patient needs to be physically held down in order to inject the medication that the restraint regulation will be triggered. In those cases, it must be determined that the restraint is necessary to ensure the immediate physical safety of the patient, or staff member or others."

In issuing his clarification, the CMS Administrator provides a workable, common sense approach ensuring that individuals who lack capacity to consent to treatment are able to receive medically necessary treatment, while maintaining their safety and their right to be free from inappropriate restraint or seclusion. In essence, CMS is stating that the act of "physically

resisting” on the part of an incapacitated individual for whom proper consent has been obtained to medicate constitutes a safety risk in and of itself. That safety risk then satisfies that prong of 42 CFR § 482.13(e) permitting the imposition of restraint or seclusion only “to ensure the immediate physical safety of the patient, a staff member, or others...”

The CMS Administrator emphasizes, however, that “the application of force to physically hold a patient who is resisting administration of a medication is considered restraint and, as such, may only be used in circumstances that meet the regulatory requirements.” Hospital staff may not therefore “routinely” impose restraint, an inherently dangerous intervention, on an incapacitated individual whose legally authorized representative has consented to his or her treatment with medication and authorized the use of restraint.<sup>iv</sup> The CMS administrator stresses that an “individualized approach” must be utilized and “as in all cases of application of restraints, the individual patient’s circumstances must be assessed, and there must be a determination that less restrictive interventions are ineffective in protecting the patient or staff from harm.”<sup>v</sup> When restraint must be imposed, it must be administered by “properly trained hospital staff acting under a restraint order from a physician or practitioner, using the least restrictive method of restraint feasible in order to safely administer treatment.”

In his clarification letter, the CMS Administrator also relies upon 42 CFR § 482.13(b)(2) acknowledging that when an individual has been deemed legally incompetent, he or she loses the right to refuse treatment. Only the person’s representative (*as allowed under State law*) has the right to make informed decisions on behalf of that person and to request or refuse treatment. CMS therefore defers to state law regarding the process for determination of legal incapacity and providing substitute consent. Laws differ throughout the country on this process. Virginia itself provides a number of different mechanisms for determining incapacity and obtaining substitute consent,<sup>vi</sup> including the process for obtaining judicial authorization for treatment for individuals who lack someone to serve as their legally authorized representative.<sup>vii</sup> CMS should therefore accept Virginia’s judicial process for ordering treatment with antipsychotic medication in the absence of a legally authorized representative available to serve in that capacity.

## **AG Advises Town Police Must Execute ECOs and TDOs**

Attorney General Ken Cuccinelli issued an official opinion on October 21, 2011 advising that town police where they exist serve as the “primary law enforcement agency of the jurisdiction,” requiring them to provide transportation for persons subject to emergency custody (“ECO”) and temporary detention (“TDO”) orders.

Karen T. Mullins, County Attorney for Wise County, asked 1) whether the sheriff’s office or police department serves as the primary law enforcement agency, and 2) whether the term “jurisdiction” as used in §§ 37.2-808 and 37.2-810 refers to counties only or includes political subdivisions located within the boundaries of the county. The Attorney General concluded that when a town has decided to establish a police department, the police force is given primary law-enforcement responsibility for that jurisdiction. Although not defined, the term “jurisdiction” encompasses any locality or political subdivision. Therefore “the magistrate

should specify the police department of the town as the ‘primary law-enforcement agency of the jurisdiction’ when the town is served by its own police department. If the town is not served with its own police department, the sheriff’s office of the surrounding county is tasked with executing such orders and with transporting persons subject to such orders.”

Sections 37.2-808(C and D) and 37.2-810 provide the framework for ordering either alternative transportation providers or law enforcement agencies to provide transportation under ECOs and TDOs. Under § 37.2-808(D) the magistrate must specify the primary law enforcement agency in the jurisdiction served by the community services board (“CSB”) that designated the person to perform the ECO evaluation to execute the order, or if the CSB serves more than one jurisdiction, the primary law-enforcement agency in that CSB service area where the person was taken into custody, or if not yet in custody, where the person is *located*. By contrast, for purposes of executing a TDO, the magistrate must specify the law-enforcement agency of the jurisdiction in which the person *resides* to execute the order under § 37.2-810(C). The statute provides an exception if the locality where the person resides is more than 50 miles from the nearest boundary of the jurisdiction in which the person is located, in which case the law-enforcement agency of the jurisdiction where the person is located must execute the order.

The rationale for this division of responsibility lies in the premise that the law-enforcement agency that is most likely to encounter the individual or be called to the scene for an individual who needs to be taken into custody under an ECO is the agency with primary patrol responsibility in the locality where the person is physically located. Once a person has been taken into custody, an immediate emergency no longer exists and the burden falls to the locality of the person’s residence to execute the order, unless for efficiency reasons, the boundary of that locality is more than 50 miles from the boundary of the locality where the person is located. These “rules” are the product of delicate negotiations between local sheriffs and police departments and their respective associations, and are designed to ensure that what is often viewed as a burden on law-enforcement is shared equally by the two law-enforcement entities. The effect of the statute, however, may now place a significant burden on town police often consisting of only one or two officers, who may be tasked with transporting the person found in or residing in their jurisdiction long distances, leaving that community without adequate police coverage. If a hospital with an emergency room is located within its town, the burden may become even greater if the person has been transported to the emergency department and the place of residence is greater than 50 miles from that hospital.

Situations also frequently arise, where one law enforcement agency maintains custody of an individual under an ECO in the emergency department or other evaluation center, and then must be relieved of custody by the law-enforcement agency of the person’s residence. The relieving agency may only need to transport the person a short distance to a TDO facility of escort the person from the emergency department to the psychiatric unit of the same hospital. If there is an alternative transportation provider, the law-enforcement agency of the person’s residence must travel to the evaluation site, relieve the first law-enforcement agency, take custody of and serve the person, and turn custody over to the transportation provider. One remedy would be to amend the statute to permit the magistrate to specify the law-enforcement agency that currently has custody to execute the TDO and provide the transportation when continued custody appears more efficient.

The Opinion does not mention, and agencies often overlook, the provision in § 37.2-810(C) that permits law-enforcement agencies to enter into mutual aid agreements to ease the burden on one another when provision of transportation by an alternative provider is not feasible, or to work out transportation arrangements that are mutually beneficial and make the best and most efficient use of public resources.

The opinion may be accessed at:  
<http://www.oag.state.va.us/Opinions%20and%20Legal%20Resources/Opinions/2011opns/11-123-Mullins.pdf>.

## **Recently Settled and Decided Cases**

### **DOJ Settles ADA Investigation of Delaware Psychiatric Center**

The United States Department of Justice (“DOJ”) entered into a Settlement Agreement with the State of Delaware in July 2011 resolving its investigation under the Americans with Disabilities Act of the Delaware Psychiatric Center, the State’s only state-run facility for persons with mental illness. *United States v. Delaware*, Civil Action No. 11-591-LPS (July 6, 2011). The Settlement Agreement followed DOJ’s on-site inspections of the hospital and community programs conducted in May 2008 and August 2010 and the issuance of its investigative “findings” letter on November, 9, 2010

The Agreement requires Delaware to implement programs and services to prevent institutionalization of at-risk individuals by offering community-based services in accordance with a strict 5-year implementation schedule beginning with the date of the Agreement and ending July 1, 2016. The target population to be served under the agreement includes individuals with serious and persistent mental illness who are at highest risk of institutionalization whose symptoms manifested in the last year, resulted in functional impairment which substantially interferes with or limits one or more major life activities and has episodic, recurrent or persistent features. Priority for receipt of services must be given to people currently at Delaware Psychiatric Center, including those on forensic status, people discharged from the Delaware Psychiatric Center in the last two years, people admitted to private institutions for mental disease (“IMDs”), people who have had an emergency room visit in the last year due to mental illness or substance abuse, people who have been arrested, incarcerated or had encounters with law enforcement in the last year due to mental illness, people who have been homeless a full year or had four or more episodes of homelessness in the last three years, and people who have requested services or who have been referred for services by others in the last year.

Services provided must be implemented statewide and be linguistically and culturally competent, solution-focused and recovery-oriented. Mandated services include crisis services, including a crisis hotline, mobile crisis teams, crisis walk-in centers, crisis stabilization services, and crisis apartments, intensive support services, including assertive community treatment,

intensive case management, and case management with specific caseload limits specified, housing, including supported housing, supported employment and rehabilitation services, and family and peer supports.

Each individual now in or being admitted to the Delaware Psychiatric Center or an IMD must have a transition plan developed through a person-centered planning process that identifies barriers to placement and steps that will be taken to address the barriers. A central specialized transition team must also be established to focus on individuals when teams have identified that the person is to remain in the Psychiatric Center or an IMD or placed in a less integrated setting, such a congregate living or a nursing home, or who have intensive behavioral or medical needs. Once a plan has been developed, the person must be discharged within 30 days. For individuals on forensic status, the State must educate judges on the recommended placement and services. All individuals must be reassessed with 30 days of the signing of this Agreement and the transitional and specialized teams must be in place within 60 days.

Central to the Settlement Agreement is a comprehensive risk management and performance improvement system that must be approved by the Monitor. The system includes a provision that all providers, including community providers have a risk management and performance improvement plan in place, including a requirement that they complete a root cause analysis within 10 days of any person receiving services experiencing harm. Harm includes any physical or emotional injury, whether caused by abuse, neglect or accidental injury. Corrective action plans must be developed and the State must establish a Performance Improvement Section that will monitor and follow-up on implementation of all corrective action plans. These expectations must be included in all contracts the State enters into with providers and must be performance-based. The State must also develop a detailed data collection process and utilize the data to identify quality of care trends and to ensure a continuous loop of performance evaluation and improvement.

DOJ and the State also appointed a Monitor, Robert Bernstein, Ph.D., to oversee all aspects of the settlement implementation. The Monitor operates as an officer of the court with authority to independently observe, report on and make recommendations concerning the State's compliance. He has unimpeded and unmonitored access to all facilities, services, programs, staff, individuals receiving services, individual records and services plans, risk management and quality improvement documents, and receive reports of serious incidents and deaths, and state implementation reports. The Monitor must report to the court, DOJ and Delaware twice a year on Delaware's progress towards implementation of the Agreement. To carry out his duties and responsibilities, the Monitor may hire staff and consultants to assist him. Delaware must pay all the Monitor's expenses, making an initial deposit of \$100,000 into a court-managed fund upon which the Monitor will draw and which the State will replenish monthly.

Robert Bernstein is a clinical psychologist and President and Executive Director of the David J. Bazelon Center for Mental Health Law in Washington, D.C. Virginia will remember him as a Department of Justice consultant in its investigations of the Northern Virginia Mental Health Institute and Western State Hospital in the 1990s.

This Settlement Agreement is similar to the one DOJ entered into with the State of Georgia in November 2010 with respect to its mental health services. DOJ also conducted an on-site investigation under the ADA of Central Virginia Training Center near Lynchburg, Virginia in August 2011 concerning services provided to individuals with intellectual disabilities, the same month it concluded its investigation of the Delaware Psychiatric Center, and issued an investigative “findings” letter to Governor Robert McDonnell on February 10, 2011. Virginia has been negotiating corrective action with DOJ since that time and can expect any DOJ settlement demands to include statewide implementation of comprehensive services, similar to those negotiated with Delaware for persons with mental illness, designed to lead to a community-oriented system to be implemented on a tight time line and subject to strict monitoring and oversight.

The DOJ/Delaware Settlement Agreement may be accessed at:  
[http://www.justice.gov/crt/about/spl/documents/DE\\_settlement\\_7-6-11.pdf](http://www.justice.gov/crt/about/spl/documents/DE_settlement_7-6-11.pdf).

## **Washington Supreme Court Holds No Constitutional Mandate to Determine Competency to Represent Self**

The Washington Supreme Court has held that a trial court is not constitutionally required to independently determine whether a defendant was sufficiently competent to waive counsel when he had previously been found competent to stand trial following a pre-trial hearing. *In re Rhome*, 2011 Wash. LEXIS 743 (September 15, 2011). The court held that a defendant’s mental health status is but one factor a trial court may consider in determining whether a defendant has knowingly and intelligently waived his right to counsel and to represent himself.

In this case, Rhome was charged with first degree murder with a deadly weapon of a 17-year old girl. Another juvenile confessed to stabbing the girl but identified the defendant as the “mastermind” behind the killing. Since early childhood, the defendant had been treated for psychiatric disturbances, including several in-patient psychiatric hospitalizations. He had received a myriad of diagnoses including, psychotic disorder, delusional disorder, oppositional defiant disorder, mild mental retardation, obsessive/compulsive traits, and pervasive developmental disorder (Aspergers disorder). The trial court held a competency hearing finding that the defendant had not proved he was incompetent to stand trial. Throughout the pre-trial proceedings, the defendant asserted his right to represent himself. The court first denied his request to proceed *pro se* indicating that his ability to do so was equivocal. After his renewed request, the court advised him of the risks and engaged in colloquy to determine if he understood the significance of this undertaking. His mental health issues were not specifically addressed during the colloquy. The court granted his request and appointed standby counsel to assist him. The jury convicted the defendant and he was sentenced to 30 years in prison. A mental health expert for the defense who later examined the defendant’s performance in representing himself testified that his mental illness impacted his ability to defend himself in court. He testified that the defendant engaged in perseverative and aggressive questioning that was incoherent or intimidating, and he was unable to self-regulate his emotions and behavior.

In June 2008, just following the state courts' denial of the defendant's direct appeals, the United States Supreme Court decided *Indiana v. Edwards*, 554 U.S. 164 (2008). In *Edwards*, the Supreme Court held that a trial court could insist that a defendant proceed with counsel even though the court had found the defendant was competent to stand trial. The Washington Court stated that the *Edwards* decision assumes that a defendant will "assist" in his defense, not "conduct" his defense when the defendant has been found competent to stand trial. Competency to stand trial does not equate with the right to represent oneself and the Supreme Court declined to set a standard for the state to follow. In determining whether a defendant has the right to waive counsel, the court considers his background, experience and conduct, which may include his history of mental illness. In denying his petition for post-conviction relief, the Washington Supreme Court held that a defendant's mental health status is but one factor a trial court must consider in determining whether a defendant has knowingly and intelligently waived his right to counsel. An independent determination of competency for self-representation is not a constitutional mandate.

### **First Circuit Denies Habeas Relief That Counsel Was Ineffective in Failing to Request Competency Evaluation**

The First Circuit Court of Appeals has denied habeas corpus relief to a petitioner who was convicted of first degree murder in Massachusetts who allowed his 11-month old son to die based upon his religious beliefs. He argued that his counsel at trial was ineffective because he had an obligation to seek a competency to stand trial evaluation and that he failed to raise an insanity or diminished capacity defense. *Robidoux v. O'Brien*, 643 F.3d 334 (1<sup>st</sup> Cir. 2011).

The defendant in this case was a member of a religious sect led by his father that believed that a number of institutions, including the legal system, medical system and mainstream religion were invalid and its members were instructed to eschew doctors and medicines. The evidence showed that until he was about 8 months old, the child was thriving and well nourished, but about that time the defendant's sister got a "leading," instructing that the mother should feed the child only breast milk in limited quantities. Thereafter, the infant began to fail. The defendant and his wife failed to take the infant to a doctor or to provide him with a proper diet. The day after the sect conducted a special meeting to pray for the child, he died. After concealing the body in his sister's house for several months, the defendant buried the baby in Maine. The police located the body a year after the burial when a defector from the sect reported the death to authorities.

At trial, the defendant argued that the prosecution could not prove the cause of death was malnutrition, based upon the testimony of his forensic expert that the infant could have died from any number of causes. The chief medical examiner testified that the condition of the decomposed body was indicative of severe malnutrition due to starvation. The defendant testified in his own defense that he had no intent to harm the child. The jury convicted him of first degree murder and he was sentenced to life in prison.

In seeking habeas corpus relief, the defendant argued primarily that his counsel should have pursued an insanity or diminished capacity defense based upon three affidavits, the first from a psychologist who never interviewed the defendant stating that the defendant was unable

to appreciate or understand that it was wrong to deprive his son of solid food. The Director of the New England Institute for Religious Research stated that the defendant's father exercised undue influence over him and other sect members that made it impossible for counsel to present an adequate defense. The defendant himself filed an affidavit stating that counsel discussed the insanity defense with him, but he refused to talk with a doctor or psychotherapist prior to trial due to his religious beliefs.

The trial court found that counsel properly defended the case based upon the judge's own observations of the defendant in court, the answers provided in colloquies from the bench, and his testimony at trial, even though he presented a rambling eve-of-trial motion to represent himself saying the government had no jurisdiction to try him, which she found appeared a tactic to delay trial. No fact-finding hearing was conducted on his competency to stand trial.

The First Circuit articulated the standard in ineffective assistance of counsel cases that there must be proof that counsel fell below the minimum standards of representation and there was a reasonable probability that the deficiency altered the outcome of the case. Where raising a particular defense is a strategy choice, counsel will be given special deference. On the other hand, if substantial indications exist that the defendant was not competent to stand trial, counsel is not faced with a strategy but with a settled obligation under Massachusetts and federal law to raise the issue with the court and seek a competency evaluation. Competency is a functional concept focusing on the defendant's part in the trial, namely whether the defendant understands the nature of the proceedings against him and is able to assist counsel in his defense. In this case, it appears that he argued that the government had no legitimate authority over him, but he engaged in an intelligent and articulate colloquy with the court and as a witness. There was no evidence that the defendant had ever suffered from a mental illness or that he failed to understand the proceedings or cooperate with counsel. Although state court findings are generally accorded no deference absent an evidentiary hearing, there was no evidence presented that a competency hearing was necessary.

In addition, the 1<sup>st</sup> Circuit held that the defendant could decline to assert an insanity defense and refuse a psychiatric examination, which he apparently did. His current defense counsel argued that he suffered from a delusional disorder based on his religious illusions that God and prayer, not ordinary nourishment, would protect his son. He also argued that his diminished capacity prevented him from forming the necessary intent to support a conviction for first degree murder. The appellate court held that there was no evidence to support a mental illness and that the law provides for the denial of medical care in certain situations based upon religious beliefs, such as for example, those held by Christian Scientists and Seventh Day Adventists, but the evidence, including the defendant's own testimony indicated that he understood the risk.

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<sup>i</sup> Marilyn Tavenner, former Virginia Secretary of Health and Human Resources, is currently the Acting CMS Administrator and President Barack Obama has nominated her for appointment as the permanent administrator.

<sup>ii</sup> Section 482.13 *Condition of Participation: Patient's rights*

(e) *Standard: Restraint or seclusion.* All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Definitions. (i) A restraint is—

- (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or
  - (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
  - (C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- (2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member or others from harm.

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- (3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
  - (4) The use of restraint or seclusion must be—
    - (i) In accordance with a written modification to the patient’s plan of care; and
    - (ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.
  - (5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.
  - (6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
  - (7) The attending physician must be consulted as soon as possible if the attending physician did not order restraint or seclusion.
  - (8) Unless superseded by State law that is more restrictive—
    - (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member , or others may only be renewed in accordance with the following limits for up to a total of 24 hours:
      - (A) 4 hours for adults 18 years of age or older;
      - (B) 2 hours for children and adolescents 9 to 17 years of age; or
      - (C) 1 hour for children under 9 years of age; and
    - (ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

<sup>iii</sup> The Report may be accessed at: <http://www.oig.virginia.gov/documents/SAR-10-1-10-03-31-11.pdf>.

<sup>iv</sup> See CMS Interpretive Guideline § 482.13(e), Tag A-0154.

<sup>v</sup> See CMS Interpretive Guideline § 482.13(e)(1)(i)(C), Tag A-0161.

<sup>vi</sup> See e.g., the Virginia Health Care Decisions Act, § 54.1-2981 *et seq.* (governing advance directives and substitute consent in absence of advance directive); Virginia Code § 37.2-1000 *et seq.* (guardianship proceedings); Virginia Code § 37.2-400 and 12 VAC 35-115-70, -145, -146 (human rights statute and implementing regulations assuring rights of individuals receiving behavioral health services); Virginia Code § 37.2-1100 *et seq.* (judicial authorization for treatment); Virginia Code § 54.1-2970 (two physician/dentist provision).

<sup>vii</sup> Virginia Code §§ 37.2-1101, -1102.