

DEVELOPMENTS IN MENTAL HEALTH LAW

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Health Department Advance Directive Registry Becomes Operational

The Virginia Department of Health’s secure on-line Advance Directive Registry, established through a public-private partnership with Microsoft® HealthVault® and UNIVAL, Inc., became operational in December 2011 for individuals to store and retrieve health care decision-related documents. An individual may now submit his or her 1) health care power of attorney, 2) advance directive created pursuant to the Health Care Decisions Act, and 3) declaration of an anatomical gift made pursuant to the Revised Uniform Anatomical Gift Act, § 32.1-291.1 *et seq.* and any subsequent revocations of those documents to the registry. Although the legislation requires the person submitting the documents to pay any fee prescribed by the Department, submission of documents to the registry is currently free.

The Advance Directive Registry may be accessed at <https://www.virginiaregistry.org>. The website provides instructions enabling an individual to register and set up an account to store the individual's documents, access to a downloadable advance directive form, the ability to view documents with an ID card, and links to Microsoft HealthVault, the Virginia State Bar and Virginia Hospital and Health Care Association websites that provide sample forms and information about advance directives, and Donate Life Virginia for access to the organ, eye and tissue donor registry.

The Virginia General Assembly enacted § 54.1- 2994 *et seq.* in 2008 directing the Department of Health to establish the secure on-line registry. Section 54.1-2995 specifies the documents that may be submitted to the registry and provides that *only* the person who executed the documents may submit them. It requires that data and information contained in the registry be kept confidential and exempts it from the Virginia Freedom of Information Act. This section also requires the Board of Health to adopt regulations pertaining to implementation of the registry including 1) determining who may access the registry, including physicians, other licensed health care providers, the individual and his legal representatives or designees, 2) providing annual reminders to registry users of which documents they have registered, and 3) setting any fees. The regulations¹ state that it is the responsibility of the person registering the document to provide persons with information necessary to access the registry, which includes the person's name, PIN and password. 12 VAC 5-67-30.

Submission of an advance directive to the registry is not required to make the directive effective. The registry has been established as a convenience to the public to provide a secure place to store these documents and to permit healthcare providers and others to easily access them when needed. Section 54.1-2996 specifically provides that failure to register a document with the registry does not invalidate the document and failure to notify the registry that a document has been revoked does not affect the validity of a revocation as long as it was revoked in accordance with statutory requirements.

In 2010, the General Assembly amended the statute to remove initial requirements that documents filed with the registry be notarized. It also added a requirement in the second enactment clause requiring the Commissioner of Health to work with the Department for the Aging, Department of Health Professions, the Bureau of Insurance, and the Virginia State Bar and obtain input from a multitude of private stakeholder organizations to develop and implement a plan for informing the public about the availability of the registry.

The General Assembly enacted the legislation establishing the registry at the onset of the current recession in 2008 with no funding available. As a result, it instructed the Department of Health to solicit grants, gifts, contributions and other assistance in establishing the registry from federal, local, or other private sources to make the registry available. As a result of this unique public-private partnership, the registry operates with no state funding.

UNIVAL, Inc. hosts the registry, providing a toll-free telephone number and help desk available Monday through Friday from 8:00 a.m. to 5:00 p.m. Documents may be submitted to

¹ The full regulations, 12 VAC 5-67-10 *et seq.*, may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC5-67-10>.

the registry through any process available to the user, such as uploading a document in .pdf or .tif format, faxing with a fax cover sheet to a toll-free number maintained by UNOVAL, or using regular mail. The individual may select five email addresses, including those of family and friends or designated representatives and health care providers with whom to share their PIN and access code to access their documents. The individual should receive a wallet card to carry with him or her to provide to healthcare providers when necessary. UNIVAL uses contact information to provide news, information about new features, services or updates to the user. It also sends yearly renewal notices to users. Users must reply that the information registered is accurate or make changes within six months of the notice or their account will be deactivated. It archives data for five years unless a registered user asks that the information be deleted.

In order to access the website, a user must agree to the Terms and Conditions currently posted on the Advance Directive Registry website, which according to the Terms and Conditions, may change at any time without notice to users. As part of the Terms and Conditions, the individual agrees not to provide any false information to the registry and to update or correct any information if it becomes outdated or misleading. This means that each user is obligated to upload new documents when changes are made, if information changes or if an agent changes. Individuals must therefore remember to update their documents when changing any end-of-life or healthcare instructions, or healthcare agent to prevent any healthcare providers to whom they may have provided access from following any outdated instructions.

During the same session at which it passed legislation enabling the establishment of the registry, the General Assembly also made significant revisions to the Health Care Decisions Act, Virginia Code § 54.1-2981 *et seq.* Prior to 2008, an individual could only make an advance directive providing instructions for care and treatment when in a terminal condition or appointing a health care agent to make health care decisions for them while incapacitated. That year, upon recommendation of the Commission on Mental Health Law Reform, the General Assembly expanded the use of advance directives to permit the individual to give instructions related to all types of health care situations, not only end-of-life decisions. It also included provisions found in other states in separate so-called “psychiatric advance directives,” with explicit provisions enabling an individual to authorize or refuse treatment for psychiatric illnesses, including authorizing treatment over their own objection or limited admission to a psychiatric hospital. It is important to note that these advance directives, including provisions related to treatment for psychiatric conditions, may all be submitted to the Advance Directive Registry.

The Advance Directive Registry is in its early implementation stages and issues concerning its implementation will undoubtedly arise. Some issues have already been identified including concerns about security of the documents. Carrying wallet cards that contain an individual’s registry access information and providing passwords to health care providers for inclusion in their patient records may pose risks.

Another issue involves the legal requirement that only the person executing the document may submit it to the registry. Many older citizens and individuals with disabilities may not have access to technology to readily enable them to submit their documents to the registry or to access them once submitted. In addition, as a person becomes more incapacitated - the very situation for which individuals execute these documents - he or she may be unable to receive or act upon the

annual notices received from the registry within the six months required and their documents may be deactivated. An open question also remains as to whether a guardian, agent or legal representative may respond to the annual notice or provide updates or changes in information to the registry. An amendment to the statute to permit the person's agent, guardian or legal representative to do this might be helpful. In the meantime, it is important that the individual provide the registry with the internet addresses of their agents, representatives or family members, so that they may assist them with this process. The Health Department is considering all of these implementation concerns to which no easy answers are available.

2012 Virginia General Assembly Update²

General Assembly Makes MOT Easier to Impose

In another attempt to make MOT work, Delegate David Albo this year introduced, and the General Assembly enacted House Bills 475³ and 476⁴. House Bill 475 clarifies a portion of the commitment criteria found in Virginia Code § 37.2-817.D pertaining to mandatory outpatient treatment (“MOT”) in lieu of inpatient hospitalization and streamlines the findings the treating physician must make under § 37.2-817.C2 when discharging an involuntary patient to “step-down” MOT. It also extends the length of the step-down MOT from the combined maximum for both the inpatient and outpatient commitment of 30 days to 90 days. House Bill 476 will authorize a court to subject a person who was subject to a civil commitment proceeding and accepted a period of involuntary inpatient treatment to MOT upon the “motion” of the individual's treating physician, family member or personal representative, or community services board.

Recent MOT History

In the wake of the Virginia Tech tragedy, the Virginia General Assembly enacted legislation in 2008 establishing a defined process through which courts could order individuals to mandatory outpatient treatment (“MOT”) in lieu of inpatient psychiatric hospitalization.⁵ In so doing, it also imposed increased accountability on the community services boards (“CSBs”) to deliver services to individuals and monitor their compliance in the belief that this would ensure another tragedy did not occur. At the same time, the legislation relaxed the “imminent danger” commitment criteria somewhat making it easier to commit an individual. Thereafter, however, MOT was used even less frequently than before the Virginia Tech tragedy. A number of reasons

² Unless indicated otherwise, all bills have been signed by the Governor and become effective July 1, 2012.

³ The full text of House Bill 475 may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0501+pdf>.

⁴ The full text of House Bill 476 may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0300+pdf>.

⁵ A summary of the literature related to assisted outpatient treatment and mandatory outpatient treatment may be found in the 2008 and 2009 Reports of the Commission on Mental Health Law Reform, Future Commitment Reforms Task Force at:

http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2009_1201_tf_commitment_rpt.pdf and http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_1201_tf_commitment_rpt.pdf.

for the decline in its use have been given, including the fact that the MOT criteria is the same as the commitment criteria for inpatient hospitalization and thus too high; the services must actually be available and service providers must actually agree to deliver them; Virginia's 48-hour maximum detention period is too short a timeframe in which to develop the required treatment plan; and the process is overly complicated and too burdensome to implement for both the courts and the CSBs.⁶

Recognizing that the MOT process was not successful and following publication of the New York Study⁷ of Kendra's law in the summer of 2009, the General Assembly enacted a "step-down" MOT process in 2010 to permit a court to order mandatory outpatient commitment following a period of inpatient commitment if the treating physician certifies a number of factors at the time of discharge. Although designed as an outpatient commitment process, the New York study revealed that Kendra's law was used most frequently as a "conditional release" form of outpatient treatment following inpatient treatment. The goal of the Virginia legislation was to permit the court to order a person to MOT following a period of inpatient hospitalization without the necessity of returning to court to obtain a new order. Rather than utilizing the commitment criteria, the General Assembly amended Virginia Code § 37.2-817 enacting a two-prong test in new subsections C1 and C2 permitting a court to commit an individual to inpatient hospitalization and then authorize mandatory outpatient treatment following a period of inpatient treatment if the court finds that the individual meets further specific criteria, namely:

(i) the person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission...;(ii) in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent a relapse or deterioration that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; (iii) as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment following inpatient treatment; and (iv) the person is likely to benefit from mandatory outpatient treatment.

At the time of discharge from the period of inpatient hospitalization, the language in subsection C2 prior to this year's amendment permits the treating physician to discharge the person to mandatory treatment if he determines that

the person (a) in view of [his] treatment history and current behavior, no longer needs inpatient hospitalization, (b) requires mandatory outpatient treatment at the

⁶ Askew, Amy Liao, Use of Mandatory Outpatient Treatment in Virginia – A Preliminary Report on the First Two Years, University of Virginia School of Medicine, Department of Public Health Services, January 2011 at: http://www.courts.state.va.us/programs/cmh/reports/2011_01_mot_report.pdf. An excerpt of the study may also be accessed in Developments in Mental Health Law, Vol. 30, Issue 2, March 2011 at: <http://ilppp.virginia.edu/PublicationsAndPolicy/Index>.

⁷ Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan, J., New York State Assisted Outpatient Treatment Program Evaluation, Duke University School of Medicine, Durham, NC, June 2009 and may be accessed at: http://www.macarthur.virginia.edu/aot_finalreport.pdf.

time of discharge to prevent relapse or deterioration of his condition that would likely result in his meeting the criteria for involuntary inpatient treatment, (c) has sufficient capacity to understand the stipulations of his treatment, (d) has expressed an interest in living in the community and has agreed to abide by his discharge plan, (e) is deemed to have the capacity to comply with the discharge plan and understand and adhere to conditions and requirements of the treatment and services, and (f) the ordered treatment can be delivered on an outpatient basis by the community services board or designated provider; and (2) at the time of discharge, services are actually available in the community and providers of services have actually agreed to deliver the services.

Until this year's amendment and as a compromise, this "step-down" MOT would only last for the maximum period of the initial commitment order, or 30 days, unless a new petition to continue the outpatient treatment is filed with the court and ordered.

No evaluation of Virginia's "step-down" process has been completed, but anecdotal information indicates that it, too, is seldom used because of the complexity of the process, the difficulty in proving the person meets the added "step-down" criteria within the 48-hour time frame to conduct a hearing, the lack of available services in the community, and the shortness of the order. The New York Study and other studies⁸ also reveal that a minimum of 180 days of mandatory outpatient treatment is needed to be effective to promote an individual's voluntary adherence to a treatment regimen and prevent future inpatient hospitalizations.

House Bill 475 – MOT Criteria Change

House Bill 475 passed this Session first simplifies the criteria for ordering MOT in lieu of inpatient hospitalization found in Virginia Code § 37.2-817.D. It retains the two prong civil commitment criteria for inpatient hospitalization, but permits the court to order MOT if it finds that less restrictive alternatives to involuntary inpatient treatment are appropriate and the "(c) person has agreed to abide by his treatment plan and has the ability to do so; and (d) the ordered treatment will be delivered on an outpatient basis by the community services board or designated provider to the person."

House Bill 475 also simplifies somewhat the findings the treating physician must make under § 37.2-817.C2 quoted above prior to discharging a person to MOT following a period of involuntary hospitalization. The physician will now be required to find that "(i) the person (a) in view of [his] treatment history and current behavior, no longer needs inpatient hospitalization, (b) requires mandatory outpatient treatment at the time of discharge to prevent relapse or deterioration of his condition that would likely result in his meeting the criteria for involuntary inpatient treatment, and (c) has agreed to abide by his discharge plan and has the ability to do so; and (ii) the ordered treatment will be delivered on an outpatient basis by the community services board or designated provider to the person."

⁸ *Id.* See also, Schwarz, M., Swanson, J., Hiday, V., Wagner, H.R., Burns, B. and Borum, R. (2001). A randomized controlled trial of outpatient commitment in North Carolina, *Psychiatric Services*, 52, 325-329.

House Bill 475 also increases the maximum length of the combined inpatient and “step-down” order from 30 days to 90 days. Although a court may now judicially authorize administration of medication over a person’s objection to a person who is subject to an order of outpatient treatment under Virginia Code § 37.2-1102(3), House Bill 475 also clarifies that restraint or physical force cannot be used to administer medications to individuals who are subject to a MOT order.

House Bill 476 – MOT for Voluntary Patients

In a more radical extension of the use of MOT, House Bill 476 will permit an individual who is the subject of a temporary detention order and elects to voluntarily admit himself to a psychiatric facility to be subjected to a MOT order upon discharge. For many years, Virginia Code § 37.2-814 has required the court at the beginning of a commitment hearing to offer the individual the opportunity to apply for voluntary admission in lieu of proceeding with the commitment hearing. Effective July 1, 2012, a treating physician, a family member or a personal representative of the person, or the CSB serving the area where the facility is located may file a “motion” with the court to subject this person to MOT. To be ordered to MOT, a voluntary patient who was the subject of a temporary detention order prior to the voluntary admission, must on at least two previous occasions within 36 months preceding the date of the hearing have been the subject of a temporary detention order and voluntarily admitted himself or been involuntarily committed. Upon the filing of such a motion, the court must hold a hearing prior to the person’s discharge and within 72 hours,⁹ (not 48 hours as is required when a temporary detention order has been issued) to determine whether the person should be ordered to MOT under subsection D of § 37.2-817, the subsection pertaining to MOT in lieu of inpatient hospitalization, and not subsection C1 and C2 pertaining to “step-down” MOT.

The Virginia General Assembly has thus expanded the use of MOT for both individuals involuntarily committed and certain individuals subject to involuntary commitment proceedings who voluntarily admit themselves. It has also lengthened the period of the initial outpatient treatment order to 90 days. Extension of the MOT period still falls short of the 180 days that research shows is necessary for it to be effective in achieving treatment adherence and preventing future hospitalizations, but it will at least provide sufficient time to permit a treatment plan to be initiated and some indication of whether the plan will be successful or not. More time will therefore be available to petition for its extension under Virginia Code § 37.2-817.4. The criteria is a little less cumbersome than the current law to implement, but probably not sufficiently less cumbersome to enable its more widespread use.

Most unfortunate is that at a time when advocates and mental health professionals are trying to move the system away from a coercive model of treatment and develop strategies to increase voluntary treatment and reduce stigma, House Bill 476 will subject those accepting voluntary treatment to the threat of additional coercive orders. It may therefore have the opposite effect of encouraging individuals to accept voluntary treatment. Research has shown that people will adhere to treatment much more effectively on a voluntary basis than when they feel coerced, and many will avoid treatment altogether for fear that involuntary and ineffective

⁹ As in the commitment process, if the 72-hour time period ends on a weekend or holiday, the time for conducting the hearing may be extended until the next business day.

treatment will be imposed.¹⁰ In order to implement an effective, but limited MOT system, the process must be further streamlined. Most importantly, the availability of voluntary mental health services needs to become more readily available and effective strategies need to be implemented to encourage their access on a voluntary basis, rather than the need to resort to additional coercive measures, as this legislation does.

Mental Health Commission’s Proposal on Judicial Authorization Bill Passes

The General Assembly has passed House Bill 638,¹¹ introduced by Delegate Christopher Stolle, and Senate Bill 371, introduced by Senator George Barker, that updates statutory provisions for the judicial authorization of treatment found in Virginia Code §§ 37.2-1101 and 37.2-1102 to conform to recent changes in the Health Care Decisions Act, § 54.1-2981 *et seq.* Approved in principal by the Commission on Mental Health Law Reform at its last meeting in June 2011, the legislation 1) clarifies what the term “unavailable” means when an individual lacks capacity to consent to treatment and no authorized representative is “available” to provide substitute consent; 2) requires judges to adhere to a person’s advance directive or preferences if known when authorizing treatment; 3) clarifies that health care providers may provide necessary treatment in an emergency without getting judicial authorization; and 4) permits judges to authorize restraint to safely administer medication to an involuntarily admitted individual.

The first amendment in § 37.2-1101.G.1 specifically permits the court to authorize treatment for an individual found to be incapacitated if there is no available person with legal authority under the Health Care Decisions Act, the Department of Behavioral Health and Developmental Services (“DBHDS”) Human Rights Regulations,¹² or under other applicable law. A potential authorized representative is deemed “unavailable” if he or she “(i) cannot be contacted within a reasonable period of time in light of the immediacy of the need for treatment..., (ii) is incapable of making an informed decision, or (ii) is unable or unwilling to make a decision regarding authorization of the proposed treatment or to serve as the legally authorized representative.” Anecdotal information indicates that some courts have held they lacked jurisdiction in the above situations, leaving the individual’s care in limbo.

The second amendment to subsection G.4 prohibits the court from authorizing treatment that is “contrary to the provisions of an advance directive executed by the person pursuant to [the Health Care Decisions Act] or is proven by a preponderance of the evidence to be contrary to the person’s religious beliefs or basic values or to specific preferences stated by the person before becoming incapable of making an informed decision, unless the treatment is necessary to prevent death or a serious irreversible condition.” If an individual has clearly stated in an advance directive or otherwise that he or she does not wish to be treated with a certain medication, or any

¹⁰ Bruce J. Winnick, *Civil Commitment – A Therapeutic Jurisprudence Model*, Carolina Academic Press (2005). See also, the 2008 Report of the Commission on Mental Health Law Reform, Task Force on Future Commitment Reforms Task Force at:

http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_1201_tf_commitment_rpt.pdf.

¹¹ House Bill 638 may be accessed in its entirety at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0378+pdf>.

¹² *The Rules and Regulations to Assure the Rights of Individuals Receiving Services From Providers Licensed, Funded or Operated by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-115-10 *et seq.* at: <http://leg1.state.va.us/000/reg/TOC12035.HTM#C0115>.

medication, a court may authorize a treatment provider to administer that treatment only when necessary to prevent death or a serious irreversible condition.

The third amendment adding a new subsection I to § 37.2-1101 clarifies that a treating physician or service provider may “administer treatment without judicial authorization when necessary to stabilize the condition of the person for whom treatment is sought in an emergency.” This clarification codifies the common law and should assist hospital emergency departments in administering treatment without the necessity of obtaining an emergency treatment order from a court.

Finally, the fourth amendment amends § 37.2-1102(4) to permit courts to authorize restraint or transportation when necessary to the administration of authorized treatment “for a mental disorder if the person is [also] subject to an order of involuntary admission.” The subsection previously only permitted the court to authorize restraint or transportation when treatment for a *physical* disorder had been authorized. This issue came to light because of the uncertainty last year concerning the interpretation of the Centers for Medicare and Medicaid Services (“CMS”) regulations regarding the use of restraint to administer medication.¹³ This amendment removes any impediment to the use of restraint for a mental disorder under state law. However, covered providers must still comply with the federal CMS regulations,¹⁴ and also any DBHDS Human Rights or Licensing¹⁵ Regulations.

Virginia P&A Agency to Become Nonprofit; Governor Recommends Amendments

The General Assembly passed House Bill 1230,¹⁶ introduced by Delegate Robert Orrock, that will make the Virginia Office for Protection and Advocacy (“VOPA”) a nonprofit entity no later than January 1, 2014. VOPA is Virginia’s Protection and Advocacy Agency (“P&A Agency”) under the federal Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 *et seq.* and the federal Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 *et seq.*

House Bill 1230 repeals all of Virginia Code §§ 51.5-39.1 through 51.5-39.12 that establish the agency. It then enacts a new § 51.5-13 that simply requires the VOPA Director, in consultation with its Board, to establish the agency as a nonprofit no later than December 31, 2013 and the Governor to designate it as such no later than January 1, 2014. The Fourth enactment clause requires the VOPA Director and the Secretary of Health and Human Resources to develop an implementation plan and to provide a report on the plan to the Governor and General Assembly by December 1, 2013.

¹³ See *Developments in Mental Health Law*, Vol. 30, Issue 6, July 2011 and Vol. 31, Issue 1, December 2011 at: <http://ilppp.virginia.edu/PublicationsAndPolicy/Index>.

¹⁴ 42 C.F.R § 482.13(e).

¹⁵ *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-105-10 *et seq.* at: <http://leg1.state.va.us/000/reg/TOC12035.HTM#C0105>.

¹⁶ The full text of House Bill 1230 and the Governor’s recommendations may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=121&typ=bil&val=hb1230>.

As originally passed by the General Assembly, the Secretary's and Governor's report was due by December 1, 2012. The Governor submitted a recommendation to change this date to December 1, 2013, which the General Assembly accepted at its Veto Session on April 18, 2012. It rejected, however, another Governor's recommendation requiring reenactment of the bill during the 2013 General Assembly Session to make it effective and requiring the Joint Commission on Health Care to study the effects of conversion and submit its report by December 1, 2012, presumably in time for the General Assembly to consider its ramifications at the 2013 Session. The Governor must now consider whether to sign the bill as amended or veto it in its entirety.

Conversion of VOPA will arguably impact adversely employees of VOPA who will lose their state employee benefits. All current VOPA employees are employees of the Commonwealth of Virginia, with most employees entitled to all of the benefits of classified state employees, including health insurance, retirement benefits, annual and sick leave accrual, professional liability insurance, and access to the state grievance procedure. Subsection C of the new § 51.5-39.13 makes it clear that current VOPA employees who transition to employment with the new nonprofit agency will not receive benefits of the Workforce Transition Act, the Act that guarantees severance benefits to employees who are laid off from their jobs. Apparently those who do not transition to the new agency and lose their jobs as a result will be eligible for these benefits.

Throughout its existence, VOPA has been plagued by claims of undue state control, either from the federal government or by individuals and other advocacy groups serving individuals with disabilities. Since its inception in 1977, Virginia's P&A agency has always been state-operated, now one of only eight state-operated P & A agencies in the country. Virginia first accepted federal funds through Executive Order in 1977 to protect and advocate for the rights of people with disabilities. The Dalton Administration withdrew Virginia from the federal program in 1981. Governor Robb began to again accept federal funds in 1982. Thereafter, the Office was established through legislation in 1984 and became the Department for the Rights of Virginians with Disabilities ("DRVD") in 1985. DRVD was first housed within the Health and Human Resources Secretariat and its director and governing board were appointed by the Governor. The Governor had to first approve any lawsuit brought against either public or private entities. In addition, the Attorney General had to approve the employment of DRVD's attorneys and provided it with legal advice and representation.

In 1991, the federal government expressed concern with the State's oversight of the program, especially the Governor's authority to veto lawsuits, and threatened to cut off funding. As a result, the General Assembly repealed the Governor's authority. Following a decade of Department of Justice investigations at four Virginia-operated mental health facilities and one training center, and the highly publicized death of an individual in seclusion at Central State Hospital, the General Assembly established the agency as an independent state agency in 2002, changing its name to the Virginia Office for Protection and Advocacy. The Governor now only appoints three members of its 11-member governing board that hires the director, and the General Assembly appoints the remaining members. The authority of the Attorney General to approve employment of attorneys and provide representation was removed.

Thereafter, VOPA brought a number of lawsuits or initiated complaints against several state agencies, including the Department of Medical Assistance Services, the Virginia Lottery and the Department of Rehabilitative Services. VOPA also brought suit against the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, now named Behavioral Health and Developmental Services, seeking the names of individuals on that Department's "ready for discharge" list. Upon settlement of the case, VOPA sought attorney's fees, which the Department opposed on the grounds that VOPA, a state agency, was not a person under 42 U.S.C. § 1983 for the purposes of bringing suit and therefore could not collect attorneys' fees. The Fourth Circuit Court of Appeals decided in the Department's favor. *VOPA v. Reinhard*, 405 F.3d 185 (4th Cir. 2005).

VOPA next sued the Commissioner to gain access to peer review records, which he defended on various grounds, including 11th Amendment sovereign immunity, arguing that one state agency cannot sue another state agency in federal court and that permitting federal court jurisdiction over essentially intramural disputes constituted an unwarranted intrusion into the internal workings of state government. That case culminated in the United States Supreme Court in a decision rendered in April 2011 in favor of VOPA in *Virginia Office for Protection and Advocacy v. Stewart*, 130 S.Ct. 1166, 175 L.Ed.2d 970, 2011 US LEXIS 3186 (Apr. 19, 2011). While that case was winding its way through the courts and to the consternation of members of the General Assembly, VOPA represented the Arc of Virginia, Inc. and several unnamed plaintiffs residing at Southeastern Virginia Training Center in a suit against the Governor and other state officials to prohibit the construction of a facility to replace the training center alleging a violation of the Americans with Disabilities Act. *The Arc of Virginia, Inc. v. Kaine*, 2009 U.S. Dist. LEXIS 117677. The court dismissed the suit, determining that it was not yet ripe for consideration, but the case garnered the ire of the General Assembly.

If the Governor does not veto the legislation and VOPA becomes a nonprofit entity, arguments over undue state control will disappear. VOPA will then be able to advocate and litigate with a free hand against the state and private entities providing services to people with disabilities. Gone also will be the humiliation involved when a state agency thwarts the will of the General Assembly or publicly "attacks" other state agencies. Its employees, however, will lose the benefits of classified state employment, but VOPA will be freer to advocate for the citizens it has been funded to serve.

Terminology Related to "Mental Retardation" Changed Throughout Code of Virginia to "Intellectual Disability;" "Consumer," "Patient," "Resident" Changed to "Individual Receiving Services"

House Bill 552,¹⁷ introduced by Delegate T. Scott Garrett, and Senate Bill 387, introduced by Senator Stephen Martin, changes the term "mental retardation" throughout the Code of Virginia to "intellectual disability" when referring to the diagnosis, and to "developmental" services when referring to services for individuals with intellectual disabilities. The bills also replace the terms "consumer," "patient," and "resident" with the term "individual receiving services" when used in connection with individuals with either mental health or

¹⁷ The full bill may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0507+pdf>.

intellectual disabilities. The bills also change the definition of “training center” to “a facility operated by the Department [of Behavioral Health and Developmental Services] that provides training, habilitation, or other individually focused supports to persons with intellectual disability.”

The Arc of Virginia and other advocacy groups have attempted for several years to update the Code of Virginia to remove the pejorative term “mental retardation” and to use “people first” language, but have met with opposition related primarily to the definition of “mental retardation” as it relates to defendants in capital cases. The term was not changed in Virginia Code §§ 19.2-19.2-264.3:1.1 and 19.2-19.2-264.3:1.2 related to imposition of the death penalty, thereby maintaining intact case law surrounding capital cases involving defendants raising the sentencing defense of “mental retardation.” Importantly, language promoting the dignity of individuals will be embodied in the Code of Virginia and will hopefully reduce some of the stigma against people with mental and intellectual disabilities.

Criteria for Hospitalizing Jail Inmates Expanded; Governor’s Amendment Limits Application

Through legislation introduced by Delegate Christopher Stolle,¹⁸ the General Assembly has amended Virginia Code § 19.2-169.6 to add a second prong to the criteria for committing inmates in local or regional jails to a psychiatric hospital. Following the General Assembly’s acceptance of the Governor’s recommendation to limit the effective date of the legislation, the change in criteria will expire July 1, 2014.

For years jail inmates have been subjected to the same first prong of the commitment criteria that applies to individuals subject to the civil commitment process, which since 2008 has been: “(i) the inmate has a mental illness; (ii) there is a substantial likelihood that, as a result of mental illness, the inmate will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and any other relevant information, if any.” The second prong of the civil commitment criteria also permits commitment if the person will, in the near future, “suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs,” but has never been available in the case of jail inmates. Ostensibly the reasoning is that the sheriff or regional jail superintendent has a duty to protect inmates from harm and provide for their basic needs for food, clothing and shelter.

Advocates and providers of services for inmates with mental illness housed in jail have long sought to add the second prong of the civil commitment criteria in order to provide needed psychiatric services to inmates. Some inmates are obviously flagrantly psychotic or are otherwise deteriorating to such an extent that they are unable to perform skills of daily living such as bathing or eating, but are not actively dangerous or causing trouble. Many refuse medication. Adding the second prong, however, would increase the number of inmates eligible for commitment, thus putting increased admission demands on the already overcrowded state-

¹⁸ The full version of House Bill 1280 and the Governor’s recommendation may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=121&typ=bil&val=hb1280>.

operated forensic hospitals and increase hospitalization costs. Instead, other advocates argue that sheriffs and regional jails should improve their provision of psychiatric care and upgrade their formularies to provide newer and more effective medications, thereby improving the care inmates receive in jail without the necessity of transferring them to state hospitals.

House Bill 1280 initially proposed adding the second prong of the criteria verbatim. The Senate objected due to the increased fiscal impact. In the conference committee, the House and Senate agreed to add one half of the second prong that provides: the inmate will “(b) suffer serious harm due to his lack of capacity to protect himself from harm as evidenced by recent behavior and any other relevant information,” thus removing the phrase “or to provide for his basic human needs.”

The Department of Planning and Budget’s (“DPB”) Fiscal Impact Statement references the “Mental Illness in Jails Report (2011)” prepared by the State Compensation Board that found approximately 6,500 locally held inmates are identified or are suspected of having mental illness, out of an average daily population of 25,000 inmates. This new criteria will expand the number of jail inmates who may be involuntarily admitted to state-operated forensic psychiatric facilities, but not as widely as adopting the full second prong of the civil commitment criteria. It is not clear how many of these inmates will now meet the second prong of the commitment criteria who also did not meet the first prong.

As a practical matter, DBHDS facilities can only admit jail inmates when they have vacancies. Expanding the criteria may result in the same numbers of inmates being admitted, but exacerbate the already extensive delays in admitting inmates, especially those charged with misdemeanors, that need competency to stand trial evaluations. Differing criteria for involuntary hospitalization of jail inmates will also cause some confusion for special justices who conduct these hearings, independent examiners and CSB pre-screeners who must implement the new criteria. The Governor’s amendment will give the Administration and General Assembly time to measure the impact of the criteria change before deciding whether to make it permanent at its 2014 Session.

SVP Commitment Criteria Expanded

Although concerned about the skyrocketing costs of housing the large numbers of sexually violent predators being committed to the Department of Behavioral Health and Developmental Services (“DBHDS”), the General Assembly has passed legislation adding an additional criterion for referring a prisoner to the Commitment Review Committee for evaluation. According to the Department of Planning and Budget’s Fiscal Impact Statement, it currently costs \$77,000 per year to house each inmate committed to DBHDS’s Virginia Center for Behavioral Rehabilitation in Nottoway County.

The Department of Corrections (“DOC”) may refer a prisoner for commitment who commits one of the defined sexually violent offenses and receives a score of four or five, depending on his offense, on the Static 99. In addition, House Bill 1271,¹⁹ introduced by

¹⁹ House Bill 1271 and the Governor’s recommendations may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?ses=121&typ=bil&val=hb1271>.

Delegate Chris Jones, and Senate Bill 314, introduced by Senator Harry Blevins, will require the DOC, effective January 1, 2013, to also refer inmates whose records contain aggravating circumstances that lead the director of DOC to determine that they appear to meet the definition of a sexually violent predator. An exception is provided for inmates who are so incapacitated by a permanent and debilitating medical condition or by terminal illness that they do not pose a threat to public safety. The second enactment clause requires the DOC Director to develop protocols to assess whether prisoners meet the definition by January 1, 2013 and report to the Governor and General Assembly on the protocol objectives, design, methodology, statistical considerations, embedded assumptions, risk assessments and organization of the full assessment process. The Commissioner of Behavioral Health and Developmental Services must designate the primary assessment tool, which must be a risk assessment instrument with a corresponding reference score. All measures must be consistent with evidence-based best practices.

After signing Senate Bill 314 into law, the Governor submitted technical amendments to House Bill 1271, which the General Assembly accepted at its Veto Session,. Under principles of statutory construction, when two similar bills are enacted that contradict one another, the later enacted bill is viewed as expressing the latest intent of the General Assembly and controls. The technical amendments to House Bill 1271 will therefore supersede the provisions in Senate Bill 314.

The General Assembly has also enacted House Bill 944,²⁰ introduced by Delegate Ronald Villanueva, and Senate Bill 461, introduced by Senator Thomas Garrett that amends Virginia Code § 37.2-906 to permit all hearings to determine whether probable cause exists to believe that the prisoner is a sexually violent predator to be held by a two-way electronic video and audio communication system. This will permit the prisoner, the witnesses and attorneys to appear before the court remotely. It will save on transportation costs and housing the respondent in the local jail pending the hearing, and will also minimize any escape risk associated with transporting violent predators.

Two College Mental Health Study Recommendations Pass

Two Recommendations of the College Mental Health Study prepared for the Joint Commission on Health Care passed the General Assembly.²¹ House Bill 852,²² introduced by Delegate Joseph Yost, and Senate Bill 375, introduced by Senator George Barker, implement the Study's recommendation clarifying Virginia Code § 23-2.1:3 that any students admitted to a public or private institution of higher education may be required to provide their mental health records from any schools from which they transfer and not just their originating secondary school.

House Bill 853,²³ also introduced by Delegate Yost, and Senate Bill 458, introduced by Senator Barker, amend Virginia Code § 23-9.2:8 that requires governing boards of all public

²⁰ House Bill 944 may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0246+pdf>.

²¹ A summary of the College Mental Health Study was published in *Developments in Mental Health Law*, Vol. 31, Issue 1 (Dec. 2011) and may be accessed at: <http://ilppp.virginia.edu/PublicationsAndPolicy/Index>.

²² House Bill 852 may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0382+pdf>.

²³ House Bill 853 may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+CHAP0697+pdf>.

institutions of higher education to develop and implement policies regarding students exhibiting suicidal tendencies by also requiring that they provide training where appropriate. The General Assembly also followed the Study Group's recommendation to delete the last two sentences in § 23-9.2:8 because they were confusing and contradictory. Those sentences required that the contents of any policy related to suicide ensure that students were not penalized or expelled solely for attempting suicide or seeking treatment for suicidal tendencies. It did permit the college or university to appropriately deal with students who were a danger to themselves or others or disruptive to the academic community.

The Study had recommended that community colleges be relieved of the obligation to develop suicide prevention policies until they have the mental health resources to carry them out. Senator Barker introduced Senate Bill 372²⁴ to do this, but the General Assembly carried this bill over until the 2013 Session of the General Assembly. The Secretary of Education submitted a fiscal impact statement indicating that implementation would initially cost \$2.5 Million to establish a secure web-based case management system with recurring costs of \$ 750,000 for licensing, staffing support, training and maintenance. In addition, another \$1 Million would be needed to retrofit existing office space to provide confidential interview rooms or to lease space from nearby locations. The Secretary further estimated that full implementation of the bill's provision to provide mental health services would exceed \$8 Million annually.

Guardianship and Power of Attorney Sections Move to New Title 64.2

For those who participate in guardianship proceedings, Senate Bill 115²⁵ introduced by Senator Ryan McDougle on behalf of the Virginia Code Commission, revises Title 64.1 pertaining to Wills and Estates and re-codifies it into a new Title 64.2 entitled "Wills, Trusts, and Fiduciaries." A new Subtitle IV has been created covering Fiduciaries and Guardians. All of chapters 10 and 10.1 in Title 37.2 pertaining to the appointment of guardians and enforcement of out-of-state guardianship proceedings have been moved into this new Subtitle as new Virginia Code §§ 64.2-2000 through 64.2-2109. In addition, all of the Title 26 provisions pertaining to powers of attorney, including the Uniform Power of Attorney Act, have been moved into the new Subtitle IV of Title 64.2. There do not appear to be any substantive changes in the law, which becomes effective October 1, 2012. Senate Document 15 (2011) contains the Report of the Code Commission describing the changes and includes comparative tables cross-walking the changes from the old to new Code sections.²⁶

Residents Move to Intervene in DOJ/Virginia Settlement Agreement Proceeding

Family members of thirteen residents in the five Virginia-operated training centers have filed a Motion to Intervene on behalf of the residents in *United States of America v.*

²⁴ Senate Bill 372 may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+SB372S1+pdf>.

²⁵ Senate Bill 115 may be accessed at: <http://leg1.state.va.us/cgi-bin/legp504.exe?121+ful+SB115ER+pdf>.

²⁶ Senate Document 15 (2011) may be accessed at: [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD152011/\\$file/SD15.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD152011/$file/SD15.pdf).

Commonwealth of Virginia (Civil Action No. 3:12-cv-059). The usually perfunctory Complaint filed by the Department of Justice (“DOJ”) against Virginia in the United States District Court in Richmond on January 26, 2012 and accompanying Motion requests the Court to approve and monitor the Settlement Agreement entered into between the parties to resolve DOJ’s investigation under the Civil Rights of Institutionalized Persons Act (“CRIPA”) of Central Virginia Training Center’s and Virginia’s compliance with the Americans with Disabilities Act (“ADA”). A portion of the Settlement Agreement requires the Commonwealth to submit a plan to the General Assembly to close four of the five training centers by June 30, 2020.²⁷

The residents are alleging that the terms of the Settlement Agreement, which they state was executed without consideration of their individual needs and desires and without consulting them or their family members, will adversely impact their rights under the ADA. Their family members allege on their behalf that the residents have chosen to reside in the training centers which is the least restrictive setting appropriate for their conditions and that their discharge or transfer from those centers may even be dangerous. The proposed Interveners have also filed a Motion to Dismiss DOJ’s Complaint, arguing among other things, that DOJ has no standing to pursue the claims it has asserted in its Complaint or to enforce the ADA; DOJ has not met the procedural prerequisites to bring a Title II ADA claim; and the DOJ Complaint abrogates the Centers for Medicare and Medicaid Services regulation of Virginia’s training centers.

Thomas York and two other members of his firm, the York Legal Group, LLC in Harrisburg, Pennsylvania, are representing the proposed Interveners. Mr. York has represented states in cases brought by DOJ in Pennsylvania, Florida, Arkansas and elsewhere, or parents’ groups in cases brought by other advocacy organizations which may have as their ultimate goal closure of state facilities for individuals with intellectual disabilities. Mr. York also assisted the Virginia Attorney General’s Office in defending the lawsuits DOJ brought under CRIPA in the early 1990s against the Northern Virginia Training Center and Eastern State Hospital.

After being bombarded with correspondence from families of individuals with disabilities, advocates and other groups, presiding District Court Judge John A. Gibney, Jr. entered a unique order on March 6, 2012 outlining a process for hearing from all concerned to assist him in deciding if the Settlement Agreement is “adequate, fair and reasonable, if the agreement is unlawful, or if it is against public policy.”²⁸ The Court authorized the submission of written comments by April 6, 2012, all of which it will consider as “briefs amicus curiae” in whatever form submitted. Amicus briefs have been filed by The Arc of Virginia, Virginia Down Syndrome Alliance, Virginia Office for Protection and Advocacy, and the Autism Societies of Northern Virginia, Tidewater, Central Virginia and the Peninsula. In addition, the Court and counsel will also visit at least one training center and other private facilities providing services for individuals with profound disabilities within a 30-mile radius of the State Capitol. The Court will then set a date for a hearing on the proposed Settlement Agreement. As of this writing, no date for hearing has been set.

²⁷ The complete Settlement Agreement and related information may be found on the Department of Behavioral Health and Developmental Services’ website at www.dbhds.virginia.gov.

²⁸ The Court’s March 6, 2012 Order is posted on DBHDS’ website at www.dbhds.virginia.gov.

The Court's Order also sets out the parameters of the Court's power. It notes that the Settlement Agreement does not force the closing of any institution in Virginia; it only requires the Governor *to submit a plan* to the General Assembly to close four of the training centers. The Court advises that the Settlement Agreement "is simply a plan or system for the Court to hold the state accountable on how it treats its disabled citizens." The Order states that "[t]he General Assembly need not close the facilities, and, in fact, can easily pass legislation requiring the Executive branch to keep the Training Centers open." Ironically, DOJ need not seek the Court's approval of the Settlement Agreement, but routinely does so as a policy matter and as a mechanism to ensure easy enforcement of settlement agreements. DOJ and Virginia could simply enter into an agreement to resolve the investigation without any court review or approval whatsoever. As the Court indicates in its Order, the only issues the Court will consider are whether the Settlement Agreement is "adequate, fair and reasonable, if the agreement is unlawful, or if it is against public policy." This should be a low hurdle for DOJ to meet.

Upcoming ILPPP Training Programs
Register at www.ilppp.virginia.edu

ILPPP ADVANCED: Evaluating Legal Sanity: Beyond the Basics

On **April 30, 2012**, Ira Packer, PhD, ABPP, of the University of Massachusetts School of Medicine, will present advanced training on evaluating legal sanity. Registration Schedule: \$50 - employees of VA DBHDS & its Community Services Boards, and employees of the Office of Attorney General. \$135 - all Others. (Agencies and organizations may consider negotiating a group discount: please advise els2e@virginia.edu.)

ILPPP ADVANCED: Motivational Interviewing

On **May 14, 2012**, David Prescott, LICSW, will present an introductory workshop on Motivational Interviewing, particularly with forensic and correctional populations. Registration Schedule: \$50 - employees of VA DBHDS & its Community Services Boards, and employees of the Office of Attorney General. \$135 - all others. (Agencies and organizations may consider negotiating a group discount: please advise els2e@virginia.edu.)

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