

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

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## **The Virginia Wounded Warrior Program: A Model for Outreach and Treatment**

**By Martha Mead, Special Projects Coordinator**

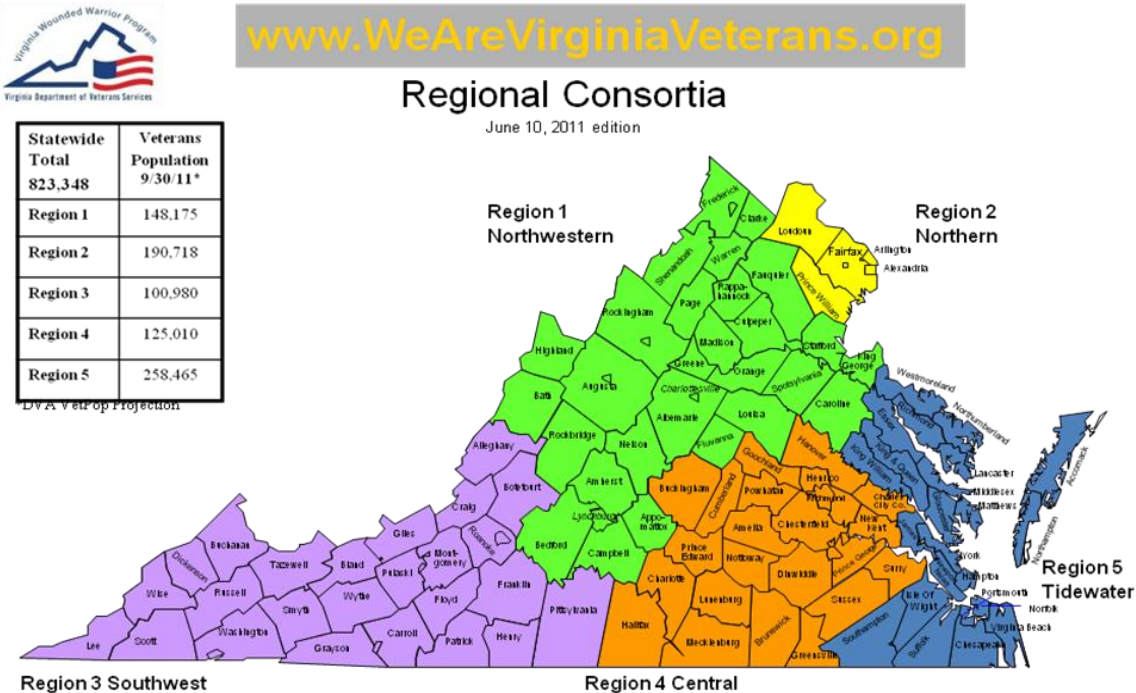
### ***The Virginia Wounded Warrior Program***

In the summer of 2007, the Joint Leadership Council of Veterans Services Organizations in Virginia (JLC) recognized the urgency of addressing the needs of veterans returning from Iraq and Afghanistan with problems caused by combat and deployment stress and traumatic brain injuries. On-going discussions and advocacy among the Virginia Department of Veterans Services, the U.S. Department of Veterans Affairs, the Virginia Departments of Behavioral Health and Developmental Disabilities (“DBHDS”) and Rehabilitative Services, representatives of the community services boards (“CSBs”),<sup>i</sup> and others, as well as the strong leadership of the JLC, resulted in legislation and funding that was approved unanimously by the General Assembly of Virginia and the Governor in 2008.<sup>ii</sup> This legislation created the Virginia Wounded Warrior Program, a statewide delivery and response system for veterans, members of the National Guard and Reserves, and their families needing behavioral health, primary healthcare,

rehabilitative services and community support.

Today, the Virginia Department of Veterans Services is led by CDR Paul Galanti, USN (Retired). CAPT Catherine Wilson, USN (Retired), Executive Director of the Virginia Wounded Warrior Program (VWWP), leads the VWWP and reports directly to Mr. Galanti. Five Regional Directors, all of whom have extensive military or state government experience combine their unique backgrounds in healthcare, behavioral healthcare, training, human resources and human services to lead the regionally contracted programs provided by locally based VWWP staff. These staff partner with local health, mental health and rehabilitative services providers, non-profit and veterans services organizations and other community-based resources. VWWP staff are based in CSBs and have regional responsibility for outreach and connections to services for veterans and their families. The VWWP regions, illustrated in Figure 1, are almost identical to the CSB health planning regions.

The regional programs offer case management, care coordination, linkages to healthcare, behavioral health care and veterans benefits, including financial assistance and employment services. Services include comprehensive assessment of individual and family needs, screening and referral for post traumatic stress disorder or traumatic brain injury, mental health and substance abuse treatment, peer and family support groups, marriage and family therapy and outreach and community education. VWWP services may vary depending upon the regional needs and makeup of the local programs. All of the VWWP programs have strong connections with the Veterans Affairs Medical Centers, the local vet centers, the community-based outpatient clinics and other local veteran-serving organizations.



Statewide toll free number: 1-877-285-1299.

**Figure 1**

In State Fiscal Year 2011, the VWWP served 3,617 veterans and family members, a 119% increase over SFY 2010. Employing the time and talents of the Executive Management Team, Resource Specialists, Peer Specialists and five dedicated VWWP Regional Coordinators, VWWP was active and visible at 615 community events reaching more than 20,000 Virginians. This includes briefings estimated to have reached 6,550 military personnel and their families.

VWWP provides services to veterans of any era and their family members. Many veterans seek assistance initially for concerns including employment or help with finances. Once a VWWP staff member begins to work with the veteran and his or her family it may become evident that other services are needed, such as healthcare or behavioral healthcare. Veterans and family members associated with all branches of service are provided assistance. The majority of those served are male, but increasingly women are seeking and receiving help from the regional programs.

Service delivery to veterans and their families has evolved in the 5 VWWP Regions based on a development strategy of community participation and involvement. If veterans are not enrolled in VA healthcare and are eligible, they are always encouraged to seek services from the VA. Some circumstances may prevent veterans from seeking services from the VA, such as: distance to a VA Medical Center, vet center or community based outpatient clinic; the veteran has not yet enrolled in service and needs immediate attention; unwillingness to seek help from the VA; VA eligibility status; or discharge status. In these instances, VWWP will assist the veteran with connections to services through local providers, including the local CSBs. The Regions have evolved into diverse service models that respect the differing resources in their communities. They are a unique blend of outreach, public education, clinical care, resource development and community support.

### ***Focus of Efforts***

In 2011 the Governor's Cabinet Secretaries of Veterans Affairs and Homeland Security, Public Safety and Health and Human Resources signed an inter-Secretariat letter of support for the VWWP. The letter reinforced the collaborative efforts of an Interagency Agreement signed at the inception of the VWWP. The Agreement governs the work of a powerful Interagency Executive Strategy Committee that includes the relevant agency heads in the three Secretariats as well as the Adjutant General of Virginia and the Director of the Veterans Integrated Services Network (VISN 6) that administers VA services in Virginia. Throughout its existence, VWWP has benefitted from an ongoing strong commitment to an integrated and collaborative approach when dealing with the many issues that face the veterans and their families. The Commonwealth has been recognized as a leader in this area by putting legislation, funding and passion into this effort.

### ***Collaboration with the Virginia National Guard***

Although media coverage has been extensive on the impact of long and multiple deployments on active duty military service members and their families, there has been a resounding toll on the Virginia National Guard and Reserves. Since September 11, 2001, over 14,000 Virginia National Guard members have been deployed to Iraq and Afghanistan. Most have now returned home or will be returning home within the next few months. The Virginia National Guard is working hard to ensure that Guard members are able to transition home to their jobs, communities and families. The stressors of military life and deployment have affected these families, including long and multiple deployments where a spouse may become a single parent for a year or more. For children, the impact of loss of one or in some cases both parents as well as family structure and routine create significant issues. For the spouse left at home, financial responsibilities must be managed alone. Civilian jobs may be affected due to extended time away. Additional stress is added by the effects of post traumatic stress, traumatic brain injury, or physical injuries.

VWWP has participated in Guard sponsored *Yellow Ribbon Reintegration* events across the Commonwealth. These events are held prior to deployment and upon return home. Community support providers are present to let the Guard members and families know what services are in place to support them while deployed and when they return home. Locally VWWP staff have reached out to the Guard units in their regions and participated in events at the armories and in the community. VWWP has developed a close working relationship with the Virginia National Guard Director of Psychological Health for assisting with care coordination for Guard or family members needing treatment services. In addition, the program has participated in de-briefings that occur after a Guard member's suicide, as well as being a close partner in crisis response, suicide prevention and resiliency. All VWWP peer and family support groups are open to Guard members and their families, as well as VWWP sponsored veteran and family retreats and couples retreats. The Virginia National Guard has recently launched a program called "Partners in Care" where the Guard chaplains are reaching out to local congregations, providing them training and developing a system for directing Guard members and families in need of community support to churches who can provide assistance through food pantries, child care, after school programs, services to homeless persons, etc. The Virginia Wounded Warrior Program serves as a resource to the chaplains as well as the churches for connections to healthcare, behavioral healthcare and other community support.

### ***Reentry for Incarcerated Veterans***

There are approximately 2,000 veterans incarcerated in Virginia state prisons. While the numbers of veterans in local jails is not known, research indicates that between 7 and 10% of jail inmates are veterans. Governor McDonnell's Reentry Initiative included a focus on the needs of veterans reentering communities from incarceration. Working with agency partners from the VA, Virginia Departments of Corrections, Correctional Education, Behavioral Health and Developmental Services, Department of Planning and Budget, House Appropriations and Senate Finance Committees and veteran members, VWWP recently revised an existing "Reentry Roadmap for Veterans Incarcerated in Virginia." In Virginia and in other states, this guidebook

had been provided previously only to veterans incarcerated in state prisons. In an unprecedented partnership with VISN 6 of the VA and with the VISN 6 Healthcare for Veterans Reentry Specialist, the guidebook was updated with resource information for veterans in jail as well as those in prisons. The Guidebook was printed, produced on CD and distributed to all prisons, jails and regional jails in the Commonwealth. A primary benefit of the Guidebook is to provide veterans with a link to the Virginia Wounded Warrior Program in the locality where they plan to return upon release. The guidebook can be accessed on the VWWP website, [www.WeAreVirginiaVeterans.org](http://www.WeAreVirginiaVeterans.org).

VWWP has hired a dedicated Reentry Specialist in Region 5, Hampton Roads, Northern Neck and Middle Peninsula and Eastern Shore, who reaches out directly to the incarcerated population. Other regions are making connections with incarcerated veterans in state prisons and local jails. These connections are being reinforced by the Criminal Justice Partners Training being conducted across the Commonwealth.

### ***Criminal Justice Partners Training***

In partnership with DBHDS, VWWP was awarded a federal grant from the Virginia Department of Criminal Justice Services to create a targeted educational program for attorneys, community corrections staff, magistrates, special justices, judges and other professionals working in criminal justice. The purpose of the training is to help criminal justice professionals understand the behavioral health impacts of the wars in Iraq and Afghanistan on military service members and their families. The *Criminal Justice Partners Training* is being presented currently by VWWP staff and local veterans across the Commonwealth. Six sessions are being held in each of the 5 VWWP Regions.

To date, participants have been police, sheriffs, local probation and parole officers, magistrates, staff who work in local community corrections offices such as pre-trial staff, jail services staff, and local forensic services staff who work in the CSBs, etc. One unexpected byproduct of the trainings is that the criminal justice professional community is filled with prior military service members. The training really touches a cord with this group. In one training session, the VWWP Regional Director and Peer Specialist noticed that the group was particularly somber. One individual in the audience had asked some pointed questions which seemed to indicate his unhappiness with the training. At the end, he introduced himself as a retired officer with the local Sheriff's department and a combat Vietnam veteran. He said that this was the best veterans training he had ever been to and that VWWP had "nailed the topic".

These sessions have led to connections between police officers and VWWP resource specialists who have intervened with veterans contemplating suicide or with family members who needed that one connection to get their loved one to seek treatment.

## *Addressing Homelessness*

In response to Governor's Executive Orders 10 and 29, VWWP staff supported the Office of the Secretary of Veterans Affairs and Homeland Security in developing initiatives to reduce homelessness among veterans and their families in the Commonwealth. The 2012-2014 biennial budget includes funding for two positions at the Department of Veterans Services to address the issues of homeless veterans.

To fulfill U.S. Secretary of Veterans Affairs Shinseki's commitment to end homelessness among veterans, all of the VAMCs in Virginia have conducted Homeless Summits engaging community partners, including VWWP, to work together to provide service to homeless veterans and to prevent homelessness. VWWP Regional Consortia staff work closely with representatives from the VA and numerous local social service agencies to directly assist veterans and their families who are homeless or at risk of homelessness. Despite these efforts, according to the Point In Time (PIT) survey of persons who are homeless, which is conducted annually on a nationwide basis in January, the number of homeless veterans identified in the PIT count in Virginia increased from 886 in 2010 to 931 in 2011, an increase of five (5) percent.

Services to homeless veterans present unique challenges. Among these is the need to reestablish identity to obtain housing, employment, mental health treatment, and support services. The Veterans ID card being issued this month by DVS and the Virginia Division of Motor Vehicles (see [www.virginiaforveterans.com](http://www.virginiaforveterans.com)) may help to address this issue, as well as other collaborative efforts to establish residency for homeless veterans. Often homeless veterans lack income so their housing options are limited and many need case management services to be successful. A complicating factor is that permanent supportive housing slots can take months to secure due to overwhelming need. VWWP staff work to assist the veteran in coordinating connections to community housing and supportive resources.

While many community-based agencies devote considerable resources and effort to serve homeless veterans on a daily basis, one program was particularly successful in expanding its array of services for veterans in 2011. Virginia Supportive Housing, based in Richmond, obtained a VA Supportive Services for Veteran Families (SSVF) grant which will provide homeless veterans and their families with a wide range of supportive services. VWWP Region 4 Resource Specialists work closely with Virginia Supportive Housing to connect veterans and families who are eligible for this support.

Figure 2 provides contact information for the VWWP Executive Team across the Commonwealth. Contact information for local program coordinators can be found on VWWP's website [www.WeAreVirginiaVeterans.org](http://www.WeAreVirginiaVeterans.org).



## Virginia Wounded Warrior Program

Established by the Commonwealth of Virginia in 2008

*Mission: To monitor and coordinate mental health and rehabilitative services and to ensure adequate and timely assessment, treatment, and support for veterans, members of the Guard and Reserves (not in active federal service), and affected family members....for stress-related injuries and traumatic brain injuries resulting from military service.*

2.2-2001.1 Code of Va. (as amended 2010)

[www.WeAreVirginiaVeterans.org](http://www.WeAreVirginiaVeterans.org)

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Figure 2

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## Recently Decided Cases

### Ninth Circuit Authorizes Medication over Objection for Pretrial Detainee on Dangerousness Grounds without Requiring *Sell* Hearing

The Ninth Circuit Court of Appeals, in a 2-1 decision issued on March 5, 2012 and amended on May 14, 2012, upheld the ruling of the United States District Court in Arizona, holding that the government may treat a pretrial defendant with serious mental illness with antipsychotic medication over his objection if the inmate is a danger to himself or others. An administrative hearing comporting with the requirements in *Harper v. Washington*, 494 U.S. 210 (1990), is sufficient without the necessity of the judicial hearing and balancing test set out in

*Riggins v. Nevada*, 504 U.S. 127 (1992) and *Sell v. United States*, 539 U.S. 166 (2003). *United States v. Loughner*, 672 F.3d 731 (9th Cir. 2012).

The defendant Jared Lee Loughner is accused of murdering six people, including U.S. District Judge John Roll, and the attempted murder of thirteen others, including Congresswoman Gabrielle Giffords in Tucson, Arizona on January 8, 2011. Loughner was committed to the Bureau of Prisons to determine whether he was competent to stand trial, and based upon the findings of the medical staff at the U.S. Medical Center for Federal Prisoners in Springfield, Missouri (“FMC-Springfield”) that he was not, he was then committed to determine whether he could be restored to competency.

While in custody at FMC-Springfield, Loughner was determined to be a danger to himself or others and the facility conducted an administrative hearing under 28 C.F.R. § 549.46(a) to determine whether he could be involuntarily medicated. A psychiatrist not involved in the defendant’s treatment presided over the hearing that took place in Loughner’s cell. A licensed clinical social worker was assigned as his staff representative. Even though Loughner requested that one of his attorneys appear at the hearing as his “witness,” counsel was not permitted to attend the hearing. Following the hearing, the presiding psychiatrist authorized involuntary medication finding that Loughner, who had been diagnosed with schizophrenia, “had become enraged while being interviewed by his attorney and yelled obscenities; had thrown objects, including plastic chairs and toilet paper; had spat on his attorney, lunged at her, and had to be restrained by staff; and his behavior had been characterized by indications that he was experiencing auditory hallucinations, including inappropriate laughter, poor eye contact, yelling “No!” repeatedly, and covering his ears.” *Id.* at 737. Loughner was given 24 hours to appeal the decision to the Administrator of the Mental Health Division, which he did. Laced with profanity, Loughner’s appeal was denied.

Upon learning of Loughner’s involuntary medication, his attorneys filed an emergency motion in the district court to enjoin FMC–Springfield from forcibly medicating him, arguing that the involuntary medication violated his substantive due process rights by treating his mental illness with medication without first considering less intrusive measures, and by failing to consider how the medication might implicate his fair trial rights. They also argued that his procedural due process rights as a pretrial detainee had been violated because the hearing should have been held before the court and the specific drug and dosage should have been specified in the hearing.

The district court denied the motion and request for an evidentiary hearing on the grounds that, even though he was a pretrial detainee, Loughner was being medicated on dangerousness grounds and that the *Harper* standards, not the *Riggins* and *Sell* standards, applied. In so deciding, the district court adopted the rationale in *United States v. Morgan*, 193 F.3d 252 (4<sup>th</sup> Cir. 1999), holding that dangerousness determinations are to be made by medical professionals and the court’s involvement should be limited to a review for arbitrariness. On appeal to the Ninth Circuit, the Motions Panel granted Loughner a stay, enjoining all involuntary administration of medication pending adjudication of this appeal.



After medication was discontinued, Loughner's condition drastically deteriorated and he was placed on suicide watch. FMC–Springfield's psychiatrists then determined that Loughner was a severe danger to himself and administered medication on an emergency basis. Loughner's attorneys immediately requested the district court to enforce the Ninth Circuit injunction, but the district court refused. FMC–Springfield thereupon conducted a second *Harper*-style hearing to continue the mediation based on Loughner's danger to himself. Loughner again requested that his attorney appear as his "witness." His attorney did not appear but submitted a written statement which contained legal objections to the involuntary medication. In justifying the administration of medication in this report, the presiding psychiatrist noted the deterioration in Loughner's condition after the administration of antipsychotic medication was discontinued. Many of his most serious symptoms had receded but he "still exhibits a tendency towards motor restlessness and pacing...cries frequently, and expresses intense feelings of guilt." *United States v. Loughner*, 672 F.3d at 739. The report also noted Loughner's current medication regimen and stated that other less intrusive measures would not address Loughner's fundamental problem.

Loughner's attorneys filed another emergency motion with the district court to enjoin the administration of the medication which the court again denied on the grounds that the administration of medication "was predicated on the grounds of dangerousness and really has nothing to do with his competency." *Id.* at 740. The district court also continued Loughner's commitment another four months for competency restoration based on his treating psychiatrist's testimony that he was likely to become competent in the near future.

On appeal, the Ninth Circuit first distinguished between the substantive due process and procedural due process issues presented. It reiterated that the substantive due process clause of the Fourteenth Amendment establishes the definition of the protected constitutional interest, here the liberty interest in being free from unwanted antipsychotic medication, and identifies the conditions under which competing state interests outweigh it. The procedural due process grounds set out the minimum procedures required to determine whether those liberty interests outweigh the government's interest in overriding them. The Court then conducted an analysis of the *Harper*, *Riggins*, *Sell* and post-*Sell* decisions.

In *Washington v. Harper*, the United States Supreme Court reviewed the State's regulation governing the forcible medication of a convicted prisoner with serious mental illness who posed a serious likelihood of danger to himself, others, or their property. In upholding the Washington regulation, the Supreme Court balanced the prisoner's interest in avoiding unwanted medical treatment with the State's penological interest in providing needed treatment to inmates. The Court held that "given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's best interest." *Washington v. Harper*, 494 U.S. at 227.

In *Riggins v. Nevada*, the Supreme Court reviewed Nevada's forced treatment of the defendant during trial. *Riggins* began taking mellaril prior to the trial, but requested it be stopped during trial because of its effect on his demeanor and his mental state. Following the testimony of three psychiatrists who questioned the need for continued medication during trial, the trial court denied *Riggins* motion to discontinue the mediation, but gave no rationale for the

decision. The Supreme Court held that pretrial detainees possessed at least the same right as the convicted prisoners in *Washington v. Harper*, and denied it had determined the full constitutional protections required for pretrial detainees in that case. The Court suggested that the prosecution could have prevailed if “the district court had found that treatment with medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins own safety or the safety of others.” *Riggins v. Nevada*, 504 U.S. at 135. The Court reversed but set no standards for pretrial detainees because the district court had made no determination related to the need for medication and no findings to support its decision.

In *Sell v. United States*, the Supreme Court set out the substantive standards for determining when the government may administer antipsychotic drugs involuntarily to restore a criminal defendant to competency to stand trial. The court must first determine “whether there are important government trial related issues at stake; that involuntary medication will significantly further these governmental interests, without causing side effects that will interfere significantly with the defendant’s fair trial rights; that the medication is necessary to further the government’s interests taking into account less intrusive alternatives; and that the administration of the antipsychotic drugs is medically appropriate, i.e., in the defendant’s best medical interest.” *Sell v. United States*, 539 U.S. at 180-181.

After reviewing the cases decided post-*Sell*, the Ninth Circuit held that “when the government seeks to medicate a detainee – whether pretrial or post-conviction – on the grounds that he is a danger to himself or others, the government must satisfy the standard set forth in *Harper*. The Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.” *United States v. Loughner*, 672 F.3d at 752. The Court then upheld the Bureau of Prison’s regulation finding that a judicial hearing was unnecessary, stating that medical decisions should be made by medical personnel. Although it questioned the effectiveness of Loughner’s prison representative, it found attorney representation not necessary. The Court also held that a specific medication regimen need not be specified finding that Loughner’s treating psychiatrist must be able to titrate his existing dosages to meet his needs and to change medications as necessary. The Ninth Circuit finally held that should Loughner be restored to competency, his arguments that the antipsychotic medications substantially alter his demeanor and make him unable or unwilling to assist his counsel are issues to be decided at the time of trial.

## **D.C. Circuit Upholds Virginia/Kansas Medicaid IMD Disallowances**

The District of Columbia Court of Appeals has upheld the Centers for Medicare and Medicaid Services (“CMS”) disallowance of matching federal financial participation (“FFP”) funds for medical services the Virginia Department of Medical Assistance Services and the Kansas Health Policy Authority paid for individuals under age 21 in inpatient psychiatric facilities under the Institutions for Mental Disease (“IMD”) exclusion. *Virginia Department of Medical Assistance Services v. U.S. Department of Health and Human Services, et al.*, 2012 U.S.App. LEXIS 9293 (May 8, 2012).

Since its enactment in 1965, the Medicaid program has excluded Medicaid payments for services provided to otherwise eligible individuals in IMDs who have not attained the age of 65 years or older. In 1972, Congress added an exception to the exclusion for “inpatient psychiatric hospital services for individuals under age 21.” 42 U.S.C. § 1396d(a)(16). In order to be eligible for FFP, the inpatient services provided to those under age 21 (1) must be provided in an institution, or distinct part thereof, which is a psychiatric hospital or other inpatient setting specified by the Secretary in regulation; 2) must involve active treatment provided by a team, consisting of a physician and other qualified mental health professionals, which has determined the inpatient services are necessary and can reasonably be expected to improve the patient’s condition to the extent that such services will no longer be necessary; and 3) are provided prior to the date the individual attains age 21 or, if the individual is receiving services immediately preceding attaining age 21, the date the individual no longer requires such services, or attains age 22. 42 U.S.C. § 1396d(h)(1)(A)-(C).

In 2001-2002, the Department of Health and Human Services Inspector General audited claims submitted for IMD residents under age 21 in several states, including Virginia and Kansas, and found that certain claims were not documented to be for “psychiatric hospital services provided in and by an IMD.” As a result, CMS disallowed \$3,948,532 in claims for Virginia, and \$3,883,143 for Kansas. Virginia’s disallowed claims included physician services, pharmacy, outpatient hospital clinical services, inpatient acute care and other services, such as laboratory, x-ray and community mental health and mental retardation services. Both Virginia and Kansas separately appealed the disallowances to HHS’ Departmental Appeals Board and then to the United States District Court for the District of Columbia, which both ruled in favor of CMS. Virginia’s and Kansas’ subsequent appeals to the District of Columbia Circuit were then consolidated. The law firm of Covington and Burling represented both states instead of their respective Attorneys’ General.

Virginia and Kansas argued, among other things, that the statute was ambiguous because it conflicted with the “comparability principle” that requires a state to provide medical assistance to individuals meeting eligibility requirements which are not less in amount, duration, or scope than the medical assistance made available to any other individuals. The States also argued that the interpretation was contrary to the legislative history that reflected Congress’ intent to improve and expand treatment for children with mental illness to permit them to rejoin and contribute to society. The States further argued that CMS’ narrow interpretation of the under-21 exception conflicts with the requirements for provisions of services under the early and periodic screening, diagnostic, and treatment (“EPSDT”) mandate and the requirement in the Home and Community Based waiver program that services provided in the community be “cost-neutral.” By failing to reimburse for expensive inpatient services, the argument went, the provision of necessary services in the community will necessarily be more expensive and thus fail the waiver test.

In upholding the CMS determination, the Appeals Court found that the legislation was clear on its face that the only exceptions to the IMD rule pertained to eligible recipients age 65 and older and individuals under age 21 receiving inpatient psychiatric hospital services. When a statute is clear on its face, no further interpretation or referral to legislation history is necessary. In rejecting all of the States’ arguments, the Court wrote that the under-21 exception to the IMD

rule “may not reflect the most compassionate or even the most prudent approach to treating young patients in IMDs, but it marks the extent of assistance the Congress unambiguously authorized in 1972 when it first decided to fund such services.” The courts are therefore obligated to interpret the law as unambiguously written by Congress.

## **US Court of Military Justice Had Jurisdiction to Court Martial Servicemember with Autism**

The Armed Forces Court of Appeals has held that the United States Military Court had jurisdiction to court martial a servicemember with autism who had been adjudicated incapacitated by the State of California and had had a conservator appointed. *United States v. Fry*, 70 M.J. 465, 2012 CAAP Lexis 201 (February 12, 2012). Joshua D. Fry, a private in the U.S. Marine Corps, was subjected to court martial for two counts of being absent without leave and four specifications of possessing child pornography, and was sentenced to a bad conduct discharge, confinement for four years and forfeiture of all pay and allowances. The sentence in excess of twelve months was suspended for twelve months. The U.S. Navy-Marine Corps Court of Criminal Appeals affirmed.

As a 16-year old, Fry initially met a Marine Corps recruiter while living in California, but was leaving at that time for Colorado to attend a school for adolescents with psychiatric, emotional or behavioral problems. Prior to his departure, his grandmother petitioned a California court for a limited conservatorship because of his autism and arrest for stealing and carrying a “dirk or dagger,” alleging that her grandson was unable to provide for his needs for health, clothing and shelter, and that he could not control his impulsivity. At the uncontested hearing, the court entered an order restricting Fry’s ability to choose a residence, access confidential papers and records, contract and give or withhold consent to medical treatment and make all decisions concerning his education. When he was 20 years old, Fry returned to California still subject to the conservatorship, met the same recruiter, and enlisted in the Marine Corps. He passed the Armed Services Vocational Aptitude Battery, certified that he understood the terms of his enlistment and obtained his birth certificate and Social Security card from his grandmother. He thereupon undertook the obligations, duties and training of a Marine and received pay and allowances.

Fry first began to have issues in basic training. He stole peanut butter and hid it in his sock, urinated in his canteen, refused to eat, and failed to shave and lied about it. He informed medical staff that he was autistic and asthmatic, and medical staff recommended that he be sent home. He nonetheless remained, convincing Marine Corps staff that he was motivated and wanted to return to training. He was found mentally fit to do so, completed his basic training and his grandmother attended graduation, never objecting to his service. He committed his offenses two or three months after being assigned to routine duty.

On appeal, Fry argued that the military court had no jurisdiction to try him because a California court had previously found him mentally incapable of contracting, and that the military court owed the California judgment full faith and credit. In upholding the military court, the appellate court found that the scope, nature and legal incidents of the relationship between a

servicemember and the Government are fundamentally governed by federal authority and not state law. The Court held that court martials need not concern themselves with the legal effect of other provisions in contracts or law. Article 2(c) of the Uniform Code of Military Justice relating to court martial specifically states that it applies “notwithstanding” any other provision of law. The Court stated that the only issue therefore is whether the person was serving in the armed forces and 1) voluntarily submitted to military authority; 2) met mental and age requirements; 3) received military pay or allowances, and 4) performed military duties, and finally whether he was mentally competent within the meaning of the statute.

The Military Court found that everyone had acted as though Fry was validly enlisted, including his grandmother conservator. His actions in enlisting were not compelled by outside influence, nor was there any evidence that he was under duress or coercion or that he could not understand the nature or significance of his actions. Two experts testified at trial. One testified for the prosecution that Fry was able to appreciate the nature and quality of his wrongful conduct. Another psychologist testified that he did not remotely have the ability to consider the long-term consequences of his actions. The military judge found that the evidence did not support a claim of impulsivity and Fry was mentally competent to enlist. His findings were supported by the record and therefore the Appellate Court would not overturn them as “clearly erroneous.” The Court of Appeals therefore found that the Military Court had jurisdiction to court martial the servicemember.

### **Privilege against Self-Incrimination Waived in Second Trial When Defendant Presented Mental Capacity Defense at First Trial**

The Pennsylvania Supreme Court has upheld the decision of the Superior Court that a defendant who voluntarily waived his 5<sup>th</sup> Amendment right against self-incrimination by presenting a mental capacity defense at his first trial opened the door to the Commonwealth’s introduction of inculpatory statements at retrial, even though the defendant did not utilize the defense at his retrial. *Commonwealth v. Rosen*, 2012 Pa. LEXIS 965 (April 25, 2012).

The defendant was charged with first degree murder in the stabbing death of his wife and sentenced to life in prison. The defendant’s wife had been stabbed to death in the early morning hours of June 30, 2001. The defendant initially claimed that two intruders in ski masks and parkas committed the murder. He later gave multiple explanations for the murder and ultimately admitted killing his wife, stating they were arguing and each had a knife. He said his wife swung the knife at him, he stabbed her in the chest, and she then plunged the knife into her own neck. At his jury trial in 2002, the defendant relied on the defense of diminished capacity. His expert psychiatrist testified that the defendant suffered from manic-depressive illness accompanied by psychotic features and paranoia. He testified that the defendant was psychotic and incapable of forming the intent to kill his wife. The Commonwealth’s expert testified that the defendant had no mental disorder that would impair his capacity to form intent to kill his wife, relying on the fact that the wife planned to divorce him, that he delayed an hour in calling police and that he initially fabricated events. The jury convicted the defendant of first degree murder and the trial court sentence him to life in prison. The Pennsylvania Superior Court upheld the conviction and the Pennsylvania Supreme Court declined review.

The defendant then filed a post-conviction petition for relief alleging ineffective assistance of counsel for failure to call character witnesses that would have established that his mental instability prompted his actions and that he neither planned nor intended to kill his wife. The trial court conducted a hearing and dismissed his petition. The Superior Court reviewed the petition on appeal, reversed and remanded the case for a new trial. At retrial, the Commonwealth sought to introduce evidence of his mental stability presented by its expert at the original trial. The trial court ruled that since the defendant was not presenting mental infirmity as a defense on retrial, the Commonwealth could not present its expert psychiatric testimony as substantive evidence in its case in chief, but if the defendant testified on his own behalf, the Commonwealth could use the admissions of guilt contained in its expert's testimony as rebuttal evidence. The defendant waived his right to a jury trial and proceeded with a bench trial. The Court found him guilty and again sentenced him to life in prison.

The Superior Court affirmed the trial court. On appeal from the Superior Court, the Pennsylvania Supreme Court relied on the decision in *Commonwealth v. Santiago*, 662 A.2d 610 (Pa. 1995) in which the court held that the defendant's waiver of the psychiatric-patient privilege carries over to his retrial and on *Commonwealth v. Boyle*, 447 A.2d 250 (Pa. 1982), holding that if a defendant waives his 5<sup>th</sup> amendment privilege against self-incrimination and testifies at his first trial, his testimony is admissible at retrial even if he does not take the stand in the second trial. The Pennsylvania Supreme Court held that the two cases taken together support the admission of psychiatric testimony at the second trial. Once the privilege is waived, it is always waived, and no distinction need be made between the defense expert and Commonwealth's expert. Either side may therefore introduce substantive evidence admitted in the first trial in the second trial.

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<sup>i</sup> In Virginia, community services boards are responsible for the delivery of publicly-funded local mental health services. Virginia Code §§ 37.2-500 and 37.2-601.

<sup>ii</sup> Virginia Code § 2.2-2001.1.