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Highlights in This Issue

- Promoting Use of Advance Directives by People with Serious Mental Illness under Virginia’s Health Care Decisions Act: Implementation Study Update
 - Survey of Stakeholder Knowledge, Experience and Opinions about Mental Health Advance Directives in Virginia Published
 - Advance Directives: A Tool for Reducing Coercion
 - Recently Decided Cases
 - Court Approves DOJ/Virginia ADA Consent Decree
 - Second Circuit Rules P&A Contractor Lacks Standing to Sue New York on behalf of Its Constituents
 - Ninth Circuit Holds District Court Decision Refusing to Seal Competency Proceedings Not Subject to Interlocutory Appeal
 - Texas Supreme Court Finds Expert Need Not Be Psychiatrist or Psychologist to Testify in SVP Commitment Proceeding
 - Massachusetts Court Permits Evidence of Sex Offender’s Lack of Participation in Treatment, But Not His Refusal to Participate, to Be Used at Commitment Hearing
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Promoting the Use of Advance Directives by People with Serious Mental Illness under Virginia’s Health Care Decisions Act: Implementation Study Update

By John Oliver, Esq.¹

¹ John Oliver is a former Deputy City Attorney for the City of Chesapeake whose many responsibilities included providing legal representation to the Chesapeake Community Services Board. Mr. Oliver is now retired but provides extensive services for the Advance Directive Implementation Project.

The Starting Point: The Legislative Expansion of Advance Directives to Include Mental Health Care

Following recommendations from the Virginia Supreme Court's Commission on Mental Health Law Reform, chaired by Professor Richard Bonnie of the University of Virginia School of Law, the 2009 Virginia General Assembly made significant changes to the Virginia Health Care Decisions Act (HCDA). Those changes include an expansion of the scope of advance health care directives to include mental health care. People can now give instructions about the mental health care they want and don't want, and can appoint an agent to make decisions for them about such care (including psychiatric hospitalization) in the event that they need such care but are unable to make an informed decision about that care.

The Challenge and the Possibilities: Low Use of Advance Directives by Persons with Serious Mental Illness vs. Promising Research at Duke University

While this inclusion of mental health care in advance directives is an important innovation, giving people with serious mental illness a potentially powerful tool for planning for and managing mental health crises, research across the nation has found that only between 3.9% and 12.9% of persons with serious mental illness have actually completed an advance directive addressing their mental health care.

Significantly, prior to the 2009 HCDA amendments, researchers at Duke University, led by Jeffrey Swanson, Ph.D., Marvin Swartz, M.D., and others, found that, when persons with serious mental illness were offered assistance in completing their advance directives (through a process of "structured facilitation" provided by trained Duke staff), over 60% of the individuals who were offered this help completed their own advance directive for mental health care. Clinicians who reviewed the contents of the completed advance directives found that the instructions in them were clinically appropriate and contained useful information that would be helpful to providers working with these individuals during a crisis. Researchers also found the following: at one month follow-up, the individuals who completed their advance directive had "significantly greater positive change in [their] working alliance with case managers and clinicians" and were "significantly more likely to report receiving mental health services they felt they needed" than individuals in the control group; at six months, they "had significantly greater improvement on [a] treatment satisfaction scale", had "higher utilization of outpatient services and medication management visits...and outpatient crisis prevention visits"; at 12 months they "had significantly increased concordance between requested and prescribed medication[s]"; and at 24 months, the "likelihood of coercive crisis interventions" for these individuals was reduced by *half*.

These potential benefits from making advance directives available to people for mental health care was one of the driving forces behind the recommendations of the Commission on Mental Health Law Reform to amend the HCDA. With the enactment of those amendments, the questions regarding the ultimate impact of the amendments included these: (1) Could similar assistance with advance directives be made available to individuals with serious mental illness on an ongoing basis in the community mental health setting? (2) Would such assistance produce

similar improved outcomes for those persons with serious mental illness who completed advance directives?

The UVA-Duke Research and Implementation Project: Replicating the Duke Experience through Facilitation of Advance Directives by Mental Health Case Managers

A UVA-Duke research team, headed by Professor Bonnie at UVA and Dr. Swanson at Duke, obtained grant funding for researching and implementing the increased use of advance directives for mental health care in Virginia. The first component of the research, completed in 2010, was to collect and analyze baseline data on knowledge, attitudes and experience regarding the HCDA amendments among hospital and community service board (CSB) administrators, clinicians, and other stakeholders (including mental health service users, family members, and advocates of those vested in the care of individuals with diagnosed mental illness), through an online survey. That research found a high level of support for advance directives among consumers, providers, and program administrators.²

The second component of the study was structured to examine whether and how a process of facilitating and completing advance directives for persons with serious mental illness (SMI) could be successfully implemented on an ongoing basis in the community mental health services setting. To carry out that study, the researchers recruited three community services boards (CSBs) - Region Ten (Charlottesville area), Prince William County, and the City of Chesapeake – to participate. They also recruited statewide mental health advocacy organizations – including VOCAL (Virginia Organization of Consumers Asserting Leadership), NAMI (National Alliance on Mental Illness) Virginia, and MHAV (Mental Health America of Virginia) – to have consumer advocates from those organizations involved. The plan was to provide information, education and training on the HCDA and its new amendments, on the resulting new advance directive forms, and on the process of one-on-one structured facilitation developed at Duke, to CSB mental health case managers and their supervisors and to consumer advocates.

The primary initial model was for the case managers to introduce advance directives to the consumers on their caseload, in the regular course of their work with consumers, and to provide facilitation for those consumers who expressed an interest in completing an advance directive. A second, but less specifically articulated model, was for consumer advocates to introduce and assist consumers with advance directives as an adjunct to some of those organizations' existing education and consumer empowerment activities, such as the Wellness Recovery Action Plan (WRAP) process and the NAMI Peer-to-Peer program. An advance directive form was developed by Professor Bonnie, and vetted by a variety of stakeholder groups, that enabled individuals to provide much more detailed information and guidance regarding the kinds of interventions that would be helpful – and harmful – in the event the individual experienced a mental health crisis. The form also included specific provisions

² Wilder C, Swanson J, Bonnie R, Wanchek T, McLaughlin L, and Richardson J., *A survey of stakeholder knowledge, experience, and opinions of advance directives for mental health in Virginia*. Administration and Policy in Mental Health and Mental Health Services Research. DOI 10.1007/s10488-011-0401-9, Vol. 40, Issue 3, May 2013. The Survey was published online on January 13, 2012 and is available at: <http://www.springerlink.com/content/9186634649v70533/?MUD=MP>. The article will be published in hard copy in Administration and Policy in Mental Health in May 2013.

enabling an individual to identify those medications and related treatments that the individual preferred, and to refuse those medications and related treatments that the individual did not want to receive under any circumstances.

One-day training was provided in June of 2010 at the Region Ten offices in Charlottesville to case management staff (and some peer specialists) from the three CSBs, and to consumer advocates from mental health advocacy organizations. Duke research team members provided a short training session on structured facilitation, a process that emphasizes the use of reflective listening and non-directive discussion and questions to help the individual to clarify and articulate his or her values and preferences in regard to the treatment choices provided in the advance directive. A written “script” was provided by the Duke researchers as a guide for the case managers and advocates.

Early Lessons: Discoveries about Project Preparation and Limitations of the Case Management Model

In the months following the June training session, some key lessons for the project emerged:

- Up-front time needs to be spent to inform and educate staff about advance directives and to get staff “buy-in” to promoting advance directives and helping consumers to complete their own.
- The advance directives effort needs a “champion” within each CSB who can (with administration support) maintain the profile and focus of the effort and monitor its effectiveness.
- While all of the CSBs provide mental health case management services, each CSB has a unique history, “culture” and organizational/operational style, all of which affect what approaches will be more or less effective in obtaining staff buy-in and support for the advance directives effort.
- People who are asked to facilitate the completion of advance directives with consumers must feel that they have received adequate training for this task, and that they will receive ongoing support for this work, including having someone available who can answer questions and concerns that arise.

While a number of advance directives were completed over the next several months, the rate of completion was slower than originally expected. In addition, in Region Ten the number of consumers who, according to the case managers, declined to complete an advance directive was surprisingly high. While feedback from case managers varied, three themes emerged: first, that informing and educating consumers about advance directives took more time than case managers felt they had available in managing their heavy caseloads; second, that a number of the case managers did not feel adequately prepared to carry out facilitation; and third, that most case managers saw advance directive facilitation as a direct service that was outside of their role – that is, they, as case managers, would certainly identify the completion of an advance directive as an appropriate consumer need or goal, but normally they should be referring the consumer to someone else to provide facilitation instead of providing that service directly themselves.

Evolving Models: Introduction and Development of the Peer Facilitation Model

In the late summer of 2010, staff on the UVA-Duke team learned that the Norfolk CSB had initiated its own program of helping consumers to complete an advance directive. That program was started at the request of well-informed consumers in the Norfolk program, who were aware of the 2009 changes to the HCDA and who were both seeking their own advance directives and a role in helping others complete theirs. In response to the consumers' request, Sandra Lee, the Norfolk CSB's Consumer Relations Coordinator, approached the CSB's administration about developing an advance directives initiative. The administration embraced the idea, but determined at the outset that case management and clinical staff did not have the time or resources to provide direct assistance to consumers in completing advance directives. Norfolk asked Dana Traynham, a staff attorney at the Virginia Office for Protection and Advocacy (VOPA), who had already made presentations to Norfolk consumers on legal matters affecting them, to make presentations to consumers and staff who expressed an interest in learning about advance directives. She agreed, and a program model developed in which Ms. Traynham would provide a general education on advance directives to a group of consumers and then schedule appointments with consumers who were interested in completing their own advance directive.

A number of consumers expressed their desire to not only complete their own advance directive, but also to be trained to help other consumers to complete theirs. Ms. Traynham agreed to provide that training, which included instruction on both the content of advance directives and the process of effectively helping people to complete their own advance directive, culminating with trained consumers conducting facilitations under Ms. Traynham's observation. The Norfolk CSB developed its own certification process to recognize those consumers who developed the capacity to effectively assist other consumers as part of the Norfolk CSB's program, and in March of 2011 nine consumers were certified as "peer facilitators" by the Norfolk CSB, in a ceremony attended by the CSB's director. The director made the completion and use of advance directives an explicit part of the CSB's program, and all case management and clinical staff are expected to understand advance directives and to refer consumers for assistance in completing their own advance directive forms. In the first year of this initiative, over 40 consumers in Norfolk completed an advance directive.

In part from the Norfolk example, and in part from their own experience, both the Region Ten CSB and the Chesapeake CSB began to look seriously at utilizing peer specialists to help consumers with their advance directives, with case managers and clinicians taking the role of informing and referring consumers. Both CSBs invited consumers to scheduled general information and education sessions on advance directives attended by 20 to 25 people, and gave interested consumers the opportunity to request one-on-one facilitation to complete their own advance directive. Tom Pratt, a peer specialist who attended the 2010 Charlottesville training, was the first person approved by the Chesapeake CSB to provide such facilitation. Chesapeake developed a training program for other interested peer specialists, and to date three additional peer specialists have been certified by Chesapeake as peer facilitators. In Region Ten, Beth Gager, the CSB's Coordinator of Consumer Empowerment, assumed primary responsibility for the advance directives initiative, in addition to her existing responsibilities. Peer specialists who are part-time employees at Region Ten have been approached about being involved in providing

facilitation for advance directives. Given the other demands on the time of these peer specialists, however, the primary responsibility for facilitation has been assumed by Ms. Gager, with case managers currently being primarily a source of referrals.

To date, thirty-two advance directives have been completed in Region Ten. Nineteen have been completed in Chesapeake, with well over 20 others currently “in process”. The high number of “in process” cases are due to a number of factors: the limited number of facilitators, all of whom have additional responsibilities at the CSB; the need for multiple sessions with a number of consumers, who currently come primarily from the CSB’s psychosocial day program and often have significant behavioral health challenges; and the problems that some of these consumers have experienced in appearing for scheduled sessions.

Getting “Buy-In”: Other Local CSB Strategies

Both Ms. Gager at Region Ten and Melissa Constantine, the Family Resource Specialist at the Chesapeake CSB, have developed additional strategies for increasing agency and consumer awareness of advance directives. Ms. Gager partnered with Dana Traynham and the Mental Health Law Clinic at UVA to provide general education to over 20 consumers at the Blue Ridge Clubhouse in April of 2011, with law students trained by Ms. Traynham providing facilitation for consumers interested in completing an advance directive. Ms. Constantine has met individually with case managers and clinicians to discuss the importance of advance directives, and has attended team meetings to raise awareness and to compare the rates of referral from different case managers. She has met with the clinical and case management supervisors in the CSB to discuss whether staff performance in reviewing advance directives with consumers and referring consumers to facilitation services should be part of annual evaluations. Peer facilitators now have “office hours” at the agency’s psychosocial day program so that consumers can just “drop in” to ask about, discuss and even complete their advance directives. The result has been an increasing number of referrals, increasing awareness among CSB staff, and broader agency commitment to advance directives.

Another Format: WRAP/Wellness Planning and the Advance Directives Initiative

From the beginning of the advance directives initiative, there has been discussion among all those involved about the extent to which wellness planning, and particularly the Wellness Recovery Action Plan (WRAP), complements the process of completing an advance directive. However, because programs like WRAP require a commitment to six or more weekly group sessions, no effort was made initially to link facilitation of advance directives to WRAP and similar wellness programs (such as NAMI Peer-to-Peer).

That is no longer the case, especially in light of the administrative and other challenges that have kept the numbers of completed advance directives below what had been anticipated. Both the WRAP and NAMI Peer-to-Peer programs include educational components about advance directives. The Chesapeake CSB and Region Ten are both making plans to provide an opportunity to consumers at the end of CSB-sponsored WRAP and other wellness programs to receive more information about advance directives and receive facilitation in completing one, either in a group setting or in one-on-one sessions. Trained WRAP facilitators already have

training and skills that complement the advance directives process, and with some education on advance directives they are able to help consumers with their advance directives.

LeAnne Brant, who heads the Office of Consumer and Family Affairs in the Virginia Beach Mental Health and Substance Abuse Services program, has introduced advance directives education at the end of one WRAP program there, and has arranged for a presentation on advance directives that was given to Virginia Beach's WRAP facilitators. The response in both settings was very positive, and the program is now planning to offer education and assistance on advance directives after the end of each WRAP process. Both Region Ten and Chesapeake are planning to add opportunities for completion of an advance directive form – with assistance available to participating consumers – after the completion of the WRAP process.

Outreach: Expanding Participation and Partnering with DBHDS

While working with the three original “vanguard” sites – Region Ten, Prince William County, and Chesapeake – the UVA-Duke project has continued to seek additional participants in its research and implementation effort, and to expand awareness and understanding of advance directives statewide. This fits with the goals of the Virginia Department of Behavioral Health and Developmental Services (DBHDS), which has made education on, and use of, advance directives by consumers an explicit part of its Comprehensive Plan. DBHDS is committing staff time and financial resources to the project.

While the Prince William County CSB chose not to pursue facilitation of advance directives by its staff, the Trillium Drop-In Center, which is an independent consumer-operated program for consumers in Prince William County, has made a commitment to offering education to consumers on advance directives and to making advance directive forms available to interested individuals. Its staff is actively participating in the UVA-Duke project, along with Prince William County, and is receiving referrals from the Prince William CSB.

Another new participant is the Middle Peninsula/Northern Neck (MPNN) CSB. An all-day training on advance directives was provided to both staff and peer specialists at MPNN in January of 2012, and was well received. While MPNN has expressed hopes of developing a “both/and” model - where both case managers and peer specialists are trained to provide facilitation services to interested consumers – MPNN is still in the development and organization stage.

Both the Norfolk CSB and Virginia Beach Mental Health and Substance Abuse Services program are participating informally with the project.

Presentations explaining the 2009 HCDA amendments, the new advance directive form that has been developed for use by persons with serious mental illness, and the current research and implementation effort in regard to advance directives, have been made to regional utilization management groups in HPR 1 and HPR 2, to the Executive Directors group in HPR 5, and to the staffs of several individual CSBs throughout the state. These presentations are available to any CSB or regional group upon request, at no cost, and in whatever length or format the CSB or

group may prefer. You can contact John Oliver, Esq., at jeogal@gmail.com (or call at 757-553-0341) to find out more about those presentations.

The project, through Mental Health America of Virginia (MHAV), under contract with DBHDS, is also maintaining a website on advance directives, managed by James Williams of MHAV. That site is www.virginiaadvancedirectives.org.

Envisioning a Statewide System: Research, Training, Models and Manuals

To enable the project to assess the effectiveness of the facilitation process, each person who completes an advance directive is asked to participate in an interview. Initial follow-up interviews focus on whether consumers are satisfied with the process and whether they find these documents beneficial to their health care and recovery. Subsequent follow-up interviews will try to assess the effect of executing advance directives on treatment engagement, the occurrence of mental health crises and on the use of coercive interventions. Facilitators are also being interviewed about their experience in working with consumers. Ultimately, it is hoped, this information will yield recommendations for improving the process of facilitating advance directives, which, in turn, may increase the number of people with mental illness who complete advance directives. Twenty-six interviews have been conducted to date with consumers who have completed the facilitation process. Those interviews have found that consumers have had a generally positive experience with the advance directive facilitation they received, but that there were discernible differences in both the facilitation practices and in the levels of consumer understanding.

As part of the effort to establish consistent facilitation practices statewide, the UVA-Duke project currently includes a curriculum development committee, which is tasked with creating a standard statewide curriculum for training individuals – agency staff, peer specialists, and others – to effectively assist individuals in completing their advance directive through facilitation. The current goal is to develop a rough draft of that curriculum, including supporting materials, by the end of 2012.

A Manual is also being developed that will use the lessons learned from this research and implementation effort to provide guidance to local CSBs on how best to implement a program for helping consumers complete and effectively utilize advance directives. Ultimately, it is hoped, the findings from this work will provide guidance for programs nationwide.

Beyond the CSBs: Inclusion of Mental Health Advocacy Organizations and Recruitment of Pro Bono Legal Services

The 2009 HCDA amendments received strong support from mental health advocacy organizations, which were ready to participate in providing direct assistance to consumers in understanding and completing advance directives to address their future care. As noted above, these organizations were included in the training for this project that was held in June of 2010. Plans for these organizations to provide direct assistance to consumers were put on hold, however, when concerns were raised that, because advance directives are legal documents, assistance by non-lawyers in completing them could constitute the “unauthorized practice of

law” (“UPL”). Recent research conducted for Dr. Swanson by Emilia Chiscop, a Duke graduate student in public policy, found that the answer to the question of whether such assistance constitutes UPL is dramatically different from state to state. Virginia takes a very conservative position on when the UPL threshold is crossed. However, the Health Care Decisions Act provides an exception to that position. Virginia Code Section 54.1-2988 specifically states that assistance in completing advance directives that is given by “health care providers” is *not* the unauthorized practice of law. Under Virginia Code Section 8.01-581.1, “health care providers” include health care entities such as community services boards and hospitals and their employees, contractors and agents who are acting within the scope of their employment or engagement “as related to health care or professional services”. CSB employees, contractors and agents who are assigned to help individuals with their advance directives as part of the CSB’s health care services are covered by the “health care provider” exception in the HCDA.

To help the advocacy and service organizations that do not come within this exception, and to also raise awareness in the legal community, Professor Bonnie contacted interested attorneys to form a *pro bono* lawyers committee on advance directives for persons with mental illness. That committee met for the first time in February of 2012. The committee currently has two major projects. One is a Continuing Legal Education (CLE) program it has developed for attorneys. The committee hopes to use this CLE program both to raise attorney awareness statewide about the use of advance directives for persons with mental illness and to recruit interested attorneys to help mental health advocacy and service organizations that want to assist people in completing their advance directives. The other project involves organizing special events at which law students and attorneys are available to assist people in completing their advance directives. That project is being developed by the law clinics at UVA and the University of Richmond.

Another approach that is currently in the discussion stage is to explore possible contractual or agency relationships between these advocacy organizations and health care providers, under which the advocacy organizations could assist consumers with their advance directives on behalf of the health care providers.

Ongoing Oversight

General oversight of this project is provided by the Coordinating Committee for Promoting Use of Advance Directives by People with Mental Illness. The Coordinating Committee includes representatives from key private organizations and public agencies as well as other individuals with specialized knowledge regarding the use of advance directives in health care. The participating organizations and agencies include: Virginia Department of Behavioral Health and Developmental Services; Virginia Hospital and Healthcare Association; Virginia Association of Community Services Boards; Mental Health America of Virginia; National Alliance on Mental Illness (NAMI) Virginia; Virginia Organization of Consumers Asserting Leadership (VOCAL).

Richard J. Bonnie (Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia) and Jeffrey Swanson, Ph.D. (Professor of Psychiatry and Behavioral

Sciences at Duke University) chair the Executive Committee that is responsible for the day-to-day activities of the project.

Contact Project Staff

If you are interested in learning more about the project, receiving additional information, or having presentations or consultations about advance directives at your organization, please contact:

John E. Oliver, Esq.: jeogal@gmail.com; 757-553-0341; or

Heather Zelle, J.D., Ph.D., a Post-Doctoral Research Associate at the Institute of Law, Psychiatry and Public Policy: Zelle@virginia.edu; 434-924-8321.

Survey of Stakeholder Knowledge, Experience and Opinions about Mental Health Advance Directives in Virginia Published

In 2009, the Virginia General Assembly enacted major revisions to the Commonwealth of Virginia's Health Care Decisions Act ("HCDA"). The revisions were based on recommendations of the Supreme Court's Commission on Mental Health Law Reform, which had solicited extensive participation from a broad spectrum of stakeholder groups during a three-year period of deliberation and drafting. As a result of these statutory revisions, the HCDA now provides a legal mechanism for persons with chronic health conditions, including serious mental illness, to document their treatment instructions and preferences, and to authorize a healthcare agent to make treatment decisions for them during periods of incapacity. These advance directives may also contain individualized, patient-centered plans to prevent crises, as well as to manage and recover from them.

Successful efforts to promote the use of advance directives by people with mental illness in accordance with Virginia's revised HCDA may hold valuable lessons for other states aiming to establish a recovery-oriented, person-centered system of mental health services and to address the problems associated with untreated mental illness in their communities. Consequently, a research study is being conducted by a team of investigators from the University of Virginia and Duke University to describe these activities and to measure their effects on a continuing basis.³

Referenced in the above article authored by John Oliver, the first component of the research was completed during the first half of 2010. Its goal was to collect baseline data on knowledge, attitudes and experience regarding the new amendments to the HCDA. Hospital and community service board ("CSB") administrators, clinicians, and other stakeholders (including mental health service users, family members, and advocates of those vested in the care of individuals with diagnosed mental illness were surveyed to assess their knowledge of and attitudes about the HCDA.

³ This research is supported by the Robert Wood Johnson Foundation Program on Public Health Law Research, the John D. and Catherine T. MacArthur Foundation Research Network on Mandated Community Treatment, and the University of Virginia Law School Foundation.

A total of 460 respondents in the five stakeholder groups completed the online survey. All respondents held favorable views of advance directives for mental health care. Identified barriers to completing and using advance directives varied by group. The Surveyors conclude that relevant stakeholders support implementation of advance directives for mental health, but the level of baseline knowledge and perception of barriers vary. A multi-pronged approach will be needed to achieve successful implementation of advance directives for mental health.

The results of this survey entitled *A Survey of Stakeholder Knowledge, Experience, and Opinions of Advance Directives for Mental Health in Virginia* is available on-line at: <http://www.springerlink.com/content/9186634649v70533/?MUD=MP>. The article will be published in hard copy in *Administration and Policy in Mental Health* in May 2013.⁴

Advance Directives: A Tool for Reducing Coercion

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

In this issue of *Developments in Mental Health Law*, John Oliver comprehensively describes the extensive efforts being employed throughout the Commonwealth of Virginia to implement the 2009 amendments to the Health Care Decisions Act (“HCSA”) that effectively give people with mental illness in Virginia the opportunity to direct their mental health treatment. The link to the first phase of research: *Survey of Stakeholder Knowledge, Experience and Opinions about Mental Health Advance Directives in Virginia*, which is designed to establish baseline data to measure the effectiveness of efforts to promote the use of Advance Directives, is also provided above. The primary purpose behind the HCDA amendments is to promote recovery-oriented and person-centered treatment and to reduce the coercion inherent in a chronically underfunded mental health system.

A service system strained for resources and experiencing high staff turnover and demoralization cannot create and sustain a recovery orientation. Indeed, rates of coercion are likely to be high in such a system. The most promising way to reduce coercion is to create an accessible recovery-oriented system that draws people into treatment because it provides what they need and want, thereby reducing the need to push them into services.

A recovery-based mental health system uses coercion only when necessary to prevent harm or arrest severe deterioration, only as a last resort, and always with respect for the person’s dignity. Recovery envisions a process by which persons experiencing a mental disorder take control of their lives, including planning for care in a crisis, assisted by caring partners. For those who are strongly treatment-resistant or have not begun the recovery process, there may be no

⁴Wilder C, Swanson J, Bonnie R, Wanchek T, McLaughlin L, and Richardson J., *A survey of stakeholder knowledge, experience, and opinions of advance directives for mental health in Virginia*. *Administration and Policy in Mental Health and Mental Health Services Research*. DOI 10.1007/s10488-011-0401-9, Vol. 40, Issue 3, May 2013.

alternative to coercion. As systems are transformed, however, more clients will undertake explicit crisis planning, which involves execution of advance directives.

Virginia is undertaking a system-wide effort to promote completion of advance directives by mental health consumers with support from community agencies, hospitals, the bar, and consumer advocacy groups. A Web site provides access to resources, along with information and guidance about the legal effect of executing an advance directive under Virginia law (www.virginiaadvancedirectives.org).

As discussion and execution of advance directives are incorporated into routine care and into peer-driven activities, it is expected that coercive interventions will be needed less often and that, when needed, they will be provided in accord with the client's previously expressed preferences, making the interventions less likely to be experienced as aversive. Ideally, advance planning will shape the way families, clinicians, and even law enforcement officers and judges respond when a client's decision making becomes impaired, allowing them to share information and provide treatment and support in accord with previous authorizations. Indeed, the term "coercion" may be out of place in these contexts because consent, when needed, has been provided by the client in advance.

From this perspective, use of advance directives, together with agreements for leveraged community treatment, represent an effort to shift the legal mode of care, even in crisis, "from coercion to contract." Community services providers should be encouraged or required to promote the use of advance directives. In time, the number and proportion of clients with executed advance directives will be a useful performance measure of progress toward a recovery-oriented system.

Recently Decided Cases

Court Approves DOJ/Virginia ADA Consent Decree

On August 23, 2012, United States District Court Judge John A. Gibney, Jr. entered an order, historic for Virginia, approving the final Settlement Agreement as a consent decree entered into between the United States Department of Justice ("DOJ") and the Commonwealth of Virginia. The Order followed a day-long "fairness" hearing⁵ in the United States District Court in Richmond, Virginia on June 8, 2012, necessitated by the intervention of family members on behalf of a number of residents of Virginia's training centers alleging that their interests had not been considered or addressed in the negotiations between DOJ and the Commonwealth. Among other things, the Agreement calls for the establishment of 4170 additional waiver slots over a ten-year period to serve individuals with intellectual disabilities in the community and for the Department of Behavioral Health and Developmental Services ("DBHDS") to submit a plan to

⁵ Designating the hearing as a "fairness" hearing refers to the fourth standard the Court must determine when approving settlement agreements, namely whether approval would be fair, adequate and reasonable to the parties affected by the settlement. *American Canoe Association, Inc., et al. v. EPA et al.*, 54 F.Supp.2d 621, 625 (E.D.Va. 1999).

the General Assembly within one year of the Agreement's approval to close four of Virginia's five state-operated training centers by the end of Fiscal Year 2012.⁶

Settlement Agreement Changes

Hearing the concerns of family members whom the Court permitted to intervene on behalf of their relatives who are residents of the training centers, the Court required the parties to include a provision prohibiting a resident from being discharged from a training center if the resident or his or her authorized representative chooses to continue receiving services in a training center as provided in Virginia Code § 37.2-837(A)(3). Although there are 42 privately operated ICF/MR facilities throughout Virginia, the Settlement Agreement now gives individuals the option to remain in a state-operated facility, although not necessarily the one in which they currently reside.⁷ The Agreement does not prevent an individual from being transferred to another state-operated training center, especially if that facility closes, but it ensures that the individual will be housed in a state-operated facility if he or his authorized representative so chooses.

The Settlement Agreement has also been amended to provide that if the General Assembly repeals or amends § 37.2-837, the repeal or amendment will permit the Court under the Federal Rules of Civil Procedure to reconsider its final order approving the Agreement.⁸ Should the General Assembly decide to close all the state-operated training centers, and thus repeals or amends this Code section, DOJ or the Intervenor may request the Court to reconsider and amend its order approving the consent decree. The new paragraph provides:

10. Nothing in this Agreement shall prevent the Commonwealth from closing its Training Centers or transferring residents from one Training Center to another, provided that, in accordance with Virginia Code 37.2-837(A)(3), for as long as it remains effective, no resident of a Training Center shall be discharged from a Training Center to a setting other than a Training Center if he or his Authorized Representative chooses to continue receiving services in a Training Center. If the General Assembly repeals Virginia Code 37.2-837(A)(3), the Commonwealth shall immediately notify the Court, the United States, and the Intervenor. The Parties agree that repeal or alteration of Virginia Code 37.2-837(A)(3) justifies consideration of relief under Fed. R. Civ. P 60(b)(6).

Virginia Code § 37.2-837 is the provision of Virginia law that governs a state facility director's authority to discharge an individual from a state hospital or training center. The provision in question, enacted in 2002, provides as follows:

⁶ The Order Approving Consent Decree with the final Settlement Agreement attached as Exhibit A is available at: <http://www.dbhds.virginia.gov/settlement/approval.pdf>. For a summary of the original Agreement, see Volume 31, Issue 2 of *Developments in Mental Health Law* (February 2012).

⁷ The current plan calls for Southeastern Virginia Training Center in Chesapeake to remain open. Construction of a \$24 Million, 75-bed replacement facility has recently been completed, and was the subject of litigation to enjoin its construction in *Arc of Virginia v. Kaine*, 2009 US Dist LEXIS 117677 (E.D.Va. Dec. 16, 2009).

⁸ Final Settlement Agreement § IV, ¶ 10, page 17, attached as Exhibit A to the Court's Order Approving Consent Decree.

- A. Except for a state hospital consumer held upon an order of a court for a criminal proceeding, the director of a state hospital or training center may discharge, after the preparation of a discharge plan:

...

3. Any consumer in a training center who chooses to be discharged or, if the consumer lacks the mental capacity to choose, whose legally authorized representative chooses for him to be discharged. Pursuant to regulations of the Centers for Medicare & Medicaid Services and the Department of Medical Assistance Services, no consumer at a training center who is enrolled in Medicaid shall be discharged if the consumer or his legally authorized representative on his behalf chooses to continue receiving services in a training center.

Not finding an applicable definition of “Authorized Representative” in the Code of Virginia, the Court further required the insertion of such a definition in the Settlement Agreement,⁹ which substantially conforms to the definition contained in the *Rules and Regulations to Assure the Rights of Individuals Receiving Services in Facilities Operated, Funded or Licensed by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-115-146, Virginia’s Human Rights Regulations, including the “next friend” provisions.

Also hearing the Intervenor’s concerns that the discharge of their relative may lead to their death or serious injury, the Court also required the Settlement Agreement to be modified to require the Commonwealth to immediately report any death of, or serious injury to, any individual discharged from a training center to the Independent Reviewer appointed under the Settlement Agreement who is then required to immediately review the death or injury and report his findings to the Court in a “special report.” This report will be filed confidentially with the Court and will not be available to the public, but will be subject to a protective order permitting it to be provided to the Intervenor’s counsel. This new provision provides as follows:

D. Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with copies to the Parties. The Parties shall seek a protective order permitting these reports to be shared with Intervenor’s counsel and upon entry of such order, shall promptly send copies of the reports to Intervenor’s counsel.¹⁰

The original Settlement Agreement already requires Virginia to maintain a real time, web-based incident reporting system and protocol mandating that any incident of abuse or neglect, serious injury or death in any training center, community services board or community provider be directly reported to DBHDS.¹¹ The original Agreement also appoints an Independent Reviewer,

⁹ Final Settlement Agreement § II., ¶ E, page 3, attached as Exhibit A to the Court’s Order Approving Consent Decree.

¹⁰ *Id.* at § VI, ¶ D, page 29.

¹¹ *Id.* at § V, ¶ C.2, pages 22-23.

Dr. Donald J. Fletcher, who has the authority to hire staff to carry out his duties under the Agreement and whose services and expenses will be paid completely by the Commonwealth.

Background

After almost one year of intense negotiations, Virginia and DOJ resolved the DOJ investigation of Central Virginia Training Center (“CVTC”) under the Civil Rights of Institutionalized Persons Act (“CRIPA”) and the Americans with Disabilities Act (“ADA”) by filing a Settlement Agreement with the United States District Court in Richmond on January 26, 2011. DOJ had initiated a CRIPA investigation into the conditions of care at CVTC in August 2008, and in April 2010, expanded the investigation to focus on Virginia’s compliance system-wide with the ADA. In February 2011, DOJ issued a lengthy “findings” letter detailing Virginia’s failure under the ADA to serve individuals with intellectual disabilities residing in state-operated training centers in the most integrated settings appropriate to meet their needs consistent with their choice. Although not addressing the conditions of care provided to residents at CVTC under CRIPA, the Settlement Agreement also terminates that investigation.

DOJ has had a long-standing policy since the 1970s of settling all investigations of civil rights complaints through negotiation of settlements that are then resolved by the simultaneous filing of a complaint together with a consent decree that is enforced through the federal courts. Following CRIPA investigations in the 1990s at the Northern Virginia Training Center and Eastern State Hospital, Virginia agreed that improvements at those facilities needed to be made, but refused to enter into a consent decree to be filed with the federal court, arguing that consent decrees gave up too much of the State’s sovereignty. DOJ thereupon filed suit and United States District Judge Leonie Brinkema, sitting in Alexandria, mediated a Settlement Agreement between DOJ and Virginia, in lieu of a consent decree, incorporating the terms of the Settlement Agreement and dismissing the case, but retaining jurisdiction to enforce the terms of the Agreement in accordance with the Agreement itself. Not termed a “consent decree,” which is difficult to modify and terminate, and subjects the State to the potential for contempt, this dismissed “settlement agreement” became the model for settling DOJ’s subsequent investigations involving the Northern Virginia Mental Health Institute and Central State Hospital.¹² Entering the orders, and modifying them to extend the deadlines under the Settlement Agreements, then became *pro forma*. Such will not be the case for this Agreement.

Intervention

Although the ADA was enacted in 1990 and the Supreme Court decided the *Olmstead* case in 1999, it was not until the appointment of Thomas E. Perez as Assistant Attorney General of the Civil Rights Division in 2009 that DOJ changed its focus in these investigations away from improving conditions within institutions to almost exclusively enforcing the community integration mandate under the ADA. Although DOJ did not demand closure of the training centers, its unwavering insistence upon the Commonwealth’s funding of vastly more waiver slots made it impossible, as the Court points out,¹³ for Virginia not to begin closure of its institutions.

¹² Western State Hospital successfully implemented its Plan of Continuous Improvement before a Settlement Agreement could be negotiated thus obviating the need for any court filing.

¹³ Order Approving Consent Decree at 11.

In previous cases, family members worried that DOJ's demands that states spend significantly more money to improve conditions in institutions would lead states to simply close them, as some have done. With DOJ's now overt goal to aggressively pursue significant community integration, family members are legitimately concerned about whether states, such as Virginia, can establish a sufficient number of quality community programs, especially given the current rate structure. Most importantly, they worry whether an adequate infrastructure can be put in place that will monitor the quality of care in dispersed community settings and be able to prevent abuse, neglect and harm to their loved ones over a sustained period of time.

As a result of these concerns, family members of thirteen residents in the five Virginia-operated training centers filed a Motion to Intervene¹⁴ on March 2, 2012 on behalf of the residents, alleging that the terms of the Settlement Agreement, which was executed without consideration of their individual needs and desires and without consulting them or their family members, would adversely impact their rights under the ADA to choose to reside in the training centers. They further alleged that the training centers are the least restrictive setting appropriate for their conditions and that their discharge or transfer from those centers may even be dangerous. The Court granted the Motion to Intervene by Order dated May 9, 2012.

The Interveners also filed a Motion to Dismiss DOJ's Complaint, arguing among other things, that DOJ lacked standing to enforce the ADA, and even if it had standing, DOJ had not followed the prerequisites for filing a Title II ADA claim. They also argued that the Settlement Agreement violated Centers for Medicare and Medicaid Services regulations governing the operation of ICF/MR facilities. The Court rejected all of the Interveners' contentions on June 4, 2012 as "either incorrect, inappropriate at this juncture, or both."¹⁵ The Court specifically found that DOJ has the authority to enforce the ADA and that, in this case, the procedural prerequisites for obtaining voluntary compliance under 42 U.S.C. § 2000d-1 had been met. As to the Interveners' argument that the Complaint violated the CMS ICF/MR regulations, the Court found that "[d]espite being an improper consideration on a motion to dismiss, this argument assumes the Agreement's closing of Virginia's Training Centers, which is false, and ignores the ADA's role in holding states accountable for providing previously-elected services to individuals with ID/DD."¹⁶ Prior to the "fairness" hearing on June 8th, the Court denied the Interveners' Motion to Dismiss the DOJ Complaint.

Shortly after the fairness hearing on June 8, 2012, the Interveners filed a Third Party Complaint against Governor McDonnell and other state officials alleging that they were being forced out of the training centers in violation of the ADA, the Rehabilitation Act of 1973 and the Medicaid statutes and regulations, making allegations similar to those raised in their previous Motion to Dismiss. The Court dismissed the Complaint in its August 23, 2012 Order Approving Consent Decree finding the complaint 1) was not a proper third-party complaint under the

¹⁴ Thomas B. York and two other members of his firm, the York Legal Group, LLC in Harrisburg, Pennsylvania, represent the 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 served as co-counsel with 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.

¹⁵ Memorandum Order at 2.

¹⁶ Memorandum Order, Footnote 4 (citation omitted).

Federal Rules of Civil Procedure; 2) the claims were not ripe because no one had as yet been moved out of a state facility; and 3) the Agreement does not require the closure of any Training Center. The Court found that the Agreement only requires that a plan be submitted to the General Assembly to close four of the state's five operated facilities, but does not require the General Assembly to close any facility.

Fairness Hearing

In addition to the Motion to Intervene, the Court also began receiving a great deal of correspondence from individuals and interest groups on both sides of the issue. In its Order dated March 16, 2012, the Court authorized the public to submit written comments, as well as formal *amicus curiae* briefs, all of which it considered as briefs *amicus curiae* in rendering a decision.¹⁷ Formal briefs were filed by The Arc of Virginia, the Virginia Down Syndrome Alliance, the Virginia Office for Protection and Advocacy, and the Autism Societies of Northern Virginia, Tidewater, Central Virginia and the Peninsula. Given the extraordinary public interest in the Settlement Agreement, the Court scheduled a hearing for June 8, 2012 to determine whether the Agreement was lawful, whether it violated public policy, whether it was the product of collusion, and whether it was fair, adequate and reasonable.

In preparation for the hearing, the Court itself also visited Southside Virginia Training Center in Petersburg, and conducted unannounced visits to various community programs in the Richmond area, including a day support program, a private home sponsored residential placement, an ICF/MR facility, a group home and a nursing home. The Court further appointed as its own expert, Mary Ann Bergeron, Executive Director of the Virginia Association of Community Services Boards, the nonprofit association composed of the 40 community services boards (CSBs") responsible for the local delivery of publicly-funded behavioral health and developmental services.

In her Report and testimony, Ms. Bergeron stated that the CSBs are responsible for providing all case management services for individuals with intellectual disabilities in the public system and provide about 25% of the services provided to individuals under the Home and Community-Based Waivers. She testified that the other 75% of services are provided by private providers. Approximately 37% of individuals with intellectual disabilities live with their families and are supported with waiver services. The Court expressed concern whether there would be sufficient services available in the community to serve the numbers of individuals needing them as the waiver slots increased and especially whether these slots would be adequately funded, given the recent cuts in provider rates and uncertainty regarding the rate structure. Ms. Bergeron testified that whenever new waiver slots had become available in the past, providers have developed the services, and that the CSBs would be "up to the task" of managing this system in the future.

The DBHDS Commissioner, James W. Stewart, Jr., testified that 5800 people received services in training centers in the 1970s. He stated that since 2000, the census in Virginia's training centers declined from 1750 individuals to 938 currently, utilizing the Home and Community Based Waiver programs. Currently, 8715 individuals receive waiver services, but

¹⁷ Order dated March 6, 2012.

these services are only available if a waiver slot is available. An additional 6300 people are on the waiting list for these services, and of these individuals, 3600 are on the urgent waiting list, meaning that these individuals are most at-risk of moving to an institutional setting. With the addition of 4170 new slots as provided in the Settlement Agreement, over 12,000 additional people can be served in the community.

Commissioner Stewart further testified that the Commonwealth plans to close these facilities in any event, with or without the Settlement Agreement. The Agreement simply provides a plan to accomplish this over the next ten years, he explained, in lieu of the current haphazard biennial funding process. Although the Settlement Agreement does not require the General Assembly to appropriate funding to implement the Agreement, Commissioner Stewart maintained that the General Assembly has in the past appropriated funding for additional waiver slots each year, and, in fact appropriated more funding during the 2012 Session than required to implement this year's requirements under the Agreement. The Assembly further mandated a study of the rate structure for private providers that will hopefully lead to a more flexible funding system based upon the intensity of services an individual needs.

The Court's Decision

In approving the Settlement Agreement as a consent decree, the Court followed the standards for approving such agreements set out in *United States v. North Carolina*, 180 F.3d 574, 581 (4th Cir.1999). The Court must ensure that the agreement is not illegal, not the product of collusion, not against the public interest, and is fair, adequate and reasonable. After considering all of the evidence presented, inspecting a sampling of programs and services, reviewing the written comments and *amicus curiae* briefs, and requiring certain protective amendments to the Agreement itself, the Court found that the Agreement was lawful because the Commonwealth has the authority to make decisions to use the State's assets in any way it determines appropriate. The Court held that the General Assembly had the legal authority to close all of its training centers if it so chooses, and appropriate the entire DBHDS budget to fund Medicaid waiver programs. The Court found no evidence that the Settlement Agreement was the product of coercion, noting that the DOJ investigation was begun under Governor Kaine's administration and was the product of a year-long, arms-length negotiation.

The Court also found that the Agreement is consistent with the public interest. It recognized that there are two sides to the public policy debate as to whether services should be provided in institutions or in the community, but it is only a debatable policy, and both sides reflect valid public policy issues. The Court deferred to the expertise of DBHDS to develop a plan that benefits Virginia's citizens with disabilities. The Court recognized the number of people who would receive greater, more beneficial services. "In Training Centers, fewer than one thousand Virginians receive services. When the waivers are fully funded, over 4000 people will be able to afford the services they need. The entry of the decree is a valid decision in the public interest."¹⁸ It therefore found that the Agreement is fair, reasonable and adequate, and in the public interest.

¹⁸ Order Approving Consent Decree at 10.

In its decision, the Court reiterated that it has no authority to close facilities, and pointed out that the Agreement itself does not provide for the closure of training centers. It is merely a tool for doing so. Rather closure of facilities is a matter for the General Assembly to decide. As a practical matter, the Court pointed out, that the General Assembly may be unable to fully fund the waivers without closing facilities. If it refuses to fund the waivers to implement the Settlement Agreement, DOJ will seek to have the Court hold the Commonwealth in contempt of court for failure to implement the Agreement. Although the Court also expressed concern with terms such as “adequate” and “sufficient” used in the Settlement Agreement believing they may not be precise enough to hold the Commonwealth in contempt of court for failure to comply with the terms of the Agreement, these terms have in the past been successfully supported by expert testimony and the reports of Independent Reviewers.

If the Court had not approved the Settlement Agreement, Virginia and DOJ could nonetheless have entered into the Agreement without Court approval. If the Commonwealth failed to comply, DOJ would have then sued Virginia in federal court to enforce the Settlement Agreement as a contract. Further, if Virginia had not reached an Agreement to resolve the DOJ investigation under the ADA on these or similar terms, DOJ could have filed a Complaint in the U.S. District Court and the matter would have been litigated, with the real potential that the Court would have ordered something similar or more onerous. Since Commissioner Stewart testified that Virginia’s long-term policy is to begin closure of the training centers and deliver services in the community in any event, the Settlement Agreement provides an orderly and accountable plan for accomplishing this purpose, and a much safer option for those receiving services.

Successful implementation of the Settlement Agreement will be long and arduous. DBHDS will need to hire additional competent staff to develop the necessary licensing and quality improvement infrastructure to effectively implement the Agreement, and the culture in the facilities that individuals with disabilities cannot succeed in the community must be changed. The Intervenors will most likely also appeal on legal grounds the denial of their Motion to Dismiss DOJ’s Complaint, the dismissal of their Third Party Complaint, and the Court’s approval of the Settlement Agreement to the Fourth Circuit Court of Appeals. The Court’s approval of the Settlement Agreement itself was based upon its sound discretion, and an appellate court will be unlikely to overturn it. After the appeals are finally resolved, the Settlement Agreement will be well on its way towards implementation. Although many hurdles will be presented, the Settlement Agreement represents the best possible avenue to achieve the ADA’s integration mandate for Virginia’s citizens with intellectual disabilities.

Second Circuit Rules P&A Contractor Lacks Standing to Sue New York on behalf of Its Constituents

The Second Circuit Court of Appeals has held that Disability Associates, Inc., a contractor for New York’s designated protection and advocacy agency, the Commission on Quality of Care and Advocacy for Persons with Disabilities, lacks standing to sue the State of New York and its officials in this long-running challenge to require New York to provide individuals with mental illness residing in adult homes with more integrated services in the community. In addition, the Court held that intervention by the United States at the remedial

phase of the litigation was insufficient to convey jurisdiction upon the federal court when it lacked jurisdiction in the first instance. *Disability Advocates, Inc. et al. v. New York Coalition for Quality Assisted Living, Inc. et al.*, 675 F.3d 149 (2012).

Disability Associates, Inc. originally filed suit against the Governor of New York and the New York Commissioners of Health and Mental Health on July 1, 2003 on behalf of its constituents, individuals with mental illness residing in, or who might one day reside in, adult homes in New York City. The suit alleged that the mental health system violated the “integration mandate” under Title II of the Americans with Disabilities Act by failing to provide mental health services in the most integrated setting appropriate to the needs of the individuals. After discovery, the State filed a Motion for Summary Judgment arguing, among other things, that Disability Associates, Inc. lacked standing to sue on behalf of its constituents. The district court found that the plaintiff did have standing and, after a five-week bench trial, that New York had violated the ADA. *Disability Associates, Inc. v. Paterson*, 653 F.Supp. 2d 184 (E.D.N.Y. 2009).

More than six years after suit was filed, the United States moved to intervene in the remedy phase of the proceeding. The Court rejected New York’s proposed remedial plan, but entered one with a few modifications submitted by Disability Advocates, Inc. The Court required, among other things, that New York afford all current and future residents desiring placement in supportive housing with such services within four years of entry of the order.

New York appealed the order on the grounds, among others, that Disability Associates, Inc. lacked standing. The appeal was argued on December 8, 2010, but it was not until April 6, 2012 that the Second Circuit dismissed the entire case for lack of jurisdiction because no Article III Case or Controversy existed. Before a party may bring a case in federal court, it must first demonstrate that it has standing, that is, it has suffered an injury-in-fact, which is a concrete and particularized harm to a legally protected interest. If the party lacks standing, no case or controversy over which a court may have jurisdiction exists. When an association seeks to bring suit solely as the representative of its members, it must allege that its members are suffering immediate or threatened injury had the members themselves sued. *Hunt v. Wash. State Apple Adver. Comm’n*, 432 U.S. 333 (1977). In *Hunt*, the Supreme Court ruled that although the Washington State Apple Advertising Commission was a state agency without actual members, its constituency possessed an “indicia of membership” and functioned as a membership organization. The record reflected that the apple growers and dealers alone elected the members of the Commission, served on the Commission, and financed its activities.

Here, the Second Circuit noted that whether P & A systems afford similar protections to their constituents, as in *Hunt*, including requirements that advisory councils be composed of at least 60% of individuals with disabilities and grievance procedures be established, has been decided differently in circuits throughout the country. The Ninth and Eleventh Circuits have found the indicia of membership to be sufficient to convey associational standing on P& A agencies. *Dr. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1110 (9th Cir. 2010); *Doe v. Stincer*, 175 F.3d 879, 886 (11th Cir. 1999). By contrast, the Fifth and Eighth Circuits have dismissed cases finding no associational standing. *Citizens of Dall. v. Dall. Cnty. Mental Health & Mental*

Retardation Ctr. Bd. of Trs., 19 F.3d 241, 244 (5th Cir. 1994); *Mo. Prot. & Advocacy Servs. Inc. v. Carnahan*, 499 F.3d 803, 810 (8th Cir. 2007).

In this case, the Second Circuit determined that it need not decide whether the P & A Agency could assert associational standing because it found Disability Advocates, Inc. was a mere contractor for the designated P & A system. Although as a contractor, Disability Advocates, Inc. was required to comply with all the requirements of the Protection and Advocacy for Individuals with Mental Illness Act, the record was devoid of any indication as to whether *its* constituents had any ability to elect *its* directors, make budget decisions, influence *its* activities or direct *its* litigation strategies. The Court found no evidence that Disability Advocates had even notified its constituents of this litigation. Without these protections, the Court held, Disability Advocates' constituents have nothing approaching the indicia of membership required to support associational standing, as found in *Hunt*.

In addition, the Second Circuit found that the United States did not intervene in the case until six years after suit was filed and after the trial phase had concluded. The Court held that a court must first have jurisdiction over a case before it can grant a motion to intervene. Because the district court lacked the requisite Article III Case or Controversy jurisdiction in the first instance, the mere fact that the United States itself might have standing could not convey jurisdiction originally upon the court. The Court therefore dismissed the entire case, relieving New York of the burden to implement the district court's order.

Ninth Circuit Holds District Court Decision Refusing to Seal Competency Proceedings Not Subject to Interlocutory Appeal

The Ninth Circuit Court of Appeals has refused to hear the interlocutory appeal of the district court's denial of defendant's motion to seal his competency proceedings under the collateral order doctrine. *United States v. Guerrero*, 2012 U.S. App. LEXIS 18504 (9th Cir. Cal. Aug. 31, 2012).

James Guerrero and a co-defendant were indicted in 2008 for the first degree murder of a United States correctional officer and the government filed a notice of intent to seek the death penalty. In April 2011, the defendant filed a motion for a hearing to determine his competency to stand trial, along with six exhibits, including a 27-page social history and a 77-page memorandum describing defense counsels' interactions with the defendant. The defendant moved the court to seal the evidentiary hearing, all exhibits, post-hearing briefs and any detailed findings of fact. The district court denied the motion to seal the proceedings and documents, finding an overriding public interest in criminal competency proceedings, and scheduled the competency hearing. The court did issue a protective order prohibiting certain privileged and confidential information from being used at trial. The defendant thereupon sought an interlocutory appeal to the Ninth Circuit.

As a general rule, an appellate court may hear appeals only from a district court's final decision concluding litigation. A court may review an intermediate decision under the collateral order doctrine only when the decision 1) has conclusively determined the disputed question, 2) resolved an important issue completely separate from the merits of the case, and 3) would be

effectively unreviewable on appeal from a final judgment. A decision that is effectively unreviewable on appeal is one that would imperil a substantial public interest or some particular value of high order, public access to criminal competency proceedings being one such interest.

The defendant argued in this case that once his personal history was publicly disclosed at the competency hearing it would intrude on the attorney/client privilege, taint the jury pool and invade his and his family's privacy, and was thus effectively unreviewable. The Ninth Circuit found in this case that the first two prongs of the standard had been met. The issue of whether to seal the competency proceedings had been conclusively determined and the competency issue was separate on the merits from the criminal proceeding. However, the Court found that the decision whether to seal the competency proceeding could be adequately vindicated on appeal through reversal of a conviction and the ordering of a new trial. Moreover, other avenues were also available to protect the defendant's interests including a petition for writ of mandamus asking a court to seal the records, rigorous jury screening, possible relocation of the trial, and entry of protective orders, prohibiting the use or disclosure of certain documents. The Ninth Circuit therefore denied the defendant's appeal and remanded the case for a determination of the defendant's competency and further trial on the merits.

Texas Supreme Court Holds Expert Need Not Be Psychiatrist or Psychologist to Testify in SVP Commitment Proceeding

The Texas Supreme Court ruled on August 31, 2012 that a licensed professional counselor and sex offender treatment provider was qualified to testify in a civil commitment proceeding for a sexually violent predator. Because the Texas statute did not limit expert testimony to only physicians or psychologists, the Court held that the general rule merely required an expert to have the knowledge, skill, experience, training or education to assist the trier of fact to understand the evidence or to determine a fact in issue. *In re Commitment of Bohannon*, 2012 Tex LEXIS 734 (Aug. 31, 2012).

On two separate occasions in 1982, the defendant Michael Wayne Bohannon stalked women, broke into their homes and raped them at knife point. He was sentenced to 25 years in prison, but was released on mandatory parole in 1991. In April 1992, he was charged with attempting to kidnap a nine-year-old girl at K-Mart and was returned to prison. The defendant was again released in 1998 on mandatory supervision and in 2000 moved to South Carolina to live with his mother. There he was convicted of indecent exposure to an eight-year-old girl in a toy store. He denied the allegations but was returned to prison in Texas. The defendant was again released on mandatory supervision in 2004, but in 2006 his release was revoked for viewing child pornography in a county law library.

At the defendant's SVP civil commitment hearing, a board certified forensic psychiatrist and board certified forensic psychologist testified that Bohannon was a sexually violent predator. Bohannon designated a licensed professional counselor as his expert. She testified outside the presence of the jury that she had been in private practice since 2000 providing behavioral therapy treatment for sex offenders, had received more than 1000 hours of training, sees more than 100 clients each week and has completed 18 SVP assessments. She also testified that, like the other experts, she had reviewed Bohannon's records and interviewed him personally. She scored him

a “5” on the Static-99 and an “8” on the MnSOST, somewhat lower than the government’s psychologist. Using the Hare Psychopathy Checklist, she also determined that Bohannon was not psychopathic. She further testified that in her opinion Bohannon did not have a behavioral abnormality at this time. The trial judge refused to permit her to testify, finding that only a physician or psychologist could provide medical testimony as to a behavioral abnormality. The jury then found Bohannon to be a sexually violent predator and the court ordered him committed.

On appeal, the Texas Court of Appeals reversed the trial court and ordered a new trial, finding that the Texas statutory definition of behavioral abnormality has two components, the first being whether a defendant has an acquired or congenital condition, and a predisposition to commit a sexually violent act to which a medical expert must testify. The second component the Court determined was whether a defendant is likely to commit a sexually violent act for which a medical expert is not required.

On further appeal, the Texas Supreme Court rejected the Court of Appeals’ bifurcated definition finding that the definition of behavioral abnormality was one all encompassing definition. It upheld the reversal, however, finding that the Texas statute did not require an expert to be a physician or psychologist. It noted that experts in criminal proceedings were required by statute to be physicians or psychologists, but no such requirement is found in the SVP statute therefore indicating that the legislature did not intend to impose such a requirement in SVP proceedings. The Supreme Court went on to find that the failure to permit Bohannon’s expert from testifying was not harmless error thus requiring a new trial.

Massachusetts Court Permits Evidence of Sex Offender’s Lack of Participation in Treatment, but Not His Refusal to Participate, to Be Used at Commitment Hearing

The Massachusetts Supreme Judicial Court has held that a prisoner’s refusal to participate in sex offender treatment programs that require a waiver of confidentiality does not violate his Fifth Amendment privilege against self-incrimination, but does violate fundamental fairness embodied in the therapist-patient privilege. A prisoner’s *refusal* to participate in sex offender treatment may therefore not be admitted into evidence in a civil commitment proceeding or used by evaluators to formulate an opinion as to whether the prisoner is a sexually dangerous predator (“SDP”), but his simple *failure* to receive any treatment may be so used. *Commonwealth v. Hunt*, 971 N.E.2d 768 (Mass. 2012).

In 1990, the defendant pled guilty to three charges of raping a child, the daughter of his live-in girlfriend, and an unrelated burglary charge, and was sentenced to 8-15 years in prison. Several times while in prison, the defendant was offered sex offender treatment. As a condition of treatment, however, he was required to sign an agreement allowing the therapist to provide information concerning his progress to the Department of Corrections and the parole board. While temporarily committed to the Massachusetts sex offender treatment center awaiting a hearing on the civil commitment petition, the defendant was again offered treatment but was required to sign a statement acknowledging that anything he said or disclosed in discussion with his therapist might be reviewed by qualified examiners to determine whether he was a SDP. The

defendant refused the treatment arguing that admission of that evidence would violate his privilege against self-incrimination.

At trial in 2008, the Commonwealth offered three experts who testified that the defendant was properly diagnosed with pedophilia and was likely to offend again. The defendant offered three psychologists who testified that the defendant may or may not meet the definition of pedophilia, but was not likely to sexually re-offend. Two of his experts testified that he did not have a sexual abnormality and one did. Before and during trial, the defendant moved to bar any reference to his refusal to participate in treatment, arguing that information concerning his refusal would violate his Fifth Amendment privilege against self-incrimination. The trial court denied his motion and a jury thereafter found him to be a SDP.

The Massachusetts Supreme Court relied on the United States Supreme Court case of *McKune v. Lile*, 536 U.S. 24 (2002), in finding that no mandatory penalty arose in Massachusetts from a prisoner's refusal to participate in treatment. In *McKune*, the U.S. Supreme Court held that an incriminating statement may be deemed "compelled" when the penalties for the defendant's refusal to incriminate himself may be so severe that they are capable of coercing incriminating testimony. The Supreme Court specifically found in that case, however, that a convicted prisoner's participation in a sexual abuse treatment program where he was required to complete a sexual history form detailing prior sexual activities regardless of whether such activities constituted uncharged crimes was not compelled even though his refusal to participate resulted in the automatic curtailment of his visitation rights and other prison privileges, and required transfer to a maximum security unit. Here, the Massachusetts Court found that an offender faces only the possibility that if he refuses to participate, the Commonwealth may offer such refusal in evidence at a future SDP hearing or an expert may use his refusal to support his opinion that the defendant is a SDP. Since the defendant's silence was not being used against him in a criminal proceeding, his silence was insufficient alone to support a SDP finding. Instead the Commonwealth was merely giving evidentiary value to his refusal. His 5th Amendment right against self-incrimination was therefore not violated.

Nonetheless, the Massachusetts Supreme Court went on to recognize that, under the common law, evidence that a defendant has refused sex offender treatment would constitute unfair prejudice. The Court pointed to the legislature's recognition of the importance of confidentiality in communications between patients and psychotherapists through its enactment of an evidentiary privilege. Citing the United States Supreme Court's decision in *Jaffee v. Redmond*, 518 U.S.1 (1996), the Massachusetts Court found that the waiver of confidentiality during sex offender treatment poses a substantial risk of impeding the development of an atmosphere of confidence and trust, chilling the candor of communication and diminishing the likelihood of successful treatment. If the Commonwealth provided treatment without the requirement of a waiver of confidentiality, the inference a jury might derive from his refusal to participate would be fair and reasonable. But the Court drew a distinction between evidence that a defendant "refused" treatment, which might prejudice a jury, and evidence that the defendant "did not receive" treatment. The Court recognized that the lack of treatment itself, either because treatment was simply not offered or because the defendant refused treatment, was directly relevant as to whether the defendant might re-offend and thus meet the definition of a SDP. Therefore, the Court held that evidence that a defendant did not receive sex offender

treatment is admissible, but it is error to admit evidence that a defendant *refused* treatment when he could receive such treatment only by waiving confidentiality and the therapist-patient privilege.

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Letters and inquiries, as well as articles and other materials submitted for review by the editors, should be mailed to DMHL, ILPPP, P.O. Box 800660, University of Virginia Health System, Charlottesville, VA 22908, or to els2e@virginia.edu, or to jhickey808@gmail.com

Editor

Jane D. Hickey, Esq.

Managing Editor

Edward Strickler, Jr. M.A., M.A., M.P.H.

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(and return to the website to see additional announcements) :

Symposium: The Prodromal Stage of Psychosis in Adolescence and Early Adulthood: Symptoms, Treatment, and Risk for Conversion

October 26 2012, Charlottesville VA : Jean Addington PhD, Novartis Chair in Schizophrenia Research and Professor of Psychiatry at the University of Calgary (Alberta), will summarize the current research on the identification, predictors, and treatment of this early and often non-diagnosed stage of a psychotic illness - the Prodromal Stage of Psychosis - and review the diagnostic criteria in the context of case studies. The goal of the program is to: (1) familiarize service providers with the common symptoms of this early state; and (2) present options for treatment to minimize the risk for conversion to psychosis and to lessen the effect of the illness should it occur.

Advanced Seminar: Cultural Competence in Forensic Mental Health Assessment and Treatment

January 25 2013, Richmond VA: This workshop will cover a range of issues related to forensic assessment of individuals from diverse ethnic and linguistic backgrounds: the construct of "cultural competence", self-assessment and pre-evaluation cultural research, decision-making regarding psychological testing and interpretation of test results, use (and misuse) of interpreters, ethical issues related to cross-cultural forensic assessment, etc. With nationally recognized presenter Barry Rosenfeld PhD, ABPP.

Advanced Seminar: Ethics in Forensic Practice

May 3 2013, Charlottesville VA : This workshop explores common ethical conflicts that psychologists encounter when working as forensic practitioners. Emphasis is on reducing the likelihood of potentially damaging cross-examination, ethics complaints and malpractice actions. Attendees are encouraged to prepare, in advance, a problem they encountered in their practice and submit it at the start of the workshop for review and possible discussion. With nationally recognized presenter Alan Goldstein PhD, ABPP.

Advanced Seminar: Understanding and Treating Juvenile Sexual Offenders

February 11 2013, Charlottesville VA: This Advanced Seminar regarding issues of sexual offenders will focus attention on Understanding and Treating Juvenile Sexual Offenders, with nationally recognized presenter John Hunter PhD, MP.

Assessing Individuals Charged with Sexual Crimes

February 28-March 1 2013, Charlottesville VA : This two-day program focuses on the assessment and evaluation of sexual offenders, including 19.2-300 pre-sentencing evaluations and 37.2-904 assessment of Sexually Violent Predators (SVPs). The program addresses the legal background relevant to sex-offender evaluation as well as the clinical background including topics such as paraphilias and base rates of reoffending. The program provides training in well-researched sex-offender risk assessment instruments.

Assessing Risk for Violence with Juveniles

January 11 2013, Charlottesville VA : This one-day program trains juvenile practitioners to apply current research pertaining to risk assessment with juveniles. The agenda includes base rate information on juvenile violence and threatening behavior, gender differences in violent and delinquent behavior, structured risk assessment instruments, clinical evaluation of violence risk among adolescents, and ethics in forensic practice.