

DEVELOPMENTS IN MENTAL HEALTH LAW

The Institute of Law, Psychiatry & Public Policy — The University of Virginia

Volume 33, Issue 2

May 2014

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Virginia General Assembly Enacts Reform Legislation in Response to Tragedy; Other Behavioral Health Legislation

Tragedy struck again in Virginia in November 2013 with the suicide of Gus Deeds, a college student and aspiring musician, following his violent assault on his father, State Senator and former gubernatorial candidate Creigh Deeds. As a result, Senator Deeds has made reform of the mental health system his life's mission to honor his son. As it did following the Virginia Tech tragedy, the Virginia General Assembly has again enacted reform legislation to address some of the gaps in the behavioral health emergency services system that led to this tragedy. It also established another study commission to recommend improvements to the mental health service system. Although enacted prior to the release of the Virginia Office of Inspector General's Report on March 27, 2014, the legislation addresses most, if not all, of the issues identified in that Report.

Inspector General's Report

The Virginia Inspector General's Critical Incident Investigation provides the factual information surrounding the events of November 18, 2013 involving the issuance of an emergency custody order (ECO) for the Senator's son and his release from custody six hours later upon the failure of the Rockbridge Area Community Services (RACS) to identify an available temporary detention bed prior to the expiration of that order. The investigation conducted by the former Behavioral Health and Developmental Services Inspector General G. Douglas Bevelacqua, who resigned in a dispute with the Commonwealth's Inspector General over changes to certain conclusions in the Report, describes a systemic and chronic failure of the Commonwealth's emergency services behavioral health system that led to this family tragedy.ⁱ

Factual Findings

According to the Inspector General's Report, a family memberⁱⁱ first contacted RACS for information on how to obtain emergency mental health services at 9:10 a.m. and was advised to try to persuade the individual to voluntarily agree to services. When he was unable to do so, the family member went to the Bath County Sheriff's Department at 10:20 a.m. to obtain an emergency custody order (ECO) that would authorize the individual to be taken into custody for evaluation by the community services board (CSB) emergency services worker to determine whether he met the criteria for a temporary detention order (TDO). A magistrate was not available but the Sheriff's Department arranged for an Alleghany County magistrate to hear the petition. At 11:23 a.m. the ECO was issued and at 12:26 p.m., a Bath County deputy sheriff executed the ECO by taking the individual into custody, triggering the beginning of the four-hour time limit on the custody order. The ECO would expire at 4:26 p.m., but could and would later be extended two hours to 6:26 p.m.

It took approximately 30 minutes for the deputy to transport the individual to the Bath County Hospital Emergency Department. As was normal practice, the Bath County Hospital was unaware that an ECO had been issued and had no information concerning the person until his

arrival in its emergency room. At 12:55 p.m., nursing staff began the medical clearance process to, among other things, rule out any physical causes for the mental disturbance reported, to screen for drugs and alcohol, and to identify any need for medical treatment for a physical illness. The Bath County Hospital has no psychiatrist on staff or available to it and relies on RACS to provide mental health services. RACS has an office in Hot Springs staffed only on Mondays and every fourth Wednesday.

It was not until 1:40 p.m. when a family member called RACS to determine when a CSB evaluator might arrive that RACS was notified that the individual had been taken into custody under an ECO. The senior clinician in the RACS Emergency Services Division was assigned to perform the evaluation. He had worked for RACS for 18 months and was a license-eligible mental health professional who had completed the Department of Behavioral Health and Developmental Services (DBHDS) pre-screener certification program and qualified examiner training. After turning another case over to a co-worker, the evaluator left Lexington at 2:00 p.m. and drove 70 minutes to Bath County, arriving at the hospital at 3:10 p.m. He obtained information about the individual from the Bath County emergency room staff and then met with the family member at 3:30 p.m. At 3:45 p.m., he conducted a five minute face-to-face interview with the individual, and at 3:50 p.m., with only 36 minutes left under the ECO, began searching for a TDO bed. The first two hospitals contacted reported no vacancies. The CSB evaluator then requested a two-hour extension to the ECO, which a magistrate granted.

Telephone records show the evaluator made 20 calls between 3:50 p.m. and 6:30 p.m., one call of which was with another family member, and also completed the pre-admission screening report during that time period. The evaluator reported contacting 10 facilities searching for a TDO bed. The Inspector General was only able to confirm cell phone and hospital telephone records documenting that the evaluator contacted seven facilities. At 5:57 p.m. the evaluator contacted Rockingham Memorial Hospital but was placed on hold. He was never able to contact a clinician or admission's staff but twice faxed the pre-admission screening report to that hospital. The fax number used was later determined to be incorrect. Rockingham Memorial later reported having a vacancy. Western State Hospital (WSH), the State hospital serving that catchment area, also later indicated it had never been contacted to see if it had a vacancy, but had previously notified the CSBs in its area to only call for "true emergencies" because it was in the process of moving patients in its admissions unit to a newly constructed hospital that day. WSH also often requires the CSB emergency services workers to call between 10-14 facilities before it will consider admitting a TDO patient. RACS reported that in two other cases in the days immediately following this tragedy, WSH had required RACS to call 14 facilities and would not admit the person if he had agreed to a safety plan and a follow-up visit had been scheduled. In the days following this incident, the University of Virginia Hospital also reported that it had vacant beds, but a physician indicated that UVA only admits patients from its own emergency department and not from other hospitals.

Under Virginia Code § 37.2-808, the facility providing the temporary detention is required to be named on the TDO. If the facility cannot be identified, the magistrate cannot issue the order. At 6:26 p.m., the deputy informed the individual that the ECO had expired. The CSB evaluator asked the individual to remain until a TDO bed could be located, but he refused. He did agree to a verbal safety plan and a follow-up appointment was scheduled for the next

morning in Lexington. The individual and family member then left the emergency room at 6:35 p.m.

OIG Recommendations

The Inspector General first castigated DBHDS in his Report for failing to implement the recommendations contained in his prior March 2012 Report No. 206-11 *OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment.*ⁱⁱⁱ This Report described failed or unexecuted TDOs in a practice he called “streeting.” The term describes the situation in which a mental health professional determines a person meets the statutory criteria for temporary detention but no psychiatric facility can be identified to provide the necessary evaluation and treatment during the 48 hours prior to a full commitment hearing. That person is then released “to the street.” While only 1 ½ % of the approximately 5000 individuals for whom a TDO was issued during the 90-day period of the IG’s investigation were released without issuance of a TDO, this situation in the Inspector General’s words “represents a failure of the system to address the needs of that individual and places the individual, his family, and the community at risk.”^{iv}

A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013^v and issued in December 2013 confirmed the small but continued practice of releasing individuals when no TDO bed can be located. Undertaken by the University of Virginia’s Institute of Law, Psychiatry and Public Policy with funding provided by DBHDS and in collaboration with the Virginia Association of Community Services Boards, one of the Study’s goals was to document the time emergency services workers spend looking for beds, the frequency and length of law enforcement custody, the extension of ECOs, and the frequency with which individuals are released because no suitable hospital bed can be found. During the month of April 2013, CSBs conducted 4502 face-to-face emergency evaluations. Of the adults and juveniles evaluated, CSBs recommended TDOs for 1370 individuals of which 1322 were granted, and 1304 or 98.2% of whom were admitted to a facility. For 19 people, a TDO was not issued because the person needed additional medical evaluation and treatment. Of the remaining 18 people, some were still under evaluation at the end of April. For 88.2% of adults, a voluntary or involuntary bed was located within four hours, for 8.4% a bed was located within 4-6 hours, and for 3.4% more than six hours was needed. Of the beds located, 85.2% were in the same region. While this Study documents that for most individuals in need of hospitalization under a TDO, a facility is quickly identified and they receive the services they need. Nevertheless, the Study documented that failure to identify a TDO bed still persists presenting a high risk of danger to individuals, their families, and the public in these situations.^{vi}

Based on this investigation, and confirmation documented by the Study that the problem still exists, the Inspector General therefore recommended that all of his recommendations contained in his March 2012 Report be implemented. These recommendations included that DBHDS identify an “unexecuted TDO” and a “TDO executed beyond six hours” as Quality Indicators of access to clinically appropriate services and develop a mechanism to allow for consistent tracking of such incidents at the CSB and regional level. It was not until December 2013 that DBHDS approved data collection instruments to track these incidents. The

recommendations also included that DBHDS review and update the *Medical Screening and Assessment Guidance* issued March 13, 2007, and that DBHDS designate a senior member of its staff to contemporaneously consult, or intervene to create an alternative to a failed TDO for persons requiring hospitalization or treatment. On January 15, 2014, DBHDS issued its Guidance for Developing Regional Admission Policy and Procedures requiring senior officials in the change of command be designated to resolve problems with an emergency admission. None of these actions were taken until after this tragedy occurred. In addition, the IG recommended that a “real time” bed registry be created to assist emergency services workers in identifying available temporary detention beds; establishing guidelines or standards of practice to ensure CSBs are notified when a person is taken into emergency custody; creating a work group to develop standards of practice, training and recertification for CSB evaluators; and uncoupling the bed search from the evaluation for temporary detention.

Civil Commitment Reform Legislation

Senator Deeds took the lead in introducing omnibus legislation during the 2014 General Assembly Session embodied in his Senate Bill 260^{vii} and two other bills, Senate Bill 261 and Senate Joint Resolution 47, to address problems in the emergency services system that led to this tragedy. Other senators also introduced separate legislation that were “rolled into” this bill. In addition, members of the House of Delegates introduced separate pieces of legislation that addressed portions of the problems identified. After much negotiation and compromise, the final legislative changes that emerged are summarized below.^{viii}

Bed Registry

Much of a trained clinician’s time during the ECO evaluation process can be spent attempting to locate a TDO bed in which to place an individual whom the evaluator has already determined to meet TDO criteria. The evaluator in this tragedy unsuccessfully spent over 2 ½ hours through trial and error trying to locate a bed by telephone, cell phone and antiquated fax machine. The development of an online “real time” bed registry that could be accessed by emergency services workers has been discussed for a number of years. Funds in the amount of \$25,000 for each year of the biennium were initially appropriated in Item 304 (I) of the 2010-2012 Appropriation Act, and have been included every year since. But administrators have also expressed significant opposition to the registry. Given the rapid admission and discharge of patients within a 24-hour period, each facility would need to update the registry at regular intervals throughout the day. Facilities would need to dedicate specific staff to complete this task. Otherwise the registry would be relatively useless to emergency services workers. As the Inspector General points out in his Report in footnote 41, identifying an “appropriate” bed is not as simple as identifying a vacancy. Facilities may have a vacancy for only a male or female for double-occupancy rooms. A person may also have other medical treatment needs that cannot be addressed in that facility. In addition, facilities may not be sufficiently staffed to handle an especially aggressive individual or one who is an escape risk. Administrators have therefore been reluctant to cede control over their admissions process, and direct contact with clinical staff will continue to be needed to ensure that a vacant bed is an appropriate bed for a particular individual.

Nonetheless, given the benefits of limiting the search for emergency services workers, individuals, families and law-enforcement agencies involved in the process, Senate Bill 260, and House Bill 1232^{ix} sponsored by Delegate Benjamin Cline, mandate the establishment of a long-overdue psychiatric bed registry in newly enacted Code § 37.2-308.1. DBHDS must develop and administer a web-based acute psychiatric bed registry to provide information about available acute beds in public and private psychiatric facilities and residential crisis stabilization units. The registry must include descriptive information about every facility, including contact information and real-time information about the number of beds available, the type of patient that may be admitted, the level of security provided and any other necessary information. Every state facility, CSB and private inpatient facility licensed by DBHDS is required to participate and designate such employees as necessary to submit information and serve as a point of contact for addressing requests for information related to the data contained in the registry. CSB employees and designated evaluators, inpatient psychiatric facilities, public or private crisis stabilization units, and emergency room staff will have access to the registry to perform searches to identify TDO beds. The General Assembly has further determined that an emergency exists and establishment of the registry became effective immediately when the Governor signed Senate Bill 260 on April 6, 2014.

Anticipating the recommendation of the Inspector General and following development and testing during the fall of 2013, DBHDS launched the Acute Psychiatric and CSB Bed Registry statewide on March 4, 2014. DBHDS has contracted with and been working with Virginia Health Information since at least 2010 to develop and maintain the registry. The registry must be updated at least every 24 hours. Although it will not obviate the need for emergency services workers to communicate with facility clinicians to provide necessary treatment information, it will provide a useful starting point for location of an appropriate bed that can serve the needs of individuals and their families involved in this process.

Duration of Emergency Custody Order

Significant debate in the General Assembly centered on the length of the emergency custody order. Under current Virginia law, §§ 37.2-808 (adults) and 16.1-340 (minors),^x an individual may be held in emergency custody for up to four hours for an evaluation to determine whether the person meets the criteria for involuntary detention. This evaluation must be completed by an employee or designee of the local community services board who has completed DBHDS mandated training. A magistrate may extend the four-hour time limit an additional two hours in order for a medical evaluation to be completed and/or a TDO facility to be identified. This tragedy demonstrated the total inadequacy of such a short period of emergency custody, especially in rural areas. The CSB evaluator was not notified and did not arrive until over 2 ½ hours after the ECO had been executed. He then spent five minutes evaluating the individual, and over another 2 ½ hours unsuccessfully attempting to locate a TDO bed.

As originally introduced, Senate Bill 260 proposed extending the ECO time period to 24 hours, but met with significant opposition from law-enforcement which must in most circumstances maintain physical custody of the individual the entire time and then transport the person, sometimes long distances, to the TDO facility. These transportation and custody

demands can be especially burdensome for town police and law-enforcement officers in rural areas where only a few officers are employed and on duty at any one time. One to two officers must be diverted from their other public safety duties to provide this service. As a compromise, the General Assembly agreed to extend the ECO time frame to eight hours and removed the unnecessary, cumbersome and bureaucratic requirement for a magistrate to extend the TDO an additional two hours.^{xi} Sections 37.2-808 and 16.1-340 also provide that once an ECO is issued, the designated law-enforcement agency must execute the order within 6 hours. The General Assembly also amended this provision to extend that timeframe to eight hours.

CSB Notification

As part of this tragedy, no one had notified the CSB responsible for conducting the evaluation that an ECO had been issued until a family member called over two hours after the individual had been taken into custody to ask when the evaluator might arrive. Nor did the CSB, Bath County Sheriff's Department or Bath County Hospital have any protocol in place to notify the CSB even though RACS was the sole provider of mental health services at the hospital and its main office was a 70-minute drive away.

Senate Bill 260, and House Bill 478 sponsored by Delegate Ronald Villanueva, therefore add a new subsection to §§ 37.2-808 and 16.1-340 requiring a representative of the law-enforcement agency that executes the ECO, or takes a person into custody pursuant to its authority to take custody without an ECO, to notify the CSB responsible for conducting the evaluation as soon as practicable after taking the person into custody.

Designation of TDO; State Facility Mandated Back-up

Senate Bill 260, and House Bill 293^{xii} introduced by Delegate Robert Bell, also amend §§ 37.2-809(E) and 16.1-340.1 to require that the individual be detained in a state facility and be designated on the TDO as the detention facility if another TDO facility cannot be identified by the expiration of the eight-hour emergency custody period. The General Assembly also enacted new Code §§ 37.2-809.1 and 16.1-340.1:1 that require the CSB upon notification that an ECO evaluation is needed to contact the state facility that serves the area where the CSB is located that the individual will be transported to the state facility upon issuance of a TDO if no other temporary detention facility can be identified. Once the CSB evaluator completes the evaluation, he or she must also send the state facility information about the individual necessary to allow the state facility to determine services the individual will require upon admission.

Once the state facility is notified of a potential admission, it may conduct its own search for an alternative facility that is able and willing to provide temporary detention services to the individual, which could include another state facility if it is unable to do so. The new statute specifically states that “[u]nder no circumstances shall a state facility fail or refuse to admit an individual who meets the criteria for temporary detention unless an alternative facility that is able to provide temporary detention and appropriate care agrees to accept the individual...” In situations in which the person is detained at a state facility, the General Assembly has also authorized the CSB and state facility to hold the person an additional four hours under an ECO to locate an alternative TDO facility. This additional four-hour provision will expire June 30, 2018.

If an alternative facility is identified and agrees to admit the individual, the state facility must notify the CSB, which must then designate the alternative facility on the prescreening report.

These new §§ 37.2-809.1 and 16.1-340.1:1 also curiously require that the individual not be released from the custody of the CSB during the temporary detention period except for the purposes of transporting the individual to the state facility or alternative facility. CSBs, however, have never held custody of an individual during the TDO process and it is unclear how they will now do so. Under both the ECO and TDO, a law-enforcement agency has been ordered to take custody of the individual. Once the TDO is executed by delivery of the individual to the TDO facility, the TDO facility assumes custody of the individual. Effective July 1, 2014, the CSB must retain custody of the individual throughout the TDO period even though the individual will remain in the physical custody of the TDO facility, and for minors, has also remained in the legal custody of their parents or guardians. What legal obligations this will impose upon the CSB is unclear.

The Fourth Enactment Clause in Senate Bill 260 and the Second enactment clause in House Bill 293 also require DBHDS to submit an annual report on the implementation of the Act to the Governor and Chairmen of the House Appropriations and Senate Finance Committees on or before June 30th of each year. The enactment clauses specifically require this report to include the number of state hospital notifications of individuals in need of facility services by the CSBs, the number of alternative facilities contacted by CSBs and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities. The Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013 indicated that CSBs conducted 4502 evaluations in that month alone and that 1322 TDOs were issued based upon those evaluations.^{xiii} Given the high numbers of ECOs and TDOs issued each year, the burden to notify state hospitals for each evaluation and collection of this data, especially on already-stressed emergency services workers, may become prohibitive.

Individual Rights Notification

Senate Bill 260 and House Bill 478 also add another new subsection to Virginia Code § 37.2-808 requiring any person taken into custody under an ECO or by a law-enforcement officer to be given a written summary of the emergency custody procedures and the statutory protections associated with the procedures. In addition, the General Assembly added a new subsection to Virginia Code § 37.2-809 requiring any person detained or in custody pursuant to a temporary detention order to also be given a written summary of the temporary detention procedures and the statutory protections associated with these procedures.

The legislation does not specify what entity must prepare the summaries or provide them to the individuals. Currently, § 37.2-814(D) requires the person who is the subject of an involuntary commitment proceeding to be provided a written explanation of the involuntary admission process and the statutory protections associated with the process and have an attorney explain its contents to him or her prior to the commitment hearing. The Executive Secretary of the Virginia Supreme Court currently prepares the form petitions, orders and written involuntary

admission process explanation. It might therefore be logical to assume that the Secretary's Office will also prepare these summaries. Either the law-enforcement agency that must execute the ECO and TDO or the CSB emergency services worker that must conduct the evaluation would be in the best position to provide these written summaries to the individual. The site of the ECO evaluation, if used on a regular basis and temporary detention facilities could also maintain copies of these summaries for individuals and their families to access. The entities participating in the ECO and detention process should develop local written protocols to ensure that this notification occurs and that the summaries are provided by the entity in each locality in the best position to deliver them to the individual.

Temporary Detention Order Extended to 72 Hours

Proposed nearly every year since the Virginia Tech massacre, the General Assembly has now extended the maximum period of temporary detention for adults from 48 hours, one of the shortest in the country, to 72 hours with an extension to the close of business on the next business day when the court is open if the 72 hours expires on a weekend, holiday, or other day on which the court is lawfully closed. The maximum TDO period for minors remains 96 hours. Contained as part of Senator Deeds omnibus Senate Bill 260, and in separate legislation in House Bill 574^{xiv} introduced by Delegate Joseph Yost, and Senate Bill 439, introduced by Senator George Barker, this extension follows the recommendation initially of the Virginia Tech Review Panel investigating the massacre at Virginia Tech on April 16, 2007 that found the shooter was released to outpatient commitment following a hearing less than 12 hours after he was taken into custody. That Panel recommended that the temporary detention period be amended to extend the time periods for temporary detention to permit more thorough mental health evaluations.^{xv}

Beginning with its first Preliminary Report^{xvi} issued December 21, 2007, the Commonwealth of Virginia Commission on Mental Health Law Reform also strongly recommended that the temporary detention period be extended, first from 4-5 days, and in later years to at least 72 hours to ensure that a thorough evaluation could be completed before the commitment hearing occurred. In addition, the Commission recommended that no commitment hearing be held less than 24 hours after the execution of the TDO. In a study presented to the Commission in 2008, researcher Sarah Barclay found that a two-day temporary detention period was not adequate for thorough assessment in some cases; that Virginia's current TDO process was of low quality with 30% of hearings conducted in less than 24 hours; that an increased TDO period should contribute to improved decision-making; but the potential for short-term bed demand might be increased if the TDO period were increased to four days.^{xvii}

Prior legislation to extend the TDO time period from 48 hours to 72 hours with a prohibition on conducting a hearing in less than 24 hours of the person's detention repeatedly failed to pass in the General Assembly due to its fiscal impact. Fiscal impact studies completed by the Department of Medical Assistance Services, which manages the Involuntary Mental Commitment Fund that covers the hospitalization and medical costs of temporary detention, estimated a huge fiscal impact.^{xviii} The fiscal projections added an extra day, plus additional days for the large number of hearings occurring in less than 24 hours and those that would end on weekends and holidays. If, as the Barclay paper predicts, an extended detention period reduces the numbers of involuntary commitments and the duration of short term hospitalization after the

commitment hearing, corresponding savings could be obtained for the funds that pay for post-hearing hospitalizations.

It was not until a study was completed at the University of Virginia matching data from the Virginia Court System to Virginia's Medicaid claims database from July 1, 2008 through March 30, 2009, that it was possible to more closely estimate the benefits of a longer detention period.^{xix} The study performed by Tanya Wanchek, Ph.D., J.D. and Richard J. Bonnie, LL.B. and published in *Psychiatric Services*, demonstrated that longer TDO periods were correlated with an increased probability of dismissal of the commitment petition rather than hospitalization after a TDO. Among those who were hospitalized, longer TDO periods were correlated with an increased likelihood of voluntary hospitalization, rather than involuntary commitment, as well as shorter hospitalizations. The study revealed, however, that net care time, which included the TDO period plus post-TDO hospitalization, did increase for individuals whose TDO length was greater than 24 hours. The study also highlighted the complexity of predicting the costs and benefits of such an extension. This 24-hour minimum requirement did not pass this Session, but hopefully with an additional day available to schedule a commitment hearing, special justices will wait a day or two before conducting the hearing. Now that the TDO period has been extended by one day, more comprehensive data must be collected to study its impact on both TDO costs and post-TDO hospitalizations, plus its impact on indirect costs related to public health and safety.

TDO Facility Transfers

Delegate Robert Bell also introduced House Bill 1172^{xx} to permit a change in the temporary detention facility to another more appropriate facility as a result of an individual's specific security, medical, or behavioral health needs. As enacted, House Bill 1172 amends § 37.2-809(E) to permit the CSB to change the temporary detention facility and designate an alternative facility at any time during the temporary detention period if an alternative facility is more appropriate based upon the specific security, medical, or behavioral health needs of the person. If the person is already located in a temporary detention facility, a magistrate may order the person's transportation to the alternative facility by the appropriate law enforcement agency or an alternative transportation provider as provided in § 37.2-810. If the CSB designates an alternative TDO facility, the CSB must provide notice to the clerk of the court issuing the TDO of the name and address of the alternative facility on a form developed by the Executive Secretary of the Virginia Supreme Court.

The legislation also amends § 37.2-810 by adding a new subsection C to provide that if the TDO facility changes while the law-enforcement agency or alternative transportation provider designated under the TDO still has custody of the person, that agency shall transport the person instead to the alternative detention facility. If the law-enforcement agency or alternative transportation provider has already transferred custody of the person to the initial TDO facility, the CSB must request and the magistrate may order an alternative transportation provider to provide the transportation, but if no alternative provider is available, willing and able to transport the person in a safe manner, the magistrate may order the local law-enforcement agency where the person resides to do so. If the nearest boundary of the jurisdiction in which the person resides is more than 50 miles from the nearest boundary of the jurisdiction in which the person is

located, the law-enforcement agency of the jurisdiction in which the person is located must provide the transportation. This provision may especially come into play if the person must be detained at a state facility and an alternative facility is located in the additional four hours given the CSB and state facility to locate an alternative placement, but adding an additional burden on law-enforcement. HB 1172, however, only applies to adults and not to minors.

The concern whether a TDO could be amended to change the designated facility originally arose in 2011 with the establishment of additional crisis stabilization units (CSUs) to address short term acute care needs of individuals in a less restrictive and costly setting than a hospital. In addition to voluntary patients, DBHDS was encouraging these facilities to admit individuals under a TDO. Most CSUs are unlocked due to fire safety requirements. They were concerned that once an individual arrived at their facility, the person might pose an escape risk or present behavioral issues that they were not aware of when accepting the admission. The person might also need medical treatment that they were not qualified to provide. The admission of such an individual would pose a safety risk to that person, other patients, the staff and the public. Currently Virginia law, §§ 37.2-809(E) and 16.1-340.1, require the CSB to determine the temporary detention facility and designate the name of that facility on the pre-admission screening report and temporary detention order. Some magistrates were willing to change or amend the order when an individual's needs warranted, but others believed they did not have that authority. House Bill 1172 should address this problem.

CSB Evaluator Qualifications

The Deeds tragedy has also called into question the qualifications and training required for CSB evaluators in the civil commitment process. The CSB evaluator in this case had completed DBHDS mandated pre-admission screening and independent evaluator training and was a license-eligible mental health professional. The type of professional was not reported. The evaluator was, however, the senior emergency services clinician at RACS, but had been in that position only 18 months. His supervisor was a licensed professional counselor, but had served in this supervisory capacity less than six months. The Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013 revealed that of the 570 clinicians conducting these evaluations that month, 43.5% were licensed, and for nine out of ten of them, their highest degree was a master's degree. The average number of years' experience in the field was 14.4 years, ranging from six with no experience to three with 40 years, with 43.9% having less than six years' experience and 9.4% less than one year experience.^{xxi}

The evaluator also spent only five minutes performing a face-to-face evaluation, although it appears he did review the emergency room records, spoke with emergency room staff, and with the family member prior to the interview. Although the Inspector General's Report does not indicate, it may have been clear without further evaluation that the individual met commitment criteria. Given the very limited time left on the emergency custody order and the need to locate a TDO bed, the evaluator may have determined that his time would be better spent searching for a bed. Nonetheless, the actual time spent focusing on the treatment needs of the individual and assessing his level of dangerousness was very limited. The Study conducted in April 2013 revealed that the average length of time of an adult emergency evaluation was two hours and ten

minutes, ranging from 10 minutes to over 24 hours. Nine out of ten evaluations were completed within 4 hours.^{xxii}

As a result, the General Assembly also passed Senate Bill 261, sponsored by Senator Deeds, and House Bill 1216^{xxiii} introduced by Delegate Robert Bell, both section 1 bills that require DBHDS to “review the requirements related to qualifications, training, and oversight of individuals designated by community services boards to perform evaluations of individuals taken into custody pursuant to an emergency custody order and to make recommendations for increasing such qualifications, training, and oversight, in order to protect the safety and well-being of individuals who are subject to emergency custody orders and the public.” DBHDS must report its findings to the Governor and General Assembly by December 1, 2014. A section one bill is a bill that does not seek to amend or enact a section in the Code of Virginia but instead directs an entity, such as a state agency, to take or refrain from taking particular action.

Joint Subcommittee Study

The Commonwealth has established a commission every few years for the past fifty years to study the delivery of mental health services, often prompted by a tragedy or crisis. These commissions or task forces have included Senator Willey’s Virginia Mental Health Study Commission in 1965; the Hirst Commission on Mental Indigent and Geriatric Patients in 1972 that led to the establishment of the community services board system; the Bagley Commission on Mental Health and Mental Retardation in 1980; the Emick Commission on Deinstitutionalization in 1986, the Hall-Gartlan Joint Committee to Study the Future Delivery of Mental Health, Mental Retardation and Substance Abuse Services from 1996 to 1998; Governor Gilmore’s Anderson/Hammock Commission on Community Services and Inpatient Care in 1999; the Commission on Mental Health Law Reform established by the Virginia Supreme Court from 2006-2011; the Virginia Tech Review Panel in 2007; Governor McDonnell’s Taskforce on School and Campus Safety Mental Health Task Force in 2013; and the Governor’s Task Force on Mental Health Services and Crisis Response in 2013 and 2014.^{xxiv} Often established following a crisis or tragedy, the Commissions have each recommended incremental changes to the mental health service delivery system and an appropriation of additional funds with a promise, usually unfulfilled, of more funding to come. Without a continual focus on improving the mental health system and additional funding for these services, often little happens in the interim, leading to yet another tragedy.

For this reason, Senator Deeds also introduced Senate Joint Resolution No. 47 establishing a Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-first Century.^{xxv} The Joint Subcommittee will be composed of five members of the Senate appointed by the Senate Committee on Rules and seven members of the House of Delegates appointed by the Speaker of the House. The joint subcommittee may also appoint work groups to assist it with its work and must

- review and coordinate its work with the work of the Governor’s Task Force on Improving Mental Health Services and Crisis Response;
- review the laws of the Commonwealth governing the provision of mental health services, involving involuntary commitment of persons in need of mental health care;

- assess the systems of publicly funded mental health services, including emergency, forensic, and long-term mental health care and the services provided by local and regional jails and juvenile detention facilities;
- identify gaps in services and the types of facilities and services that will be needed to serve the needs of the Commonwealth in the twenty-first century;
- examine and incorporate the objectives of House Joint Resolution 240 (1996)^{xxvi} and House Joint Resolution 225 (1998)(Hall-Gartlan Study Resolutions)^{xxvii} into its study;
- review and consider the report *The Behavioral Health Services Study Commission: A Study of Virginia's Publicly Funded Behavioral Health Services in the 21st Century*; and
- recommend statutory or regulatory changes needed to improve access to services, the quality of services, and outcomes for individuals in need of services.

The Joint Subcommittee must also consider whether the current fiscal incentives for expanding regional jail capacity should be eliminated and replaced with new incentives for construction, renovation or enlargement of community mental health facilities or programs. These facilities or programs may be co-located with selected jails on a regional basis. Consideration must also be given to the appropriate location of such facilities, cooperative arrangements with community services boards, behavioral health authorities, and public and private hospitals; licensing, staffing, and funding requirements; and the statutory and administrative arrangements for governance of such facilities. This provision is significant because jails have become the *de facto* mental institutions in Virginia and across the country. According to the Virginia Inspector General's Report issued in January 2014, 48% of inmates in Virginia's jails qualify for a serious mental illness diagnosis, making the jail system the largest mental health service provider in the Commonwealth.^{xxviii}

The Joint Subcommittee must submit an interim report by December 1, 2015 to the Governor and General Assembly and its final report by December 1, 2017. The work of the Joint Subcommittee must coincide with and coordinate its work with that of the Governor's Task Force on Mental Health Services and Crisis Response established through Executive Order by Governor Bob McDonnell on December 10, 2013 following the Deeds family tragedy, and continued by Governor Terry McAuliffe

Law-enforcement Transportation

In a piece of common sense legislation, the General Assembly passed House Bill 323,^{xxix} introduced by Delegate John O'Bannon, that amends § 37.2-810 containing the transportation provisions related to persons under a TDO. Section 37.2-810 requires the magistrate to designate the primary law-enforcement agency and jurisdiction in the locality where the person subject to the TDO resides unless the person resides more than 50 miles from the nearest boundary of the jurisdiction in which the person is located. In that case, the jurisdiction in which the person is located must execute the TDO and provide the transportation.

Delegate O'Bannon's amendment permits the magistrate to order "any other willing law-enforcement agency that has agreed to provide transportation." Although the last sentence in § 37.2-810(C) has long authorized law-enforcement agencies to "enter into agreements to facilitate the execution of temporary detention orders and provide transportation," law-enforcement agencies have continued to argue about which of them should perform this duty. Notable exceptions include the Henrico County and Newport News Sheriffs' Departments that have contracted with their Police Departments to provide the transportation involved in the civil commitment process. This legislation should also prove beneficial to town police with limited staff when one of its residents is the subject of a TDO. The legislation will permit it to contract with the law-enforcement agency from a surrounding county to provide this service.

In the Fifth enactment clause in Senate Bill 260,^{xxx} the General Assembly also mandates the Governor's Task Force on Improving Mental Health Services and Crisis Response, to identify and examine issues related to the use of law enforcement in the involuntary admission process. Specifically, the task force must consider options to reduce the amount of resources needed to detain individuals during the ECO period, including the amount of time spent providing transportation throughout the admission process. Among the options required to be studied include developing crisis stabilization units in all regions in the state and contracting for retired officers to provide needed transportation. The task force must report its findings and recommendations to the Governor and General Assembly by October 1, 2014.

The Commonwealth of Virginia Commission on Mental Health Law Reform also previously established a Transportation Work Group that studied alternatives to law-enforcement transportation. Strategies identified by that Group included developing a dedicated funding stream through Medicaid and private insurance to encourage the development of alternative transportation providers when safety is not an issue; developing "no refusal drop-off centers" to permit law-enforcement officers to take individuals in their custody for evaluation rather than to jail; and utilizing off-duty, retired and paid security guards to maintain custody of individuals during the evaluation period.^{xxxi} These reports may be of use to the Governor's Task Force.

MOT Monitoring

The General Assembly also passed House Bill 574,^{xxxii} introduced by Delegate Joseph Yost, and Senate Bill 439, introduced by Senator George Barker. In addition to extending the TDO time period from 48 to 72 hours, these bills also require the community services board ordered to monitor a person who is the subject of a mandatory outpatient treatment order to acknowledge receipt of the order within five business days. If the person's case is transferred to another jurisdiction, the community services board serving that jurisdiction must also acknowledge the transfer and receipt of the order within five business days.

Crisis Prevention Strategies

The General Assembly also enacted House Bill 1222,^{xxxiii} another section 1 bill introduced by Delegate Vivian Watts, directing the Secretaries of Public Safety and Health and Human Resources to encourage the dissemination of information to law-enforcement personnel, other first responders, hospital emergency department staff, school personnel, and other interest

parties about specialized training in evidence-based strategies to prevent and minimize mental health crises. These strategies include “(i) crisis intervention team (CIT) training for law-enforcement personnel and other first responders” and “(ii) mental health first aid training for other first responders, hospital emergency department personnel, school personnel and other interested parties.”

The bill also directs the Secretaries to “encourage adherence to models of training and achievement of programmatic goals and standards.” The bill specifies the goals of CIT training to include “(i) training participants to recognize the signs and symptoms of behavioral health disorders; (ii) teaching participants the skills necessary to de-escalate crisis situations and how to support individuals in crisis; (iii) educating participants about community-based resources available to individuals in crisis; and (iv) enhancing participants’ ability to communicate with health systems about the nature of the crisis to include rules regarding confidentiality and protected health information.” The mental health first aid goals include teaching “the public (to include first responders, school personnel, and other interested parties) how to recognize symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other supportive help.”

Firearms Prohibition Reporting

The General Assembly also passed House Bill 743,^{xxxiv} introduced by Delegate Jennifer McClellan, and Senate Bill 576, introduced by Senator Donald McEachin that amends § 37.-819 by adding a new subsection A requiring any judge or special justice conducting a commitment hearing to file any order for the involuntary admission or mandatory outpatient treatment of any individual or the certification of any person for voluntary admission who was the subject of a TDO with the clerk of the district court where the hearing took place as soon as practicable but no later than the close of business on the next business day following the hearing. The statute continues to require the clerk to submit a copy of any order for involuntary admission or certification to the Central Criminal Records Exchange (CCRE) by the close of the next business day of receipt of the order, and any order for mandatory outpatient treatment on the same day of receipt. The purpose of the requirement is to ensure that the name of anyone who loses their right to purchase, possess or transport a firearm as a result of involuntary commitment will appear on the CCRE to prevent their purchase of a gun from a licensed dealer and to assist police in the enforcement of the prohibition. The legislation addresses situations in which some special justices hold on to orders they have entered and submit them in batches to the clerk, occasionally up to 30 days after the orders have been entered, thereby delaying the submission of the mental health firearms prohibition to the registry.

Other Behavioral Health Legislation

In addition to major changes to the civil commitment process, the Virginia General Assembly made two minor changes to the statutes relating to evaluations for competency to stand trial to make the process more efficient and reduce the delay in delivering restoration services to defendants. It also enacted a provision requiring the evaluation of the adult respondent in a guardianship proceeding to be filed under seal to protect the privacy of the

individual's sensitive medical information. The General Assembly also continued its work on strengthening mental health services available to students in Virginia's public colleges and universities. Finally, the General Assembly enacted another section 1 bill related to discharges and transfers from state operated training centers under the Department of Justice Settlement Agreement with the Commonwealth.

Competency to Stand Trial

The General Assembly passed House Bill 584,^{xxxv} introduced by Delegate John O'Bannon and Senate Bill 357 introduced by Senator Janet Howell, that amends Virginia Code § 19.2-169.1(D) related to the contents of the competency to stand trial report. In the event the court finds the defendant is incompetent to stand trial but restorable to competency, the evaluator must include in the report whether he or she recommends inpatient or outpatient treatment. By including this information in the report, courts will not automatically consider inpatient commitment for treatment to restore competency to stand trial. Hopefully, with opportunities for outpatient treatment identified, pressure on inpatient admissions to state forensic units will be lessened, especially for defendants charged with misdemeanors who must wait for an available bed before being restored to competency and then returned to jail for trial.

Delegate O'Bannon's House Bill 585^{xxxvi} and Senator Howell's Senate Bill 541 also amend Virginia Code § 19.2-169.2 pertaining to the disposition when a defendant is found incompetent to stand trial. The new section amends subsection A requiring any psychiatric records and other information provided by the defendant's attorney as well as the competency reports to be provided to the CSB or the inpatient treating facility within 96 hours of the court's order requiring treatment to restore the defendant's competency. If the 96-hour period expires on a Saturday, Sunday, or other legal holiday, the 96 hours is extended to the next day that is not a Saturday, Sunday, or legal holiday. By imposing a deadline on transmitting needed psychiatric records to treatment providers, restoration services can be delivered to defendants on a more expeditious basis.

Guardianship Report

The General Assembly also enacted House Bill 413^{xxxvii} introduced by Delegate Patrick Hope that amends Virginia Code § 64.2-2005 relating to the report evaluating the condition of the respondent in guardianship proceedings. The amendment will require the report to be filed with the court under seal, meaning it will not be available as a public record. The report must be provided to the guardian *ad litem* and now to the respondent and all adult individuals and entities to whom notice of the guardianship proceedings must be sent. These individuals and entities include the respondent's spouse, adult children and adult siblings, or if these relatives are unknown, three other relatives including stepchildren. The report must also be sent to any individual or entity responsible for or assuming responsibility for the care and custody of the respondent, and any agent under a durable power of attorney or advance directive, and any guardian, committee or conservator, and any proposed guardian or conservator. Although the report must be filed under seal, it may, however, be admitted into evidence in open court unless counsel for the respondent or guardian *ad litem* objects. This change in the law will protect the

sensitivity and confidentiality of the information contained in the report that could be potentially embarrassing to the individual.

Higher Education: Violence Prevention Teams

The General Assembly amended Virginia Code § 23-9.2:10(C) pertaining to the duties of violence prevention committees. House Bill 1268,^{xxxviii} introduced by Delegate Timothy Hugo, and Senate Bill 239, introduced by Senator Chap Petersen, require each violence prevention team to establish policies and procedures that outline circumstances under which all faculty and staff must report behavior that may represent a physical threat to the community. The policies and procedures must also provide for the notification of family members or guardians or both, unless such notification would prove harmful to the individual in question. Any policies and procedures developed must be consistent with state and federal law.

Interpretation of the Federal Educational Rights and Privacy Act (FERPA),^{xxxix} and especially its interrelationship with the Health Insurance Portability and Accountability Act Privacy Rule, has been a source of confusion to college and university faculty and staff. The Campus Suicide Prevention Center at James Madison University has provided guidance to faculty and staff on whether and to what extent faculty and staff may report concerns about student's potential dangerousness in its faculty handbook *Recognizing and Responding to Students in Distress*.^{xi} An overview of permissible faculty disclosures under FERPA, including notification to parents, can be found in *Developments in Mental Health Law*, Vol. 32, Issue 1 (January 2013).^{xli} Development of specific instructions to faculty and staff will be useful in preventing violence on public college and university campuses and may encourage private institutions to follow suit.

Higher Education: Mental Health Resources

The General Assembly also enacted a Section 1 bill requiring each four-year institution of higher education to create and feature on its website a page dedicated solely to the mental health resources available to students at the institution. Effective July 1, 2015, House Bill 206^{xlii} was introduced by Delegate Patrick Hope and will provide information to students and their families about mental health treatment resources available at their college or university.

Training Center Discharges and Transfers

Senator Stephen Newman also introduced a section 1 bill, Senate Bill 627,^{xliii} requiring DBHDS to provide written certification to any training center resident or his legally authorized representative before transferring the resident to another training center or to community-based care. The certification must state “that (i) the receiving training center or community-based option provides a quality of care that is comparable to that provided in the resident’s current training center regarding medical, health, developmental, and behavioral care and safety and (ii) all permissible placement options available under the Commonwealth’s August 23, 2012, settlement agreement with the U.S. Department of Justice, including the option to remain in a training center, have been disclosed to the training center resident or his legally authorized representative.” The resident or his authorized representative may waive this requirement.

The bill also requires DBHDS to convene a work group to include members of the General Assembly to consider options for expanding the number of training centers that remain open in whole or in part in the Commonwealth. Hopefully, these requirements will alleviate some family fears of family members that their family member will be prematurely discharged to an unsafe setting. All but one of Virginia's five training centers, the newly rebuilt Southeastern Virginia Training Center in Chesapeake, are slated to close by FY 2020 under the DOJ Settlement Agreement.^{xliv} The first, Southside Virginia Training Center in Petersburg, closed in May 2014.

Recently Decided and Pending Cases

Washington Supreme Court Holds Insanity Acquittee Must Be Found Dangerous before Conditional Release May Be Revoked; Preponderance of Evidence Is Appropriate Standard

The Washington Supreme Court has upheld the trial court's revocation of an insanity acquittee's conditional release based upon its finding of dangerousness. In so doing, it reversed the decision of the Washington Court of Appeals holding that an acquittee's failure to adhere to the terms and conditions of his conditional release is sufficient alone to justify revocation. The Supreme Court also determined that a preponderance of the evidence standard of proof is sufficient to support revocation. Finally, the Court held that the trial court must find good cause to admit both documentary and testimonial hearsay evidence in a limited due process rights hearing such as conditional release revocation. *State v. Bao Dinh Dang*, 178 Wash.2d 868, 312 P.3d 30 (2013).

In November 2006, Bao Dinh Dang walked up to a gas pump at a Chevron station in Seattle, set fire to a newspaper, and attempted to pump gas in order to ignite the gas supply. The station attendant successfully knocked the newspaper out of Dang's hand with a window-washing squeegee while a customer called the police. Dang was arrested and charged with attempted arson. At trial, Dang raised the insanity defense. The trial court acquitted Dang by reason of insanity, and in the same order, released him on conditional release. As part of his conditional release, the court required Dang to report to a Department of Corrections community corrections officer, live with his mother in Washington, not possess explosives, break additional laws, or drink alcohol, and seek psychiatric treatment at Harborview Medical Center and follow all treatment recommendations. Dang's conditional release was further contingent on his mental illness being in a state of remission and on his having no significant deterioration in his mental condition.

Dang's conditional release proceeded without incident until the summer of 2008 when the trial court permitted him to travel to Vietnam for one month. Following his return from Vietnam, Dang's community corrections officer and Harborview case manager noticed he was exhibiting signs of depression and paranoia. Dang's case manager reported that Dang stated he was not taking medication and felt like setting a gas station on fire. He told his community

corrections officer he wanted to “do something big.” The corrections officer and case manager also noticed that Dang was experiencing delusions concerning his mother’s power and control over him. When Dang was taken to Harborview Mental Health Services, he recanted his statements and was released.

The State then moved the court for a bench warrant for Dang’s arrest and commitment pending a hearing on his conditional release. The court issued the warrant, ordering Dang’s commitment to Washington’s Western State Hospital for evaluation and treatment. During this period, several reports were issued concerning Dang’s mental health outlining his treatment and recommending he not be released due to his risk for future violence and criminal behavior.

After extensive evaluations, the State moved to revoke Dang’s conditional release. At the hearing, the court heard testimony from the community corrections officer, case manager, a Department of Social and Health Services psychologist, Dang’s mother and Dang. Several of the witnesses testified that his mental health had deteriorated and he should remain hospitalized. The trial court also permitted Dang’s case worker and a community corrections officer to testify about statements made by Harborview Medical Center’s mental health providers about his desire to blow up a gas station. Following the hearing, the court revoked Dang’s conditional release and while his appeal was pending, issued findings of fact and conclusions of law finding, among other things, that Dang’s mental disease had not remained in a state of remission and his release would present a substantial danger to others and jeopardize public safety.

The Court of Appeals affirmed the revocation of Dang’s conditional release based on Dang’s non-adherence to the terms and conditions of his release but found a specific finding of dangerousness was not required. That Court also determined that preponderance of the evidence was the appropriate standard of proof in a conditional release revocation hearing. The Court of Appeals also held that in cases limiting due process rights to confront and cross-examine witnesses, such as parole revocation hearings, only *documentary* hearsay evidence was prohibited but hearsay could be admitted through live testimony.

The Washington Supreme Court affirmed the Court of Appeals, holding that Dang’s conditional release was properly revoked by the trial court based upon its finding of his actual dangerousness. But the Supreme Court found that failure to adhere to the terms and conditions of conditional release alone are not sufficient to revoke conditional release. A specific finding of dangerousness before an acquittee may be confined is required. In so holding, the Court relied on prior United States Supreme Court cases, including *O’Connor v. Donaldson*, 422 U.S. 563 (1975), that held a finding of mental illness alone is not sufficient to confine a person against his will if he is not dangerous to anyone and can live safely in freedom. Similarly, *Foucha v. Louisiana*, 504 U.S. 71 (1992), held that an insanity acquitted may continue to be confined as long as he is both mentally ill and dangerous, but no longer. The Court reasoned that the same dangerousness criteria that applies in the context of civil commitment and continued commitment of insanity acquittees should also apply in the context of conditional release revocation.

The Supreme Court next determined that a preponderance of the evidence standard is appropriate in conditional release hearings even though Dang argued that a clear, cogent and

convincing evidentiary standard should be applied. The court found that there are significant differences between civil commitment and commitment following an insanity acquittal. In *Jones v. United States*, 463 U.S. 354 (1983), the United States Supreme Court found that the insanity acquittee himself raises the insanity defense and therefore a diminished concern for a risk of error in confining the acquittee exists. The criminal conduct which the acquittee acknowledges is also not within the range of generally accepted conduct. Because there is less risk of error in confining an individual in the insanity acquittee context than in the civil commitment context, the lesser standard of proof of preponderance of the evidence is sufficient.

In reviewing the issue of whether hearsay evidence may be introduced at a conditional release revocation hearing, the Court considered various cases involving limited due process hearings where there was good cause to limit the individual's due process rights to confront and cross-examine witnesses, such as *Morrissey v. Brewer*, 408 U.S. 471 (1972), involving parole revocation. Other similar cases involved sentencing modification hearings due to violations of community custody terms and conditions, and revocation of special sex offender sentencing alternatives. Similarly, a trial court's revocation of an insanity acquittee's conditional release implicates a conditional liberty interest dependent on the observance of special terms and conditions. Under these situations, hearsay evidence may be considered if the trial court finds good cause to forgo live testimony.

In this case, the trial court permitted Dang's case manager and community corrections officer to testify about statements made by other Harborview mental health providers about his desire to blow up a gas station. The trial court did not engage in a good cause analysis of the difficulty and expense of procuring live witnesses or the reliability of the evidence, which the Supreme Court found was error. The Court, however, found that this was harmless error because there was enough direct evidence in the record to support its finding of dangerousness. Nonetheless, the Supreme Court found no distinction between documentary evidence and live testimony evidence as the court of Appeals did, and held in both instances that the trial court must articulate a good faith basis for considering either type of evidence.

California Supreme Court Finds Evaluation and Certification Procedures Not Commitment Criteria under Mentally Disordered Offender Act

The California Mentally Disordered Offender Act, Penal Code § 2962, requires a state prisoner either during or after parole to be civilly committed whenever a Department of Corrections and Rehabilitation chief psychiatrist certifies that he suffers from a serious mental disorder that is not or cannot be kept in remission without treatment, that the disorder was one of the causes of or an aggravating factor in the crime, that the prisoner has been in treatment for at least 90 days within the year preceding release on parole, and that the prisoner presents a substantial risk of physical harm to others as a result of the disorder. The California Supreme Court reversed the ruling of the Court of Appeals that held that the evaluation and certification *procedures* used to determine a prisoner is a mentally disordered offender also constitute the criteria which the state must prove to civilly commit him. *People v. Harrison*, 57 Cal.App.4th 1211, 164 Cal.Rptr.3d 167, 312 P.3d 88 (2013).

Kelvin Harrison had been convicted of battery with serious bodily injury in March 2009 and sentenced to two years in prison. At his parole release date in February 2010, Harrison was required to accept treatment as a mentally disordered offender and in April 2010, the Board of Parole Hearings upheld that determination. Harrison then petitioned for a hearing in superior court challenging the Board's determination. At trial, a forensic psychologist testified that he had interviewed Harrison at the request of the Parole Board in March 2010, and had reviewed his mentally disordered offender evaluations, his psychiatric records and prison file. Harrison had been discharged from the military in 1983 with a diagnosis of schizophrenia and depression. The psychologist testified that he diagnosed Harrison as suffering from schizophrenia, paranoia type, which impaired his thoughts and perceptions of reality and grossly impaired his behavior. Harrison displayed paranoid and grandiose delusions that San Luis Obispo County officials and law enforcement were conspiring against him and trying to do him harm. He further testified that Harrison's schizophrenia was an aggravating factor in his crime. At the time of the offense, Harrison believed that grapes in a bag on the ground were filled with blood, interpreting this to mean his victim intended to harm him. He then struck the victim several times with a pipe. Harrison had also received more than 90 days of treatment within the prior year, both in prison and at Patton State Hospital. The psychologist also testified that Harrison lacked insight into his disorder and that he was prone to misinterpret environmental clues suggesting he was at physical risk. As a result, Harrison was unable to control his behavior, unlikely to seek treatment, and therefore presented an ongoing risk of committing violent crime. After hearing the evidence presented, the superior court found Harrison met the criteria for a mentally disordered offender and committed him to the Department of State Hospitals for one year.

The California Mentally Disordered Offender Act was enacted in 1985 and requires a prisoner convicted of certain felonies related to a severe mental disorder who continues to pose a danger to the public to receive appropriate treatment until the disorder can be kept in remission. The purpose of the Act is to protect the public while treating severely mentally ill offenders. The initial commitment is a condition of parole. Prior to release on parole, the person in charge of treating the prisoner and a psychiatrist from the Department of State Hospitals must evaluate the prisoner. If the prisoner is at the time being treated in a state hospital, the person treating the prisoner and a psychiatrist from the Department of Corrections and Rehabilitation must examine him. These evaluators must find, and a chief psychiatrist of the Department of Corrections and Rehabilitation must certify, that the prisoner has a severe mental disorder, that the disorder is not in remission or cannot be kept in remission without treatment, that the disorder was a cause of or an aggravating factor in a crime for which he was sentenced, that the prisoner had been in treatment for 90 days or more in the year preceding his release on parole, and the prisoner represents a substantial danger of physical harm to others because of the disorder. If the professionals conducting the evaluation disagree, the Board of Parole Hearings must order a further examination by two independent professionals. A prisoner who wants to challenge his certification may request a hearing before the Board of Parole Hearings. If he disagrees with this decision, the prisoner may petition the superior court for a determination as to whether he met the statutory criteria as of the date of the Parole Board hearing. The burden is on the state to prove the statutory criteria beyond a reasonable doubt.

Harrison appealed the commitment decision to the Court of Appeals arguing that the statutory criteria also included the evaluation and certification *procedures* because they were

contained in the same statute, and the state had failed to present evidence that they had been performed. The Court of Appeals agreed and ordered his release on the grounds that there was no evidence in the record that Harrison had been evaluated and certified by the various staff specified in the statute. The Court of Appeals held that the criteria required to certify a prisoner as a mentally disordered offender included not only the *substantive* criteria used by the mental health professionals to determine whether he was such an offender, but also the *procedures* by which that determination was made.

The State appealed that decision to the California Supreme Court. The Supreme Court, by contrast, reviewed the legislative history and found that the legislature had clearly distinguished between the substantive criteria used by the specified mental health professionals to determine whether a prisoner is a mentally disordered offender from the process by which the determination was to be made. In addition, the Department of Corrections and Rehabilitation and the Department of State Hospitals, the two state agencies responsible for implementing the law, both had adopted implementing regulations setting out the criteria for determining which offenders are mentally disordered offenders, specifying only the substantive criteria, and not the procedures by which the determination is made. The Supreme Court therefore found that an administrative agency's interpretation of a statute governing its powers and duties is entitled to great weight. The Court held that this interpretation also comports with the purpose of the statute. It said that the public's interest in safety and the prisoner's need for treatment are not furthered by having the trier of fact determine whether a particular certification was performed by a specified professional or at a particular place.

The Supreme Court compared this Act with the Sexually Violent Predator Act, Welf. & Inst. Code, § 6600 *et seq.*, another involuntary commitment scheme sharing the same purpose. Before an SVP commitment petition may be filed two evaluators must agree that the person has a diagnosed mental disorder and is likely to engage in acts of sexual violence without appropriate treatment. The Court stated that in these cases the State does not need to prove this concurrence to the trier of fact. Rather it is a collateral procedural condition designed to ensure that SVP proceedings are initiated only when there is a substantial factual basis for doing so.

The Court also reasoned that requiring the State to prove only that a chief psychiatrist certified the prisoner as presenting substantial harm to others, as Harrison argued, and not that the prisoner actually did meet these requirements would raise constitutional concerns. It stated that the equal protection clause of the federal and state constitutions would require proof of present dangerousness. The Supreme Court also found that simply because the criteria only contains the substantive provisions of the statute and not the procedural conditions, the Court of Appeals fear that the Department of Corrections would not follow them and the prisoner could not then challenge compliance with them was not possible. A defendant in any case may raise similar procedural challenges before a trial court. These include objections to venue or speedy trial rights. If the prisoner raises the flaw prior to trial, he may obtain the relief needed without resort to a full trial. Here, however, Harrison did not object to any defect in the procedures underlying the evaluation process and therefore waived them. Absent an objection, the State does not have an obligation to prove compliance with the underlying procedures.

The Supreme Court therefore held that the Mentally Disabled Offender statute only requires that the prisoner meet the *substantive* criteria that must be proved beyond a reasonable doubt. The statute does not require that compliance with the evaluation and certification *procedures* be proved to the trier of fact. That becomes a question of law to be addressed by the court upon the prisoners' objection.

California Court Finds Unconstitutional Probation Condition Requiring Sex Offender to Waive Privilege against Self-Incrimination; Psychotherapist-Patient Privilege Waiver Narrowed

Under California law, Penal Code § 1203.067, any person placed on probation for a registerable sex offense must waive his Fifth Amendment right against self-incrimination and submit to regular polygraph examinations, and must also waive his psychotherapist-patient privilege. The California Court of Appeals of the Sixth Appellate District held on March 27, 2014 that this statutory requirement that an offender waive his Fifth Amendment privilege against self-incrimination is overly broad and all-inclusive, and is therefore unconstitutional. The Court also held that the requirement that the offender waive the psychotherapist-patient privilege is only valid insofar as necessary to enable communication between the probation officer and psychotherapist as to the offender's progress in treatment and his risk assessment scores. *People v. Friday*, 225 Cal.App.4th 8, 170 Cal.Rptr.3d 38 (March 27, 2014).

Jeffrey David Allen Friday pled no contest to possession of child pornography that he had downloaded to his computer in August 2012. Information revealed that he had been downloading pornography since he was 14 or 15 years old and was 19 at the time of the offense with which he was charged. Because there was "no identifiable victim," his level of risk as a future offender was not assessed. He had no prior convictions.

As part of a plea agreement, Friday agreed to spend six months in jail without early release. The trial court suspended imposition of the sentence and imposed a three-year term of probation, including six months in jail and mandatory participation in a sex offender management program as a condition of probation. The court required Friday to comply with the following probation conditions: (1) to waive any privilege against self-incrimination and participate in polygraph examinations, which must be part of the sex offender management program; (2) to waive any psychotherapist-patient privilege to enable communication between the sex offender management professional and the probation officer; (3) not to purchase or possess any pornographic or sexually explicit material as it relates to minors, as defined by the probation officer; (4) not to possess or use any data encryption technique program; and (5) not to frequent, be employed by, or engage in any business where pornographic materials are openly exhibited. Both the conditions requiring waiver of the privilege against self-incrimination and the psychotherapist-patient privilege are required under California law.

Friday appealed the conditions of probation arguing that the requirement that he waive his privilege against self-incrimination and the psychotherapist-patient privilege were overbroad and therefore in violation of his constitutional rights. He also challenged as overbroad the condition requiring him to participate in polygraph examinations. He further challenged as vague and lacking a requirement of scienter or knowledge of the conditions prohibiting purchase or

possession of pornography, possession or use of data encryption, and frequenting businesses where pornography is exhibited. The Appellate Court agreed with most of his arguments.

The Appellate Court first reviewed the requirements of the California law, Penal Code § 1203.067, that were enacted in 2010 to amend the Sex Offender Punishment, Control, and Containment Act of 2006. The amendments mandate that any person placed on formal probation for any offense requiring registration as a sex offender after July 1, 2012 successfully complete a sex offender management program. Subdivision (b)(3) requires the offender to waive his privilege against self-incrimination and participate in polygraph examinations as part of the program. Subdivision (b)(4) requires the offender to waive any psychotherapist-patient privilege to enable the sex offender management professional to communicate with the supervising probation officer. Specifically, the sex offender management professional must communicate with the probation officer at least once a month about the offender's progress in the program and dynamic risk assessment issues and share pertinent information with the certified polygraph examiner as required. The professional must also administer the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO) in two forms, the "SARATSO dynamic tool" and the "SARATSO future violence tool," and provide these scores to the probation officer. The probation officer must in turn provide the scores to the Department of Justice which makes the scores accessible to law enforcement on its website.

The statute also requires the California Sex Offender Management Board to publish certification requirements for sex offender management programs and professionals. All certified programs must implement a "Containment Model" of treatment, the goal of which is "community and victim safety." In direct contradiction of the statute, the certification standards state that "invocation of the Fifth Amendment right not to incriminate oneself during a sexual history polygraph cannot legally result in revocation." Also, polygraphs must be used to enhance the assessment process and to help monitor the sex offender's deviant fantasies and external behaviors, including access to potential victims.

The Court then reviewed the language of the Fifth Amendment and its jurisprudence. The Fifth Amendment provides that no person "shall be compelled in any criminal case to be a witness against himself." Under *Minnesota v. Murphy*, 465 U.S. 420 (1984), the Fifth Amendment right may be asserted in any proceeding, civil or criminal or judicial, investigatory or adjudicatory, and protects against any disclosures that the witness reasonably believes could be used in a criminal prosecution or lead to other evidence that could be so used. The Fifth Amendment does not, however, provide an absolute right to remain silent. Under "use and derivative use immunity," a witness may be compelled to testify provided the state does not use the testimony or any use derived from it in a criminal prosecution against the witness.

The Court then found that the probation condition in this case required Friday to waive *any* privilege against self-incrimination and forgo *any* claim of immunity from prosecution. The Court found that the waiver included any claim of immunity Friday might have from prosecution for any past acts, whether sexual offenses or otherwise, that might be revealed through treatment or polygraph examination, and not just those related to the offense for which he was convicted. Although the Court recognized that convicted felons lose some of those constitutional rights that

law-abiding citizens enjoy, *Murphy* held that the privilege against self-incrimination applies to both prisoners and probationers.

The Court also recognized that the state may require probationers to answer questions as a condition of probation provided the statements are not used against the probationer in a criminal prosecution. The Court stated that the requirement that the offender waive his right to self-incrimination undoubtedly furthers the public safety when it allows a sex offender who admits to ongoing dangerous offenses that would otherwise go unreported, but the Court found that the scope of the waiver goes too far in this case because it would allow the prosecution of an offender for any offense. The Court found that the state could accomplish the same goal by requiring the offender to answer questions truthfully without requiring a waiver of the privilege. If necessary, immunity could then be given the offender.

The Court also pointed out that a secondary purpose of the program was treatment and rehabilitation of the offender. By encouraging the offender to reveal and discuss mental dysfunctions, but compelling him to disclose incriminating information that could be used against him in subsequent prosecutions would discourage honesty and openness between the offender and his therapist and therefore thwart the purpose of the program. The Court also declined to limit the parameters of the waiver, finding that the statutory language was plain on its face and it had no authority to so limit it other than to hold it unconstitutional.

The Court also found that parameters of the polygraph examinations were overly broad and no limits were placed on the questions that could be asked. Under California case law, the Court found that conditions of probation are invalid when they have (1) no relationship to the crime for which the offender was convicted, (2) relate to conduct which is not in itself criminal, and (3) require or forbid conduct not reasonably related to future criminality. The Court held that the questions that could be posed during polygraph examinations must reasonably relate to the offender's successful completion of the sex offender management program; the crime for which the offender was convicted; or to criminal behavior, whether past or future.

The Court then reviewed the arguments related to waiver of the psychotherapist-patient privilege, finding that the privilege falls within the zone of privacy first recognized by the United States Supreme Court in *Griswold v. Connecticut*, 381 U.S. 479 (1983). In this case, the statutory language states that the purpose of the waiver is to enable communication between the sex offender management professional and the supervising probation officer. The Court held that it would narrowly construe the requirement that the offender waive the privilege only as necessary to allow the sex offender management professional to communicate with the probation officer and provide the SARATSO scores. The Court also permitted the probation officer to communicate the scores to the Department of Justice to make them available to law enforcement. But beyond those communications, the information would remain confidential and could not be provided to third parties or used to prosecute the offender.

Finally, the Court also agreed with the defendant that the requirements of scienter, or knowledge that the conditions of probation would be violated, must be added to the conditions. The Court found that the offender could inadvertently or unknowingly come into possession of pornographic materials, obtain encryption programs that are readily available, or enter into an

establishment that openly displays pornographic materials. The Court determined that the term “frequent” was also imprecise. The Court therefore modified the remaining terms to require that the offender not knowingly purchase or possess pornographic material, not knowingly utilize encryption techniques, and not knowingly enter into an establishment that openly displays pornographic material.

Indiana Supreme Court Finds Juvenile Mental Health Statute Conveys Use and Derivative Use Immunity during Therapeutic Polygraph Examination

The Indiana Supreme Court has held that the State’s Juvenile Mental Health Statute, Ind. Code § 31-23-2-2.5(b), that bars a minor’s statement to a mental health evaluator from being admitted into evidence to prove delinquency conveys both use and derivative use immunity to a minor in a later delinquency proceeding based on new charges. To hold otherwise, the Court held, would violate the youth’s Fifth Amendment privilege against self-incrimination. *State v. I.T.* 4 N.E.3d 1139 (Ind. 2014).

I.T., a minor, admitted to felony child molesting that would have been a felony if he had been an adult. As a condition of probation, I.T. was ordered to undergo treatment for juveniles with sexual behavior problems, including polygraph examinations. During one of the exams, I.T. admitted to molesting two other children. As a result, I.T. was removed from his home and placed in juvenile detention, and then moved to a residential treatment program, the Sexually Traumatized Adolescents in Residential Treatment (START) program. The Department of Child Services and the police also investigated the minor’s admissions and interviewed one of the victims and I.T. The State then filed a new delinquency petition based on I.T.’s statements to his therapist. Under Indiana law, the juvenile court must approve the filing of a new petition. It initially did so, but I.T. moved to dismiss the petition on the grounds that the Juvenile Mental Health Statute barred the State’s evidence. The trial court agreed finding that absent the minor’s statements to the evaluator, it could find no other evidence to support a probable cause finding to support the petition. The court then gave the State ten days to file a new petition based upon independently obtained evidence, but the State instead appealed to the Court of Appeals.

The Court of Appeals found that the State has no authority to appeal a juvenile court’s order withdrawing its approval of the filing of a delinquency petition under state law and dismissed the appeal. The State then appealed to the Indiana Supreme Court and that Court granted *certiorari* and reviewed the case. The Supreme Court found that the trial court’s order withdrawing its approval of the filing of the petition was essentially an order suppressing evidence. When the ultimate effect of a trial court’s order is to preclude further prosecution, the Court held, the State may appeal that order even though there was no statute authorizing appeal in this situation.

On the merits, the State argued that the Juvenile Mental Health Statute prevents it from using I.T.’s actual statements at trial, but does not prevent it from using his statements to develop other evidence. The State conceded that it had no other evidence than that derived from the youth’s statements. Under this argument, the Statute would provide “use immunity” under the Fifth Amendment, but not “derivative use” immunity, meaning the State could use the statement to pursue and develop other evidence to prosecute the juvenile. The Supreme Court disagreed

finding that the plain language of the statute conveys “use immunity” except in limited situations, such as a probation revocation hearing, a modification of disposition proceeding or a proceeding in which the juvenile raises the insanity defense. The Court then went on to find that “use immunity” alone cannot protect an individual’s Fifth Amendment right against self-incrimination unless it also conveys “derivative use” immunity. Otherwise investigators could still use compelled testimony to search out other evidence against the individual. The Court noted that the trial court had ordered I.T. into treatment as a condition of his probation and his remaining silent during that therapy could be found to violate his probation due to his failure to participate. To permit the filing of a new petition based upon compulsory participation in a therapeutic polygraph examination without any independent evidence to prove the violations would therefore run afoul of his constitutional privilege against self-incrimination.

The conveyance of derivative use immunity, the Court held, is also consistent with the purposes of the juvenile code. In enacting the Juvenile Mental Health Statute, the legislature found that well over half of minors detained had mental health or substance abuse problems. The legislative history also revealed that encouraging research-based programs can reduce recidivism and future involvement in the juvenile justice system, but that without open and honest communications between treatment providers and patients, the rehabilitative process would fail. The Court found that, as a result, the Statute must prevent the use of information obtained through the treatment process, including therapeutic polygraph examinations. The Supreme Court therefore held that a juvenile’s compelled statements cannot be used against him even in a probable cause affidavit and dismissed the State’s appeal.

Ninth Circuit Holds Expert in Competency Evaluation May Testify As to Diminished Capacity Defense

The Ninth Circuit Court of Appeals held on April 17, 2014, that the district court abused its discretion in refusing to permit an expert psychologist who had completed a competency evaluation of the defendant to testify in support of the defendant’s diminished capacity defense. The Court of Appeals determined that the district court had focused in error on the different legal standards related to competency to stand trial and diminished capacity rather than focusing on whether the substance of the expert’s testimony would have assisted the jury in deciding whether the defendant could form the requisite intent to commit the crimes charged. *United States v. Christian*, _F.3d _, 2014 WL 1491887 (9th Cir. Apr. 17, 2014).

Eric Leon Christian was convicted of two counts of sending threatening emails through interstate commerce. In May 2009, he first emailed the then Chief of the North Las Vegas Police Department asking for assistance in retrieving his car, which had been repossessed several months earlier. When the police chief responded that the police could not assist him, he sent an email containing several threats of violence, including “I will have to kill to retrieve my stolen and items [sic] if you do not return them” and “This communication is protected by the First Amendment and my undying declaration of ridding the earth of terrorist, [sic] who take away Constitutional Rights like YOU and the thief who has my car.” Christian also emailed threats to the then chief deputy city attorney and the chief prosecutor for North Las Vegas. He had requested copies of case files for two cases, neither of which had been prosecuted by the attorney or the city attorney’s office. Christian followed with an email threatening to “get a mob together

and start a civil war” to kill a state court judge or the attorney himself unless the attorney “g[ot] the Writ of Habeas Corpus out of the way.”

In an unrelated state court proceeding, a psychologist had evaluated Christian’s competency to stand trial. The psychologist interviewed Christian for about an hour, following an outline designed to assess the core competencies related to a defendant’s ability to assist in his defense. Christian was hostile and uncooperative during the interview, and the psychologist assessed his competence level in all areas to be inadequate. He determined that Christian could not communicate relevant information to his attorney, make rational decisions about plea bargaining or asserting a mental illness defense, or behave appropriately in the courtroom. The psychologist diagnosed Christian with psychosis, not otherwise specified, probably delusional or paranoid; personality disorder, not otherwise specified; and probable learning disabilities, not otherwise specified. He also believed Christian was at high risk for homicidal behaviors and recommended his transfer to another facility for treatment and medication management.

Prior to trial on these charges, Christian gave notice of his intent to call the psychologist as an expert witness. His sole defense to the charges was diminished capacity in which he argued that he was incapable of forming the specific intent required by the charge, in this case, the specific intent to threaten. The police chief and attorney both testified for the prosecution that they had felt threatened by the emails and had taken precautions to protect themselves and others. The police chief also testified that he thought Christian was very upset and “very disturbed.” At the close of the government’s case, Christian’s attorney informed the district court that he intended to call the psychologist to testify regarding Christian’s diminished capacity defense. Without conducting a *voir dire* of the psychologist to determine the substance of his testimony or to permit counsel to proffer what his specific testimony would be, the district court determined that because the legal standards for competency to stand trial and the diminished capacity defense, which concerns “whether the defendant has the ability to attain the culpable state of mind which defines the crime,” the expert could not testify. Christian’s attorney then rested his case without presenting any other evidence or calling Christian to testify. He then asked for a diminished capacity instruction to the jury, which the district court denied because there was no evidence in the record that would support such an instruction. The jury convicted Christian on both counts.

Christian appealed to the Ninth Circuit Court of Appeals arguing that the district court had abused its discretion by refusing to let him introduce expert testimony in support of his diminished capacity defense and refusing his diminished capacity instruction. The Court of Appeals agreed with Christian on the district court’s refusal to admit the expert testimony, finding that the district court had focused exclusively on the different legal standards. Instead the court should have determined whether the testimony regarding the psychologist’s observations and diagnoses of Christian would have been relevant and helpful to the jury in evaluating his diminished capacity defense. The Court then decided that the failure to allow the expert testimony was not harmless error and a new trial was necessary. Because the district court had not conducted a *voir dire* of the expert, the district court on remand must first do so, assessing whether the testimony would in fact be relevant and would assist the jury in assessing the diminished capacity defense. Once the district court does this, and if it then determines the evidence is relevant and would be of assistance to the jury, it should allow the testimony.

The Ninth Circuit rejected Christian’s argument that the district court erred in not giving the jury a diminished capacity instruction. He had argued that the threats in the emails themselves were inherently irrational and were sufficient to warrant a diminished capacity instruction. He also argued that even the police chief believed him to be “very disturbed.” The Ninth Circuit found that these arguments alone were insufficient to require a diminished capacity instruction, but if there had been *any* evidence in the record, the instruction should have been given. The Appellate Court then held, however, that if any evidence on remand, expert or otherwise, supports a link between Christian’s mental illness and his ability to form the intent to threaten, then the instruction must be given. The Ninth Circuit vacated the conviction and remanded the case to the district court for a new trial.

Institute Programs

Please visit the Institute’s website at <http://cacsprd.web.virginia.edu/ILPPP/OREM/TrainingAndSymposia> this Summer for announcements of programs being offered in the period September 2014 through June 2015. Please re-visit the website for updates.

Developments in Mental Health Law is published electronically by the Institute of Law, Psychiatry and Public Policy (ILPPP) with funding from the Virginia Department of Behavioral Health and Developmental Services. The opinions expressed in this publication do not necessarily represent the official position of either the ILPPP or the Department.

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ISSN 1063-9977

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- ⁱ Office of the Inspector General, Critical Incident Investigation, Bath County, Virginia, November 18, 2013 issued March 2014 available at <http://osig.virginia.gov/media/2562/2014-bhds-006bathcountyci.pdf>.
- ⁱⁱ In order to protect the confidentiality of the individuals involved in this critical incident, the Inspector General's Report does not identify the individuals involved.
- ⁱⁱⁱ OIG Report No. 206-11 is available at <http://www.oig.virginia.gov/documents/SS-EmergencySvcsReview206-11.pdf>.
- ^{iv} *Id.* at 31.
- ^v The full Study is available at http://www.law.virginia.edu/pdf/news/face_to_face_emergency_evaluations_report_v2.pdf.
- ^{vi} *Id.* at 30-35.
- ^{vii} SB 260 is available in its entirety at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0691+pdf>.
- ^{viii} Except as specifically indicated otherwise, all legislation becomes effective July 1, 2014.
- ^{ix} House Bill 1232 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0774+pdf>.
- ^x Parallel provisions in the Psychiatric Commitment of Minors Act contained in Title 16.1 have also been amended.
- ^{xi} House Bill 478, introduced by Delegate Ronald Villanueva also extends the ECO to eight hours and is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0761+pdf>.
- ^{xii} House Bill 293 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0773+pdf>.
- ^{xiii} A Study of Face-To-Face Emergency Evaluations Conducted by Community Services Boards in April 2013 at 3.
- ^{xiv} House Bill 574 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+sum+HB574>.
- ^{xv} Mass Shootings at Virginia Tech April 16, 2007, Report of the Review Panel, Presented to Governor Kaine, Commonwealth of Virginia, August 2007, Recommendation IV-13 at 60 available at <http://cdm16064.contentdm.oclc.org/cdm/ref/collection/p266901coll4/id/904>.
- ^{xvi} A Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform, December 21, 2007 available at http://www.courts.state.va.us/programs/concluded/cmh/reports/2007_0221_preliminary_report.pdf.
- ^{xvii} Barclay, Sarah E., Increasing the Temporary Detention Period Prior to a Commitment Hearing: Implications and Recommendations for the Commonwealth of Virginia Commission on Mental Health Law Reform, April 2008, available at http://www.courts.state.va.us/programs/concluded/cmh/reports/2008_04_tdo_period_barclay_report.pdf.
- ^{xviii} Department of Planning and Budget Fiscal Impact Statement available at <http://leg1.state.va.us/cgi-bin/legp504.exe?101+oth+SB85F122+PDF>.
- ^{xix} Wanchek, Tanya Nicole, Ph.D., J.D.; Bonnie, Richard J., LL.B., Use of Longer Periods of Temporary Detention to Reduce Mental Health Civil Commitments, *Psychiatric Services* 2012; doi: 10.1176/appi.ps.201100359, abstract available at <http://ps.psychiatryonline.org/article.aspx?articleid=1151384>.
- ^{xx} HB 1172 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0675+pdf>.
- ^{xxi} A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013 at 5-8.
- ^{xxii} *Id.* at 33-35.
- ^{xxiii} House Bill 1216 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0292+pdf>.
- ^{xxiv} <http://www.dbhds.virginia.gov/documents/140107Stewart.pdf>.
- ^{xxv} SJR 47 may be found in its entirety at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+SJ47ER+pdf>.
- ^{xxvi} HJR 240 (1996) is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?961+ful+HJ240ER+pdf>.
- ^{xxvii} HJR 225(1998) is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?981+ful+HJ225ER+pdf>.
- ^{xxviii} Office of the Inspector General, A Review of Mental Health Services in Local and Regional Jails, issued January 2014 and available at <http://osig.virginia.gov/media/2409/20140113jailstudyreport.pdf>.
- ^{xxix} House Bill 323 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0317+pdf>.
- ^{xxx} These requirements are also contained in the second enactment clause to House Bill 478.
- ^{xxxi} The December 2008 Report to the Commission on Mental Health Law Reform from its Working Group on Transportation is available at http://www.courts.state.va.us/programs/concluded/cmh/taskforce_workinggroup/reports/2008_1216_wg_transportation_rpt.pdf; its 2009 Report is available at http://www.courts.state.va.us/programs/concluded/cmh/taskforce_workinggroup/reports/2009_1201_wg_transportation_rpt.pdf.
- ^{xxxii} House Bill 574 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0499+pdf>.
- ^{xxxiii} House Bill 1222 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0601+pdf>.

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- ^{xxxiv} House Bill 743 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0336+pdf>.
- ^{xxxv} House Bill 584 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0329+pdf>.
- ^{xxxvi} House Bill 585 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0408+pdf>.
- ^{xxxvii} House Bill 413 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0402+pdf>.
- ^{xxxviii} House Bill 1268 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+HB1268ER2+pdf>.
- ^{xxxix} 20 U.S.C. § 1232g; 34 C.F.R. Part 99.
- ^{xl} The faculty handbook is available at www.campusuicidepreventionva.org.
- ^{xli} This article is available at <http://cacsprd.web.virginia.edu/ILPPP/PublicationsAndPolicy/Index> and at www.dmhl.typepad.com/my-blog/college-and-univeristy-faculty/.
- ^{xlii} House Bill 206 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0558+pdf>.
- ^{xliiii} Senate Bill 627 is available at <http://leg1.state.va.us/cgi-bin/legp504.exe?141+ful+CHAP0639+pdf>.
- ^{xliiv} A summary of the Department of Justice Settlement Agreement with the Commonwealth of Virginia can be found in *Developments in Mental Health Law*, Vol.31, Issue 2 (February 2012) available at <file:///C:/Users/Jane/Downloads/Final%20edits%20Developments%20February%202012.pdf.pdf>.