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I. Feature Article

Responding to Concerned Family Members during a Mental Health Crisis: Reflections on a Critical Incident

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On February 28, 2015, Ms. Jodi Hall-Gadshian, a 32-year-old registered nurse and mother of a young child, died from a self-inflicted gunshot wound. Just three days earlier, she had been discharged from a psychiatric hospital, her fourteenth psychiatric

hospitalization in three years. Many of those hospitalizations had been involuntary, initiated at the request of her mother, Ms. Deborah Hall, and carried out through the actions of a local magistrate, first by issuing an emergency custody order (ECO) for Ms. Hall-Gadshian to be taken into custody for evaluation, and then by issuing a temporary detention order (TDO) when that evaluation found that Ms. Hall-Gadshian met the statutory criteria for temporary involuntary psychiatric hospitalization. Just hours before her death in February of 2015, Ms. Hall, recognizing behaviors in her daughter that in the past had signaled that she was in crisis and in danger of harming herself or others, had again requested that a magistrate issue an order for her daughter to be taken into custody and evaluated. That request, however, was denied. Hours later Ms. Hall's daughter was dead.

Magistrates serve a vital role in Virginia's legal system, and it is a role that is increasingly complex and demanding. As judicial officers, their duty is to provide an independent and unbiased review of facts and claims presented to them before authorizing government action that takes or restricts a person's liberty or property. Magistrates issue arrest warrants, search warrants, and subpoenas; they set or deny bail to individuals who have been taken into custody; and they perform a number of related functions set out in the Virginia Code, which is the sole source of their authority.

Magistrates have been given specific authority, in Title 37.2 of the Virginia Code, to restrict the liberty of a person who is alleged to be in a mental health crisis and in need of psychiatric hospitalization or treatment. Specifically, magistrates can issue emergency custody orders (ECOs), authorizing law enforcement officers to take such a person into custody and transport them to an appropriate site for a mental health evaluation; they can also (following an evaluation) issue temporary detention orders (TDOs) authorizing the temporary placement of such a person in a psychiatric facility (until a hearing can be held before a judge or special justice to determine whether the person should remain in such placement).

Virginia Code Sections 37.2-808 and 809 set out that a magistrate "shall" issue an ECO or TDO for a person *only* if the available evidence provides "probable cause" to find that (1) the person has a mental illness; (2) there's a "substantial likelihood" that, due to that mental illness, the person will, in the near future, (a) cause serious physical harm to self or others (as evidenced by "recent behavior" and "other relevant information", if any); or (b) suffer serious harm due to lack of capacity to protect or provide for self; (3) the person needs hospitalization or treatment; and (4) the person is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.

Those same sections go on to provide that, when considering whether there is probable cause to issue an ECO or TDO for a person, the magistrate may consider—in addition to the information in the petition that is filed seeking the psychiatric hospitalization of the person—the following: "(1) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (2) any past actions of the person, (3) any past mental health treatment of the person, (4) any relevant hearsay evidence, (5) any medical records available, (6) any affidavits submitted, if the witness is unavailable and it

so states in the affidavit, and (7) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue" the ECO or TDO.

As noted in a presentation recently made to the SJ 47 Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (which can be found here), "mental health law is one of the largest blocks of instruction" in the certification process for magistrates, and they participate in "mock mental health hearings" as part of that training. Even with that preparation, each magistrate faces a challenging task in gathering the necessary facts and applying the statutory standards to decide whether a person alleged to be in mental health crisis should be taken into custody.

For a family member who brings to the magistrate's office the lived experience of having seen their loved one in mental health crisis, and who firmly believes that their loved one is in danger, the facts may seem obvious and the standards may seem like impediments to getting their loved one help. For Ms. Hall, who had found help for her daughter from magistrates in prior situations that, to her, were similar to the one in February of 2015, the denial of her request for help left her surprised, confused, and upset. She also felt helpless, and did not know what else to do.

Ms. Hall reported in an interview that her daughter's life growing up gave Ms. Hall no clue that her daughter's life would end in suicide. Her daughter was a high achiever at school, became a registered nurse by age 21, and enjoyed professional success and a large circle of friends and colleagues. According to Ms. Hall, her daughter's descent into psychiatric instability and extreme behaviors—episodes of mania (loud and pressured speech, inappropriate laughter, dangerous driving and risk taking), alcohol abuse, multiple suicide attempts, periods of disorientation and memory loss, and periods of depression and incapacity—began after her daughter entered what Ms. Hall observed to be an abusive relationship. According to Ms. Hall, when her daughter's condition or behaviors became so extreme that Ms. Hall feared that her daughter was placing herself or others in danger of harm, she went to the magistrate in Chesapeake, the city where her daughter was living at the time.

Ms. Hall reported that each time she went to the magistrate's office and described to the magistrate on duty her daughter's condition and behaviors and the reasons for her concerns, the magistrate asked Ms. Hall to fill out a petition seeking involuntary commitment of her daughter, and entered an emergency custody order (ECO) to arrange for Jodi Hall-Gadshian's transport to a site where she could be examined by an evaluator from the Chesapeake Community Services Board (now Chesapeake Integrated Behavioral Healthcare). Each time, according to Ms. Hall, the evaluator found that her daughter met the criteria for a Temporary Detention Order (TDO), and her daughter was hospitalized. Unfortunately, those hospitalizations provided only temporary respite and stability. Ms. Hall reports that, during the last three years of her daughter's life, she never remained out of the hospital for more than a few months at a time. Some of those hospitalizations occurred after Ms. Hall had to intervene to stop her daughter from actively attempting to take her own life.

By February of 2015, Jodi Hall-Gadshian had moved to Virginia Beach. When she was discharged from a psychiatric hospital on February 25 of that year, Ms. Hall and her husband both observed that their daughter "wasn't right." Two days later, Ms. Hall's other daughter contacted her by phone. She reported that she was in the car with Jodi and was frightened by her sister's behavior. She reported that Jodi was drinking alcohol, driving fast and dangerously, had the radio blasting and was laughing inappropriately. These were all behaviors that Ms. Hall recognized as signs that her daughter was deteriorating again and that, without treatment intervention, she would harm herself or someone else.

Ms. Hall reported that she went to the magistrate's office in Virginia Beach for help, and she described her experience there. (What follows is a report of Ms. Hall's account alone. The Judicial Canons provide that it is a violation of the Canons for judicial officers to comment on the factual circumstances relating to the exercise of their judicial duties except in a proper legal forum. Given that, DMHL has not attempted to identify or interview the magistrate.)

According to Ms. Hall, she told the magistrate on duty that "I need some help with my daughter." She then explained that her daughter had just recently been discharged from a psychiatric hospital and was acting "wild and crazy"—speeding and driving dangerously, with the radio "blasting", and her sister being afraid of harm. Ms. Hall expressed to the magistrate that her daughter was a threat to herself and to others on the road. When the magistrate asked if her daughter was drinking (alcohol), she replied "yes." The magistrate responded that her daughter's behavior was "typical" of people who are drinking alcohol, and that this was not enough to allow him to act. Ms. Hall noted to the magistrate that her daughter had a history of multiple involuntary psychiatric hospitalizations, and the magistrate, according to Ms. Hall, confirmed this by checking the electronic record available to him. After looking at that record, the magistrate's response was that Ms. Hall was "going on her [Jodi's] past history", and that Jodi's condition and behavior as reported by Ms. Hall did not give him "enough to go on." As a result there was nothing he could do.

In response to an interview question, Ms. Hall reported that the magistrate did not request or take a written statement from Ms. Hall or indicate that she could file a petition to request her daughter's involuntary commitment. The magistrate did not refer Ms. Hall to any of the city's mental health services or provide any information regarding those services. The magistrate did note that there was another magistrate's office in the city (located a considerable distance away) and that she might get a different response there. To Ms. Hall's knowledge, no written record was made of her encounter with the magistrate.

Ms. Hall, in her interview, noted that all she wanted was for someone with mental health expertise to "check on" her daughter, whose history told Ms. Hall that she was again in serious trouble. Ms. Hall did say that she later confirmed that her daughter had attended a scheduled appointment at the hairdresser later that same day, apparently without

incident. At that point, she hoped that her daughter had then gone home and gone to sleep. Although Jodi Hall-Gadshian did return home, she killed herself a few hours later.

Like every critical incident, the Jodi Hall-Gadshian case creates an opportunity to reflect on important aspects of the Commonwealth's statutes and practices relating to emergency mental health interventions. They include the following:

1. *The legal threshold for state intervention* - Virginia's requirement that there be probable cause for finding a "substantial likelihood" of "harm" before an ECO can be issued for a person alleged to be mentally ill is similar to the standard used in a majority of the states in the U.S., but it has been criticized as preventing more timely intervention for someone who is in crisis and needs treatment but is too incapacitated to recognize their need for treatment. (See, for example, this article that was submitted by the Virginia Treatment Advocacy Center as part of its presentation to the SJ 47 Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century.) Even within this "harm" framework, however, there are the additional, and often difficult, issues of how the evidence of past conduct should guide the assessment of current threat. In addition, when considering whether to issue an ECO (or TDO), how much action, if any, should a magistrate take to gain information from the various sources listed in the statute?

2. *ECO/TDO process* – Sections 37.2-808 and 809 provide that a magistrate may issue an ECO or TDO "upon the sworn petition of any responsible person, treating physician or his own motion." In addition, as noted above, the evidence that a magistrate can consider in deciding whether to issue an ECO or TDO includes the sworn petition. Given this, when an ECO or TDO is being sought by a family member or other responsible person, should the magistrate have that person fill out a petition in every instance, or only when, based upon the potential petitioner's evidence, the magistrate finds that there is sufficient evidence to support an ECO (or TDO)? The language in both sections regarding the evidence to be considered by the magistrate appears to assume that a petition is filed *before* the magistrate makes a decision on the sufficiency of the evidence for an ECO or TDO. The practice in Virginia Beach (and at least some other localities), however, appears to be one in which the concerned family member or other responsible person requests an ECO (or TDO, as the case may be) and presents the evidence supporting that request without first filing a petition for involuntary admission. Although this approach seems more convenient and efficient, regularity of the process might be enhanced if a petition were filed in every case for the magistrate's formal consideration. This matter should be studied.

The events in this case highlight another important question about the process: What recourse did Ms. Hall have when the magistrate denied her request for an ECO? If the magistrate denies the request for an ECO (or TDO), should there be an opportunity for immediate formal review of that decision? In the absence of a process for direct review, the Virginia Supreme Court's website invites dissatisfied citizens to file a formal complaint with the Court. Does this process provide a sufficient review and ensure an adequate response? How does the absence of any written record affect that procedure?

2. *Records* – Regardless of what procedure is decided upon for processing requests for ECOs and TDOs, should magistrates be required to maintain a record of all requests that are denied? Should reasons for denials be recorded? (Currently, when TDOs are *issued*, the TDOs and all related documents become part of the file ultimately maintained by the District Court Clerk's office.) Should database systems be improved to allow uniform collection of such records?

3. *Referral for services/less restrictive intervention* – When there is insufficient evidence to support an ECO or TDO, should there be a standard protocol for referring the family to emergency mental health services, to approach the crisis from a treatment standpoint and look for other ways to resolve the crisis? Do local Community Services Boards (CSBs) have the capacity to accept such referrals?

4. *Wellness and crisis planning* – As a person who had experienced multiple involuntary psychiatric hospitalizations and who had a supportive family, Ms. Hall-Gadshian seems to have been a person who would have benefitted significantly from having a wellness and crisis plan—including an advance directive for mental health care—to provide daily guidance on maintaining wellness and to address her treatment in a future crisis (e.g., having an agent to make mental health care decisions for her, including temporary psychiatric hospitalization) if she became incapacitated during a crisis. Did she receive any education or assistance on such planning? (Her mother, Ms. Hall, reports that such wellness and crisis planning was never suggested to her as a possible strategy for helping her daughter, and that her daughter never mentioned this.) How available is such education and assistance to others? What are the obstacles to implementing such a plan—especially the advance directive—during a crisis?

These cases can be extremely difficult, and in any number of them reasonable people can disagree on whether the available facts support the findings required by law for the issuance of an ECO or TDO. Knowing this and knowing what is often at stake for these individuals and their families, the questions raised above by the case of Jodi Hall-Gadshian merit ongoing attention.

II. Updates

The SJ 47 Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

The October 2015 issue of *Developments in Mental Health Law* (found at http://www.ilppp.virginia.edu/PublicationsAndPolicy/Index) provided an overview of the mandate of the SJ 47 Joint Subcommittee and a summary of the work that it had accomplished (including presentations made to the Subcommittee and its work groups) up through its meeting on September 24, 2015. Since that time, the Subcommittee has had one meeting in the community on November 13, 2015 in Woodbridge, Virginia, followed by a meeting in Richmond on January 12, 2016, at which the members adopted

and released an interim report to the Governor and the General Assembly. (That report can be found here.)

The report provides a chronological summary of the meetings of the Subcommittee over the first two years of its existence, and the various presentations made to the Subcommittee as a whole and to the three work groups it established (Work Group #1: Crisis Intervention; #2: Continuum of Care; #3: Special Populations). In the concluding section of the report, entitled "Interim Recommendations," the SJ 47 Joint Subcommittee noted that its first two years of work "concentrated on reviewing the works and recommendations of previous studies on the provisions of mental health services in the Commonwealth and on familiarizing itself as to the current state of the mental health system in Virginia," receiving "extensive testimony" from mental health experts in both the public and private sectors as part of that effort. The members also toured "numerous mental health facilities and service providers" in the state.

The Joint Subcommittee's stated plan for its *final* two years is to "utilize the information it has collected" and "make recommendations as to what services should be provided and the statutory or regulatory changes necessary to improve access to such services by persons who are in need of mental health care." As explained by Senator Creigh Deeds, and summarized in an article found here, the Joint Subcommittee plans to focus on changes in four areas: modifying the structure and financing of mental health services system to assure access to the full continuum of adequate services and supports; identifying and implementing the best models of emergency evaluation and intensive interventions for individuals in mental health crisis; assuring adequate access to supportive housing for individuals with serious mental illness; and diverting individuals with mental illness from the criminal justice system and assuring access to treatment for individuals in custody or detention. The members intend to "reconfigure the membership and subject matter areas of its work groups" "to facilitate the making of such recommendations." Specifically, the Joint Subcommittee asked Professor Richard Bonnie, one of the nation's leaders on mental health law and policy, to assemble panels of experts to aid in the exploration of innovations that have occurred in other states and study of the scientific literature to learn about policies and practices that have worked. The reconfigured Joint Subcommittee membership and expert panels will thus identify policy options for the Joint Subcommittee's consideration over the next two years.

Although the Joint Subcommittee did not as a body recommend changes to Virginia law to the 2016 General Assembly session, Del. Rob Bell, who co-chairs the Joint Subcommittee with Sen. Creigh Deeds, has introduced at least one bill that is similar to bills actively discussed by the Crisis Intervention Workgroup (which Del. Bell chaired). That bill is House Bill 811 (found here), which adds provisions to sections in Title 37.2 to improve notice to, and the opportunity for participation and input by, a person's family members and health care agents before a magistrate decides whether to issue a temporary detention order (TDO) and before a special justice decides whether to enter an involuntary commitment order. (Drafts of the bills discussed by Work Group #1 can be found by clicking the "Materials" link for the Work Group's November 13, 2015 meeting, which can be found here on the DLS webpage for the Joint Subcommittee.)

No formal recommendations from the three Work Groups are cited in the Joint Subcommittee Interim Report, but the Work Group on Special Populations did draft some tentative recommendations that were publicly shared (and can be found here). Those recommendations call for the development of comprehensive children's mental health services in all of the state's CSBs, with those services to include child psychiatry, crisis intervention (including mobile crisis units and residential Crisis Service Units (CSUs)), intensive in-home services, and case management. The Work Group also identified the shortage in qualified mental health staff as a serious issue, and recommended establishment of a student loan repayment fund that would provide grants to mental health professionals who work in Virginia's CSBs, BHAs, and DBHDS facilities, to help them pay off their student loans.

It is notable that, at the meeting of the entire Joint Subcommittee on November 13, 2015, held after the Work Group sessions, the Subcommittee heard presentations on the multiple challenges presented by the large number of individuals in our Virginia jails and prisons who have serious mental illness. Michael Schaefer, Ph.D., Assistant DBHDS Commissioner for Forensics, provided an overview of some of the key problems facing Virginia's criminal and mental health systems in properly addressing the needs of these individuals. His presentation, which includes a description of current and proposed efforts to divert from the criminal justice system, and into treatment, those nonviolent persons with mental illness who are more appropriate candidates for treatment, can be found here.

The agenda for the November 13 session also shows that a presentation was made on "Mental Illness and the San Antonio Model." Although there are no materials on the DLS website associated with that presentation, the Joint Subcommittee's Interim Report devotes a few paragraphs to describing the presentation made by Gilbert Gonzales, Director, Mental Health Department, Bexar County, Texas, and Mike Lozito, Director, Judicial Services Office, Bexar County, Texas. (San Antonio is located in Bexar [pronounced "Bear"] County.) According to the report, in an effort that started in 2000, Bexar County "law enforcement, the county jail, the courts, hospitals, and other county services"—most particularly, mental health services—have "integrated their efforts" to keep out of jail and move into treatment those individuals in the community who were experiencing mental health crisis and whose behaviors, under the old model of intervention, normally resulted in their incarceration. The Bexar County model, which "focuses on diversion and treatment," was developed specifically as a jail diversion program, and it has succeeded in dramatically reducing the census in the Bexar County jails (they are currently under capacity) and at the same time has both increased timely mental health services to people in crisis and saved the county money. Central to the program has been the development of a Crisis Care Center, to which individuals in crisis are brought for psychiatric evaluation, observation and treatment, and basic medical screening and care. Like the Psychiatric Emergency Services (PES) Unit that is the centerpiece of the Alameda County, California model (described in the April 2015 issue of *DMHL*, which can be found here), the Crisis Care Center holds and treats patients for a limited period of time (up to 24/48 hours), and then discharges or transfers them to

appropriate services. Unlike the Alameda model, the Bexar County Crisis Care Center exists specifically as part of a jail diversion program, and it has been consistently successful in not only diverting individuals from jail to needed mental health treatment and services, but also diverting them from county hospital Emergency Departments. The Center also enables law enforcement officers who bring individuals there to quickly return to duty on the streets.

The Bexar County Jail Diversion Program also addresses a key concern raised in the September meeting of the Joint Subcommittee by Virginia Beach Sheriff Ken Stolle: the pattern of many individuals with serious mental illness of repeatedly cycling through the criminal justice system because they have no stable placement when they are released from that system. The Bexar County program includes a homeless shelter, a rehabilitation program, job training, and other forms of longer term assistance. In 2014, Kaiser Health News covered the program in an article that can be found here. The program has published a manual ("Blueprint for Success: The Bexar County Program," found here) that not only describes the program but also sets out how a community can develop one of its own.

Minor Consent for Voluntary Inpatient Psychiatric Treatment

The Joint Commission on Healthcare (JCHC) embarked in 2014 on a study of the laws and practices relating to the psychiatric hospitalization of minors. Part of that study resulted in JCHC Report Document No. 459 (found here), and recommendations by the JCHC that Virginia amend its statutes regarding the standards for involuntary psychiatric hospitalization of minors age 14 through 17 when the minor objects to such hospitalization but the parents consent to it (and, as may often be the case, seek it). Those recommendations were incorporated into Senate Bills 773 and 779, which were enacted by the 2015 Virginia General Assembly. (A description of the bills and a link to them are in the April 2015 issue of *DMHL*, which can be found here.)

In 2015, at the suggestion of State Senator Barker, JCHC staff reviewed "the implications of allowing a minor to consent for inpatient treatment at a mental health facility without the consent of the minor's parent." The result was JCHC Report Document No. 552 (found here). As noted in that document, currently "the parent(s) and the minor aged 14 through 17 must apply jointly in order for a minor to be admitted voluntarily into an inpatient psychiatric treatment center. In instances in which the minor child (aged 14 through 17) consents but the parent does not consent, a range of actions may be taken including the parent taking custody of the child and returning home, a request for an emergency custody order or temporary detention order, and a report to child protective services for medical neglect on the part of the parent."

As the staff report notes, there has been no prior study or data collection in Virginia specifically addressing how often the situation arises in which an older adolescent needs and wants psychiatric hospitalization but the parent/custodian refuses to consent. Drawing from various sources, the JCHC report finds that this "may occur" in Virginia approximately 120 times a year. JCHC staff also found that a number of states have

already determined that this is a situation that needs to be addressed: 19 states have enacted statutes that "explicitly authorized voluntary admission for inpatient psychiatric treatment of a minor without the consent of the parent. Most of the authorizing statutes include provisions that balance the minor's rights to voluntary admission with language that protects the minor, clinicians and providers from abuses of the authorization."

The JCHC staff study found a wide range of views among professionals, parent organizations and mental health advocacy organizations in Virginia over both how often this situation arises in this state and how (or even whether) such a situation should be addressed through legislative action. Six "policy options" were submitted to the JCHC in the report. Ultimately, the JCHC voted to take no action.

Senator Barker has since submitted proposed legislation to the 2016 General Assembly (Senate Bill 432, found here), which would enable a minor 14 years of age or older to consent to psychiatric hospitalization in a "willing facility," even if the parent/custodian objected, once a preadmission screening by an evaluator from the local community services board confirmed that the minor met the criteria for psychiatric hospitalization and that no less restrictive treatment modalities were available. The bill provides specifically for prior notice to the parent/custodian, and for subsequent petition by the facility caring for the minor to the local Juvenile and Domestic Relations District Court, for a hearing to determine whether continued hospitalization should be authorized by Court order (if the objection of the parent/custodian continues). The bill does not appear to address the issue of how the hospital would be paid for its services to the minor if the parent/custodian objects to the hospital care.

III. ILPPP Data Corner

Response Time of Public Outpatient Mental Health Providers to Requests for Emergency Evaluations

In response to concerns about excessive delays in CSB emergency evaluations of individuals admitted to emergency departments (ED), the Virginia state legislature enacted HB 2368 (2015) requiring the Department of Behavioral Health and Developmental Services (DBHDS) Commissioner to review current emergency evaluation practices for individuals subject to involuntary civil admission and to develop a plan to authorize psychiatrists and emergency physicians to perform evaluations in order to expedite the process. The Commissioner convened a workgroup of stakeholders and subject matter experts to conduct this review.[1] In order to make evidence-based policy recommendations, the workgroup conducted a survey of Community Services

[1] A full report on the activities of the Commissioner's workgroup can be found at http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3872015/$file/RD387.pdf.

Board (CSB) response time. This issue's *ILPPP Data Corner* presents a brief summary of the response time data collected by the survey.

Data Collection

The survey was conducted over a period of two consecutive weeks in June 2015 (6/14/15-6/28/15). CSB emergency services staff filled out a survey response for each CSB emergency evaluation that occurred in an emergency department, as well as each evaluation that met any of the following conditions:

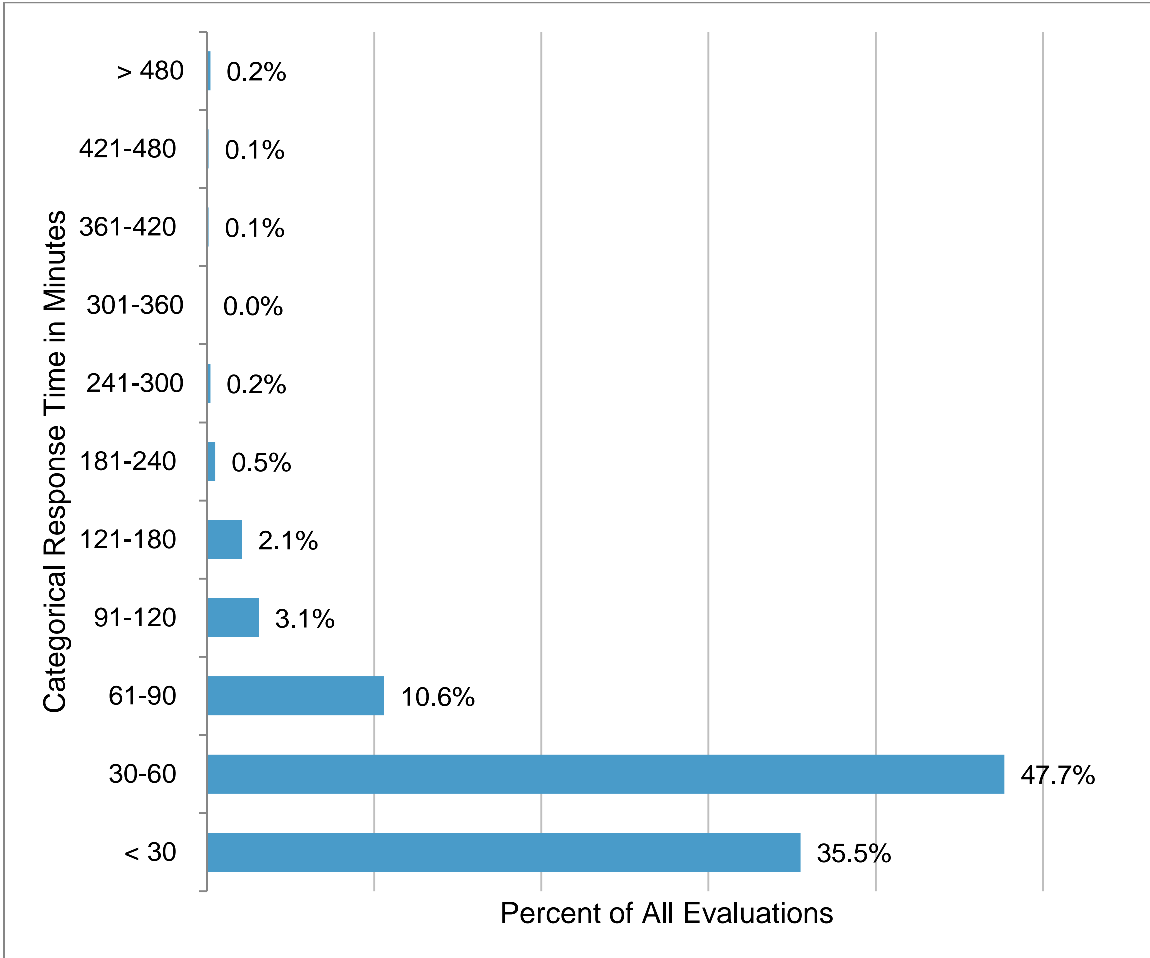
1. Under a paperless or paper ECO in any location; or
2. In an emergency department, not under a paperless or paper ECO, when there was a mutual agreement between the ED and the CSB that a prescreening was warranted. (This excludes instances in which the CSB was contacted to provide consultation or other services.)

Data were collected on the date and time of the initial request, the date and time when the face-to-face evaluation was initiated, the location of the evaluation, the type of evaluation (i.e., paperless ECO vs. paper ECO vs. no ECO), and the CSB. These data were used to calculate the response time, which corresponds to the length of time that elapsed from when the CSB was notified of the need for an evaluation to the time at which the evaluator arrived to conduct the evaluation. Data were reviewed and cleaned by ILPPP research staff before analysis.

Survey Results

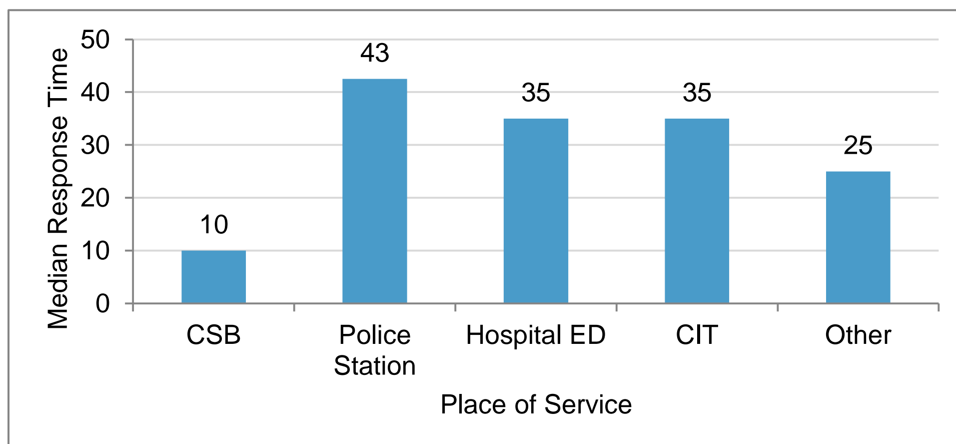
Over the two week period of the survey, 1,309 evaluations met inclusion criteria. Response times ranged from 0 minutes (for cases in which the evaluee was under an ECO and already at the CSB) to 703 minutes, with a median time of 33 minutes, and an average time of 42 minutes. For the vast majority (approximately 94%) of these cases, a CSB emergency services staff person met the evaluee within 90 minutes (see Figure 1). For six cases, the response time was over 4 hours. The reasons for those extended response times were not recorded as part of the survey.

Figure 1. CSB Response Time



Response time was statistically significantly related to place of service, $F(4, 1308) = 6.41$, $p < .001$. Response time for CSB place of service was significantly shorter than for Emergency Department, $p < .0001$, and for CIT place of service, $p = .048$.

Figure 2: Median Response Times for Places of Service



ILPPP staff built a multiple linear regression model[2] to evaluate the effects of several potential predictors on CSB response time. Multiple linear regression allows one to isolate the effect of an individual variable while taking into account the effects of covariates; it also allows one to identify the strongest predictors of an outcome. The following predictors were included in the model:

- Population density
- Number of evaluations meeting inclusion criteria
- CSB budget
- Location of evaluation
- Day of the week
- Presence of an operational Crisis Intervention Team (CIT) program
- Health Planning Region (HPR)

This model, which included many factors presumed to be driving influences for CSB response time, explained only a small percentage (< 10%) of variation in response time. Some variables did emerge as statistically significant predictors of response time, including evaluation location, type of prescreen, and CSB budget; however, these variables were all weak predictors, suggesting that other factors are at play in how quickly a CSB pre-screener responds to evaluation requests.

Note that as the data were self-reported, there is some room for error and inconsistency in the data collected, and derived results. However, these limitations are mitigated by the large sample size and independent reporting by 40 different CSBs. Future surveys of emergency evaluation response time should include data collection from hospital EDs to provide more comprehensive data and allow for data validation.

In Closing

CSB emergency services staff arrive within 90 minutes of a request for an emergency evaluation in the vast majority of cases. There is some variation in response time, though, including some outlier events with response times longer than 4 hours. Future analyses should include data on CSB service models, the presence of partnerships between hospital EDs, CSBs, and other community agencies, and other factors that may influence response time. Additionally, future surveys should collect detailed qualitative data on outlier response times, so that these events can be characterized and eventually prevented.

The involuntary commitment workgroup convened in response to HB 2368 has already committed itself to continue its progress so that yet more evidence will be available within a year to inform needed policy and procedure changes to Virginia's emergency mental health and civil commitment system.

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[2] See page 23 of the "Review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission" report for detailed results about this regression model.

IV. Case Law Developments

United States Fourth Circuit Decisions

Due process and capacity determinations in immigration proceedings: Immigration judge's inquiry into appellant's mental competence to participate in removal proceedings met due process requirements, and resultant denial of appellant's request for further delay to obtain a mental health evaluation did not violate due process and is upheld on appeal

Diop v. Lynch, 807 F.3d 70 (4th Cir. 2015)

Background: Madiagne Diop, an alien and native of Senegal, who was diagnosed with psychosis. Following an arrest related to a psychotic episode at his workplace, Diop appeared before an immigration judge in Baltimore, Maryland five times between November 2012 and May 2013. At a hearing in December 2012, the immigration judge questioned Diop regarding his mental health and competency and found Diop competent to participate in the removal proceedings. In April 2013, Diop moved to administratively close or continue proceedings pending the passage of an immigration reform bill in Congress. The immigration judge refused and ordered Diop's removal if he would not voluntarily depart. On June 6, 2013, Diop filed an appeal to the BIA arguing that the immigration judge should have administratively closed or continued the case in order to allow him to receive a psychological evaluation. The BIA found no clear error in the immigration judge's determination of Diop's competency, and Diop petitioned for review by the Fourth Circuit.

Holdings: The Fourth Circuit Court of Appeals rejected Diop's procedural due process claim. It held that Diop's procedural due process rights were satisfied by the immigration judge's cautionary measure of assessing Diop's competency in a separate hearing and "inquiring specifically about his mental health and ability to communicate with counsel." Because competency has "long been considered an issue of fact," the immigration judge's finding of competency was reviewed under a "substantial evidence standard": findings of competency are treated as conclusive unless the evidence presented "was such that any reasonable adjudicator would have been compelled to conclude the contrary."

Notable Points:

***The process for addressing competency in removal proceedings*:** The BIA stated that the immigration judge should start from a presumption of competency and that if there are no indicia of incompetency, the inquiry ends. It established a competency standard in *Matter of M-A-M* requiring (1) "rational and factual understanding of the nature and object of the proceedings," (2) ability to "consult with the attorney or representative if there is one," and (3) "a reasonable opportunity to examine and present evidence and cross-examine witnesses."

Other Federal Circuit Court Decisions

Ineffective assistance of counsel: Failure of defense counsel to present mitigation evidence regarding defendant's history of mental illness in sentencing phase of murder trial was prejudicial

Saranchak v. Sec'y, Pa. Dep't of Corr., 802 F.3d 579 (3d Cir. 2015)

Background: Following affirmance of his state court conviction for first degree murder and sentence of death, and denial of his motion for state post-conviction relief, Daniel Saranchak filed a petition for a federal writ of habeas corpus. The United States District Court for the Middle District of Pennsylvania granted the petition in part, but the Third Circuit Court of Appeals reversed and remanded. On remand, the District Court denied the petition. Saranchak appealed the denial, claiming that (1) his attorney's cumulative errors at trial prejudiced the guilt phase of the trial, and (2) his attorney was constitutionally ineffective at the penalty phase of his trial.

Holdings: The Third Circuit Court of Appeals, hearing Saranchak's appeal for the second time, held that Saranchak was not prejudiced by trial counsel's failure to present evidence of Saranchak's mental health history in conjunction with the admission of his confession. It did, however, find that the district court had been unreasonable in finding that (1) the background information available to trial counsel was insufficient to prompt further investigation regarding Saranchak's mental health, and (2) petitioner was not denied effective assistance due to this failure to investigate.

The Third Circuit found that Saranchak's trial counsel had access to enough background information regarding the client to warrant further investigation regarding Saranchak's mental health. The Third Circuit pointed to specific "red flags": (1) Saranchak stated that he was treated for one-month at an inpatient clinic; (2) Saranchak had once ingested 250 pills in response to his wife having an affair; and (3) a neutral expert noted that Saranchak "appeared to suffer from a personality disorder" with antisocial traits.

The Third Circuit also held that this failure to investigate amounted to ineffective assistance of counsel because counsel believed that Saranchak's mental health was a major issue in the case. Additionally, none of the petitioner's psychological diagnoses were presented to the jury, and "additional evidence revealed that petitioner's troubled past and psychological problems were significant factors affecting his life." This met the prejudice test required by *Strickland*.[1]

Ineffective assistance of counsel: Failure of defense counsel to present mitigation evidence regarding defendant's history of mental illness in sentencing phase of murder trial was prejudicial

[1] The standard requires that a defendant show 1) that counsel's performance was deficient and 2) that the deficient performance prejudiced the defense so as to deprive the defendant of a fair trial. *Strickland v. Washington*, 466 U.S. 687-696 (1984).

Hardwick v. Sec'y, Fla. Dep't of Corr., 803 F.3d 541 (11th Cir. 2015)

Background: After affirmance of his state murder conviction and death sentence and denial of state post-conviction relief, John Gary Hardwick, Jr. petitioned for federal habeas relief. Hardwick based his claim of ineffective assistance on his counsel's failure to conduct a professionally reasonable mitigation investigation regarding his mental health during the penalty phase, and that it was reasonably probable that he would not have been sentenced to death but for this deficient performance. After an initial denial followed by remand and an evidentiary hearing, the United States District Court for the Middle District of Florida determined that Hardwick's counsel had been ineffective at the penalty phase of his trial and set aside his capital sentence.

Holdings: The Eleventh Circuit Court of Appeals affirmed, holding that Hardwick was entitled to a writ of habeas corpus setting aside his capital sentence and requiring the imposition of a life sentence, unless the State provided him with a new penalty phase. Although trial counsel's decision not to present mitigating evidence at the penalty phase of a capital trial is not per se ineffective assistance, the strategic choice not to present mitigating evidence must be objectively reasonable. Here, as in *Saranchak*, there were several "red flags" that should have signaled to counsel the need to conduct a life-history investigation, to interview family members, and provide the information to a mental health expert.

<u>Ineffective assistance of counsel</u>: Granting of habeas relief and finding of ineffective assistance of counsel in sentencing phase vacated by Circuit Court

Morris v. Carpenter, 802 F.3d 825 (6th Cir. 2015)

Background: Following affirmance of his convictions for first-degree murder and aggravated rape and the imposition of a capital sentence, Farris Morris sought federal habeas relief in the United States District Court for the Western District of Tennessee. Specifically, Morris argued that his trial counsel failed to investigate his mental illness or to use a mitigation specialist at the penalty phase. The District Court granted his petition and vacated his sentence on the basis of ineffective assistance of counsel at the penalty phase of Morris's trial. The Warden appealed.

Holding: The Sixth Circuit Court of Appeals vacated the District Court's grant of habeas relief. The Court held that Morris's trial counsel's failure to present additional mental-health testimony as mitigation evidence at sentencing did not render counsel's performance deficient. Unlike the counsel in *Saranchak* and *Hardwick*, the Sixth Circuit found that Morris's trial counsel had a legitimate strategy reason for not presenting additional mental health testimony in the penalty phase—the additional evidence could have opened the door to "rebuttal evidence of Morris's history of drug dealing, drug use, and other illegal acts." This risk of damaging rebuttal evidence made defense counsel's decision to avoid presenting additional mental health evidence reasonable and not constitutionally deficient.

Notable Points:

***Reasonable refusal to introduce additional mental health evidence*:** Counsel presented testimony at the guilt phase "to show how cocaine intoxication and withdrawal can affect the user's ability to reason." Although, the defense team did not present new expert testimony at sentencing, they consulted with mental-health experts to form their strategy, and expert testimony was already before the jury. Additionally, mitigation witnesses testified about "Morris's character, work habits, and good behavior in prison."

Qualified immunity: State psychiatric ER employees are entitled to qualified immunity against claim by the estate of a man who died in the ER

Pena v. Givens, No. 14-11020, 2015 WL 7434253 (5th Cir. Nov. 23, 2015)

Background: After arriving at a fire station and complaining that he was being chased, George Cornell was taken by police to the Parkland psychiatric emergency room (the "Psych ER"). Cornell resisted when technicians tried multiple times to take his vitals, and tried to leave the Psych ER. Cornell was taken into a seclusion room, held on a mat on the floor, and given a mixture of Haldol, Ativan, and Benadryl to calm him. When Cornell became agitated again and ripped up a floor tile, the technicians attempted to move him to a new room, but he resisted and they administered another injection of the same three medications. Cornell was held on his stomach for some amount of time (possibly up to 15 minutes) following the second injection before the technicians left the room. A nurse found him lying prone in the room, and Cornell was transferred to the main emergency room, where he died. Following Cornell's death, the medical examiner found the cause of death to be undetermined but listed three potential causes: (1) mechanical compression; (2) underlying cardiac issues; or (3) effects of the medication he received in the Psych ER. Cornell's representatives sued technicians, doctors, nurses, and hospital supervisors alleging excessive force, physical restraint, denial of adequate medical care, staff supervision violations. The United States District Court for the Northern District of Texas denied defendants' motions for summary judgment on grounds of qualified immunity, and the defendants brought an interlocutory appeal.

Holding: On interlocutory appeal, the Fifth Circuit held per curiam that the technicians, nurse, doctor, and supervisors were all entitled to qualified immunity. The Court noted a lack of binding authority holding that "a medical professional's restraint of an individual in an emergency medical situation constitutes a Fourth Amendment seizure." Further, the Court noted that "even *police officers'* use of restraint does not implicate the Fourth Amendment if they are acting in an emergency-medical-response capacity" (emphasis in original). Important to the Fifth Circuit on both the excessive force and substantive due process claims was the fact that Cornell resisted the Parkland staff. Regarding the substantive due process violation due to physical restraint, the Fifth Circuit noted that the staff's conduct violated hospital policy but did not amount to conduct that "shocks the conscience."

Regarding the denial of adequate medical care, the Fifth Circuit noted the "recognized…special relationship for incarcerated and involuntarily committed individuals," which requires a state to protect the citizen from harm.[2] Plaintiffs must demonstrate that state official acted with "deliberate indifference." Thus, the defendants must have been "on notice" of Cornell's heart condition and then consciously refused to provide further care. Here, the Fifth Circuit pointed out that "Cornell resisted the officers when they tried to provide care," and posited that they could not say "that a reasonable jury could conclude that the failure to treat a heart condition after a patient refuses care and begins attacking staff amounts to deliberate indifference." Finally, regarding the lack of supervision claim, the Fifth Circuit noted that the subordinates' actions had not been found to be a constitutional violation, therefore the supervisors could not be held liable for constitutional violations.

Notable Points:

***Restraint while rendering emergency medical aid*:** Even though the training given to technicians warned not to hold patients in a prone position for extended periods of time, the Fifth Circuit cited *Sheehan* in saying that "if an officer acts contrary to her training…that does not itself negate qualified immunity where it would otherwise be warranted."

<u>Qualified immunity</u>: Officers involved in the subduing and arresting of a man experiencing "excited delirium" were entitled to qualified immunity against an excessive force claim by the man's estate

Waters v. Coleman, No. 14-1431, 2015 WL 6685394 (10th Cir. Nov. 3, 2015)

Background: On July 18, 2011, Alonzo Ashley and his girlfriend visited the Denver Zoo. Zoo patrons called security when Ashley tried to cool off under a water fountain, and the police were called when zoo security reported that Ashley attacked a security officer. When the first officer on scene, Jones, approached Ashley, he noticed that Ashley was sweating profusely—a symptom of excited delirium. Ashley and Jones struggled, and Jones eventually tackled Ashley with the assistance of two zoo officers. Ashley attempted to punch Jones, and Jones deployed his Taser to Ashley's back. When the second officer, Coleman, arrived, Ashley was still resisting, and Jones deployed his Taser again. Coleman also deployed his Taser two times and noticed that "Mr. Ashley seemed extremely strong." When three more officers, the officers were eventually able to subdue Ashley, and after he was handcuffed he remained on his stomach for between 2 and 5 minutes. Noticing that Ashley had vomited, Conner called for medical assistance. Ashley vomited once more and then stopped breathing. The officers began chest compressions, but Ashley was pronounced dead after paramedics transported him to the

[2] See *DeShaney v. Winnebago Cty. Dep't of Co. Servs.*, 489 U.S. 189 (1989), as well as *Cantrell v. City of Murphy*, 666 F.3d 911 (5th Cir. 2012) and *Doe ex rel. Magee v. Covington Cty. Sch. Dist.*, 675 F.3d 849 (5th Cir. 2012).

hospital. Ashley's mother, Gail Waters, brought a § 1983 action against the police officers alleging excessive use of force that led to his death. The United States District Court for the District of Colorado denied the officers' motions for summary judgment on the grounds of qualified immunity. The officers appealed.

Holding: The Tenth Circuit Court of Appeals reversed in part and dismissed in part, holding that all officers who participated in the arrest were entitled to qualified immunity. Additionally, the Tenth Circuit held that the Court of Appeals lacked jurisdiction to consider the denial of qualified immunity for lieutenant's supervisory conduct as the ranking officer on scene after Ashley was handcuffed.

Notable Points:

***Excessive force when detainee may be suffering from excited delirium*:** The Tenth Circuit did not reach the question of whether any officer's conduct was objectively unreasonable and therefore unconstitutional because it found that, on the day of the incident, the law was not clearly established so as to alert the officers to the potential illegality of their conduct. Even though Ashley presented symptoms of excited delirium, the Tenth Circuit stated that it has never "required officers to refrain from a minimal use of force when dealing with an impaired individual," noting several times the fact that a struggle was ongoing at the time that force was used. The Court noted that existing case law does, however, make it clear that continued use of force against a subdued or non-resisting person is not constitutionally permissible.

<u>Due process requirements for involuntary hospitalization</u>: Florida's statutory structure for involuntary commitment of persons with intellectual disability violates the 14th amendment, as it allows for indefinite commitment without periodic review

J.R. v. Hansen, 803 F.3d 1315 (11th Cir. 2015)

Background: Plaintiff-Appellant J.R., an intellectually disabled man with an IQ of 56, was charged with sexual battery and, after being found incompetent to stand trial, was admitted to non-secure residential services under F.S.A. § 393.11. He claimed that Florida's involuntary commitment laws denied due process because they permitted the State to keep intellectually disabled people committed indefinitely without periodic review. When a person is admitted, the circuit court that first ordered the admission keeps jurisdiction over the order, and the person "may not be released except by order of the court." The court, however, is "*never* required to review a continuing involuntary admission" (emphasis in original). Admitted persons may only challenge their support plans in administrative proceedings, but administrators cannot change or vacate the admission order or require release. Thus, the only means of securing release was by writ of habeas corpus.

Holding: The Eleventh Circuit held that Florida's statutory scheme was facially unconstitutional because it violated the Due Process Clause of the Fourteenth Amendment by failing to require periodic review of continued commitments "by a

decision-maker with the duty to consider and the authority to order release." Even if the statutory scheme did require administrative agencies to conduct period reviews, however, it would still be facially unconstitutional because the agency did not have the *authority* to order release nor was it required to petition the circuit court.

Notable Points:

***The availability of habeas corpus does not provide constitutionally adequate process*:** The Eleventh Circuit, relying on *Williams v. Wallis*, 734 F.2d 1434 (11th Cir. 1984), stated that "habeas corpus is not adequate in and of itself" and "can be at most a backstop." The Court distinguished habeas from periodic review because habeas is only available if a petitioner seeks it.

<u>Reasonable accommodations under ADA and 14th Amendment</u>: Medical school failed to meet "reasonable accommodations" standards of ADA regarding exams for student with mental illness, but due process afforded to the same student in regard to dismissal from school for inadequate performance met constitutional standards

Dean v. University at Buffalo School of Medicine and Biomedical Sciences, 804 F.3d 178 (2nd Cir. 2015)

Background: Maxiam Dean began to experience increased symptoms of depression after failing Step 1 of the United States Medical Licensing Examination. He met with an internist who recommended pharmacological treatment and provided him with an "excuse slip" recommending a leave of absence due to his situational depression. Dean presented the slip to his medical school, and was informed that it did not provide sufficient information to support an extended leave. The defendants offered a 10 week leave in response to Dean's request for 3 months and informed him that he would not be extended any additional accommodations, and that he must sit for his Step 1 by May 21, 2007. After failing to pass (or sit for) his third attempt at Step 1, Maxiam Dean was dismissed from the program. Dean brought suit under Title II of the Americans with Disabilities Act ("ADA"), Section 504 of the Rehabilitation Act of 1973, and 42 U.S.C. § 1983. The United States District Court for the Western District of New York granted summary judgment to the defendants and dismissed Dean's complaint. Dean then appealed.

Holdings: The Fifth Circuit held that the district court had erred in granting summary judgment to the defendants on the ADA and Rehabilitation Act claims because the defendants failed to show that the requested accommodation was unreasonable and to provide a "plainly reasonable" alternative. The Fifth Circuit found the record "devoid of evidence" regarding defendants' consideration of whether Dean's proposed accommodation would impose undue financial or administrative hardship on the M.D. program. Thus the lack of evidence regarding "the basis for denying Dean's requested modification to the exam schedule preclude[d] any conclusion on summary judgment as to the unreasonableness of that accommodation." Defendants would be entitled to summary judgment only if "the undisputed record reveals that the plaintiff was accorded

a plainly reasonable accommodation", but a reasonable juror could have found that the "abbreviated study period encompassed within Dean's leave" would not have been sufficient to prepare him to sit the exam.

The Court held that Dean's procedural due process rights had not been violated, though, because he "received notice of potential termination…and a careful and deliberate decision."

Intellectual Disability (ID) and the death penalty: Defendant Brumfield found intellectually disabled and therefore ineligible for the death penalty, under the standards set out by the Supreme Court in *Atkins* and *Brumfield*

Brumfield v. Cain, 2015 WL 9213235 (5th Cir. 2015)

Background: Kevan Brumfield was convicted of first-degree murder in 1995 and sentenced to death. After exhausting his state court remedies, Brumfield filed a petition for a writ of habeas corpus in the United States District Court for the Middle District of Louisiana, arguing that he was intellectually disabled and thus ineligible for the death penalty under *Atkins v. Virginia,* 536 U.S. 304 (2002). The District Court held that the state courts had erred by failing to hold an *Atkins* hearing and granted Brumfield a writ of habeas corpus after holding such a hearing. On appeal, the Fifth Circuit reversed without reaching the merits of the *Atkins* claim, holding that Brumfield had not satisfied the procedural requirements for habeas relief. The Supreme Court of the United States reversed, finding that he did meet the requirements, and remanded the case to the Fifth Circuit to ascertain whether the District Court's determination that Brumfield was intellectually disabled was clear error.

Holdings: On remand, the Fifth Circuit held that the District Court's determination was not clearly erroneous because it was "plausible in light of the record as a whole." Although the State argued that prior assessments placed Brumfield consistently in the 70-85 range,[3] the Fifth Circuit noted that "no actual IQ scores…were reported anywhere in Brumfield's records" and that tests provided only "descriptions of the ranges into which Brumfield's scores fell", and every expert witness before the district court "agreed that Brumfield's scores satisfied the first prong of the intellectual disability test." Additionally, the District Court found that Brumfield had significant conceptual limitations and "carefully explained its reasoning, identified the specific evidence it relied upon, and specifically credited the testimony of certain experts." Where the court's reasoning was so careful and its conclusions not implausible—even if it rejected the State's equally coherent and plausible story—the Fifth Circuit refused to disturb or second-guess its findings.

Although Brumfield was not formally diagnosed as intellectually disabled until after age 18, the district court found that the evidence produced showed this failure to diagnose

[3] An IQ score of 70 (two standard deviations below the mean) is typically used to indicate subaverage intellectual functioning that qualifies for a finding of intellectual disability.

was related to incentives in the school system not to identify students as intellectually disabled. Again, the district court pointed to specific evidence—Brumfield's poor academic record, below grade reading comprehension, and etiological factors (e.g., low birth weight, family history of intellectual disability). The Fifth Circuit noted that these factors "certainly bolster[ed] the court's conclusion that Brumfield's intellectual disability manifested" before 18.

State Court Decisions

Forced administration of medication to restore defendant to competency to stand trial under the *Sell* standard: Trial court's order "was insufficient in numerous respects" to support defendant's forced medication for the sole purpose of restoring his competency for trial

Warren v. State, 778 S.E.2d 749 (Ga. 2015)

Background: After Jesse James Warren was indicted on four counts of murder in connection with a mass shooting, he was found incompetent to stand trial and placed in the custody of the Department of Behavioral Health and Development Disabilities. The state of Georgia filed a petition under *Sell* to medicate Warren involuntarily in an attempt to restore his competency. The Superior Court for Cobb County granted the state's motion and the defendant appealed.

Holdings: The Georgia Supreme Court held that, although the state had important governmental interests in restoring Warren's competency for a timely prosecution and no special circumstances significantly undermined those interests, the factual findings were insufficient to support Warren's involuntary medication. Important to the Georgia Supreme Court was the "absence of a specific treatment plan" that identified the drugs the State proposed to administer, in what doses and by what methods. The Court noted that "courts must consider less intrusive means for *administering* the drugs" (emphasis added by Georgia Supreme Court). Finally, the Court pointed to an absence of evidence in the record suggesting that the State sought to involuntarily medicate Warren for "the alternative purpose of preventing him from being a danger to himself or others."

Therapists' duty to disclose client's threats to harm third parties: Minnesota statutory law provides no "threats exception" to privileged mental health client information

State v. Expose, No. A13-1285, 2015 WL 8343119 (Minn. Dec. 9, 2015)

Background: Jerry Expose, Jr. was required as a probation condition for a prior conviction to attend anger-management therapy sessions with N.M., a mental-health practitioner. During one session, Expose became increasingly angry and made several threatening statements against D.P., a child caseworker, whom Expose felt was "a barrier to him getting his kids back." N.M. felt that these "specific threats of physical violence against an identifiable person" had triggered her statutory duty to warn, and she reported

Expose's statements to the police. N.M. testified to the statements at Expose's trial, and Expose was convicted in the Ramsey County District Court of making terroristic threats. Expose appealed arguing that N.M.'s testimony was inadmissible because it broke the therapist-client privilege. The Court of Appeals reversed and remanded, and the Supreme Court of Minnesota granted review.

Holdings: The Supreme Court of Minnesota affirmed the judgment of the Court of Appeals and remanded the case to the district court. The Supreme Court held that the therapist-client privilege statute, as an evidentiary rule, lacked a "threats exception" either "by implication from the duty-to-warn statute or under our authority to promulgate rules of evidence." Thus, the Court found that the district court had abused its discretion in allowing N.M. to testify about Expose's statements without his consent.

<u>Treatment provider's duty of care to third parties</u>: Duty of care to third party who was attacked by person terminated from residential substance abuse program

Oddo v. Queens Vill. Comm., 21 N.Y.S.3d 53 (N.Y. App. Div. 2015)

Background: On July 17, 2010, Sean Velentzas, a nonparty to the current action, stabbed plaintiff Anthony Oddo in the shoulder. Until shortly before the stabbing, Velentzas had been a patient in a residential drug treatment facility operated by Queens Village Committee for Mental Health for Jamaica Community Adolescent Program, Inc. ("Queens Village"). Oddo brought an action against Queens Village. The facility moved for summary judgment, and the Bronx County Supreme Court denied the motion. The facility then appealed.

Holdings: The Supreme Court, Appellate Division found that the facility owed a duty of care to third parties against whom a discharged resident committed a violent act. Additionally it held that whether or not the facility properly discharged its duty of care to the third party victim was a material fact issue precluding summary judgment in favor of the defendants.

The Court noted that, although the common law does not generally impose a duty to control the conduct of third persons, liability for the negligent acts of third persons can arise when "the defendant has the authority to control the actions" of the third person. Because New York has no bright line rule concerning whether mental health care providers owe a duty of care to the general public, courts are to examine the issue on a case-by-case basis. The Appellate Division found that Queens Village failed to carry the initial burden of establishing that it owed no duty of care to the plaintiff as a matter of law. Because the record presented an issue of material fact (whether a duty of care was owed by Queens Village), summary judgment was precluded.

Notable Points:

***Facility's recognition of duty to general public*:** Although Queens Village did not intend to release Velentzas into the general public, the Court also notes that they did not

"advise the police that Velentzas should be taken to Faith Mission or held" in custody. The Court used the admission that Queens Village did not intend to release Velentzas into the community as evidence of the facility's recognition that it owed some duty to the general public.

***Whether the treatment facility had sufficient authority to control the actions of the patient*:** The Appellate Division found there to be "no question" that Queens Village had sufficient authority to control Velentzas's actions. Key facts in this inquiry were that (1) residents were not free to leave the facility without an escort; and (2) residents who left against clinical advice would be dismissed and returned to the criminal justice system.

<u>Intellectual disability and the death penalty</u>: Death sentence vacated because (along with other reasons) the lower court refused mitigation evidence of intellectual disability (ID) after defendant's IQ was shown to be in the 80s and because release of new diagnostic standards requires new *Atkins* hearing

State v. Agee, 358 Or. 325 (2015)

Background: Following an *Atkins* hearing at which Agee was found not to be intellectually disabled, Agee was convicted of aggravated murder in the Marion County Circuit Court and sentenced to death in 2011. The case came before the Supreme Court of Oregon on automatic direct appeal. Agee argued, among other points, that the lower court's holding in the *Atkins* hearing was error given the release of new diagnostic standards in 2013 and that the trial court erred in refusing his request to present mitigation evidence of intellectual disability based on its finding in the *Atkins* hearing.

Holdings: The Supreme Court of Oregon affirmed Agee's conviction, but vacated his sentence of death, and remanded the case to the trial court for a new *Atkins* hearing. The Supreme Court of Oregon held that although the trial court's initial finding that Agee was not intellectually disabled was not clear error, a new *Atkins* hearing was still required to determine whether Agee was intellectually disabled because updated standards were now articulated in the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. ("DSM-5"). In addition, the Court found the trial court's proscription of ID mitigation evidence was error that was not harmless.

Notable Points:

***No clear error in initial determination under DSM-IV-TR criteria*:** The Supreme Court rejected Agee's argument that the trial court used a bright-line rule to arrive at the conclusion that he was not intellectually disabled. Instead the Supreme Court held that the trial court had merely determined that Agee had failed to meet the intellectual functioning prong of the *Atkins* analysis, and that the trial court's ultimate decision rested on that fact as well as consideration of Agee's IQ subtest scores and the results of other neuropsychological tests.

***Remand and new hearing required despite lack of clear error in first determination*:** The Supreme Court held that allowing the trial court's ruling to stand "would create an unacceptable risk that a person with intellectual disability will be executed." The court made this determination largely on the basis that the standards for determining intellectual disability were under review by the psychological community at the time of the first *Atkins* hearing. Thus "even though the trial court's ruling comported with the published standards existing at the time that the court ruled" the trial court "did not apply now-current medical standards in determining that the defendant had not met his burden of proof."

Forced administration of medication to restore defendant to competency to stand trial under the *Sell* standard: Mandamus action cannot be used by hospital where defendant is being treated to challenge decision of trial court that *Sell* standard has been met

Oregon State Hosp. v. Butts, 359 P.3d 1187 (Or. 2015)

Background: Daniel Butts was charged with 21 felony counts, including nine counts of aggravated murder. When the Circuit Court found him unable to assist in his own defense, Butts was committed to a state hospital. The Circuit Court then entered a *Sell* order, directing the hospital to involuntarily medicate Butts in order to restore his competency to stand trial. The hospital, having determined that the treatment was not medically necessary, petitioned the Supreme Court for a writ of mandamus directing the trial court to vacate the order, and the Supreme Court of Oregon issued an alternative writ of mandamus while it heard the parties' arguments.

Holdings: The Supreme Court of Oregon ultimately dismissed the alternative writ of mandamus. It held that (1) mandamus relief was not available to the hospital based solely on its disagreement with the trial court's findings of fact, and (2) the trial court had implied authority under the applicable statute (determination of fitness statute) to issue a *Sell* order. The Supreme Court began its discussion of the mandamus issue by stating that "it has become hornbook law in this state that the writ of mandamus cannot be used as a means of controlling judicial discretion." A writ of mandamus can only be used if the trial court's decision represents "fundamental legal error" or is "outside the permissible range of discretionary choices." Thus, the primary issue on review was whether the trial court had the power to order the hospital to involuntarily medicate Butts when the hospital did not agree that the medication was medically necessary.

The Supreme Court of Oregon noted that it had already concluded that courts have implicit authority to issue *Sell* orders. It noted that the trial court "made extensive findings of fact based on medical evidence" and did so "after resolving disputed factual issues based on medical testimony in the proper exercise of its role as factfinder." Ultimately, the Supreme Court of Oregon rejected the hospital's argument that it should be granted "veto power" where a hospital disagrees with a court's issuance of a *Sell* order.

<u>ADA and "reasonable accommodations" requirement</u>: Americans with Disabilities Act applies to services and programs offered to a parent who has mental illness and other disabilities and whose children are in foster care

State in Interest of K.C., 2015 UT 92, 2015 WL 7571828 (Utah Nov. 24, 2015) (not yet released for publication in permanent law reports and thus subject to revision or withdrawal)

Background: The state of Utah sought to terminate a mother's parental rights to the minor child, K.C. After several previous hearings, mother argued at hearing on termination of her residual parental rights that social services agency had failed to comply with ADA in providing services to her. The Juvenile Court terminated the mother's parental rights despite her invocation of the ADA, holding that it is not a defense in termination proceedings because the proceeding is not "a service, program, or activity." Alternatively, the court held that the mother had not suffered harm because her disabilities had been accommodated through previous changes made by the Department of Child and Family Services. K.C.'s mother appealed.

Holdings: The Supreme Court of Utah first held that the Americans with Disabilities Act applied to situations in which the government was asked to provide reunification services to a parent in a dependency hearing. According to the Supreme Court of Utah, reunification services qualified as "services provided by a public entity" and a reunification plan qualified as "a program or activity, as the terms are used in the ADA."

Despite reversing the trial court's ruling that the ADA did not apply to the provision of reunification services, the Supreme Court of Utah upheld the trial court's alternative determination that further modification of the submitted reunification would be unreasonable. That determination by the trial court was not an abuse of discretion where the trial court "found that the plan had already been tailored to the mother's individual needs, including needs related to the mother's mental illnesses and physical limitations." Additionally, the Court noted that K.C.'s mother, N.D. had not "identified any specific modification that she requested that was denied by the court" and claimed only that "she should have been granted additional time to complete the objectives of the reunification plan."

V. Institute Programs

Please visit the Institute's website at
http://cacsprd.web.virginia.edu/ILPPP/OREM/TrainingAndSymposia

The Institute announces opportunities for learning in the program year August 2015 through June 2016. Additional programs will be announced. Please visit the Institute's website to see new and updated announcements. The Institute appreciates support for its programs. Please share this edition of *DMHL* and share announcements of programs that may interest your professional, workplace, and community colleagues.

Announced programs:

Assessing Risk for Violence with Juveniles

May 11 2016, Charlottesville VA: This one-day program trains mental health professionals, juvenile and criminal justice professionals, social and juvenile services agencies, educators, and others to apply current research pertaining to risk assessment with juveniles. Along with theoretical foundations the program includes review of legal parameters, impact of online behavior, and student threats. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: $65. Others: $150. Cancellation fee: $25

Juvenile Forensic Evaluation: Principles and Practice

April 18-22 2016, Charlottesville VA: This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation with juveniles. Content includes clinical, legal, ethical, practical and other aspects of forensic evaluation with juveniles. The format combines lectures, clinical case material, and practice case examples for evaluation of juveniles. To be authorized to perform juvenile competence evaluations in Virginia please review Advanced Case Presentation requirements. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: $300. Others: $750. Cancellation fee: $25

Evaluation Update: Applying Forensic Skills with Juveniles

April 18, 19, 20 2016, Charlottesville VA : This three-day program is for experienced adult forensic evaluators - who have already completed the five-day "Basic Forensic Evaluation" program (regarding evaluation of adults) and accomplished all relevant qualifications for performing adult forensic evaluation - and wish to become qualified to perform juvenile forensic evaluations. To be authorized to perform juvenile competence evaluations in Virginia please review Advanced Case Presentation requirements. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: $150. Others: $190. Cancellation fee: $25.

Advanced Case Presentation: Juvenile Adjudicative Competence

May 4 2016, Charlottesville VA: Advanced Case Presentation is a follow-up training for all evaluators who have successfully completed the Juvenile Forensic Evaluation training or Evaluation Update training and who wish to complete the training requirements of the VA DBHDS Commissioner for individuals authorized to conduct juvenile competence evaluations. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: $65. Others: $150. Cancellation fee: $25

Assessing Individuals Charged with Sexual Crimes

May 5-6 2016, Charlottesville VA: This two-day program focuses on the assessment and evaluation of individuals charged with sexual crimes, sexual offenders including 19.2-300 pre-sentencing evaluations, and 37.2-904 assessment of sexually violent predators. The program provides discussion of legal background relevant to assessment involving sexual offenses, paraphilias, base rates of reoffending, and well-researched sexual offender risk assessment instruments. *This program may meet needs of providers for renewal of SOTP certification in Virginia*. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: $130. Others: $190. Cancellation fee: $25

Conducting Mental Health Evaluations for Capital Sentencing Proceedings

February 29-March 1 2016, Charlottesville VA : This two-day program prepares experienced forensic mental health professionals to meet the demands of a capital sentencing case, in which the accused faces the possibility of the death penalty. Attorneys and others are welcome. The agenda includes statutory guidelines for conducting these evaluations, the nature of the mitigation inquiry, the increased relevance of intellectual disabilities, the process of consulting with both the defense and the prosecution, and ethics in forensic practice. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: $130. Others: $190. Cancellation fee: $25

Other programs to be announced include a one-day seminar with a leading expert on issues of mental health involved with juvenile justice tentatively scheduled for mid-May; and a one-day seminar or workshop on issues involved with sexual offenders expected to be offered before June (*which may meet needs of providers for renewal of SOTP certification in Virginia*). Please visit the Institute's website at

http://cacsprd.web.virginia.edu/ILPPP/OREM/TrainingAndSymposia

Questions about ILPPP programs or about *DMHL*?: please contact ***els2e@virginia.edu***

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Letters and inquiries, as well as articles and other materials submitted for review, should be mailed to DMHL, ILPPP, P.O. Box 800660, University of Virginia Health System, Charlottesville, VA 22908, or sent electronically to the Managing Editor at *els2e@virginia.edu* Thank you.

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