DEVELOPMENTS IN MENTAL HEALTH LAW

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

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I. Updates

A. SJ 47 Joint Subcommittee Actions and Recommendations to the 2017 General Assembly Session

As noted in the last issue of DMHL, at the October 26, 2016 meeting of the SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century the Subcommittee's Work Groups and members appeared to move closer to adopting a shared vision of a future statewide system of mental health services, while acknowledging the significant obstacles to realizing that vision. Each Work Group chairperson set out recommendations for budget and statutory actions in the 2017 General Assembly session to support a variety of mental health reform measures. They also described ongoing work and goals for the balance of 2017.

At its next meeting, on December 6, the Joint Subcommittee formally considered and approved those Work Group recommendations. Specific bills, resolutions and budget proposals to implement those recommendations have since been drafted and submitted to the General Assembly. Significantly, the members reached a consensus that the implementation of meaningful reform will be a multi-year process, and that it was vital that the Joint Subcommittee continue its operations beyond its current termination date of December 2017 in order to monitor reform efforts and ensure that they are fully implemented.

Below is a summary of the Joint Subcommittee's actions on December 6. (Another summary by Division of Legislative Services staff is available here on the DLS website.) Also included is identification of, and a link to, the bills, resolutions and budget proposals developed as a result of the Joint Subcommittee's actions. Those matters are now pending before the General Assembly.

Work Group #1: System Structure and Financing

1. ***Adopting and funding a new model for public mental health system services***

a. Adopting the STEP-VA model: The Work Group recommended endorsing the goal of the Department of Behavioral Health and Developmental Services for the Commonwealth's public mental health system to provide equal access for individuals throughout the state to ten key services: emergency services; same day access to mental health screening services; outpatient primary care screening and monitoring services; crisis services; outpatient mental health and substance abuse services; psychiatric rehabilitation services; peer support and family support services; mental health services for members of the armed forces and veterans; care coordination services; and case management services, including targeted mental health case management services. (This model, now known as the STEP-VA (System Transformation, Excellence and

Performance in Virginia) program, is discussed in more detail in the July 2016 issue of DMHL, with DBHDS Commissioner Barber's explanatory power point available here.)

b. Implementing the STEP-VA model over a period of years, beginning with 2017: Because full implementation of the STEP-VA model involves a major financial investment, and therefore cannot be fully financed in one budget cycle, the Work Group supported full funding by the 2017 General Assembly of two of the ten core services - same day access to mental health screening and timely access to assessment, diagnostic, and treatment services (estimated cost: $1.5 million in FY 2017, $12.3 million in FY 2018, and $17.3 million annually thereafter) and outpatient primary care screening and monitoring services (estimated cost: $3.72 million in FY 2019 and $7.44 million annually thereafter). Along with (and subject to) this funding being provided, the mandated "core" services to be provided by local CSBs under Virginia Code Section 37.2-500 would be expanded to include these services. (Currently, the core services are limited to emergency services, and, "subject to the availability of funds appropriated for them," case management services.)

These two "core" services were recommended for implementation first because they enable individuals to access mental health care in a timely way when they are seeking care. Currently in many jurisdictions people seeking help are given initial appointments that are weeks away, and their untreated conditions may lead to mental health crises or to other life disruptions while they wait to be seen. The goal of same-day access is to help people avoid these crises and disruptions in their lives.

The subsequent expansion of the "core" services to include all ten services identified in the STEP VA program would occur in a later budget cycle, with the dedication of the additional funds needed to implement those services.

Discussion among the Joint Subcommittee members noted some key continuing concerns, including: how to ensure that the nature of these new services is sufficiently defined so that all CSBs are providing the intended "baseline" of services and quality of care; and how to square the "standard services" ideal with the remaining reality that some local CSBs receive far more financial support from their local governments than others and will therefore always be able to provide a richer array of services.

Legislation to implement this: HB 1549 and SB 1005 (identical bills) would expand the set of "core" services set out in Virginia Code Section 37.2-500 that CSBs (and BHAs) are required to provide, with the inclusion and implementation of the first two STEP-VA core services being effective July 1, 2018, and the implementation of the rest of the core services being effective July 1, 2021. The funding for the first implementation is included in the Governor's budget submission to the 2017 General Assembly.

2. ***Providing DBHDS with access to involuntary commitment records for purposes of research***

The Work Group recommended amending Va. Code § 37.2-818 to allow transmission of records related to involuntary admission proceedings to the Department of Behavioral Health and Developmental Services (DBHDS) to enable it to maintain statistical archives and conduct research on the consequences and characteristics of such proceedings. The Work Group found that lack of access to this information limited needed research into the effectiveness of the involuntary commitment process.

Legislation to implement this: HB 1551 and SB 1006 (identical bills) would amend Virginia Code Section 37.1-818 by enabling DBHDS to receive such records upon request, with a provision requiring DBHDS to maintain the confidentiality of those records.

3. ***Directing DBHDS and DMAS to study the use of the Involuntary Mental Health Commitment Fund to also pay for certain voluntary hospitalizations*** (***as part of a larger strategy for reducing the numbers of patients at DBHDS facilities)***

The Work Group's report noted a recent agreement between DBHDS and CSBs statewide to implement a number of practices to stabilize and reduce the census in state psychiatric hospitals. While finding this a positive development, the Work Group also saw the need for other actions to address this significant and growing hospital census problem. The Work Group recommended the following:

1. Implementation of the census reduction initiatives adopted by DBHDS and the Community Service Boards;

2. Development of budget requests by DBHDS for FY 2018 to stabilize and maintain state hospital utilization at no more than 90 percent of capacity;

3. Continued study by the Work Group of the statutory, policy, financing, and administrative elements of the current mental health system that are not aligned with the Work Group's strategic and operational objectives; and

4. Study by DBHDS and the Department of Medical Assistance Services (DMAS) of the potential use of the Involuntary Mental Commitment Fund for both involuntary and voluntary temporary detention. (This recommendation was prompted by the Work Group's finding that, in a number of involuntary commitment cases, the individuals in mental health crisis and in need of hospitalization had been willing to consent to hospitalization in a local psychiatric facility but could not be admitted because the person had no (or inadequate) insurance to pay for care. Involuntary commitment became necessary in order for the person to be eligible for funding from the Fund to pay for the needed hospital care.)

Legislation implementing this: HB 1550 and SB 1007 (identical bills), if enacted, would require DBHDS and DMAS to study "the potential use" of the Involuntary Mental Commitment Fund to "fund mental health treatment" in Virginia, including (1) the

"potential use" of the funds for voluntary as well as involuntary treatment in a mental health care facility; (2) the "potential benefits" of enabling DBHDS instead of DMAS to administer the funds; and (3) "any other strategies" for improving use of the funds.

4. ***Expanding telemental health services***

The Work Group recommended that the Joint Commission on Health Care (JCHC) be asked to review the telemental health work group's report on telemental health services and develop recommendations for increasing the use of telemental health services. (The significant value of such services, recognized by the Joint Subcommittee, is set out in a presentation from the UVA telemental health program available here.)

Legislation to implement this: HJ 568 and SJ 257 (identical resolutions) would direct the JCHC to "study options for increasing the use of telemental health services in the Commonwealth," and specifically to "study the issues and recommendations set forth in the report of the Telemental Health Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century."

Work Group #2: Criminal Justice Diversion

1. ***Require the use of a standardized instrument by jails to screen individuals for mental illness during intake process***

The Work Group found that there is not a standard practice among the local or regional jails in Virginia in regard to screening incoming inmates for mental illness and providing services for those found to need them. The Work Group recommended that all jails use the same intake screening instrument (to be identified by DBHDS based on proven effectiveness in identifying persons with mental illness) and to require follow-up services when mental illness is identified.

Legislation to implement this: HB 1783 would modify Virginia Code Section 9.1-102 to require the Department of Criminal Justice Services (DCJS) to work with DBHDS and the State Board of Corrections to identify a "scientifically validated instrument" to screen correctional inmates to identify those needing mental health services and "develop and deliver" a training program for correctional facility staff to administer that instrument. The bill would add Virginia Code Section 53.1-126.1 to require the use of this instrument to screen all prisoners at intake, and to require that anyone identified by the instrument as needing mental health services be seen by a "qualified mental health professional" (also defined in the bill) within 72 hours of screening.

2. ***Require discharge planning for persons with mental illness leaving jail***

The Work Group recommended that DBHDS be directed to develop a plan for providing discharge planning services to persons with mental illness being released from any jail in the Commonwealth. The plan would include cost estimates for implementation, and an

estimate of cost savings from preventing re-arrest and/or the provision of emergency services for these individuals following discharge.

Legislation to implement this: HB 1784 and SB 941 (identical bills) would direct the Commissioner of DBHDS, in consultation with relevant stakeholders, to develop and submit such a plan to the Joint Subcommittee (and to the House and Senate Committees for Courts of Justice) by November 1, 2017.

3. ***Provide authority to the Board of Corrections to investigate in-custody deaths in jails.***

In the wake of the 2015 death of Mr. Jamycheal Mitchell in the Hampton Roads Regional Jail, and numerous concerns raised over the adequacy of the investigation into that death conducted by the State Office of the Inspector General, the Work Group recommended that the Board of Corrections be given explicit authority to conduct any investigations into the "in-custody" deaths that occur in local and regional jails.

Legislation to implement this: SB 942 would add Virginia Code Section 53.1-69.1, which would authorize the Board of Corrections to investigate any in-custody jail deaths, determine whether the death involved violation of existing regulations and standards, and take enforcement action and recommend any changes needed to existing regulations and standards. A report setting out all findings, actions and recommendations in response to a death must be completed and submitted to the Governor, the General Assembly, and the DOC.

Work Group #3: Mental Health Crisis and Emergency Services

1. ***Alternative transportation services for persons in mental health crisis***

Finding that programs in Virginia (including a DBHDS-funded pilot project) and in other states have confirmed the safety and efficacy of using transport services *other* than law enforcement for most transportation of individuals in mental health crisis, the work group recommended that DBHDS be required to develop (in collaboration with other relevant stakeholders) a model for using alternative transportation providers, including the criteria for the certification of such providers and the costs and benefits associated with the implementation of the model. The goal of such a model is to reduce the sense of stigma and coercion experienced by individuals when being transported in a law enforcement vehicle, and to enable law enforcement officers to return to their normal public safety duties.

Legislation to implement this: SB 1221 requires DBHDS and DCJS to develop the model, and to include in that process stakeholders identified in the bill (as well as any others that the agencies wish to add), with the model to be submitted to the SJ 47 Joint Subcommittee and the House and Senate Courts of Justice Committees by October 1, 2017.

2. ***Facilitating the use of telemental health services (particularly for prescribing controlled substances via telemental health)***

Following a report from Sen. Dunnavant and the stakeholder group she formed to determine what actions were needed to enable physicians to prescribe controlled substances via telemental health to the extent allowed under federal law (a number of key conditions have been set by the Drug Enforcement Administration [DEA] for such telemental health prescribing of controlled substances), the Work Group recommended that Virginia's statute governing telemedicine be amended to authorize the prescription of controlled substances via telemedicine to the extent allowable under federal law.

Legislation to implement this: HB 1767 and SB 1009 (identical bills) amend Virginia Code Section 54.1-3303 by stating that a medical practitioner is authorized to prescribe Schedule II-VI medications via telemedicine if the practitioner is in compliance with federal requirements for doing so. The bill also amends Virginia Code Section 54.1-3423 to make clear the authority of the Board of Pharmacy to "register" an entity as a site where controlled substances can be prescribed via telemedicine, with the Board applying certain specified criteria (which meet DEA requirements) in determining whether an entity should be so registered. This clarification will allow Community Services Boards to serve as originating sites for prescribing via telemedicine. (The DEA recognizes such registrations as making the site an authorized site under federal law.)

Work Group #4: Housing

1. ***Provide additional funding for permanent supportive housing targeted to "frequent users" of high-cost systems.***

As described in more detail in an accompanying article in this issue, studies in Virginia and other states have shown conclusively that the stability brought to the lives of persons with serious mental illness through permanent supportive housing significantly reduces their use of costly emergency services. They have fewer emergency room visits, fewer psychiatric hospitalizations, and fewer incidents of arrest and incarceration in local jails. The Work Group recommended that the 2017 budget include an appropriation of $10 million in new funding for permanent supportive housing targeted to address frequent users of high-cost systems, and thereby reduce demand on these overburdened correctional, medical and psychiatric facilities.

Legislation to implement this: A budget amendment has been submitted to add $10,260,000 in additional funding in FY 2018 to expand permanent supportive housing (PSH) for individuals with serious mental illness. In addition to the program funding, $260,000 in general funds are to be provided for three positions to oversee the program. This is identified as Item 315 #2s, and can be found here on the General Assembly website.
(A House version of this budget amendment has been submitted as Item 108 #2H, and can be found here.)

2. ***Develop strategies for housing individuals with serious mental illness***

The work group recommended that the Department of Housing and Community Development be required, in consultation with other agencies and stakeholders, to develop and implement strategies for housing individuals with serious mental illness.

Legislation to implement this: A budget amendment has been submitted (without any identified funding) directing the Department of Housing and Community Development (DHCD) to "develop and implement strategies for housing individuals with serious mental illness," and to include a number of identified state agencies and public and private stakeholder groups (including NAMI Virginia, the Virginia Housing Alliance, and the Virginia Sheriff's Association) in the process. An annual report on progress and strategies is to be provided to the Chairmen of the House Appropriations and Senate Finance Committees. This is identified as Item 108 #1s on the Senate side (and can be found here), and as Item 108 #2h on the House side (and can be found here).

3. ***Financing permanent supportive housing services through Medicaid***

Studies and reports cited by the Work Group note that a key to the success of permanent supportive housing is the provision of supportive services to the individuals living in that housing. Many states have recognized a number of these services as mental health treatment services that qualify for Medicaid reimbursement. As a result, the Work Group recommended that DMAS be required, in consultation with other agencies and stakeholders, to research and recommend strategies for financing permanent supportive housing services through Medicaid reimbursement.

Legislation to implement this: A budget amendment has been submitted directing the Department of Medical Assistance Services (DMAS) to "research and recommend strategies for the financing of supportive housing services through Medicaid reimbursement." DMAS is directed to include a number of identified state agencies and public and private stakeholder groups (including NAMI Virginia, the Virginia Housing Alliance, and the Virginia Sheriff's Association) in this process. A report to the Chairmen of the House Appropriations and Senate Finance Committees and the Chairman of the Joint Subcommittee to Study Mental Health Services in the Twenty-First Century is due by September 30, 2017." This is identified as Item 306 #34s on the Senate side (and can be found here), and as Item 306 #34h on the House side (and can be found here).

Extending the Joint Subcommittee

At the Joint Subcommittee's December 6 meeting, Senator Deeds presented a proposal that, after the expiration of the Joint Subcommittee's charge at the end of 2017, the Joint Commission on Health Care be required to oversee the continuing public mental health system reform effort, including making recommendations on issues related to the organization, delivery, financing, management, and oversight of publicly funded

behavioral health care services in the Commonwealth. In the ensuing discussion, the Joint Subcommittee members expressed their conviction, based on their work to this point, that the success of a meaningful system-wide reform effort required that the legislators continue to be involved with the process as they are currently constituted and monitor its implementation. The Joint Subcommittee members unanimously approved submitting to the General Assembly a resolution extending the Joint Subcommittee's charge for another two years.

Legislation to implement this: HJ 637 would continue the SJ 47 Joint Subcommittee through December 1, 2019.

B. Other Mental Health Related Bills in the 2017 General Assembly

HB 1480 (Helsel, Boysko, Kory and Peace) – ***Mental health awareness training for emergency services professionals***. Amends Virginia Code Sections 9.1-102, 27-23.11 and 32.1-111.4 to require biennial training for law-enforcement officers, firefighters, and emergency medical services personnel on mental health awareness, with the focus being on recognizing and responding to mental health issues arising among emergency services professionals due to the stresses of their work environments. Section 37.2-312.3 is added to require DBHDS to establish and administer the training program and to also provide certification of similar programs developed by others for use by emergency services professionals. (Senate version: SB 1064 (Deeds))

HB 1508 (Hope) – ***DBHDS critical incident reports: expanding reporting requirement to include incidents in licensed programs***. Currently, the DBHDS commissioner is required by Virginia Code Section 37.2-304(7) to provide to the Director of the Commonwealth's designated protection and advocacy system a written report on critical incidents or deaths of individuals in DBHDS facilities. The amendment would expand the reporting requirement to include any such incidents occurring in either facilities or programs operated or licensed by the Department. Reports are due within 15 working days of the critical incident or death. (Senate version: SB 894 (Favola))

HB 1522 (Leftwich) ***Death penalty in capital case; proof that defendant had a severe mental illness at the time of the offense precludes death penalty.*** Adds Virginia Code Section 19.2-264.3:1.4 to provide that a defendant in a capital case who shows by a preponderance of the evidence that he had a severe mental illness (as defined in the bill) at the time of the offense is not subject to the death penalty. The bill establishes procedures for making and processing such a claim, and includes the appointment of expert evaluators.

HB 1548 (Farrell) ***Advance directives; authorizing certain professionals to activate an advance directive in regard to consenting to admission to a mental health facility.*** Amends Virginia Code Section 54.1-2983.2 by providing that, where a person has executed an advance directive authorizing an agent to consent to the person's admission to a mental health facility, the determination that the person is incapable of making an

informed decision regarding such admission (thereby activating the advance directive and the agent's authority to make that decision) may be made by the attending physician or a psychiatrist, licensed clinical psychologist, licensed psychiatric nurse practitioner, or designee of the local community services board following an in-person. Admission to the facility must still meet the requirements of Section 37.2-805.1. (Senate version: SB 1511 (Deeds))

HB 1567 (Orrock) ***Advance directives; requiring that persons applying for medical assistance services and social services be informed about advance directives.*** Amends Sections 32.1-325 and 63.2-501 by requiring that all entities that receive applications and determine eligibility for medical assistance must provide applicants with information about advance directives, including information about the purpose and benefits of advance directives and how the applicant can make one.

HB 1642 (Hope) ***Naloxone; authorizing possession and administration of Naloxone by trained staff of Department of Forensic Science and Office of the Chief Medical Examiner.*** Amends Virginia Code Section 54.1-3408(X) by adding to the list of persons who can possess and administer Naloxone "or other opioid antagonist" to a person to reverse a life-threatening overdose (provided that they have completed training and follow protocols developed by the Board of Pharmacy) to include staff of the Department of Forensic Science and the Office of the Chief Medical Examiner. Currently the list is limited to law enforcement officers and firefighters. (Senate version: SB 1031 (Marsden))

HB 1747 (O'Bannon) ***Advance directives; authorizing persons trained as facilitators to assist individuals in completing advance directives, and allowing "ministerial" assistance.*** Amends Virginia Code Section 54.1-2982, and adds 54.1-2988.1, to provide that persons who have completed certain training as "facilitators" (either in programs identified in the bill or as approved by the Department of Health) may assist people in completing their advance directive without being engaged in the unauthorized practice of law ("UPL"). The bill also defines "ministerial" assistance that any person can provide to another person in completing an advance directive without violating UPL standards. (Senate version: SB 1242 (Dunnavant))

HB 1750 (O'Bannon) ***Naloxone; authorizing Commissioner of Health to issue a standing order for the dispensing of Naloxone for overdose reversal.*** Amends Virginia Code Section 54.1-3408(X) by authorizing the Commissioner of Health to issue a standing order authorizing the dispensing of Naloxone or other opioid antagonist for overdose reversal, in the absence of an oral or written order for a specific patient issued by a prescriber.

HB 1758 (Sullivan) ***Firearms; temporary removal through court warrant and order from persons upon application and evidence by police or prosecutor that person poses substantial risk of harm to self or others.*** Adds Virginia Code Section 19.2-60.2 to create a procedure in which a local prosecutor or law-enforcement officer may apply to a circuit court judge for a warrant to remove firearms from a person who poses a substantial risk of injury to himself or others. A hearing must be held within 14 days of

execution of the warrant, to determine whether the firearms should be returned or retained by law enforcement. The Court may order retention for up to 180 days, and may also approve transfer of firearms by the person to a third party. A person subject to a warrant or order cannot have a concealed gun permit, purchase a firearm or be employed by a firearms dealer; knowing sale of firearms to such a person would be a class 6 felony. (Senate version: SB 1443 (Barker))

HB 1777 (Stolle) ***Board of Health regulations on admission of persons to psychiatric facilities; procedures regarding denial of admission***. Amends Virginia Code Section 32.1-127 by requiring the Board of Health to develop regulations requiring that each hospital that provides psychiatric services establish a protocol that (i) requires, prior to refusing the admission of a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician and (ii) prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication with a referring physician.

HB 1845 (Cox) ***Local and regional correctional facilities; addiction recovery program to be developed by DCJS***. Adds to the powers and duties of DCJS by amending Virginia Code Section 9.1-102 to provide that DCJS, in consultation with DBHDS, will develop a comprehensive "model addiction recovery program" that "may" be administered by local and regional jail officials.

HB 1885 (Hugo) ***Prescribing controlled substances containing opioids; limits set.*** Adds Virginia Code Section 54.1-3408.05 to limit prescriptions for opioid containing drugs to a 7-day supply unless the prescriber finds more is needed to (1) stabilize a patient's "acute medical condition," or (2) manage pain from cancer, use in palliative/hospice care, or manage non-cancer-related chronic pain.

HB 1894 (Herring) ***Law enforcement training; DCJS to train on community "engaged" policing.*** Amends Virginia Code Section 9.1-102 to provide that DCJS training of local law enforcement include community "engaged" policing, and that DCJS encourage such policing philosophy and practices throughout the state, with an emphasis on transparency, reflecting community values, working effectively with underserved populations and those with special needs, and including strategic hiring and comprehensive officer training. (Senate version: SB 1047 (Lucas))

HB 1898 (Bell) ***Prescribing controlled substances containing opioids in emergency department setting; limits.*** Adds Virginia Code Section 54.1-3408.05 to place a 3-day limit on prescriptions for drugs containing opioids for patients treated in emergency department settings, and directs pharmacists to make sure this limit is honored when filling such prescriptions. (Senate version: SB1232 (Dunnavant))

HB 1910 (Yost) ***Physician assistant as "mental health provider"; duty to take protective action when client threatens harm to a third party.*** Amends Virginia Code Section 54.1-2400.1 by adding "physician assistant" to the list of professionals who are defined

as a "mental health provider" having a duty to take specified precautions to protect third parties when a client threatens harm to such parties. (Senate version: SB 1062 (Deeds))

HB 1918 (Robinson) ***Establishing an acute psychiatric patient registry.*** Adds Virginia Code Section 37.2-308.2 to require DBHDS to develop and administer a web-based acute psychiatric patient registry containing de-identified information about individuals who meet the criteria for a temporary detention order (TDO) in order to facilitate the timely identification of a facility for temporary detention and treatment of the individual. Local CSBs are required to update registry information and private providers are required to check the registry and notify the involved CSB or state facility if such provider is able to provide temporary detention and treatment for certain patients. (Senate version: SB 1222 (Barker))

HB 1930 (Carr) ***Drug overdose; expanding protection for reporting.*** Amends Virginia Code Section 18.2-251.03 by expanding the affirmative defenses to criminal charges for an individual's unlawful purchase, possession or consumption of alcohol or controlled substances to include situations where another person in good faith seeks or obtains emergency medical attention for the individual because the individual is experiencing an overdose.

HB 1944 (Peace) ***Regulations from DMAS and DBHDS; giving providers prior notice of and access to proposed regulations and opportunity to comment; analysis of economic impact of proposed regulations to be included in the process.*** Adds Virginia Code Sections 32.1-321.4 and 37.2-203.1 to require DMAS and DBHDS to give affected providers certain notice of and opportunity to review and comment on proposed regulations, to have the Department of Planning and Budget conduct an economic impact analysis, and allow providers a period of time to come into compliance with finalized regulations. The bill also amends Virginia Code Section 2.2-4007.04 by allowing providers to submit comments to the Department of Planning and Budget regarding the economic impact of proposed DMAS and DBHDS regulations.

HB 1948 (Peace) ***Drug possession convictions; "recovery community organization" included as treatment option in court sentencing disposition***. Amends various sections of Title 18.2 by providing that, if the Court determines that any part of sentencing or deferred sentencing is to include completion of a substance abuse treatment program, the treatment options from which the Court may choose shall include a "recovery community organization," defined as "a nonprofit organization composed of and governed by representatives of local communities of addiction recovery that offers peer recovery support services for persons with substance abuse and is accredited by the Council on Accreditation of Peer Recovery Support Services."

HB 1975 (Yost) ***Temporary detention pending involuntary commitment hearing; setting a minimum time period of detention.*** Amends Virginia Code Sections 19.2-169.6 and 19.2-182.9 by providing that, when an inmate in a jail or an acquittee on conditional release is psychiatrically hospitalized under a temporary detention order (TDO), the involuntary commitment hearing for that person shall be heard "no sooner

than" 23 hours after the execution of the TDO," and also amends Sections 37.2-809 and 37.2-814 by providing that individuals hospitalized under a TDO shall be held for a duration pending the involuntary commitment hearing that is sufficient not only for "completion of the examination required by § 37.2-815" and "preparation of the preadmission screening report required by § 37.2-816" (as currently required by law) but also for the " provision of mental health treatment for up to 24 hours after admission to the facility of temporary detention, as determined by the treating physician at such facility to be reasonably necessary." (The maximum TDO period remains 72 hours, with specified exceptions.)

HB 1996 (Hope) ***Defendants ordered restored to competency in hospital setting; 10 day limit for transfer to hospital for competency restoration.*** Amends Virginia Code Section 19.2-169.9 to require that, when a defendant is found by a Court to be incompetent to stand trial for a crime and is ordered to receive treatment in a hospital to restore competency, the defendant must be transferred to the hospital as soon as practicable, but no later than 10 days from the issuance of the order.

HB 1997 (Hope) ***Misdemeanor arrest without a warrant; officer's option to take person to crisis stabilization unit instead of magistrate if person appears mentally ill.*** Amends Virginia Code Section 19.2-82 by providing that an officer who arrests a person without a warrant for a misdemeanor and believes that the person has a mental illness may, in lieu of bringing such person before a magistrate, transport the person to a crisis stabilization unit or similar facility, and issue a summons instead. (The chief judge of the Circuit Court must have approved the facility for this purpose.)

HB 2042 (Murphy) ***Suicide prevention; continuing education requirements for health care providers.*** Amends various sections of Title 54.1 to require the Board of Health Care Professions to establish regulations requiring continuing education for health care providers on suicide assessment, treatment, and management.

HB 2059 (Watts) ***Drug Treatment Court; expanding offenders who are eligible to participate in Drug Treatment Court.*** Amends Virginia Code Section 18.2-254.1 (The Drug Treatment Court Act) to eliminate the current restriction that makes persons convicted of certain violent felonies within the preceding 10 years ineligible to participate in a drug treatment court. (However, persons convicted of felony "acts of violence" (i.e, offenses that result in life imprisonment upon conviction of a third offense) within the preceding 10 years remain ineligible to participate in a drug treatment court.) (Senate version: SB 1227(Barker))

HB 2095 (Price) ***Creation of categories "peer recovery specialist" and "qualified mental health professional" as professional positions registered by the Board of Counseling.*** Amends various sections of Title 37.2 and 54.1 by creating the professional categories of "peer recovery specialist" and "qualified mental health professional," the qualifications, education, and experience for which will be set by the Board of Behavioral Health and Developmental Services, for registration by the Board of Counseling. (Senate version: SB 1020 (Barker))

HB 2109 (Kory) ***Service dogs for persons with disabilities; expansion of approved activities for service dogs.*** Amends Virginia Code Section 51.5-40.1 by deleting current language stating that the provision of "emotional support, well-being, comfort, or companionship" is not part of the definition of "service dog," and inserting language stating that "providing therapeutic contact to help with depression, anxiety, or certain phobias, or to improve physical or cognitive functioning; and providing emotional support, well-being, comfort, or companionship" are activities that are included in the definition of "service dog."

HB 2161 (Pillion) ***Education of health care professionals on prescribing opioids; task force.*** Directs the Secretary of Health and Human Resources to convene a workgroup with a variety of stakeholders, including DBHDS, the State Council of Higher Education and representatives from each medical, dental, pharmacy and nursing school, to develop standards and curricula for training health care providers in the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse. Requires a report on progress to the Governor and the General Assembly by December 1, 2017. (Senate version: SB1179 (Chafin))

HB 2163 (Pillion) ***Prescription of buprenorphine without naloxone; limitation***. Adds Virginia Code Section 54.1-3408.4 to provide that prescriptions for buprenorphine mono or products containing buprenorphine without naloxone shall be issued only for a patient who is pregnant. (Senate version: SB 1178 (Chafin))

HB 2165 (Pillion) ***Opiate prescriptions; requiring that prescriptions be solely electronic by 2020.*** Amends sections of Title 54.1 of the Virginia Code Section to require that a prescription for any controlled substance containing an opiate must be issued as an electronic prescription and prohibits a pharmacist from dispensing a controlled substance that contains an opiate unless the prescription is issued as an electronic prescription, beginning July 1, 2020. The bill defines "electronic" and requires the Secretary of Health and Human Resources to convene a work group to review actions necessary for the implementation of the bill and report on the work group's progress to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2017, with a final report due by November 1, 2018. (Senate version: SB 1230 (Dunnavant))

HB 2183 (Yost) ***Medicaid; providing for suspension instead of termination of Medicaid eligibility for persons who are incarcerated more than 30 days.*** Amends Virginia Code Section 32.1-325 by directing the State Board of Health to include in its state Medicaid Plan a provision for a person's Medicaid eligibility to be suspended, instead of terminated, in the event of incarceration for over 30 days, and to ensure that the person's time incarcerated is not included in determining the date by which the person must re-certify eligibility for medical insurance.

HB 2184 (Yost) ***Psychiatric hospitalization of inmates; ensuring required evaluations are performed.*** Amends Virginia Code Section 19.2-169.6 to require that the person

having custody of an inmate ensure that the inmate receives any evaluation or assessment that is required to be considered in a hearing related to inpatient psychiatric hospital admission.

HB 2258 (Filler-Corn) ***Suicide awareness and prevention; directive for comprehensive statewide initiative.*** Directs the Secretaries of Health and Human Resources and Public Safety to convene a task force to develop a comprehensive campaign to raise public awareness of suicide and increase suicide prevention education in multiple venues across the state. A website with resources would be developed, and a report to the Governor and the General Assembly would be made by December 1, 2017.

HJ 597 (Marshall) ***Heroin use in the Commonwealth***; ***JCHC to study.*** Directs the JCHC (Joint Commission on Health Care) to study heroin use in the Commonwealth, including rates of use, pathways that lead individuals to use, possible education and prevention strategies, and heroin overdose prevention initiatives, including the use of naloxone to prevent heroin overdoses. Requires annual reports for the two year project to the General Assembly.

HJ 616 (O'Bannon) ***Health care quality in jails; JCHC to study.*** Citing the de-centralized, highly variable and inconsistent quality of care among the state's correctional facilities, the bill directs the JCHC (Joint Commission on Health Care) to (i) review the requirements for delivery of health care services in jails and prisons; (ii) review the oversight of health care service delivery in jails and prisons, including the process for the development and implementation of performance measures and oversight and enforcement of contracts for the delivery of health care services in jails and prisons; (iii) evaluate the current quality of health care services delivered in jails and prisons; and (iv) develop recommendations for improving the quality of health care services delivered in jails and prisons in the Commonwealth.

HJ 695 ***Sentencing of drug offenders; JLARC to study effectiveness of approaches.*** Noting the high and continuing rate of drug abuse and drug overdose-related deaths, the frequent association of drug abuse with a mental health condition, and the development of evidence-based alternatives to prosecution, conviction and incarceration for addressing such use, the bill directs JLARC (the Joint Legislative Audit and Review Commission) to study and report on the efficiency and effectiveness of Virginia courts' sentencing of Schedule I and II drug offenders. Requires reports at the end of 2017 and 2018.

SB 797 (McDougle) ***Competency to stand trial; court discretion to order additional evaluation.*** Amends Virginia Code Section 19.2-169.1 by providing that, after the initial competency evaluation report on a defendant is received but before the court makes a determination of the defendant's competency to stand trial, the court, on its own motion or that of either party, may order an additional evaluation and report of the defendant's competency.

SB 811(Favola) ***DCJS training of law enforcement; inclusion of de-escalation training.***

Amends Virginia Code Section 9.1-102 by adding to the powers and duties of DCJS to include the establishment of compulsory training for law enforcement personnel that ensures training in "de-escalation techniques."

SB 848 (Wexton) ***Naloxone; authorizing more individuals to administer naloxone for purposes of opioid overdose reversal.*** Amends Virginia Code Sections 8.01-225 and 54.1-3408 to allow a person who is authorized by DBHDS "to train individuals on the administration of naloxone for use in opioid overdose reversal and who is acting on behalf of an organization that provides substance abuse treatment services to individuals at risk of experiencing opioid overdose or training in the administration of naloxone for overdose reversal and that has obtained a controlled substances registration from the Board of Pharmacy pursuant to § 54.1-3423 to dispense naloxone to a person who has completed a training program on the administration of naloxone for opioid overdose reversal, provided that such dispensing is (i) pursuant to a standing order issued by a prescriber,(ii) in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, and (iii) without charge or compensation". Individuals receiving naloxone as provided for by the bill may possess the drug and administer it to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. A person who dispenses naloxone as provided for by the bill is immune from civil liability for ordinary negligence for acts or omissions from the rendering of naloxone treatment if the person acts in good faith.

SB 895 (Marsden) ***Petition for psychiatric hospitalization of inmate of local correctional facility; removing the current requirement that the inmate cannot currently be found to be incompetent to stand trial***. Amends Virginia Code Section 19.2-169.6 by removing existing language stating that, for psychiatric hospitalization of a local correctional inmate to be sought under Section 19.2-169.6, the inmate must be a person who is "not subject to the provisions of Section 19.2-169.2", which address the disposition for a defendant who has been found by a court to be incompetent to stand trial.

SB 933 (Favola) ***DCJS training standards for jail officers; inclusion of mental health first aid.*** Amends Virginia Code Section 9.1-102 by expanding the powers and duties of DCJS to include "annual training in mental health first aid" as part of the compulsory training standards for local deputy sheriffs and jail officers.

SB 975 (Lucas) ***CSBs and regional jails; responsibility for psychiatric hospital pre-admission screening for jail inmates from CSB's jurisdiction.*** Amends Virginia Code Section 37.2-505 by providing that CSBs must provide psychiatric hospital pre-admission screening services for regional jail inmates who were "convicted in the county or city served by" the CSB, unless the CSBs in the region served by the jail agree to a different arrangement.

SB 1078 (Edwards) ***DBHDS; Catawba State Hospital expansion.*** Directs DBHDS to develop a comprehensive plan to expand Catawba Hospital to include a step-down

facility of 40 or more beds for individuals who no longer require acute care. Plan completion and a report to the General Assembly would be due by November 1, 2017.

SB 1180 (Chafin) ***Prescribing of opioids and buprenorphine; Boards of Dentistry and Medicine to adopt regulations.*** Adds Virginia Code Sections 54.1-2708.4 and 54.1-2928.2 to require the Boards of Dentistry and Medicine to adopt regulations for the prescribing of opioids and products containing buprenorphine. The bill contains an emergency clause.

SB 1233 (Chafin) ***Temporary detention orders (TDOs) for psychiatric hospitalization; authorizing certain hospital emergency department providers to perform evaluation for issuance of TDOs in lieu of CSB designee if designee is not available***. Amends Virginia Code Sections 37.2-804.2 and 37.2-808 through 37.2-810 by enabling emergency physicians and psychiatrists and other named medical professionals to become "certified evaluators" through training provided by the Department of Behavioral Health and Developmental Services. These "certified evaluators" would be authorized to perform the evaluations of individuals that are required for a Temporary Detention Order (TDO), placing such individuals in a mental health treatment facility, in those cases where the local Community Services Board (CSB) designee who normally performs these evaluations "is not available to perform the evaluation within two hours of receipt of notification that an evaluation is required." The local CSB retains full responsibility for finding an available mental health facility for placement of individuals found by a "certified evaluator" to meet the criteria for a TDO, and to communicate with local and state mental health facilities regarding placement of those individuals.

II. Article

The Case for Permanent Supportive Housing for Persons with Serious Mental Illness: Improved Lives, Reduced Costs, and Compliance with Federal Law

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The problem

Virginia's mental health system has historically viewed traditional mental health care services like outpatient treatment, medication management, and case management as the backbone of a well-functioning mental health care system. While these are all essential components of a strong treatment system, community-based supportive housing must also be viewed as a core component because treatment interventions are less effective when individuals do not have access to safe, affordable housing.[i]

Chronic housing instability and homelessness among people with serious mental illness are correlated with high health, behavioral health, and criminal justice system costs. Nationwide and in Virginia a notable subset of individuals with serious mental illness are unstably housed or are homeless and, as a result, have poor behavioral health outcomes and are high utilizers of costly treatment and criminal justice resources. Further, in Virginia unstably housed individuals with behavioral health disorders are over-institutionalized because less restrictive, more effective, and less costly community-based supportive housing options are not available.[ii]

Permanent Supportive Housing (PSH) as part of the solution

To combat the many problems associated with lack of housing and mental illness, many states, including Virginia, have begun implementing a model called permanent supportive housing (PSH). PSH is an evidence-based practice for adults with serious mental illness (SMI) that has been implemented, refined, and studied for more than 30 years. The core components of the PSH model are 1) affordable rental housing and 2) housing-focused, community-based supportive services designed to support individuals in securing income, treatment, and rehabilitative services to improve their behavioral health conditions. More specifically, permanent supportive housing is:

1. Permanent. There are no time limits to the provision of housing. Individuals live in lease-based housing in the community, not segregated group homes.
2. Supportive. Housing is coupled with a flexible array of voluntary supportive services that are available to participants and designed to assist them with securing and maintaining housing and addressing health and behavioral health needs.
3. Housing. Namely, affordable rental housing. Participants generally pay 30% of their income to rent. Housing is not affordable on a Supplemental Security Income (SSI)[1] in any part of Virginia.[iii] Therefore a long-term rental subsidy is generally needed to make housing affordable.

The effectiveness of permanent supportive housing in improving lives: National research

PSH is widely endorsed as a critical resource to prevent unnecessary institutional stays and facilitate discharges from institutions for persons with disabilities. Peer-reviewed research studies have consistently shown that PSH is particularly effective in improving participants' housing stability and reducing their emergency department and inpatient hospital utilization.[iv] According to a report by the Center on Budget and Policy Priorities, the research supports four main conclusions[v]:

- Supportive housing helps people with disabilities live stably in the community.

[1] Supplemental Security Income (*SSI*) is a federal income supplement program. It is designed to help aged, blind, and disabled people who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.

- People with disabilities in supportive housing reduce their use of costly systems, especially emergency health care and corrections.
- Supportive housing can help people with disabilities receive more appropriate health care and may improve their health.
- People in other groups, including seniors trying to stay in the community as they age and families trying to keep their children out of foster care, likely also benefit from supportive housing.

The effectiveness of permanent supportive housing in improving lives: The Virginia experience

There have also been studies in Virginia of the impact of housing and supports on health care utilization. According to a 2005 study by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) of homeless and housed consumers of mental health services in local Community Services Boards (CSBs), the average homeless CSB consumer had *four times* the number of admissions, *three times* the number of hospital bed days, and *three times* the total estimated cost for local psychiatric inpatient care as housed CSB consumers.[vi]

A 2013 study of 155 supportive housing clients in Richmond compared their utilization of Virginia Commonwealth University (VCU) Health System's ED and inpatient care in the year before they were housed to the year after entering supportive housing. That report found[vii]:

- Overall 56% reduction in ED visits,
- Overall 43% reduction in inpatient visits,
- 74% reduction in ED visits for psychiatric care,
- 67% reduction in inpatient visits for psychiatric care, and
- 112 fewer bed days for psychiatric treatment – a savings of $278,185 for this group.

As reported at the June 23, 2016 meeting of the Housing Work Group of the SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century[2], more than 93% of the people who enter Virginia Supportive Housing, the state's largest PSH provider, do not return to homelessness.[viii]

The effectiveness of permanent supportive housing in reducing costs: The Virginia analysis

The DBHDS Office of Adult Community Behavioral Health Services recently conducted an analysis of the estimated cost reductions to Virginia if 660 current "high utilizers" of CSB and state hospital services were provided with permanent supportive housing, an initiative that would require an investment of $10 million. That analysis found that the state of Virginia could expect to avoid spending between $2.1 and $6.8 million annually by reducing inpatient services through PSH, or between $4,433 and $14,684 per client,

[2] Additional information from the report is included in this issue's Data Corner.

per year.[ix] Reductions in jail utilization could save an additional $311 to $1,510 per client, per year.[x] This analysis did not even include cost avoidance for settings such as emergency department visits and inpatient stays paid by Medicaid or state indigent care payments to hospitals—widely acknowledged as some of the largest public cost drivers for this population. The analysis also does not capture the dramatic improvement in quality of life that these individuals would experience with stable housing and support services.

Below is a cost comparison that shows the higher costs of treating a person in a medical or mental health facility, or incarcerating them in a local jail, over helping that person live in permanent supportive housing:

Location	**Cost Per Bed Day***
Local Jail	$77[xi]
State Psychiatric Facility Inpatient	$602[xii]
Emergency Department	$1,043[xiii]
Local Psychiatric Hospital Inpatient	$2,099[xiv]
Permanent Supportive Housing (rental subsidy[xv] and services[xvi]):	
• Moderate Cost Housing Area	$14 - $54
• High Cost Housing Area	$20 - $60
• Extremely High Cost Area	$44 - $84

The need for permanent supportive housing programs to meet the requirements of the Americans with Disabilities Act and the U.S. Supreme Court's Olmstead decision

In a presentation to the Housing Work Group on June 23, 2016, Ms. Martha Knisley, an expert on permanent supportive housing, noted that the U.S. Department of Justice has been actively enforcing the 1990 Americans with Disabilities Act, which prohibits discrimination of persons with disabilities by public entities in services, programs and activities. A key requirement of the ADA is that persons with disabilities must receive services and have access to programs "in the most integrated setting appropriate," with the "most integrated setting" being one that "enables people with disabilities to interact with people without disabilities to the fullest extent possible."

In *Olmstead v. L.C.*, the U.S. Supreme Court interpreted Article II of the ADA as imposing on states "an affirmative obligation to ensure that individuals with disabilities live in the least restrictive, most integrated settings possible." Compliance with the ADA requires that persons with serious mental illness who are receiving services be able to live in settings that enable them to "interact with nondisabled persons to the fullest extent

possible," to have "opportunities to live, work and receive services in the greater community," and to "have choice in daily life activities" and in access to services. Ms. Knisley is an appointed "Olmstead Independent Reviewer" tasked with monitoring implementation of *Olmstead*-related settlement agreements between the Department of Justice and various states (including North Carolina). She emphasized that "congregate" settings like nursing homes and assisted living facilities are considered "segregated" community housing settings because they are populated exclusively or primarily with persons with disabilities.

Virginia's funding for permanent supportive housing: Recent General Assembly appropriations

In the 2015 legislative session, the Virginia General Assembly approved $2.1 million in new funding for permanent supportive housing to provide rental subsidies and supportive services for people with serious mental illness, and in 2016 the legislature doubled that amount. The target population for this permanent supportive housing funding included:

- Frequent users of hospitals emergency departments and inpatient care,
- Individuals experiencing or at risk of homelessness (e.g., unstably housed), and
- Individuals in state hospitals who are capable and willing to live in PSH upon discharge.

The 2015-2016 allocations were issued through Community Services Boards' performance contract modifications and through a Request for Proposals published in October 2015 by DBHDS.[xvii] Contracts were awarded to Norfolk, Hampton-Newport News, and Arlington CSBs, and to Pathway Homes (a private, non-profit organization) and The Keys Project associated with Hampton-Newport News CSB. The FY 2015-2016 funding has housed 125 participants to date and it is expected to house at least 149 individuals at full capacity.[xviii,xix] DBHDS next requested proposals in the summer of 2016 for the FY 2017-2018, and focused these funds on the areas served by Fairfax-Falls Church CSB, Richmond Behavioral Health Authority, and the Virginia Beach CSB, as those three areas together "represented 40% of the entire state's chronic homeless population, 33% of the state's homeless adults with SMI, and almost one quarter of the individuals on the state psychiatric hospitals' extraordinary barriers list (based on 3Q 16 data)."[xx] DBHDS recently awarded contracts to Fairfax County CSB (sub-contracted to New Hope Housing), Richmond Behavioral Health Authority, and Virginia Beach Department of Human Services for the use of those funds for permanent supportive housing, focusing on frequent users of hospital emergency departments and inpatient care, individuals experiencing or at risk of homelessness, and individuals in state hospitals who are capable and willing to live in PSH upon discharge. It is estimated that the FY 2017-2018 funding will provide permanent supportive housing to about 137 people.

The remaining unmet need for permanent supportive housing (PSH)

According to analyses conducted by the Virginia Department of Behavioral Health and Developmental Services, there are roughly 5,000 people with serious mental illness who need permanent supportive housing. The breakdown includes[xxi]:

- People with serious mental illness who are unstably housed, receiving mental health case management from a Community Services Board, and were in the top 20% of crisis and emergency services utilizers across the state: 2,684
- People with serious mental illness in Virginia's jails in need of permanent supportive housing: 1,056
- People with serious mental illness in Virginia's assisted living facilities: 824
- People with serious mental illness who are homeless: 516
- Total = 5,080

Recommendations for the 2017 General Assembly

Based on the analysis of the DBHDS Office of Adult Community Behavioral Health Services cited above, the Housing Work Group of the SJ 47 Joint Subcommittee to Study Mental Health Services in the 21st Century submitted a recommendation at the Joint Subcommittee's December 6, 2016 meeting that the General Assembly allocate an additional $10 million in new general fund dollars for FY 2017-2018 to expand permanent supportive housing for adults with mental illness to serve the 660 "high utilizers" of community services board and state hospital services cited in the DBHDS analysis. The investment would address 25% of the "Unstably Housed/CSB Clients" subgroup and 13% of the estimated total statewide PSH need, and has the potential of dramatically improving the lives of these individuals and reducing their need for their current high use of local and state psychiatric hospital beds and other intensive services. The Joint Subcommittee approved that recommendation, along with two other recommendations from the Work Group: 1) to require the Department of Housing and Community Development, in consultation with other agencies and stakeholders, to develop and implement strategies for housing individuals with serious mental illness; and 2) to require the Department of Medical Assistance Services (DMAS), in consultation with other agencies and stakeholders, to research and recommend strategies for financing permanent supportive housing through Medicaid reimbursement. Positive action by the 2017 General Assembly on these recommendations could significantly improve Virginia's mental health services system.

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[i] Update on Permanent Supportive Housing Initiatives for Adults with Serious Mental Illness; *Senate Finance Committee: HHR Subcommittee,* July 21, 2016, Kristin Yavorsky, DBHDS, Homeless Projects Coordinator, Office of Behavioral Health; Retrieved from http://sfc.virginia.gov/pdf/health/2016/Interim/072116_No3_Yavorsky.pdf

[ii] Ibid.

[iii] Technical Assistance Collaborative: *The Housing Crisis for People with Disabilities; Priced Out in 2014*; Retrieved from http://www.tacinc.org/media/52012/Priced%20Out%20in%202014.pdf

[iv] Center for Budget and Policy Priorities. Supportive Housing Helps Vulnerable People Live and Thrive in the Community. (2016) Retrieved from http://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community#_ftn27

[v] Ibid.
[vi] Permanent Supportive Housing: Presentation to SJ47 Housing Workgroup; June 23, 2016, Kristin Yavorsky, MSW Homeless Projects Coordinator Virginia Department of Behavioral Health and Developmental Services
[vii] Community Impact of Permanently Housing Homeless Adults in Richmond. Unpublished report. Virginia Supportive Housing (2015).
[viii] Permanent Supportive Housing: Presentation to SJ47 Housing Workgroup; June 23, 2016, Kristin Yavorsky, MSW Homeless Projects Coordinator Virginia Department of Behavioral Health and Developmental Services
[ix] DBHDS Office of Adult Community Behavioral Health Services, PSH Investment and Estimated State Cost Avoidance, December 2016
[x] Ibid.
[xi] Compensation Board Report to the General Assembly; FY 2014 Jail Cost Report Annual Jail Revenues and Expenditures Report (2015); Retrieved from http://www.scb.virginia.gov/docs/fy14jailcostreport.pdf
[xii] Virginia DBHDS estimate of $220,000 annual cost of state hospital bed
[xiii] Virginia Health Information; Average charge for "Medium" complexity visit. Retrieved from http://www.vhi.org/health_care_cost.asp?id=ER1
[xiv] Virginia Hospital & Healthcare Association; Average daily charge for 31 Virginia hospitals for Schizophrenia DRG; Retrieved from http://www.vapricepoint.org/ReportINP.aspx
[xv] National Low Income Housing Coalition, *Out of Reach 2016*: Virginia. Retrieved from http://nlihc.org/oor/virginia
[xvi] Community Services Board Reported Services Costs; CCS_3, (2016)
[xvii] Update on Permanent Supportive Housing Initiatives for Adults with Serious Mental Illness; *Senate Finance Committee: HHR Subcommittee*, July 21, 2016, Kristin Yavorsky, DBHDS, Homeless Projects Coordinator, Office of Behavioral Health; Retrieved from http://sfc.virginia.gov/pdf/health/2016/Interim/072116_No3_Yavorsky.pdf
[xviii] Virginia Department of Behavioral Health and Developmental Services, *Permanent Supportive Housing – Program and Participant Characteristics* (Item 315 AA), October 1, 2016, Retrieved from http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3372016/$file/RD337.pdf
[xix] Kristin Yavorsky, MSW Homeless Projects Coordinator Virginia Department of Behavioral Health and Developmental Services, Personal Communication, January 24, 2017.
[xx] Update on Permanent Supportive Housing Initiatives for Adults with Serious Mental Illness; *Senate Finance Committee: HHR Subcommittee*, July 21, 2016, Kristin Yavorsky, DBHDS, Homeless Projects Coordinator, Office of Behavioral Health; Retrieved from http://sfc.virginia.gov/pdf/health/2016/Interim/072116_No3_Yavorsky.pdf
[xxi] DBHDS Office of Adult Community Behavioral Health Services, PSH Investment and Estimated State Cost Avoidance, December 2016

III. ILPPP Data Corner

Permanent Supportive Housing: Virginia Investment and Estimated State Cost Avoidance

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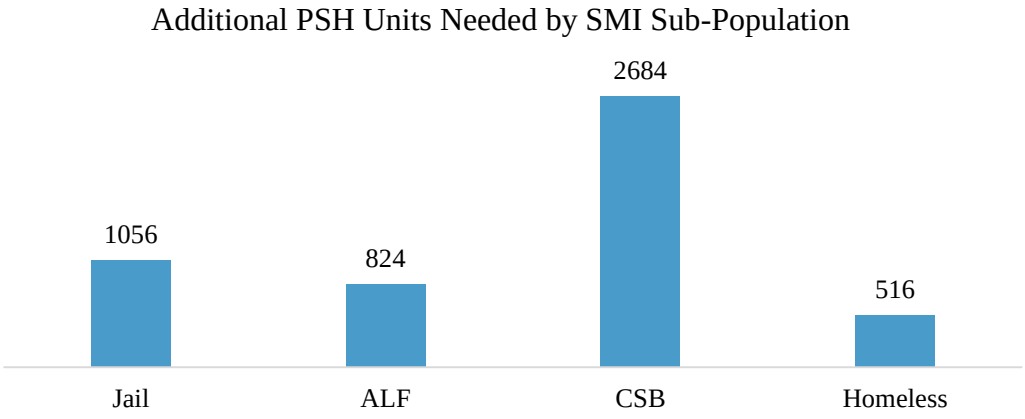
In order to inform the deliberations of the Housing Work Group of the SJ 47 Joint Subcommittee to Study Mental Health Services in the 21st Century, the Virginia Department of Behavioral Health and Developmental Services conducted analyses utilizing multiple agency administrative databases. The following results were prepared to share with the Work Group in answer to particular questions posed by its members about estimating potential state cost avoidance through investment in permanent supportive housing (PSH). The cost avoidance estimates described below were limited by the scope of the request as well as time and data-sharing constraints. As a result, it is important to note that the cost avoidance estimates attend to only two types of services: state psychiatric inpatient care and state-funded locally purchased psychiatric inpatient care. Nonetheless, the results speak to the great potential for cost savings via investment in permanent supportive housing.



Data Sources: Jail: Mental Illness in Jails Report (Virginia Compensation Board, 2015); ALF: Auxiliary Grant payments to localities (Virginia DARS, 2016); CSB: CSB CCS3 data submissions (DBHDS, 2016); Homeless: The State of Permanent Supportive Housing in Virginia, 2015 (Virginia Housing Alliance)

Available data indicate that approximately 5,080 individuals living with serious mental illness are in need of permanent supportive housing. Over 1,000 of those individuals are currently incarcerated in local jails, 824 are currently in assisted living facilities, and 516 are currently living on the streets or in homeless shelters. The majority of people identified as likely candidates for PSH were CSB clients. Those individuals were unstably housed, receiving mental health case management or assertive community treatment from CSBs, and were among the top 20% of crisis and emergency services utilizers across the state.

Because client-level data is available for the identified CSB sub-population, more precise cost avoidance estimates can be provided for this group. A $10 million investment in PSH could house about 660 of those unstably housed consumers with serious mental illness who are high utilizers of CSB and state hospital services. Such an investment would address a quarter of that sub-population, which represents the largest share of statewide PSH need.

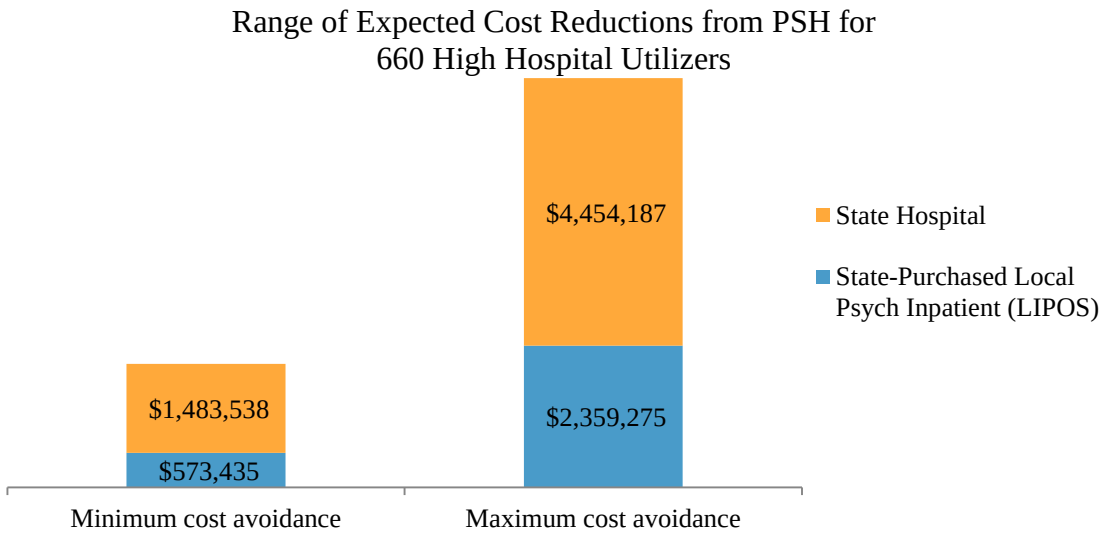
Using only state psychiatric facility and state-purchased local inpatient psychiatric bed days, the 660 PSH-eligible consumers' one year use of inpatient treatment costs approximately $24,702,759. Cost avoidance per client, per year estimates ranged from

$4,433 to $14,684, which in turn suggested total state cost avoidance estimates ranging from $2,056,973 to $6,813,462.

Cost avoidance estimates assume that PSH providers would house the most costly eligible consumers for the 660 PSH units, and that reductions in consumer inpatient utilization would be similar to those published in randomized control trials and quasi-experimental studies of high-fidelity PSH interventions with similar populations. Cost reductions are based on statewide average bed day costs per consumer. (Note that because this sub-population has been identified as high-utilizers crisis and emergency services, using state average bed day costs likely underestimates the actual inpatient costs for these clients.)

State-Funded Service	FY16 Average Bed Days Per Consumer	Expected Range of Bed Day Savings Post–PSH	N
State Purchased Local Psychiatric Inpatient (LIPOS)	7 days	-1 to -7 days	341
State Hospital-Psychiatric Inpatient	70 days	-7 to -14 days	404

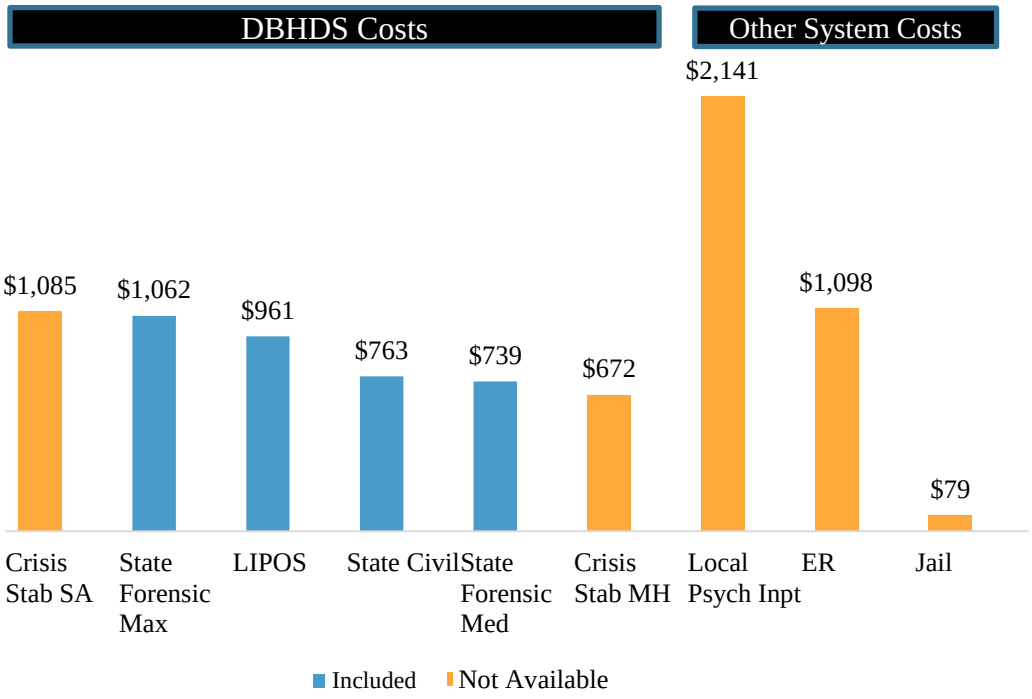
(Bed day reduction estimates are based on research published on similar populations.)



Emergency department visits, crisis stabilization stays, CSB emergency services, jail stays, and other local psychiatric inpatient costs are not included in this analysis due to time and data sharing constraints. PSH has also been shown to reduce service utilization for these services, so total public cost avoidance is likely much greater than presented here.

In order to put the "state hospital and LIPOS only" estimates into context, comparing available cost-per-day estimates (adjusted for inflation) in other settings for which additional data were not currently available reinforces that there is likely much more to be saved through providing PSH.

Virginia Bed Day Costs-Crisis and Institutional Settings



As a final point of comparison, the following chart provides the range of cost-per-day for a PSH "bed," all of which fall well below other settings' bed day costs (with the exception of jail).

PSH Bed Day Costs by Rental Housing and Service Intensity Costs

Rental Housing Cost	Rental Subsidy + Moderate Intensity Services	Rental Subsidy + High Intensity Services
Extremely High (e.g., Northern Virginia, Charlottesville)	$44	$84
High (e.g., Hampton Roads, Greater Richmond)	$20	$60
Moderate (other localities)	$14	$54

IV. Case Law Developments

Federal Circuit Court Decisions

Editor's Note: It is notable that this issue of *DMHL* has four separate federal circuit court decisions regarding claims of excessive force by police officers in their interactions with people with mental illness in the community. This area of the law is continuing to evolve, and concerns about the proper use of force by law enforcement remain, especially since the response to those concerns nationally has been uneven at best. The Washington Post database on police shootings shows that, of the 963 people shot and killed by police in 2016, 241 were individuals with mental illness. (The figures for 2015: 991/258) It must be noted that in a substantial majority of these cases the individual had a weapon of some kind, highlighting the challenges faced by officers. Excessive force litigation can result in new guidelines for police conduct (see, for example, the decision of the Fourth Circuit Court of Appeals in *Estate of Armstrong v. Village of Pinehurst*, 810 F.3d 892 (4th Cir., 2016) ,covered in the March 2016 issue of DMHL, setting new standards for officers' use of Tasers); however, real and lasting improvement will come only when officers are provided with the training they need and deserve to have. Recognized "best practices" do exist for responding to individuals who are in mental health crisis. A number of Virginia communities have been training some or all of their officers in one such set of practices: CIT (Crisis Intervention Team) training. Future issues of *DMHL* will look more closely at this important issue.

Federal Excessive Force and Unlawful Seizure Cases

Excessive Force: Ninth Circuit reverses district court's grant of summary judgment to police officers based on qualified immunity when there were disputed facts as to whether the officer acted reasonably when he shot a woman who was holding a knife, but not acting aggressively.

Hughes v. Kisela, 841 F.3d 1081 (9th Cir. 2016)

Background: In May 2010, three officers responded to a welfare check call and reports of a woman acting erratically and hacking at a tree with a large knife. Soon after the officers arrived, Amy Hughes exited her house carrying a large kitchen knife at her side with the blade pointing backwards. Sharon Chadwick, who lived with Hughes, was standing outside the house near the driveway at the time. She later testified that Hughes was composed and content. Chadwick also testified that she did not consider Hughes a threat and was not in any fear. The three officers each drew their guns and ordered Hughes to drop the knife; Corporal Kisela contended that the officers yelled several times but Chadwick remembered hearing only two commands in rapid succession. Corporal Kisela testified that he saw Hughes raise the knife as if to attack, but the other two responding officers told investigators that they did not see her raise the knife. Corporal Kisela fired four shots each of which struck Hughes, but the injuries were not fatal. Chadwick testified that Hughes was taking medication for bipolar disorder, and Chadwick was always able to manage Hughes's behavior in the past. Chadwick also

testified that she believes Hughes did not understand what was happening when the police yelled for her to drop the knife. The district court granted summary judgment in favor of the police officer on a theory of qualified immunity.

Holding: The Ninth Circuit ruled that the officer was not entitled to summary judgment with respect to the reasonableness of his actions. The court also explained that qualified immunity requires a determination that the actions of the officer were reasonable, which in this case involved disputed facts that should properly be weighed by a jury. The Ninth Circuit reversed the grant of summary judgment and remanded for a jury to determine whether the responding officer acted reasonably.

Notable Point:

Excessive Force and Mental Illness: The Ninth Circuit noted that there are not separate excessive force analyses for those with mental illness and serious criminals, but the government interest in using such force is diminished when confronted with an individual with mental illness.

Excessive Force: The Tenth Circuit (following remand from the U.S. Supreme Court) reverses its prior decision that had denied qualified immunity to police officers in regard to a claim they used excessive force in subduing a medical patient attempting to leave the hospital (and risking death) due to temporary delirium, finding on remand that there were no existing case decisions that would have clearly informed those officers that their conduct violated Fourth amendment standards.

Aldaba v. Pickens, 844 F.3d 870 (10th Cir. 2016)

Background: Johnny Manuel Leija was admitted to the hospital after feeling ill for several days and was diagnosed with dehydration and severe pneumonia in both lungs. He was initially alert and cooperative and he was given an IV and an oxygen tube. The treatment improved Leija's condition, but a nurse later found that Leija had cut his IV and removed his oxygen tube. She also found blood on the floor and in the bathroom. The nurse reconnected his IV and oxygen tube, but Leija became increasingly agitated. A doctor prescribed Xanax to treat his anxiety, but Leija refused to take it and again removed his IV and oxygen tube while loudly claiming that the nurse was telling lies and trying to poison him. The female nurse became concerned for her safety based on Leija's behavior and a male nurse was sent to try to calm Leija. The male nurse found Leija claiming to be god and superman. The nurse attempted to inject Leija with Haldol and Ativan to calm him, but Leija refused to cooperate. The doctor was concerned about Leija's low oxygen levels, and the nurse did not think they could restrain Leija sufficiently to administer the drugs for treatment.

Law enforcement was called to assist. Three officers responded and found Leija in the hallway walking toward the hospital lobby and exit. The doctor told the officers that if Leija left the hospital he would die. The officers ordered Leija to return to his room, but he grew more agitated. Leija removed bandages from his arms and a "fairly steady stream of blood" began to flow from both of his arms. The officers tried to calm Leija and warned him that they might use a Taser. When Leija refused to cooperate, a Taser was

deployed, but one of the probes missed. The other officers grabbed Leija and struggled to subdue him. As the three officers struggled with Leija, the male nurse injected him with Haldol and Ativan. Leija went limp, grunted and vomited clear liquid almost immediately after being injected with the drugs. Medical staff began CPR, but were unable to revive him. The cause of death was determined to be respiratory insufficiency secondary to pneumonia that was exacerbated by Leija's exertion during the struggle with the officers.

The Tenth circuit originally affirmed the district court's denial of summary judgment for the officers, but the U.S. Supreme Court remanded with instructions to reconsider consistent with *Mullenix v. Luna*, 136 S. Ct. 305 (2015). In *Mullenix*, the Court ruled that qualified immunity should be denied only when "clearly established case law" would put officers on notice that it was "beyond debate" that their actions amounted to excessive force.

Holding: The Tenth Circuit found no cases that would have informed the officers "beyond debate" that their actions would be excessive force. Accordingly, the court remanded the case with instructions for the district court to grant summary judgment in favor of the officers based on qualified immunity.

Notable Point:

> **Qualified Immunity analysis:** The *Mullenix* court emphasized that courts should not define clearly established case law at a high level of generality. The Court explained that "specificity is especially important in the Fourth Amendment context" because officers may have difficulty in determining how the legal doctrine will apply to the particular factual situation with which an officer may be confronted. The Court stressed that the inquiry must be focused on the specific facts and context of a particular case.

<u>Excessive Force:</u> Eleventh Circuit upholds district court's refusal to grant law enforcement officer's motion for summary judgment based on qualified immunity in response to a claim that he used excessive force in responding to a person in mental health crisis where there was evidence that the officer Tasered the detained person at least twice after the person had stopped actively resisting the officer.

Wate v. Kubler, 839 F.3d 1012 (11th Cir. 2016)

Background: James Barnes was visiting a beach on Honeymoon Island in Florida with his aunt Paula Yount in order to conduct a baptismal ritual. While in the water, Barnes began acting erratically by flailing around and yelling about a demon. The only law enforcement officer on the Island at the time was Officer Tactuk, who responded to the commotion in the water. Yount came out of the water to speak with Tactuk, who then believed there was probable cause to arrest Barnes for battery on Yount. Tactuk entered the water and attempted to arrest Barnes, but a struggle ensued and Tactuk repeatedly struck Barnes in the face. Tactuk was able to place a handcuff on one of Barnes's hands and they continued to struggle in the water. Bystanders eventually helped Tactuk drag Barnes onto the beach. Multiple witnesses had called 911 to report the incident and Tacktuk called for backup over the police radio. Tactuk attempted to place Barnes's other

hand in handcuffs, and a bystander observed that during the struggle, Barnes was coughing blood and appeared to have difficulty breathing. Officer Kubler responded to the incident about seven minutes after Tacktuk's initial encounter with Barnes. Kubler and Tactuk continued to struggle with Barnes until Kubler deployed his Taser a total of five times over the course of nearly two minutes. Barnes became still and the officers were able to handcuff him. There was a dispute between the officers' testimony and that of bystanders regarding when Barnes stopped resisting. An off-duty fire lieutenant who came to the scene at that point told the officers to take the handcuffs off because Barnes was not breathing and had turned blueish gray. The officers then removed the handcuffs and began CPR. Rescue personnel responded to the scene and took over the rescue, but Barnes died two days later. The cause of death was determined to be complications of asphyxia with contributory conditions of blunt trauma and restraint. Barnes's representative brought suit against the officers and agencies involved. The other parties in the case settled with the plaintiff, but Officer Kubler moved for summary judgment based on qualified immunity. The district court denied the motion and Kubler appealed.

Holding: The Eleventh Circuit ruled that Kubler was not entitled to summary judgment and affirmed the holding of the district court. The court found that by reviewing the evidence in the light most favorable to the plaintiff, as required at the summary judgment stage, "a reasonable officer in Kubler's position and under these circumstances would have had fair warning that repeatedly deploying a Taser on Barnes, after he was handcuffed and had ceased resisting, was unconstitutionally excessive."

Unlawful Seizure: Eleventh Circuit reverses district court's grant of summary judgment based on qualified immunity in seizure of individual for mental health evaluation, finding that although the evidence supported the officer's initial seizure, the officer carried out the seizure in a manner that violated the individual's constitutionally protected privacy interests.

May v. City of Nahunta, 841 F.3d 1173 (11th Cir. 2016)

Background: Phyllis May was the sole caregiver for her mother who was suffering from Alzheimer's with sundowning syndrome, a condition that caused her to stay awake for days at a time. May became exhausted and called her brother to come help care for her mother before lying down. When her brother arrived several hours later, he was unable to wake May and called 911. Four EMTs responded and used an ammonia capsule to wake May. The EMTs evaluated May, but she refused to be transported to the hospital and the EMTs determined that she did not require further treatment. May executed a form refusing treatment. At the same time, Officer Allen responded to a 911 call requesting assistance at May's residence. The EMTs told Allen that May had "been a little combative to herself" and was upset. Allen entered May's bedroom to investigate and found her hair in disarray and decided to transport her to a hospital for a psychological evaluation. Allen instructed the EMTs to leave the bedroom and then locked himself in the bedroom with May. He instructed her to take off her nightgown and put on suitable clothes to go to the hospital. May became upset and began to cry, but Allen insisted that she change, even pulling on her nightgown to remove it. May put on shorts, but Allen

insisted she take them off and first put on undergarments. May refused, but Allen patted his gun and told her "yes you will." Allen remained in the locked room with May for 15 to 20 minutes, while her sister was outside requesting the door be opened. When they emerged from the bedroom, Allen stated that he was taking May to the hospital and she again objected. Allen escorted May to the emergency room and asked hospital staff about May's prior diagnoses before leaving. May was subsequently released from the hospital after no more than two hours. May brought suit alleging unlawful seizure, false imprisonment, assault and battery, and invasion of privacy. The district court granted Officer Allen's motion for summary judgment based on qualified immunity

Holding: The Eleventh Circuit affirmed the district court's finding of qualified immunity for Allen's decision to seize May for a mental health evaluation, but reversed and remanded to determine whether the manner of the seizure unreasonably violated May's privacy interests.

Notable Point:

> **Manner of Seizure:** The court explained that searches conducted in an abusive fashion may violate the Constitution. The court emphasized that if Officer Allen's alleged conduct were proven, it would be "representative of the type of unnecessarily invasive and demeaning intrusion that is undoubtedly within the sphere of what the Fourth Amendment prohibits."

Other Federal Circuit Court Decisions

Conditions of Pre-trial Confinement: Fifth Circuit upholds jury verdict finding a county jail liable for unconstitutional conditions of pre-trial confinement that resulted in the death of an inmate who was mentally ill, but assumed to be under the influence of bath salts, because evidence showed a "de facto" policy of prolonged detention without proper medical supervision for inmates held in a jail infirmary observation room for detoxification.

Montano v. Orange Cnty., Tex., 842 F.3d 865 (5th Cir. 2016)

Background: Robert Montano was arrested for public intoxication and was taken to the county jail after a judge signed an affidavit of probable cause. The arresting officer told the intake officer at the jail that she suspected Montano was under the influence of bath salts. Montano was placed in an observation cell because he was determined to be incoherent and unable to complete the booking process. The cell did not have a sink, toilet or toilet paper. Montano was previously treated for mental illness and was in the state mental-health database, but no database query was run during his intake despite a Texas requirement to do so. While in the cell, Montano was observed by a Licensed Vocational Nurse (LVN), the Texas equivalent of a Licensed Practical Nurse, but no contract physician visited the jail during the four-and-one-half days that Montano was in the cell. There was little or no attention given to Montano during his time in the cell, and no jail staff entered the cell until the morning of his death, more than four days later. There was evidence at trial that 1) the view of Montano's cell was partially obscured by paper taped over the cell's glass walls, 2) his vitals were taken no more than once, and 3)

food was offered through a slot in the door. More than four days after being detained in the cell, an LVN reported that it appeared as though Montano was not breathing. At that time, the cell was littered with uneaten food and human waste. The LVN reported Montano's condition to the jail control room, but waited 20 minutes for a corporal to respond before calling an ambulance or entering the cell. Montano was pronounced dead 34 minutes later and the cause of death was determined to be acute renal failure. An action was filed against the county for unconstitutional confinement and episodic acts or omissions. A jury found in favor of the plaintiffs and awarded $1.5 million for pain and $917,000 for wrongful death. The county appealed seeking a new trial contending that insufficient evidence had been presented to support the jury's verdict and the damages awarded were excessive.

Holding: The Fifth Circuit denied the county's motion and upheld the jury verdict finding that sufficient evidence was presented for a reasonable jury to conclude that the conditions of confinement caused Montano's death, and that those conditions were the result of a "de facto" policy that denied detainees adequate care for an indefinite period of time. The Court further found that the damages awarded were not excessive.

Sentencing of Persons with Mental Illness: Seventh Circuit holds a defendant's history of mental illness and ineffective treatment can be considered by the sentencing judge as a prediction of the potential for future misconduct without violating the defendant's due process rights when reasonably based on factually accurate information.

United States v. Kluball, 843 F.3d 716 (7th Cir. 2016)

Background: Alexander Klubal pled guilty and was sentenced to 10-years confinement for transporting a 17-year-old girl across state lines to engage in prostitution. A presentence report detailed Kluball's history of mental illness, which included diagnoses of oppositional defiant disorder, attention deficit hyperactivity disorder, bipolar disorder, posttraumatic stress disorder, and depression. Klubal had received counseling, was hospitalized several times, and was treated with drugs including Adderall, Depakote, Eskalith, Fluoxetine, lithium, Prozac, Remeron, Ritalin, Seroquel, Strattera, Valium, Zoloft, Zydis, and Zyprexa. None of the treatments succeeded or lasted very long. During sentencing, the judge remarked that Kluball's history of mental illness did not alleviate any responsibility for his crimes and suggested that mental health treatment would not have a lasting impact on his ability refrain from engaging in criminal conduct in the future. The judge then sentenced Kluball to the statutory maximum of 10 years. Kluball appealed the sentence, challenging the judge's assertion that treatment would not have a lasting impact on his conduct as a violation of his due process rights.

Holding: The Seventh Circuit affirmed the 10-year sentence finding no violation of due process.

Notable Point:

Sentencing: The Seventh Circuit explained that during sentencing judges are routinely required to make predictions about a defendant's future conduct and

response to treatment. The court explained that such predictions do not violate due process when they are based on accurate information rather than unsupported speculation. The court was satisfied that Kluball's history of mental illness and response to past treatment was factually accurate and sufficient to support the judge's predictions about Kluball's future conduct.

Virginia Court Decisions

Involuntary Commitment of Sexually Violent Predators: Supreme Court of Virginia holds that in an action to involuntarily commit a convicted rapist as a sexually violent predator testimony by victims of sexual assault committed by the defendant is relevant and corroborative of the evaluation of the defendant and is not unfairly prejudicial, and the trial court's exclusion of such victim testimony is reversible error.

Commonwealth v. Proffitt, 792 S.E.2d 3 (Va. 2016)

Background: The Commonwealth of Virginia initiated proceedings to involuntarily commit Brady Arnold Proffitt, Jr. as a sexually violent predator under the Sexually Violent Predator Act (SVPA). A clinical psychologist evaluated Proffitt and diagnosed him with sexual sadism disorder, antisocial personality disorder, and alcohol use disorder. She gave testimony during the trial that Proffitt was a sexually violent predator and at risk of reoffending if released without treatment. The Commonwealth then attempted to call two of Proffitt's rape victims as witnesses. Proffitt objected to the testimony as unfairly prejudicial because his rape conviction was already in evidence. The circuit court agreed and excluded the testimony.

Holding: The Supreme Court of Virginia ruled that the victim testimony was not unfairly prejudicial because the testimony would directly support the elements of the case that Proffitt met the statutory definition of a sexually violent predator.

Notable Point:

Rules of Evidence: The court conceded that the rules of evidence prohibit the introduction of evidence to prove that a defendant acted in conformity with a character trait. However, in the present case the material issue was whether Proffitt had a mental abnormality or personality disorder making him likely to engage in sexually violent acts in the future. The court explained that this made it proper to introduce evidence of specific conduct to prove the existence of a character trait that was a required element of the case.

State Court Decisions

Death Penalty and Intellectual Disability: Florida Supreme Court reaffirms the rejection of a bright-line IQ cutoff of 70 in determining eligibility for the death penalty and holds it would be a manifest injustice not to give a defendant the benefit of the three-pronged test set forth in the Supreme Court's decision in *Hall*.

Thompson v. State, 41 Fla. L. Weekly 510 (2016)

Background: William Lee Thompson was convicted of first-degree murder and sentenced to death for a 1976 murder committed when Thompson was 24 years old. His sentence became final in 1993. Thompson filed numerous post-conviction motions claiming he is ineligible for the death penalty because of intellectual disability. Thompson's IQ was measured by multiple experts with estimates ranging from 71–88. Thompson's most recent post-*Hall* motion was denied by the circuit court because his IQ scores were generally over 80 and *Hall* only required courts to consider IQ scores 75 and below.

Holding: The Florida Supreme Court reversed the circuit court and remanded the case for a new evidentiary hearing regarding Thompson's intellectual disability. In reaching its decision, the Florida Supreme Court rejected a bright-line IQ cutoff for intellectual disability and directed lower courts to apply all three prongs of the *Hall* test rather than relying on any one prong as dispositive.

Notable Point:

Retroactive Effect of Hall: In a short dissent two justices reject the idea that *Hall* should apply retroactively and would therefore have denied Thompson relief.

<u>Involuntary Commitment of Sexually Violent Predators</u>: Supreme Court of Kansas holds that an ad hoc analysis of all of the factors resulting in a pretrial delay must be used to determine whether a defendant's due process right to a speedy trial has been violated during proceedings for his involuntary civil commitment as a sexually violent predator.

In re Care & Treatment of Ellison, 384 P.3d 15 (Kan. 2016)

Background: Todd Ellison was a convicted sex offender, and the state of Kansas sought to have him involuntarily committed under the Kansas Sexually Violent Predator Act (KSVPA). The KSVPA allows for the civil commitment of persons alleged to be sexually violent predators after the completion of their criminal sentences. A person suspected of meeting the statutory definition of a sexually violent predator is entitled to a probable cause hearing and a jury trial during which the state must prove its case beyond a reasonable doubt. The state filed a probable cause petition against Ellison in June 2009, but his trial was delayed more than 4 years due to multiple continuances. Ellison filed a motion claiming the delay violated his due process right to a speedy trial. The district court ruled that the delay violated Ellison's due process rights and ordered his release. The court of appeals reversed and the state supreme court granted Ellison's petition for review to determine the appropriate standard to measure due process claims for pretrial delays in KSVPA proceedings.

Holding: The Kansas Supreme Court ruled that the ad hoc analysis from *Barker v. Wingo*, 407 U.S. 514 (1972) in which courts must weigh various factors including the length of the delay, reason for the delay, defendant's assertion of the right, and prejudice to the defendant applies to pretrial delays in KSVPA proceedings. The court held that the

district court did not err in weighing the different factors that caused the delay in Ellison's trial under the *Barker* analysis and affirmed the order for his release.

Notable Points:

Barker Factors: The court of appeals reversed the ruling of the district court on the assumption that too much weight was given to the 4-year delay and other factors were not properly considered. The Kansas Supreme Court emphasized that no one factor is either necessary or sufficient in determining whether a defendant's due process rights have been violated and that the district court had properly considered other factors in reaching its decision.

Reason for Pretrial Delay: The district court inquired into which party was responsible for the continuances that led to the delay in Ellison's trial. The court determined that some of the continuances were attributable to Ellison and others were by agreement. When the party responsible for any delay could not be determined, the court attributed it to the state. The court considered only the delay that was attributable to the state in reaching its decision in this case.

Not Guilty by Reason of Insanity (NGRI): Supreme Court of North Carolina rules that a prosecutor's closing argument exaggerating the likelihood of defendant's release if found not guilty by reason of insanity constituted prejudicial error because the statements were not supported by the evidence.

State v. Dalton, No. 336PA15, 2016 N.C. LEXIS 1121 (Dec. 21, 2016)

Background: Melissa Amber Dalton had a history of substance abuse and mental illness. She received inpatient treatment in July 2009 and was diagnosed with cocaine dependence, cannabis abuse, substance abuse mood disorder, borderline personality disorder, and intrauterine pregnancy. Dalton's treating physician prescribed Lexapro, an SSRI, but was unaware that Dalton had previously reacted negatively to a different SSRI. Dalton was released approximately three days later. About three weeks later, Dalton went to the apartment of two neighbors, claiming to have money she owed them. When the neighbors opened the door, Dalton stabbed both of them repeatedly, killing one and seriously wounding the other. Dalton was indicted for first-degree murder, first-degree burglary, and assault with a deadly weapon with intent to kill inflicting serious injury. Dalton pled not guilty by reason of insanity. During closing arguments, the prosecutor told the jury that if Dalton was found not guilty by reason of insanity that it was "very possible" she would be back home within 50 days. The jury found Dalton guilty on all counts. The court of appeals found prejudicial error in the prosecutor's closing arguments and granted Dalton a new trial.

Holding: The Supreme Court of North Carolina ruled that statements in closing arguments about a defendant's likelihood of release must be supported by evidence presented at trial. The court found no evidence to support the prosecutor's statement that it was "very possible" Dalton would be released within 50 days. The court affirmed the opinion of the court of appeals.

Notable Point:

Miranda Rights and Insanity Defense: On appeal the defendant also raised the issue of the prosecutor using evidence that she invoked her Miranda rights after arrest to prove she was sane. However, the court of appeals did not address this argument in reaching its decision and relied solely on the prosecutor's statement in closing arguments about her possibility of release.

Liability to Third Parties: Supreme Court of Washington rules that victims of violence committed by a person in outpatient mental health treatment are allowed to pursue a claim against a therapist for "medical negligence," even in the absence of any evidence that the patient made statements of any kind to the therapist that identified any intention to harm the plaintiffs, with the Court ruling that the "foreseeability" of the patient's attack on the plaintiffs was a question of fact for the jury.

Volk v. DeMeerleer, No. 91387-1, 2016 Wash. LEXIS 1374 (Dec. 22, 2016)

Background: In September 2001, Dr. Howard Ashby began treating Jan DeMeerleer, who had previously been diagnosed with bipolar and associated disorders. Ashby was aware of DeMeerleer's treatment history including that he had been hospitalized in 1992 for suicidal ideation and sought outpatient treatment in 1997 for suicidal ideation, and that he was prescribed Depakote both times, but stopped taking the medication because of side effects. Ashby prescribed DeMeerleer Depakote and noted that it would be necessary to monitor compliance with the medication regimen. In 2003, DeMeerleer learned his wife was having an affair, and they divorced shortly thereafter. He suffered severe depression and again expressed suicidal and homicidal thoughts, but assured Ashby that he would not act on them. In 2005, DeMeerleer began a relationship with Schiering. The relationship progressed rapidly but fell apart when DeMeerleer struck one of Schiering's sons in 2009. DeMeerleer also lost his job around this time. Ashby last met with DeMeerleer in April 2010, at which time he reported suicidal ideation but stated that he would not act on it.

DeMeerleer and Shiering attempted to mend their relationship, but Schiering ended it in July 2010. The next day DeMeerleer shot and killed Schiering and her son and attempted to kill her other son, who was able to escape. DeMeerleer then went home and took his own life. Schiering's mother and surviving son filed medical malpractice and medical negligence claims against Ashby alleging a failure to follow the accepted standard of care in treating DeMeerleer. Ashby moved for summary judgment on the basis that the attack was not foreseeable and that Ashby did not owe the victims a duty of care. The trial court granted summary judgment in favor of Ashby, but the court of appeals reinstated the medical negligence claim.

Holding: The Washington Supreme Court reaffirmed the common law of Washington that the state does not recognize a cause of action for medical malpractice for third parties. Regarding the medical negligence claim, the court relied on its decision in *Petersen v. State*, 100 Wash. 2d 421, 671 P.2d 230 (1983) to find that a "special relationship" existed between Ashby and DeMeerleer such that Ashby owed a duty of

reasonable care to DeMeerleer's foreseeable victims. The court explained that this duty extended to *anyone* who may foreseeably be endangered by a patient. The court recognized the difficulty of predicting behavior, but reasoned that requiring due care of mental health professionals counterbalanced that difficulty: as long as a mental health professional exercised due care (i.e., acted in line with standards of professional care) to reach an informed assessment of dangerousness, the professional would not be liable. The court found, however, that Ashby had not met such standards based on an affidavit from the plaintiff's forensic psychiatrist, which, the Court noted, asserted that "Ashby's failure to schedule additional meetings, follow up with DeMeerleer, and monitor DeMeerleer's condition was a breach of professional standards and was a causal and substantial factor of the harms that befell Schiering and her sons." The court held that whether Schiering and her sons were foreseeable victims was a material fact to be determined by a jury and, thus, summary judgment was inappropriate. The court remanded the case to consider the medical negligence claim.

Notable Point:

Dissent: A strongly worded dissent challenged the majority holding that mental health professionals can be held liable to third parties absent the ability to control the patient. The dissent argued that the holding significantly expands liability for mental health professionals and could chill the provision of mental health services.

Editor's note: Virginia practitioners should be familiar with Virginia Code Section 54.1-2400.1, entitled "Mental health service providers; duty to protect third parties; immunity," which sets out in clear language the circumstances that trigger a mental health provider's duty to take action to protect a third party from harm, and also describes the actions by the provider that "discharge" that duty. Compliance with this section gives immunity protection for providers from claims of various kinds.

IV. Institute Programs

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

The Institute continues to announce new offerings for the program year August 2016 through June 2017. Please visit and re-visit the Institute's website to see new and updated announcements. The Institute appreciates your interest and support for its programs. Please feel free to share this edition of *DMHL* and to share announcements of programs that may interest your professional, workplace, and community colleagues. Thank you.

Announced programs:

Substance use disorders and young people: Epidemiology, Impact, Treatment and Recovery

March 8 2017, Charlottesville VA: This one-day program with expert John Kelly PhD, ABPP will present and discuss substance use disorders and young people covering state of the art information about epidemiology, impact, treatment and recovery. Dr Kelly is Elizabeth R. Spallin Associate Professor of Psychiatry at Harvard Medical School, Harvard University.

Juvenile Forensic Evaluation: Principles and Practice

March 27-31 2017, 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.

Evaluation Update: Applying Forensic Skills with Juveniles

March 27, 28, 29 2017, 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 now to complete relevant qualifications to perform juvenile forensic evaluations

Assessing Individuals Charged with Sexual Crimes

April 26-27 2017, 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 re-offending, and well-researched sexual offender risk assessment instruments. This program may meet needs of providers for renewal of SOTP certification in Virginia.

Cognitive and social psychological bases of bias in forensic mental health evaluations

May 2 2017, Charlottesville VA: This one-day program with expert Tess Neal PhD integrates findings from cognitive neuroscience, cognitive psychology, and social psychology into the basic science of bias in human judgment as relevant to judgments and decisions by forensic mental health professionals. The program will be interactive, including experiential exercises and discussion activities to demonstrate the topics described. We close with a discussion of directions for future research and practice.

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

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