

DEVELOPMENTS IN MENTAL HEALTH LAW

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

Volume 36, Issue 1

Spring 2017

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I. Updates

The 2017 General Assembly Session: A New Framework, and Some New Money, for Virginia’s Public Mental Health System

There were a number of significant legislative and budgetary actions in the 2017 General Assembly session relating to mental health. Of particular importance was the General Assembly’s passage of legislation that establishes a comprehensive framework for Virginia’s community-based public mental health care system, built around ten mandated “core” services to be provided by local community services boards (CSBs) and behavioral health authorities (BHAs). This framework, originally presented by the Director of the Virginia Department of Behavioral Health and Developmental Services (DBHDS) as “STEP VA” (System Transformation, Excellence and Performance in Virginia), was supported by the Governor’s proposed budget, endorsed by the SJ 47 Joint

Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century, and reflected in bills introduced by Joint Subcommittee members. As part of its adoption of the STEP VA framework, the General Assembly appropriated additional funding to enable CSBs and BHAs to implement by 2019 two of the new core services of this new framework. The implementation of the new system in its entirety remains a years-long project that will extend into the next budget cycle. This action by the Governor and the General Assembly was particularly notable because it came in a session that had to grapple with a significant revenue shortfall.

The General Assembly also extended the life of the SJ 47 Joint Subcommittee for another two years, affirming the Joint Subcommittee members' consensus that their continued involvement was needed to ensure that meaningful positive change in the system of care will take place. Other important initiatives supported by the Joint Subcommittee were also successful in the session, including additional funding for Permanent Supportive Housing programs, and amendments to Virginia's drug prescription laws to increase the availability and utility of tele-mental health services. The specific proposals from the SJ 47 Joint Subcommittee, and their fates in the General Assembly session, are summarized in section A.

A number of other bills relating to mental health services, and a number aimed at addressing the current opioid crisis, were also introduced in this session, and are summarized in section B.

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

From Work Group #1: System Structure and Financing

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

The proposal: HB 1549 and SB 1005 (identical bills) were introduced as action items from the Joint Subcommittee to expand the "core services" to be provided by the state's community services boards (CSBs) and behavioral health authorities (BHAs). Currently, Virginia law mandates only the provision of emergency mental health services by CSBs and BHAs. Virginia Code Sections 37.2-500 and 37.2-601 also list "case management services" as being provided by these agencies, but this is specifically made "subject to the availability of funds appropriated for them." These bills would add eight other "core services" identified by the Commissioner of DBHDS as being necessary parts of the STEP VA model (System Transformation, Excellence and Performance in Virginia, see July 2016 issue of DMHL and Commissioner Barber's presentation) proposed by the Commissioner, and endorsed by the Joint Subcommittee, for community-based mental health services. (Case management services would also be expanded in nature and scope.)

The bills, and an accompanying budget request to pay for these expanded services, provided for phasing in the expansion of these core services, with two of the core services

—*same day access to mental health screening and timely access to assessment, diagnostic, and treatment services and outpatient primary care screening and monitoring services*—being the only new services mandated effective July 1, 2018. The rest of the “core” services under these bills would become mandated “core” services effective July 1, 2021, with the assumption that the funding to support these additional services would become a part of the state budget by that time.

General Assembly action: Amended versions of SB 1005 and HB 1549 were enacted that mandate the addition of the two new core services—same day access and primary care coordination—with an effective date of July 1, 2019. The General Assembly also approved appropriations to help pay for these two new core services, as requested by the Governor, but made no commitment to funding for the other services in the future. (Relatedly, through Budget Item 306 #8c the General Assembly approved additional funds to expand access for persons with serious mental illness to medical and mental health services provided under the Governor’s Medicaid GAP [Governor’s Access Plan] program to include all adults whose income is at or below the federal poverty level. (Previously eligibility was capped at 80% of the federal poverty level.) Based on the additional access to services provided by GAP expansion, the General Assembly reduced the Governor’s requested general funding for the new core service of “same day access.”)

Both enacted bills also include language that, while not currently modifying the Virginia Code, provide that, effective July 1, 2021, the core services provided by community services boards and behavioral health authorities will *also* include, (1) crisis services for individuals with mental health or substance use disorders, (2) outpatient mental health and substance abuse services, (3) psychiatric rehabilitation services, (4) peer support and family support services, (5) mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility, (6) care coordination services, and (7) case management services. The Department of Behavioral Health and Developmental Services is directed to report to the General Assembly by December 1 of each year on progress in implementing this. No funds were appropriated by the General Assembly for these additional services, which are not required by these bills until a later budget cycle.

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

The proposal: HB 1551 and SB 1006 (identical bills) proposed to amend Virginia Code Section 37.2-818 by enabling DBHDS to receive from the courts, upon request, copies of the records of involuntary commitment hearings, to enable DBHDS to maintain statistical archives and conduct research on the consequences and characteristics of such hearings.

General Assembly action: HB 1551 was enacted by the General Assembly, but with two key amendments to the original bill(s): (1) Section 37.2-818 now provides that, instead of being able to request the hearing records directly from the courts involved, DBHDS is authorized to request the records from the Office of the Executive Secretary of the

Virginia Supreme Court; (2) Section 2.2-3705.5 is amended to specifically provide that this information is exempt from the mandatory disclosure requirements of the Virginia Freedom on Information Act.

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 proposal: HB 1550 and SB 1007 (identical bills) proposed to 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. 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.

General Assembly action: The bills failed to make it out of committee in their respective houses.

4. Expanding telemental health services

The proposal: HJ 568 and SJ 257 (identical resolutions) proposed to direct the (Joint Commission on Health Care) 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.” This had been a specific recommendation from Work Group #1, based upon the substantial evidence of the effectiveness of tele-mental health services, particularly in providing vital services to under-served rural communities. (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](#).)

General Assembly action: Both resolutions failed to make it out of committee in their respective houses. However, the General Assembly did pass language directing such a study by the JCHC in Budget Item 30 #1c.

5. Study of Key Elements of the Mental Health Services System

In its report to the October 26, 2016 meeting of the Joint Subcommittee, Work Group #1 proposed a number of actions to improve the functioning of the state’s public mental health system as currently structured. One was to study the “statutory, policy, financing,

and administrative elements of the current mental health system” that are not “aligned” with the vision of system reform.

General Assembly action: In Budget Item 284 #2c, the General Assembly appropriated funds to the Office of the Secretary of Health and Human Resources (OSHHR) to create a plan for the “financial realignment” of Virginia's public behavioral health system. This plan will include such things as eliminating the “extraordinary barriers list,” made up of people ready for discharge from state hospitals but unable to find a community placement; ensuring continuity of care for individuals transitioning from the hospital to the community; using state funds to enable communities to treat individuals locally and avoid hospitalization; creating financial incentives for community services boards to serve individuals in the community rather than in state hospitals; developing employee transition plans to enable employees at downsizing state hospitals to find work in other DBHDS facilities or community services boards; determining what legislation and Appropriation Act language is needed to “achieve financial realignment;” and developing “matrices” for assessing performance outcomes.

However, the General Assembly removed from the budget the \$4.5 million that the Governor had included to enable Health and Human Resources to conduct a “statewide gap analysis of the community mental health system.”

From 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 proposal: HB 1783 proposed to 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. DCJS would provide training on the instrument. This proposal came out of the Work Group’s finding 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 have a mental illness

General Assembly action: The bill was slightly tweaked in the Courts of Justice subcommittee on Mental Health (by placing responsibility solely on the DBHDS Commissioner to designate the uniform screening instrument to be used by facilities), and passed through the Courts of Justice Committee without opposition. However, the bill did not make it out of the House Appropriations Committee. Similarly, SB 940, after having SB 933 (described below) incorporated into it, was passed by the Senate but did

not make it out of the House Appropriations Committee. (Implementation of the bill was estimated to carry a price tag of \$4.2 million annually for needed staff and training.) The General Assembly did enact a Budget amendment, Item 70 #1c, which requires every local and regional correctional facility to screen every inmate entering the facility for mental illness, with a “scientifically validated” instrument designated by the Commissioner of DBHDS for such screening and capable of being administered by staff other than a health care provider if such staff are trained to use the instrument.

On the Senate side, SB 940 (“*Requiring the use of a standardized instrument by jails to screen individuals for mental illness during intake process*”), was similar to HB 1783 but directed that the Director of DBHDS would designate the “scientifically validated instrument” to be used to screen correctional inmates to identify those needing mental health services. (HB 1783 was later amended in the House to match that language.) In addition, SB 933 (which would have amended 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) was incorporated into SB 940 before SB 940 was passed by the Senate.

General Assembly action: While the bill easily passed the Senate, it failed to make it out of the House Appropriations Committee.

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

The proposal: HB 1784 and SB 941 (identical bills) proposed to direct the Commissioner of DBHDS, in consultation with relevant stakeholders, to develop and submit 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. It would be submitted to the Joint Subcommittee (and to the House and Senate Committees for Courts of Justice) by November 1, 2017.

General Assembly action: The bills were enacted by the General Assembly.

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

The proposal: SB 942 proposed to 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. This proposal was prompted by concerns over the adequacy of the investigation by the State Office of the Inspector General into the death at the Hampton Roads Regional Jail of Mr. Jamycheal Mitchell, a young man with serious mental illness who

had been charged with petty larceny and who, at the time of his death in the jail, had been waiting for a period of months for transfer to Eastern State Hospital for inpatient restoration of competency to stand trial.

General Assembly action: While still in the Senate, SB 942 was incorporated into SB 1063, introduced by Senators Deeds and Cosgrove, which also addressed the investigative authority of the Board of Corrections. Amendments were added to the version of SB 1063 that was enacted by the General Assembly. Those amendments specify that the BOC’s membership must include a current or former sheriff or other correctional official; an employee of a public mental health services agency with relevant training or experience; an individual with experience overseeing compliance by a correctional or mental health facility with legal requirements; an individual with experience with vocational education; two individuals with experience with conducting criminal, civil or death investigations; and a citizen member representing community interests. Under the bill, the BOC has the power to develop policies and procedures on the investigation of deaths in correctional facilities, and to carry out (at its discretion) investigations into any such deaths and issue reports and recommendations for correctional changes to the General Assembly, and also require facilities to make changes where problems are found. The BOC can request staff support from the Department of Corrections, but such staff are considered agents of the Board when doing this work. In addition, the BOC can request the Office of the State Inspector General (OSIG) to conduct an investigation if the entity involved falls within the jurisdiction of the OSIG. Budget Item 394 #1c funds one staff position for BOC investigations.

From Work Group #3: Mental Health Crisis and Emergency Services

1. Alternative transportation services for persons in mental health crisis

The proposal: SB 1221, which was introduced after findings by the Joint Subcommittee confirming the safety and efficacy of using transport services *other* than law enforcement for most transportation of individuals in mental health crisis, proposed to require DBHDS and DCJS to develop a model for “alternative” transport. The agencies are to include the stakeholders identified in the bill (as well as any others that the agencies wish to add) in the process of developing this model. The heads of DBHDS and DCJS are directed to also “identify any barriers to the use of alternative transportation in the Commonwealth and detail the costs associated with the implementation of such a model, along with the cost savings and benefits associated with the successful implementation of such a model.” The proposed model is to be submitted to the SJ 47 Joint Subcommittee and the House and Senate Courts of Justice Committees by October 1, 2017.

General Assembly action: This bill was enacted by the General Assembly without opposition.

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

The proposal: HB 1767 and SB 1009 (identical bills) proposed to 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 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 state-based registrations as making the site an authorized site under federal law.)

General Assembly action: With just a few amendments, including language to confirm the range of medical practitioners authorized under this bill to prescribe controlled substances via telemedicine, HB 1767 and SB 1009 were enacted by the General Assembly.

From Work Group #4: Housing

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

The proposal: A budget amendment (Item 315 #2s) was 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 were identified for three positions to oversee the program. This initiative was prompted by the Joint Subcommittee’s findings that permanent supportive housing has a dramatic positive effect on the stability of individuals who have serious mental illness, significantly reducing their use of costly emergency services, reducing their involvement in the criminal justice system, and providing them with a higher quality of life at a lower cost to government.

General Assembly action: The General Assembly approved \$4,900,000 of the \$10,260,000 request for additional funding for permanent supportive housing in an amendment identified as Item 315 #1s.

2. Develop strategies for housing individuals with serious mental illness

The proposal: A budget amendment was 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 as Item 108 #2h on the House side.

General Assembly action: The General Assembly approved this language in Budget Item 108 #1c, though no funds were appropriated to carry out this work.

3. Financing permanent supportive housing services through Medicaid

The proposal: A budget amendment was 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 was identified as Item 306 #34s when introduced to the Senate, and Item 306 #34h in the House. This action was requested because of the finding by the Joint Subcommittee 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.

General Assembly action: The Senate approved this initiative, without any additional funding, as Item 306 #13s. The House approved identical language in Item 306 #34h.

Extending the Joint Subcommittee

The proposal: HJ 637 and SJ 279 were introduced to continue the SJ 47 Joint Subcommittee through December 1, 2019. This was done after the members of the Joint Subcommittee, in a public discussion at its December 6, 2016 meeting, expressed their agreement 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.

General Assembly action: Both of these bills failed to make it out of the House Rules Committee. However, the General Assembly did pass Budget Item 1 #11c, which provides: “Notwithstanding any other provision of law, the Senate Joint Resolution 47 (2014 Session) Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century shall continue its work until December 1, 2019." A separate budget item, 6 #1c, provides additional funding for the Joint Subcommittee’s work.

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

1. Successful Bills

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 (operating as The disAbility Law Center of Virginia authorized under Section 51.5-39.13) a written report on critical incidents or deaths of individuals in DBHDS facilities. The amendment proposed to expand the reporting requirement to include any such incidents occurring in facilities or in programs that are operated or licensed by the Department. Reports are due within 15 working days of the critical incident or death. (Senate version: SB 894 (Favola))

General Assembly action: Amended versions of HB 1508 and SB 894 were enacted, with the House and Senate each adding modifying language that largely serves to define the terms “critical incidents” and “serious injuries” through references to code sections and regulations where the terms are currently defined.

HB 1548 (Farrell) **Advance directives; (1) authorizing certain professionals to activate an advance directive in regard to consenting to admission to a mental health facility; (2) authorizing additional professionals to confirm capacity of a person to execute a “protest provision” in an advance directive.** This bill proposed to do the following:

- (1) Amend 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 (a) the attending physician, (b) a psychiatrist, (c) a licensed clinical psychologist, (d) a licensed psychiatric nurse practitioner, or (d) a designee of the local community services board, following an in-person evaluation. Admission to the facility must still meet the requirements of Section 37.2-805.1, and the person’s capacity to give informed consent to treatment following admission must be separately determined.
- (2) Amend Virginia Code Section 54.1-2986.2 to provide that, if a person executes a “protest provision” in their advance directive (giving the person’s agent the authority to consent to treatment even over the person’s objection after the person has lost capacity to make informed decisions) the person’s capacity to make the decision to give the agent this authority can be confirmed in writing not only by an attending physician or licensed clinical psychologist (the current requirement) by also by (a) a licensed physician assistant, (b) a licensed nurse practitioner, (c) a licensed professional counselor or (d) a licensed clinical social worker. (Senate version: SB 1511 (Deeds))

General Assembly action: Amended versions of HB 1548 and SB 1511 were enacted by the General Assembly. The amendments were to the provisions modifying Section 54.1-2983.2, and included the following: (1) A person must specifically provide in their advance directive that a single physician, psychiatrist, etc. may activate their advance directive in regard to consenting to admission to a psychiatric hospital in order for this provision to take effect. (2) The list of professionals authorized to make this determination was expanded to include licensed clinical social workers.

HB 1567 (Orrock) *Advance directives; requiring that persons applying for medical assistance services and social services be informed about advance directives.* This bill proposed to amend 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.

General Assembly action: This bill was enacted as proposed.

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.* This bill proposed to amend 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))

General Assembly action: This bill was enacted as proposed.

HB 1747 (O’Bannon) *Advance directives; authorizing persons trained as facilitators to assist individuals in completing advance directives, and allowing “ministerial” assistance.* This bill proposed to amend Virginia Code Sections 54.1-2982 and 54.1-2988, and adds Sections 54.1-2988.1 and 54.1-2993.1, to authorize additional persons to help people complete their advance directives. Because advance directives are enforceable legal documents, the Virginia State Bar has taken the position that assisting a person in completing one constitutes the practice of law, so that non-lawyers would be engaged in the “unauthorized practice of law” (“UPL”) if they were to assist someone. The current Section 54.1-2988 exempts only “health care providers” without defining that term. The bill provides 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 “UPL.” The bill also defines “health care provider” and specifies that health care providers’ “authorized agents and employees” are also included in the exemption from the UPL restriction. Finally, the bill provides that any person can provide “ministerial” assistance (which is defined in the bill) to another person to help that person complete an advance directive without violating UPL standards. (Senate version: SB 1242 (Dunnavant))

General Assembly action: Amended versions of HB 1747 and SB 1242 were enacted by the General Assembly. The primary amendment was to remove the statutory approval of specified facilitator training programs and leave such approval in the discretion of the Department of Health.

HB 1750 (O’Bannon) *Naloxone; authorizing Commissioner of Health to issue a standing order for the dispensing of Naloxone for overdose reversal.* This bill proposed

to amend 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.

General Assembly action: This bill was enacted by the General Assembly without any changes to the bill as submitted.

HB 1777 (Stolle) *Board of Health regulations on admission of persons to psychiatric facilities; procedures regarding denial of admission.* This bill proposed to amend 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.

General Assembly action: An amended version of HB 1777 was enacted to require such communication between the referring physician and the on-call physician in the psychiatric unit only if such communication is requested by the referring physician.

HB 1845 (Cox) *Local and regional correctional facilities; addiction recovery program to be developed by DCJS.* This bill proposed to add 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.

General Assembly action: This bill was enacted, though only after a Senate amendment added, but then withdrew (following House opposition), language that would have made this provision effective only after funding for developing the model addiction recovery program had been provided. Budget Item 398 #3c provides continuing funding to the Department of Criminal Justice Services “to award grants for up to four pilot sites administering model addiction recovery programs in local or regional jails, pursuant to House Bill 1845.”

HB 1885 (Hugo) *Prescribing controlled substances containing opioids; limits set.* This bill proposed to amend Virginia Code Section 54.1-2522.1 and to add 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.

General Assembly action: An amendment in the nature of a substitute for HB 1885 was approved by the General Assembly. The enacted version maintains the proposed 7-day limit on opioid prescriptions, but does *not* include the broad exceptions proposed in the

original bill's new Section 54.1-3408.05; instead, it keeps intact the listed exceptions to that limit that are already set out in Section 54.1-2522.1(C). In addition, it *further* limits one of those listed exceptions by allowing the prescribing of an opioid to a patient “as part of treatment for a surgical or invasive procedure” only for a maximum of 14 consecutive days. The law has a sunset provision for July 1, 2022.

HB 1898 (Bell) *Prescribing controlled substances containing opioids in emergency department setting; limits.* This bill proposed to amend 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: **SB 1232** (Dunnavant))

General Assembly action: HB 1898 did not make it out of the Health, Welfare and Institutions Committee in the House. Instead, an amendment in the nature of a substitute for SB 1232 was passed by the Senate. The language in that amendment significantly re-wrote SB 1232, with provisions that are identical to the enacted HB 1885.

HB 1910 (Yost) *Physician assistant as “mental health provider”; duty to take protective action when client threatens harm to a third party.* This bill proposed to amend 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))

General Assembly action: These bills were enacted without any changes to the language of the bills as submitted.

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.* This bill proposed to amend 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 would also amend 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.

General Assembly action: The General Assembly enacted an amendment in the nature of a substitute for HB 1944 that was introduced in the House. The enacted bill does not include the new code sections on notice, review and comment that were part of the original bill. Instead, it adds subsection E to Code Section 2.2-4007.4, requiring each department to revise and reissue its economic impact analysis if, as a result of public comment, it finds either “significant errors” in its original analysis or a “significant or material difference” between its analysis and the public comment on the “anticipated negative economic impacts to the business community” that would “materially change”

the Department's analysis. The amendment specifies that the Department's decision on any such finding is final and not subject to judicial review.

HB 1944 (Hope) *Defendants ordered restored to competency in hospital setting; 10 day limit for transfer to hospital for competency restoration.* This bill proposed to amend 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. (Additional time is allowed when the 10th day falls on a weekend or holiday.)

General Assembly action: An amended version of HB 1944 was enacted by the General Assembly. The changes provide that the defendant must be transferred to “and accepted by” the hospital for treatment within 10 days of the hospital's “receipt” of the court's order.

HB 2095 (Price) *Creation of categories “peer recovery specialist” and “qualified mental health professional” as professional positions registered by the Board of Counseling.* This bill proposed to amend 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))

General Assembly action: Some minor modifications to each bill were made, and the amended bills were enacted.

HB 2161 (Pillion) *Education of health care professionals on prescribing opioids; task force.* This bill proposed to direct 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))

General Assembly action: The General Assembly enacted this bill, with the only change being a finding that an emergency exists, thereby putting the legislation in force “from its passage.”

HB 2163 (Pillion) *Prescription of buprenorphine without naloxone; limitation.* This bill proposed to add 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))

General Assembly action: The bills were enacted (HB 2163 and SB 1178) with amendments that allowed these prescriptions not only for patients who are pregnant, but also “when converting a patient from methadone to buprenorphine containing naloxone for a period not to exceed seven days,” and “as permitted by regulations of the Board of Medicine or the Board of Nursing.” The bills, which have a sunset date of July 1, 2022, were enacted as emergencies.

HB 2165 (Pillion) ***Opiate prescriptions; requiring that prescriptions be solely electronic by 2020.*** This bill proposed to amend various 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))

General Assembly action: The bills were enacted (HB 2165 and SB 1230) with several amendments. The key substantive amendments required the inclusion of specific stakeholder groups in the Secretary’s work group, and directed that the work group also evaluate the “hardships” experienced by prescribers in trying to comply with this requirement by the deadline and to make recommendations to the General Assembly on “extension or exemption processes relative to compliance or disruptions due to natural or manmade disasters or technology gaps, failures or interruptions of services.”

HB 2183 (Yost) ***Medicaid; providing for suspension instead of termination of Medicaid eligibility for persons who are incarcerated more than 30 days.*** This bill proposed to amend 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.

General Assembly action: A substitute version of HB 2183 was enacted which, instead of amending the Virginia Code, directs DMAS to convene a work group to find ways to streamline the application and enrollment process for services under Medicaid and FAMIS for “eligible incarcerated individuals” so that such services are available to those individuals “immediately upon release from the correctional facility.”

HB 2184 (Yost) ***Psychiatric hospitalization of inmates; ensuring required evaluations are performed.*** This bill proposed to amend 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.

General Assembly action: The amended HB 2184 directs the person with custody of the inmate to advise the appropriate community services board that a preadmission screening is needed, and to contact the CSB’s director or other senior management if there is no response or a failure to complete the screening.

HB 2258 (Filler-Corn) ***Suicide awareness and prevention; directive for comprehensive statewide initiative.*** This bill proposed to direct 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.

General Assembly action: A substitute version of HB 2258 was enacted that, instead of mandating a task force at the Secretariat level for a statewide campaign, directed DBHDS to report by December 1, 2017, to the Governor and the General Assembly on its activities related to suicide prevention across the lifespan pursuant to § 37.2-312.1 of the Code of Virginia.

HB 2457 (Garrett) ***Health and Human Resources Secretariat; single state agency for data collection and sharing; report.*** This bill proposed to amend Virginia Code Section 2.2-212 (which creates the position of Secretary of Health and Human Resources), by providing in subsection B that the agencies of this Secretariat “shall be deemed a single state agency for the purposes of data collection and sharing and shall share data, records, and information about applicants for and recipients of services from the agencies of the Secretariat, to the extent allowed by federal law.” The stated purposes for establishing this “single agency” status for the multiple departments of the Secretariat (including the Department of Health, the Department of Behavioral Health and Developmental Services BHDS, the Department of Aging and Rehabilitative Services, the Department of Social Services, and the Department of Health professions): (i) streamlining administrative processes and reducing administrative burdens on the agencies, (ii) reducing paperwork and administrative burdens on the applicants and recipients, and (iii) increasing access to and quality of services provided by the agencies. A report from the Secretary on implementation would be due on October 1, 2017.

General Assembly action: A substitute version of HB 2457 was enacted by the General Assembly. The enacted bill does not deem the Secretariat to be “a single state agency,” and instead provides that, “as requested by the Secretary and to the extent authorized by federal law,” the agencies of the Secretariat will share information. The purposes for such sharing remain the same. The Secretary is to report to the Governor and General Assembly on implementation of these provisions by October 1, 2017.

SB 848 (Wexton) ***Naloxone; authorizing more individuals to administer naloxone for purposes of opioid overdose reversal.*** This bill proposed to amend 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. (House version: HB1453 (LaRock))

General Assembly action: With an amendment offered as a substitute, SB 848 was enacted by the General Assembly, with the enacted bill providing that it is an exception to any other applicable law (as opposed to the original bill’s narrower exception, providing that it was effective “notwithstanding the provisions of Section 54.1-3310” only). In addition, the enacted bill specifies that the dispensing of the naloxone “may occur at a site other than that of the controlled substance registration,” provided that “the entity possessing the controlled substances registration maintains records in accordance with regulations of the Board of Pharmacy.” The original bill did not address this.

SB 935 (Lucas) ***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.*** This bill proposed to amend 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 of a defendant who has been found by a court to be incompetent to stand trial).

General Assembly action: The Senate enacted a substitute version of SB 935 that kept the same language of the original bill and incorporated SB 895 (which had identical language) into it.

SB 975 (Lucas) ***CSBs and regional jails; responsibility for psychiatric hospital pre-admission screening for jail inmates from CSB’s jurisdiction.*** This bill proposed to amend 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.

General Assembly action: Both the Senate and the House added amendments, so that the enacted SB 975 now requires each CSB that serves a county or city that participates in

the regional jail to “review any existing Memorandum of Understanding between the community services board and any other community services boards that serve the regional jail to ensure that such memorandum sets forth the roles and responsibilities of each community services board in the preadmission screening process, provides for communication and information sharing protocols between the community services boards, and provides for due consideration, including financial consideration, should there be disproportionate obligations on one of the community services boards.”

SB 1180 (Chafin) *Prescribing of opioids and buprenorphine; Boards of Dentistry and Medicine to adopt regulations.* This bill proposed to add 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.

General Assembly action: The bill was enacted by the General Assembly, with language added to require annual reporting by the Prescription Monitoring Program regarding “unusual patterns of prescribing or dispensing of a covered substance by an individual prescriber or dispenser or on potential misuse of a covered substance by a recipient.”

1(a). A Bill Reborn Through a Budget Amendment

HB 1894 (Herring) *Law enforcement training; DCJS to train on community “engaged” policing.* This bill proposed to amend Virginia Code Section 9.1-102 to provide that DCJS training of local law enforcement should 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))

General Assembly action: This bill did not make it out of the House Appropriations Committee. However, the General Assembly did enact Budget Item **395 #1c**, which requires DCJS, “in conjunction with the relevant stakeholders” to review all compulsory minimum training standards for law enforcement officers and ensure that those standards “appropriately educate law-enforcement officers in the areas of mental health, community policing, and serving individuals who are disabled.” DCJS is to identify available resources for helping officers deal with situations related to mental health, and identify what resources are needed. Any updates to the compulsory minimum training standards shall be completed by October 1, 2019, and shall be reported to the Chairmen of the House Committees on Militia, Police, and Public Safety, Courts of Justice, and Appropriations, and to the Chairmen of the Senate Committees for Courts of Justice and Finance.

2. Unsuccessful Bills

[Limited details are included here but more information can be found in the Winter 2016 issue of DMHL.]

HB 1480 (Helsel, Boysko, Kory and Peace) *Mental health awareness training for emergency services professionals.* (Senate version: SB 1064 (Deeds))

General Assembly action: While an amended version of the bill made it out of the Senate, the bills failed to make it out of committee in the House.

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.*

General Assembly action: The bill failed to make it out of committee.

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.*

(Senate version: SB 1443 (Barker))

General Assembly action: Both bills failed to make it out of committee in their respective houses.

HB 1918 (Robinson) *Establishing an 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.* (Senate version: SB 1222 (Barker))

General Assembly action: Although SB 1222 was approved by the Senate, neither bill was able to make it out of committee in the House.

HB 1930 (Carr) *Drug overdose; expanding protection for reporting.*

General Assembly action: This bill did not make it out of the House Courts of Justice committee.

HB 1948 (Peace) *Drug possession convictions; “recovery community organization” included as treatment option in court sentencing disposition.*

General Assembly action: This bill did not make it out of the House Courts of Justice Committee.

HB 1975 (Yost) *Temporary detention pending involuntary commitment hearing; setting a minimum time period (23 hours) of detention.*

General Assembly action: This bill did not make it out of the House Courts of Justice Committee.

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.*

General Assembly action: This bill did not make it out of the House Courts of Justice Committee.

HB 2042 (Murphy) *Suicide prevention; continuing education requirements for health care providers.*

General Assembly action: This bill did not make it out of the Health, Welfare and Institutions Committee.

HB 2059 (Watts) ***Drug Treatment Court; expanding offenders who are eligible to participate in Drug Treatment Court.*** (Senate version: SB 1227(Barker))

General Assembly action: Both bills were left in the House Courts of Justice Committee.

HB 2109 (Kory) ***Service dogs for persons with disabilities; expansion of approved activities for service dogs.***

General Assembly action: This bill did not make it out of the Health, Welfare and Institutions Committee.

HJ 597 (Marshall) ***Heroin use in the Commonwealth; JCHC to study.***

General Assembly action: The resolution failed to make it out of the House Rules Committee.

HJ 616 (O'Bannon) ***Health care quality in jails; JCHC to study.***

General Assembly action: The resolution failed to make it out of the House Rules Committee

HJ 695 ***Sentencing of drug offenders; JLARC to study effectiveness of approaches.***

General Assembly action: The resolution failed to make it out of the House Rules Committee

SB 797 (McDougle) ***Competency to stand trial; court discretion to order additional evaluation.***

General Assembly action: The bill failed to make it out of the Senate Finance Committee.

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

General Assembly action: The bill failed to make it out of the Senate Courts of Justice Committee

SB 1078 (Edwards) ***DBHDS; Catawba State Hospital expansion to include a step-down facility of 40 or more beds for individuals who no longer require acute care.***

General Assembly action: The bill failed to make it out of the Senate Rules Committee.

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.***

General Assembly action: This bill did not make it out of the Senate Finance Committee.

II. Update

Federal Government Finalizes Changes to 42 CFR Part 2 (Confidentiality of Substance Use Disorder Records)

The U.S. Department of Health and Human Services (HHS) published in the Federal Register on January 17, 2017 the Final Rule making changes to 42 CFR Part 2, the federal regulations formerly entitled “Confidentiality of Alcohol and Drug Abuse Patient Records” and now re-titled “Confidentiality of Substance Use Disorder Patient Records.” (The published rule is available at <https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records>). The new regulations were first scheduled to become effective on February 17, 2017. The effective date was postponed by the new administration as part of an Executive-branch-wide regulatory review process, and appears to have been finalized on March 21, 2017.

These are the first changes to the 42 CFR Part 2 regulations since they were first published in 1975. A written announcement by SAMHSA (the Substance Abuse and Mental Health Services Administration) states that the goal of the changes was “to facilitate health integration and information exchange within new health care models while continuing to protect the privacy and confidentiality of patients seeking treatment for substance use disorders.”

The SAMHSA announcement reminds readers that the 1975 regulations were enacted “because of the concern that if the identities of people in treatment for substance use were revealed those patients might be subject to criminal prosecution and a wide range of other serious social consequences,” and thereby deter people from seeking needed treatment. The new regulations attempt to remain true to the original mission, while recognizing changes in the health care delivery system, and the need to “promote health integration and permit appropriate research and data exchange.” “This final rule,” the announcement claims, “carefully balances the public health benefits of information exchange and continued protection of patient privacy.”

Some of the changes highlighted in the announcement were:

- Any “lawful holder of patient identifying information” can “disclose Part 2 patient identifying information to qualified personnel for purposes of conducting scientific research if the researcher meets certain regulatory requirements. SAMHSA also permits data linkages to enable researchers to link to data sets from data repositories holding Part 2 data if certain regulatory requirements are met. These will enable more needed research on substance use disorders.”
- In completing an authorization form for release of patient information, a patient can consent to disclosing their information “using a general designation to individual(s) and/or entity(-ies)(e.g., “my treating providers”) in certain circumstances. This change is intended to allow patients to benefit from integrated health care systems. This provision also ensures patient choice, confidentiality, and privacy *as patients do not have to agree to such disclosures.*” (emphasis added)

- Those patients who do make a more general disclosure designation also have the option to receive, upon their request, a list of entities to whom their information has been disclosed. (The Legal Action Center has pointed out that the new regulations also require the authorization form to be more specific in the section setting out the “Amount and Kind” of information to be disclosed.)
- “SAMHSA has made changes that outline the audit or evaluation procedures necessary to meet the requirements of a CMS-regulated accountable care organization or similar CMS-regulated organizations (including CMS-regulated Qualified Entities)...”
- The rule has been updated “to address both paper and electronic documentation.”

SAMHSA also notes that it is developing “additional sub-regulatory guidance and materials on many of the finalized provisions,” and that it will be monitoring compliance with the new regulations. In addition, it is looking at issuing “some additional clarifications and suggestions, especially regarding the important role of contractors, subcontractors and legal representatives in the health care system with respect to payment and health care operations.”

III. ILPPP Data Corner

Timelines of Emergency Prescreenings Conducted at Community Service Boards

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Every year in Virginia, tens of thousands of emergency evaluations are conducted to assess the needs of people in mental health crises. Community Services Board (CSB) “prescreeners” (i.e., people “who [are] skilled in the diagnosis and treatment of mental illness and who [have] completed a certification program approved by the Department,” Va. Code §§ 37.2-808 and 809) are required to perform these screenings if the client is to receive involuntary inpatient admission through a temporary detention order (TDO), or if they are to be placed at a crisis stabilization unit (CSU). They may also agree to conduct emergency screenings for other purposes, such as enrolling the person in outpatient therapy or recommending them for voluntary hospitalization. Due to the fact that every individual in psychiatric crisis must have access to a hospital bed if needed, the CSB prescreening process has been under increased scrutiny from the General Assembly. In January 2015, House Bill 2368 (HB2368) was introduced in response to concerns about tardiness on the part of CSB prescreeners. The bill’s purpose was to establish a workgroup to develop a plan for ED physicians to conduct TDO prescreenings “where appropriate to expedite emergency evaluations.” The work of the HB2368 workgroup led to data collection on the prescreening process.

Emergency prescreenings are most often conducted in hospital emergency departments (ED), but they can take place anywhere. One of the more commonly used alternate sites is the CSB office. While another report recently release by the Department of Behavioral

Health and Developmental Services (DBHDS) delves into ED-based prescreenings, this ILPPP data corner focuses on prescreenings conducted at CSB offices, and the amount of time taken on different parts of the process.

Data Source

A survey of CSB prescreeners was conducted from November 7-20, 2016. The survey was filled out in real time for all emergency evaluations that were completed during the survey time frame, except for recommitment evaluations. It contained questions on the time in which different parts of the prescreening time line were started or completed, in addition to some information about the initial circumstances of referral and the outcome of the evaluation.

Results

During the survey time frame, 250 evaluations took place at CSB offices statewide out of a total of 1843 evaluations. There were diverse reasons for these emergency evaluations (Figure 1). The most common were the mandatory evaluations: TDO (36%) and CSU (31%). The other third of evaluations consisted of other consults, in which a person is evaluated without a preconceived idea of which treatment they might need, and evaluations for outpatient services, substance abuse services and voluntary hospitalization. Five survey forms did not indicate a reason for screening. Most of the 87 TDO evaluations were started in a timely manner, with only 1 evaluation (1%) taking more than two hours after initial contact with the CSB emergency services unit to start. Time from initial contact to evaluation could not be calculated for one of the TDO forms.

Prescreeners took longer to begin hospitalization-related prescreenings (Table 1) than other prescreenings (Chi-square=8.5, df=1, p=0.0035), possibly due to time spent waiting for the client to arrive at the CSB office. Even with the longer starting times, most of the time from initial contact alerting the CSB to the need for an evaluation to the end of the evaluation was spent on the face to face part of the evaluation (median 75%, IQR 50-89). Among other types of prescreenings (Table 2) the median percentage of time spent on the face to face part of the evaluation was 86% (IQR 65-100).

These bed search timeframes (Table 3) should be interpreted with caution because the missing data percentages ranged from 16-23%. With this caveat in mind, the greatest source of delay between patient contact and acceptance for a hospital bed appears to be the bed search (median 41% of time taken, IQR 28-64). In some instances, considerable time is also spent between recommending the person for hospitalization and beginning the bed search. Many psychiatric facilities require a person to be cleared medically before they will accept them. While some CSB offices have medical staff available, others do not. In such cases, the prescriber may decide to relocate the person to an ED for medical testing before starting the bed search.

Figure 1: Reasons for prescreening indicated among CSB office-based surveys (n=245).

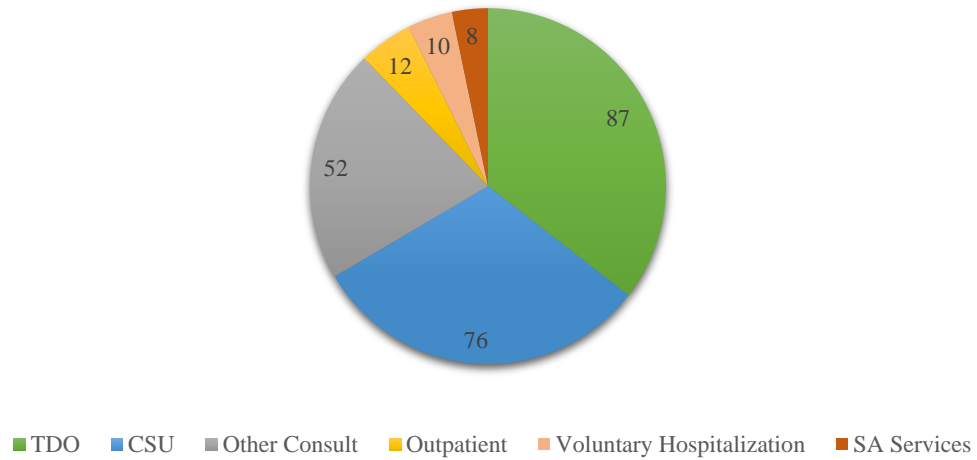


Table 1: Time taken (in minutes) for different components of the prescreening process up until end of evaluation, where the evaluation site is a CSB and the client is referred for possible hospitalization (TDO or voluntary, n=97).

Prescreen Component	Median Time	Interquartile Range	Missing Data
From contact to arrival at the CSB	0	0-5	0
From arrival on site to start of evaluation	9.5	0-30	1
From start of evaluation to start of FTF* part of evaluation	0	0	1
From start of FTF part of evaluation to end of evaluation	60	45-75	5
Total time from contact to end of evaluation	81	60-115	4

*FTF=Face-to-Face

Table 2: Time taken (in minutes) for different components of the prescreening process up until end of evaluation, where the evaluation site is a CSB and the client is referred for a reason other than hospitalization (n=148).

Prescreen Component	Median Time	Interquartile Range	Missing Data
From contact to arrival at the CSB	0	0	10
From arrival on site to start of evaluation	5	0-15	6
From start of evaluation to start of FTF* part of evaluation	0	0	0
From start of FTF part of evaluation to end of evaluation	60	35-82	4
Total time from contact to end of evaluation	70	45-111	13

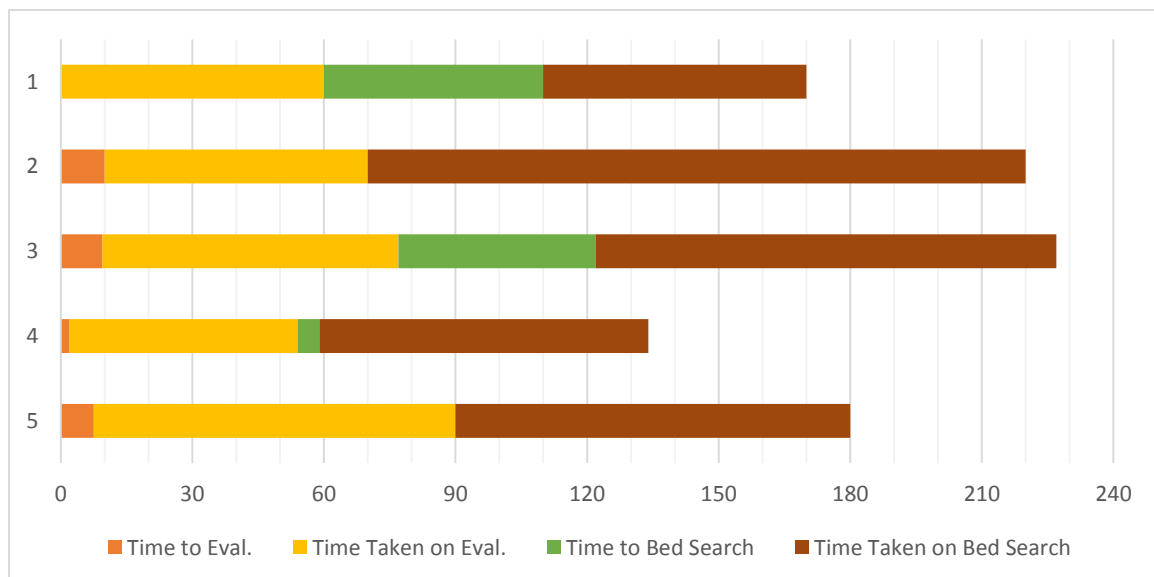
*FTF=Face-to-Face

Table 3: Bed search time frames in minutes for patients who were recommended for hospitalization, and whose evaluations took place in a CSB (n=73).

Timeframe	Median	Interquartile Range	Missing data
Time from the end of the evaluation to the start of the bed search	12.5	0-47.5	17
Time from the start of the bed search to the evaluatee’s final acceptance for a hospital bed	98	45-150	14
Time from initial contact to final acceptance for a hospital bed.	225	151-310	12

Figure 2: Time taken on elements of the prescreening process for patients who were recommended for hospitalization and whose evaluations took place in a CSB (n=73), by health planning region (HPR).

Conclusions



The process for screening someone at a CSB office appears to be efficient, with most of the time to recommendation spent on the important and necessarily time-consuming process of conducting the evaluation itself. Because CSB offices typically have prescreeners on site, the time taken before starting the evaluation is much shorter. In spite of these advantages, those clients who are ultimately recommended for hospitalization can spend hours waiting for a facility to accept them.

IV. Case Law Developments

Federal Circuit Court Decisions

Eighth Amendment/Conditions of Confinement/Deliberate Indifference: Seventh Circuit reverses grant of summary judgment to contract psychiatrists in state prison system where inmate with serious mental illness alleges that psychiatrists effected his transfer out of a special mental health treatment unit in retaliation for the inmate's grievances against staff, resulting in denial of effective treatment.

Rasho v. Elyea, No. 14-1902, 2017 U.S. App. LEXIS 3976 (7th Cir. Mar. 7, 2017)

Background: Ashoor Rasho arrived at an Illinois prison in 2003. Rasho had a history of mental illness including auditory hallucinations, severe depression, agitation, self-mutilation, and suicide attempts. In April 2004, he was transferred to the prison's mental health unit after he stopped taking his medication and his symptoms began to escalate. Rasho remained in the mental health unit at the prison until November 2006, when he was transferred to one of the prison's segregation units. Rasho claimed that he was transferred out of the mental health unit in retaliation for complaints he had filed, and not based on a determination that he no longer required treatment. He further alleged that he was denied mental health care for 20 months after the transfer. He filed suit against the staff psychiatrist who recommended the transfer, the warden, medical director, and director of mental health. The district court granted summary judgment for all of the defendants.

Holding: The Seventh Circuit reversed the grant of summary judgment for the individuals who ordered Rasho's transfer out of the mental health unit finding that sufficient evidence was presented for a reasonable jury to conclude that the reason for the transfer was retaliation for the complaints. The court affirmed the grant of summary judgment for the remaining defendants (i.e., the warden, the director of mental health, the medical director) finding they were not personally responsible for the transfer decision.

Notable Points:

§ 1983 Liability: The court explained that an inmate must show a defendant is personally responsible for a violation of the inmate's constitutional rights to hold that defendant liable under § 1983. The defendant need not have participated directly in the constitutional violation, but must have known about the conduct or facilitated,

condoned, approved or turned a blind eye to the violation to be subject to § 1983 liability.

Qualified Immunity: The Seventh Circuit interpreted the U.S. Supreme Court's denial of qualified immunity to employees of private prisons to extend to employees of private corporations that contract with the state to provide medical care to prisoners.

Injury: The Seventh Circuit rejected the district court's suggestion that Rasho could not establish he was harmed by the transfer because he self-mutilated both before and after the transfer. The Seventh Circuit explained that it was sufficient to show that the transfer increased the risk of self-mutilation to establish that Rasho suffered an injury.

Civily Committed Dangerous Sex Offenders: Eighth Circuit reverses a district court's finding of substantive due process violations in the statute and treatment program for dangerous sex offenders established by the State of Minnesota.

Karsjens v. Piper, 845 F.3d 394 (8th Cir. 2017)

Background: The Minnesota Sex Offender Program (MSOP) was created in 1994 pursuant to the Minnesota Civil Commitment and Treatment Act: Sexually Dangerous Persons and Sexual Psychopathic Personalities (MCTA). Since its inception in 1994, approximately 714 individuals have been accepted into the MSOP, but no individual has been fully discharged from the program and only three have been provisionally discharged. In January 2012, multiple individuals in the MSOP were granted class certification in a constitutional challenge to the MCTA. Plaintiffs argued that the statute is unconstitutional because the statutory standards for discharge are more stringent than for initial commitment. Specifically, the statute requires that the state demonstrate by clear and convincing evidence that an individual is sexually dangerous or has a sexually psychopathic personality and the individual is highly likely to reoffend. However, discharge requires a showing that the individual is no longer dangerous. The plaintiffs also argued that the statute is unconstitutional because no individual has ever been discharged from the program and there is no automatic, independent review process to assess an individual's need for continued commitment. The district court applying strict scrutiny held that the MCTA was a violation of the plaintiff's substantive due process rights.

Holding: The Eighth Circuit reversed and held that the proper standard of scrutiny was rational basis review. Applying that standard, the Eighth Circuit found no substantive due process violation.

Notable Point:

Fundamental Liberty Interest: The Eighth Circuit explained that although civil commitment is a significant deprivation of liberty, the Supreme Court has never held that individuals "who pose a significant danger to themselves or others possess a fundamental liberty interest in freedom from physical restraint." The Due Process

Clause requires that the state demonstrate a reasonable relation between the nature and duration of the civil commitment and the purpose of the individual's commitment.

State Court Decisions

Criminal Sentencing; Mitigating Factors Due to Mental Illness: While finding no error in the sentencing decision of the trial court, the Indiana Supreme Court, in a *per curiam* decision, reduces the sentence of an offender with a history of mental illness in recognition of the illness's impact on the offender's behavior.

Wampler v. State, 67 N.E.3d 633 (Ind. 2017)

Background: Wampler had a history of mental health problems and hospitalizations dating back to 1981. In 2014, he became obsessed with his former elementary school classmate. Wampler began making unusual attempts to interact with the classmate, which included leaving notes and sitting outside his house. Wampler broke into the classmate's house one evening, watched him sleep, drank a beer, and left a love note. The incident was reported to police, and Wampler was charged with felony burglary. He was initially found incompetent to stand trial, but was found competent after receiving treatment. He was found guilty of two counts of felony burglary and sentenced to eighteen years in prison enhanced by fifteen years due to a finding that he was a habitual offender. The court of appeals affirmed the sentence, and the Indiana Supreme Court granted review.

Holding: The Indiana Supreme Court found that the trial court did not abuse its discretion in imposing an aggregate sentence of thirty-three years, but reduced the sentence to an aggregate of sixteen years based on a determination that the original sentence was "inappropriate in light of the nature of the offense and the character of the offender."

Notable Points:

Indiana Constitution: The Indiana Constitution authorizes independent appellate review of trial court sentencing decisions even when there is no abuse of discretion.

Due Process and Equal Protection: Massachusetts Supreme Court interprets state statutory requirements for when criminal charges must be dismissed against a defendant who is incompetent to stand trial, and upholds the statutes against claims of Due Process and Equal Protection violations.

Commonwealth v. Calvaire, 476 Mass. 242, 66 N.E.3d 1028 (2017)

Background: In 2012, Calvaire was charged with assault and battery by means of a dangerous weapon on suspicion of stabbing a woman with a pocket knife at a metro station in Boston. Calvaire was committed to a state hospital and only intermittently found competent to stand trial. The state attempted to proceed to trial on a number of occasions, but each time the trial was either continued or Calvaire was found incompetent. Calvaire filed three motions to dismiss the charges pursuant to a statute

permitting the dismissal of charges for defendants found incompetent to stand trial after one-half the maximum sentence for the most serious charged offense. The statute prevents charges pending indefinitely for incompetent individuals. A judge denied Calvaire's motions and he appealed.

Holding: The Massachusetts Supreme Court upheld the dismissal of the motions finding no Equal Protection violation because competent defendants and incompetent defendants are not similarly situated. Applying strict scrutiny, the court found no violation of substantive due process, finding the state's interest in protecting incompetent defendants from indefinitely pending charges and protecting the public from potentially dangerous offenders are compelling state interests.

Notable Points:

Dismissal in the Interest of Justice: The court left open the possibility of the charges being dismissed by a judge in the interest of justice as allowed by the statute.

Involuntary Commitment and Loss of Right to Possess Firearms: Pennsylvania Supreme Court interprets Pennsylvania statute governing challenges to loss of right to possess firearms following involuntary civil commitment for mental health treatment, holding that when reviewing a physician's decision to involuntarily commit an individual, a court must find that the physician's decision was supported by a preponderance of the evidence available to the physician when the decision was made.

In re Vencil Appeal of Pa. State Police, 152 A.3d 235 (Pa. 2017)

Background: In 2003, Vencil went to a hospital emergency room complaining of burning eyes, swollen nostrils, and pulmonary problems. She told hospital staff that she became sensitive to chemicals after being exposed to turtle wax in 2002. She explained that as a result of this sensitivity, she was forced to move out of her home and stay in hotels to avoid chemical smells. She also explained to a crisis intervention worker at the hospital that she had suicidal ideations as a result of her condition. Vencil initially agreed to voluntary commitment, but fled the hospital prior to signing the paperwork. Police located Vencil and brought her back to the hospital where a physician determined that she was severely mentally disabled and required involuntary commitment for treatment. In 2012, Vencil applied to have her record of involuntary commitment expunged pursuant to a Pennsylvania statute that prohibits an individual who was involuntarily committed for psychiatric treatment from possessing a firearm. The statute allows a person who was involuntarily committed to challenge the sufficiency of the evidence to support the commitment. If a court finds there was insufficient evidence, the record of the civil commitment will be expunged and the prohibition on possession of firearms will be lifted. On appeal, the superior court applied a clear and convincing evidence standard to the physician's involuntary commitment decision. The state appealed.

Holding: The Supreme Court of Pennsylvania reversed the finding of the superior court and held that a court is required to give deference to a physician's involuntary

commitment decision and that it must only be supported by a preponderance of the evidence available to the physician at the time the decision was made.

Sexually Violent Predators and Ineffective Assistance of Counsel: The South Carolina Supreme Court rules that a person has a due process right to effective assistance of counsel during civil commitment proceedings for sexually violent predators, but that a claim contesting such commitment due to ineffective assistance of counsel must be raised in a habeas corpus petition as South Carolina statutory law does not provide for making such a claim on direct appeal.

In re Chapman, No. 27705, 2017 S.C. LEXIS 29 (Feb. 15, 2017)

Background: In 2013, the state filed a petition to civilly commit Chapman as a sexually violent predator prior to his release from prison. Chapman was serving a 5-year prison sentence after pleading guilty to one count of lewd act on a minor involving a 10-year-old female. Chapman also had four prior convictions for sexual assault. At the commitment hearing an expert for the state testified that Chapman suffered from biastophilia, anti-social personality disorder, substance abuse disorder, and was likely to reoffend. Chapman presented testimony from several personal acquaintances as to his good character and an expert for the defense disagreed with the state's expert regarding Chapman's diagnoses of biastophilia and anti-social personality disorder. During the two-day trial, Chapman's counsel made no motions and objected only once. The jury found that Chapman met the statutory definition of a sexually violent predator, and the court ordered Chapman's civil commitment.

Holding: The Supreme Court of South Carolina held that defendants have a due process right to the effective assistance of counsel when facing civil commitment as a sexually violent predator. However, the issue must be raised in a habeas corpus petition, rather than on direct appeal.

Notable Points:

***Strickland* Standard:** The court held that the appropriate standard for granting relief for ineffective assistance of counsel in this context is the two-prong *Strickland* standard rather than the ordinary standard in habeas proceedings. The *Strickland* standard requires an applicant to prove deficient performance of counsel and resulting prejudice.

Involuntary Commitment and Right to Waive Counsel: Supreme Court of Vermont holds that the Fourteenth Amendment precludes a patient from waiving counsel and proceeding *pro se* in involuntary commitment and involuntary medication proceedings.

In re G.G., 2017 VT 10

Background: G.G. had been hospitalized in the Vermont Psychiatric care hospital since 2015. G.G. had been subject to a series of renewed orders for involuntary medication, and in 2016 the state filed an application to involuntarily medicate G.G. with 20 milligrams of Prolixin by injection every two weeks. Prior to the hearing on the state's application,

G.G. filed a motion to dismiss his attorney and proceed *pro se*. The court found that G.G.'s waiver of counsel was not "knowing, intelligent, and voluntary," and denied the motion to dismiss his attorney and proceed *pro se*. The court did allow G.G. to cross examine witnesses after his attorney concluded her cross examinations. G.G. was also allowed to make closing arguments. The court found that G.G. was a patient in need of further treatment and that there was no less restrictive alternative than involuntary commitment and treatment. The court ordered G.G.'s continued hospitalization and treatment for one year. G.G. appealed.

Holding: The Supreme Court of Vermont held that the due process clause of the Fourteenth Amendment precludes the waiver of counsel in civil commitment proceedings.

Notable Points:

Balancing: The Supreme Court of Vermont explained that a trial court should balance a defendant's dignity and autonomy interests with the state's interest in ensuring a fair and accurate proceeding when considering the level of the defendant's participation at trial.

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

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ISSN 1063-9977

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