DEVELOPMENTS IN MENTAL HEALTH LAW

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Special Message to DMHL recipients: It is with a great deal of sadness that we mourn the passing in February of two great leaders who have been instrumental in bringing about mental health law reform in the Commonwealth.

Leroy Rountree Hassell Sr., Chief Justice of the Virginia Supreme Court from 2003 to 2011, established the Commonwealth of Virginia's Commission on Mental Health Law Reform in 2006. Appalled at the disrespect often shown to people with mental illness when they were transported to and from hospitals in handcuffs, Chief Justice Hassell cared so deeply about addressing these problems that he made reforming Virginia's mental health laws a signature initiative of his leadership at the Supreme Court even when those efforts were the receipt of occasional resistance and criticism. All constituencies and stakeholder groups affected by mental health services (including consumers, families, police officers and mental health providers alike) are grateful for his commitment to justice, his courage, and his independence of mind. His leadership will be missed.

Terry Grimes was a devoted and passionate advocate for those suffering from mental illnesses. Terry co-founded Empowerment for Healthy Minds, a nonprofit consumer-run mental health education organization. Terry served with distinction as a member of the Commonwealth of Virginia's Commission on Mental Health Law Reform and as Chairperson of the Task Force on Empowerment and Self-Determination. The Commission issued a Resolution of Appreciation honoring Terry "for her openness of mind, for her wisdom, and for her unyielding belief that, acting together, we have the power to transform our systems and ourselves to improve the wellbeing of each and every person." Terry deeply touched and changed for the better every person she encountered.

Articles and information on the following topics appear below:

Use of MOT and Step-Down MOT in Virginia
Draft Rules of Court for Involuntary Civil Commitment Proceedings
DOJ Finds Virginia Violates ADA/Olmstead
Recently Decided Cases

USE OF MANDATORY OUTPATIENT TREATMENT IN VIRGINIA A PRELIMINARY REPORT ON THE FIRST TWO YEARS

Excerpts from a Report by Amy Liao Askew
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The civil commitment reforms adopted by the Virginia General Assembly in 2008 included changes designed to make mandatory outpatient treatment (MOT) a more effective component of Virginia's commitment process. The new legislation, which became effective on July 1, 2008, provides detailed procedures for implementing MOT orders under Virginia Code §37.2-817. Most of this report focuses on the use of MOT as a less restrictive alternative to involuntary inpatient admission pursuant to the procedures enacted in 2008 and found beginning at http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-817. The 2010 General Assembly authorized so-called "step-down" MOT as a transition to the community for patients being discharged from an inpatient commitment, but that procedure did not go into effect until July 1, 2010. As summarized in the last section of this report, the procedure was rarely used during the first half of FY 2011.

Data from Court Files

Beginning July 1, 2008, the Commonwealth's Commission on Mental Health Law Reform requested the files from the courts of every case that resulted in an MOT disposition, asking specifically for copies of the 1006-CO (the commitment order), 1006-IE (the report of the independent examiner) and MOT plan from each of these cases. A total of 120 MOT files were received through 10/31/10; however, not every file included all of the requested information. Data entered for this same period in the Supreme Court's Case Management System record 75 MOT orders from July, 2008 through June, 2009, 86 for July, 2009 through June, 2010, and 11 for July, 2010 through October, 2010, a total of 172. This suggests that researchers for the Commission are receiving about 70% of the files.

In general, a majority of MOT cases came from the Prince William and Staunton General District Courts. MOT was used most frequently in cases involving clients found by the court to be either "likely to harm self" or to "lack[] the capacity to protect self or provide for basic human needs." In the files where information was available, most of the clients agreed to the use of MOT, signifying that MOT is used when clients express a willingness to accept treatment. Also, in most of the cases, MOT was ordered in accordance with the Independent Examiner's recommendation.

About one-third of the clients placed under MOT were required to receive substance abuse treatment services as well as services for treatment for mental illness. A wide variety of services were offered to clients in their treatment plans, although the degree of detail varied among CSBs. At a minimum, compliance with the treatment plans included the condition that clients "must attend all meetings and appointments;" however there were other conditions specified in the plans according to the client's needs. Although most of the treatment plans involved CSB staff only, a handful of treatment plans included private providers. Compliance was generally monitored through meetings and appointments that were scheduled as part of a client's treatment. A majority of these meetings and appointments occurred once a week. Most CSBs determined a client to be materially non-compliant if the client missed three consecutive appointments without making arrangements to reschedule; however this was not a common occurrence.

Table 1. Frequency and Percentage of MOT Orders Received by Locality

Locality	Frequency	Percentage
Prince William	46	38.3
Staunton	23	19.2
Fairfax	12	10.0
Smyth	12	10.0
Danville	10	8.3
Russell	5	4.2
Roanoke	3	2.5
Montgomery	2	1.7
Salem	2	1.7
Lancaster	1	0.8
Richmond	1	0.8
Missing	3	2.5
Total	120	100.0

The 1006-CO form was completed and included in 112 of the 120 files. In the majority of MOT cases, the court determined that the client was either "likely to harm self" (48.7%) and/or "lacked the capacity to protect self or provide for basic human needs" (52.2%). Only 16.5% of the files were for clients found by the court to be "likely to harm others."

Of the 120 cases, only 50 files had concrete documentation of whether the client agreed or disagreed with the use of MOT. Of these 50 documented cases, 46 clients agreed and 4 disagreed. Many of the clients who agreed with the use of MOT did so because they did not want to be hospitalized.

Of the 120 cases, only 28 files had concrete documentation of whether the CSB agreed with the use of MOT. Of these 28 documented cases, 3 files included notes indicating that the CSB had objected to the use of MOT for that particular client. In two cases, the CSB objected because it felt that inpatient treatment was more appropriate for the client or because it did not feel that it had adequate resources to support MOT for that client. In one case, the CSB "refused to accept on outpatient basis" citing "lack of available resources" and the case was continued at the request of the patient until an agreement could be reached with the CSB. In that case, the attending physician at the psychiatric facility where the patient was being evaluated was also involved in negotiating with the CSB.

Whether MOT was being used in cases where a different course of action had been recommended by the Independent Examiner was also examined. Eighty-two files provided this information from the Independent Examiner's report (1006-IE). These IE reports indicated that the Independent Examiner had recommended involuntary inpatient

treatment for 28 cases, dismissal for 1 case, and MOT for 53 of the 82 cases. These results are shown in Table 2.

Table 2. Frequency and Percentage of Independent Examiner Recommendations among Received MOT Orders

I.E. Recommendation	Frequency	Percentage
MOT	53	44.2
Involuntary Inpatient Tx	28	23.3
Dismissal	1	0.8
Missing	38	31.7
Total	120	100.0

Of the 120 files, 98 included an MOT treatment plan. Treatment plans were categorized as offering mental health services, substance abuse services, or both. While almost all of the plans ordered mental health services, 44.9% of them also included substance abuse services. Table 3 shows the frequency and percentages for the category of services offered to clients.

Table 3. Frequency and Percentage of Service Category

Category of Service	Frequency	Percentage
Mental Health only	54	55.1
Substance Abuse	4	4.1
Both	40	40.8
Total	98	100.0

MOT clients were offered a variety of specific services in their treatment plan. Of the 97 MOT plans that have information about the services offered to the client, 88 were offered more than one service. Table 4 shows the frequency and types of other services that were provided to clients at the CSBs.

Table 4. Frequency and Percentage of Services Provided to MOT Clients

Type of Service	Frequency	Percentage of Plans
Individual Therapy	75	77.3
Case Management	60	61.9
Medication Services	55	56.7
Substance Abuse Service	19	19.6
Support Services	14	14.4
Group Therapy	15	12.5
PACT/ICT Services	12	12.4
Crisis Intervention Services	11	9.2
Residential Services	3	3.1

Individual therapy was the most common service provided, followed by case management and medication services. When case management was provided, a case manager was usually assigned to monitor and follow up with the client on a regular basis. Case managers were also in charge of addressing the client's general needs during treatment, such as in "linking and coordinating" the client's treatment overall. Some case managers offered supportive counseling and symptom management skills; however, this was mostly left to the therapists.

Individual therapy was often used for psychoeducation. Individual therapy was also used to help evaluate medication needs and to monitor medication compliance, as well as to help clients learn coping skills, including anger management, impulse control, and relaxation techniques.

Medication services ranged from therapists prescribing and monitoring medications to requiring clients to go into the CSB to swallow pills or receive injections. Medication services often included a meeting with a psychiatrist every 90 days for medication evaluation.

The MOT plans also provided data on treatment conditions that were specified in the plans. All but three plans included the condition that the client must attend all appointments and meetings. Other conditions that were commonly included in the plans are listed below in Table 5.

Table 5. Frequency and Percentage of Plans by Treatment Conditions

Treatment Condition	Frequency	Percentage of Plans
Must attend all appointments and meetings	94	96.9
Must be compliant with medications	85	87.6
Psychoeducation	34	35.1
Must remain sober	29	29.9
Must improve family relationships	10	10.3
Must maintain behaviors to care for self	6	6.2
Must improve social relationships	4	4.1
Other	3	3.1

The treatment plan conditions were often listed as measurable objectives. For example, one client's MOT plan included objectives for many of the treatment conditions listed in Table 5:

1) Identify consequences of his chemical use
2) Identify how a clean and sober lifestyle will improve various areas of his life
3) Attend five meetings weekly
4) Develop a close relationship with his sponsor and others in recovery
5) Develop skills to identify relapse
6) Pass all screens for alcohol and other drugs

7) Be seen by staff psychiatrist for evaluation of depressive symptoms and follow recommendations
8) Identify how his chemical use has negatively impacted his self concept and begin to challenge irrational beliefs

The MOT plans also provided data on whether patients were involved in the development of their treatment plans and in the specification of the conditions. Of the 97 plans included in the MOT files, 30 plans (30.9%) expressly indicated that the patient was involved in the development of the plan as evidenced by phrases such as, "The patient agrees…" and "The patient prefers…" in the plan narrative. One file recorded the client's goals:

Client's Statement #1: I would like to remain at my current residence with my parents.
Client's Statement #2: I would like to build a social life.
Client's Statement #3: I would like to return to school for HVAC.
Client's Statement #4: I would like to be more stable on my medication in order to feel better about myself.
Client's Statement #5: I would like to remain sober.
Client's Statement #6: I would like to remain healthy.
Client's Statement #7: I will continue to care for myself independently.

This client's statements were then used to help the CSB build a treatment plan. Many of the services and conditions were aimed at helping the client to achieve the stated goals.

The Prince William County CSB often attached a form cover letter with the MOT plan when they sent the plan to the judge for approval. Form letters stating that the patient was involved in the development of the plan were not counted in the analysis unless the plan's narrative provided evidence in support of this statement. Additionally, as further evidence of client involvement and approval, 88.7% of the MOT plans received were signed by the client. When they were not signed, a few plans noted "Client refused to sign."

Table 6 shows the frequency and percentage of the MOT cases by the CSB that is in charge of monitoring the case.

Table 6. Frequency and Percentage by CSB in Charge of Monitoring Compliance

CSB	Frequency	Percentage
Prince William County CSB	45	37.5
Fairfax-Falls Church CSB	11	9.2
Valley CSB	10	8.3
Mt. Rogers CSB	6	5.0
Central Virginia CSB	5	4.2

Danville-Pittsylvania CSB	5	4.2
Alleghany Highlands CSB	3	2.5
Blue Ridge Behavioral Health Care	3	2.5
Cumberland Mountain CSB	3	2.5
New River Valley CSB	3	2.5
Piedmont CSB	3	2.5
Harrisonburg-Rockingham CSB	2	1.7
Rappahannock-Rapidan CSB	2	1.7
Dickenson County BHS	1	0.8
Highlands CSB	1	0.8
Middle Peninsula-Northern Neck CSB	1	0.8
Northwestern CSB	1	0.8
Region Ten CSB	1	0.8
Richmond BHA	1	0.8
Southside CSB	1	0.8
Missing	12	10.0
Total	120	100.0

Compliance is monitored through CSB staff members' appointments with the clients. Clients are required to attend all appointments and if they cannot make it, they are instructed to call and reschedule in advance. Of the 96 MOT plans that contained this information, 66 plans specified how often the CSB would be meeting with the client to monitor compliance, 16 plans mentioned the CSB staff monitoring compliance but did not specify how often, and 14 plans did not mention anything about monitoring compliance. Table 7 shows how often CSB staff were required to check in with clients by the 66 plans that included this information. A substantial majority of the plans (71.2%) required CSB staff to check in with clients weekly to monitor compliance with the treatment plan.

Only 19 of the plans included private providers, and only eight of these specified how often private providers should check in with the CSB to monitor compliance of the clients. Seven out of the eight plans asked private providers to monitor compliance once a week, while one of the plans asked the private provider to monitor compliance once a month. Private providers were instructed to notify CSBs immediately following a missed appointment by a client.

Table 7. Frequency in Days that CSB are Asked to Monitor Compliance

How Often (in Days)	Frequency	Percentage
1	5	7.6
2	1	1.5
3	1	1.5
4	1	1.5
7	47	71.2
14	4	6.1
30	6	9.1
60	1	1.5
Total	66	100.0

It is difficult to determine how compliant clients are being with each of their MOT treatment appointments. Out of the 120 files received, only 4 files contained Petitions for Review of MOT and 3 files contained Orders for Review of MOT. Of the 4 petitions, two were filed because the clients refused to take any part in their MOT treatment plans. One petitioner wrote, "Client refuses any participation with PACT services and refuses to accept treatment from other treatment providers." In this case, the special justice ordered that the client be admitted for involuntary inpatient treatment, in accordance with the petitioner's recommendation.

In two other Petitions for Review of MOT, the clients were determined to be materially non-compliant because they had missed three consecutive appointments with their treatment providers. The outcome of these petitions was determined on a case-by-case basis based on the information that was included with the petition. In one of these cases, the judge dismissed the case because the MOT order had already expired. In the other case, the judge ordered a rescission of the MOT plan after an independent examiner certified that the client no longer met the criteria for commitment.

Interviews and Surveys on MOT Use

The use of MOT seems to have decreased substantially since the new laws went into effect. Only 120 MOT files were received during the entire study period. In comparison, in the Commission's study of commitment hearings conducted during May, 2007, the month immediately following the Virginia Tech tragedy, 73 of the respondents were committed for outpatient treatment during that month alone. In response to the apparent decrease in MOT use, the Commission interviewed a sample of CSB representatives from Fairfax-Falls Church CSB and Prince William County CSB, and conducted a survey on MOT to explore the reasons for the decline. A total of 32 CSBs responded to the survey.

Interviews

CSB representatives brought up a few barriers to the use of MOT since the new laws went into effect. First, some of the special justices are opposed to MOT because they "don't want the headache," and because the MOT cases "keep them on the hook." Special justices are required to approve of the comprehensive treatment plan that is drafted by CSBs after the hearing occurs, and are also responsible for overseeing the compliance process if a client is non-compliant. CSB representatives reported that some special justices have expressed the view that the new MOT statutes involve too many complicated steps and they are not given additional compensation to follow through with each step. In fact, MOT use declined significantly in Fairfax-Falls Church from FY10 to the beginning of FY11. Fairfax-Falls Church CSB reported it has been getting more resistance from special justices against MOTs because of this "hassle factor." In some cases, the special justices are so resistant that even when the CSB, the independent examiner, the attorney and the client are all in agreement with MOT, the special justices are still reluctant to approve it. However, other CSB representatives felt that as more MOTs are ordered, everyone involved in the process becomes more comfortable doing MOTs. In Prince William County CSB, there were 36 MOT orders in FY10, a substantial increase from FY09, when there were only 13 entered during the entire year.

From the perspective of the Fairfax-Falls Church CSB, MOT may be more difficult to implement due to a general lack of resources. Many of the services that are appropriate for a client's treatment have long waiting lists. To further complicate things, CSBs are required to draft a comprehensive MOT treatment plan within 5 days of the commitment hearing. Meeting this 5-day deadline can be especially challenging since the CSB has to get all of the resources in place, all of the providers on board, and the providers, CSB, client and special justice must all agree on a treatment plan. If a particular service is unavailable to the client at the time of the hearing, the CSB often cannot recommend MOT for that client. CSB representatives have expressed the view that implementing MOT might be less challenging if they had a longer turnaround time.

At Prince William County CSB, two aspects of their civil commitment process help make MOT more feasible. First, they almost always wait a full 48 hours for the temporary detention period. CSB representatives stated that this period of detention "can be helpful to the client and can change the way the client is thinking and behaving," oftentimes allowing them to become more open to treatment on an outpatient basis. Secondly, in addition to the required prescreening that takes place following a TDO, Prince William County CSB performs a second evaluation of the client immediately prior to the hearing. It is often during this second prescreening that a client might express a willingness to participate in outpatient treatment and the CSB representative will draft an initial treatment plan to submit to the special justice at the hearing.

Prior to the revision of MOT laws, Prince William County CSB would often recommend dismissal for clients who they felt were not exhibiting symptoms severe enough to warrant inpatient treatment. They would then schedule outpatient follow-up care to these clients so that they could monitor the client's progress after the hearing.

Now, these clients are the ones who are being recommended for MOT. The revised MOT laws provide a more formal infrastructure for the CSBs to follow-up with and offer outpatient treatment to clients who "fall somewhere in between inpatient and dismissal, almost as a compromise." With few exceptions, clients who are under MOT orders in Prince William County and Fairfax-Falls Church have been very cooperative with treatment.

Survey

A ten-question survey was conducted using the online survey tool Survey Monkey from November 10, 2009 through November 30, 2009. A total of 32 CSBs responded. The surveys contained a combination of multiple choice and open-ended answer formats. A key issue explored in the survey is why MOT is so rarely used.

Of the 32 respondents, a large majority (87.5%) reported having a total of five or fewer MOT cases since the new laws went into effect on July 1, 2008. One CSB reported having seven cases and three CSBs reported having more than ten cases. (See Table 8). This data confirms the finding that a majority of MOT cases are occurring in a very small number of jurisdictions. In fact, 80% of CSB respondents reported that MOT cases at their CSB had stayed the same or decreased since the new laws went into effect.

Table 8. Frequency of MOT Cases at CSBs Since July 1, 2008

# of Reported MOT Cases in CSBs since July 1, 2008	# of CSBs
None	13
1 – 5	15
6 – 10	1
More than 10	3

The survey results on the services that are being provided to MOT clients corresponded with the analysis of MOT plans. CSB survey respondents indicated that Medication Management, Individual Therapy, and Case Management were the top three services being provided, followed by Substance Abuse Services and PACT/ICT Services. Interestingly, a majority of CSB respondents (73.3%) reported that their CSB had adequate resources to deal with clients under MOT orders. However, respondents also indicated that the availability of the clinical staff to see clients is very limited, and many of the respondents reported that their CSBs would not be adequately prepared to handle additional cases, if MOT use were to increase.

The Commission's survey on MOT also asked CSBs to indicate the most common circumstances for which they would recommend MOT for a patient at their commitment hearing. The most common scenario that would warrant a recommendation for MOT is a situation in which a client has been through multiple hospitalizations and failed to comply with outpatient follow-up upon discharge.

The second most common circumstance for which CSBs would recommend MOT is when a client is actively engaged in treatment or understands and acknowledges a need for treatment. Lastly, noncompliance with outpatient services in general, with or without a history of multiple hospitalizations, was a common circumstance for which MOT would be deemed appropriate by CSB staff. When asked for their opinions of why MOT orders might be declining, CSB respondents cited similarities between MOT criteria and inpatient admission criteria, as well as the burden of MOT laws on judges and CSBs. Table 9 shows the explanations and the percent of CSBs who thought the explanation was "highly relevant" or "relevant."

Table 9. Explanations for Decline in MOT Use

Explanation	% of CSBs
MOT criteria are the same as inpatient admission criteria	70.3%
Burden of new MOT laws on judges	66.7%
Burden of new MOT laws on CSB	62.9%
Judges' interpretation of new laws	59.2%
Insufficient behavioral health resources	55.5%
Turnaround time for development of MOT plan is too short	40.7%

Survey on Step-Down MOT Use

The 2010 General Assembly approved a provision for the use of a "step-down" MOT, as a transition to the community for patients being discharged from inpatient commitment. This "step-down" MOT applies to persons who have had two or more prior commitments within the past 36 months and a history of lack of compliance with treatment. Although this procedure went into effect on July 1, 2010, there is very little evidence that it is being used. In December of 2010, an e-mail survey about "step-down" MOT use was sent to the 40 CSBs in Virginia. They were asked the four following questions: 1) Has your CSB used the "step-down" MOT procedure? 2) Have you found it useful? 3) What kind of cases have you been using it for? and 4) What kinds of problems have you run into? 33 out of 40 CSBs responded to the survey. According to the responses, 29 CSBs had never used the "step-down" MOT procedure, while four CSBs reported that they had used it. These four were Cumberland Mountain, Harrisonburg-Rockingham, Region Ten, and Valley CSB.

Of the four CSBs who reported using the "step-down" MOT procedure, two of them had only used it once. Both of these CSBs had a positive experience with their "step-down" case and it also seemed that in both cases, the client agreed with the plan to use a "step-down" procedure. The remaining two CSBs that reported using the "step-down" procedure had each used it a couple of times. One CSB stated that they had used it a couple times with Western State Hospital with moderate success. They felt that, "it's a good structure to have, but still very cumbersome to implement the review process if there are compliance problems." Furthermore, local special justices are still skeptical and

unenthusiastic about oversight: "He'd rather we just TDO the person back to the hospital." The other CSB stated that they used it most often with "individuals who are chronic and are frequently non-compliant/detained who 'buy into' being compliant with the Court." They also reported some resistance from the special justices in their jurisdiction because of a "continued lack of understanding," stating that they were "continuing to educate."

Twenty-nine CSBs reported that they had never used the "step-down" MOT procedure. The major reasons for the lack of use are listed below:

1. ***Documentation of prior commitments***. A "step-down" MOT may be used only if the person has been subject to an order for involuntary admission at least twice within the past 36 months. Special justices in some jurisdictions say that testimony regarding two prior commitments is hearsay and is therefore inadmissible in court unless a court-certified copy of the commitment order is admitted. In addition, even if the CSB could obtain certified copies of prior commitment orders, step-down MOT may be ordered only if the person has "a history of lack of compliance with treatment." For this, respondents' attorneys are saying that the testimony is hearsay unless it is provided by the prior treatment providers with first-hand knowledge of the client.

2. ***Resistance by special justices.*** Many CSBs have stated that MOTs and the new "step-down" MOTs are unpopular with the special justices because MOT "has no teeth" and "is more of a hassle than it's worth."

3. ***Concerns regarding the consequences of "step-down" MOT non-compliance.*** Many of the CSBs expressed concerns about the lack of consequence for clients who are non-compliant with the MOT order. One CSB said, "In reality if the client doesn't follow through with the MOT we can do nothing unless they again met commitment criteria and then they should be re-detained. So what is the point of doing?" Another CSB expressed, "If there was a clear consequence for the client (jail, state hospitalization, mandatory 14 day stay, etc.) when they did not comply with the order, perhaps we would feel better about using it."

4. ***Limited resources for outpatient treatment***. CSBs cite a lack of resources as another major reason why the "step-down" MOT procedure is not being used. For some, it is the fear of "a lot of case management, paperwork, and manpower." Others feel that they do not have the outpatient services that are needed to adequately support an MOT order. One CSB stated "the biggest roadblock is the collaboration it would take between CSB, the hospital, the legal team and the courts and everyone is already overwhelmed."

5. ***Restrictiveness of eligibility criteria***. Many of the CSBs have not been able to use the "step-down" procedure because they feel that the criteria required for a "step-down" case are too narrow and restrictive. They have not been able to identify a case that meets the criteria for "step-down" MOT.

Concluding Comments

There were great variations in the information recorded in each MOT file and the Commission was unable to interview and survey every CSB in the state. However, it appears that CSBs and special justices are reluctant to order MOT for a variety of reasons. Moreover, when used, the MOT process still lacks standardization. Although each court must fill out the 1006-CO, the 1006-IE, and approve of an MOT treatment plan for each client, there are large differences in the specificity and detail of the information included in these forms, specifically in the MOT treatment plan. Some of the plans were very comprehensive, with goals, objectives and strategies. Others only outlined the treatment plan in general terms.

Supreme Court Considers Adopting Rules of Court for Involuntary Civil Commitment Proceedings

The Supreme Court of Virginia has begun the process of adopting a new Part 9 to the Rules of Court for Involuntary Civil Commitment Proceedings under Title 37.2 of the Code of Virginia. The Rules of the Supreme Court of Virginia establish the procedures by which all civil and criminal proceedings in Virginia are conducted. Currently general Rules governing the practice of all civil cases in the Commonwealth have applied to civil commitment proceedings although none specially address this specialized type of case.

In the fall of 2010, the Commonwealth of Virginia's Commission on Mental Health Law Reform established a task force to study whether adopting court rules would promote uniformity in the application of commitment laws and procedures throughout the Commonwealth. Then Chief Justice Leroy Rountree Hassell, Sr. selected and appointed the members of the task force, chaired by Gregory E. Lucyk, Chief Staff Attorney for the Virginia Supreme Court. The task force consists of one circuit court judge, one general district court judge, six special justices who preside over civil commitment cases throughout the Commonwealth, one attorney representing individuals in civil commitment proceedings, one representative from the Attorney General's Office, and staff from the Office of the Executive Secretary of the Supreme Court.

The task force conducted an extensive review of data collected by the Court and the Commission regarding variations in the way commitment proceedings are conducted throughout the state. The 2009 and 2010 data reveal significant variations in dismissal rates, commitment rates, voluntary hospitalizations and mandatory outpatient treatment orders. These variations suggest that commitment criteria are being applied inconsistently across the state and that judges and special justices may have different perspectives on whether and when voluntary hospitalization may be offered as an option to involuntary admission. Information also indicates that judges and special justices are interpreting the statutes differently. Moreover, systemic variations in evidentiary and procedural rulings appear to exist resulting in a wide discrepancy in outcomes. Unlike other types of cases, there is little appellate precedent on how to interpret the civil

commitment statutes and procedures. Only respondents may appeal commitment cases and their cases are often moot (meaning the commitment order has expired and the person is no longer in custody) before a case can be heard before the Virginia Supreme Court.

To address these concerns, the task force drafted proposed Rules and circulated the drafts in November-December 2010 to various stakeholder groups, including all of the special justices, independent examiners, community services boards, advocacy groups, and the Department of Behavioral Health and Developmental Services. The task force considered all of the comments received and made numerous revisions to the draft resulting in a Final Draft prepared and circulated to the Task Force on January 12, 2011.

Written in a clear, concise and straightforward format, the draft Rules are designed to be an easy reference for those participating in the commitment process, including individuals subject to involuntary commitment and their families. For the most part, the draft Rules recite existing law but in simple and comprehensible sentences unlike the complex legal drafting found in the current law.

The stated **Purpose of these Rules** are to: "(a) [p]romote uniformity in the application of the laws governing the involuntary civil commitment process in the General District Courts and Circuit Courts of the Commonwealth; (b) [a]ssure a full and fair adjudication of involuntary civil commitment proceedings, and to enable mental health professionals to carry out their statutory and professional duties to the fullest extent; [and] (c) [r]espect the rights, needs and interests of persons subject to these proceedings, and to ensure that the timing, location and conduct of such proceedings are not detrimental to the best interests of the respondent." Draft Rule 9.2.

The draft Rules contain a section on the **Rights of Respondents** (draft Rule 9.3); **Duties of Counsel for the Respondent**, including the requirement that the person's attorney endeavor to notify the court prior to the hearing if the person objects to the independent examiner's examination or will require his live testimony at the hearing (draft Rule 9:4); **Rights of the Petitioner**, including the *petitioner's* right to receive adequate notice of the place, date, and time of the hearing, to be present at the hearing, to testify and to present relevant evidence, and to retain counsel (draft Rule 9.5).

Draft Rule 9:6 pertains to **Release Prior to Hearing** and provides that when the respondent is released by the detention facility director prior to the hearing and the judge or special justice receives such verification either in writing or under oath, the judge or special justice must enter an order of final disposition. A comment to the draft Rule also recommends that the order form be amended to reflect such a disposition.

Significantly, draft Rule 9:7 pertaining to **Voluntary Admission** states that if the respondent expresses an interest in voluntary admission *at any time prior to the court's final decision*, and the judge or special justice finds that the respondent is capable and willing to consent to voluntary admission, the court is *required* to afford the person the opportunity to agree to voluntary admission. In considering whether the respondent is

capable and willing to consent to voluntary admission, the judge or special justice is required to consider any relevant evidence, including any prior compliance with treatment, and testimony from the community services board representative, the independent examiner, the treating physician and hospital staff.

Draft Rule 9:8 also specifies how the requirement that the **Independent Examination** found in Virginia Code § 37.2-815 must be performed. The examination must be "conducted in private, in a separate room, outside the sight or hearing of any person who is not participating in the examination." Specifically, "[t]he judge or special justice shall, at no time, be present for the independent examination." The draft Rule does allow other people to be present during the examination if the independent examiner determines that such persons are necessary. These persons are "(i) medical or hospital personnel for the purpose of ensuring the medical well-being of the person, (ii) security personnel to ensure the safety of the examiner or person, [and] (iii) an interpreter." In addition, the independent examiner may permit family members or others similarly situated to be present at the request or with the concurrence of the respondent, if he or she determines their presence will not be detrimental to the conduct of the examination.

Draft Rule 9:9 clarifies issues related to the admission of **Evidence**. It provides that the independent examination may be admitted into evidence unless the court sustains objections to its admission. It further clarifies that electronic signatures on the preadmission screening report and examiner's report are permitted. In addition, the draft Rule further clarifies that the court is not limited to consideration of submitted reports, but has the authority to consider any relevant evidence and medical records admitted at the hearing or elicited by the court on its own initiative.

Draft Rule 9:10 covers the **Timing and Location of the Commitment Hearing**. Significantly, the time and location of the hearing must be selected "to avoid inconvenience and any unnecessary travel for the respondent" and "should be held where the respondent is located in the absence of some compelling justification for holding it elsewhere." Presumably, it would no longer be permissible to hold commitment hearings at medical or detention facilities other than the facility where the person is hospitalized absent compelling circumstances.

To reiterate the importance of reducing the dependence on sheriffs to provide transportation, draft Rule 9:11 on **Alternative Transportation** requires the judge or special justice to consider an alternative mode of transportation whenever a person volunteers for admission or is ordered admitted to a facility.

To ensure accountability, draft Rule 9:12 applies to the **Appointment and Supervision of Special Justices**. The draft Rule emphasizes that the chief judge of each judicial circuit may appoint one or more special justices to conduct civil commitment hearings in the circuit. The draft Rule specifically requires each special justice to meet the qualifications, continuing education requirements and other requirements contained in the Training Standards and Appointment Guidelines adopted by the Judicial Council of Virginia, effective October 20, 2008:

http://www.courts.state.va.us/courts/specialjustices/training_stndrds_appt_guidelines.pdf. Most importantly, the circuit court judge is required after appointing a new special justice to monitor the performance of the special justice and periodically obtain information from parties who regularly appear before the special justice to assure that he or she is conducting hearings in accordance with the law and any Rules that are adopted by the Supreme Court and to obtain such information before reappointing any special justice to a new six-year term.

Draft Rule 9:13 addresses the requirements for **Circuit Court Appeals** and clearly states that the order "continuing involuntary admission or mandatory outpatient treatment" may only be entered if the criteria found in Virginia Code § 37.2-817 are met at the time the appeal is heard by the court.

The draft Rules will be presented to the Supreme Court's Advisory Committee on Rules of Court at its meeting in early May. If approved by the Advisory Committee, the draft Rules will then be considered by the Judicial Council. If the Judicial Council approves them, the draft Rules will be presented to the full Supreme Court, and if so approved, will be posted on the Supreme Court's website for 60 days for comment. Upon receipt of comment and revisions, the Justices of the Supreme Court may adopt the Rules by late summer or early fall. These new Rules if adopted will greatly assist all participants in understanding the process, ensure consistency in interpretation and implementation throughout the Commonwealth, and protect the rights and assure the dignity of those who are subject to these proceedings.

(Editor's note: Special thanks to Joanne Rome from the Supreme Court of Virginia who provided the information for this article.)

DOJ Finds Virginia Violates ADA/Olmstead

The Civil Rights Division of the United States Department of Justice notified Governor Robert F. McDonnell by letter dated February 10, 2011 of the findings that Virginia is violating the Americans with Disabilities Act as interpreted by the United States Supreme Court in *Olmstead v. L.C.,* 527 U.S. 581 (1999), http://www.justice.gov/crt/about/spl/documents/cvtc_findlet_02-10-2011.pdf. DOJ wrote: "The inadequacies we identified have resulted in the needless and prolonged institutionalization of, and other harms to, individuals with disabilities in [Central Virginia Training Center] and in other segregated training centers throughout the Commonwealth who could be served in the community." DOJ faults Virginia for its reliance on "unnecessary and expensive institutional care" which has led not only to these civil rights violations, but also "incurs unnecessary expense."

In August 2008, DOJ notified then-Governor Kaine of its intent to conduct an investigation into the quality of services and treatment at CVTC under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. CRIPA was enacted in 1980 to authorize DOJ to investigate what was then described as squalid conditions in state-

operated facilities for persons with mental illness and intellectual disabilities and to take remedial action to force states to provide an acceptable level of care and treatment as later established under *Youngberg v. Romeo*, 457 U.S. 307 (1982). CRIPA also covers conditions in state and local prisons and jails, juvenile correctional facilities and nursing homes, but does not authorize investigations at private facilities. CRIPA only permits DOJ to investigate *systemic* constitutional and federal law violations (hence the ADA violations found), but not individual complaints. DOJ investigated four Virginia psychiatric facilities and one training center in the 1990s.

DOJ conducted on-site visits at CVTC in November and December 2008, and again in April 2009. In October 2009, Thomas E. Perez was sworn in as Assistant Attorney General for the Civil Rights Division at DOJ. Shortly thereafter, Mr. Perez announced a shift in priority away from investigating and improving conditions of confinement in government-operated facilities towards enforcement of the Americans with Disabilities Act and its mandate requiring that individuals with disabilities receive services in the most integrated setting appropriate to their needs. On April 23, 2010, DOJ advised Governor Kaine of its expansion of the CRIPA investigation to focus on the State's compliance with the ADA and the *Olmstead* decision. It conducted a 4-day on-site investigation at CVTC in August 2010, reviewing not only the policies and practices at CVTC, but also visiting community programs in the region and examining the Commonwealth's efforts as a whole to both discharge individuals to more integrated settings and to prevent unnecessary institutionalizations.

Specifically, DOJ found that Virginia systemically violates the rights of those living in its institutions by failing "to develop a sufficient quantity of community-based alternatives for individuals currently in CVTC and other training centers, particularly for individuals with complex needs;" by failing "to use resources already available to expand community-based services and its misalignment of resources that prioritizes investment in institutions rather than in community-based services;" and by implementing "a flawed discharge planning process at CVTC and other training centers that fails to meaningfully identify individuals' needs and the services necessary to meet them and address barriers to discharge." DOJ further found that the Commonwealth also places individuals currently living in the community at risk of institutionalization by failing "to develop a sufficient quantity of community services to address the extremely long waiting list for community services, including the 3,000 people designated as 'urgent' because their situation places them at serious risk of institutionalization; and by failing to ensure a sufficient quantity of services, including crisis and respite services, to prevent the admission of individuals to training centers when they experience crises."

As is required under CRIPA, DOJ also set out a number of remedial remedies that it has determined Virginia must undertake to address these violations related to both serving individuals with intellectual disabilities in the community and discharging individuals from CVTC and its four other training centers. These include providing a sufficient number of waiver slots " – far more than what the Commonwealth has currently budgeted – " to address the needs of those currently in training centers and those on the waiting list, and taking full advantage of funding opportunities, including the

Money Follows the Person program. Virginia must also align its investment in services away from institutions to prioritize community-based services. It should develop crisis services, preserve respite services already being provided and provide integrated day services, including supported employment without relying on segregated sheltered workshops, as Virginia currently does. The state should also make modifications to its Medicaid waivers or develop new targeted waivers for specialty populations including those with complex physical, medical and behavioral needs. The Commonwealth should also ensure that its quality management and licensing systems are sufficient to monitor and assure the adequacy and safety of treatment services provided by the community services boards, private providers and state training centers. "The systems must be able to timely detect deficiencies, verify implementation of prompt corrective action, identify areas warranting programmatic improvement, and foster implementation of programmatic improvement."

In addition, DOJ states that the Commonwealth must implement "a clear plan to accelerate the pace of transitions to more integrated community-based settings" and overcome the institutional bias in its system. Discharge planning must begin at the time of admission and be improved and simplified, focusing on needed services, rather than whether an individual is "ready" for discharge. Virginia must focus on which services each individual will require in the community and begin constructing a plan for providing those services. Assessment teams must become knowledgeable about services available in the community and engage community providers in the discharge planning process as far in advance as possible. It must develop and implement a system to follow up with individuals after discharge to identify gaps in care and reduce the risk of re-admission. DOJ will require that community-based agencies must be made full partners in the process of planning and developing services for individuals. The Commonwealth must also develop a quality assurance or utilization review process to oversee the discharge process, including "developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged individuals to determine if they receive care in the community that is prescribed at discharge; and identifying and assessing gaps in community services identified through tracking of discharge outcomes."

And DOJ insists that if individuals, guardians or family members oppose discharge, the training center must document steps taken to ensure that they are making an informed choice and adopt strategies to address their individual concerns and objections. Families should also be provided the opportunity to visit potential placements and talk with provider staff and other families with relatives living in the community.

Under CRIPA, DOJ must give the state notice of the conditions which leads it to believe that the state is systemically violating the constitutional or federal rights of persons in its institutions and give the state at least 49 days to correct the violations before it initiates a law suit. Obviously, correcting long-term systemic violations or even negotiating a settlement that establishes a roadmap to correct those deficiencies with terms similar to those found in the *United States v. Georgia* settlement agreement http://www.justice.gov/crt/about/spl/documents/ga_settlement_fact_sheet.pdf will take

much longer than 49 days. However, if DOJ finds that the state is entering into good faith negotiations to timely resolve the violations identified in accordance with DOJ's overall objectives, then DOJ will allow a reasonable amount of time to negotiate the terms of any settlement and correct the violations.

Upon receipt of the letter, Governor McDonnell promptly introduced House Bill 2533 (Cox) and Senate Bill 1486 (Northam) to amend § 37.2-319 that establishes the Behavioral Health and Developmental Services Trust Fund to authorize the expenditure of funds to facilitate the transition of individuals with intellectual disabilities from state training centers to community-based services. The legislation that the General Assembly passed on the last day of the session directs the Secretary of Health and Human Resources to develop a plan to transition individuals from state training centers to community-based settings and to include facility specific objectives and timeframes to implement the changes with input from the individuals receiving services and their families: http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB2533H3+pdf. The plan must be submitted to the House and Senate money committees by November 1, 2011 with reports on development and implementation of the plan submitted in July and December of each year beginning July 1, 2011. In addition, the bills authorize any funds to be deposited into the trust fund to finance a broad array of community-based services including up to 600 Intellectual Disability waiver slots, one-time transition costs for community placements, appropriate community housing and other identified community services that may not be covered through the waiver program.

Recently Decided Cases

Virginia Supreme Court Permits SVP to Rescind Refusal to Cooperate; General Assembly Establishes Procedure

On November 4, 2010, the Virginia Supreme Court reversed the finding of the Pittsylvania County Circuit Court and remanded for a new trial a case decided under the Sexually Violent Predator Act. *Hood v. Commonwealth*, 280 Va. 526, 701 S.E.2d 421 (2010), found at http://www.courts.state.va.us/opinions/opnscvwp/1092402.pdf. The Supreme Court determined that the circuit court's decision that it had no discretion to permit a prisoner to rescind his refusal to cooperate with the Commonwealth's mental health expert during the assessment examination violated the respondent's procedural due process rights. The Court held that Virginia Code § 37.2-901 permitted, but did not require, the trial court to admit evidence of the respondent's refusal and bar the respondent from introducing his own expert evidence. Virginia Code § 37.2-907(A) relating to the appointment of experts must be read in conjunction with § 37.2-901, even though it states that if the respondent refuses to cooperate with the examination under § 37.1-901, any expert appointed shall not be permitted to testify at trial nor any report be admissible. The Supreme Court held that due process requires the trial court to consider the circumstances surrounding the respondent's refusal to cooperate and whether the respondent is currently ready to cooperate. The trial court thus has discretion as to what limits to place on admissibility of evidence. In this case, the respondent refused to cooperate before counsel was appointed to represent him and he was currently expressing

a desire to cooperate. Virginia appears to be the only state that has such an evidentiary provision in its SVP Act.

In response to this decision, the General Assembly passed House Bill 1698 (Athey) and Senate Bill 1275 (Obenshain) http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB1698H1+pdf on February 23, 2011, establishing procedures surrounding the respondent's decision to rescind any refusal to cooperate. The respondent may rescind his refusal to cooperate and elect to cooperate with the mental health examination within 21 days of retention or appointment of counsel. Counsel for the respondent must provide written notice of the respondent's election to cooperate to the court and the attorney for the Commonwealth within 30 days of the appointment or retention of counsel. The probable cause hearing is then postponed until 30 days after receipt of the mental health examiner's report. If the respondent thereafter refuses to cooperate with the mental health examination, the court is *required* to admit evidence of such failure or refusal and to bar the respondent from introducing his own expert evidence. These bills are awaiting signature by the Governor.

Court Authorizes Lay Testimony of Defendant's Behavior for Three Years Since His Return from Iraq to Support Insanity Defense

In a case from Oklahoma, the 10th Circuit Court of Appeals has overturned the conviction of an Iraqi war veteran convicted of three armed robberies and an attempted armed robbery and ordered a new trail. *United States v. Goodman*, 2011 U.S.App. LEXIS 1760 (10th Cir. Jan. 28, 2011). Relying solely on the insanity defense, the defendant who suffered a mental breakdown on the battle field, argued and the 10th Circuit agreed, that the district court improperly limited lay testimony to observations of his behavior immediately before and after his eight-day robbery spree rather than permitting testimony about his erratic behavior for the three years since his return from Iraq. The Court found that the temporal limits imposed were improper because the evidence excluded was not too stale. The evidence was only at most three years old and part of a continuous pattern beginning with his post-combat psychiatric treatment. The Court also held that the trial court improperly precluded opinion testimony by lay witnesses under Federal Rule of Evidence 704(b). Rule 704(b) only bars experts from offering opinions about a criminal's state of mind. Rule 704(a) permits lay opinion on the ultimate issue before the court.

Civil Rights Complaint Alleging 4th Amendment Violation in Death of Man with Bipolar Disorder Dismissed

The 6th Circuit Court of Appeals upheld the trial court's dismissal of a § 1983 complaint brought by the widow of a man with bipolar disorder against two city police officers alleging violation of the Fourth Amendment's prohibition against unlawful search and seizure that resulted in his death. *Johnson v. City of Memphis*, 617 F.3d 864 (6th Cir. 2010). The plaintiff called 911 seeking assistance for her husband, but hung up and left the house before the operator answered. Receiving no response to a follow-up call, the operator dispatched two patrol officers to the house. Upon arrival, the officers

found the door open and after announcing their presence and receiving no response, entered the house with their weapons drawn. The man jumped on one officer grabbing his gun; a scuffle ensued; and the plaintiff's husband was killed. The Court held that the entry met the exigent circumstances emergency aid exception to the 4th Amendment's prohibition against unlawful searches and seizures based upon the factual circumstances in this case.

Tennessee Dismisses EMTALA Complaint in Suicide Case

A United States District Court in Tennessee dismissed this lawsuit brought by the executor of Joshua Ashley Burd against Lebanon HMA, Inc. under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C § 1395dd. *Burd ex rel. Burd v. Lebannon HMA, Inc.*, 2010 U.S.Dist. LEXIS 124696 (M.D. Tenn. Nov. 23, 2010). Burd was initially brought to the emergency room after attempting suicide by hanging himself. Finding him to have high "suicide lethality" and testing positive for cocaine and opiates, Burd was committed to Middle Tennessee Mental Health Institute, a state mental health facility. A psychiatrist at the facility found him not to be a suicide risk and did not admit him. A police officer checking on his condition at home later that evening found an outstanding arrest warrant and learned that Burd had consumed two bottles of vodka. Believing he was a suicide risk, the officer returned Burd to the emergency room. Emergency room staff assessed him and determined he was suffering from acute situational anxiety, not an emergency medical condition, and discharged him. Burd was found dead the next morning from hanging. The trial court dismissed the EMTALA claim finding that the plaintiff had presented no proof of improper motive on behalf of emergency room staff. It found that there was no evidence that the decedent would have been assessed differently had he had health insurance. The court also found that if hospital staff does not have actual knowledge that an emergency medical condition exists, EMTALA does not apply. Any allegations related to medical malpractice must be decided in state court under state malpractice law.

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