

# *DEVELOPMENTS IN MENTAL HEALTH LAW*

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

Volume 34, Issue 3

October 2015

---

## **In This Issue:**

- I. Feature Article: The Gun Violence Restraining Order: An Opportunity for Common Ground in the Gun Violence Debate** [p. 1]
- II. Updates: The SJ 47 Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century** [p. 13]
- III. ILPPP Data Corner** [p. 22]
- IV. Case Law Developments** [p. 27]
- United States Fourth Circuit Decisions [p. 27]
  - Other Federal Circuit Court Decisions [p. 28]
  - State Court Decisions [p. 37]
- V. Institute Programs** [p. 40]
- 

## **I. Feature Article**

### **The Gun Violence Restraining Order: An Opportunity for Common Ground in the Gun Violence Debate**

Kelly Ward\*

#### **Introduction**

In March of 2013, shortly after the massacre at Sandy Hook Elementary School, experts in the areas of mental health, public health, law enforcement, law and gun violence prevention met for a two-day conference to discuss research and identify areas of consensus regarding the intersection of gun violence, public health and mental health. This meeting resulted in the formation of the Consortium for Risk-Based Firearm Policy

and the publication of two reports outlining research and recommending evidence-based gun violence prevention policies at the State and Federal level.<sup>1</sup>

The Consortium determined that a tool was needed to enable law enforcement and family members to keep firearms out of the hands of individuals who may be a danger to themselves or others, but who have committed no crime, and do not meet the clinical criteria for involuntary psychiatric hospitalization. To address this compelling public safety need, the Consortium reviewed innovative state statutes from Connecticut and Indiana and developed a proposal for a Gun Violence Restraining Order (GVRO). A GVRO would “authorize law enforcement to remove guns from any individual who poses an immediate threat of harm to self or others,” and “create a new civil restraining order process to allow private citizens to petition the court to request that guns be temporarily removed from a family member or intimate partner who poses an immediate risk of harm to self or others.”<sup>2</sup> An important component of this recommendation was a restoration process that provided respondents the opportunity to participate in a hearing to seek the return of removed firearms and a suggested duration for the order of one year.<sup>3</sup> This article outlines the history of GVRO policies in Connecticut, Indiana, California, and summarizes a similar proposal under consideration in Virginia.

### **Connecticut**

The 1998 Connecticut Lottery shooting, in which a disgruntled Connecticut Lottery accountant stabbed and shot one of his bosses and shot three other top executives before turning the gun on himself, prompted the Connecticut legislature to pass, and the governor to sign, legislation that established a process to remove firearms from individuals who pose “a risk of imminent injury to self or others.”<sup>4</sup>

Under the Connecticut statute, two law enforcement officers, a state’s attorney or an assistant state’s attorney, may submit a complaint under oath to a judge of the Superior Court [which hears all legal controversies except those over which probate court has jurisdiction] asserting probable cause to believe that “(1) a person poses a risk of imminent personal injury to himself or herself or to other individuals, (2) such person possesses one or more firearms, and (3) such firearm or firearms are within or upon any

---

\* General Counsel, Educational Fund to Stop Gun Violence

<sup>1</sup> The Consortium for Risk-Based Firearm Policy. (2013). *Guns, Public Health, and Mental Illness: An Evidence-Based Approach for State Policy*. Retrieved July 20, 2015, from <http://www.efsgv.org/wp-content/uploads/2014/10/Final-State-Report.pdf>; see also The Consortium for Risk-Based Firearm Policy. (2013). *Guns, Public Health, and Mental Illness: An Evidence-Based Approach for Federal Policy*. Retrieved July 20, 2015, from <http://www.efsgv.org/wp-content/uploads/2014/10/Final-Federal-Report.pdf>

<sup>2</sup> The Consortium for Risk-Based Firearm Policy. (2013). *Guns, Public Health, and Mental Illness: An Evidence-Based Approach for State Policy*. Retrieved July 20, 2015, from <http://www.efsgv.org/wp-content/uploads/2014/10/Final-State-Report.pdf>

<sup>3</sup> *Id.*

<sup>4</sup> Rabinovitz, Jonathan. "Connecticut Lottery Worker Kills 4 Bosses, Then Himself." *The New York Times*. The New York Times, 06 Mar. 1998. Web. 20 July 2015. <http://www.nytimes.com/1998/03/07/nyregion/rampage-connecticut-overview-connecticut-lottery-worker-kills-4-bosses-then.html>; Conn. Gen. Stat. Ann. § 29-38c (West).

place, thing or person.”<sup>5</sup> Law enforcement, state’s attorneys and assistant state’s attorneys are directed to make such a complaint only after they “have conducted an independent investigation and have determined that such probable cause exists and that there is no reasonable alternative available to prevent such person from causing imminent personal injury to himself or herself or to others with such firearm.”<sup>6</sup>

A judge may issue a warrant only on a complaint outlined above that establishes the grounds for issuing a warrant. In determining whether grounds for the warrant exist, a judge shall consider the following: “(1) Recent threats or acts of violence by such person directed toward other persons; (2) recent threats or acts of violence by such person directed toward himself or herself; and (3) recent acts of cruelty to animals ... by such person.”<sup>7</sup> A judge may also consider other factors including, but not limited to, the following: “(A) the reckless use, display or brandishing of a firearm by such person, (B) a history of the use, attempted use or threatened use of physical force by such person against other persons, (C) prior involuntary confinement of such person in a hospital for persons with psychiatric disabilities, and (D) the illegal use of controlled substances or abuse of alcohol by such person.”<sup>8</sup>

If a judge finds there is probable cause to believe that the grounds for firearms seizure exist, the judge “shall” issue a warrant stating the grounds for the warrant and “commanding” any state and local police officer to search “within a reasonable time” the “person, place or thing” named in the warrant, for firearms and ammunition. When the warrant is executed by an officer, a copy must be given to the person, along with a notice informing the person of his or her right to a hearing and to be represented by counsel at the hearing. Connecticut law mandates that a hearing be held within fourteen days to consider whether the guns should be removed for up to one year or returned to the owner.<sup>9</sup> At this hearing the state must prove by clear and convincing evidence that the owner remains “a risk of imminent injury to self or others” for the order to be extended.<sup>10</sup>

### **Indiana**

In 2004, the shooting of five Indiana police officers, in which one officer was killed and four others were injured, prompted the passage of similar legislation that allows law enforcement to remove firearms from individuals they deem dangerous. An individual is defined as “dangerous” if: “(1) the individual presents an imminent risk of personal injury to the individual or to another individual; or (2) the individual may present a risk of personal injury to the individual or to another individual in the future and the individual: (A) has a mental illness (as defined in IC 12-7-2-130) that may be controlled by medication, and has not demonstrated a pattern of voluntarily and consistently taking the individual's medication while not under supervision; or (B) is the subject of

---

<sup>5</sup> Conn. Gen. Stat. Ann. § 29-38c(a) (West).

<sup>6</sup> *Id.*

<sup>7</sup> Conn. Gen. Stat. Ann. § 29-38c(b) (West).

<sup>8</sup> *Id.*

<sup>9</sup> Conn. Gen. Stat. Ann. § 29-38c(d) (West).

<sup>10</sup> *Id.*

documented evidence that would give rise to a reasonable belief that the individual has a propensity for violent or emotionally unstable conduct.”<sup>11</sup> The Indiana law provides two mechanisms for the removal of firearms from individuals whom law enforcement deem to be dangerous; a warrant-based removal process, similar to Connecticut’s, and a warrantless removal process.

Under the Indiana law, a circuit court or superior court judge may issue a warrant to search for and seize a firearm in the possession of a dangerous person if:

- (1) The law enforcement officer provides the court a sworn affidavit that: (A) states why the law enforcement officer believes that the individual is dangerous and in possession of a firearm; and (B) describes the law enforcement officer's interactions and conversations with: (i) the individual who is alleged to be dangerous; or (ii) another individual, if the law enforcement officer believes that information obtained from this individual is credible and reliable; that have led the law enforcement officer to believe that the individual is dangerous and in possession of a firearm;
- (2) the affidavit specifically describes the location of the firearm; and
- (3) the circuit or superior court determines that probable cause exists to believe that the individual is: (A) dangerous; and (B) in possession of a firearm.<sup>12</sup>

If the court issues a warrant for the seizure of firearms, the law enforcement officer executing the warrant shall file, within 48 hours of the execution of the warrant, a return with the court that states that the warrant was served and informs the court of the time and date that the warrant was served, the name and address of the individual named in the warrant, and the quantity and identity of any firearms seized by the law enforcement officer.<sup>13</sup>

If a law enforcement officer, without obtaining a warrant, seizes a firearm from an individual whom the officer believes to be dangerous, the officer is required to submit to the circuit or superior court having jurisdiction over the individual believed to be dangerous a written statement under oath or affirmation describing the basis for the officer's belief that the individual is dangerous.<sup>14</sup> If the court finds there is probable cause to believe the individual is indeed dangerous, the court shall order the law enforcement agency that has custody over the seized firearms to retain them.<sup>15</sup> (Note: The section authorizing a warrantless firearms seizure by an officer *also* states that it “does not authorize a law enforcement officer to perform a warrantless search or seizure if a warrant would otherwise be required.”)

---

<sup>11</sup> Ind. Code Ann. § 35-47-14-1 (West).

<sup>12</sup> Ind. Code Ann. § 35-47-14-2 (West).

<sup>13</sup> Ind. Code Ann. § 35-47-14-4 (West).

<sup>14</sup> Ind. Code Ann. § 35-47-14-3 (West).

<sup>15</sup> *Id.*

Not later than fourteen days from the date a return is filed for a warrant-based seizure, or the date on which a written submission is made for a warrantless seizure, the court shall conduct a hearing to determine whether the seized firearm should be returned to the individual or retained by law enforcement.<sup>16</sup> The court shall inform the prosecuting attorney and the individual from whom firearms were seized of the date, time, and location of the hearing.<sup>17</sup> The burden at this hearing is on the state to prove by clear and convincing evidence that the respondent is dangerous.<sup>18</sup> If the state meets the standard, any firearms seized may be held, until the court orders the firearms to be returned or otherwise disposed of, by the state.<sup>19</sup> (If the person has a license to carry a handgun, the Court “shall” suspend that license.) The respondent also has the option of selling the firearms.<sup>20</sup>

One hundred eighty days after the date on which a court orders a law enforcement agency to retain an individual's firearm, a respondent may petition the court for return of the firearm. The court shall schedule a hearing and inform the prosecuting attorney, who shall represent the state, of the date, time, and location of the hearing. At the hearing, the respondent bears the burden of proving by a preponderance of the evidence that he or she is not dangerous. If the respondent meets this burden, the court shall order the law enforcement agency having custody of the firearm to return the firearm to the individual. If the respondent fails to meet this burden, the individual may not file a subsequent petition until at least one hundred eighty days after the date on which the court denied the petition.<sup>21</sup>

### **California Gun Violence Restraining Order**

On May 23, 2014, Elliot Rodger killed six people and injured fourteen others in Isla Vista, California near the University of California, Santa Barbara. He first stabbed three men in his apartment. Afterward, he drove to a sorority house and shot three women, killing two. Rodger then drove to a nearby deli and shot a male student to death. He drove around Isla Vista shooting and wounding several pedestrians. Rodger finally shot and killed himself.

A month prior to the rampage, Rodger's mother, alarmed at some “bizarre” videos Rodger had posted on YouTube, contacted Rodger's therapist. The therapist called a mental health crisis service and they referred the matter to police. On April 30, 2014, police officers arrived at Elliot Rodger's residence to conduct a welfare check but felt they did not have a legal basis to intervene.<sup>22</sup>

---

<sup>16</sup> Ind. Code Ann. § 35-47-14-5(a) (West).

<sup>17</sup> Ind. Code Ann. § 35-47-14-5(b) (West).

<sup>18</sup> Ind. Code Ann. § 35-47-14-6 (West).

<sup>19</sup> *Id.*

<sup>20</sup> Ind. Code Ann. § 35-47-14-10 (West).

<sup>21</sup> Ind. Code Ann. § 35-47-14-8 (West).

<sup>22</sup> Mather, Kate, Richard Winton, and Adolfo Flores. "Deputies Didn't View Elliot Rodger's Videos in Welfare Check." *Los Angeles Times*. Los Angeles Times, 29 May 2014. Web. 20 July 2015.

<http://www.latimes.com/local/la-me-rodger-welfare-20140530-story.html>

Shortly after the shooting in Isla Vista, Assemblywomen Nancy Skinner (D- Berkeley) and Das Williams (D- Santa Barbara) introduced Assembly Bill No. 1014. The law, passed by the legislature and signed by the governor, allows law enforcement and immediate family members to petition the court for a Gun Violence Restraining Order (GVRO).<sup>23</sup> There are three types of GVROs established by Assembly Bill No. 1014: a temporary emergency GVRO, an ex parte GVRO and a GVRO issued after notice and hearing.

#### Temporary Emergency GVRO

A temporary emergency GVRO may be sought only by a law enforcement officer based on a petition or oral request to a judicial officer any time of day or night.<sup>24</sup> A temporary emergency GVRO may be issued on an ex parte basis if a law enforcement officer asserts, and a judicial officer finds, there is reasonable cause to believe that a person poses an immediate and present danger of injury to self or others by having a firearm in his or her possession and that less restrictive alternatives have been ineffective, inadequate, or inappropriate.<sup>25</sup> The temporary emergency GVRO shall prohibit the subject of the petition from having in his or her custody or control, owning, purchasing, possessing, or receiving, or attempting to purchase or receive, a firearm or ammunition, and shall expire twenty-one days from the date the order is issued.<sup>26</sup>

#### Ex Parte GVRO

An ex parte GVRO may be sought by a law enforcement officer or immediate family member who submits a petition to a judicial officer during normal court hours.<sup>27</sup> A court may issue an ex parte GVRO if the petition shows that there is a substantial likelihood that “(A) the subject of the petition poses a significant danger, in the near future, of personal injury to himself, herself, or another by having in his or her custody or control, owning, purchasing, possessing, or receiving a firearm ...” and “an ex parte gun violence restraining order is necessary to prevent personal injury to the subject of the petition or another because less restrictive alternatives either have been tried and found to be ineffective, or are inadequate or inappropriate for the circumstances of the subject of the petition.”<sup>28</sup> The court must consider the following types of evidence to determine whether to issue an ex parte GVRO:

- (1) A recent threat of violence or act of violence by the subject of the petition directed toward another.
- (2) A recent threat of violence or act of violence by the subject of the petition directed toward himself or herself.
- (3) A recent violation of a protective order of any kind.
- (4) A conviction of a violent offense.

---

<sup>23</sup> Assembly Bill No. 1014 goes into effect on January 1, 2016.

<sup>24</sup> Cal. Penal Code § 18125 (West).

<sup>25</sup> Cal. Penal Code § 18125(a)(1),(2) (West).

<sup>26</sup> Cal. Penal Code § 18125(b) (West).

<sup>27</sup> Cal. Penal Code § 18150(a)(1) (West).

<sup>28</sup> Cal. Penal Code § 18150(b)(1),(2) (West).

- (5) A pattern of violent acts or violent threats within the past 12 months, including, but not limited to, threats of violence or acts of violence by the subject of the petition directed toward himself, herself, or another.<sup>29</sup>

The court may also consider any other evidence of an increased risk for violence, including, but not limited to, evidence of any of the following:

- (1) The unlawful and reckless use, display, or brandishing of a firearm by the subject of the petition.
- (2) The history of use, attempted use, or threatened use of physical force by the subject of the petition against another person.
- (3) Any prior arrest of the subject of the petition for a felony offense.
- (4) Any violation of a protective order of any kind.
- (5) Documentary evidence, including, but not limited to, police reports and records of convictions, of either recent criminal offenses by the subject of the petition that involve controlled substances or alcohol or ongoing abuse of controlled substances or alcohol by the subject of the petition.
- (6) Evidence of recent acquisition of firearms, ammunition, or other deadly weapons.<sup>30</sup>

The ex parte GVRO shall prohibit the subject of the petition from having in his or her custody or control, owning, purchasing, possessing, or receiving, or attempting to purchase or receive, a firearm or ammunition, and shall either be dissolved or extended at a hearing to be held within twenty-one days of the issuance of an ex parte GVRO.<sup>31</sup>

#### GVRO Issued After Notice and Hearing

Not later than twenty-one days after the issuance of an ex parte GVRO, the court shall provide a hearing for the respondent to determine if a more permanent gun violence restraining order should be issued.<sup>32</sup> At the hearing, the petitioner shall have the burden of proving, by clear and convincing evidence, that “[t]he subject of the petition, or a person subject to an ex parte gun violence restraining order, as applicable, poses a significant danger of personal injury to himself, herself, or another by having in his or her custody or control, owning, purchasing, possessing, or receiving a firearm or ammunition” and “[a] gun violence restraining order is necessary to prevent personal injury to the subject of the petition, or the person subject to an ex parte gun violence restraining order, as applicable, or another because less restrictive alternatives either have been tried and found to be ineffective, or are inadequate or inappropriate for the circumstances of the subject of the petition, or the person subject to an ex parte gun

---

<sup>29</sup> Cal. Penal Code §§ 18150(b)(1); 18155(b)(1)(West).

<sup>30</sup> Cal. Penal Code §§ 18150(b)(1); 18155(b)(2)(West).

<sup>31</sup> Cal. Penal Code § 18165 (West).

<sup>32</sup> *Id.*

violence restraining order, as applicable.”<sup>33</sup> If the court finds that there is clear and convincing evidence to issue a GVRO, the court shall issue a GVRO that prohibits the subject of the petition from having in his or her custody or control, owning, purchasing, possessing, or receiving, or attempting to purchase or receive, a firearm or ammunition for up to one year, subject to termination or renewal.<sup>34</sup>

#### Termination and Renewal

A respondent may petition for the termination of a GVRO issue after notice and hearing one time while the order is in effect.<sup>35</sup> If the court finds after the hearing that there is no longer clear and convincing evidence to believe that that the subject of a GVRO poses a significant danger of personal injury to himself, herself, or another by having in his or her custody or control, owning, purchasing, possessing, or receiving a firearm or ammunition and a GVRO is not necessary to prevent personal injury to the subject of the GVRO or another because less restrictive alternatives either have been tried and found to be ineffective, or are inadequate or inappropriate for the circumstances of the subject of the GVRO are true, the court shall terminate the order.<sup>36</sup>

A law enforcement officer or immediate family member of the respondent may request a renewal of a GVRO at any time within the three months before the expiration of a GVRO.<sup>37</sup> The evidentiary requirements and standard of review are the same as those of an initial GVRO issued after notice and hearing.<sup>38</sup>

#### Surrender of Firearms

Upon issuance of a GVRO, the court shall order the restrained person to surrender to the local law enforcement agency all firearms and ammunition in the restrained person’s custody or control, or which the restrained person possesses or owns.<sup>39</sup> Surrender shall occur by immediately surrendering all firearms and ammunition in a safe manner, upon request of any law enforcement officer, to the control of the officer, after being served with the restraining order.<sup>40</sup> A law enforcement officer serving a gun violence restraining order that indicates that the restrained person possesses any firearms or ammunition shall request that all firearms and ammunition be immediately surrendered.<sup>41</sup> Alternatively, if no request is made by a law enforcement officer, the surrender shall occur within 24 hours of being served with the order, by either surrendering all firearms and ammunition in a safe manner to the control of the local law enforcement agency, or by selling all firearms and ammunition to a licensed gun dealer.<sup>42</sup> The law enforcement officer or licensed gun dealer taking possession of any firearms or ammunition shall issue a receipt

---

<sup>33</sup> Cal. Penal Code § 18175(b)(1),(2) (West).

<sup>34</sup> Cal. Penal Code § 18175(c)(1),(d) (West).

<sup>35</sup> Cal. Penal Code § 18185(a) (West).

<sup>36</sup> Cal. Penal Code § 18185(b) (West).

<sup>37</sup> Cal. Penal Code § 18190 (West).

<sup>38</sup> *Id.*

<sup>39</sup> Cal. Penal Code § 18120(b)(1) (West).

<sup>40</sup> Cal. Penal Code § 18120(b)(2) (West).

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*



to the person surrendering the firearm or firearms or ammunition or both at the time of surrender.<sup>43</sup> A person ordered to surrender all firearms and ammunition shall file the original receipt with the court that issued the GVRO and a copy of the receipt with the law enforcement agency that served the gun violence restraining order within 48 hours of service of the order.<sup>44</sup>

### **Experience Under Temporary Firearm Removal Statutes**

In the first ten years that the Connecticut statute was in effect, law enforcement officers and states' attorneys made at least 277 warrant requests resulting in the issuance of 274 warrants and removal of more than 2000 firearms from individuals who were deemed to pose an imminent risk of violence.<sup>45</sup> An additional evaluation, covering October 1, 1999 to July 31, 2013, found that 764 warrants had been served, that the number served had increased significantly after 2010, and that most had been based on threats to self.<sup>46</sup> The evaluation also found that only 1% of individuals served with warrants were in active psychiatric treatment and the majority on individuals served had no history of psychiatric treatment.<sup>47</sup>

During 2006 and 2007, the first two years the Indiana law was in effect, one county court in Indianapolis heard 133 cases involving firearms removed under the new statute.<sup>48</sup> In only 6% of cases the judge ordered the firearms returned to the owner; in 53% of the cases, the court retained the weapons and in 42% of cases the gun owners voluntarily gave up their weapons.<sup>49</sup> In 2007, the pattern of hearing outcomes changed dramatically.<sup>50</sup> Retention of firearms by decision of the court dropped to only 8% of cases, and in only 14% of cases did gun owners voluntarily surrender their weapons.<sup>51</sup>

More recent data from Marion County (Indianapolis), covering the first eight years of implementation (2006-2013), shows that the court heard 404 cases regarding firearm removal by police.<sup>52</sup> Risk of suicide was the most common reason for firearm removal by police (68% of cases overall, peaking at 88.9% in 2009). Risk of actual or threatened violence occurred in 21% of cases, and psychosis was reported in 16% of cases.<sup>53</sup> More

---

<sup>43</sup> *Id.*

<sup>44</sup> Cal. Penal Code § 18120(b)(2)(A),(B) (West).

<sup>45</sup> The Consortium for Risk-Based Firearm Policy. (2013). *Guns, Public Health, and Mental Illness: An Evidence-Based Approach for State Policy*. Retrieved July 20, 2015, from <http://www.efsgv.org/wp-content/uploads/2014/10/Final-State-Report.pdf>.

<sup>46</sup> Michael A. Norko & Madelon Baranoski, *Gun Control Legislation in Connecticut: Effects on Persons with Mental Illness*, 46 Conn. L. Rev. 1609, 1624-1630 (2014).

<sup>47</sup> *Id.*

<sup>48</sup> Parker, G. (2010). Application of a firearm seizure law aimed at dangerous persons: outcomes from the first two years. *Psychiatric Services*, 61(5), 478-482.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> Parker, G. (2015). Circumstances and Outcomes of a Firearm Seizure Law: Marion County, Indiana, 2006–2013. *Behavioral Sciences & the Law*, 33(2-3), 308-322. doi:10.1002/bsl.2175

<sup>53</sup> Parker, G. (2015). Circumstances and Outcomes of a Firearm Seizure Law: Marion County, Indiana, 2006–2013. *Behavioral Sciences & the Law*, 33(2-3), 308-322. doi:10.1002/bsl.2175

than a quarter of the cases noted intoxication by drugs or alcohol.<sup>54</sup> During the initial hearing, the court retained firearms in 63% of cases (primarily associated with the individual failing to appear in court) and dismissed 29% of cases. From February 2008 through 2013 the court ordered retention of firearms only in cases where the defendant failed to appear for the scheduled hearing.<sup>55</sup>

The Indiana law has rarely been used outside Marion County, according to the study author. On the whole, most of the individuals whose firearms were removed under the Indiana law did not request return of their firearms.<sup>56</sup>

The California GVRO does not go into effect until January 1, 2016, and therefore there is no available data regarding implementation of the law.

### **Proposed Gun Violence Restraining Order in Virginia**

During the 2015 General Assembly Session, Virginia State Senator George Barker introduced Senate Bill No. 1429 which would have, among other things, established a warrant-based firearm removal process modelled closely on Connecticut's law.<sup>57</sup> The bill was referred to the Courts of Justice Committee and failed to report by a vote of 4-10.<sup>58</sup>

The bill would have authorized a circuit court judge to issue a warrant for the removal of firearms "[u]pon complaint under oath by any attorney for the Commonwealth or by any law-enforcement officer . . . that such attorney for the Commonwealth or law-enforcement officer has probable cause to believe that (i) a person poses a substantial risk of personal injury to himself or to other individuals in the near future, (ii) such person possesses one or more firearms, and (iii) such firearms are within or upon any place, thing, or person."<sup>59</sup>

In determining whether probable cause to issue a warrant exists, a circuit court judge would have been required to consider evidence of the following:

- (1) recent threats or acts of violence by such person directed toward other persons;
- (2) recent threats or acts of violence by such person directed toward himself;
- (3) recent issuance of a protective order;
- (4) recent violation of an unexpired protective order; and

---

<sup>54</sup> Parker, G. (2015). Circumstances and Outcomes of a Firearm Seizure Law: Marion County, Indiana, 2006–2013. *Behavioral Sciences & the Law*, 33(2-3), 308-322. doi:10.1002/bsl.2175

<sup>55</sup> Parker, G. (2015). Circumstances and Outcomes of a Firearm Seizure Law: Marion County, Indiana, 2006–2013. *Behavioral Sciences & the Law*, 33(2-3), 308-322. doi:10.1002/bsl.2175

<sup>56</sup> Parker, G. (2015). Circumstances and Outcomes of a Firearm Seizure Law: Marion County, Indiana, 2006–2013. *Behavioral Sciences & the Law*, 33(2-3), 308-322. doi:10.1002/bsl.2175

<sup>57</sup> Senate Bill 1429, 2015 Reg. Sess. (Va.2015). <http://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+SB1429>

<sup>58</sup> <http://lis.virginia.gov/cgi-bin/legp604.exe?151+sum+SB1429>

<sup>59</sup> Senate Bill 1429, 2015 Reg. Sess. (Va.2015). <http://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+SB1429>

- (5) recent acts of cruelty to animals.<sup>60</sup>

In determining whether probable cause to issue a warrant exists, a circuit court judge would have been allowed to consider other factors, including the following:

- (1) the reckless use, display, or brandishing of a firearm by such person;
- (2) a history of the use, attempted use, or threatened use of physical force by such person against other persons;
- (3) prior involuntary confinement of such person in a hospital for persons with psychiatric disabilities;
- (4) prior involuntary confinement of such person in a hospital for persons with psychiatric disabilities;
- (5) any history of a violation of a protective order
- (6) the illegal use of controlled substances or abuse of alcohol by such person; and
- (7) evidence of recent acquisition of firearms or other deadly weapons by such person.<sup>61</sup>

The bill further provided that not later than fourteen days after the execution of a warrant the circuit court for the jurisdiction where the person named in the warrant resides shall hold a hearing to determine whether any firearm taken should be returned to the person named in the warrant or should continue to be held by the agency that took the firearms.<sup>62</sup> The attorney for the Commonwealth, who would represent the Commonwealth, would bear the burden of proving by clear and convincing evidence that the person poses a substantial risk of personal injury to himself or to other individuals in the near future.<sup>63</sup> If the attorney for the Commonwealth met this burden, the court would order that any firearm taken pursuant to the warrant issued under this section continue to be held by the agency that took the firearm for a period not to exceed one hundred eighty days.<sup>64</sup> A person who would have been the subject of an order would have been allowed to petition the court one time during the one hundred eighty days for the return of his firearms after thirty days from the date the order was issued.<sup>65</sup>

### **Summary**

The GVRO is an evidence-based policy that seeks to provide law enforcement and families with a tool to temporarily remove firearms from an individual during times of crisis regardless of whether that person has been diagnosed with a mental illness. It also seeks to provide a less restrictive means of preventing tragedy from occurring. The GVRO simply prohibits an individual from purchasing or possessing firearms for a temporary period of time. If an individual were involuntarily committed, not only would

---

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

the person be confined to a hospital, but the accompanying firearm prohibition could be permanent. Variations of this policy have been enacted in Connecticut, Indiana and, most recently, California. The judicial procedures used in these GVRO statutes, which parallel those used in connection with domestic violence restraining orders, satisfy constitutional requirements under both the due process clause and the Second Amendment.<sup>66</sup> Enactment of a GVRO statute merits serious consideration in Virginia.

\* \* \*

[*Editor's Observations:* It is notable how many of the GVRO cases in Connecticut and Indiana involved individuals who were threatening *self-harm* (with only 1% of these individuals in Connecticut being in psychiatric treatment at the time of the GVRO, and a majority having never been in psychiatric care), and how many of these individuals did not seek the return of their firearms.<sup>67</sup> This is particularly interesting in Connecticut, because the Connecticut system seems comparatively cumbersome and slow to respond; specifically, in Connecticut there is no mechanism for immediate or near-immediate removal of the firearm from the person who is in danger of inflicting self-harm. Law enforcement must wait until the Superior Court is open for business (and two officers, or the local state's attorney's office, must file the required complaint). Even with these limitations, the GVRO statute was used by Connecticut law enforcement most often in cases of threatened self-harm, and their use by law enforcement increased significantly after 2010, suggesting their continuing efficacy in addressing such cases. The GVRO laws in Indiana have provisions not found in the Connecticut statute that, it would appear, could enhance their efficacy in responding to cases of threatened self-harm. For example, in Indiana, the officer can make the firearms removal at the scene based on the officer's judgment—something that would appear to be very important for self-harm cases. California's GVRO law, effective January 1, 2016, makes a judicial officer readily available to authorize needed firearms removals. In addition, California's GVRO law will also enable family members to directly seek from that judicial officer a GVRO to remove firearms from the possession of a family member threatening harm to self or others. Given that current research indicates that over 60% of all deaths by firearms in the United States each year—a total of approximately 20,000 people—are suicides, the indications that GVRO statutes can be effective tools for reducing suicides must be taken seriously. This deserves ongoing attention and study.]

Note: WVTF published [an article](#) this month about GVRO laws in the context of college campus shootings.

---

<sup>66</sup> See Law Center to Prevent Gun Violence. (2014). *Memo: California's New Gun Violence Restraining Order Law*. Retrieved October 21, 2015, from <http://smartgunlaws.org/californias-new-gun-violence-restraining-order-law/>

<sup>67</sup> See John Hopkins Bloomberg School of Public Health. (2015). *Suicide-By-Firearm Rates Shift in Two States After Changes in State Gun Laws*. Retrieved October 31, 2015, from <http://www.jhsph.edu/news/news-releases/2015/suicide-by-firearm-rates-shift-in-two-states-after-changes-in-state-gun-laws.html>

## II. Updates

### **The SJ 47 Subcommittee to study mental health services in the Commonwealth in the 21st century**

*I. The mandate:* The 2014 General Assembly created the joint subcommittee, consisting of 12 legislative members (five from the Senate, seven from the House) with a 7-part, comprehensive mandate to review and assess Virginia’s mental health laws and services system, including consideration and incorporation of prior reviews and reports, and to make recommendations on “statutory or regulatory changes needed to improve access to services, the quality of services, and outcomes for individuals in need of services,” and recommendations on needed public and private services, programs, and facilities and the staffing, licensing, funding and governance requirements needed to sustain them. The joint subcommittee must submit its report to the Governor and the 2018 Regular Session of the General Assembly.

*II. The first year - meetings and reviews:* The SJ 47 joint subcommittee has formally met in one-day or two-day sessions on eight different occasions, beginning in July of 2014, with the most recent meeting being held in Suffolk on September 24 and 25, 2015. The subcommittee has formed three ongoing workgroups: Crisis Intervention; Continuum of Care; and Special Populations.

The focus for the subcommittee members for much of the first 15 months has been on learning as much as possible about Virginia’s behavioral health care system. This has involved presentations from a variety of experts and practitioners in the field. The summary below focuses on the overviews of the behavioral health care system considered by the subcommittee, and on issues related to crisis intervention. More coverage will be provided in a later issue on matters relating to continuum of care and special populations.

### *III. An overview of Virginia’s publicly funded mental health system – challenges and changes:*

#### A. DBHDS (Department of Behavioral Health and Developmental Services) perspective:

At the July 21, 2014 meeting, then-Commissioner Ferguson’s overview of Virginia’s mental health system noted the following key “challenges” to that system:

- Prevention and early intervention system is underdeveloped.
- Lengthy community waiting lists—3,200 adult mental health, 1,200 children/adolescents mental health, 1,100 substance abuse.
- Intensive supports such as PACT [Program of Assertive Community Treatment], housing, and employment are inconsistently available across Virginia.
- Underdeveloped peer support services delivery.
- Limited availability of mid-level crisis supports such as crisis stabilization services, CIT secure assessment centers.

- The low income threshold for Medicaid presents challenges for providing services for the uninsured and underinsured.
- Virginia ranks 39<sup>th</sup> in community funding and 10<sup>th</sup> in facility funding nationwide.

Commissioner Ferguson also used that presentation to describe the “Transformation Effort” to develop priorities and examine the entire delivery system for behavioral health and developmental services. (The presentation made to the Continuum of Care Work Group by Jim Martinez, then-Director of the DBHDS Office of Mental Health Services, on October 23, 2015 further supplemented the overview of the “Transformation Effort.”)

At the September 24, 2015 meeting of the subcommittee, interim Commissioner Jack Barber, M.D., provided an update that highlighted several key themes:

- An increased effort to align and integrate primary health care and mental health care, with recognition of the importance of stable housing, employment and community-based services
- A focus on wellness and early access to services
- The adoption in Virginia of the mental health service framework set out in the federal Excellence in Mental Health Act (EMHA), with Virginia applying for federal grant funds from the EMHA to establish Certified Community Behavioral Health Clinics (CCBHCs) in 8 participating sites in Virginia. This effort, now designated the STEP VA (System Transformation, Excellence and Performance Virginia) program, would provide the model for integrated community-based care in the state
- Continued work on the Transformation Effort

#### B. Private Provider Perspective:

In a presentation to the subcommittee’s “Continuum of Care” work group, Jon Morris, CEO of Family Preservation Services, Inc., indicated his concerns that Virginia’s public mental health system made it more difficult for private mental health service providers to provide services optimally. He described the current behavioral health system as a “complex network” that is difficult to navigate, and that effective behavior health care reform is compromised by the fact that current “rates and rate structure” for reimbursing services “are not aligned with evidence-based practices and outcomes-based performance.” He submitted that any transformation effort should explore:

- “Care coordination and integration of primary and behavioral health care”
- “Outcomes-based performance expectations and accountable care models”
- “Collecting better data to guide rate setting and regulatory changes”
- “Providing case management free from any conflict”

#### C. Consumer and Advocacy Perspective:

At the September 24, 2015 meeting, Ms. Mira Signer, Executive Director of NAMI (National Alliance on Mental Illness) Virginia made a presentation on the Virginia system from the perspective of “individuals and families.” The presentation notes the difficulties for families in navigating between public and private mental health care, with

many families finding that having private insurance coverage for mental health services can result in reduced access to needed services. Ms. Signer described both key strengths and weaknesses in Virginia’s system, and set out 10 recommendations for system reform, including:

1. Fund peer support specialists and parent support partners.
2. Expand early intervention and “First Episode” models.
3. Expand array of services for individuals under 18 years old.
4. Strengthen jail diversion
5. Improve use of mandatory outpatient treatment.

#### D. Governor’s Task Force on Improving Mental Health Services and Crisis Response

At the subcommittee’s December 16, 2014 meeting, William Hazel, M.D., Secretary of Health and Human Services, made a presentation on the findings and recommendations of the Governor’s Task Force on Improving Mental Health Services and Crisis Response. The December, 2014 issue of DMHL includes detailed coverage of the deliberations, findings and recommendations of the Task Force.

### ***IV. Crisis Intervention Issues***

#### A. Historical Background and Perspective: Professor Richard Bonnie

Professor Richard Bonnie of the University of Virginia School of Law, and Director of the Institute of Law, Psychiatry and Public Policy at UVA, presented on the history of civil commitment in Virginia<sup>1</sup> at the June 30, 2014 subcommittee meeting. Professor Bonnie noted that when the General Assembly enacted laws in the 1970’s reforming the involuntary psychiatric hospitalization process, attention was on providing “safeguards against unwarranted long-term hospitalization.” The “judicial certification” model adopted in 1974 has remained in effect, but with ongoing revisions and. Among those reforms was the requirement for evaluation of a person in crisis by a Community Services Board evaluator before entry of a Temporary Detention Order (TDO)—a reform, Professor Bonnie noted, that arose out of a desire to establish greater uniformity, clinical independence and fairness in assessments, and to thereby bring about greater efficiency and reduced costs.

Professor Bonnie identified “Unfinished Business/Priorities in Commitment Reform and Crisis Response”:

- Access to safe, non-stigmatizing transportation
- Alternatives to hospital Emergency Departments (EDs) for crisis evaluations, especially custodial evaluations
- Removal of impediments to voluntary admission, especially for uninsured individuals

---

<sup>1</sup> The presentation outline is available [here](#).

- Facilitating execution and activation of advance directives
- Continued improvement in data regarding emergency evaluations, ECOs, TDOs, commitment hearings to facilitate oversight, quality assurance, program evaluation and evidence-based policy-making

## B. Considerations and Possible Models for Improved Emergency Response to Mental Health Crises

In its meeting on September 24, 2015, the Crisis Intervention Work Group heard from four speakers in regard to current challenges in responding to mental health crises and possible models for more effective response to and resolution of those crises. The presentations of those speakers, and the resulting Work Group discussion, are set out below.<sup>2</sup>

### *1. The reality of “psychiatric boarding” in hospital emergency departments: Bruce Lo, M.D., Emergency Department (ED) Director, Sentara Norfolk General Hospital*

**People with mental illness in the ED:** Dr. Lo stated that there are times when 40% of his beds are occupied by patients whose issue is mental illness, with only a small percentage being there under an ECO (and therefore being without an 8-hour mandate for action). He has to devote considerable staff resources to monitoring these individuals

**Obstacles to placement:** Many patients are often in a kind of “limbo” because issues relating to capacity/incapacity, the severity of their presenting symptoms, and insurance coverage, can all result—singly or in combination—in making a person ineligible or inappropriate for a particular placement.

**Behaviorally challenging patients:** Patients with dual diagnoses and gero-psychiatric patients are presenting particular challenges in the ED, and a number of Dr. Lo’s nurses have experienced assaults from patients with mental illness. Some of his staff have training similar to CIT (Crisis Intervention Team) on de-escalating agitated behavior, but the ED environment can be challenging.

**Prescribing and dispensing drugs:** This issue came up several times throughout the day and deserves ongoing attention because of its impact on treatment. Dr. Lo noted the limitations on doctors in regard to prescribing and administering drugs in the hospital setting. There was also discussion of the fact that the drug formularies are different in different settings and that there are also limits on how much medication a patient can be allowed to have in hand when leaving the hospital.

**Wake County as a possible model:** Dr. Lo noted the program in Wake County, North Carolina, where a Psychiatric Emergency Services unit with active treatment is on

---

<sup>2</sup> The materials made available to the Work Group members included the following: a memorandum entitled “Emergency Psychiatric Services Models: Finding the Best Ways to Help People Resolve Mental Health Crises;” and the April 2015 issue of *Developments in Mental Health Law*, which includes an article entitled, “Mental Health Crises and Hospital Emergency Departments.”



campus with other medical facilities. He noted that the Sentara Healthcare System at one time had attempted to build a similar unit at the Norfolk General Hospital complex, but that neighborhood opposition prevented Sentara from getting the necessary approvals for the unit.

*2. Reducing involuntary commitment through early response and diversion: Derek Curran, Director of Crisis Services, Hampton-Newport News (H-NN) CSB*

Mr. Curran provided some history regarding the evolution of the various community-based crisis intervention services provided by the H-NN CSB.<sup>3</sup> He then offered a number of observations on trying to help people in mental health crisis under the current system in Virginia:

**Crisis Stabilization Units (CSUs):** CSUs are voluntary, and depend upon the cooperation of residents. They are not secure facilities. They are intended to “catch” a person in the early part of a crisis. The average stay is multiple days: 4.5 to 7.

**The value of expanding the time frame for resolution of a crisis:** Mr. Curran related that if you can “spread out” the time that a person is in a local assessment/treatment setting and give that person the opportunity to de-escalate, the greater the chances are that you can resolve the person’s crisis in a local setting, with the least restrictive treatment.

**The stress that the ECO creates by narrowing the time frame for decision-making:** Mr. Curran noted that, valuators have an immediate obligation to advise the regional state hospital about the potential admittance and then contacting local facilities to see if they will take the person. This compromises the ability of the CSB evaluator to see if non-hospital resolutions are viable.

**The need to pass individuals through the ED because of screening demands by psychiatric hospitals:** Mr. Curran reported that many psychiatric hospitals require such detailed medical testing and clearances for individuals that the person must be seen and screened in the ED.

**The insurance paradox:** The high denial rate by psychiatric hospitals for admission of persons in crisis who have insurance is driven by the insurance companies’ high thresholds for admission and their rigid interpretation of those thresholds (e.g., requiring suicidal behavior, not ideation alone).

**Police and the paperless ECO:** Police in the region prefer the magistrate-issued ECO because it “covers” them. They will transport a person who wants to go to the hospital and appears to understand their need to go; most paperless ECOs arise when a person changes their mind on the way.

---

<sup>3</sup> Summarized in “Emergency Psychiatric Services Models: Finding the Best Ways to Help People Resolve Mental Health Crises”, found [here](#).

**Regional integrated services center:** Mr. Curran also shared his vision for a regional center that would enable the evaluation and treatment of individuals in mental health crisis in the least restrictive setting possible. The campus setting would house programs of varying levels of intensity and types of evaluation and care.<sup>4</sup>

**Losing local engagement when a person is involuntarily committed:** Mr. Curran noted that, once a person is committed to a psychiatric hospital, the local CSB often has little input. Treatment decisions are made by hospital staff based upon the person's presentation at the hospital; the drug formulary at the hospital is different from the one maintained by the CSBs, so it is often the case that the person is given a whole new set of medications that do not match what the local agency has or would recommend. Often, the person has been so traumatized by the involuntary process that the person is angry and refuses any services upon returning, and stops taking the medication given at the hospital. Not long after this, the person often has another crisis.

*3. The Psychiatric Emergency Center in mental health crises: Damien Cabezas, MSW, MPH, LCSW, Executive Director, Horizon Behavior Health (a CSB)*

In a key part of a larger presentation to the Work Group regarding community-based services provided by Horizon Behavioral Health, Mr. Cabezas discussed the use of a "psychiatric emergency center" in his jurisdiction in the management of mental health crises.

According to Mr. Cabezas, this center first took the form of space within the Emergency Department (ED) at Centra Lynchburg Gen. Hospital that was specifically reserved for psychiatric emergencies. This began in 2014, with "one bay" in the ED, 12 hours per day, staffed with a program coordinator, one peer specialist and medical personnel.

A new, physically separate "Psychiatric Emergency Center" opened in October of 2015. It consists of four bays, and 24/7 staff. There is a coordinator, a licensed clinician, a peer specialist, hospital medical personnel, and an off-duty police officer who assumes custody of a person brought to the facility by a law enforcement officer so that the transporting officer can return to duty.

The key benefits from this center that were identified by Mr. Cabezas were: (1) diversion of a significant number of people to mental health screening at the center who previously would have been arrested and incarcerated; (2) quick return of officers to their street duties; (3) given the medical capacity of the unit, individuals in crisis do not have to be "run through" the general ED first for medical evaluation to be cleared for psychiatric hospitalization.

---

<sup>4</sup> Further detail can be found in the memorandum "Emergency Psychiatric Services Models: Finding the Best Ways to Help People Resolve Mental Health Crises," which was provided to participants of the September 24 meeting and is available on the Division of Legislative Services [website](#).

Mr. Cabezas' description of the Psychiatric Emergency Center appeared to focus on its role in conducting "assessments." He made no reference to active treatment: "in 8 hours they're going somewhere" (and he noted that extension of ECO time to 8 hours had been a positive development for their program).

4. *The Alameda Model: resolving mental health crises without psychiatric hospitalization through a Psychiatric Emergency Services Unit (PES) - Scott Zeller, M.D., Director of the PES unit for Alameda County, California*

Dr. Zeller spoke telephonically to the Work Group from California. The key points from his presentation included the following:

**Key claim: The great majority of psychiatric emergencies can be resolved in 24 hours.** Dr. Zeller submitted that by having a "centralized place" where you have up to 24 hours to make decisions regarding the treatment needed by individuals in psychiatric crisis it is possible to resolve the vast majority of those crises. If you have a narrower time frame, there is more of a "default" to hospitalization.

**Nature of Regional PES unit in Alameda County:** Dr. Zeller described his PES unit as "a Crisis Stabilization Unit (CSU) on steroids." Dr. Zeller noted that California has a billing code for CSUs that reimburses providers \$100/hr for a maximum of 20 hours. His PES unit is considered an outpatient facility, so it keeps people no longer than 23 hours 59 minutes, with 78% returning home or to a step-down program at the end of that time.

**Cost savings:** Dr. Zeller noted that the \$2,000 per patient average for PES patients is *less* than the estimated per-patient costs to EDs from "psychiatric boarding" of persons with mental illness (as found in prior research on this).

**The PES unit as the destination for all people in psychiatric crisis in Alameda County for initial psychiatric evaluation and treatment:** The unit accepts all referrals, regardless of insurance, etc., if medically stable and in need of psychiatric evaluation. Alameda County has 1.5 million people. The PES unit sees 1,500 to 1,800 individuals per month. Most are brought to the PES unit under an involuntary "5150 hold" (which can be effected by certain law enforcement officers and designated mental health professionals, as permitted by California law). However, the goal is voluntary treatment and least restrictive care.

**Restraint and seclusion of patients in crisis at the PES unit:** The rate of restraint/seclusion at the Alameda PES unit is 0.2%.

**Getting to the Alameda PES unit:** People can come directly to the facility, by self-referral or with family or others. The majority are transported from the community by medical transport. Even when a police officer is the initial responder, when the officer finds the person to be in psychiatric crisis and determines the person is safe enough for medical transport, an ambulance is called. Paramedics at the scene make a medical (not a psychiatric) assessment. If the person is deemed medically stable, the person is brought

directly to the PES unit. If not stable, the person is transported to the nearest ED, where the person is evaluated and treated medically. An ED doctor then consults with a PES unit doctor regarding the readiness of the person to be transported to the PES Unit.<sup>5</sup>

**Treatment in the PES unit:** A person arriving by ambulance is normally greeted by a nurse who confirms the patient's medical stability. The person is then seen by a psychiatrist, who conducts a quick initial assessment, especially to see if the person is in a state for which a response with medication might be appropriate. Clinical staff and psychiatrists are regularly meeting with and periodically are re-evaluating patients, and before the end of their 24-hour time in the facility a decision is made regarding their next step.<sup>6</sup>

**Replication:** Given the size of his program in Alameda County, Dr. Zeller was asked whether it was possible to carry out a similar program in smaller settings. Dr. Zeller noted a program in Texas that overcomes its low numbers and rural setting by using tele-psychiatry. He noted that the program has a similar record of success in resolving crises at the local level.

*5. Work Group Discussion about Psychiatric Emergency Services Response: September 24, 2015 meeting*

The general themes that seemed to emerge in questions and comments from the Work Group members at the September 24, 2015 meeting coalesced around the following:

**Impact of current statutes on psychiatric emergency treatment:** The members discussed generally whether the current statutory framework for emergency mental health care intervention – the 8-hour ECO period and the current TDO period – may have the effect of limiting the ability of evaluation and treatment providers to treat and resolve crises without having to resort to involuntary psychiatric hospitalization. It was noted that the lengthened minimum time from entry of a TDO to the holding of the involuntary commitment hearing had resulted in an increasing number of case dismissals at the commitment hearing stage (because people in crisis had stabilized and no longer needed inpatient care).

**Treatment vs. “warehousing” during TDO period:** It was noted that a TDO does not authorize treatment, and that authorization for treatment has to be separately sought from the court if the person refuses treatment or is incapable of giving informed consent. Mr. Curran noted to the Work Group that there are hospitals that, in his experience, do not try to engage the individual in active treatment pending the commitment hearing. (The value of advance care planning and in particular advance directives in enabling the start of the treatment process during such hospitalization was noted.) Mr. Curran also noted that, while Virginia law authorizes facility directors to discharge patients prior to the

---

<sup>5</sup> Further details are outlined in the April 2015 issue of DMHL.

<sup>6</sup> Further details are described in the April 2015 issue of DMHL.

commitment hearing, facilities in his experience almost never do that, and instead wait until the hearing so that the special justice releases the patient rather than the facility.

**“Silo” issues re both budgeting and services:** There appeared to be increasing recognition among the legislators that the actual costs of the current psychiatric emergency response system are not being captured, so that the real cost savings from spending money for various diversion and early intervention services are not being appreciated – for example, reduced ED costs, reduced jail costs, etc., which are currently in separate budgets and simply not identified as costs incurred because of the lack of other emergency mental health services. The “silo” metaphor was also seen as applying to different parts of the health care provision system, with providers being separated rather than integrated.

**Law enforcement transport vs. medical transport:** The legislators and speakers shared comments on the limitations and problems with law enforcement transport, and the potential value of developing a model using medical transport as the default mode in mental health emergencies.

**The drug formulary conundrum:** Del. Watts noted the complaints from parents of young adults with serious mental illness that, when their child requires emergency hospitalization, the hospital or other facility will not accept their child’s medication, so there is often a period of no medication, followed by new medication (and adjustment to this changed medication) and then discharge to the community where the person cannot get the medication that was prescribed in the hospital. Dr. Lo discussed some of the constraints on hospital doctors in regard to formularies and available medications.

#### C. The “Need for Treatment” Standard for Involuntary Commitment and the Use of Mandatory Outpatient Orders: Report from the Treatment Advocacy Center

The Treatment Advocacy Center made two major presentations to the subcommittee on July 21, 2014 (by Executive Director John Snook and Kathryn Cohen, legislative and policy counsel) and September 24, 2015 (by Policy Director Brian Stettin). In the first presentation, the Center provided its February 2014 report entitled “Mental Health Commitment Laws: A Survey of the States,” and an article by Mr. Stettin and colleagues. The second presentation was accompanied by slides entitled “The Untapped Power of Virginia’s Mandatory Outpatient Treatment Law” and an article by Mr. Stettin. Among the key positions by the Center were the following: (1) A central obstacle to stability for many people with mental illness is their inability to gain insight into their illness (“anosognosia”). (2) Given this lack of insight, these individuals are unable to appreciate their need for treatment and often stop treatment unless there is external pressure. Once they stop treatment, their decompensation is inevitable, and the high threshold for involuntary psychiatric treatment set by most state laws often makes that descent agonizing, destructive, and costly. (3) Given this, involuntary psychiatric treatment laws should include a “need for treatment” standard, allowing earlier intervention. (4) “Assisted Outpatient Treatment” (AOT, aka “Mandatory Outpatient Treatment”) should also be utilized to provide the necessary external pressure for persons with a history of

treatment non-compliance to continue in the treatment they need. (5) The experiences of New York and North Carolina show that AOT works, though their success does depend on increased funding for improved community treatment and support. (6) Although Virginia law includes MOT, the Center considers it flawed for several reasons. The main flaw: the requirement that the patient, who has a history of non-compliance and lack of insight, must *agree* to the proposed outpatient treatment. The Center calls for reform of MOT in Virginia and for funding of the community services needed to make MOT viable.

### III. ILPPP Data Corner

Public response to mass shootings in the United States has created a link between gun violence and mental illness. Most gun violence is not committed by people with serious mental illness, however, and most people with mental illness do not commit gun violence.<sup>1</sup> Even among individuals who were involuntarily committed, few go on to commit violence using a gun, and even fewer commit gun violence against a stranger.<sup>2</sup> Although most gun violence is not attributable to mental illness, there is a modest association between mental illness and violence.<sup>3</sup> Most significantly, serious mental illness is a major contributor to gun-related suicide in the United States.

This issue's *ILPPP Data Corner* presents available data<sup>4</sup> on firearm access of adults in Virginia who were evaluated to determine whether they appeared to meet inpatient commitment criteria for the purposes of securing a temporary detention order (TDO). During an evaluation, clinicians meet with an evaluatee and review available records to assess a wide array of information, including the presence or absence of behaviors relevant to commitment criteria. In considering risk assessment and clinical options for each evaluatee, clinicians consider risk factors such as access to weapons.

*(Note that for Chi-square tests presented, significant test results only confirm the presence of a correlation between the tested variables, and do not imply causation.)*

#### Firearm Access around the Commonwealth

There was regional variation in firearm access among evaluated individuals, with the Northern Virginia Planning Partnership Region (PPR) having the lowest proportion of individuals with easy access to a firearm (2.9%), and the Southwestern Virginia PPR

---

<sup>1</sup> Swanson, J.W., Sampson, N.A., Petukhova, M.V., Zaslavsky, A.M., Appelbaum, P.S., Swartz, M.S., & Kessler, R.C. (2015). Guns, Impulsive Angry Behavior, and Mental Disorders: Results from the National Comorbidity Survey Replication (NCS-R). *Behavioral Sciences and the Law*, 33, 199–212. doi: 10.1002/bsl.2172

<sup>2</sup> Steadman, H. J., Monahan, J., Pinals, D., Vesselinov, R., & Robbins, P.C. (2015). Gun Violence and Victimization of Strangers by Persons With a Mental Illness: Data From the MacArthur Violence Risk Assessment Study. *Psychiatric Services in Advance*. doi: 10.1176/appi.ps.201400512

<sup>3</sup> Swanson et al., *supra* note 1.

<sup>4</sup> Data were gathered in April 2013 as part of a larger study of such evaluations conducted in Virginia.

having the highest proportion of individuals with easy access to a firearm (11.5%). Of all 3,436 evaluatees, 6.8% owned or had easy access to a firearm, 66.3% had no access, and access was unknown for 26.9% of evaluatees. For reference, approximately 29.3% of Virginians aged > 18 *owned* a firearm in 2013.<sup>5</sup>

### Engagement in Treatment by Evaluatees with and without Firearm Access

Only 16.3% of evaluatees with known access to a firearm were receiving treatment at the CSB at the time of the evaluation, compared with about one-third of evaluatees without access to a firearm, and one-fourth of evaluatees with unknown access to a firearm. Many evaluatees were not receiving any type of treatment at the time of the evaluation, including over half of evaluatees with easy access to a firearm, and two out of five evaluatees without access or with unknown access to a firearm.

**Table 1. Treatment status of evaluated adults, by firearm access**

Treatment provider	Evaluatees who own or have easy access to firearm	Evaluatees without access to firearm	Evaluatees with unknown access to firearm
	% (n)	% (n)	% (n)
CSB	16.3 (38)	32.3 (737)	26.2 (242)
Other community agency	2.5 (6)	4.3 (99)	3.6 (33)
Private practitioner	16.3 (38)	17.6 (401)	16.5 (152)
Private/community psych facility	1.3 (3)	3.3 (76)	3.3 (31)
DBHDS facility	0.0 (0)	0.4 (8)	0.1 (1)
None	56.7 (132)	40.1 (914)	42.4 (392)

### Mental Health Diagnoses of Evaluatees with and without Firearm Access

Nearly all evaluatees with access to a firearm presented with mental illness. One third of evaluatees presented with a substance abuse/use disorder, and about one quarter of evaluatees presented as dually diagnosed. A Chi-square test of independence did not reveal a statistically significant relationship between firearm access and category of mental illness diagnosis,  $\chi^2 (4, N = 3,058) = 5.867, p = .209$ .

### Relationship between Firearm Access and Risk of Harm to Self

There was a statistically significant, moderate relationship between firearm access and the presence of recent behaviors or symptoms indicating an elevated risk of serious

<sup>5</sup> Kalesan, B., Villarreal, M.D., Keyes, K.M., & Galea, S (2015). Gun ownership and social gun culture. *Injury Prevention*. 0, 1–5. doi:10.1136/injuryprev-2015-041586.

physical harm toward self,  $\chi^2 (2, N = 3,436) = 45.85, p < .001$ , Cramer's  $V = 0.12$ .<sup>6</sup> Specifically, evaluated individuals who had easy access to a firearm were more likely than those without access to have recent behavior or symptoms indicating elevated risk.<sup>7</sup>

In addition, there was a statistically significant, strong relationship between firearm access and threatening to commit suicide,  $\chi^2 (2, N = 3,436) = 73.69, p < .001$ , Cramer's  $V = 0.15$ . Specifically, evaluated individuals who had easy access to a firearm were more likely to have recently threatened to commit suicide and those who did not have access to a firearm were less likely to have recently threatened to commit suicide.

**Table 2. Risk of harm to self in evaluated adults, by firearm access**

<b>Behaviors related to harm to self</b>	<b>Evaluees who own or have easy access to firearm % (n)</b>	<b>Evaluees without access to firearm % (n)</b>	<b>Evaluees with unknown access to firearm % (n)</b>
<b>Any recent behavior or symptoms indicating an elevated risk of serious physical harm toward self</b>	72.1 (168)	49.7 (1,133)	55.5 (511)
<b>Ingested pills or poison</b>	10.3 (24)	8.5 (194)	12.0 (111)
<b>Injured self with sharp object</b>	3.9 (9)	4.5 (102)	5.3 (49)
<b>Other self-injurious behavior</b>	6.9 (16)	5.4 (124)	6.1 (56)
<b>Threatened to commit suicide</b>	45.5 (106)	20.7 (472)	22.5 (208)
<b>Threatened other serious harm</b>	5.2 (12)	3.3 (75)	3.2 (30)
<b>Voiced suicidal thoughts without threats</b>	14.2 (33)	15.6 (33)	14.7 (136)

### **Relationship between Firearm Access and Risk of Harm to Others**

There was a statistically significant, weak association between firearm access and the presence of recent behaviors or symptoms indicating an elevated risk of serious physical harm toward others  $\chi^2 (2, N = 3,436) = 32.30, p < .001$ , Cramer's  $V = 0.10$ . Specifically, individuals with access to a firearm were more likely to have displayed recent behaviors or symptoms indicating an elevated risk of harm to others than individuals without access to a firearm.

There was a statistically significant, moderate association between firearm access and threatening someone with a gun, knife, or other weapon,  $\chi^2 (2, N = 3,436) = 70.22, p < .001$ , Cramer's  $V = 0.14$ . Specifically, evaluated individuals with access to a firearm were

<sup>6</sup> Common guidelines for interpreting Cramer's  $V$ , an estimate of effect size, are:  $> .25$  = very strong relationship,  $.15-.25$  = strong relationship,  $.11-.15$  = moderate relationship,  $.06-.10$  = weak relationship, and  $.01-.05$  = negligible relationship.

<sup>7</sup> Post-hoc analyses for all significant Chi-square results were conducted via analysis of standardized residuals.



most likely to have recently threatened someone with a weapon. There was a statistically significant, weak association between firearm access and verbally threatening to seriously harm someone,  $\chi^2 (2, N = 3,436) = 18.70, p < .001$ , Cramer's  $V = 0.07$ . Specifically, individuals with access to a firearm or unknown access to a firearm were more likely to have recently made a verbal threat to harm someone.

Notably, far fewer people (about one tenth of individuals) with access to a firearm had recently threatened to seriously harm others than had threatened to seriously harm themselves (about half of individuals).

**Table 3. Risk of harm to others in evaluated adults, by firearm access**

<b>Behaviors related to harm to others</b>	<b>Evaluees who own or have easy access to firearm % (n)</b>	<b>Evaluees without access to firearm % (n)</b>	<b>Evaluees with unknown access to firearm % (n)</b>
<b>Any recent behavior or symptoms indicating an elevated risk of serious physical harm toward others</b>	32.6 (76)	18.3 (416)	23.3 (215)
<b>Injured someone</b>	0.9 (8)	1.7 (39)	1.1 (10)
<b>Hit, kicked, pushed someone without injury</b>	3.4 (8)	4.8 (111)	3.9 (36)
<b>Threatened or endangered someone with a gun, knife, or other weapon</b>	11.2 (26)	2.0 (46)	2.1 (19)
<b>Verbal threat to seriously physically harm someone</b>	12.0 (28)	6.5 (147)	10.2 (94)
<b>Voiced thoughts of harming someone, without threats</b>	5.2 (12)	4.9 (112)	5.6 (52)

### **Relationship between Firearm Access and Commitment Criteria at Time of Evaluation**

There was a statistically significant, moderate association between the evaluatee's access to firearms and the clinician's ultimate opinion about whether the evaluatee met commitment criteria for harm to self,  $\chi^2 (2, N = 3,436) = 51.53, p < .001$ , Cramer's  $V = 0.12$ . Specifically, individuals with easy access to a firearm were more likely to be opined to meet criteria for harm to self. There also was a statistically significant, moderate association between the evaluatee's access to firearms and whether the clinician opined that the evaluatee met commitment criteria for harm to other,  $\chi^2 (2, N = 3,436) = 38.95, p < .001$ , Cramer's  $V = 0.11$ . Specifically, individuals with easy access to a firearm were more likely to be opined to meet criteria for harm to others.

**Table 4. Clinician opinion regarding the evaluatee’s status at the end of the evaluation**

Evaluatee presented a substantial likelihood of causing serious physical harm to...	Evaluees who own or have easy access to firearm % (n)	Evaluees without access to firearm % (n)	Evaluees with unknown access to firearm % (n)
<i>Self</i> in the near future	59.0 (135)	36.8 (834)	44.5 (408)
<i>Others</i> in the near future	28.4 (65)	13.6 (309)	18.1 (166)

**Relationship between Firearm Access and Recommended Evaluation Disposition**

There was a statistically significant, moderate association between recommended disposition and firearm access,  $\chi^2 (2, N = 3,436) = 67.94, p < .001$ , Cramer’s  $V = 0.14$ . Specifically, clinicians were more likely to recommend a TDO for individuals with easy access to a firearm or unknown access to a firearm. Nonetheless, it should be noted that nearly half of individuals with easy access to a firearm who presented for emergency mental health evaluation were not found by the evaluator to meet criteria for a TDO and potentially involuntary commitment.

**Table 5. Recommended disposition after emergency evaluation, by firearm access**

Disposition recommended by CSB clinician	Evaluees who own or have easy access to firearm % (n)	Evaluees without access to firearm % (n)	Evaluees with unknown access to firearm % (n)
<b>TDO disposition</b>	51.9 (121)	35.3 (797)	49.3(452)
<b>Other disposition</b>	48.1 (112)	64.7 (1,462)	50.7 (464)

**In Closing**

Although nearly all evaluatees presented with mental illness, many evaluatees were not receiving mental health treatment at the time of the evaluation, including over half of evaluatees with easy access to a firearm. Evaluatees with easy access were significantly more likely to have recently threatened to commit suicide, with nearly half of evaluatees with access to a firearm having recently threatened to commit suicide. In fact, many more evaluatees had recent behavior or symptoms that indicated an elevated risk harm to *self* than recent behavior or symptoms that indicated an elevated risk of harm to *others*. Nonetheless, evaluatees with access to a firearm were significantly more likely than evaluatees without access to a firearm to have (1) recently exhibited symptoms or behaviors indicating an elevated risk of harm to others, (2) recently threatened someone with a weapon, and (3) recently made a verbal threat to harm someone.

An evaluatee’s access to a firearm was also associated with clinician opinion regarding whether that evaluatee presented a substantial likelihood of causing serious physical harm to self or others in the *near future*. Accordingly, clinicians were more likely to recommend a TDO disposition for evaluatees with easy access to a firearm; however,

nearly half of evaluatees with easy access to a firearm were not found by clinicians to meet criteria for a TDO (and involuntary commitment).

Taken together, these data collected in the context of emergency mental health evaluations in Virginia accord with previous research demonstrating the complex relationship between access to firearms and danger to self or others.

## IV. Case Law Developments

### United States Fourth Circuit Decisions

**Restoration of competency through forcible medication: *Sell* standard requires government to make a particularized showing by clear and convincing evidence that proposed treatment is substantially likely to restore defendant to competency**

*United States v. Watson*, 793 F.3d 416 (4th Cir. 2015)

**Background:** The government requested court authorization to medicate defendant involuntarily in order to restore him to competency to stand trial. The district court granted the request finding that the government had met the *Sell* requirements<sup>8</sup> by clear and convincing evidence. Defendant appealed, claiming that the government failed to satisfy (1) the first *Sell* prong because the “important governmental interest at stake” in prosecuting Watson was mitigated by the fact that Watson had the “possibility” of an affirmative defense of “not guilty by reason of insanity” and (2) the second *Sell* prong because the government did not prove that the proposed forced medication was substantially likely to render Watson competent to stand trial.

**Holdings:** In a 2-1 panel decision, the Court reversed the District Court, holding that the record showed that the government not only failed to meet the second *Sell* prong, but *could* not meet it, and it dismissed the matter, without remand to the District Court for further hearing.

**Notable Points:** Emphasizing the importance of the liberty interest at stake, the intrusiveness of the act of forcible medication, and the burden of “clear and convincing evidence” that the government had to meet, the Court ruled that the evidence in the record failed to show that the forced medication proposed for Watson was substantially likely to restore Watson to competency. The Court, noting that Watson had a “rare” delusional disorder, concluded that the government’s expert, and the research relied upon

---

<sup>8</sup> (1) Important governmental interests were at stake and special circumstances did not sufficiently mitigate those interests; (2) involuntary medication was (a) substantially likely to render the defendant competent to stand trial and (b) substantially unlikely to have side effects that would interfere significantly with the defendant's ability to assist counsel at trial; (3) the involuntary medication was necessary to further the government's interests and less intrusive means were unlikely to achieve substantially the same results; and (4) the administration of drugs was *medically* appropriate and in the patient's best medical interests in light of [his] medical condition. 539 U.S. at 180 et seq.

by that expert, addressed the efficacy of the proposed forced medication for people suffering from psychosis *in general* and that the government failed to address the medication's likely effect on this defendant *in particular*.

### Other Federal Circuit Court Decisions

#### **Excessive use of force: Claim that officer used excessive force in taking person into custody for involuntary commitment survives summary judgment**

*Clay v. Emmi*, No. 14-2351, 2015 WL 4758917 (6th Cir. Aug. 13, 2015)

**Background:** Police officer Emmi went to the home of Clay upon call from Clay's counselor, who reported that Clay, who had diagnoses of schizophrenia and bipolar disorder and a history of suicidal ideation, was making suicidal statements. Clay voluntarily rode with Emmi to the hospital and entered the hospital "to talk to somebody." When hospital staff asked Clay to disrobe and put on a gown, he refused. In a § 1983 action against Emmi and others for excessive use of force, Clay claimed that, despite his offering no resistance, he was wrestled to the ground, handcuffed and turned face-down, and then tasered in the back by Emmi while handcuffed and offering no resistance. Emmi claims that Clay attempted to leave the hospital, physically resisted efforts to keep him there, and had to be tasered and then handcuffed in order to overcome his resistance. Witnesses provided support for Emmi's version of events, but there was no definitive evidence (such as a video recording). Emmi moved for summary judgment on the grounds that a 14<sup>th</sup> Amendment "subjective use of force" analysis applied to his actions, he had no reason to think that his actions violated Clay's due process rights, and therefore he was entitled to "qualified immunity" for his actions.

**Holdings:** The district court found, and the Court of Appeals affirmed, that (1) the 4<sup>th</sup> Amendment's "objectively reasonable" standard for use of force applied to Emmi's actions because Clay was not in custody until the initial "seizure" in the hospital, and (2) because key facts were in dispute that related directly to the need to use force to manage Clay in the hospital, summary judgment action was not supported at that stage of the proceedings.

**Notable Points:** The Court noted that "among the factors to be considered" in determining whether an officer's use of force was objectively reasonable were "whether the person being seized poses an immediate threat to the safety of officers or others" and "whether the person is actively resisting."<sup>9</sup> Therefore, "Clay's level of resistance and whether he was handcuffed before being tasered" were "central to this inquiry."

#### **Excessive use of force: Post-*Sheehan* analysis of two separate excessive force claims in mental health emergencies results in *sustaining* summary judgment in one case and *denial* of summary judgment in the second case**

---

<sup>9</sup> Quoting *Graham v. Connor*, 490 U.S. 386, 391 (1989).

*Estate of William E. Williams, et al. v. Indiana State Police Department (No. 14-2523), Nancy Brown v. Wayne Blanchard and Walworth County, Wisconsin (No. 14-2808)*  
(7<sup>th</sup> Cir. August 13, 2015)

**Background:** In the Williams case, family members reported to the police that Williams had taken all of his remaining Xanax, locked himself in a bathroom and reported that he had cut himself, and threatened to kill anyone who tried to enter the bathroom. The officers who responded were unable to look into the bathroom to confirm Williams' condition, and carried out a plan in which they unlocked the bathroom door and then tasered Williams to keep him from carrying out his threats of self-harm and harm to others. The tasers had no effect on Williams, who pursued the officers through the house, swinging his knife. Officers shot and killed him. Williams' estate brought suit alleging excessive use of force by the officers in violation of the 4<sup>th</sup> amendment. The district court granted the defendants summary judgment based upon a finding that the officers were protected by qualified immunity. The Williams estate appealed.

In the Brown case, Nancy Brown's son John had cut himself, had a knife in his possession and was locked in his bedroom, but his mother had a key and went into her son's room and spoke with him. He refused help, but did not threaten to harm his mother or anyone else. The first responding officer (Officer Such) spoke with Ms. Brown and then attempted to speak with Mr. Brown through the door, but Brown only responded with a profanity. A second officer (Officer Blanchard) arrived, spoke briefly with Ms. Brown and Such, and proceeded down the hall to the bedroom door as Such went outside to look at Mr. Brown through the window. Such radioed to Blanchard that Brown was sitting at his desk, in front of his computer, drinking a beer and smoking. Declining an offer by Brown's mother to unlock the door to Brown's room, Blanchard kicked in the door, gun drawn. Officer Such came back inside, backing up Blanchard with his taser drawn. Brown rose with knife in hand, crossed the room, and slammed the door shut. Blanchard again kicked open the bedroom door. The officers later reported that Blanchard ordered Brown to drop the knife and advised Brown that he would have to shoot him, and that Brown responded by rolling his shoulders forward and advancing toward the officers while moving the knife "in an upward position." The officers reported that when Brown was 5 or 6 feet away from them, Blanchard shot him twice, killing him. Nancy Brown, who was in the living room at the time of the shooting, reported that she never heard either officer tell Brown to drop his knife and that she heard the fatal shot fired almost immediately after the bedroom door was kicked open the second time. Ms. Brown sued Officer Blanchard and the county, claiming excessive force was used against her son in violation of the 4<sup>th</sup> amendment. Blanchard moved for summary judgment but the district court denied the motion, ruling that there were material facts in dispute, and that the jury's findings on those disputed facts could result in a finding of liability on the part of the officer, under one or both of two legal theories: (1) that Blanchard's unreasonable "pre-seizure conduct" provoked the actions by John Brown that resulted in the shooting, and (2) that at the time of the shooting, John Brown at most was only passively resisting the officers, so that the use of lethal force against Brown was unreasonable. Blanchard appealed. The Court of Appeals consolidated the two cases.

**Holdings:** A 3-judge panel of the Court of Appeals upheld the rulings of each district court. In upholding *Williams*, the panel cited and closely followed the reasoning of the U.S. Supreme Court in *City and County of San Francisco v. Sheehan*, 35 S. Ct. 1765 (2015), noting that the plaintiffs could not cite *any* case law existing at that time that found “objectively unreasonable” the strategy of the officers. In fact, the panel noted, a number of appellate courts had specifically found similar actions in other cases to be objectively reasonable. Hence, the officers were not on notice that their actions were an excessive use of force.

In *Brown*, the panel upheld the district court’s *denial* of the officer’s request for summary judgment based on qualified immunity. The panel, noting again its reliance on *Sheehan*, rejected the district court’s concept of liability for “pre-seizure conduct” as not having the support of case law that would put the officer on notice that his conduct violated 4<sup>th</sup> amendment standards. However, the panel sustained the district court’s denial of summary judgment in regard to the second theory, noting that under longstanding case law it was clear that it was unreasonable for an officer to use deadly force in response to an individual who was presenting only passive resistance to the officer.

**Notable Points:** The opinion is a careful and detailed consideration of the facts of each case and of the proper legal framework for a court’s analysis of those facts, particularly under the guidance provided by the U.S. Supreme Court in *Sheehan*. The panel rejected the *Brown* court’s first theory of liability: “Our case law is far from clear as to the relevance of pre-seizure conduct, or even as to a determination as to what conduct falls within the designation ‘pre-seizure,’ although the majority of cases hold that it may not form the basis for a Fourth Amendment claim.”

***Why the result in Brown was different:***

Review standard for interlocutory appeal: The panel noted that, because Blanchard’s appeal was an interlocutory appeal from the district court’s *denial* of qualified immunity, the scope of the panel’s review was limited to “the purely legal question of whether ‘a given set of undisputed facts demonstrates a violation of clearly established law.’”

Panel’s acceptance of district court’s second theory of liability: The panel found that the law was clear that officers cannot use significant force on non-resisting or passively resisting suspects; so, if a jury found that the facts were as Nancy Brown described them, then Blanchard’s use of deadly force against a “passively resisting” John Brown would violate the 4<sup>th</sup> amendment.

Blanchard’s “pre-seizure conduct” is relevant to this analysis because it is part of the “totality of the circumstances” that must be considered in evaluating the reasonableness of the seizure. The panel noted factors, such as: John never threatened to harm anyone else; John allowed his mother to enter his room and hug him; John was clearly seen to be passively sitting at his computer; and Blanchard chose to kick in the door to John’s room, and to immediately resort to deadly force when the non-lethal taser was immediately available.

**Unreasonable seizure of firearms: Deputy’s warrantless seizure of firearms from the home of a person after the person had been removed from the home and hospitalized for suicidal behavior constitutes unreasonable seizure under 4<sup>th</sup> amendment, but deputy entitled to qualified immunity**

*Arden v. McIntosh, et al.* (No. 14-1517) (10th Cir. July 23, 2015)

**Background:** Sheriff’s deputies were dispatched to Arden’s home after a caller reported to emergency staff that Arden had called her and in slurred speech had stated that he was taking pills and would continue taking them because nobody cared about him. Deputies found the front door to Arden’s home open. Officers announced their presence, found Mr. Arden in his bedroom, incoherent and unresponsive. Medics soon arrived and took Mr. Arden to the hospital, where he was placed on an “emergency mental health hold.” While still at the home, a deputy saw 23 firearms and ammunition in plain sight; these were collected and held for safekeeping at the police station. After Mr. Arden was released from the hospital, the firearms and ammunition were returned to him.

Mr. Arden filed suit in state court alleging a 4<sup>th</sup> amendment violation and that the Sheriff failed to provide proper policies, training, and supervision in regard to such activities. The defendants removed the case to federal court, and moved for summary judgment, claiming they were entitled to “qualified immunity” for their actions. The district court granted the motion, finding no constitutional violations in the deputies’ conduct. Mr. Arden appealed, arguing that once he was taken from his home to the hospital, exigency ended, so that the subsequent warrantless search and seizure were not justified. The deputy argued that, because she was already authorized to be in the home and the weapons were in plain sight and her seizure was temporary and carried out for public safety purposes, her actions were authorized by law enforcement’s “community caretaking” role.

**Holdings:** A 3-judge panel of the Circuit Court ruled that the exigency was removed when Arden was removed from the home to the hospital, so that there was no cited legal authority for removing the firearms from the home. As a result, the firearms seizure constituted an unlawful seizure under the 4<sup>th</sup> amendment. However, at the time of that seizure, there was no existing case law that gave the deputy “fair warning” that this conduct was unreasonable. Accordingly, the deputy was protected by “qualified immunity” from liability because she could have a good faith belief that her conduct was lawful.

**Notable Points:** The panel noted that no authority could be found “authorizing a police officer to confiscate weapons that would otherwise be left in an unoccupied house,” but also that no authority clearly established “that firearms may not constitutionally be removed from a residence under these circumstances.”

**Forced medication of involuntarily committed patients: State administrative procedure authorizing hospital medical panel review and approval of forced**

**medication of patients in non-emergency situations does *not* violate ADA or constitutional rights of patients**

***Disability Rights New Jersey, Inc. v. Comm'r, New Jersey Dep't of Human Servs.*, No. 13-4255, 2015 WL 4620273 (3d Cir. Aug. 4, 2015)**

**Background:** Plaintiffs brought action challenging New Jersey's administrative policy for the forcible medication of involuntarily committed persons in state psychiatric hospitals in non-emergency situations. The plaintiffs alleged that the policy—which required in-hospital medical panel review, approval and oversight of all proposed involuntary medications, with various procedural requirements and the right to in-hospital appeal and review—violated the Americans with Disabilities Act (ADA), Rehabilitation Act (RA), and the 14<sup>th</sup> Amendment, and asked that the Court require the state to establish a procedure for judicial review. The district court found that the state's administrative policy was valid, *except* as to patients who had been found by a court to be ready for discharge and were in the hospital awaiting transfer to the community (“CEPP” patients). The district court granted summary judgment to the state in regard to all but the CEPP patients. Summary judgment was awarded to the plaintiffs in regard to the CEPP patients. Both the plaintiffs and the state appealed.

**Holdings:** A 3-judge panel of the Court of Appeals affirmed the district court's ruling, “though not for all its stated reasons.” The panel, relying heavily on the U.S. Supreme Court's decision in *Washington v. Harper*, 494 U.S. 210 (1990), found that New Jersey's medically-based panel review process properly balanced the liberty interests of *the non-CEPP* patient with the state's interests in both the safety of the hospital and the treatment and return to the community of the patient. Relying on *Mathews v. Eldridge*, 424 U.S. 319 (1976), however, the panel found the CEPP patients' due process rights were violated by New Jersey's policy.

**Notable Points:**

***Due process analysis by the Court for non-CEPP patients:*** Noting that the U.S. Supreme Court had never addressed the constitutional right of involuntarily committed patients to refuse recommended medications for treatment, the panel adopted the balancing test applied to prisoners who refuse recommended psychotropic medications. The panel explained that, although convicted criminals in prisons do not have the same due process rights as persons held in non-criminal facilities, the U.S. Supreme Court's treatment of forced medications in such cases makes clear that they can be justified only for non-punishment purposes; thus, application of *Harper* was not confined to prisoners. Because the New Jersey policy was essentially identical to the policy challenged in *Harper*, the panel found that it met all due process and related constitutional standards.

***Due process analysis by the Court for CEPP patients:*** The panel specifically found that the standards in *Harper* could not be applied to CEPP patients, who had been “adjudicated by a court to be nondangerous.” The panel turned to the 3-pronged



balancing test set out in *Mathews v. Eldridge*.<sup>10</sup> The panel noted that the administrative policy would permit forcible medication “even after a judge has ruled that the factual basis for their continued civil commitment has disappeared.” If a patient on CEPP status had so deteriorated that forcible medication of that patient had become necessary, the “appropriate course” for the state would be to recommit the patient.

**Cruel and unusual punishment: Claim by prisoner with history of mental illness and behavioral disorder that being restrained naked in a chair for 14 hours violated the 8<sup>th</sup> amendment survives summary judgment**

*Young v. Martin*, No. 13-4057, 2015 WL 5202968 (3d Cir. Sept. 8, 2015)

**Background:** State prisoner Young brought a § 1983 action alleging violations of the 8<sup>th</sup> Amendment. Young had a long history of serious mental illness and extensive disciplinary problems in different Pennsylvania prisons, and had been in solitary confinement for several years, during which time his symptoms of mental illness had intensified. The incident resulting in his being placed naked in four-point mechanical restraint in a restraint chair occurred when a guard inadvertently left Young’s cell door open. Young went out to an internal ledge above the prison’s law library, where he voiced his objections to the conditions of his confinement. Young never acted aggressively, never threatened others, and when taken into physical custody by guards he initially cooperated, and then engaged in passive resistance, forcing guards to carry him but offering no active resistance to being stripped naked, subjected to a body cavity search and secured to the restraint chair. Prison policies provide for use of the restraint chair when an inmate acts or threatens to act in a manner that places the inmate or others at risk of harm, and provides for a maximum time period of 8 hours (with extension requiring a written request and approval that was never obtained here).

The district court granted defendants' motion for summary judgment, finding that the guards “acted professionally and within constitutional parameters” in “subduing” Young and placing him in the restraint chair. The district court also denied Young’s request for a stay of the proceedings to allow for the release of the U.S. Department of Justice’s report on its investigation of the Pennsylvania prison system’s treatment of inmates with serious mental illness.

**Holdings:** A 3-judge panel of the Court of Appeals found that the conduct of the guards alleged by Young fell under the “use of excessive force” test to determine whether Young had been subjected to cruel and unusual punishment in violation of the 8<sup>th</sup> Amendment. Reviewing the record under the criteria identified in *Hope v. Pelzer*, 536 U.S. 730 (2002)<sup>11</sup>, and “drawing all inferences in favor of Young as the nonmoving party,” the

---

<sup>10</sup> (1) "the private interest that will be affected by the official action"; (2) "the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards"; and (3) "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."

<sup>11</sup> (1) where the inmate had "already been subdued, handcuffed, [and] placed in leg irons," and (2) there was a "clear lack of an emergency situation" such that "[a]ny safety concerns had long since abated," then

Court ruled that “we cannot say that ‘there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.’”<sup>12</sup> The Court thereupon remanded the case back to the district court. The panel directed that the district court on remand consider whether the DOJ report was admissible, and whether such admission would be “unduly prejudicial” to the defendants.

**Notable Points:**

***Eighth amendment analysis of use of mechanical restraints—“excessive force” vs. “conditions of confinement”:*** The panel rejected the defendants’ claim that their treatment of Young should be analyzed under the “conditions of confinement” framework. The panel noted that the U.S. Supreme Court in *Hope* ruled that the use of mechanical restraints in a prison setting could constitute cruel and unusual punishment. Applying the *Hope* criteria, the panel found the following: (1) Young was already subdued, and further was not violent, combative or self-destructive at any point during the incident leading up to his being placed in the restraint chair, (2) the events involved in the incident leading to Young’s placement in the restraint chair did not amount to an “emergency situation,” and (3) there was an issue of fact as to whether the guards’ use of the restraint chair subjected Young to “substantial risk of physical harm” and “unnecessary pain.”

***Qualified immunity of the guards:*** The panel noted that the defendants made a one-sentence claim in their appeal that they were entitled to summary judgment on the grounds of qualified immunity—that the state of the law at that time did not give them fair warning that their treatment of Young was unconstitutional. Noting that this claim was not addressed by the district court or briefed on appeal, the panel remanded the issue to the district court for consideration.

**Cruel and unusual punishment: Claim by surviving family member that inmate’s suicide was result of deliberate indifference by jail staff survives motion for summary judgment in claim against sheriff in his official capacity, but summary judgment is granted to sheriff on claim against him in his individual capacity due to qualified immunity**

***Cox v. Glanz*, No. 14-5022, 2015 WL 5210607 (10th Cir. Sept. 8, 2015)**

**Background:** Charles Jernegan surrendered to the Tulsa, Oklahoma jail in response to a warrant for his arrest. His intake screening included a mental health and suicide questionnaire. Jernegan reported that he was taking medication for paranoid schizophrenia, and he answered “yes” to questions asking about experience of paranoia and experience of nervousness or depression. Jail protocols called for a person with such responses being directly referred to mental health staff, but no such referral was made. Jernegan did deny to jail staff and a screening nurse that he had any suicidal thoughts.

---

subjecting the inmate to "substantial risk of physical harm" and "unnecessary pain" through the use of mechanical restraints “serves no penological justification” and constitutes cruel and unusual punishment.

<sup>12</sup> Fed. R. Civ. P. 56(a).

Jernegan later made a request to “talk” with jail mental health staff about unspecified “problems,” but the responding staff person reported that when she went to see Jernegan he had been moved to another cell. The staff person had not followed up on this or seen Jernegan when, two days later, Jernegan committed suicide by hanging himself with a sheet. Jernegan’s mother brought § 1983 action against the county sheriff, in both his personal and official capacity, alleging that the jail’s “deliberate indifference” to her son’s mental health needs constituted cruel and unusual punishment in violation of the 8th amendment. The district court denied the sheriff’s motion for summary judgment, on the grounds that there were facts in controversy in the matter that were determinative of the issue of the sheriff’s liability. The sheriff filed an interlocutory appeal.

**Holdings:**

***Qualified immunity for individual liability granted and claim dismissed:*** A 3-judge panel found that at the time of Jernegan’s suicide in 2009, there was no “clearly established” law that would have put the sheriff on notice that his conduct constituted “deliberate indifference” to Jernegan’s mental condition in the jail in violation of the 8<sup>th</sup> amendment. The Court found that the then-existing law required a threshold finding that the sheriff had personal knowledge that Mr. Jernegan “presented a substantial risk of suicide” before liability could attach.

***Summary judgment motion for official capacity liability claim denied:*** The sheriff argued that “official capacity” liability requires proof of a policy, pattern or practice that resulted in the alleged constitutional violation, and that the record did not support a finding of any such policy, pattern or practice in this case. The panel responded that, although denial of a claim of qualified immunity is a final action that can be heard and reviewed on interlocutory appeal, the denial of a motion for summary judgment that is unrelated to a denial of qualified immunity is *not* a final action and therefore cannot (except in rare instances) be heard and reviewed on interlocutory appeal.

**Notable Points:** The panel’s decision is notable for its review of federal case law relating to jail operations that would put jail officials on notice as to what conduct constitutes such “deliberate indifference” to an inmate’s condition that it amounts to “cruel and unusual punishment” in violation of the 8<sup>th</sup> amendment. That review included mention of the U.S. Supreme Court’s recent decision in *Taylor v. Barkes*, --- U.S. ---, 135 S. Ct. 2042 (2015) (per curiam), where the Court found that, as of November 2004, there was no clearly established “right” of an inmate to be adequately screened for suicide.

**Excessive force, conspiracy, and municipal liability under §1983: District court abused its discretion in dismissing plaintiff’s §1983 claims at the pleading stage on technical, procedural grounds; plaintiff’s allegation as sufficient to state a claim against individual deputies, but not the sheriff’s office as a unit, for use of excessive force and conspiracy to deprive plaintiff of constitutional rights**

***Weiland v. Palm Beach Cnty. Sheriff’s Office*, 792 F.3d 1313 (11th Cir. 2015)**

**Background:** Christopher Weiland brought an action against the sheriff's office and deputies, asserting claims under § 1983 based on allegations of excessive force and malicious prosecution, and state law claims for excessive force, intentional infliction of emotional distress, and malicious prosecution. On April 6, 2007, Weiland's father called 911 alleging that his son, who had bipolar disorder, was "acting up," was "on drugs," and "probably had a gun." Two sheriff's deputies were dispatched and met Weiland's father outside the house. They then proceeded, with guns drawn, toward Weiland's bedroom and found him sitting on the edge of his bed with a shotgun in his lap. One of the deputies fired two rounds at Weiland and knocked him off the bed. While he was on the floor bleeding, the other deputy tasered him and then both deputies physically beat him before handcuffing him to a dresser. In an effort to cover up the assault, the deputies fabricated a story that Weiland first ran from the officers then pointed the shotgun at them. The district court dismissed the plaintiff's § 1983 claims, finding that the complaint failed to comply with the form for pleadings. Weiland appealed.

**Holdings:** The Court of Appeals held that: (1) the district court had abused its discretion in dismissing the § 1983 claims for failure to comply with requirements for form of pleadings; (2) allegations were *sufficient* to support claims for use of excessive force and conspiracy to deprive arrestee of his constitutional rights; (3) allegations were *insufficient* to support claims for § 1983 failure-to-train and conspiracy claims against the sheriff's office; and (4) allegations were *insufficient* to support a § 1983 claim that the sheriff's office had a policy of using internal affairs investigations to cover up use of excessive force against mentally ill citizens.

**Notable Points:**

***Claims against individual deputies:*** Construing the allegations in the light most favorable to the plaintiff, the Court had little difficulty in deciding that Weiland had stated a claim for use of excessive force. The Court concluded that Weiland's injuries were cognizable under both the Fourth and Fourteenth Amendments and that his claim specified a "causal connection between the alleged cover up and the specific deprivation of [his] constitutional rights."

***Failure-to-train and claims against the sheriff's office:*** Plaintiffs cannot hold local government liable under § 1983 under a respondeat superior theory, so to be successful, a plaintiff must establish that the government unit has a "policy or custom" that caused his injury. The Court held that the claims resulted from an isolated incident involving only two deputies, and that Weiland had not provided any facts supporting either a widespread deficiency in training regarding interactions with mentally ill individuals, or a deliberate indifference to the specialized training needs of deputies interacting with the mentally ill. The Court found the conspiracy allegation against the sheriff's office similarly deficient.

## State Court Decisions

**Mootness: Appeals challenging the sufficiency of the evidence in involuntary commitment cases are moot after the commitment period has passed; the respondent has the burden to establish factual basis for a finding of collateral consequences**

*In re Dakota K.*, No. S-15428, 2015 WL 5061844 (Alaska Aug. 28, 2015)

**Background:** Dakota K. sought to appeal 30-day involuntary psychiatric commitment. Even though the appeal came after the passage of the entire commitment period, Dakota argued that the collateral consequences exception to the mootness doctrine applied as the Supreme Court of Alaska has presumed that collateral consequences will flow from a respondent's first involuntary commitment.

**Holdings:** The court held that the burden of proving a first involuntary commitment lay with the respondent, who must “*make some evidentiary showing at least raising a genuine issue of material fact, that the commitment was a first involuntary commitment—or make an evidentiary showing attempting to establish some factual basis for a finding of collateral consequences.*”

**Waiver of jury trial: Under the California NGI and the MDO commitment statutes, the trial court must advise the defendant personally of his or her right to a jury trial and must obtain a waiver of that right from the defendant unless there is substantial evidence that the defendant lacks the capacity to waive right**

*People v. Blackburn*, 354 P.3d 268 (2015) & *People v. Tran*, 354 P.3d 148 (2015)

**Background:** In the *People v. Blackburn* the Supreme Court of California addressed the meaning of provisions in the statutory scheme for extending the commitment of a mentally disordered offender (MDO) that require the trial court to “advise the person of his or her right to be represented by an attorney and of the right to a jury trial” and to hold a jury trial “unless waived by both the person and the district attorney.” (Pen. Code, § 2972, subd. (a)).

In the companion case, *People v. Tran*, the Court addressed nearly identical language in the statutory scheme for extending the involuntary commitment of a person originally committed after pleading not guilty by reason of insanity (NGI) to a criminal offense.

**Holdings:** Under both the NGI statute and the MDO statute, the trial court must advise the defendant personally of his or her right to a jury trial and, before holding a bench trial, must obtain a waiver of that right from the defendant unless the court finds substantial evidence that the defendant lacks the capacity to make a knowing and voluntary waiver, in which case defense counsel may control the waiver decision.

**Notable Points:**

***The jury trial guarantee:*** In MDO and NGI commitment proceedings, as in a criminal trial, the jury guarantee is a basic protection the precise effects of which are unmeasurable and the denial of which defies analysis by harmless-error standards. Thus, the total deprivation of a jury trial without a valid waiver in such proceedings requires automatic reversal.

***Lack of explicit findings regarding mental capacity:*** Acceptance by the trial court of counsel's waiver of an MDO or NGI defendant's right to a jury trial without an explicit finding of substantial evidence that the offender lacked the capacity to make a knowing and voluntary waiver may be deemed harmless if the record affirmatively shows that there was *substantial* evidence that the offender lacked that capacity at the time of counsel's waiver. The requirement of an affirmative showing means that no valid waiver may be presumed from a silent record.

**Conditional release for NGI acquittees: Revoking an insanity acquittee's conditional release without a judicial finding that the acquittee currently suffers from a mental illness does not violate substantive or procedural due process**

***State v. Beaver*, No. 91112-6, 2015 WL 5455821 (Wash. Sept. 17, 2015)**

**Background:** Ricky Beaver was found not guilty by reason of insanity on a charge of residential burglary in 2005, and the court committed him. Beaver petitioned for and was granted conditional release in 2007, but violated the terms of his conditional release in 2011 by using cocaine, drinking alcohol and driving a motor vehicle, and being charged with driving under the influence. Beaver appealed, arguing that due process required a finding of current mental illness before the court could revoke his conditional release. While his appeal was pending, he was granted final discharge, mooting his appeal, but the Court still reviewed the merits of the case.

**Holdings:** Sitting en banc, the Supreme Court of Washington held first that, though moot, the case presented issues of continuing and substantial public interest such that resolution of the merits was beneficial. Second, the Court held that revoking an insanity acquittee's conditional release without a judicial finding that the acquittee currently suffers from a mental illness does not violate substantive or procedural due process.

**Notable Point:** Regarding substantive due process, the Court wrote that an acquittee's insanity was presumed to continue throughout conditional release until proven otherwise, and that acquittees had opportunities to prove lack of suffering from mental defect and to petition for final discharge. Regarding procedural due process, the Court wrote that, although the private interest in liberty or freedom from state constraint was substantial, revocation of acquittee's conditional release implicated a conditional liberty interest, and that the procedures to revoke an acquittee's conditional release provided protections against erroneous deprivation of liberty. Additionally, the Court found that the government had a strong interest in protection of public safety by detaining mentally unstable individuals who presented a threat to society.

**Jury instructions: Where a defendant has provided evidence of involuntary intoxication and unconsciousness, he is entitled, upon request, to a jury instruction on the defense of unconsciousness; refusal to provide the requested instruction constitutes prejudicial error**

***People v. James*, 238 Cal. App. 4th 794, 189 Cal. Rptr. 3d 635 (2015), as modified on denial of reh'g (Aug. 12, 2015), review filed (Aug. 24, 2015)**

**Background:** James was charged with aggravated mayhem and assault producing great bodily injury and pled not guilty by reason of insanity. The court-appointed clinical psychologist's report stated that James had been shot in the head in 1998 and, as a result, had a seizure disorder. Another head trauma occurred in 2011. James had been diagnosed with Mood Disorder, PTSD, and Polysubstance Dependence. In addition, James regularly used cocaine and marijuana, and occasionally used ecstasy, methamphetamine, acid, and mushrooms. The court-appointed psychologist opined that during the offense, James suffered a Psychotic Disorder [not otherwise specified], with psychosis present, and that James "was not capable of knowing or understanding the nature and quality of his act and of distinguishing right from wrong." Another psychologist's report chronicled the same history, but concluded that his behavior was more likely the result of drug-induced psychosis or delirium, and that James was not legally insane. In a bifurcated trial, a jury found James guilty, but then found him not guilty by reason of insanity.

**Holdings:** Finding substantial evidence that James was unconscious within the legal meaning of the defense of unconsciousness when he committed the offenses, the court of appeal reversed, holding that the trial court erred in refusing to instruct the jury on that defense.

**Notable Points:**

***It was error to refuse appellant's request to give a jury instruction on the defense of unconsciousness, and appellant was prejudiced:*** The Court began by stating that evidence raising a reasonable doubt as to whether the defendant was conscious at the time of acting is a complete defense to a criminal charge, and that where a defendant provides evidence of involuntary unconsciousness, "the refusal of a requested instruction on the subject, and its effect as a complete defense if found to have existed, is prejudicial error." Drawing a link between the voluntary intoxication doctrine and the insanity defense accepted by the jury, the Court stated: "if the jury had concluded that appellant's mental state at the time of the February 19 event was the product of his own voluntary intoxication, it necessarily was required to reject his defense of not guilty by reason of insanity; its contrary finding clearly implies that the jury was not so convinced."

***Unconsciousness caused by voluntary intoxication is not a defense to a general intent crime, and may be raised in any potential retrial:*** The Court emphasized that unconsciousness is not always a complete defense, and that voluntary intoxication could not be a defense to a general intent crime. It made clear that "the issue of voluntary intoxication may also be raised as an exception to [the unconsciousness] defense, and both may be presented to the jury to decide."

## V. Institute Programs

Please visit the Institute's website at

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

Please visit and re-visit the Institute's website to see new and updated announcements. The Institute appreciates support for its programs. Please share this edition of *DMHL* and share announcements of programs that may interest your professional, workplace, and community colleagues.

### **Announced programs:**

#### **Seminar: PTSD: Evidence-based Assessment and Treatment**

November 12 2015, Charlottesville VA : This one-day program, in a seminar setting with limited attendance, will provide an overview of issues of trauma and treatment. Matthew Yoder PhD, with the National Center for PTSD's Consultation Program, and formerly with the Ralph H. Johnson VA Center in Charleston SC, will be lead faculty. Trauma and treatment issues with veterans will be highlighted. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: \$65. Others: \$150. Cancellation fee: \$25

#### **Evaluating Individuals Found Not Guilty by Reason of Insanity**

December 11 2015, Petersburg VA: This one-day program addresses assessment of persons who have been found Not Guilty by Reason of Insanity (NGRI) in criminal cases and therefore require forensic evaluation regarding commitment or conditional release. Please note that this program is most relevant for VA DBHDS staff involved in evaluation and supervision of NGRI acquittees. This program meets the training requirements for clinicians who conduct VA DBHDS Commissioner-appointed evaluations of NGRI acquittees. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: \$65. Others: \$150. Cancellation fee: \$25

#### **Assessing Risk for Violence with Juveniles**

January 22 2016, Charlottesville VA: This one-day program trains mental health professionals, juvenile and criminal justice professionals, social and juvenile services agencies, educators, and others to apply current research pertaining to risk assessment with juveniles. Along with theoretical foundations the program includes review of legal parameters, impact of online behavior, and student threats. Registration fees: Employees of VA DBHDS facilities and Community Services Boards/Behavioral Health Authorities: \$65. Others: \$150. Cancellation fee: \$25



## **Conducting Mental Health Evaluations for Capital Sentencing Proceedings**

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

## **Juvenile Forensic Evaluation: Principles and Practice**

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

## **Evaluation Update: Applying Forensic Skills with Juveniles**

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

## **Advanced Case Presentation: Juvenile Adjudicative Competence**

Spring 2016, Date TBD, Charlottesville VA: Advanced Case Presentation is a follow-up training for all evaluators who have successfully completed the Juvenile Forensic Evaluation training or Evaluation Update training and who wish to complete the training requirements of the VA DBHDS Commissioner for individuals authorized to conduct juvenile competence evaluations. [NOTE: The Date will be determined.] Registration fee: TBD.

Questions about ILPPP programs or about *DMHL*?: please contact [els2e@virginia.edu](mailto:els2e@virginia.edu)

*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.

*Developments in Mental Health Law (DMHL)* is available as a *pdf* document via the Institute of Law, Psychiatry and Public Policy's website within the "Publications/Policy&Practice" section. Please find the archive of electronic issues in that section at <http://cacsprd.web.virginia.edu/ILPPP/PublicationsAndPolicy/Index>

The complete archive of *DMHL* may be accessed electronically on the Internet at HeinOnline at <http://home.heinonline.org/> ILPPP maintains a complete, original archive on paper from Volume 1, Number 1, January 1981.

To be notified via email when a new issue of *DMHL* is posted to the website please sign up at <http://cacsprd.web.virginia.edu/ILPPP/MailingList>. You are welcome to share these links with others who may wish to join the list to receive *Developments in Mental Health Law*. There is no charge.

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

The Editor may be contacted at [jeogal@gmail.com](mailto:jeogal@gmail.com)

**Editor**

John E. Oliver, J.D.

**Co-Editor for Issue**

Heather Zelle, J.D., Ph.D.

**Managing Editor**

Edward Strickler, Jr., M.A., M.A., M.P.H., CHES

**ILPPP Research Assistants**

Ashleigh Allen, MPH; Carrington Giammittorio

ISSN 1063-9977

© 2015