

# *DEVELOPMENTS IN MENTAL HEALTH LAW*

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## **I. Update**

**Update: SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21<sup>st</sup> Century**

### ***Background***

As described in more detail in the October and December 2015 issues of *DMHL* (available [here](#)) the SJ 47 Joint Subcommittee, consisting of twelve legislative members (five from the Senate, seven from the House) was given a comprehensive mandate by the 2014 General Assembly to review and assess Virginia’s mental health laws and services system and to make 1) 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 2) 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.

Much of the Joint Subcommittee's first two years was spent gathering information about, and opinions regarding, all aspects of the operation of Virginia's mental health services system and how it compares with those of other states. (Much of that process is described in the October and December 2015 issues of *DMHL* cited above.) The Joint Subcommittee's plan for its final two years, as described by its co-chair, Sen. Creigh Deeds, is to "utilize the information it has collected" and "make recommendations as to what services should be provided and the statutory or regulatory changes necessary to improve access to such services by persons who are in need of mental health care." The Joint Subcommittee's Work Groups were re-organized into the following four groups, reflecting the selected areas of focus: Work Group #1: System Structure and Financing, chaired by Sen. Hanger; Work Group #2: Criminal Justice System Diversion, chaired by Del. Bell; Work Group #3: Crisis and Emergency Services, chaired by Del. Garrett; and Work Group #4: Housing, chaired by Sen. Howell. The Joint Subcommittee developed a document (available [here](#)) that sets out the purpose of each Work Group and the specific topics they are to address.

The Joint Subcommittee also asked Professor Richard Bonnie, one of the nation's leaders on mental health law and policy, to assemble panels of experts to provide information and recommendations to each of these Work Groups and to respond to questions and concerns raised by Work Group members.

#### ***April 19, 2016 meeting***

At its April 19, 2016 meeting (summarized [here](#) on the Division of Legislative Services website), the Joint Subcommittee's key agenda items were the following:

*Report by DBHDS Interim Commissioner Barber.* Dr. Barber spoke on the proposed reform of Virginia's public behavioral healthcare system. (His accompanying power point presentation is available [here](#).) Dr. Barber cited the following as the "framing factors" to understand the issues facing Virginia's public behavioral health system: (1) available services, and access to them, vary considerably across Virginia, depending upon the locality, as Virginia's CSBs "are of inconsistent size, geography, local funding, payor mix, local priorities, etc.;" (2) insurance coverage for services is inadequate, as approximately 50% of individuals served by CSBs have *no* payor (private insurance, Medicare, Medicaid); (3) state inpatient mental health facilities are over-utilized, in part because they are "no cost" options for CSBs, jails, and the Department of Medical Assistance Services (adults); (4) federal laws (Olmstead/ADA) require integrated services; (5) nationwide, major reforms in health care overall are moving the system toward outcomes-based payment and a focus on lower cost, preventative care to decrease ER visits and hospitalizations; and (6) significant disparities exist in population health, health opportunities, and health outcomes across the state.

The Commissioner submitted that the model of the "Certified Community Behavioral Health Center" (CCBHC), set out in the federal Excellence in Mental Health Act, provides "the way forward" with a framework for statewide mental health services

delivery that DBHDS is now pursuing, both through a federal grant that would enable the state to establish eight CCBHC “model sites” and through system-wide adoption of this framework. The nine core services, linked by ongoing care coordination (resulting in reference to the “9 + 1” set of services), are the following:

1. Screening, assessment and diagnosis (including risk assessment)
2. Patient-centered treatment planning
3. Outpatient mental health and substance abuse services
4. Targeted case management
5. Crisis Services; 24 hour mobile, crisis intervention and stabilization
6. Outpatient clinic; primary care screening and monitoring
7. Care for members of the Armed Forces and veterans
8. Peer support and Family support
9. Psychiatric rehabilitation services

Under the CCBHC model, the delivery of these services will be assessed across four evaluative categories: access, quality, consistency and accountability.

The Commissioner noted that, even if Virginia were not awarded a federal grant for establishing the first eight CCBHCs in Virginia, the plan of DBHDS was to move forward with this model for mental health services throughout the state.

*Report by OSIG on death investigation.* June W. Jennings, State Inspector General, and Ms. Priscilla Smith reported on the Office of the State Inspector General's investigation into the August 2015 death of Jamycheal Mitchell in the Hampton Roads Regional Jail (HRRJ). (Their accompanying power point presentation can be found [here](#).) At the time of his death, Mr. Mitchell, who had been found by a Portsmouth General District Court judge in May of 2015 to be incompetent to stand trial on charges of petty larceny and trespassing, had been kept in jail for three months for transfer to Eastern State Hospital for competency restoration services.

The OSIG report noted that the DBHDS investigation into Mr. Mitchell's death had focused too narrowly on an administrative error at Eastern State Hospital that had resulted in Mr. Mitchell not even appearing on the hospital's jail transfer list. The OSIG investigation found that the transfer process from the jail to the hospital had multiple decision and risk points, and that, with no existing protocols governing these transfers, there were “numerous opportunities” for variations in practice that could have “negative outcomes.” The OSIG found that the recommended changes in practice from the DBHDS investigation were (like the investigation's focus) too narrow and did not address the systemic problems plaguing the transfer system. The OSIG noted that the substantive recommendations for system change made by the DBHDS' own “Transformation Team for the Justice Involved” did address those problems, and that if those recommendations had been in place when Mr. Mitchell was incarcerated, the outcome might have been different. (It should be noted that the OSIG also pointed out that the records from HRRJ's contracted mental health care provider were poor, and indicated poor medical care for Mr. Mitchell and a lack of adequate oversight of

treatment of inmates by the HRRJ administration, which bore ultimate responsibility for the conduct of the contract provider.) Among other recommendations, the OSIG found that DBHDS should implement a “regional protocol” for management of persons with mental illness in the regional jail, and should also immediately implement the recommendations of its own Transformation Team on the Justice Involved.

*Work Plan.* Sen. Deeds noted the development of the work plans for each of the four newly formed Work Groups (described above), and the creation of the “expert advisory panels” to assist the Work Groups.

### ***June 23, 2016 meeting***

Between the April 19 meeting and the June 23 meeting, the expert advisory panels convened, and members of each Work Group prepared for the Work Group meetings that were held prior to the full Joint Subcommittee meeting at the State Capitol Building on June 23. The summaries of those meetings are as follows:

#### *Work Group #1: Service System Structure and Financing*

This group met on May 17 at the General Assembly Building. HHS Secretary Hazel attended, and in remarks to the group noted his support for the CCBHC model (Certified Community Behavioral Health Center), describing it (as stated in the DLS summary of the meeting) as “a promising approach to the delivery of coordinated services that will improve system efficiency and outcomes for individuals receiving services” and requesting General Assembly support. In response to questions from members, Secretary Hazel identified the following as key weaknesses in the current system: (1) the variability in services provided by CSBs across the state; (2) the difficulties in retaining quality mental health staff; (3) the focus on crisis services without adequate funding of prevention and ongoing care; (4) current funding models that limit development of needed services; and (5) inadequate data collection and analysis.

The Work Group members at the May 17 meeting also received an update on the expert Advisory Panel established to assist the Work Group (also described in the DLS summary). After noting key issues that the panel had discussed at its initial meeting, the update stated that the panel would be focusing on the following: “(i) how the public mental health service system is structured in other states to identify alternative service system models; (ii) examples of state-local service system structures in the Commonwealth, including the public health system, the social services system, and the public school system; and (iii) the content of performance contracts between the DBHDS and the community services boards.” A written progress report from Professor Bonnie was provided, describing the formation of the advisory panels and the research team available to assist the Work Groups. A draft work plan was submitted by staff for review, and the group invited comments from members of the public attending the meeting.

At the Work Group #1 meeting on June 23, the Advisory Panel submitted an initial report to the Work Group regarding its findings and recommendations on the state’s

“governance structure” for providing public mental health services. (A chart setting out the current flow of funds from and through federal, state and local governments for public community-based mental health services was also provided.) That report noted that the SJ 47 Joint Subcommittee had identified three major problems with Virginia’s current system: (i) lack of a consistent array of services across the Commonwealth; (ii) need for uniform measures of performance and outcomes; and (iii) lack of accountability for performance and for achieving desired outcomes. The Panel reviewed the three major state models for community-based public mental health service systems in the U.S. – state operated (4 states); state-funded, with services provided by private entities (profit and non-profit) and no local government involvement (31 states); and “largely” state funded but provided by local government entities (directly or by contracting with private/non-profit entities, the model in Virginia). It then offered the following key observations:

*“The Panel has provisionally concluded that the current system requires substantial modification, characterized by greater state direction and control and a strengthened partnership with local governments; however, the Panel also believes that the Commonwealth should retain the system’s current structure rather than abandoning it in favor of one of the other two models.”*

*“The Panel is inclined to retain the basic principle of local responsibility for delivery of public mental health services while strengthening the state-local partnership, bolstering state oversight, achieving greater efficiency, and making local entities more accountable for their performance to the state and to the populations they serve.”*

With the Work Group and the Joint Subcommittee accepting the Panel’s report and recommendation, the Panel plans to “concentrate on identifying and evaluating the different approaches for filling the gaps in accessible services, measuring outcomes and enhancing accountability.” The experiences of other “comparable” states will be reviewed. Candidates include Oregon (which adopted a “local governance” model) and North Carolina (which did not). The panel also plans to “carefully review” the DBHDS initiative to establish “Certified Community Behavioral Health Clinics” (CCBHCs) under the federal Excellence in Mental Health Act (2014).

Daniel Herr, DBHDS Assistant Commissioner for Behavioral Health, made a PowerPoint presentation to Work Group #1 on the annual Community Services Board “Performance Contract” into which DBHDS enters with every CSB. The contract, which has been used by DBHDS since 1985, serves the following primary functions: (i) “defines the relationship between and the responsibilities of DBHDS and CSBs;” (ii) “is the mechanism by which DBHDS funds community services;” and (iii) “communicates state and federal accountability requirements to CSBs.” While the main contract terms are identical for all CSBs, the contract “exhibits” include: (in Exhibit A) a description of the resources and services provided by the individual CSB and information about funding of services as negotiated between DBHDS and the CSB; (in Exhibit B) information

regarding 17 “performance measures” by which each CSB is assessed as part of a “Continuous Quality Improvement” program; and (in Exhibit D), the negotiated requirements for new funds or actions that the CSB has agreed to take to address performance issues.

DBHDS “monitors CSB performance” in various ways, including: (i) mid-year and end of fiscal year financial reports on funds and expenditures; (ii) reports on individuals served and types of services provided; (iii) CPA audits of CSBs that are “operating boards” or “behavioral health authorities;” (iv) financial reviews of CSBs identified as being a higher risk; (v) five regional consultants providing oversight and technical assistance; and (vi) a behavioral health services quality monitoring process with measures and benchmarks.

Mr. Herr noted that the General Assembly’s 2016 Appropriations Act requires DBHDS to develop a plan to implement a “performance based contracting system” for CSBs. A report to the General Assembly on that plan is due on November 1, 2016. According to Mr. Herr, current research on performance based contracts finds the following: (1) that they are most effective when there are “mutually agreed upon measures between funder and provider;” (2) that a “key concept” is the “value of small, incremental rewards and penalties rather than large;” and (3) that the “focus” of such contracts is “visibility of provider performance while minimizing disruption to services.”

In the Work Group’s report to the Joint Subcommittee, the Work Group’s chair, Sen. Hanger, noted the importance of developing more robust state standards for community-based mental health services, to reduce the variation in available services across localities and regions in the state. The goal, he stated, is to have the same services available “everywhere”—a goal that might require additional collaboration and perhaps consolidation among CSBs in order to obtain the “volume” needed to sustain service programs. It was also noted that some services could be “contracted out” to other entities to provide. The CCBHC service model will be a focus of the Work Group’s ongoing work.

#### *Work Group #2: Criminal Justice Diversion*

At the June 23 meeting of Work Group #2, the Advisory Panel shared the input and findings from its May 6, 2016 conference call and May 31, 2016 meeting.

A key part of the panel’s May 6 conference call was a discussion of the use of “Cross Systems Mapping” and the “Sequential Intercept Model” (SIM) to identify where and why individuals with mental illness move between the treatment services system and the criminal justice system. The model and mapping process are widely accepted and allow for the organized identification of key points in the criminal justice process where different service strategies might enable individuals to achieve stability and prevent or mitigate their illness-related behaviors from becoming further “criminalized” or leading to additional behavior problems. The key “intercept” points are: (1) law enforcement/emergency services encounter with the individual; (2) post-arrest: initial

detention/initial hearings; (3) post-initial hearings: jail/prison, courts, forensic evaluations and forensic commitments; (4) re-entry from jails, state prisons and forensic hospitalization; (5) community corrections and community support.

The panel agreed at its May 6 conference call to continue using the Sequential Intercept Model to provide the framework for its study of criminal justice system diversion, and to look at how successful programs in other states (e.g., Bexar County, Texas; Miami, Florida; and Seattle, Washington) have worked. Virginia has engaged in Cross Systems Mapping previously: a statewide initiative was directed by the Commonwealth Consortium for Mental Health and Criminal Justice Transformation (created in 2008 by Executive Order of then-Governor Tim Kaine), and involved the participation of all 40 CSBs and local criminal justice entities. The expert panel reviewed the “Final Report of the Department of Behavioral Health and Developmental Services (DBHDS) on the Cross Systems Mapping Statewide Initiative (2008–2013),” noting agreement with its suggested priorities.

At the panel’s May 31 meeting, Jana Braswell, Statewide Crisis Intervention Team Program Coordinator for DBHDS, reviewed with the panel two key DBHDS studies: “Mental Health & Criminal Justice: The Challenge to Provide For Incarcerated Virginians with Behavioral Health Issues”, and “Recommendations from the Justice Involved Transformation Team.” Not surprisingly, the presentations overlap, but each is packed with information and recommendations. Among points specifically discussed by the panel was the fact that, while jails have a constitutional duty to provide inmates with appropriate medical care, including mental health care, each Sheriff has total discretion to determine how to provide such care, and that many contract with private providers for such services. While some CSBs provide in-jail mental health services under contracts with the local Sheriff, there is no funding and no mandate from the state for the CSBs to provide in-jail treatment services. As a result, there are no uniform practices or standards of care in providing treatment.

Notably, the Justice Involved Transformation Team report cited the various reasons why designating CSBs to be the providers of those services would best promote quality, access and continuity of care, but stepped back from recommending a mandate that the CSBs provide the needed array of services identified by the report, citing the logistical and workforce obstacles to such a mandate being successful. However, the report did recommend that the General Assembly require and fund designated jail and CSB staff to carry out and coordinate “release planning” and follow-up community services for inmates with mental illness.

The panel also reviewed the cited list of programs currently active in Virginia:  
*Intercept 1* (law enforcement/emergency services): 37 Crisis Intervention Team (CIT) Programs & 32 CIT Assessment Sites  
*Intercept 2* (booking/initial court hearings): 4 General Fund funded magistrate level booking programs

*Intercept 3* (jails/courts): 5 General Fund funded jail diversion programs including 1 funded Mental Health Docket (10 Dockets total), Drug Courts (37), Regional Jail Team (re-investment funds)

*Intercept 4* (re-entry from jails or prisons): 2 General Fund funded jail diversion programs, 7 forensic discharge planners

*Intercept 5* (community corrections/community support): 1 General Fund funded specialized probation program.

The panel determined that updating and expansion of DBHDS-created tables of information about the programs will be helpful for organizing and exploring future work.

The Transformation Team report ends with five major recommendations for more effective diversion of persons with mental illness from the criminal justice system:

1. Support localities in developing mental health dockets (broadly understood to include not only defendants with mental illness but also those with substance use issues and veterans who are struggling), with such support including not only funding for the court docket process itself but also funding for services that enable defendants to maintain stability, particularly housing and transportation.
2. Amend the Virginia Code to allow judges to order pretrial mental health evaluations to aid judges in making bail/bond determinations, and provide the funding for such evaluations.
3. Provide judges with education on the “Risk Need Responsivity model of risk management”, which research has shown is a better model for identifying those at risk of acting out or failing to return to court if released pending trial, so that more low-risk offenders can be diverted from jail.
4. Provide an oversight system of evaluators who conduct pre-trial evaluations to ensure the evaluations meet the standard of practice, and provide remediation for those who do not meet that standard.
5. Ensure that all law enforcement agencies have Crisis Intervention Team (CIT) programs, with CIT Assessment Sites “within reach of every Virginia jurisdiction.” Relatedly, “Crisis Stabilization Programs should be integrated into the emergency response network and should be expanded to include possible admission of individuals destined for incarceration.”

At the May 31 meeting, the panel discussed the value of the previous work on criminal justice diversion in Virginia and discussed how to focus its activities, given the wide range of potential foci. Leslie Weisman, the panel chair, noted that the Work Group members have a particular interest in information on how persons with mental illness are diverted from the criminal justice system in other states, including the stage or stages in the criminal justice process at which diversion occurs and the crimes eligible for diversion. In a later call with other advisory panel chairs, Ms. Weisman noted that the



other key areas of interest expressed by the Work Group members included: (1) mental health courts, with a focus on showing how such courts actually improve outcomes for the individuals who participate in them, and how best to ensure uniform “best practices” in their operation across the state (if implemented); (2) the continued expansion of CIT training and the establishment of CIT assessment centers; and (3) how best to standardize mental health screening for inmates, ensure access to needed drugs for those in jail, and provide effective discharge planning to link inmates with mental illness to community services upon release.

At the Joint Subcommittee’s June 23 meeting, Del. Bell, the chair of Work Group #2, provided the following summary regarding the work and findings of that Work Group:

1. There will always be a significant number of individuals with mental illness in Virginia jails, even with reforms; thus, attention must be paid to improving treatment in jails.
2. A key challenge is to put these individuals on a path so that they do not come back to jail, which will require attention to models for discharge and connection to services.
3. The effort to divert from the criminal justice system those individuals whose primary problem is mental illness must be made without compromising public safety.
4. Some of the key potential diversion points in the criminal justice process include the following:
  - a. Police officer decision-making at the scene: the officer’s options range from making an arrest to taking the person into custody under an (“orderless”) ECO to releasing the individual and taking no action. The training of officers (e.g., Crisis Intervention Training, or “CIT”) can result in better outcomes for individuals in crisis.
  - b. Bail and bond decision-making: changing the bail and bond system to provide more opportunities for evaluation, community release and supervision can improve outcomes for individuals with mental illness.
  - c. The court docket: establishing a “mental health docket” that is structured to take into account the mental health needs of a defendant who has mental illness can improve outcomes for those individuals.

After Del. Bell’s summary, Sen. Cosgrove noted that he introduced a bill, with only a small accompanying funding request, to establish a “mental health docket” in the Chesapeake General District Court, but that, to his surprise and disappointment, it was not supported by the General Assembly. (The General Assembly did direct DBHDS to conduct a study of mental health courts and to make recommendations to the legislature by December 1, 2016.) Sen. Deeds noted that mental health dockets already exist, with local funding, in other jurisdictions, including Richmond and Norfolk, and that he liked the program developed in Bexar County, Texas, as a possible model for Virginia’s courts.

While not included as part of its agenda for the June 23 meeting, the Work Group did receive from the Treatment Advocacy Center its recent report, which documents the

abysmal state of data collection nationwide in regard to encounters in the community between law enforcement officers and individuals with mental illness that result in fatality. The report also notes that there is no meaningful data collection regarding encounters in which lethal force is used by officers against a person but there is not a fatality. These encounters, the report argues, deserve equal scrutiny. While supporting the efficacy of CIT programs and similar officer training for better managing these encounters, the authors also argue that better community-based mental health services provide the most appropriate remedy, by reducing or eliminating the crises that result in the call for law enforcement response in the first place.

*Work Group #3: Crisis Response and Emergency Services*

There were three main presentations (described in more detail in the DLS summary) at the June 23 meeting of Work Group #3:

1. From the Advisory Panel, on priority issues: The panel’s chair, John Oliver, reported that the panel had identified four main subject areas in need of immediate attention: (i) the development of regional psychiatric emergency services (PES) units, which are used in other states and appear to help more individuals in crisis resolve their crisis without psychiatric hospitalization, while also reducing “psychiatric boarding” in hospital Emergency Departments; (ii) the use of telepsychiatry in the crisis context, in both rural and urban settings, to increase access to psychiatric treatment in mental health crises; (iii) the use of a medical or other alternative model of transportation for individuals in crisis in place of the current law-enforcement model, to reduce trauma for individuals and families while maintaining safety and to use law enforcement services more effectively; and (iv) the identification of a core service model of treatment services for those in crisis, with the goal of ensuring that such “core services” are available in all localities. A subcommittee has been formed for each of these subject areas, composed of two to three experts from the panel. Mr. Oliver also emphasized that a shortage of trained mental health professionals and peer specialists was a continuing issue that impacted any reform attempt. (A copy of the Advisory Panel’s summary is available here, as well as summaries of each of the panel’s deliberations on May 3, May 17 and June 8.)

2. From John Jones, Director of the Virginia Sheriffs’ Association, on transport of individuals in mental health crisis by law enforcement: Mr. Jones noted that Sheriffs’ offices statewide are short-handed; they do not have the full complement of staff that even the State Compensation Board says they ought to have, so taking deputies off the street (or out of the courtrooms, where deputies provide security) for these transport cases degrades the ability of the sheriffs to carry out their core public safety duties.

Mr. Jones noted that the State Compensation Board reimburses sheriffs at a set rate for each transport in mental health crisis cases (one officer for 3.0 hours for each in-jurisdiction transport; one officer for 4.5 hours for each out-of-jurisdiction transport). This does not fully compensate for the costs actually incurred, as many cases require far more time (with a key frustration being the long waits for “medical clearance” before transport to a psychiatric hospital can occur), and some cases requiring two deputies.

Moreover, although the Sheriffs are committed to providing transportation services where their involvement is needed for safety purposes, they are seeing increasing numbers of cases that appear totally inappropriate for law enforcement transport, especially geriatric patients.

Mr. Jones noted that the Virginia Sheriffs Association strongly supports the following reforms to the current system: (i) expanding assessment centers, (ii) funding the existing staffing standards, (iii) using alternative transportation whenever possible to allow sheriffs to devote more time to their primary public safety mission; (iv) provide alternative/medical options for nonviolent individuals (geriatric); and (v) consider allowing other state law enforcement to transport. Mr. Jones noted that the Sheriff involved in the Southwest Virginia Alternative Transportation Project (described below) is very happy with the results so far, as it has reduced his transport workload by a third. (A copy of Mr. Jones' accompanying PowerPoint presentation is available [here](#).)

3. From Mr. Will Frank, DBHDS, on the Southwest Virginia Alternative Transportation Project: This project was initiated by DBHDS, with support from the local CSB, law enforcement and other stakeholders. Mr. Frank noted that, although Virginia law allows magistrates to authorize transport of individuals in crisis by means other than law enforcement, most individuals with mental illness are transported by law-enforcement officers in a police vehicle, and usually in handcuffs. In addition to often feeling marginalized, criminalized, and traumatized from the experience, families and individuals receiving assistance have reported that this criminal-like transportation can serve as a roadblock to seeking help during a crisis. This "recovery focused" project attempts to make alternative transportation more readily available through a commercial service using unmarked cars with drivers wearing casual uniforms who have completed training, similar to Crisis Intervention Training, prior to providing transportation.

In response to a call for interested companies/providers, only one company, Steadfast Security (which has experience transporting individuals for the Department of Juvenile Justice) expressed an interest. The challenge: the program's infrastructure had to be built from the ground up, including a dispatch center operating 24 hours a day. Although this impacted costs, the benefits of the program have been clear. The magistrates, after considering the recommendations of the CSB evaluators, have authorized transport by Steadfast in a third of all crisis cases, resulting in significant relief to local law enforcement. There have been no elopements, and every individual has been transported successfully. However, unless more funding is provided the pilot will have to terminate within the next six months. (Mr. Frank's accompanying PowerPoint can be found [here](#).)

In summarizing the Work Group's meeting to the Joint Subcommittee on June 23, Del. Garrett, the Work Group chair, highlighted four issues in crisis response and emergency services: (1) the use of alternative transportation (noting that the Work Group was "asking for data" from DBHDS and the hospitals on the cost effectiveness of using alternative transport for individuals in mental health crisis); (2) the use of tele-psychiatry (with a focus on the potential barriers to its effective use due to (a) limitations on drug prescriptions via tele-psychiatry, (b) issues regarding the establishment of the physician-

patient relationship when doctor and patient are not physically together, and (c) the current lack of insurance reimbursement for using this technology in treatment); (3) “regional approaches” to community-based emergency services (with the Advisory Panel having recommended development of regional Psychiatric Emergency Services (PES) units); and (4) the availability of treatment services for “emergent” mental health conditions.

#### *Work Group #4: Housing*

As noted at the Joint Subcommittee meeting by Senator Howell, Work Group #4’s Advisory Panel showed that there is a “universally accepted ‘best practice’” in effectively reducing homelessness among persons with serious mental illness: a program of “permanent supportive housing.” What remained was for the Work Group (chaired by Sen. Howell) to get a better handle on the numbers of people currently needing such a program and the data on the cost-effectiveness of such a program, and how best to pull together the various agencies and services required to make such programs available where they are needed and find the funding necessary to support them.

In the Work Group’s June 23 meeting, Kristin Yavorsky, MSW, the Homeless Projects Coordinator for DBHDS, explained in her PowerPoint presentation (found [here](#)) that when homeless individuals with serious mental illness are placed in Permanent Supportive Housing, there is not only a dramatic improvement in the life experience and stability of the persons but there is also a dramatic reduction in the costs of services for these individuals, as they experience an improvement in their overall health and a significant decline in their rates of both medical and psychiatric hospitalization and their rates of arrest and incarceration. Permanent Supportive Housing is a defined model in which “permanent” means that there are “no time limits, so that individuals can live in lease-based housing in the community” indefinitely; “supportive” means that a “flexible, voluntary array of supportive services is available to participants and is designed to assist individuals with securing and maintaining housing and addressing health and behavioral health needs;” and “housing” means “affordable rental housing” for which participants generally pay “30% of their income to rent.”

Ms. Yavorsky noted that Virginia currently has permanent supportive housing programs, and the improvements in life outcomes for those participating in the programs is dramatic. The largest provider of this service, Virginia Supportive Housing (VSH), “consistently reports that 93% or more of its housed clients do not return to homelessness.” Moreover, the annual utilization rate of Emergency Department and inpatient psychiatric services by persons in these programs is 71% lower than the rate for those who are homeless. Not only do persons who are homeless require more frequent medical hospitalizations than those who are not, but their stays are four days longer on average. Ms. Yavorsky also noted that the average cost of permanent supportive housing is between \$34 and \$55 dollars per day, while the average cost of a state psychiatric bed is \$632 per day, and that the “primary barrier” to state psychiatric hospitals being able to discharge patients who no longer meet hospital criteria is the lack of suitable community-based housing. Ms Yavorsky reported that, according to the Virginia Coalition to End

Homelessness, there are currently 2,886 units of permanent supportive housing in Virginia, with a shortage of just under 2,500 *additional* units to meet the existing need.

The Advisory Panel to the Work Group, in the “initial policy suggestions” it submitted for the June 23 meeting, also highlighted the central value of supporting and expanding permanent supportive housing, and made a number of recommendations for ways in which such support and expansion could occur:

1. Taking a “proactive” approach to *Olmstead* Compliance: The Department of Justice, to ensure compliance with the Supreme Court’s decision in *Olmstead*, required Virginia to enter into a settlement agreement to provide services in the least restrictive community-based setting to Virginians with intellectual disabilities and/or developmental disabilities (ID/DD). The Panel noted that *Olmstead*’s requirements apply equally to persons with serious mental illness so that community-based housing for such persons should promptly be expanded.
2. Amending Virginia Housing Trust Fund legislation: The panel recommended that the existing statute be amended to allow more funds to be available for the Trust Fund to finance supportive housing programs.
3. Prioritizing individuals with serious mental illness in Department of Housing and Community Development housing strategies.
4. Providing tax credits/housing choice vouchers to “incentivize creation of affordable housing for individuals with serious mental illness,” following the existing model for persons with ID/DD.
5. Maximizing Medicaid funding: explore the degree to which Medicaid might pay for services provided as part of a supportive housing program.
6. Piloting alternative uses of Discharge Assistance Program (DAP) funds: Noting that the intent of DAP has been to enable people to be discharged from state psychiatric hospitals into permanent community placements, the panel submitted that too many DAP-funded placements are supporting other institutional residences: assisted living facilities, group homes, etc. The panel recommends the use of DAP funds for permanent supportive housing placements instead.
7. Supporting “Frequent User System Engagement” (FUSE) pilot projects: The panel noted that a FUSE program “targets” individuals who are heavy users of emergency rooms, psychiatric facilities, jails, and other institutions—all of which involve high costs with little positive long-term outcomes—and provides them with permanent supportive housing. An existing FUSE program in Richmond was cited.
8. Utilizing “Capacity Building Training”: The panel recommends that “existing state and nonprofit technical assistance resources” can be used “to develop the capacity of providers to operate and fund permanent supportive housing.”

***Presentation by Interim Commissioner Barber at the June 23 Joint Subcommittee meeting:***

Dr. Barber provided a power point presentation entitled “Update: Virginia’s Community Behavioral Health System”. He began with an update on the current effort to meet

federal grant requirements for the “Certified Community Behavioral Health Center” model program (described in Dr. Barber’s presentation at the April Joint Subcommittee meeting, summarized earlier). The eight participating CSBs have been going through a Needs Assessment to determine the extent to which they are able to meet the 9+1 service standards required by the grant. Dr. Barber reported that, although none of these CSBs are ready on all 9+1 services currently, each is ready on several of the services. He noted that the methodology used to establish the level of service readiness at each of the eight participating CSBs can be used for the remaining 32 CSBs to assess their service capacity.

According to Dr. Barber, the “key issues related to services and access” are:

- (1) “workforce and recruitment of psychiatrists and other clinical staff”
- (2) funding, and
- (3) transportation.

Dr. Barber noted that the developing the “Virginia model” for behavioral health services would involve “integrating” the CCBHC model and the recommendations of the DBHDS Transformation Teams. If this model were accepted, it would take “several biennia” to build up the required service capacity across all the CSBs, starting with the provision of same-day access to care and the provision of primary care screening.

The areas of service in the Virginia model that Dr. Barber envisions include the following key services *beyond* the requirements of the CCBHC model:

- Medication Assisted Treatment for opiate addiction (which can be contracted)
- In-home children’s services
- Housing, employment, education, and Social Services
- Primary Health Care for true care coordination

Dr. Barber then reviewed three critical service areas that particularly impact persons with serious mental illness: jail services, crisis services, and housing.

In regard to jail services, Dr. Barber set out as system goals the recommendations of the Justice Involved Transformation Team (summarized above in regard to Work Group #2), noting the importance of having services in place for (1) diversion at the time of initial intervention and hearing, (2) screening to identify persons with mental illness at the time of admission to a correctional facility, (3) assessment (and effective treatment) of individuals found through screening to be in need of mental health services, and (4) diversion and planning for post-release services.

In regard to crisis services, Dr. Barber noted, “A Crisis System that relies on Inpatient beds or Crisis Stabilization Units is expensive and not recovery oriented;” instead, the system should have “the capacity to make acute medications available, next-day referrals for assessment and establishment of a plan of care, emergency housing, direct social supports, and the like...” He also noted the rising qualifications standards for CSB Emergency Services evaluators (as now required by the General Assembly) that will help to enhance the quality of crisis interventions.

Housing loomed large for Dr. Barber as an “integral component to a community [behavioral health] system.” Noting that housing is “a key determinant of health”, Dr. Barber used the same data summarized above in the meeting of Work Group #4 to show the dramatic reduction in individuals’ use of emergency services, and in their involvement with the criminal justice system, when they have stable housing.

### *Next meeting*

The Work Groups and Joint Subcommittee, along with the Advisory Panels, will next meet on August 22<sup>nd</sup> in Richmond. The Work Groups will meet individually beginning at 10:00 and the full Subcommittee will convene at 1:00. Meeting agendas and materials can be found [here](#).

## II. Case Law Developments

### United States Fourth Circuit Decisions

**42 U.S.C Section 1983 Liability; Emergency Custody: Claim of Fourth Amendment seizure violation by officers who used independent emergency custody authority to take person into custody for mental health evaluation survives officers’ motion to dismiss, as facts alleged by plaintiff, if proved, would establish unlawful seizure. Related claim against CSB evaluator dismissed.**

*Goines v. Valley Cmty. Servs. Bd.*, No. 15-1589, 2016 U.S. App. LEXIS 8512 (4th Cir. May 9, 2016)

**Background:** In a complaint filed in the district federal court, Gordon Goines alleged that, on May 15, 2014, he was experiencing problems with his cable television service and was informed by a technician that one of his neighbors had spliced into his cable, and that that was the cause of the connectivity issues. Goines, according to his complaint, went across the street to a police station to report the theft. Goines took two officers back to his apartment, but the officers did not turn on the television and so did not hear the strange noises. Instead, according to Goines, the officers asked if Goines had any mental health issues or if he “wanted to talk to someone.” Goines believed they were referring to the problem with his television and so said yes. The officers then handcuffed Goines and transported him involuntarily to the area medical center. There he was interviewed by an intake clinician employed by Valley Community Services Board, who concluded that Goines suffered from a mental illness and posed a threat to the safety of his neighbors.

Goines was hospitalized until his release on May 20, 2014. Goines then brought an action under 42 U.S.C. § 1983, alleging that he was unlawfully seized without probable cause in violation of the Fourth and Fourteenth Amendments. Goines noted in his complaint that he suffers from cerebellar ataxia, which affects his speech, balance and fine motor coordination, but that he has no mental health issues. The district court granted

defendants' motion to dismiss for failure to state a claim and dismissed the complaint in its entirety.

**Holding:** On appeal, the Fourth Circuit held that the claims against the mental health intake clinician and her employer were properly dismissed, but that the claims against the two officers had been dismissed in error. The court found that the allegations in Goines' complaint were sufficient to survive a motion to dismiss with regard to the officers because the complaint provided no reasonable basis for the officers to have concluded that Goines was a danger.

**Notable Points:**

***Goines' complaint plausibly alleged facts that no reasonable officer would have found sufficient to justify an emergency mental health detention:*** The Appeals Court noted that "a motion to dismiss tests the sufficiency of a complaint," so that the Court's review was limited to "a review of the allegations in the complaint itself." The defendant officers, noting that Goines had included the officers' Incident Report as an attachment, argued that, by including the Report, Goines had adopted all of the statements in the Incident Report as true. Those statements, which described behaviors by Goines and observations of Goines by the officers that Goines did not allege in his complaint, were cited by the officers as showing good cause for Goines' seizure, and thereby supporting the officers' motion to dismiss. Goines argued, and the Appeals Court agreed, that while Goines relied on the Incident Report for some of the facts in his complaint, he did not base his claims on the Incident Report, and none of his claims were dependent on the truth of any statements contained in the Incident Report. Goines merely used the report to support his theory that the police assumed from his physical difficulties that he was mentally ill. The Fourth Circuit determined that Goines' complaint alleged facts indicating that the officers failed to make a sufficient inquiry before assuming a threat and transporting him to the evaluation center. Also important to the court were the alleged facts that (1) Goines had reported to the stationhouse seeking police assistance and (2) the officers were not faced with an emergency situation that would limit their ability to conduct further inquiry.

***Goines' complaint failed to allege a constitutional violation by intake clinician:*** In contrast to the officers' Incident Report, the Fourth Circuit found that Goines had incorporated by reference the intake Screening Report. Probable cause to seize a person for psychological evaluation exists "when the facts and circumstances within the defendant's knowledge and of which the defendant had reasonably trustworthy information were sufficient to warrant a prudent man to believe that the person poses a danger to himself or others." The Screening Report, which Goines had adopted for purposes of his claims against the clinician and community services board, showed that the clinician had observed Goines "behaving as if he were responding to visual hallucinations" and had received seemingly trustworthy information from the officers that Goines had been suffering from auditory hallucinations. Additionally, Goines, while in the clinician's presence, threatened to attack his neighbors after his release. Taken together, the court held that these facts established probable cause for the emergency mental health detention, and supported the clinician's motion to dismiss.



**Treatment over Objection to Restore Defendant to Competency to Stand Trial: Fourth Circuit upholds district court order authorizing treatment.**

[Editor’s Note: This is an unpublished opinion and, thus, is not binding precedent. It is included because it is an instructive case regarding fact-finding under *Sell* and *United States v. Watson*, 793 F.3d 416 (4th Cir. 2015). DMHL previously covered *Watson* in Volume 34, Issue 3.]

***United States v. Sheikh*, No. 15-4616, 2016 U.S. App. LEXIS 9920 (4th Cir. June 1, 2016)**

**Background:** The United States charged Basit Javed Sheikh with one count of violating 18 U.S.C. § 2339B after his alleged attempt to join al-Nusrah Front, a foreign terrorist organization designated by the Secretary of State as an alias for al-Qa’ida. The district court concluded that Sheikh was incompetent to stand trial after two pretrial competency examinations, and ordered him hospitalized for attempted competency restoration. Sheikh refused to cooperate with treatment, and the United States moved for permission to involuntarily medicate him based on his psychiatric evaluation. At the *Sell* hearing, three medical experts testified and the district court determined that involuntary medication was appropriate. The order was stayed pending Sheikh’s anticipated interlocutory appeal.

**Holding:** The Fourth Circuit affirmed, holding that the district court had properly applied the four-part test established by *Sell*, and had adequately explained its findings. The court found that involuntary medication of the defendant would significantly further the United States’ prosecution interests without a substantial likelihood of producing side effects that would interfere with the defendant’s ability to assist counsel in conducting a defense.

**Notable Points:**

***The possibility of civil commitment did not sufficiently mitigate the United States’ prosecutorial interest to preclude involuntary medication:*** The first *Sell* factor weighs the government’s interest in bringing to trial an individual accused of a “serious” crime. Fourth Circuit precedent has recognized that a crime carrying a statutory maximum of ten years or more qualifies as “serious” within the *Sell* context—the crime of which Sheikh was accused carried a statutory maximum of fifteen years. Despite this strong prosecutorial interest, Sheikh contended that the district court had erred by failing to find the possibility of his civil commitment to be a special circumstance sufficient to negate the United States’ prosecutorial interests (see *U.S. v. Onuoha* below, which discusses special circumstances as well). Sheikh argued that the likelihood of his civil commitment mitigated (and negated) the government’s prosecutorial interest because they “need not be concerned that he will be released to the public” even in the absence of a conviction.

The Fourth Circuit disagreed. Although the district court did weigh the possibility of civil commitment, it found that, particularly given the nature of the charges against Sheikh, that possibility did not negate the government’s prosecutorial interests. Stating that “not every serious crime is equally serious,” the Fourth Circuit found that

the government's interest in combating terrorism is "an urgent objective of the highest order" and that the relevant criminal statute (§ 2339B) represents the "considered judgment of Congress and the Executive that providing material support to a designated foreign terrorist organization—even seemingly benign support—bolsters the terrorist activities of that organization." Ultimately, the Fourth Circuit held that although the possibility of civil commitment mitigates one aspect of the government's prosecutorial interest (i.e., ensuring Sheikh will not be released into the community), it did not address the additional prosecutorial interest of general deterrence that is achieved when "a person is convicted of a serious crime, thus deterring others from making the same mistake."

### Other Federal Circuit Court Decisions

**Liability Under 42 U.S.C. Section 1983 for Involuntary Custody: Second Circuit finds that the district court record was insufficient to support a finding of qualified immunity for police officer responding to child protective services report who took a mother into custody based on finding of danger to self or others due to mental illness, and remands for further proceedings.**

***Myers v. Patterson*, 819 F.3d 625 (2d Cir. 2016)**

**Background:** A Child Protective Services caseworker, Jodi Weitzman, was assigned to investigate Julia Johnson after reports from her son's school. Weitzman eventually summoned police to Johnson's home, believing that she should be sent for a psychological evaluation. The only record of the arrest was Weitzman's handwritten notes; the police officer did not take notes and did not testify. The notes described Johnson as annoyed and uncooperative, and her son, DJM, as fearful. The officer, Patterson, arrested Johnson and she was sent to a medical facility for evaluation. The district court granted Patterson qualified immunity under 42 U.S.C. Section 1983 because Johnson did not put forth evidence that would suggest Patterson was not making a reasonable decision as a police officer when he detained her. The officer's motion for summary judgment was granted.

**Holding:** A police officer must have probable cause to believe a person is at risk of harming himself or others in order to lawfully detain them. A police officer would have probable cause if other reasonable police officers would not disagree with his conduct or he was acting under the professional judgment of a licensed caseworker. The Second Circuit found that the record had insufficient detail to make a probable cause determination, one way or the other. The court vacated the district court's assignment of qualified immunity and remanded the case to that court in order to further develop the record and reconsider the question of qualified immunity.

#### **Notable Points:**

***Assessment for probable cause is anchored at time of custody:*** After Johnson was arrested, she was found to be a danger to herself and others, according to the psychological evaluation. Eventually, her parental rights were severed. Regardless of

whether the subsequent facts make Patterson's arrest seem more plausible, the court would only consider the facts at the time of the conduct.

**ADA Integration Mandate: For the purposes of the ADA integration mandate, protection is not limited to just those who are institutionalized. A state may violate the integration mandate if it refuses to provide already-existing treatment to disabled people where such services would improve community integration.**

*Steimel v. Wernert*, 15-2377, 823 F.3d 902 (7th Cir. 2016)

**Background:** Section 1915(c) of the Social Security Act established the Home and Community-Based Care Waiver Program, which allowed states to diverge from the traditional Medicaid program to provide community-based care for Medicaid receivers who would have otherwise been institutionalized. Nonetheless, the states must comply with the ADA's integration mandate, which requires that the states administer services in "the most integrated setting appropriate" for qualified individuals.

The Indiana Family and Social Services Administration (The Agency) runs three of many home- and community-based services in the Medicaid program: the Aged and Disabled Medicaid Waiver Program (A & D waiver), the Community Integration and Habilitation Medicaid Waiver Program (CIH waiver), and the Family Supports Medicaid Waiver Program (FS waiver). The relevant differences between the three are the monetary cap on services and what must be demonstrated to qualify for said services. The FS waiver had a service cap of \$16,545, whereas the CIH and A & D waivers did not have caps. In 2011, The Agency felt that it needed to change its policies to better adhere to A & D rules. The plaintiffs were moved to the FS waiver and were ineligible for the CIH waiver; they subsequently filed their claim, alleging that, because of this change, they enjoyed 30 fewer hours in the community than they did before the change. Furthermore, plaintiffs' guardians alleged that the restriction of services led to lapses in supervision of plaintiffs that had and would result in injuries. The plaintiffs argued that this waiver structure violated the integration mandate because it effectively institutionalized the plaintiffs within their own homes and put them at risk for being institutionalized. The district court granted summary judgment to the defendants; plaintiffs appealed.

**Holding:** The Seventh Circuit extended the meaning of "institutionalized" to include in one's own home, thus qualifying plaintiff's argument. The court further noted that a state may be in violation of the integration mandate if it refuses to provide already-available services to individuals who could be more integrated into the community with such services. And because the plaintiffs sought services that already existed within the structure, the state was obligated to provide them if they enabled the plaintiffs to live in a more community-integrated setting.

**Liability of Correctional and Mental Health Officials: Correctional and mental health officials do not owe a duty to third parties for injuries inflicted by inmates who are returned to the community following assessment by those officials.**

***Glasgow v. Nebraska*, 819 F.3d 436 (8th Cir. 2016)**

**Background:** Nikko Jenkins was a mentally ill inmate who was released from prison after 10.5 years of his sentence because the state changed Jenkins' recommendation from inpatient to outpatient treatment, which accelerated his release. Upon his release, Jenkins killed 4 people in Omaha, one of them Curtis Bradford. Bradford's mother, Velita Glasgow, filed suit against the state of Nebraska, among other defendants, for violation of Bradford's substantive due process rights under the Fourteenth Amendment (§1983) and a state law negligence claim, arguing that the state acted with deliberate indifference in accelerating a dangerous prisoner's release and violated Bradford's right to life. Additionally, she argued that the state had a duty to protect Bradford from their prisoners and the state abandoned that duty when they knowingly released a mentally-ill prisoner who allegedly threatened to kill someone if he was released. The district court dismissed Glasgow's claim, stating that the complaint was "devoid of any plausible allegation against [the] defendants." Glasgow appealed.

**Holding:** The Eighth Circuit affirmed the lower court's dismissal of all claims. An official may be sued if they violated a statutory or constitutional right that was "clearly established" at the time of the conduct. The Eighth Circuit held that "there is no general substantive due process right to be protected against the release of criminals from confinement." Furthermore, because there was no evidence that the state's conduct created a significant risk to a precisely defined group of people and that, if that group existed, Bradford was a part of that group, the state was not required by the Due Process clause to protect Bradford's life from private actors. The court quickly did away with the negligence claim by holding that the plaintiff did not provide any legal authority to explain that the state had a legal duty to Bradford.

**Competency Evaluations: The Ninth Circuit finds that 7-day deadline for competence to stand trial evaluations is not constitutionally required and, therefore, the lower court's permanent injunction required modification.**

***Trueblood v. Washington State Dept. of Soc. and Health Services*, 822 F.3d 1037 (9th Cir. 2016)**

**Background:** In Washington, if a judge, defense attorney, or prosecutor raises a doubt about a criminal defendant's competency, the court must order an evaluation. If the defendant is found incompetent, the court may order restorative services, dismiss the case, or refer the defendant for civil commitment. Washington law, as of July 2015, set a target deadline of 7 days or less for the state to complete a competency evaluation, with the option to extend the deadline to 14 days for clinical reasons and several defenses for failing to meet the deadline. Cassie Trueblood brought a Section 1983 claim on behalf of a plaintiff who was found legally incompetent to stand trial and detained in solitary confinement awaiting transfer to a hospital and the class of past and future detainees. Trueblood claimed that the current waiting times in jail for competency evaluations were so long that they were "beyond any constitutional boundary." The district court granted Trueblood's motion for summary judgment, stating that any waiting period beyond 7

days is suspect of infringing the detainee’s liberty interest in freedom from incarceration. The court also ordered a permanent injunction because it found that the state “‘had a long history of failing to adequately protect the constitutional rights’ of the class and had ‘demonstrated a consistent pattern of intentionally disregarding court orders.’” The state appealed only the part of the injunction that required a competency evaluation within 7 days, or longer upon a court-ordered extension for “clinical good cause.”

**Holding:** According to previous Supreme Court decisions, the length of the commitment must have a reasonable relation to the purpose of the commitment and the interests of the detainee and state must be weighed in light of constitutionally acceptable timeframes. The due process clause of the Fourteenth Amendment applies to the circumstances of pretrial detainees and their confinement. When the constitutionality of competency evaluation deadlines is challenged, a court must weigh the interests of the detainees and the state and benchmark those interests against what is constitutionally reasonable, not simply decide whether the deadlines are reasonable and achievable. The Ninth Circuit found that the lower court made no such analysis and erroneously based its findings on what was reasonable and achievable. The Ninth Circuit held that, for this reason, the lower court erred in upholding the 7 day deadline and, thus, that part of the permanent injunction was vacated and the case was remanded to the lower court. The Ninth Circuit charged the lower court with modifying the permanent injunction while “taking into account the balancing of interests related specifically to initial competency evaluations.”

**Treatment over Objection to Restore Defendant to Competency to Stand Trial:**  
**Ninth Circuit vacates and remands district court order authorizing treatment, finding government failed to show proposed treatment is in the defendant’s best medical interests.**

*U.S. v. Onuoha*, 820 F.3d 1049 (9th Cir. 2016)

**Background:** From 2004 to 2012, Onuoha served in the National Guard. From 2006 to September 2013, when he resigned, Onuoha worked as a Transportation Security Administration (TSA) screener at LAX Airport. A few hours after resigning, Onuoha returned to TSA headquarters at LAX and left a note for a former supervisor who had been involved in a suspension of Onuoha earlier that summer. The government alleged that Onuoha then made calls to a TSA checkpoint and to the LAX police department alluding to sending a message to America and the world and telling them to evacuate LAX. TSA headquarters was evacuated. Law enforcement officials went to Onuoha’s apartment and discovered that all of his belongings had been removed and all that remained was a large note reading “09/11/2013 THERE WILL BE FIRE! FEAR! FEAR! FEAR!” Later that day, Onuoha called LAX police and told them that he was at a church in Riverside, CA. He told police that he did not intend to make a bomb threat or injure anyone and that he only wanted to deliver a message. Onuoha waited at the church until he was apprehended.

Onuoha’s defense counsel submitted a report that Onuoha suffered from paranoid schizophrenia and planned to raise a diminished-capacity defense. The government

requested a competency evaluation, and Onuoha was found not competent to stand trial. The government then filed a motion for an order to involuntarily medicate Onuoha with the goal of restoring him to competency, which the district court granted.

**Holding:** On appeal, the Ninth Circuit vacated and remanded, holding that the district court erred in finding that the proposed treatment was in Onuoha's best medical interest under the *Sell* test. The court of appeals held that the district court was correct in finding that there is an important government interest at stake in prosecuting Onuoha, but the district court clearly erred in finding that the proposed course of treatment was in Onuoha's best medical interests.

**Notable Points:**

***The seriousness of the offense outweighed the "special circumstance" of time detained:*** The first *Sell* factor requires the government to prove that important governmental interests are at stake in prosecuting Onuoha. In *Sell*, the court recognized that there may be some special circumstances that diminish the government's interest in prosecution, including the amount of time the defendant had already been confined. In this case, the court considered that Onuoha had already spent time in custody since September 2013, amounting to confinement beyond the minimum possible sentence. Nevertheless, the court found it important that a conviction and resulting sentence for the serious crime at issue is significant in terms of general deterrence, not just incapacitation of a specific individual. Here, the court concluded that the government's valid interest in prosecuting Onuoha outweighed any special circumstances of Onuoha's detention.

***The government did not meet its burden for proving the fourth Sell factor by clear and convincing evidence:*** The fourth *Sell* factor requires the government to prove that administration of the drugs is medically appropriate and therefore in Onuoha's best medical interest in light of his medical condition. The Ninth Circuit held that after hearing the testimony of a medical expert experienced in administering involuntary medication, the district court could not credit the expert's testimony without exploring contradictory evidence in the record. In this case, contradictory evidence included that the recommended treatment increased the risk of side effects, the dosage proposed was higher than is generally recommended, and the use of the proposed drug does not conform to the community standard of care. Because involuntary medication orders are disfavored in light of the significant liberty interests at stake, and because the record demonstrated that the proposed treatment included dosages higher than generally recommended, the medication was not in Onuoha's best medical interest.

**Ineffective Assistance of Counsel in Death Penalty Case: Failure of defense counsel to adequately investigate and present at penalty hearing the deprivations and traumas of the defendant's past as mitigation evidence may constitute ineffective assistance of counsel and entitle defendant to a new penalty phase hearing.**

*Daniel v. Commr., Alabama Dept. of Corrections*, 822 F.3d 1248 (11th Cir. 2016).

**Background:** Renard Daniel was convicted of murder and sentenced to death. He filed for habeas corpus alleging ineffective assistance of counsel at the guilt and penalty phases of his trial. Daniel claimed that counsel was deficient in investigating and presenting mitigating evidence and rebutting aggravating evidence. Daniel's childhood included witnessing his mother kill his father when he was three years old, being sexually abused by his stepfather for several years beginning when he was nine years old, and a history of borderline intellectual functioning. Daniel's petition claimed that the sentencing judge and jury heard none of these details, and that the failure to present this evidence also prejudiced the outcome of the penalty phase of his trial. The District court, for procedural and substantive reasons, denied his claim. Daniel appealed to the Circuit court.

**Holding:** The Second Circuit looked to the American Bar Association (ABA) guidelines to evaluate the standard for investigations into mitigating evidence. The ABA suggests that investigations "should comprise efforts to discover all reasonably available mitigating evidence and evidence to rebut any aggravating evidence that may be introduced by the prosecutor." The court found that Daniel's trial counsel made no meaningful contact with Daniel's mother, siblings, or mental health professionals and actually ignored the family's request to inform him of Daniel's extensive history of intellectual disabilities and being sexually abused. The court found that any reasonable and competent attorney would have made a deeper investigation of Daniel's history, and thus there was enough evidence to bring an ineffective assistance of counsel claim. The court noted that evidence of mental problems, childhood abuse, and non-violent characterizations of past crimes is inherently mitigating and could change the jury's mindset. It also found that the district court's conclusion that Daniel failed to plead how he was prejudiced was an unreasonable application of Supreme Court precedent and federal law.

## Virginia Court Decisions

**Sexual Abuse and Psychological Injury; Statute of Limitations:** For cases where the childhood sexual abuse occurred before October 1977, the two-year statute of limitations for civil action seeking damages starts when the victim reaches majority. As of October 1977, the two-year statute of limitations starts to run either after the victim has attained majority or after the victim has been advised by a licensed physician or psychologist that the person has an injury caused by the prior abuse.

*Haynes v. Haggerty*, 784 S.E.2d 293 (Va. 2016)

**Background:** Nancy Haynes alleged that Sean Haggerty had a sexual relationship with her between the years of 1971 and 1975, while she was a minor. Haynes reached majority in March of 1975. In October 1977, Virginia Code Section 8.01-249(6) was passed, which dictated that causes of action based on childhood sexual abuse accrue when the fact of the injury and its causal connection to the abuse is first communicated to the victim by a licensed physician, psychologist, or clinical psychologist. This statute

specifically noted that victimizations that occurred before the passing of this statute would be dictated by the former statute, which stated that causes of action based on childhood sexual abuse accrue upon reaching majority. In May of 2012, Haynes was diagnosed by her therapist with Dysthymic Disorder, which the therapist said was a result of Haggerty sexually abusing her when she was a minor. Haynes brought suit against Haggerty seeking damages for sexual assault and battery.

The circuit court held that the statute of limitations applicable in 1975 had expired before the passage of 8.01-249(6) and thus its application to this case would deprive Haggerty of due process and property right to a statute of limitations defense. Also, the court concluded that Haynes' extremely protracted failure to act though being fully aware of Haggerty's sexual misconduct would egregiously undermine Haggerty's constitutional rights to due process. Haynes appealed the decision.

**Holding:** The Supreme Court held that Haynes' causes of actions were dictated by the preceding statute, which stated that the statute of limitations governing the claims would be tolled until the alleged victim reached majority. 8.01-249(6) therefore did not apply to Haynes' claim and the circuit court did not err in granting Haggerty's plea in bar.

**Sex Offender; Probation Violation:** A defendant whose probation requirements necessitate a sex offender program may be held in violation of his probation when he refuses to abide by a central requirement of the program, namely admitting to the misconduct for which he was convicted. Defendant who entered an *Alford* plea is treated as if he entered a guilty plea after conviction; therefore, an admission of guilt to the crimes he was charged with does not invoke Fifth Amendment protection.

***Zebbs v. Com.*, 785 S.E.2d 493 (Va. Ct. App. 2016)**

**Background:** Defendant Zebbs entered an *Alford* plea, pleading guilty to forcible sodomy, among two other charges. An *Alford* plea is treated the same as a guilty plea after the defendant is tried and convicted. Zebbs was required to successfully complete a sex offender treatment program to satisfy the terms of his probation, among other terms. Admitting to the offense for which the offender received probation is a mandatory part of the program. Zebbs refused to admit to his misconduct, arguing that it was a violation of his Fifth Amendment right to require him to verbally incriminate himself and punish him for not doing so. The circuit court found Zebbs in violation of his probation, and he subsequently appealed.

**Holding:** A valid Fifth Amendment claim must include an admission that may carry the risk of incrimination and a substantial penalty for not giving the incriminating testimony. There was no risk of incrimination here because the misconduct Zebbs was required to admit to had already been litigated and thus an admission after the fact would not give rise to incrimination. Double jeopardy would bar the prosecution of Zebbs for admitting to misconduct for which he had been tried and convicted. Therefore, the Fifth Amendment did not protect Zebbs from cooperating with the sex offender treatment



terms and the circuit court did not err in finding that he violated his probation by not completing the treatment.

## **Other State Court Decisions**

**Provider Liability; Claims by Third Parties: Idaho Supreme Court rules that the victim of a shooting by a person with mental illness who had been discharged from treatment services by the state’s mental health services program may pursue a claim against the state that his injury was the result of a negligent termination of services.**

***Mitchell v. State, 369 P.3d 299 (Idaho 2016)***

**Background:** Gerald Simpson had been receiving mental health services from the Idaho Department of Health and Welfare’s (IDHW) Adult Mental Health program until he was released on June 23, 2010. On September 27, 2010, Simpson shot Ryan Mitchell in the back outside of a coffee shop. Approximately ten days after the shooting, psychologist Daniel Traugher, Ph.D., prepared a memorandum on behalf of the IDHW explaining the processes and procedures that were used to terminate mental health services, subsequent to budget cuts, in a way that “reduced the risk of harm to patients and/or the community.” In August 2012, the district court dismissed the criminal charges against Simpson due to Simpson’s lack of competency to stand trial. Shortly thereafter, Mitchell filed this suit alleging that the State violated Mitchell’s constitutional and victims’ rights and was negligent when it discontinued Simpson’s mental health services. The district court issued an order granting summary judgment to the State on all claims.

**Holding:** On appeal, the Supreme Court of Idaho held that Mitchell’s victims’ rights claim was properly dismissed, but that the claim for negligence had been dismissed in error. The court determined that there was insufficient admissible evidence for the district court to make a determination as to whether the decision to cut Simpson from IDHW’s mental health services was operational or discretionary. Thus, the district court erred in holding that the State’s decision to close Simpson’s file was discretionary and therefore erred in granting summary judgment to the State on Mitchell’s negligence claim.

### **Notable Points:**

***Mitchell’s negligence claim turns on whether IDHW’s decision to release Simpson from its Adult Mental Health program was a discretionary function or an operational function:*** If the State’s decision to discontinue Simpson’s mental health services was a discretionary function then it would entitle the State to immunity. Here, there were insufficient facts for the trial court to determine whether IDHW’s decision to cut Simpson from its health services was operational or discretionary. The evidence did not indicate who made the decision to close Simpson’s file or how that decision was made.

**Juvenile Offenders; Life Sentence without Parole: Iowa Supreme Court reverses and remands sentencing of a juvenile offender to life without parole in a double-murder case, on the grounds that such a sentence violates the Iowa Constitution.**

**(Vigorous dissent notes that the Court’s “categorical bar” of life without parole for juveniles goes beyond the U.S. Supreme Court’s decision in *Miller v. Alabama*.)**

***State v. Sweet*, 879 N.W.2d 811 (Iowa 2016)**

**Background:** Isaiah Sweet was 17 years old when he shot and killed his grandparents, who had raised him since the age of 4. He pled not guilty to two counts of first-degree murder, but after the State concluded its case, he pled guilty as part of a plea agreement with the State. The court entered an order for a presentence investigation report, per recent Iowa precedent concerning the sentencing of juveniles convicted of murder. After review of the report and expert testimony from a clinical psychologist, which detailed hardships in his life and the inherent difficulties of assessing risk in adolescents, Sweet was sentenced to life without the possibility of parole. Sweet appealed the sentence.

**Holding:** On appeal, The Iowa Supreme Court ruled that a sentence of life without the possibility of parole (LWOP) for a juvenile offender violates article I, section 17 of the Iowa Constitution. The Court noted that Sweet did not expressly cite the federal Eighth Amendment, so it proceeded with its analysis under the Iowa Constitution. The Court reviewed the history of federal Eighth Amendment case law up through the recent cases concerning juveniles (e.g., *Miller v. Alabama*), then reviewed Iowa case law. It noted that Iowa has extended the reasoning of recent federal cases to provide even greater protection to juveniles (e.g., requiring individualized hearings in cases involving long prison sentences short of life in prison without the possibility of parole). The Court ultimately held that a categorical bar on life without parole sentences was required under the Iowa Constitution.

**Notable Points:**

***Categorical bar to LWOP replaces case-by-case analysis:*** The Iowa Supreme Court first assessed whether a consensus existed in favor of a categorical approach. The Court noted that nine states have abolished LWOP sentences for juveniles, and that another 13 have functionally barred the practice. It also noted, however, that several state supreme courts have concluded that a categorical bar is not necessary. Concluding that a consensus was not present, the Court then exercised its “independent judgment to determine whether to follow a categorical approach,” ultimately concluding “that sentencing courts should not be required to make speculative up-front decisions on juvenile offenders’ prospects for rehabilitation because they lack adequate predictive information supporting such a decision.” Instead, “[t]he parole board will be better able to discern whether the offender is irreparably corrupt after time has passed, after opportunities for maturation and rehabilitation have been provided, and after a record of success or failure in the rehabilitative process is available.”

**Intellectual Disability and Death Penalty: Kentucky Supreme Court overturns trial court ruling that defendant waived claim that he was not subject to the death penalty due to intellectual disability after defendant had refused to accept**

**evaluation by a state psychiatric center to determine intellectual disability and insisted on state payment for evaluation by a private psychologist.**

***White v. Commonwealth*, No. 2013-SC-000791-MR, 2016 WL 2604759 (Ky. May 5, 2016)**

**Background:** In 1980, White was convicted by a Powell Circuit Court jury of three counts of capital murder, three counts of first-degree robbery, and one count of burglary. He was sentenced to death for each of the three murders. Less than a month after he was sentenced, White was subjected to a psychological evaluation, which determined that he had an overall IQ score of 81. In 2004, White filed a motion in the Powell Circuit Court, based on *Atkins v. Virginia*, to set aside his death sentences on the grounds that he was intellectually disabled. White argued that the Kentucky Correctional Psychiatric Center (KCPC) was incapable of conducting the necessary evaluations to determine his competence for the death penalty, and that the state should instead pay for an independent evaluation by an intellectual disability expert selected by White. Over the next several years, several orders for evaluation by the trial court and subsequent writs of prohibition by both White and the Commonwealth were entered. The trial court ultimately rejected White's demand for an independent evaluation and ordered an evaluation by the KCPC. White refused to cooperate with the evaluation by the KCPC, which the trial court ruled was a waiver of his intellectual disability claim.

**Holding:** On appeal, the Kentucky Supreme Court affirmed in part and reversed in part, holding that White is not entitled to public funds for an expert of his choosing. The court reversed the trial court's judgment that White waived his right to an intellectual disability claim by refusing an evaluation by the KCPC.

**Notable Points:**

***An evaluation by the KCPC does not violate a defendant's Fifth Amendment right to remain silent during post-conviction proceedings:*** The court ruled that White's Fifth Amendment rights would be minimally affected, if at all, by an evaluation by the KCPC. White was already tried and convicted of three murders; therefore, any inquiry by the mental health professionals into these crimes would not implicate the right.

***Kentucky law barring executions of only those individuals with an IQ score of 70 or less was invalidated by the U.S. Supreme Court Decision in Hall v. Florida, 134 S. Ct. 1986 (2014):*** The Kentucky Supreme Court noted that the *Hall* decision "effectively invalidated our arbitrary intelligence score standard for evaluating" intellectual disability.

**Provider Liability:** In a case involving a minor with history of suicidal behavior, hospital's affirmative defense of statutory immunity applied to the decision to deny admission to an inpatient mental health unit, but not to decisions regarding what care to provide the patient after leaving the hospital.

***Binkley v. Allina Health Sys.*, 877 N.W.2d 547 (Minn. 2016)**

**Background:** Binkley sued Allina Health System (“Allina”) for negligence in failing to properly examine, evaluate, and provide services to her son, Lloyd, who committed suicide after being denied admission into an inpatient mental health unit. In 2009, Lloyd began to experience suicidal thoughts and ideation, which resulted in his participation in the “United Partial Program” (“partial program”), an outpatient mental health treatment program. About nine months after completing the program, Lloyd again experienced suicidal ideation and self-harm behavior. He told his mother that he wanted to go to United in order to get help and stop his pattern of self-harm. Binkley and Lloyd went to the United Health emergency room and repeatedly requested that Lloyd, who consented, be admitted to United's inpatient mental health unit. Lloyd was examined by United staff, but was informed that he would not be admitted to the inpatient unit and, further, he was not “a good candidate” for the outpatient program because of a previous failure to follow through with that program. Lloyd returned home with his mother and committed suicide less than 24 hours later. Respondents asserted an affirmative defense of statutory immunity and, in the alternative, claimed that Binkley's expert affidavit failed to satisfy the statutory requirements under Minnesota law. The district court denied the motion for summary judgment.

**Holding:** On appeal, the Minnesota Supreme Court held that Respondents' good-faith decision to deny Lloyd admission to the inpatient mental health unit was entitled to immunity. However, the court also held that decisions regarding what care to provide to Lloyd after he left the hospital were not entitled to immunity.

**Notable Points:**

***The immunity provision of the Minnesota Commitment and Treatment Act (“CTA”) applies to both voluntary and involuntary commitments:*** The CTA creates a state policy in favor of voluntary treatment. The voluntary treatment section of the CTA, which applied to Lloyd's circumstances, prohibits the arbitrary denial of admission and requires that treatment facilities use “clinical admission criteria consistent with the current applicable inpatient admission standards established by the American Psychiatric Association or the American Academy of Child and Adolescent Psychiatry” when “making decisions regarding admissions.”

**Firearms Possession by Persons with Mental Illness; Negligent Entrustment:** Missouri Supreme Court rules that a claim of negligent entrustment can be brought against a seller who sold a firearm to an individual after the seller had been specifically informed that the purchaser was mentally ill and had attempted suicide recently and was likely to do harm to self or others if given possession of a firearm, where the purchaser did subsequently use the firearm to kill another person.

***Delana v. CED Sales, Inc.*, No. SC95013, 486 S.W.3d 316 (Mo. 2016) (en banc)**

**Background:** On June 25, 2012, Colby Weathers' mother called the store manager of Odessa Gun & Pawn and asked him to refrain from selling a gun to her daughter who was severely mentally ill, informing him that Ms. Weathers had purchased a gun at the

pawnshop the previous month and attempted to commit suicide. Two days later, the store manager sold a gun to Weathers and within two hours, Weathers had shot and killed her father. The State charged Weathers with murder but accepted her plea of not guilty by reason of mental disease or defect and ordered her committed to the Missouri Department of Mental Health. Weathers' mother filed a wrongful death action alleging that the pawnshop was liable under theories of negligence.

The circuit court entered summary judgment in favor of Respondents, finding that Weathers' mother's negligence claims were preempted by the Protection of Lawful Commerce in Arms Act (PLCAA), which protects the sellers of firearms against negligence claims. The court also determined that although the PLCAA provides an exception to this protection in cases of negligent entrustment, Missouri law does not recognize a cause of action for negligent entrustment against sellers.

**Holding:** On appeal, the Supreme Court of Missouri held that the district court erred in determining that Weathers' mother was precluded from proceeding with her negligent entrustment claim. The court found that, because Congress had expressly and unambiguously exercised its constitutionally delegated authority to preempt state law negligence actions against sellers of firearms, the PLCAA clearly preempted state law on point; thus, the PLCAA's exception for negligent entrustment actions applied. What is more, the Court found that Missouri law does recognize a cause of action for negligent entrustment. The court concluded that negligent entrustment occurs when the defendant "supplies" a chattel (i.e., item of personal property) to another with actual or constructive knowledge that, "because of youth, inexperience or otherwise," the recipient will likely use the chattel in a manner that will result in an unreasonable risk of physical harm. Because Weathers' mother presented sufficient evidence, the circuit court erred in entering summary judgment in favor of the pawnshop.

**Provider Liability; Claims by Third Parties: Nebraska Supreme Court rules that state mental health service providers not liable for injuries to victim of a shooting by a mentally ill person released from prison upon completion of his sentence.**

***Holloway v. State*, 875 N.W.2d 435 (Neb. 2016)**

[Editor's Note: An 8<sup>th</sup> Circuit case related to the same incident, *Glasgow v. State*, is covered above.]

**Background:** On July 20, 2013, Nikko Jenkins was released from prison after serving 10.5 years of his 21-year sentence. While in prison, Jenkins engaged in numerous violent activities and repeatedly exhibited signs of a serious mental health problem. On August 24, Jenkins shot Shamecka Holloway as she walked in her front yard in Omaha, Nebraska. As a result of the shooting, Holloway suffered permanent damage and incurred medical bills; she sued the State, the state department of corrections, and the company that provided mental health services for the department and several of its providers. In her complaint, Holloway stated that the State's responsibilities with respect to the inmates included assessing and evaluating inmates in order to determine the need for mental health commitment, and providing adequate advance notice to members of the

public regarding the release of a prisoner who threatened serious bodily harm to others. The complaint further alleged that Jenkins had told Baker and staff evaluators that he would hurt others upon his release. Thus, Holloway claimed that the State knew or should have known of the foreseeability of harm to her once Jenkins was released, and mental health care providers owed a duty to the citizens of Nebraska to correctly evaluate and treat all inmates. The district court dismissed all claims brought by Holloway. Holloway appealed.

**Holding:** On appeal, the Supreme Court of Nebraska held that the district court did not err in dismissing Holloway’s complaint. The court found that the State and its employees were entitled to immunity from suit because whether to seek commitment falls under the “discretionary function” exception to the State Tort Claims Act. Further, the Supreme Court of Nebraska affirmed the district court’s ruling that Holloway failed to plead sufficient facts to show that the mental health care provider was liable.

**Notable Points:**

*A state actor’s performance or nonperformance of a discretionary function cannot be the basis of liability:* The State Tort Claims Act (“Act”) contains a discretionary function exception to the waiver of sovereign immunity for certain claims. A two-step analysis is used to determine whether the discretionary function exception applies. The court must first consider whether the action is a matter of choice for the acting employee. Under the applicable statute of the Nebraska Mental Health Commitment Act, whether to communicate a belief that another person is believed to be mentally ill and dangerous is a matter of choice. Thus, the first step of the analysis was satisfied. The second step requires that when a statute involves an element of judgment, the judgment must be of the particular kind that the discretionary function exception was designed to protect. The court concluded that the decision as to whether to report to the county that another person is thought to be mentally ill is a policy decision that the legislature intended to shield from liability.

*Mental health treatment providers are only liable for failing to warn of a patient's threatened behavior under certain exceptional circumstances:* A psychologist or mental health practitioner is not liable for failing to warn of a patient’s threatened violent behavior unless the patient has threatened violence toward a reasonably identifiable victim. Here, Jenkins did not specify a particular person but rather threatened the “citizens of Nebraska.” Another source of liability could be founded on a custodial relationship, but the court concluded a custodial relationship did not exist because CCS was only contracted to provide medical services for inmates, not to exercise any kind of custody over inmates.

**Juvenile Offenders; Knowing Waiver of Right Against Self-Incrimination: Ohio Supreme Court rules that Ohio law providing that recorded statements made by defendant in custodial setting are presumed to be voluntary violates juvenile’s right to due process and does not remove burden from the state to prove that waiver of right against self-incrimination was knowingly made.**

***Ohio v. Barker, 2016 Ohio 2708 (Ohio 2016)***

**Background:** In October 2011, Tyshawn Barker was questioned by police while in custody concerning the shooting deaths of two individuals. The detectives recorded the interrogation, read Barker the Miranda warnings, and asked him to sign a “Notification of Rights” form, explaining “...I am going to ask you to sign it. You’re not admitting to anything. I am just telling you it just says that I read you this [the warnings], okay?” The form included a preprinted statement, “I understand my rights,” but did not indicate that by signing the form it would waive rights. Barker was evaluated as part of the juvenile court’s determination about transfer, and he was found to have a low IQ, below-grade-level academic abilities, and to have an individualized education plan. Barker was transferred to adult court, where he moved to have his statements suppressed, arguing that he had not knowingly, intelligently and voluntarily waived his *Miranda* rights. The trial court dismissed his motion, not making a finding on his waiver, but finding that he had voluntarily made statements. Ohio law (R.C. 2933.81(B)) stated that recorded interrogations were presumed voluntary. Barker was convicted and he appealed. The First District Court of Appeals affirmed his convictions, finding support in the record for the trial court’s decision about his rights waiver despite the absence of an express finding on the point. Barker appealed.

**Holding:** The Supreme Court of Ohio reversed and remanded. The Court distinguished two issues: the rights waiver issue, which was rooted in the Fifth Amendment right against self-incrimination, and voluntary statements issue, which was rooted in the Fourteenth Amendment due process right. Addressing the rights waiver, the Court found that R.C. 2933.81(B) did not apply to waiver of Fifth Amendment rights, and noted that state and federal case law make clear that rights waivers cannot be presumed and state legislatures cannot supersede federal constitutional law. Ultimately, the Court held that the state retains the burden of proving that Barker waived his rights. As to the second issue, the Court noted that juveniles require greater protections than adults. The Court noted that voluntariness of statements is assessed via the totality of circumstances test, and that R.C. 2933.81(B) effectively blocked consideration of the totality of circumstances, at least in juvenile cases, by its presumption of voluntariness. Ultimately, it held the law to be unconstitutional as applied to juveniles.

**Sex Offenders; Conditions of Probation: Vermont Supreme Court rules that certain probation conditions placed by the trial court on a convicted sex offender improperly infringe on the offender’s liberty, privacy and autonomy rights.**

***Vermont v. Cornell, 2016 VT 47 (Vt. 2016)***

**Background:** Owen Cornell was convicted of lewd and lascivious behavior with a 12-year-old boy in 2013. His prison sentence was suspended and multiple probation conditions were imposed. Cornell appealed the conditions, arguing that the “boilerplate” restrictions were invalid for a number of reasons (e.g., not sufficiently individualized, in violation of due process rights, impermissible delegation of authority to his probation officer). On remand, the trial court took consideration of additional information

submitted by Cornell and testimony from his probation officer, then issued 21 new probation conditions. Cornell objected to six of the conditions, arguing that four of them had already been deemed unlawful in previous cases and two of them infringed on his liberty, privacy and autonomy rights under the U.S. and Vermont Constitutions.

**Holding:** The Vermont Supreme Court affirmed two conditions (prohibition on violent or threatening behavior; prohibition from places where children are known to congregate) and remanded as to four conditions. The Court found the delegation of authority to the probation officer to dictate treatment requirements to be overbroad. The Court found the condition of requiring probation officer approval for living and working location to be insufficiently specific to Cornell. The Court also agreed with Cornell that the condition requiring him to give search and seizure privileges to his probation officer was unconstitutional because it did not require reasonable suspicion for such searches. Finally, the Court found the condition imposing a blanket restriction on computer use to be overly restrictive, given that Cornell did not utilize any such technology in his offense. Concerning the computer restriction condition, the Court summarized, “We do not see a sufficient justification for such a sweeping restriction, which would render nearly all the activities of life incalculably difficult in the modern age, when such a condition would not have prevented the crime of which [a defendant] was convicted” (internal quotations removed, quoting *U.S. v. Barsumyan*, 517 F.3d 1154 (9th Cir. 2008)).

**Notable Points:**

***Insufficiency of proof for “boilerplate” conditions:*** Prior to considering the specific challenges, the Court engaged in a brief excursus to note that the State’s “proof” concerning the appropriateness of probation conditions was insufficient, in that it merely rested upon the testimony of the probation officer that Cornell was a sex offender.

***Balancing Fourth Amendment rights in sex offender cases:*** In the latter portion of the opinion the Court addressed the conditions that Cornell had argued infringed his liberty, privacy and autonomy rights. The Court discussed the balance of interests, including somewhat lessened rights of the probationer, but the overall need to narrowly tailor such conditions in order to avoid infringing liberty and privacy interests. The Vermont Supreme Court noted that some states (e.g., California, Indiana) have allowed suspicionless searches of probationers (and parolees), but that Vermont would continue to require reasonable suspicion for such searches.

**Provider Liability; Claims by Third Parties: Vermont Supreme Court rules that individuals who are known to residential and outpatient mental health providers as the caretakers of a patient have a right to be informed by those providers of the patient’s mental health status, his danger to the caretakers or others, and how to perform their caretaker role in light of these warnings; thus, a claim that the failure of the providers to so inform resulted in injury to the caretakers or other third parties survives a motion to dismiss for failure to state a claim.**

***Kuligowski v. Brattleboro Retreat*, 2016 VT 54 (Vt. 2016)**



**Background:** In October 2010, E.R. was voluntarily admitted to the Psychiatric Department at Central Vermont Medical Center (CVMC) with a “psychotic disorder” after having threatened young children in his home. A few days later he was involuntarily committed with a diagnosis of schizophreniform disorder and was subsequently transferred to the Retreat, a nonprofit psychiatric hospital in Vermont. At the Retreat, there were reports indicating E.R. had auditory and visual hallucinations, menacing behavior, and homicidal and suicidal ideation. In November of 2010, E.R. was discharged from the Retreat with an aftercare treatment plan that was shared with his parents. In mid-December, E.R. told his mother that he had stopped taking his medication. His mother reported this to Northeast Kingdom Human Services (NKHS), part of his aftercare treatment plan, but was told that E.R. had to decide to take care of himself. Between mid-December 2010 and March 2011, E.R. did not meet with anyone from NKHS and no one from NKHS reached out to E.R. On February 26, 2011, E.R. assaulted Michael Kuligoski at an apartment building. Kuligoski sued both the Retreat and NKHS. The superior court granted defendants’ motion to dismiss concluding that the defendants owed no duty to plaintiffs under *Peck v. Counseling Service of Addison County, Inc.*, 146 Vt. 61 (1985).

**Holding:** On appeal, the Supreme Court of Vermont held that the failure-to-warn claims against defendants were improperly dismissed, but that the failure-to-treat and negligent-undertaking claims were properly dismissed. The court found that the defendants had a duty to provide information to parents, as patient's caretakers, to warn them of patient's risk of violence to themselves and others and to advise them on how to manage patient's conduct. However, the court concluded that neither defendant had a duty, as a matter of public protection, to refrain from releasing E.R.

**Notable Points:**

***Peck and other precedents bar duty-to-treat and negligent-undertaking claims:*** The general rule is that there is no duty to control the conduct of another in order to protect a third person from harm. Previous Vermont cases held in favor of rehabilitation in a non-institutional setting, which precluded the plaintiffs’ duty-to-treat and therefore duty not to release argument. Further, a negligent-undertaking claim requires plaintiffs to show that defendants’ failure to exercise reasonable care increased the risk of the harm that occurred. In this case, plaintiffs did not allege and could not show that defendants’ care increased the risk to third persons.

***Peck extends to identifiable and foreseeable victims, and plaintiffs' duty-to-warn claims should not be dismissed at this stage in the litigation:*** The Court noted that *Peck* and *Tarasoff* established the clear duty of the mental health professional or institution to warn identifiable third parties of threats of harm made by patients, but that many courts have been reluctant to extend that duty beyond identifiable third parties. This reluctance, the Court wrote, was based on those courts’ recognition of the interests of the mental health profession in honoring the confidentiality of the patient-therapist relationship and in respecting the humanitarian and due process concerns that limit the involuntary hospitalization of the mentally ill. However, the Court went on, several courts have extended the duty to foreseeable victims or to

those whose membership in a particular class—such as living with the patient—places them within a zone of danger. Here, the Court found that *Peck* is not limited to circumstances in which there is an identifiable victim. Rather, the defendants did have a duty to warn E.R.'s caretakers based on their assumption of custody and caretaking responsibilities of E.R.

**Chief Justice Reiber's dissent:** The Chief Justice filed a strong dissent to defining a “new common-law duty” for mental health care providers: to train or assist caretakers in order to protect the public. Justice Skoglund also filed a dissent on the same grounds.

**Involuntary Commitment; Constitutional Due Process: Washington Supreme Court upholds constitutionality of state statutory provisions authorizing commitment and re-commitment of individuals with mental illness on the grounds that they were charged with violent felonies and continued to present substantial likelihood of repeating similar acts, even after original charges dismissed on the grounds that the individuals were unrestorably incompetent to stand trial.**

*In re the Det. of M.W. & W.D. v. Dep't Soc. & Health Serv., Washington, W. State Hosp., No. 90570-3, 2016 WL 3249495 (Wash. June 9, 2016) (en banc)*

**Background:** The respondents' cases were unrelated but they were consolidated because they both challenged the constitutionality of involuntary recommitment. M.W. and W.D. were both charged with violent felonies and had their charges dismissed without prejudice after a judge determined that they were incompetent to stand trial and their competency could not be restored. In each case, the court ordered mental health evaluations to determine if they should be involuntarily committed, and each man was committed for 180 days of involuntary treatment. Prior to the expiration of the men's commitments, the State utilized a new procedure for recommitting a person based on a judge's finding that the person committed a violent felony. The new procedure allowed for recommitment in some circumstances based on a preliminary hearing, rather than a full evidentiary hearing, to determine whether “the person continues to suffer from a mental disorder or developmental disability that results in a substantial likelihood of committing acts similar to the charged criminal behavior.” The individual would then have the opportunity to rebut any findings through admissible expert testimony. The superior court commissioner declared the former statute unconstitutional and ordered the recommitment process to proceed without the unconstitutional provision. M.W. and W.D then received full evidentiary hearings assessing their eligibility for further involuntary treatment and were each recommitted to an additional 180-day period on other grounds.

**Holding:** On appeal, the Washington Supreme Court ruled that the procedure for involuntary commitment did not violate substantive or procedural due process, vagueness or equal protection. The court also ruled that the statute did not violate an individual's right to a jury trial because the periods of commitment are short and the state has a high burden of proof for recommitment. The Washington Supreme Court reversed the judgment of the superior court and upheld the statute at issue as constitutional.

**Sex Offenders; Post-Sentence Civil Commitment: Wisconsin Supreme Court rejects offender's post-conviction motion to withdraw his guilty plea to child sexual assault charges, where offender argued his attorney's failure to advise him that he could be civilly committed as a violent sex offender violated his Sixth Amendment right.**

*State v. LeMere*, 879 N.W.2d 580 (Wis. 2016)

**Background:** LeMere was charged with one count of first-degree sexual assault of a child under the age of 13, one count of second-degree reckless endangerment, and one count of strangulation and suffocation. A status conference became a plea hearing when counsel for the parties informed the court that they had negotiated a plea agreement. Under the agreement, LeMere agreed to plead guilty to first-degree sexual assault of a child under the age of 13 in exchange for the other two charges against him being dismissed. The court then informed LeMere about the consequences of a guilty plea, including the possibility of continued civil commitment after the completion of his criminal incarceration. LeMere indicated that he understood and the court noted that LeMere appeared capable of understanding the proceedings. At a subsequent sentencing hearing, the court ordered 30 years of initial confinement followed by 15 years of extended supervision. One year later LeMere filed a motion to withdraw his guilty plea and vacate his conviction. He argued ineffective assistance of counsel because he was not informed of the possibility of lifetime civil commitment as a sexually violent person. The circuit court denied the motion and the court of appeals affirmed.

**Holding:** On appeal, the Wisconsin Supreme Court affirmed, holding that the failure to inform a defendant of the possibility of lifetime civil commitment does not form the basis of a claim of ineffective assistance of counsel and is not a violation of the Sixth Amendment.

**Notable Points:**

***Failure to inform about the possibility of lifetime civil commitment as a sexually violent person distinguished from failure to inform about possibility of deportation:*** The Wisconsin Supreme Court distinguished this case from the failure to inform a defendant about the possibility of deportation, which the U.S. Supreme Court ruled was a violation of the Sixth Amendment. The Wisconsin Supreme Court emphasized that unlike deportation, civil commitment is not automatic or penal in nature. The court also explained that civil commitment is not meant to be permanent and is rehabilitative in nature.

### III. Institute Programs

Please visit the Institute's website at  
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The Institute has started announcing its offerings for the program year August 2016 through June 2017. Additional programs will be announced. 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:

##### **Bullying, cyberbullying and dating violence: Developmental considerations and prevention programming**

September 29 2016, Charlottesville VA: This one-day program with expert Dorothy Espelage PhD will present and discuss the range of risk and protective factors associated with bullying, cyberbullying, sexual and dating violence experienced by youth and young adults, and will examine and discuss a variety of evidence-based prevention program across K-12 educational grades. Fidelity, sustainability, and contextual considerations with prevention programming will be discussed.

##### **Static-99R Training: How to Code, Interpret, and Report Scores Using the New (2016) Manual and Procedures**

October 11 2016, Charlottesville VA: This one-day program with expert L. Maaike Helmus PhD, Director of Research with the Global Institute of Forensic Research, will present and discuss Static-99R Training: How to Code, Interpret, and Report Scores Using the New (2016) Manual and Procedures. This training is appropriate for anyone involved in risk assessment with sexual offenders. This is an opportunity to be among the first to hear Dr Helmus on this topic. As of Fall 2016 the Static-99 developers are releasing a new manual and risk categories, along with recommendations that users receive updated training on the revised manual from a certified Static-99R trainer. Dr. Helmus is a certified trainer and co-author of this new manual. Her presentation will be among the first live trainings to address these 2016 updates. Her training will be suitable for long-term Static-99R users who are transitioning to the new manual, but also accessible to professionals just learning to use the Static-99R.

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

October 24-28 2016, Charlottesville VA: This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation. Content includes clinical, legal, ethical, practical and other aspects of forensic evaluation with adults. The format combines lectures, clinical case material, and practice case examples for evaluation of adults. Day five incorporates a report writing exercise.

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

January 27 2017, 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.

### **Adolescent substance abuse: What are kids doing, what are the effects, and how do we intervene, successfully?**

March 8 2017, Charlottesville VA: This one-day program with expert John Kelly PhD, ABPP will present and discuss 'Adolescent substance abuse: What are kids doing, what are the effects, and how do we intervene, successfully?' Dr Kelly is Elizabeth R. Spallin Associate Professor of Psychiatry at Harvard Medical School, Harvard University.

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

March 27-31 2017, Charlottesville VA : This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation with juveniles. Content includes clinical, legal, ethical, practical and other aspects of forensic evaluation with juveniles. The format combines lectures, clinical case material, and practice case examples for evaluation of juveniles.

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

March 27, 28, 29 2017, Charlottesville VA: This three-day program is for experienced adult forensic evaluators - who have already completed the five-day "Basic Forensic Evaluation" program (regarding evaluation of adults) and accomplished all relevant qualifications for performing adult forensic evaluation - and wish now to complete relevant qualifications to perform juvenile forensic evaluations

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

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