

Work Group # 1 - Crisis Intervention
Joint Subcommittee to Study
Mental Health Services in the Commonwealth in the
21st Century

dls.virginia.gov/interim_studies_MHS.html

Thursday, September 24, 2015, 9:00 am

Suffolk City Hall

442 W. Washington Street, Suffolk, Virginia

I. Introductions and Opening Remarks

II. PRESENTATION: Alameda Model and Other Innovations in Emergency Assessment and Treatment

- **Mental Health Crises and Psychiatric Boarding as Experienced by an Urban Emergency Department in Virginia: Treatment Challenges and Solutions from the Perspective of an Emergency Department Director** - Dr. Bruce Lo, Medical Director, Department of Emergency Medicine, Sentara Norfolk General Hospital
- **A Coordinated Care Response to Mental Health Emergencies: The Impact and Role of a New Psychiatry Emergency Services Wing at Centra Lynchburg General Hospital** - Damien Cabezas, LCSW, MPH, MSW, Chief Executive Officer, Horizon Behavioral Health
- **Early Crisis Intervention Strategies to Minimize Hospitalization and Resolve Crises: Current Crisis Programs and a Vision for a Regional Crisis Stabilization Center** - Derek Curran, Director of Crisis Services, Hampton-Newport News Community Services Board
- **The Alameda Model: How an Independent Psychiatric Emergency Services Unit Can Effectively Engage People in Mental Health Crises, Treat and Resolve the Majority of Those Crises, and Reduce Both Psychiatric Boarding in Emergency Departments and Unnecessary Commitments to Psychiatric Hospitals** - Dr. Scott Zeller, Chief of Psychiatric Emergency Services, Alameda County Health System, San Leandro, California

III. Discussion of proposed legislative drafts

IV. Public Comment

V. Adjourn.

Work Group Members

Delegate Robert B. Bell, III, Chairman
Delegate Vivian E. Watts
Delegate Margaret B. Ransone
Senator George L. Barker
Senator R. Creigh Deeds, ex officio

Emergency Psychiatric Services Models: Finding the Best Ways to Help People Resolve Mental Health Crises

Introduction: The Limits of the 2014 Reforms – Psychiatric Boarding and the Search for Timely Emergency Mental Health Care

The 2014 statutory reforms of Virginia’s involuntary commitment process were positive and significant. The key reform was an amendment to Virginia Code Section 37.2-809 (and related sections) that ensures that every person who is brought into custody for evaluation under an Emergency Custody Order (ECO) and is found to meet the criteria for a Temporary Detention Order (TDO) for temporary psychiatric hospitalization (pending an involuntary commitment hearing) is *guaranteed* placement in a psychiatric hospital until that hearing.

Prior to the 2014 amendment, if a psychiatric bed could not be identified for such a person by the time the ECO expired (then a maximum of 6 hours), a TDO could *not* be issued for that person, and the person could not be held. The law now requires that, if a local bed is not available for such a person, a bed in a state psychiatric hospital will be provided. The Virginia Department of Behavioral Health and Developmental Services, to its credit, has informally adopted a practice of also accepting into state hospitals individuals in crisis who are *not* under an ECO, but who have been found by the local community services board (CSB) evaluator to meet TDO criteria and have no available local psychiatric bed.

These reforms have increased the safety of many individuals in mental health crisis who otherwise would have returned to their homes or the streets untreated and in danger of experiencing further crisis or harm, or causing harm to others. At the same time, however, these reforms have placed increasing strain on state hospitals and may be compromising the efficacy of the emergency care provided to these individuals. For example, admission to the state hospital may require an hours-long drive to the facility, a drive that cannot be made until a law enforcement officer is available to make that trip. The state hospital, in turn, sends the person back to the person’s place of origin as soon as a local psychiatric bed becomes available, so that the person may spend many hours, or even a period of days, without a stable placement or opportunity for further assessment or treatment. So, while there have been demonstrable gains in safety, serious questions remain about the efficacy of the care provided under the new model.

A key aspect of that model that warrants examination is the focus now placed on making a quick determination as to whether a person in crisis meets, or does not meet, the criteria for psychiatric hospitalization. While the 2014 reforms increased the time period for an ECO, during which that determination can be made, to 8 hours, there is evidence that this is simply not enough time in many cases to fully assess the nature and extent of the person’s crisis and underlying conditions *and* to determine whether the person’s crisis might be effectively resolved in a *less* restrictive setting than a psychiatric hospital. At the same time, the fact that the reform statute limits the guarantee of a hospital bed to persons who are under an ECO, and provides only 8 hours for determining whether those persons should receive a TDO, means that those who are in mental health crisis and need intervention but are *not* under an ECO are unlikely receive the same immediacy or intensity of attention. The consequence is that many people in Virginia who come to hospital Emergency Departments (EDs), or who are brought there by family members or friends, and therefore are not under an ECO, find themselves waiting for hours or even days for the mental health evaluation and treatment that EDs are unable to provide. The prolonged presence of these individuals in the ED, without receiving active evaluation and treatment services, is referred to as “psychiatric boarding”, a phenomenon that is being experienced throughout the country. The frustration of many ED directors over psychiatric boarding is at least one of the factors behind the introduction and passage of HB 2368 by the 2015 General Assembly. That bill mandates a study of how

timely evaluations of individuals in crisis in the EDs can be made to determine whether they meet the criteria for a TDO, and whether and to what extent doctors in the EDs should be able to conduct that evaluation for use by the magistrate. (Currently the magistrate must wait for an evaluation by a CSB evaluator before deciding whether to issue a TDO.)

The Alameda Model: resolving crises locally in a Psychiatric Emergency Services (PES) unit

There are some who submit that the better approach is to quickly move people who are in mental health crisis out of the ED (once it is established that they do not have an underlying medical condition that requires ED or hospital treatment) and to a psychiatric emergency services unit for evaluation and care. The Alameda model, discussed in an article in the [April 2015 issue](#) of *Developments in Mental Health Law*, utilizes a Psychiatric Emergency Services (PES) unit, staffed by mental health professionals, to which individuals in mental health crisis are directly transported (most often by ambulance rather than law enforcement) from the community, or from hospital EDs in the region if they were brought there first (on their own, by family or friends, or by ambulance if an underlying medical condition needing assessment and treatment was found.) The Alameda PES unit is designed as an outpatient unit, with an emphasis on patient engagement and consent and a time frame of 24 hours for determinations regarding the patient's need for treatment or appropriateness for discharge. According to the program's director, Scott Zeller, M.D., close to 80% of the patients seen in the Alameda PES unit achieve a level of stability within 24 hours to be discharged to their homes (with arrangements for follow-up outpatient services) or to step-down residential treatment programs in the community. The remaining 20% are found to need inpatient psychiatric care. According to Dr. Zeller, this approach has both largely eliminated psychiatric boarding in the participating Alameda County EDs and has reduced the number of individuals who have to undergo involuntary commitment to a psychiatric hospital.

Dr. Zeller's key claim is that patient engagement and consent-based treatment in a welcoming setting can help most individuals who are in mental health crisis achieve sufficient stability to remain in the community and not be psychiatrically hospitalized. He notes that key factors to making this model work include: (1) a provision in California law that authorizes law enforcement officers and certain specified mental health clinicians to keep a person in a treatment setting for up to 72 hours, without having to seek court authorization for such action, provided that they document that the person's mental health condition/behaviors pose a risk of harm to self or others, or render the person "gravely disabled", to the degree required by California statute (referred to as a "5150 hold"); (2) a billing code under California health insurance law that enables the PES unit to charge for services at a level that adequately compensates the program for its services-rich environment.

While Virginia currently has neither of these provisions, there are a number of programs developing in different parts of the state that attempt to provide evaluation, treatment and resolution for mental health crises through means that share important features with the Alameda model.

Centra Lynchburg General Hospital: adding a Psychiatric Emergency Services wing to the ED

One brand new program is a regional psychiatric emergency services center that will be opening in early October of 2015 in Lynchburg. Operated by Centra Health, this center will be a separate wing of the Emergency Department at Centra Lynchburg General Hospital. Ted Stryker, a Centra vice president for mental health services, states that, unlike the Alameda model, this center will have private rooms that, in his view, afford people experiencing mental health crisis the protection, privacy and dignity they need. (He noted that, in many hospital EDs, people brought there in mental health crisis can experience severe embarrassment and even humiliation when they are seen in their vulnerable crisis state - and sometimes in physical restraints applied to them by ED staff to prevent harm - by others in their community who are at the ED for other kinds of medical issues.)

Like Dr. Zeller, Mr. Stryker noted that properly understanding and addressing the underlying problems in a person's mental health crisis often requires a period of observation, and that time itself, especially if spent in a safe setting, can be an important factor in the resolution of a crisis. While in a certain percentage of cases a person's need for inpatient psychiatric care will be immediately apparent, for many others the 8 hours afforded under the ECO, and the focus of the ECO period on evaluating a person for involuntary hospitalization, often provide too little time and attention for effective engagement and treatment.

Patients who have come directly to Centra's PES unit or who are transferred there from the hospital ED (at Centra Lynchburg General Hospital and other area hospitals) because their primary problem is a mental health problem that the ED is not equipped to address, will be placed in private rooms for observation and treatment. The goal in having this center is to enable people in mental health crisis to move quickly out of the standard ED setting, where their mental health needs cannot be met, and into a safe facility staffed by mental health professionals who can provide evaluation and treatment services and coordinate with the local CSB and other community mental health providers to help these individuals transition successfully back to the community.

Challenges affecting the efficacy of emergency mental health services

Mr. Stryker, who noted that for 18 years he operated a regional psychiatric emergency services center in New Jersey (which has a provision in its statute similar to California's "5150 hold") before coming to Virginia, reported that the lack of such regional psychiatric emergency centers in Virginia was far from the only difference between the mental health service systems in New Jersey and Virginia. Some of his observations include the following:

1. System fragmentation in Virginia: Mr. Stryker noted that the outpatient and inpatient systems in New Jersey are well integrated. A key consequence is that, whenever a mental health patient who has been in an outpatient program in the state enters a psychiatric facility, that facility can access that person's treatment records. In Virginia, facilities often are in the dark about the background and needs of a patient in crisis, even though that patient may have an extensive record of outpatient services at a CSB (and inpatient services at other hospitals). This puts practitioners at a significant disadvantage in providing timely diagnosis and treatment and making medication decisions during a crisis. In addition, the transitions from inpatient to outpatient treatment in Virginia are also more fragmented and difficult than was the case in New Jersey.

(Note: Chuck Hall, the Executive Director of the Hampton/Newport News CSB, has noted that the lack of a uniform Electronic Health Records (EHR) system in Virginia is a serious impediment to the achieving the integrated care - and in particular, the quick (and critically needed) access by health care providers to patients' medical information during mental health crises - that the adoption of EHR was intended to promote. Mr. Hall writes: "The elements of the system have no practical way to share information in real time. In HPRV [Health Planning Region V], among the nine CSBs, there are four different EHRs that do not speak with one another (CoCentrix/Profiler, Netsmart/Avatar, Credible, Anasazi). Most of our regional hospital systems are converting to EPIC, a very powerful, and expensive, and state of the art system. The two public state facilities in HPRV (ESH and SEVTC) have no EHR at all and none is contemplated in the near future. The experience that we patients of private health care now take for granted of having our PCP [primary care physician] share our medical records with specialty physicians (with no paper exchanging hands) is impossible in the behavioral health care field" at this time. This is a problem that deserves priority attention.)

2. The involvement of law enforcement in transporting individuals in mental health crisis: Mr. Stryker noted that almost all transport of individuals in mental health crisis in New Jersey is carried out by medical transport (ambulances, etc.) and *not* by law enforcement, and that during his 18 years in New Jersey there were almost no problems with security arising out of this arrangement. Law enforcement officers did handle certain forensic cases, where the person was already involved with the criminal justice system, but otherwise became involved only if a medical transport crew requested assistance. Mr. Stryker noted that law enforcement officers in Virginia normally place individuals who are in mental health crisis in handcuffs and other physical restraints in order to transport them. This is often emotionally traumatizing for these individuals, who have committed no crime but who feel that they are being treated like criminals (and appear that way as well). The fundamental dignity of these individuals is breached by this arrangement, without a clearly demonstrated need (given the experience of New Jersey) for this level of security.

Mr. Stryker also noted that, because of Virginia's reliance on law enforcement officers to transport people in mental health, law enforcement officers in many jurisdictions, because of their other responsibilities, often are not able to respond that quickly to requests for transport, particularly when a person has to be taken to a facility in another jurisdiction. Even when an ECO or a TDO has been issued for a person, that person can languish for hours while waiting for transport.

It should be noted that the law enforcement community, while increasingly sensitive to the needs of persons in mental health crisis, has also raised ongoing questions as to whether alternative means of transport would be better for these persons. The actual costs of the current transport role to local law enforcement agencies, and to the communities they serve, both in dollars spent and in reduced law enforcement presence on the street, currently remain largely hidden in law enforcement budgets. Those costs should be made explicit, in order to demonstrate that the use of medical transport instead of law enforcement transport in these cases will actually save the Commonwealth money, as well as saving many individuals in crisis from the emotional trauma and loss of dignity they now experience when transported in handcuffs in the back of a law enforcement vehicle.

Other Models of Early Intervention and Resolution During Mental Health Crises

The Hampton/Newport News Community Services Board (H/NN CSB) has taken a different approach to reducing psychiatric boarding, by developing several complementary approaches for providing timely evaluation for persons in mental health crisis and connecting these persons to appropriate treatment, so that psychiatric boarding does not occur *and* unnecessary psychiatric hospitalizations are avoided.

Responding to the site of the crisis: First, the H/NN CSB follows a philosophy of responding to any call alleging that a person is in mental health crisis, regardless of the person's location (as long as it is within the CBS's jurisdiction) and regardless of whether the person's described condition or behavior indicate that the person currently meets the criteria for an ECO or TDO. Information is gathered to make sure that a CSB evaluator is not being sent into an unsafe setting, but in normal practice the CSB does not require that the person be brought to a hospital ED or other evaluation site. This practice is built upon the experience and philosophy of the program that meeting the person in his or her home/community often gives the evaluator important insights into factors that may be contributing to the person's crisis (and factors may be protective against future relapse) and that may need to be addressed as part of the CSB's response to and resolution of that crisis. In addition, the CSB has staff who have been trained as part of the Hampton/Newport News Crisis Intervention Team (CIT) to respond to any request by Hampton or Newport News police officers for assistance with an individual reported to be in mental health crisis. (Note: the H/NN CSB serves a relatively compact urban/suburban community, so that it does face the challenges of distance and isolation that many rural CSBs face.)

Responding to magistrate referrals: Second, H/NN CSB has an arrangement with the local magistrate's office, under which magistrates contact the CSB to evaluate any person for whom a member of the community has asked the magistrate to issue an ECO or TDO due to mental health crisis. This way, the magistrate does not have to make a determination about whether the person in crisis meets the criteria for an ECO at that time. This is a significant practice for a number of reasons. First, the person requesting the ECO/TDO may not have enough information to enable the magistrate to make the findings needed to issue an ECO, even when the person may in fact meet the criteria for an ECO. A CSB evaluator going out to see the person can gather information and make observations that the magistrate cannot, which results in more reliable and appropriate findings and decisions. If the evaluator finds that the person meets the criteria for a TDO, the practice in Hampton and Newport News is for the magistrate to then issue the TDO on the magistrate's own motion. The petition for involuntary commitment is completed and signed later, on the day of the involuntary commitment hearing. If the evaluator finds that the person does *not* meet the criteria for a TDO, the evaluator is in a position to offer and arrange services to meet the needs of the person and help the person avoid further decline that might otherwise result in the need for a TDO. Finally, even if the person is found to meet the criteria for a TDO at the time of the CSB evaluator's assessment of the person, the evaluator may also find that the person appears amenable and responsive to treatment that is less restrictive than involuntary psychiatric hospitalization, and can help to resolve the person's crisis with less restrictive treatment measures.

Partnering with area Emergency Departments: Third, two hospital systems - Sentara and Bon Secours - currently have contracts with the H/NN CSB for CSB evaluators to respond to their hospital emergency departments (EDs) in Newport News and Hampton to evaluate and assist any person who arrives in the ED in mental health crisis. (The only exception is a person who is admitted primarily for medical reasons and only then is found to also present significant mental health issues.) As in the case of a call from a magistrate or from the community, the CSB evaluator can evaluate the person in crisis and recommend treatment and services that match the person's apparent needs. Some cases may be resolved in the ED itself, with (for example) the patient being provided with a follow-up mental health outpatient appointment, or being helped into a Crisis Stabilization Unit (CSU) for care, or being assisted in gaining voluntary admission to a local psychiatric hospital. In more serious cases the evaluator may contact the magistrate and recommend a TDO for the person.

The hospital systems have a contract with the H/NN CSB under which they provide an annual payment that essentially covers the costs of one CSB evaluator per hospital, an arrangement that, on balance, appears to be a bargain for the hospitals. According to H/NN CSB staff, this arrangement has been successful in eliminating, for the most part, psychiatric boarding in the EDs of those hospitals. (The few exceptions can occur when a person who is not under an ECO is found to be in need of a TDO and a willing psychiatric hospital cannot be identified.)

Mobile crisis response teams: Fourth, H/NN CSB uses a "mobile crisis response team" (MCRT) comprised of a Psychiatric Physician Assistant, Emergency Services Workers, Peer Support Specialists, and Mental Health Support Workers (with medical supervision and direction by a H/NN CSB psychiatrist) to provide individuals in mental health crisis with intensive treatment and support services in those individuals' homes. Emergency Services staff who initially respond to a person's home make the initial assessment as to whether the person is a good candidate for MCRT services. On-site "crisis intervention services" by the MCRT include "rapid and comprehensive needs assessments, crisis counseling and on-site psychopharmacological intervention". On-site "crisis stabilization" includes "ongoing monitoring for safety, mobilizing family and community supports, monitoring compliance and linking to follow-up services". Normally, the length of "intensive engagement" is up to 24 hours. The MCRT works with the police department's Crisis Intervention Team (CIT) officers in responding to crises in the community, and also works with the Crisis Stabilization Units (CSUs) in discharge planning and follow-up services for individuals returning home from the CSU. In-home follow-up services are

also provided to individuals referred by Emergency Services staff. Currently, the MCRT operates five days a week, from 2 p.m. to 10 p.m. (the peak time period for emergency calls), but the program intends to adjust its staffing, hours and other aspects of its operation to match the demands. The program currently serves the “Greater Virginia Peninsula” - Hampton, Newport News, Poquoson, Williamsburg, James City County and York County – so it includes, urban, suburban and rural communities in its coverage.

A goal of the program is to reduce by 15% the number of people in mental health crisis who require facility-based care to resolve that crisis. The program also hopes to reduce the length of stay for those persons who do need treatment in a CSU or inpatient hospital setting, by providing more robust discharge planning and post-discharge home-based services.

Crisis Stabilization Units: Fifth, H/NN CSB and other CSBs in the Hampton Roads region (specifically, Health Planning Region [HPR] V) have developed and operate Crisis Stabilization Units (CSUs) that provide short-term residential treatment services for individuals in mental health crisis. There are three adult units in HPR-V - one in Hampton, one in Virginia Beach and one in Norfolk, with all three units accepting individuals from any of the participating jurisdictions in HPR-V. The facilities in Hampton and Virginia Beach are capable of accepting some individuals who are under a TDO, though they are not able to manage persons who are physically aggressive and threatening. They are also designed to accept individuals for a “step-down” transition from more intensive inpatient psychiatric hospital care. The average length of stay for these individuals in the CSUs is 4 to 5 days.

The H/NNCSB also helped to establish a Children’s Behavioral Health Urgent Care Center (CBHUCC) in the Behavioral Medicine wing of Maryview Hospital in Portsmouth, Virginia. This facility, which also serves all of HPR-V, is staffed by a Board-certified child psychiatrist, a program manager, an LCSW, and qualified mental health providers and mental health technicians, and provides assessment and crisis intervention, psychiatric evaluation, and comprehensive discharge planning, for children and adolescents (ages 5 through 17 years). Significantly, children and families have been referred to this unit not only from Emergency Services staff of the HPR-V CSBs, but also from staff in the ED units of some of the area’s hospitals.

A proposal - Regional Crisis Stabilization Center: The early intervention approach of Emergency Services staff in the H/NNCSB, coupled with the availability of less restrictive local treatment programs and facilities, helps more people to resolve their crises at an early stage. However, this early intervention approach, and the less restrictive local treatment programs, generally are not as available in other CSBs, either in HPR-V or elsewhere in the state. In addition, even the CSUs currently operating in HPR-V lack certain key elements that, if present, would enable them to accept and work with individuals who are presenting more difficult conditions and behaviors than can currently be managed. Some of the staff at the H/NNCSB have sought to address this by proposing (informally at this time) a “Regional Crisis Stabilization Center” that would provide, in a single setting with separate wings or buildings, differing levels of care that would match the crisis being experienced by the person brought to the facility. (This is not unlike the regional center proposed by Ted Stryker in his June 17, 2014 email to Jim Martinez at DBHDS during the deliberations of the Governor’s Task Force, which is archived [here](#) on the DBHDS website: scroll down to page 38.) The staff’s vision for the Center has the elements set out below.

For the most acute cases, there would be an “initial assessment area” where an individual would receive both a psychiatric assessment by a psychiatrist (or by another mental health clinician) and a medical assessment by a nurse practitioner or physician’s assistant (who would be available 24 hours a day). The presence of a nurse practitioner or physician’s assistant would allow for on-site management of certain medical problems, such as hypertension, diabetes, and minor infections, with patients having more acute medical problems being sent to the local hospital ED.

Less psychiatrically acute clients could be assessed for a “23 hour program”. As envisioned by staff, this 2 bed section would be utilized to monitor clients who need short term care for needs such as getting prescriptions or who need to be started on medications with minimal monitoring by a psychiatrist.

Once a person admitted to the Center was medically stable that person would be formally admitted. As envisioned by staff: “Clients would be seen daily by the psychiatrist. Clients would be medically evaluated by the NP/PA as needed. Have individual therapist, group therapist, and activity therapist. The community room would be large enough to accommodate all the clients for seating for community meetings. Clients would be able to be seated comfortably at tables for nutritious meals. We would have a large group room which would also include a TV for educational videos. There would be a separate room [equipped with] relaxation tapes, reading, working puzzles and playing games. Groups would begin in the morning and continue through the evening. Clients would also be monitored for chemical dependency issues including withdrawal from substances and those dually diagnosed. AA and NA groups will be included on the schedule.”

The envisioned staffing for this regional center, which would be capable of serving ___ clients at any one time, would run along these lines: (1) 7 a.m.-3:30 p.m.: Psychiatrist, RN-Nurse Manager, RN, LPN, PT, Administrative Assistant/ billing clerk, Therapist, Clinical Services Supervisor; (2) 3 p.m.-11:30 p.m.: RN, LP, PT, Therapist, (3) 11 p.m.-7:30 a.m.: RN, LPN, PT.

Current Virginia law and emergency mental health treatment practices

The ability of a magistrate to issue a temporary detention order (TDO) for a person in crisis to be placed (or remain in) Centra Lynchburg General Hospital’s new Psychiatric Emergency Services wing, or in a future regional Crisis Stabilization Center, is not limited by the current law, but may be limited by available resources and state licensing standards for facilities to be able to accept a person who is subject to a TDO. It’s notable that, under Virginia Code Section 37.2-809, entry of a temporary detention order (TDO) requires that the magistrate find that a person (1) has a mental illness, (2) presents a potential for harm to self or others in the foreseeable future as a result of that illness, (3) needs “hospitalization or treatment” for the illness, and (4) is unable or unwilling to consent to such “hospitalization or treatment” While Virginia Code Section 37.2-809 requires the TDO to identify the “facility” where the person is to be detained, it does not require that such a facility be an inpatient psychiatric hospital. Moreover, the 2014 reform amendments to Section 37.2-809 allow amendment of the TDO to change the facility where the person is detained, to reflect changes in the person’s condition, behavior and needs.

So, under the existing statute, a TDO could authorize continued placement of a person in crisis in the psychiatric wing of the ED at Centra Lynchburg Hospital, or in any other “facility” where the person’s condition and behaviors can be managed, if they have the requisite licensing. It is not known, however, (by this author at least) whether current facility licensing standards, or current insurance and other compensation standards for mental health treatment, allow or provide meaningful payment for the care and treatment in such settings to persons who are under a TDO. It is also not known (by this author) how the treatment modalities and discharge standards now compare (and would compare) among these different local/regional treatment facilities. It’s notable that, while Dr. Zeller reports that his PES unit in Alameda County normally discharges patients within 24 hours (with close to 80% of them stabilizing and either returning home or being discharged to a step-down facility within that period, and the remaining 20+% being admitted to a psychiatric hospital), all of the existing CSU models in Virginia have average patient lengths-of-stay of several days. These differences warrant further study to determine what treatment framework is most effective in helping people in crisis return to stability in the shortest time possible.

Even the development of a more robust system of emergency mental health care, however, fails to address the unfortunate reality identified by former DBHDS Commissioner Jim Stewart, in his January 2014 presentation at the first session of the Governor’s Task Force on Improving Mental Health Services and Crisis Response: “Due to the inadequate capacity of ongoing treatment and support services, the crisis response network has often become the default system.” If more robust resources are not committed to the other parts of the treatment system to create a truly integrated system, then people with serious mental illness will continue to experience crises that might have been avoided entirely. (One small but critically important example of how deficits in other parts of the treatment system contribute to repeated crises: Chuck Hall at H/NN CSB notes “the lack of a uniform psychiatric medication formulary among CSBs and State Facilities, and the acute care private hospitals that participate in the network of care.” The result: “patients who are fortunate enough to get into an acute care setting, will come out from the hospital stay, most likely, with a psychiatric prescription that is different from that used routinely by the OP [outpatient] setting that they are referred to. As psychotropic medication is so important to maintaining stability for the individual during this critical time in treatment, changing these prescriptions often leads to a relapse.” On a broader scale, Mr. Hall notes that critically important community-based mental health services that can help people with mental illness maintain stability are not mandated services for the CSBs, and consequently are unfunded or underfunded, and that, even for individuals with health insurance, insurance reimbursement rates for key mental health services are “inadequate to non-existent”.)

Partnership

Finally, the search for more effective responses to mental health crises would benefit from being guided by this observation by John Dool, the HPR-V Reinvestment Project Director: to the extent that a person experiences mental health treatment as something that is being done *to* that person, instead of something that is being done *with* that person, the treatment is likely to be resented and resisted and ultimately to fail. The more that we can avoid coercion and enable persons in crisis to be partners in their own care, the better our outcomes will be. Mr. Dool notes that, with that as a guide, any system for emergency mental health services, regardless of its specific shape or focus, should include the following elements: provisions for advance care planning, and in particular for advance directives, so that individuals can designate agents to make needed treatment decisions for them during incapacitating crises and can guide their agents and providers on what treatments work for them (and what treatments do not); ready access for individuals to less intensive treatments than Emergency Departments and hospitals, so that individuals who realize that they need help can get help early; and system “navigators” – most often, peer support specialists – who understand what individuals who are in mental health crisis are likely experiencing, and who are available to individuals in crisis to help them find their way through the treatment system. Any treatment, including and perhaps especially emergency treatment, needs to respect the patient as a partner.

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Key Points that Differentiate Unity

September 17, 2015

Unity has served as a nexus to help focus the individual resources and efforts that are currently being made by four individual organizations into a coordinated effort to improve access and care for patients with behavioral health disorders by bringing the group together a more uniform approach to patient centered care can be developed and perfected

- More optimal utilization of scarce professional resources
- State of art facility with enhanced treatment options such as multiple therapy venue, exercise opportunities, beautiful outdoor space, and mostly private patient rooms
- Incorporation of peers into the treatment milieu and process

The Psychiatric Emergency Services (PES)

- Brings a new capability to the Portland region
- Will focus Behavioral health crisis as a medical not a criminal issue
- Availability of onsite providers 24 hours a day/7days a week guarantees the patients gets a rapid evaluation by a trained professional with the establishment of patient specific treatment plan very shortly after arrival
- The patient will be given every opportunity to get well while receiving treatment in the PES which will hopefully allow them to avoid acute inpatient admission
- Patients will have access to Peers 24/7 to help them adapt to the environment and to begin to build strategies for recovery

The Community Center for Transitions of Care

- Unity will provide space and energize a collaborative process among multiple community outpatient providers to streamline and organize care for the acutely ill patients
- Create a dialogue among community providers and organizations managing Unity to look for better ways to provide care and to insure patients are linked with their outpatient providers before leaving the center, thus guaranteeing the patients have a better opportunity for success after receiving services at Unity

Become a Nexus for Training professionals and students in Behavioral health skill

- OHSU, one of the partners, is bringing a significant part of their psychiatry residency program to Unity
- In addition to residents, Unity will provide a unique opportunity for Medical students, psychiatric Nurse practitioners, students, nursing students, etc. To gain a first-hand experience that will cover the spectrum of psychiatric emergencies, acute inpatient care, and ongoing treatment

Environment for Continuous Improvement in Care

- Outcome studies are already being designed to measures of effectiveness of the treatment protocols
- LEAN processes have been used to help design the facility and LEAN methodologies such as Plan, Do, Check, Act will be utilized to learn and continuously improve the programs

More efficient utilization and requirement for backroom process such as billing, coding, development of enhanced Electronic medical records, etc. This will minimize overhead costs and maximize the percentage of resources being used for patient treatment.



August X, 2015
For Immediate Release

Contact: Name
Number

Largest non-profit behavioral health hospital one step closer to reality

The region is one step closer to a new model of care for people having a psychiatric emergency and for inpatient mental health treatment. Legacy Health, Oregon Health & Science University, Adventist Health and Kaiser Permanente have all signed a Joint Operating Agreement (JOA) to proceed with the formation of the new ***Unity Center for Behavioral Health***.

In February, the four major healthcare providers came together and signed a Letter of Intent (LOI) to create the region's largest non-profit hospital focused on behavioral health. The JOA outlines specifically how Unity Center will be managed and operated, and outlines the financial and clinical management of the new organization. With the signed JOA, work can now begin to create the space to house the Unity Center and to begin to bring physicians and staff onboard.

Since the signing of the LOI, over 20 physician-led design groups have been realizing the vision of Unity Center for Behavioral Health. These design groups cover every aspect of the patient journey, including such things as patient experience, clinical care and building design. There are other operational planning groups that have started developing plans that cover areas from information technology to staffing. This work is expected to continue over the next year.

Preliminary work on the design of the new facility has included working with community members and patient advocates to ensure the design will contribute to the healing process. Space within the building will include an area for community-based support groups to help transition patients upon discharge.

Each year in Oregon, an estimated 1 in 20 adults experience a serious mental illness and 31,000 adolescents suffer a major depressive episode that often leads to other social issues. Untreated mental illness is common among the prison population both nationally and locally. The Oregon Department of Corrections (ODOC) has determined that more than half of Oregon's prison population has been diagnosed with a mental illness.

As the first behavioral health center of its kind in the region, the Unity Center for Behavioral Health is expected to become a national model for providing compassionate mental health care in times of crisis, without unnecessary waiting. This unprecedented collaboration of four health systems shares the goal of providing care for all those in need through a combination of emergency, inpatient and outpatient services and embraces the concepts of hope, recovery and resilience.

-MORE-

Largest non-profit behavioral health hospital one step closer to reality

2-2-2

The Unity Center will include 79 adult patient beds and 22 beds for adolescents and will also house organizations that provide community behavioral health services, helping to coordinate continued support to patients after discharge.

About Adventist Health

[Adventist Health](#) is a faith-based, not-for-profit integrated health care delivery system serving communities in California, Hawaii, Oregon and Washington. Our workforce of 28,600 includes more than 20,500 employees; 4,500 medical staff physicians; and 3,600 volunteers. Founded on Seventh-day Adventist health values, Adventist Health provides compassionate care in 19 hospitals, more than 220 clinics (hospital-based, rural health and physician clinics), 14 home care agencies, seven hospice agencies and four joint-venture retirement centers.

About Kaiser Permanente

[Kaiser Permanente](#) is committed to helping shape the future of health care. We are recognized as one of America's leading health care providers and nonprofit health plans. Founded in 1945, our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. We currently serve approximately 9.5 million members in eight states and the District of Columbia, including more than 500,000 medical and 230,000 dental members in Oregon and Southwest Washington. Care for members and patients is focused on their total health and guided by their personal physicians, specialists and team of caregivers. Kaiser Permanente is dedicated to care innovations, clinical research, health education and the support of community health.

About Legacy Health

[Legacy Health](#), Oregon's only locally owned nonprofit healthcare organization, includes Legacy Emanuel Medical Center, Randall Children's Hospital at Legacy Emanuel, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, Legacy Salmon Creek Medical Center, Legacy Laboratory Services, Legacy Research, Legacy Medical Group and CareMark/Managed HealthCare Northwest PPO.

About OHSU

[Oregon Health & Science University](#) is the state's only public academic health and research university. As one of Oregon's largest employers with more than 14,600 employees, OHSU's size contributes to its ability to provide many services and community support not found anywhere else in the state. OHSU serves patients from every corner of Oregon and is a conduit for learning for more than 4,400 students and trainees. OHSU is the source of more than 200 community outreach programs that bring health and education services to each county in the state.

DEVELOPMENTS IN MENTAL HEALTH LAW

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

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I. Mental Health Law and Services Reforms in the 2015 Virginia General Assembly

The 2015 Virginia General Assembly session included statutory reforms that supplemented or clarified some of the significant reforms of 2014 regarding the government's response to individuals in mental health crisis. It also substantially changed the criteria for psychiatrically hospitalizing children 14 years of age and older over the minor's objection. The General Assembly approved some of the funding for outpatient and related services for persons with serious mental illness proposed by Virginia Governor McAuliffe as part of his Governor's Access Plan (GAP) initiative, and funding for several community-based mental health services recommended by the Governor's Task Force on Improving Mental Health Services and Crisis Response. Those actions are nicely summarized in a PowerPoint presentation made by Mr. Joe Flores, Deputy Secretary of the Department of Health and Human Services, at the final meeting of the Governor's Task Force on Improving Mental Health Services and Crisis Response, held on March 23, 2015 (and which can be found [here](#) on the Virginia

Department of Behavioral Health and Developmental Services [DBHDS] website [on pages 14 through 27]).

The Governor's Access Plan

Because the General Assembly has declined to adopt Medicaid expansion under the Affordable Care Act as recommended by Governor McAuliffe, the governor submitted a narrower plan, which received waiver approval for federal funding. The proposed "Governor's Access Plan" (GAP) would provide insurance coverage for key outpatient medical services (such as primary care, specialty care, laboratory tests, pharmacy services - including prescription medications - and outpatient behavioral health services) for all uninsured Virginians with a diagnosis of serious mental illness and an income at or below 100% of the federal poverty level (currently \$11,670). It was estimated that GAP could provide coverage for up to 20,000 people. The General Assembly approved funding to provide coverage for those with incomes up to 60% of the federal poverty level.

Implementing Recommendations of the Governor's Task Force on Improving Mental Health Services and Emergency Response

Other behavioral health items included in the Governor's budget amendments (reflecting recommendations from the Task Force) and approved by the General Assembly included:

- 3 million dollars in additional funding to create 3 new PACT (Program of Assertive Community Treatment) Programs (adding to the current total of 20 teams statewide);
- 2.2 million dollars in additional funding to enable Community Services Boards to "purchase" psychiatric beds in local hospitals for the treatment of uninsured individuals needing such hospitalization;
- 2.1 million dollars in additional funding for permanent supportive housing;
- 2 million dollars in additional funding for children's mental health services;
- 1.9 million dollars in additional funds to cover the growth in "special hospitalization costs";
- 1.8 million dollars in additional funding for 6 additional therapeutic assessment "Drop Off" centers (for a total of 24 such centers statewide);
- 800 thousand dollars in additional funding for increased staffing at certain state hospitals.

Other Initiatives

In the appendices to his [presentation](#) (pages 28-35), Mr. Flores noted (and provided additional information on) several important initiatives by the administration to improve healthcare services and outcomes for Virginians:

- encouraging uninsured Virginians who may be eligible for tax credits to purchase health insurance on the federal marketplace (affecting up to 300,000 Virginians);
- providing outreach and education to Virginians about their healthcare coverage options so they can make appropriate choices;

- improving the access to, and quality of, health care provided to veterans (almost 800,000 Virginians);
- improving outcomes for persons with serious mental illness by providing “Medicaid Behavioral Health Homes” that provide coordinated and integrated health, mental health and substance abuse treatment services (presented to but not funded by the 2015 General Assembly);
- establishing a Task Force to address prescription drug and heroin abuse.

Statutory Changes Affecting Behavioral Health Services

The following bills were enacted by the 2015 General Assembly:

SB 773 (McWaters) and SB 779 (McWaters) – Changing the criteria and certain procedures for psychiatric hospitalization of minors 14 years of age and older over the minor’s objection:

These bills reflect the recommendations of the Joint Commission on Health Care (JCHC) following a months-long study conducted upon the request of the Senate Committee on Courts of Justice. That committee asked the JCHC to review “the minor consent requirement for voluntary inpatient psychiatric treatment proposed in Senate Bill 184 (McWaters).” Senate Bill 184, which was proposed in the 2014 General Assembly session but was “passed by indefinitely”, would have, among other changes, removed the existing statutory requirement that a minor 14 years of age or older must give consent (in addition to the minor’s parent) before the minor can be admitted to a mental health facility for inpatient treatment (Va. Code §§ 16.1-338 & 339). As set out in detail in the JCHC Report Document No. 459 (found [here](#)), the JCHC conducted a thorough review of key issues regarding the psychiatric hospitalization of older minors and such a minor’s objection to hospitalization. The JCHC recommended, and SB 773 and 779 enacted, these key changes:

- (1) The criteria for a Court to authorize the admission of a minor 14 years of age or older to a psychiatric facility over the minor’s objection were changed to be the *same* as the criteria authorizing a facility (without Court involvement) to admit the child with the child’s consent (Va. Code § 16.1-338(B)) rather than the more stringent criteria previously required.
- (2) If the minor objects to continued hospitalization after initially consenting, the statute will now require the hospital to notify immediately the consenting parent of the minor’s objection and to provide the parent with a summary (prepared by the Office of the Attorney General) of the procedures for requesting the Court to authorize continued inpatient treatment of the minor.

SB 966 (Barker) [identical to HB 1694 (Yost)] – Clarifying an individual’s custody status while under an ECO/TDO:

2014 amendments to the involuntary commitment statutes (for both adults and minors) stated (in Sections 16.1-340.1:1 and 37.2-809.1) that an individual for whom a temporary detention order (TDO) had been issued remained “in the custody” of the local community services board (CSB) until transported to a receiving mental health facility. This quoted language conflicts with other, longstanding, Code sections that require that such an

individual remain in the custody of *law enforcement* until custody is transferred to a facility or to an alternative transportation provider. It is the role of the local CSB to conduct an evaluation of the person who is in custody, not to hold the person in custody. SB 966 simply removes the 2014 language that had referred to the individual being in the custody of the CSB instead of law enforcement.

SB 1263 (Deeds) [identical to HB 1693 (Bell, Robert)] – Expanding the discretion to authorize alternative transportation to a facility under an ECO or TDO:

This bill expands the circumstances in which a magistrate can authorize someone other than a law enforcement officer to transport a person to a hospital or other facility for evaluation and/or treatment under an Emergency Custody Order (ECO) or Temporary Detention Order (TDO). Current law allows the magistrate to authorize alternative transportation only if the magistrate finds, in regard to the person in crisis who is to be transported, that “there is no substantial likelihood that the person will cause serious physical harm to himself or others...” This bill removes that required finding, but leaves it in the discretion of the magistrate to determine whether the proposed alternative transportation is safe and appropriate. The bill also provides that a person who provides such alternative transportation will *not* be liable “to the person being transported” for any civil damages for “ordinary negligence” in providing the transportation. Similar liability protection is provided for those who provide alternative transportation for a person to a hospital following a commitment hearing. Similar provisions are included in the commitment of minors legislation in Title 16.1. *Note:* The reduction in the involvement of law enforcement in providing transport in cases of civil commitment has been a key goal for both law enforcement authorities and mental health advocates.

SB 1265 (Deeds) [identical to HB 2118 (Cline/Hope)] – Clarifying the statutory requirement for updating the psychiatric registry:

Concerns were raised over whether the information from each hospital on the statewide “psychiatric bed registry” regarding the availability of a psychiatric bed was being updated with sufficient frequency so that the registry could reflect a “real time” picture of whether and where beds were available. This bill addresses those concerns by requiring each hospital to do the following: (1) make an update whenever there is an actual change in bed availability; and (2) make an update each day even if there is no actual change that day.

SB 1114 (Barker) – Clarifying the timeline and procedure for conducting an evaluation for a TDO of an individual who is under both an ECO and a “medical hold” under Section 37.2-1104:

Virginia Code Section 37.2-1104 already provides that, upon the “advice” of a licensed physician and upon finding “probable cause to believe” that a patient needs testing, observation or treatment for a serious condition but is incapable of giving informed consent to such action, a judge or magistrate may authorize a hospital ER or other facility to hold that person for up to 24 hours to provide the needed medical attention. (This can be extended only through an order, following a hearing, upon the filing of a petition seeking judicial authorization for treatment under Section 37.2-1101.) SB 1114 amends Section 37.2-808, on the issuance of emergency custody orders (ECOs), by providing that

the issuance of an ECO for a person does not preclude the issuance and execution of an order for temporary detention under Section 37.2-1104 for that same person during the same crisis. This bill specifies that, when there is both an ECO and a “medical hold” under 37.2-1104, the window of time for determining whether the person meets TDO criteria is not the 8 hours that an ECO is in effect, but instead is the 24-hour “medical hold” period authorized under Section 37.2-1104.

SB 1264 (Deeds) – Providing information about an individual to law enforcement regarding prior Court commitment(s) and findings of incapacity:

This bill is one piece of a larger discussion about how much information about a person’s diagnosed mental health condition, and about past court determinations about that person’s condition, should be shared with and among law enforcement officers, health care providers and others when a person is in mental health crisis. Current law requires that a report be made to the Central Criminal Records Exchange (CCRE) whenever a person has been involuntarily committed, or has chosen voluntary hospitalization in lieu of involuntary commitment (see Section [37.2-819](#)), and whenever a person is found mentally incapacitated by a court in a guardianship proceeding (see Section [64.2-2014](#)). The CCRE can use that information only to enter onto the person’s record that the person is prohibited from owning or possessing a firearm. The CCRE is not allowed to disseminate to any third party the specific records or findings of mental illness or incapacity upon which the person’s firearms prohibition was based. SB 1264 carves out a specific exception to that limitation. The bill authorizes the CCRE to provide information sent to it pursuant to Sections [37.2-819](#) and [64.2-2014](#) to law enforcement personnel defined in the statute. The purpose behind allowing such dissemination is to enable law enforcement personnel to have what may be important relevant information about the person’s mental health history and capacity when working with that person during a crisis.

The Governor’s Task Force on Improving Mental Health Services and Crisis Response has also addressed information sharing in its recommendations (See Recommendations 14 and 15 in the final report, found [here](#).)

HB 2368 (Garrett) – Directing a plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission:

This bill directs the Commissioner of Behavioral Health and Developmental Services, working with various stakeholders, to develop, by October 1, 2015 a comprehensive plan to “authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission.” That plan, along with recommended legislative changes needed to implement the plan, must be submitted by November 15, 2015 to several committees for consideration by the 2016 General Assembly. HB 2368, as originally presented on January 23, passed with almost no dissenting votes. However, the Governor drafted a proposed revision of HB 2368 for consideration by the General Assembly at its April 15, 2015 “reconvened” session and that version was enacted.

In the Governor’s revised version of HB 2368, found [here](#), the DBHDS Commissioner, with the listed stakeholders, would be directed to:

- (1) “review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission”;
- (2) “identify” in that review “community services boards and catchment areas where significant delays in responding to emergency evaluations are occurring or have occurred in recent years”;
- (3) “develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations”;
- (4) complete the plan and submit it to the Governor and the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century, the House Committee on Health, Welfare and Institutions, and the Senate Committee on Education and Health by November 15, 2015.

The General Assembly passed HB 2368 as revised by the Governor. The bill deserves particular attention because it touches on a pervasive problem in the mental health response system – the increasing pressures on hospital emergency departments presented by those experiencing mental health crises. The editor is devoting a significant portion of this issue of DMHL to this problem.

II. Feature Article: Mental Health Crises and Hospital Emergency Departments

John E. Oliver

While Virginia enacted important reforms in 2014 regarding the state’s response to people experiencing mental health crises, it is still the case that many individuals in mental health crisis may spend long hours (and even days in some states) in a hospital emergency department (ED), medically stable but too psychiatrically ill to be safely discharged, waiting for admission to a psychiatric hospital or other suitable secure placement for mental health treatment. These prolonged waits in EDs are often referred to as “psychiatric boarding,” and they occur with increasing frequency in almost every state. Nationwide, a variety of [studies](#) have documented that the overcrowding of EDs while patients await transfer to another facility results in poorer outcomes for them and for ED patients overall. It has also been documented that psychiatric patients are boarded in the ED longer than any other type of patient. A 2012 [study](#) of one hospital found that the financial loss from boarding psychiatric patients averaged over \$2,200 per patient. The problems in poor patient outcomes and financial losses from psychiatric boarding have reached the point that the American College of Emergency Physicians (ACEP) has made the reform and reduction of psychiatric boarding a major priority for its 2015 agenda. (See [article](#) detailing ACEP president’s initiatives.)

Many factors contribute to psychiatric boarding, including the time required to arrange and conduct emergency psychiatric evaluation in the ED and the legal requirements relating to these evaluations, a shortage of acute care psychiatric hospital beds, and the

gaps in intensive community-based placements as alternatives to hospitalization for individuals experiencing a mental health crisis. The review of the evaluation process for involuntary hospital admission mandated by HB 2368 can address only a part of this complex problem. The Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century has a broader mandate to look at possible innovations in psychiatric emergency treatment as well as emergency evaluations. In the sections that follow, this issue of DMHL will look briefly at some of the possible tensions within the current psychiatric emergency evaluation process, and then provide an overview of some innovative emergency psychiatric service models that might have some application in Virginia to improve interventions and outcomes for people in crisis.

The TDO Process

HB 2368 focuses on the time required to complete an emergency evaluation of a person who is in mental health crisis to determine whether a temporary detention order (TDO) should be issued to psychiatrically hospitalize that person. Virginia Code Section 37.2-809 requires that, before a TDO can be issued, it must be found that the person: (1) has a mental illness; (2) has a “substantial likelihood,” as a result of that illness, of causing serious physical harm to self or others, or suffering serious harm due to incapacity, “in the near future”; (3) needs hospitalization or treatment; (4) is unwilling to volunteer or is incapable of volunteering for hospitalization or treatment; and (5) has an appropriate facility willing to accept the person if a TDO is issued. In Virginia, the emergency evaluation process involves several players, each with their own roles and responsibilities in that process, and each, consequently, with a different perspective on that process.

The CSB evaluator’s role

Community services board (CSB) evaluators are authorized and mandated by law to evaluate individuals in mental health crisis to determine whether a Temporary Detention Order (TDO) should be sought from a magistrate for the temporary psychiatric hospitalization of those individuals (pending an involuntary commitment hearing). Sometimes these individuals are brought to the hospital ED by law enforcement officers under an Emergency Custody Order (ECO), which authorizes holding the individual in custody for up to 8 hours while the evaluation is conducted and a decision about a TDO is made. At other times (particularly in urban and suburban areas, where hospitals are more accessible) people who are in crisis come to the ED on their own or are brought there by others, and ED staff contact the local CSB to request evaluations of these individuals for a TDO. (A 2013 UVA study found that well over half of all CSB evaluations of people for issuance of a TDO occur in the ED setting.)

It is important to highlight that CSB evaluators are trained and expected to seek the least restrictive services and placements appropriate for the individual in crisis, ranging from outpatient and community based services to crisis stabilization or detoxification programs or voluntary admission to a local psychiatric facility, and thus avoid a TDO whenever appropriate. Under Virginia Code Section [37.2-809](#), a magistrate cannot enter a TDO until a CSB evaluator has completed an evaluation of the individual and has submitted

findings and recommendations to the magistrate. Although the magistrate is not required to follow the CSB evaluator's recommendations, in practice the CSB evaluator's recommendation that an individual should be psychiatrically hospitalized through a TDO is followed by the magistrate in the vast majority of cases.¹ If the CSB evaluator does find, and the magistrate agrees, that an individual in crisis meets the criteria for entry of a TDO, that order cannot be entered until the magistrate is able to identify in the order the facility to which that individual will be taken for temporary detention. A final part of the CSB evaluator's role, then, is to find an appropriate psychiatric facility that will accept the person.

The challenge of finding psychiatric beds for people in crisis

Prior to the 2014 General Assembly amendments to Section 37.2-809, there was no state statutory requirement that private or public psychiatric facilities accept the placement of a person under a TDO. Once an ECO expired, the individual could no longer be held against his or her will unless a TDO had been issued; such a TDO could *not* be entered unless and until the psychiatric hospital in which the person would be detained could be identified in the TDO itself. The limited and decreasing number of psychiatric hospital beds in Virginia, coupled with the behavioral challenges sometimes posed by individuals experiencing mental health crisis, has made CSB evaluators' task of finding psychiatric facilities willing and able to accept individuals under a TDO increasingly difficult. Sometimes finding beds for voluntary hospitalization is also difficult. On infrequent but recurring occasions, the ECO expired before a bed could be found for people who met the TDO criteria. If they were unwilling to remain in the ED (or other location where the evaluation was conducted) or to agree to a crisis service plan, they could slip through the safety net and put themselves and others at risk.

In 2014, SB [260](#) amended Section 37.2-809 and other statutes regarding involuntary commitment. A key change was a new requirement: if an individual in custody under an ECO is found to meet the criteria for a TDO, a state mental health facility *must* accept that person for admission under a TDO at the expiration of the ECO if another facility has not been found for that person. Significantly, the 2014 General Assembly did not provide any similar guarantee for individuals who are *not* being held under an ECO but who are in mental health crisis and meet criteria for a TDO.

The ED physician's perspective

ED physicians' concerns about the Virginia TDO evaluation process, even after the 2014 General Assembly reforms, were highlighted last year in the Governor's Task Force Work Group meetings. At the May 21, 2014 meeting of the "Crisis Response" work group of the Task Force, Dr. Bruce Lo, Chief of Emergency Medicine at Sentara Norfolk General Hospital, submitted a statement asking that the work group also "focus on persons who are not necessarily under an ECO but whose situation may lead to a TDO or

¹ No systemic study has been conducted regarding the frequency of cases in which the CSB evaluator does not find that the TDO criteria are met while other clinicians believe that they are met.

possibly a voluntary admission and their need for timely disposition just as for those in custody of law enforcement.”

In that same May 21 meeting, Dr. Douglas Knittel, an emergency psychiatrist at the Naval Medical Center in Portsmouth, Virginia, expressed the view that the existing evaluation process of having a CSB evaluator determine whether a TDO should be issued for a person in crisis is “redundant and wasteful.” His view was that a physician or licensed psychologist should be able to conduct the screening evaluation currently performed by the CSB evaluator.

Discussions during that May 21 meeting, as captured in the meeting minutes, responded in part to the concerns raised by Dr. Lo and Dr. Knittel. Mr. Lawrence “Buzz” Barnett, the (now-retired) director of Emergency Services for Region 10, noted that “individuals under ECOs or TDOs are only a small percentage of the much larger group of individuals who seek voluntary care during a psychiatric crisis.” Dr. Knittel’s proposal for physician-conducted TDO evaluations brought two responses. The first was that physicians are not as familiar with less restrictive community based treatments to which people in crisis could be diverted. As noted above, CSB evaluators are trained to seek least restrictive services, yet ED physicians normally do not interact with such treatment facilities and programs, which may limit the ability of the ED physician to adequately assess the possible treatment options of the individual outside the ED and/or psychiatric inpatient units. The second response to Dr. Knittel was that sometimes “there is some benefit to not making the decision to TDO too rapidly,” as the pre-screening process with the CSB evaluator itself sometimes can be a “therapeutic” process for a person in crisis that helps that person achieve more stability and choose a different treatment path than hospitalization. (See pp. 30-37 of the meeting minutes [here](#).)

These comments in the Crisis Response Work Group minutes provide a brief and incomplete glimpse into the differences in perspective that can develop between ED physicians and CSB evaluators regarding the best ways to respond to persons in the ED who are in mental health crisis. They also highlight important questions that remain about the proper role of the ED in managing such crises. For example, what should be done if the ED provider believes that the patient warrants (and that EMTALA mandates) admission but CSB does not believe the criteria are met? The DBHDS Commissioner’s HB 2368 stakeholders’ group will be exploring these issues and others, including challenges in achieving consensus on medical clearance, and whether the magistrate may consider the ED provider's opinion in determining whether to issue a TDO even if CSB does not recommend it.

However these issues about the TDO process are resolved by the DBHDS study group and, eventually, by the General Assembly, they will have only a marginal impact on the pressures being faced by EDs in trying to respond to increasing numbers of patients experiencing mental health crises. In order to address these problems, it is necessary to address the underlying causes of the “psychiatric boarding” and to envision service models that can provide better targeted services for evaluation, stabilization and treatment. In the remainder of this article, DMHL will review models that have

developed in other parts of the country for providing psychiatric emergency evaluations and services to people in crisis. Perhaps this review will help to inform the upcoming discussions of both the DBHDS Commissioner's HB 2368 stakeholders' group and the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century.

Models for Mental Health Crisis Response

In a June 1, 2010 article entitled "Treatment of Psychiatric Patients in Emergency Settings", published in *Primary Psychiatry* (available [here](#)), Dr. Scott Zeller, the Chief of Psychiatric Emergency Services at the John George Psychiatric Hospital in San Leandro, California, notes that the steadily increasing percentage of hospital ED visits nationwide that involve mental health issues and require psychiatric emergency services (now estimated to be between 6% and 9% of all ED visits), has led to the development of "psychiatric emergency services" as a medical sub-specialty. Dr. Zeller identifies three primary models of emergency delivery of psychiatric services (with various hybrid versions of each of these models having also developed in various states): (1) the psychiatric consultant in the ED; (2) the dedicated mental health wing in an ED; (3) the free-standing Psychiatric Emergency Services (PES) unit. Below is a summary of Dr. Zeller's discussion of those models.

Psychiatric consultant in the medical ED

Many hospital EDs employ a mental health services consultant, who often is not a psychiatrist, and in many cases may be a nurse practitioner, LCSW, or other licensed therapist. The advantages of this model: (1) it is "the lowest cost and easiest to implement"; (2) the patients all receive a medical screening so that organic causes for the person's psychiatric symptoms can be ruled out; (3) these patients are treated together with all other ED patients, so there is "less opportunity for stigma and delays in treatment than segregation might cause."

The disadvantages: (1) it may be hours before the mental health consultant can arrive, resulting in the patient going for a long period with "little or no treatment"; (2) "the consultant's decision is usually restricted to the choice either to admit for psychiatric hospitalization or to discharge, with little chance to observe a patient sufficiently to see if improvement or decline in status might change the disposition"; (3) the ER setting is not designed or intended for "extended psychiatric treatment"; (4) the high activity levels and serious patient health emergencies normally found in an ED work against the effort to calm a person in mental health crisis; (5) the ED can be unsafe because of the medical instruments and machinery found there; (6) staff may view mental health patients as inappropriate for that setting, and treat such patients poorly; (7) when understaffed, the ED may resort to using restraints to keep a mental health patient safe; (8) if the consultant is not a psychiatrist, the ED physicians may not respect that person's findings; (9) when the consultation is provided by psychiatrists from an area inpatient psychiatric facility, impartiality may be a concern.

Dedicated mental health wing of ED

Dr. Zeller notes that this model (1) provides a more nurturing environment; (2) provides more skilled treatment staff; (3) still ensures that there is a medical screening and history; (4) may allow “more time for medications and interventions to have effect prior to disposition decisions.”

The disadvantages: (1) the potential stigma for patients referred to this unit as being “different” or “crazy”; (2) the potential for overflow of medical ED patients into the unit during times of high ED use; (3) the potential evolution of these units into “holding areas” or “dumping grounds”, used primarily to get these individuals out of the ED, with little actual treatment until they are “placed.”

A stand-alone psychiatric emergency services unit: The “Alameda Model”

The John George Psychiatric Hospital, in Alameda County, California, is home to a stand-alone PES unit that has garnered attention and come to be known as the Alameda Model. The model, described in an article by Dr. Zeller, and his colleagues (available [here](#)), makes a significant claim: Dedicating sufficiently intensive services in an appropriate psychiatric emergency services (PES) setting to treat persons experiencing mental health crisis can bring sufficient stability to most of these individuals within 24 hours. Thus, people are able to return home or to a community-based program from the PES unit, so that (1) the disruptions to these people’s lives are minimized while their treatment needs are met in the least restrictive treatment setting, (2) psychiatric boarding in hospital emergency departments is ended, and (3) unnecessary psychiatric hospitalizations are prevented.

Dr. Zeller describes the PES unit as “typically a stand-alone program dedicated solely to the treatment of individuals in mental health crisis.” It can be locked, unlocked, or a combination; community-based or in-hospital. Normally it would be staffed with psychiatric nurses and other mental health professionals on a 24-hour basis, with psychiatrists either on-site or readily available. Set up and staffed this way, the PES unit can assess and treat people right away, “with the potential for patients to stabilize quickly.” The PES unit operates as an outpatient facility. The timeline for treating and discharging patients at the PES unit is 23 hours and 59 minutes.

As described in more detail in a February 15, 2015 article on the Alameda Model published by [AHC Media](#) (entitled, “Intriguing model significantly reduces boarding of psychiatric patients, need for inpatient hospitalization”, and found [here](#)), when a patient first arrives at the PES unit, a triage nurse conducts an initial evaluation for medical stability and then [if appropriate] sends the patient to a triage psychiatrist, stationed by the ambulance bay, who again assesses and makes “a quick determination if some immediate medicines are needed prior to full evaluation”. Once cleared through that process, the patient goes to “a large waiting-room type area where people can sit in chairs or lie down with a pillow or a blanket”. Patients do not have individual rooms because it is an outpatient service. Intensive supportive services are provided over the next several

hours. Within 24 hours of a patient's admission, a decision must be made on whether the patient needs hospitalization or can return home or go to a placement less restrictive than an ED.

According to Dr. Zeller and his colleagues, the first two models described above tend to follow a "triage" approach in dealing with patients in mental health crisis, focusing on "rapid evaluation, containment and referral." In contrast, the PES model follows a "treatment" approach, with the goal of treating the person "to the point of stabilization onsite." This is possible because "many PESs have extended observation capability, allowing them to treat patients for up to 24 hours or even longer. This can often be sufficient time for many patients to stabilize and thus avoid inpatient hospitalization." (As noted above in the discussions of the Crisis Response work group of the Governor's Task Force, this process is consistent with the practice and goals of the CSB evaluator, who is seeking the least restrictive appropriate treatment to resolve a person's mental health crisis, but it is different from the practice and goals of the standard hospital ED, which needs to move a medically stable but psychiatrically distressed patient to another setting as quickly as possible.)

Evidence of improved outcomes in the Alameda Model

Dr. Zeller and colleagues have reported on the model's efficacy (found [here](#)) and a recent article from [AHC Media](#) (found [here](#)) has updated Dr. Zeller's earlier findings. Those findings include the following:

Reducing law enforcement involvement in psychiatric emergencies: California law ([WIC 5150-5155](#)) gives police, as well as designated doctors, clinicians and facilities the authority to detain, transport, and involuntarily hold an individual in acute mental health crisis for up to 72 hours. A police officer who places an individual under such a "5150 hold" will bring that person to a county ED, where ED staff must evaluate and stabilize the person and find an appropriate placement for that person. Many of these individuals end up being "psychiatrically boarded" in the EDs because there are no available psychiatric hospital beds.

Under the Alameda Model, the police make a "5150 hold", but then contact an EMS ambulance service, and transfer custody of the person to the ambulance crew, who perform a "field screening" of the person, "looking only for medical stability issues". If the person is deemed medically stable, the ambulance will bring the person directly to the Psychiatric Emergency Services (PES) unit. Roughly two-thirds of persons placed on "psychiatric holds" in the Alameda County program go directly from the community to the PES unit in this manner for evaluation and treatment. Police officers are able to return to their work more quickly.

Reducing ED involvement in psychiatric emergencies: When ambulance crews find that a person in crisis is medically unstable and needs further evaluation and "medical clearance", then the person is taken to one of the county's 11 EDs. A "streamlined process", in which no specific laboratory tests (including alcohol level screening) are required, is in place (developed jointly by the area EDs and the PES unit at John George Psychiatric Hospital) to facilitate transfer of these individuals to the PES unit as soon as

they are medically cleared. Dr. Zeller relates that experience has shown that time-consuming laboratory testing seldom identifies conditions that preclude safe transfer to the PES unit. In addition, an onsite psychiatric consult in the ED regarding these patients is not necessary, as the attending ED physician consults by phone with a psychiatrist at the PES unit. If the doctors agree that transfer is appropriate, the patient is accepted by the PES unit without regard to the person's psychiatric diagnosis or history, and without regard to whether the person has medical insurance or has access to a psychiatric hospital bed if hospitalization is ultimately found to be needed. The PES unit, as a "high acuity site", is set up for people deemed "psychiatric emergencies" under EMTALA (the federal Emergency Medical Treatment and Labor Act). The PES unit is available for these patient transfers from the county EDs on a 24-hour-a-day basis. Patients may also "self-present" at the PES for care.

Improved outcomes for patients and hospitals: Dr. Zeller reports that the Alameda Model has effectively eliminated psychiatric boarding because, in his words, "The only boarding in our county is the length of time it takes for emergency providers to arrange transport from their facility to our facility, and two-thirds of the patients aren't even stopping at an ED anyway." (See AHC article [here](#))

In addition, Dr. Zeller and colleagues' 2013 study (found [here](#)) made the following key findings:

- a. County hospital EDs participating in the study had an average psychiatric "boarding time" of 1 hour and 48 minutes (a reduction of over 80% in the average length of boarding times statewide in California during that period).
- b. Only 24.8 percent of the patients experiencing psychiatric emergency in the referring EDs were admitted for inpatient psychiatric hospitalization from the PES.

A year later, the AHC Media article (found [here](#)) indicates that those outcomes have continued: only 22% of the patients treated in the PES unit ultimately need to be hospitalized; the other 78% are able to go home or to a community-based program (e.g. detox, crisis residential housing, or "a board and care arrangement").

(Note: Neither Dr. Zeller's published study nor the follow-up AHC article included any data on readmission rates; that is, there is no information on whether and/or how frequently individuals are re-admitted to the PES unit within specified periods of time.)

Financial considerations and replication of the Alameda Model

Dr. Zeller reports that the Alameda Model produces "overall" cost savings in terms of reduced time of patients in emergency departments and the stabilization and diversion of patients from psychiatric hospital placements. The Alameda Model benefits from having a supportive funding situation through California Medicaid, which has a "unique facility-based billing code for "Crisis Stabilization" that allows for sustainability in a locality with "a high enough census." In most states, however, the cost savings cited by Dr. Zeller do not automatically translate into an income stream that can sustain the

operational costs of a PES unit. Dr. Zeller has proposed that “[i]nstituting a national billing code [especially for Medicare and Medicaid] for crisis stabilization might facilitate development of more programs such as the Alameda Model.” (See the conclusion of his article [here](#)) Others have expressed support for the idea, including Kimberly Nordstrom, MD, JD, the president of the American Association for Emergency Psychiatry and director of a Denver, CO-based model similar to the Alameda model. In the AHC article noted above (found [here](#)), Dr. Nordstrom reports that her program, while able to discharge 76% of its patients despite seeing only those in acute mental health crisis, is reimbursed “on an outpatient level” of service despite its high (and costly) level of care, so that the program “barely squeaks by” financially, making it doubtful that this kind of program will be replicated across the nation until the billing issue is resolved.

Suggestions for psychiatric emergency services in non-urban settings

In his writings, Dr. Zeller agrees that the financial viability of a PES unit depends upon a demand for services that exists only in urban and some suburban communities. In his October 6, 2014 article for *Psychiatry Advisor*, entitled “New Strategies to Reduce Psychiatric Boarding in ERs” (found [here](#)), Dr. Zeller writes that, even in areas where there is not sufficient population to support a PES unit like the one in Alameda County, there are other available strategies for providing quality psychiatric emergency services to individuals in crisis to help them to find stability and avoid psychiatric boarding on the one hand and psychiatric hospitalization on the other. Those strategies include:

“Commencement of Care Algorithms”: Dr. Zeller argues that many “straightforward treatments” can be started by ED physicians for persons in psychiatric distress “using standard protocols created in concert with their psychiatric consultant.” This can alleviate pain and stress for the patient in the ED, and even enable sufficient improvement to make diversion from hospitalization a viable option when the psychiatric consultant does arrive.

“On-Demand Emergency Telepsychiatry”: Dr. Zeller cites in particular the success of a telepsychiatry consultation program for EDs in South Carolina, with “improved patient outcomes and rapid stabilization of psychiatric crises.” (An article on the success of the telepsychiatry program, which is operating under grant funding in South Carolina and in North Carolina, can be found [here](#). A separate article on the North Carolina program, published in the *North Carolina Medical Journal*, can be found [here](#).)

“Crisis Stabilization Units” & “Crisis Residential/Acute Diversion Units”: In his article Dr. Zeller describes “crisis stabilization units” as being “like psychiatric emergency rooms”, as they “will attempt to resolve psychiatric crises in less than 24 hours.” That does not appear to be the current model for CSUs in Virginia, where the average length of stay (in a 2010 [study](#)) was over 8 days. Virginia CSUs appear to more closely resemble “crisis residential/acute diversion units”, which Dr. Zeller describes as “longer-term programs” (3-14 days). However, while Dr. Zeller describes the focus of these programs as being on “subacute mental health patients in need of a period of stabilization,” it is the case that a number of Virginia CSUs clearly include people in

acute crisis (with some accepting individuals under TDOs). Studies and surveys of CSUs in Virginia in recent years indicate that they are viewed as effective in helping people in crisis avoid psychiatric hospitalization, yet considerable differences remain among the various CSUs across the Commonwealth. Dr. Lo at the Sentara Norfolk General ED notes that there are ongoing challenges for EDs in understanding the differing criteria among CSUs in accepting or not accepting patients.

Best Practices in all Models

In his Primary Psychiatry article (available [here](#)) Dr. Zeller describes best practices for psychiatric services in *all* emergency settings. He sets out and then describes the “treatment goals of emergency psychiatry”: “exclude medical etiologies for symptoms”; “rapid stabilization of acute crisis”; “avoid coercion”; “treat in the least restrictive setting”; “form a therapeutic alliance”; and “appropriate disposition and aftercare plan.”

What is particularly noteworthy is Dr. Zeller’s emphasis on establishing and maintaining a “therapeutic alliance” with the patient in the emergency setting. Dr. Zeller describes the therapeutic alliance as “a collaborative relationship between a patient and a clinician”, which, in practice, means, among other things, “avoiding coercion, which is the use of force or threats to make patients do things against their will. In emergency psychiatry, this includes the use of oral medications with informed consent as opposed to forcible injections; verbal de-escalation of agitated individuals instead of physical restraints; and little or no infringement on a patient’s rights when possible. Treating in the least restrictive level of care is another means of avoiding coercion.”

Innovative Psychiatric Emergency Services in Virginia: Developments and Proposals

Crisis Intervention Teams (CIT), Therapeutic Assessment “Drop Off” Centers, Crisis Stabilization Centers (CSU), Mobile Crisis Units, and Triage Centers

Different programs in different parts of Virginia operate a number of different services, including CIT programs, Therapeutic Assessment Drop Off Centers, CSUs and Triage Centers, that respond to individuals experiencing mental health crises in the community and resolve them in the least restrictive manner possible. Their expansion, strengthening and coordination have been recommended by the Governor’s Task Force, and many received additional funding support from the Governor and the 2015 General Assembly. From the perspective of the physician in the hospital ED, where psychiatric patients and psychiatric boarding remain difficult issues, navigating these options and finding willing placements for psychiatric patients among these options remains a challenge. As noted above, the different standards across programs for “medical clearance” of these individuals before they will be accepted from the ED can result in confusion and delay. In addition, none of these existing services appears to provide the model of service intended in the PES unit described by Dr. Zeller, either in terms of intensity of treatment or length of stay. The CSU’s for example, have an average patient stay of several days, and the Triage Center concept is focused less on providing intensive coordinated psychiatric treatment and stabilization than on providing a safe place where the police can leave a

person in crisis and return to the street while the CIT officer provides coverage and CSB staff provide an evaluation for possible issuance of a TDO.

A proposal for “regional psychiatric emergency centers”

On June 17, 2014, a member of the Governor’s Task Force on Improving Mental Health Services and Crisis Response sent an email to Mr. Jim Martinez of DBHDS proposing regional psychiatric emergency centers. (That email can be found [here](#), on page 38.) The Task Force member, Mr. Ted Stryker, observed that, “in all of the recommendations of the various workgroups of the Task Force, it is striking to me there is relatively little said about reforming the delivery system of care for the purposes of strengthening the integration of services; reducing unnecessary hand-offs; and increasing accountability. Some of the workgroups have kind of mentioned it (Ongoing Treatment talks about an ‘integrated community system of care – public/private partnership’ and Public Safety talks about creating ‘functional CIT Assessment Centers’), but, he noted, no “bold delivery system changes” had been proposed. Mr. Stryker went on to suggest discussion of regional psychiatric emergency centers that could “effectively combine four separate, fragmented levels of care”: “Crisis Screening Centers operated by CSB’s; Crisis Stabilization Centers; CIT Secure Assessment Centers; & Hospital ED’s. A unified system of psychiatric care under one roof,” he wrote, would improve coordination of care (single point of access; unified and common clinical electronic record; single point of accountability; and reduced system hand-offs) to create a high reliability system of care for people seeking care when they are in psychiatric crisis.”

Concluding Observations

The best solution for reducing the current pressure on Virginia’s mental health crisis response system is adequately funded community-based care that enables people to avoid crises through effective treatment, advance care planning, and early intervention services. That solution remains a goal, but even in an ideal system crises will regularly occur and must be resolved appropriately. While Virginia has been developing innovative practices and programs to improve the system’s response to mental health crises, with the Governor’s Task Force recommending the spread and strengthening of many of them, it’s appropriate to ask whether we currently have, or can develop, a consensus on an overarching model of psychiatric emergency care into which these various innovative practices and program can fit. The program in Alameda, California, as noted above, submits this significant claim for an overarching model: that with the delivery of intensive emergency psychiatric services in a dedicated PES unit at the time of mental health crisis, most people in such crisis can achieve stability and return to the community within 24 hours. If that claim is sound, and the model described by Dr. Zeller works, more people can return to their lives more quickly, fewer of them will experience unnecessary psychiatric hospitalization, and psychiatric boarding in many hospital EDs will be dramatically reduced. In addition, even in those rural communities where a PES unit cannot be maintained, improved protocols for psychiatric care in the ED setting, and both consultation with, and treatment by psychiatrists through tele-psychiatry, can improve outcomes and reduce the pressures on EDs.

The 2014 reforms to Virginia law have helped to ensure that those who experience a mental health crisis and are evaluated while being held under an Emergency Custody Order (ECO) will receive psychiatric hospital care if they meet the criteria for a Temporary Detention Order (TDO). The law now mandates that the state psychiatric hospital system accept these individuals if no one else will do so before their 8-hour ECO period expires, so that they do not slip out of the “safety net” of care while still in crisis. However, those very reforms place additional pressures on the system to make quick decisions to hospitalize when other dispositions might better serve some of these individuals, and they place additional pressures on hospitals that must treat more patients without having more beds for them. Moreover, those reforms do not address the root causes of the problem. Nor do they address the needs of many others who also experience a serious mental health crisis but who, for various reasons, are not being held under an ECO, and who are finding that they are in hospital EDs that do not meet their mental health needs and are unable to enter facilities or services that could meet those needs. As studies have shown, the extended stay of these individuals in the hospital ED can result not only in poorer outcomes for them, but also in poorer outcomes for other patients who are in the hospital ED for other kinds of care.

The search for a more comprehensive response to mental health crisis needs to continue.

III. Case Law Developments

Supreme Court Round-Up

ADA: Application of “accommodation” requirement to emergency police encounters with persons with mental illness

Sheehan v. City & Cnty. of San Francisco, 743 F.3d 1211 (9th Cir.) cert. granted sub nom. *City & Cnty. of San Francisco, Cal. v. Sheehan*, 135 S. Ct. 702 (2014).

Lower Court Opinions:

Plaintiff, Teresa Sheehan, filed suit under 42 U.S.C. 1983 against police officers and the city after the officers entered her home without a warrant and shot her five or six times when she reacted violently to the officers' presence, grabbing a knife and threatening to kill the officers. Plaintiff, a woman in her mid-50s suffering from a mental illness, told the officers that she did not want to be taken to a mental health facility. The United States District Court for the Northern District of California granted summary judgment in favor of the defendants finding that the officers (1) were justified in entering Sheehan's home, (2) did not use excessive force when they shot Sheehan, and (3) could not bring against the individual officers or the city under the Americans with Disabilities Act. The district

court relied on language from a 5th Circuit case in reaching this third conclusion: “section 12132 does not permit a cause of action based on an “officer's on-the-street responses to reported disturbances or other similar incidents, whether or not those calls involve subjects with mental disabilities, prior to the officer's securing the scene and ensuring that there is no threat to human life.”

The 9th Circuit affirmed in part, holding that the officers were justified in entering plaintiff's home initially under the emergency aid exception because they had an objectively reasonable basis to believe that she was in need of emergency medical assistance and they conducted the search or seizure in a reasonable manner up to that point. The court held that there were triable issues of fact as to whether the second entry violated the Fourth Amendment where a jury could find that the officers acted unreasonably by forcing the second entry and provoking a near-fatal confrontation. The court further held that there were triable issues of fact as to whether the officers used excessive force by resorting to deadly force and shooting plaintiff. Finally, the court held that the district court properly rejected claims of municipal liability; the court joined the majority of circuits that have addressed the issue and held that Title II of the Americans with Disabilities Act, 42 U.S.C. 12132, applied to arrests; on the facts presented here, there was a triable issue as to whether the officers failed to reasonably accommodate plaintiff's disability; and the court vacated summary judgment on plaintiff's state law claims and remanded for further proceedings.

Briefs of Petitioners and Respondent:

On appeal to the Supreme Court, both parties raised two questions in their original briefs. First, whether the accommodation requirement of Title II of the Americans with Disabilities Act requires law enforcement officers to provide accommodations during the course of bringing an armed and mentally ill suspect into custody. Second, for the purpose of determining whether officers were entitled to qualified immunity, whether it was clearly established that even if an exception to the warrant requirement applied, entry into a residence may be unreasonable under the Fourth Amendment when officers enter the home of an armed and mentally disturbed individual.

According to petitioners (City and County of San Francisco), Sheehan was not entitled to accommodations during her arrest process because she was not “qualified...to invoke a public entity's duty to modify its activities” because she posed “a direct threat or significant risk to the safety of others” at the time of her arrest. Petitioners contended that, because the determination of threat or risk is to be based on the reasonable judgment of the person from whom the accommodation is demanded, and the officers made an objectively reasonable judgment based on the information they had at the time, Sheehan was not entitled to an accommodation during her arrest. In regard to the Fourth Amendment warrant-exception issue, the petitioners contended that the rule articulated in the case below—that absent an immediate need police officers are prevented from entering the residence of an armed, violent, and mentally ill person and even in the case of an immediate need to enter the officers are prevented from using force to defend

themselves against even a provoked attack—both contradicted Supreme Court precedent and was not clearly established by 9th Circuit precedent.

In response, the brief for Teresa Sheehan argued at the outset that it did not make “legal” sense to apply an exception to Title II’s reasonable accommodation requirement when an individual’s mental illness is the reason for the police’s interaction with that person. Further, the brief for the respondent contended that, as a factual matter, Sheehan could not have been considered a reasonable direct threat for the purpose of the exception because (1) she was alone in the residence and the officers were on the outside of the door, (2) Sheehan was not a flight risk, and (3) Sheehan had only ever threatened individuals who entered her room without permission. In response to the petitioners’ claim that delay would have been an unreasonable accommodation, respondent contended that the proposed modifications put forward were “consistent with applicable training materials and universally accepted police practices designed to minimize the risk of a violent confrontation with a mentally ill individual.” Finally, Sheehan contended that the officers should not be entitled to qualified immunity in respect to their actions because forcibly reopening the door to Sheehan’s room and shooting her multiple times without taking her mental illness into account or identifying a countervailing need to enter was objectively unreasonable.

Reply Brief of Petitioners:

In their reply brief, the petitions began by identifying that while Title II of the ADA “does not permit police officers to assume that erratic conduct caused by mental illness is dangerous” it also does not “require officers to ignore dangerous conduct because it may be caused by mental illness.” The reply brief emphasized that arrest situations—especially ones involving mentally ill persons who are armed, acting erratically, and potentially violent—involve split-second judgments that should not be assessed “[w]ith the benefit of hindsight and calm deliberation.” Thus, the risk determination should be assessed in the closed universe of the facts of the situation as available to the officers at the time of the arrest. The reply brief also took issue with the temporal focus on the respondent’s brief (i.e. solely focusing on the “second” entry when the officers entered Sheehan’s closed-off bedroom). Instead, petitioners argued that the second entry could not be considered in isolation, but must be analyzed in the context of the entire encounter up to that point: “[W]hen the officers decided to reenter Sheehan’s room, they knew beyond question that Sheehan was violent and intended harm.”

Briefs of Selected Amici Curiae:

American Psychological Association (et alia): The American Psychological Association filed a brief in conjunction with several other amici. The complete list of joint amici included the American Psychiatric Association, American Psychological Association, Delaware, Illinois, New Mexico, Ohio, and Vermont Psychological Associations, National Council on Disability, National Alliance on Mental Illness, and Judge David L. Bazelon Center for Mental Health Law. The joint brief took the position that the question of whether an individual is “qualified” within the meaning of the ADA should be

determined by analyzing the *entire* encounter between law enforcement and the mentally ill individual. Further, the brief argued that it is precisely the situation in which failure to provide accommodation is the partial cause of threatening or violent behavior that the statute's protection is important. Finally, the APA brief took the position that an obligation to provide reasonable accommodations when interacting with mentally ill individuals at the time of arrest would not impose any undue burden on law enforcement or other public entities.

Policy Council on Law Enforcement and the Mentally Ill ("Policy Council"): The Policy Council filed a brief in strong support of respondent Teresa Sheehan, opening their argument with the proposition that it is "critical to the safety and well-being of those suffering from mental illness, as well as their loved ones, that the Americans with Disabilities Act (ADA) apply vigorously to police encounters" because they are "acutely vulnerable." The Policy Council's brief highlighted the public policy concerns that support the enforcement of the ADA's accommodation requirement: namely, "the importance of encouraging people who need help to seek it." The brief also took the position that in "barricade situations involving mentally ill individuals, there should rarely be a question as to the [ADA]'s applicability." Finally, the Policy Council argued that "fairness and equity suggest that the ADA accommodation requirement should apply when officers are present for the sole purpose of assisting" mentally ill persons.

United States: The amicus brief of the United States of America supported vacatur in part and reversal in part. As to the ADA claim, the United States agreed that "[b]y its plain terms, the provision...extends to arrests." The government did, however, also argue that when "police officers arrest an individual with a disability who is armed and violent, any deviation from ordinary law enforcement tactics will generally present very real safety risks." Still, while of the mind that in the ordinary run of cases no modifications to the ADA will be required, the government espoused the position that a plaintiff should still "remain free to show that special circumstances rendered a modification reasonable" given the facts of any particular case." Given the facts of the instant case, the government argued that Sheehan's being armed and violent put the burden on her to show that an accommodation would not have presented safety concerns for the officers involved.

National League of Cities: The National League of Cities, filing in support of the petitioners, began by arguing that the holdings of the 9th Circuit below ignored the "practical reality faced by police officers who must routinely confront seriously mentally ill suspects who are armed and violent." Taking a position quite different from the other amici curiae, the National League of Cities, while acknowledging that some cities have adopted special procedures for responding to incidents with mentally ill individuals, claims that "there is no conclusive evidence that these specialized approaches reduce the rate or severity of injuries suffered during police encounters with mentally ill suspects." Further, the National League of Cities argued that requiring police officers to "undertake special procedures to accommodate an armed and violent suspect's mental disability during an emergency situation" would have serious consequences for the safety of

officers and the public because it would encourage them to “hesitate or delay in confronting an armed and violent suspect who displays any sign of a mental illness.”

Argument Analysis:

[*from* Lyle Denniston, *Argument Analysis: Can a Really Rough Start be Overcome?*, SCOTUSBLOG.COM, (Mar. 23, 2015, 3:07 PM),

<http://www.scotusblog.com/2015/03/argument-analysis-can-a-really-rough-start-be-overcome/>]

In the opening moments of the oral arguments, Justice Scalia expressed concern (and thinly veiled annoyance) at his perception that the case “may have changed markedly once it got on the Court’s docket.” Justice Scalia questioned Christine Van Aiken, deputy city attorney for San Francisco, on the apparent discrepancies between the question on which the Court granted certiorari and the arguments raised in the city’s merits brief. According to Justice Scalia, the Court had taken the case to decide whether the ADA should apply at all in the context of an arrest (the position taken in the city’s lower court briefs), but the briefs filed by the city with the Supreme Court couched the question in terms of *when* the ADA’s protections kick in during an arrest. The city’s articulated position in its merits brief (as read out from petitioners’ filings by Justice Scalia and also remarked upon by Justice Sonia Sotomayor) was that the ADA’s protections only apply once “a threat [posed by a disabled person] has been eliminated.” Justice Samuel Alito also introduced another complicating factor—although no one had addressed the issue in a brief—by articulating the opinion that the definition of discrimination in the context of police activity could be a threshold matter.

By the time Van Aiken’s time had expired, the Court had only spent a little time on the merits of the case. Ian H. Gershengorn, Deputy Solicitor General, spoke next, advancing the view espoused in the federal government’s brief that the protection of the ADA “definitely does, and should, apply to police arrests.” He received some pushback from the Justices, but held strongly to his argument even under fire on the topic of the questions that might arise in the “tense situations” when officers confront a potentially violent and mentally ill individual.

Soon after Leonard Feldman, Sheehan’s lawyer, began his arguments, the Justices seemed to be “developing some skepticism about how police could actually try to calm a situation when an armed and violent person came at them with a knife and with a threat to kill them.” Specifically, Chief Justice John Roberts raised the issue of whether Sheehan might have been a suicide risk—suggesting that a reasonable fear of an individual posing a risk of self-harm might be enough to trigger exceptions to the ADA and the Fourth Amendment warrant requirement.

Ultimately, the court seemed confused (or at the least to have serious lingering questions) about (1) which standard each party was advocating for the Court to apply in interpreting the ADA’s applicability to arrests, and (2) the factual specifics of whether Sheehan did actually pose a “direct threat” to the officers.

Virginia and the Fourth Circuit

NGI: trial court complied with statutory criteria for ordering inpatient hospitalization vs. conditional release of NGI acquittee

Bates v. Com., 287 Va. 58, 752 S.E.2d 846 (2014).

After being found not guilty by reason of insanity on a charge of arson pursuant to Va. Code Ann. § 18.2-77, Tanisha Bates was remanded to the temporary custody of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services (the “Commissioner”) in order to evaluate options for her treatment or release. The clinical psychologist who performed the evaluation recommended inpatient hospitalization whereas the psychiatrist recommended conditional release coupled with outpatient treatment. The Northern Virginia Mental Health Institute (“NVMHI”) then prepared a court-ordered conditional release plan in advance of hearing “to determine the appropriate disposition of the acquittee” in accordance with Va. Code Ann. §§ 19.2–182.3 and 19.2–182.7. At the request of the Commissioner, the Forensic Review Panel also submitted a report, concluding that “Bates’ continued delusions, risk of suicide, lack of substantial response to treatment, and history of deadly and dangerous behavior” all supported a recommendation that Bates should remain committed to inpatient hospitalization. The circuit court followed that recommendation and entered an order committing Bates to the custody of the Commissioner.

Bates appealed the order, contending that the circuit court misapplied the relevant Virginia Code sections in reaching the decision that she required inpatient hospitalization. The Virginia Supreme Court affirmed the commitment order of the court below, holding that it had correctly applied the statutory criteria. Although the court below had acknowledged that the NVMHI report stated that Bates was “ready to leave” inpatient treatment, the finding that there was “no means for controlling her on an outpatient basis” was enough to warrant an order committing Bates to inpatient hospitalization. Further, the Supreme Court held that the provisions in Va. Code Ann. § 19.2–182.7 do not require lower courts to “fashion an appropriate plan for [] outpatient treatment and supervision when it [has] already determined that [a defendant] [is] not eligible for conditional release, and that she require[s] inpatient hospitalization.”

Competency to Stand Trial: no error in trial court’s determination of defendant’s “present” ability to understand the proceedings and assist counsel, including denial of motion for a second hearing based on “new evidence”

Dang v. Com., 287 Va. 132, 752 S.E.2d 885 cert. denied sub nom. *Dang v. Virginia*, 135 S. Ct. 130, 190 L. Ed. 2d 99 (2014).

On appeal from his conviction for murder and violation of a protective order, petitioner Lam Dang argued that the circuit court erred in failing to order a second competency

evaluation after his counsel uncovered new evidence concerning head trauma he suffered as a child. In his first competency evaluation, Dang was found competent to stand trial and seemed particularly focused on providing “his side of the story” and repeatedly had to be constantly redirected to the question posed. Dang’s evaluator noted that he exhibited a high degree of situational anxiety, but that it was not indicative of a mental illness relevant to competency but was “consistent with most defendants who face legal charges.”

Four days prior to his trial, Dang’s counsel moved for a second competency evaluation based on evidence he had recently uncovered that, beginning at age six and continuing until sixth or seventh grade, Dang had been subject to repeated physical assaults that included being pelted in the head with rocks. The circuit court denied the motion, finding no probable cause that Dang “lack[ed] substantial capacity to understand the proceedings against him or to assist his attorney in his own defense.”

The Supreme Court of Virginia upheld the Court of Appeals’ denial of Dang’s petition. The Supreme Court found that the circuit court had given adequate weight to the new information acquired by defense counsel and had focused on the proper issue at hand—Dang’s “*present* ability to understand the proceedings and assist his counsel.” Given the first evaluator’s opinion that Dang’s shifting focus was representative of “situational anxiety” and the “wide latitude” offered to circuit courts in light of their “first-hand interactions with, and observations of, the defendant and the attorneys at bar” the Supreme Court of Virginia found that the circuit court did not abuse its discretion in denying the request for a second evaluation.

Sexually Violent Predators: burden of proof on Commonwealth to prove in annual review hearing that continued involuntary confinement necessary

***Gibson v. Com.*, 287 Va. 311, 756 S.E.2d 460 (2014).**

Overruling *Commonwealth v. Bell*, 282 Va. 308, 714 S.E.2d 562 (2011), the Supreme Court of Virginia held that the Commonwealth is the party who bears the burden of proving that no suitable, less restrictive alternative to involuntary inpatient treatment exists for someone declared to be a sexually violent predator. After a jury found that the defendant, Donald Gibson, was a sexually violent predator within the meaning of Va. Code Ann. § 37.2-900, the circuit court continued the trial in order to hear additional evidence related to Gibson’s suitability for conditional release as an alternative to involuntary commitment.

In moving forward, Gibson argued that the burden was on the Commonwealth to prove “by clear and convincing evidence” that the elements of Va. Code Ann. § 37.2-912 were not satisfied, whereas the Commonwealth, relying on *Commonwealth v. Bell*, argued that burden was on Gibson to prove “by a preponderance of the evidence that he meets the criteria for conditional release.”

The Virginia Supreme Court noted that statements in *Commonwealth v. Bell* seemed to conflict with the earlier decision *McCloud v. Com.*, 269 Va. 242, 261, 609 S.E.2d 16, 26 (2005) which held that “the burden of proving that there is no suitable less restrictive alternative to involuntary confinement rests with the Commonwealth, and that burden cannot be shifted to the [respondent].” Finding no reason “to draw a distinction between an initial sexually violent predator trial and an annual review hearing in terms of which party bears the burden of proof on the issue whether there are no suitable less restrictive alternatives to involuntary confinement,” the Supreme Court of Virginia overruled *Bell* and returned to the rule in *McCloud* instead of reconciling the two by drawing such a distinction.

Sexually Dangerous Offenders: period in confinement pending civil commitment determination not applicable as “credit” toward time served for criminal sentence

United States v. Hass, 575 Fed. Appx. 139 (4th Cir. 2014) (unpublished per curiam opinion).

In appealing the district court’s judgment revoking his supervised release and sentencing him to eighteen months in prison followed by an additional thirty months of supervised release, defendant Johnny Hass argued that the district court erred in fashioning his sentence by refusing to factor in time he spent in Bureau of Prisons (“BOP”) custody awaiting civil commitment proceedings. After the Government certified that Hass qualified as a sexually dangerous person under the Adam Walsh Child Protection and Child Safety Act of 2006, the court stayed his release pending the outcome of a hearing to determine whether Hass was sexually dangerous. After his supervised release was revoked and a new prison sentence imposed by the district court, Hass argued on appeal to the Fourth Circuit that he should have been granted credit for time served equal to the time he spent in BOP custody awaiting his civil commitment hearing.

Given the deference due to the district court, the Fourth Circuit stated it would only reverse if the sentence imposed was “plainly unreasonable.” A sentence can be either procedurally or substantively unreasonable. Procedural reasonability is determined by examining the district court’s consideration of “applicable 18 U.S.C. § 3553(a) (2012) factors and the policy statements contained in Chapter Seven of the Guidelines.” Substantive reasonability is determined by examining whether the district court stated a “proper basis for concluding that the defendant should receive the sentence imposed.”

The Fourth Circuit rejected Hass’ claim that failing to give him credit for his prior time spent in BOP custody was a basis for plain error, stating that “it is unthinkable to lend support to any judicial decision which permits the establishment of a line of credit for future crimes.” Because Hass “was being sentenced for violating the terms of his supervised release” and cited “no precedent to support his claim that over-service of a prior sentence is even a proper consideration for a court when imposing a revocation sentence,” the Fourth Circuit affirmed the sentence imposed by the district court.

NGI: delay in commitment proceedings justified by acquittee's misconduct

United States v. Conrad, 776 F.3d 253 (4th Cir. 2015).

Defendant-appellant Samuel Robert Conrad III, currently serving an eight-year term of imprisonment, appealed both the district court's denial of his motion to dismiss commitment proceedings arising from a 2007 insanity acquittal (arising from a separate set of offenses) and the district court's order to delay those commitment proceedings until he is released from prison. At issue for the Fourth Circuit on Appeal was 18 U.S.C. § 4243, which provides the "procedural framework for the evaluation and commitment of defendants adjudicated NGI."

Initially, Conrad's § 4243 hearing following the 2007 acquittal resulted in the district court's imposition of a conditional release, which was subsequently revoked when Conrad was charged by the Commonwealth of Virginia for the murder of his sister-in-law. Conrad appealed the revocation of his conditional release, and the order originally granting it was vacated by the Fourth Circuit in 2010 based on that court's determination that the language of § 4243 "allows only two forms of disposition--unconditional release or indefinite commitment; it does not authorize conditional release." A new hearing was thus required under § 4243(e), but never actually took place because in 2013 Conrad was charged with possession of a firearm by a convicted felon and conspiracy to distribute controlled substances—charges which lead to his current incarceration. When Conrad moved to dismiss the pending § 4243 commitment proceedings arising from the prior case (arguing that § 4243 was no longer applicable to him because he could not pose a threat to public safety while incarcerated), the district court denied his motion, ordering instead that a delay of the proceedings until Conrad completes his current term of imprisonment would best serve the statute's purposes."

The Fourth Circuit affirmed the denial of Conrad's motion to dismiss as well as the order delaying the § 4243 proceedings. In affirming the denial of the motion to dismiss, the Fourth Circuit held that § 4243 "applies on its face to NGI acquittees" and "unambiguously requires a hearing to determine commitment or release," and so in the absence of any "provision permitting nullification of the statute's applicability through subsequent commission of crime and incarceration," the district court was within its discretion to refuse dismissal of the § 4243 hearing. Further, the Fourth Circuit held that the delay ordered by the district court was permissible, confronting the timing requirement of § 4243(c) which "requires a hearing within 40 days of the NGI verdict, which, under a separate provision, may be extended only by 30 days, and only by the director of the facility to which the acquittee has been committed." The Fourth Circuit stated that both parties agreed that there is at least one implicit exception to the 40-day requirement of § 4243(c) and cited to other opinions in which a delay greater than 40 days was allowed and found to be justified due to "circumstances outside of the acquittee's control--such as a commitment facility's inadequate resources to promptly conduct the evaluation." Given this precedent, the Fourth Circuit stated that a delay would "would seem even more fitting" in circumstances *within* the acquittee's control and held that because Conrad "has been the principal architect of the delay he faces, and

such delay is reasonable under the statute when the acquittee is serving a term of incarceration” the district court did not err in delaying the proceeding.

Sexually Dangerous Offender: establishing personal jurisdiction over defendant for civil commitment hearing does not require service of summons under Rule 4

United States v. Perez, 752 F.3d 398 (4th Cir. 2014).

Jose De La Luz Perez appealed the determination of the district court that he was a "sexually dangerous person" under the Adam Walsh Child Protection and Safety Act of 2006 (the "Act"). On appeal, Perez asked the Fourth Circuit to vacate the civil commitment order, contending that the district court lacked personal jurisdiction because the government failed to serve him with a summons pursuant to Rule 4 of the Federal Rules of Civil Procedure. The Fourth Circuit affirmed the order, holding that although the Federal Rules of Civil Procedure are broadly applicable in civil commitment proceedings, that does not mean that they "cannot be displaced by specific procedural provisions included in the Act." The central question on appeal was whether the Act required the government "to serve a summons pursuant to Rule 4 [of the Federal Rules of Civil Procedure] upon a respondent in federal custody despite the obvious differences between the initiation of civil commitment proceedings under § 4248 and a typical civil action."

The Fourth Circuit pointed to a "streamlined procedure for initiating commitment proceedings against individuals in BOP custody" contained in the statutory language that served to supplant the usual summons requirements of Rule 4. Apart from the view that the text of the statute is sufficient to displace the summons requirement of Rule 4, the Fourth Circuit pointed out that while "physical custody is no longer necessary to endow a civil court with personal jurisdiction over a defendant, it is clearly sufficient to do so," and so the fact that the government "has physical custody over the respondent in § 4248 civil commitment proceedings obviates the need for a summons."

Treatment of Mentally Ill Individuals in Custodial Settings

Eighth Amendment: Failure to follow national suicide screening prevention standards with prisoner who later commits suicide presents colorable eighth amendment claim that survives summary judgment motion

Barkes v. First Corr. Med., Inc., 766 F.3d 307 (3d Cir. 2014).

After Christopher Barkes committed suicide while being held at a correctional facility in Delaware, his wife and children brought a § 1983 suit against the commissioner of the state department of corrections ("DOC"), the warden, and the private company with whom the DOC contracted to provide medical services to the prison ("FCM") alleging violations of the Eighth Amendment of the federal Constitution.

When Barkes was arrested in November, 2004, he underwent a medical intake screening procedure conducted by a licensed nurse employed by LCM, the private contractor hired to provide medical services to the prison. The procedure involved (1) a self-report intake form that included questions about suicidal ideation, (2) screening for seventeen suicide risk factors, and (3) a standard medical intake form with questions about “altered mental status ... or abnormal conduct.” Barkes indicated that he had attempted suicide in 2003, but made no mention of three other attempts (one in 1997 and two in 2004) and checked only two of the seventeen suicide screening factors (eight were required to initiate suicide prevention measures). Finally, the licensed practical nurse who conducted the evaluation reported that Barkes showed no signs of either altered mental status or abnormal conduct. Barkes did, however, place a call to his wife that evening and express his intention to kill himself, but his wife did not inform the DOC. The next morning, Barkes was observed lying on his bed in his cell at 10:45, 10:50, and 11:00 a.m. When an officer came to deliver his lunch at 11:35 a.m., Barkes had hanged himself with a bed sheet.

The Third Circuit held (1) for purposes of determining whether the warden and DOC commissioner were entitled to qualified immunity, Barkes’ constitutional right to “proper implementation of adequate suicide prevention tools” was clearly established at the time of his suicide; (2) that summary judgment was inappropriate given evidence that “FCM's policies and procedures in place at the time of Barkes's suicide created an unreasonable risk of a constitutional deprivation;” and (3) that a reasonable jury could have found that Barkes’ suicide was caused by the DOC’s failure to supervise FCM. The second holding was based on evidence of the DOC’s awareness that “FCM's suicide prevention screening practices were not in compliance with [National Commission on Correctional Health Care] standards, as required by their contract with the DOC.” The Third Circuit reached its third holding despite the fact that Barkes did not self-report any suicidal ideation or exhibit any suicidal behavior because, in the court’s view, “had Appellants properly supervised FCM and ensured compliance with the contract, Barkes's answers during his screening would have resulted in additional preventive measures being taken.”

Custodial Interrogation: Police conduct with 18-year-old with Intellectual Disability is coercive under “totality of the circumstances”, rendering confession inadmissible

***United States v. Preston*, 751 F.3d 1008, 1010 (9th Cir. 2014).**

The 9th Circuit, sitting en banc, held that under the totality of the circumstances, including the eighteen-year-old defendant's intellectual disability, a confession that resulted from police questioning was involuntarily given and should not have been admitted at trial. In reaching this decision, the court overruled *Derrick v. Peterson*, 924 F.2d 813 (9th Cir.1991) as well as subsequent cases relying on it, which had held that individual characteristics are “relevant to our due process inquiry *only if* we first conclude that the police's conduct was coercive.”

The court divided its initial inquiry into two categories—defendant’s reduced mental capacity and the techniques used during the interrogation. As to the first category, the

court found that the intellectually impaired have a demonstrated increased vulnerability to coercion. The court also relied on scholarly assessment of common traits of intellectually disabled persons that may make them more susceptible to coercive interrogation techniques and then used those traits to inform their analysis of the techniques used to question the defendant, noting that “[A]s interrogators have turned to more subtle forms of psychological persuasion, and away from physical coercion, courts have found the mental condition of the defendant a more significant factor in the ‘voluntariness’ calculus.”

The court based its totality of the circumstances inquiry into the coercive nature of the interrogation on several factors: (1) defendant's severe intellectual impairment, (2) repetitive questioning and the threats that questioning would continue without end, (3) pressure placed on the defendant to adopt certain responses, (4) the use of alternative questions that assumed defendant's culpability, (5) the officers' multiple deceptions about how the statement would be used, (6) suggestive questioning that provided details of the alleged crime, and (7) false promises of leniency and confidentiality.

Liberty Interest Deprivation and Eighth Amendment: Claim of prisoner with mental illness that liberty deprivations from facility's Behavior Action Plans were imposed without due process and resulted in Eighth Amendment violations raises genuine issues of fact and survives motion for summary judgment

***Townsend v. Cooper*, 759 F.3d 678 (7th Cir. 2014).**

Townsend, a prisoner at the Green Bay Correctional Institution (GBCI), sued GBCI officials for civil rights violations. Townsend suffered from significant mental illness and engaged in disruptive behavior, including suicide attempts and fighting. Townsend was repeatedly subjected to observation placements and Behavioral Action Plans (BAPs). Vacating the judgment below, the Seventh Circuit held that Townsend had raised genuine issues of material fact regarding whether the imposition of the BAP violated his due process rights by imposing an atypical and significant hardship compared to the ordinary incidents of prison life, without appropriate notice and an opportunity to be heard and whether the BAP imposed conditions of confinement that denied Townsend the minimal civilized measures of life's necessities.

To succeed on his Fourteenth Amendment due process claim, Townsend was required to “establish that he ha[d] a liberty interest in not being placed in the [BAP]—as it was administered to him—without procedural protections,” noting that it was “undisputed that he received no procedural due process, so the claim turns on whether he can establish a liberty interest.” Prisoners have a liberty interest, guaranteed by the Fourteenth Amendment, in “avoiding transfer to more restrictive prison conditions if those conditions result in an *atypical and significant hardship* when compared to the *ordinary incidents of prison life*.” In order to succeed on an Eighth Amendment claim, a prisoner must show that the BAP “imposed conditions that denied him the minimal civilized

measure of life's necessities” and that defendants “acted in disregard of a substantial risk of serious harm to him.”

Other Cases

Mental Condition as Mitigating Evidence in Criminal Sentencing: voluntary intoxication instruction upheld

***Sprouse v. Stephens*, 748 F.3d 609 (5th Cir.) cert. denied, 135 S. Ct. 477, 190 L. Ed. 2d 362 (2014).**

After being convicted of capital murder of a police officer, petitioner Sprouse was sentenced to death. On state habeas review, Sprouse challenged jury instructions that “effectively precluded the jury from considering voluntary intoxication as mitigating evidence.” Raising the issue again on federal habeas review, Sprouse contended that the state court “unreasonably applied” *Penry v. Lynaugh* (“*Penry I*”), 492 U.S. 302, 109 S.Ct. 2934, 106 L.Ed.2d 256 (1989), *Boyde v. California*, 494 U.S. 370, 110 S.Ct. 1190, 108 L.Ed.2d 316 (1990), and *Penry v. Johnson* (“*Penry II*”), 532 U.S. 782, 121 S.Ct. 1910, 150 L.Ed.2d 9 (2001). The Fifth Circuit affirmed the federal district court’s denial of Sprouse’s habeas petition.

At the close of the punishment phase of the trial, the jury received three general instructions regarding the proper treatment of mitigating evidence. First, what constituted mitigating evidence, second that “neither intoxication nor temporary insanity of mind caused by intoxication constitute [*sic*] a defense to the commission of a crime,” and a final instruction on temporary insanity. On appeal to the Fifth Circuit, Sprouse argued that the voluntary-intoxication instruction (instruction two) “unconstitutionally limited the jury's ability to consider mitigating evidence.” The Fifth Circuit affirmed the district court’s denial of Sprouse’s federal habeas petition, holding that neither the state court nor the federal district court were unreasonable in their application of Supreme Court precedent. Further, the Fifth Circuit stated that “the fact that Sprouse perceives a negative inference in one sentence of his jury charge does not demonstrate that his jury was confused about, and precluded from following, the comprehensive and catch-all affirmative command to the jury to consider mitigation circumstances.”

In November 2014, the United States Supreme Court denied certiorari.

Involuntary Psychiatric Hospitalization of Minor: Parents’ claim that doctors’ “medical hold” keeping child in hospital over their objection violated their right to familial association survives motion to dismiss.

***Thomas v. Kaven*, 765 F.3d 1183 (10th Cir. 2014).**

Legina and Todd Thomas, parents of M.T., a twelve-year-old girl at the time of the events at issue in this case, placed M.T. in the University of New Mexico Children's

Psychiatric Center after she revealed suicidal tendencies during a police investigation of a potential sexual assault. She was diagnosed as exhibiting several serious psychiatric problems and her doctors recommended a prescription of psychotropic drugs. The Thomases resisted both the diagnoses and the doctors' recommendations. M.T. was evaluated for several weeks until Mrs. Thomas decided to remove her from the hospital. Concerned about her safety, M.T.'s doctors and therapist placed her on a medical hold and initiated an involuntary residential treatment petition in state court. After a seven-day hold, M.T. was released before the involuntary commitment proceedings began.

The Thomases claimed that when doctors and the hospital placed a medical hold on M.T. and filed a petition for involuntary residential treatment they violated (1) their constitutional right to direct M.T.'s medical care and (2) their right to familial association. The defendants moved to dismiss, asserting absolute and qualified immunity. The district court granted the motion on qualified immunity grounds, and the Thomases appealed. The Court of Appeals for the 10th Circuit affirmed the decision of the district court with regard to the alleged violation of the right to direct M.T.'s medical care. In regard to the violation of the right to familial association, however, the Court held that the Thomases *had* stated a claim eligible for relief and remanded the case for further proceedings. As the case had come up as an appeal of a motion to dismiss (not a motion for summary judgment), the decision was made on the basis of the pleadings alone, and the defendants could not "establish as a matter of law at this point in the proceedings that the relevant state interests outweighed the Thomases' interest in their right to familial association."

Competency to Stand Trial/Restoration of Competency: *Sell* criteria for involuntary treatment to restore competency apply to sentencing phase

***United States v. Cruz*, 757 F.3d 372 (3d Cir. 2014) cert. denied, No. 14-7512, 2015 WL 133477 (U.S. Jan. 12, 2015).**

Cruz was arrested and convicted on two counts of threatening a federal law enforcement officer. After the court received the pre-sentence investigation report, the prosecution successfully moved for a determination of competency. A Federal Bureau of Prisons forensic psychologist concluded that Cruz was mentally incompetent and suffered from schizophrenic disorder, bipolar type. After a hearing, the court concluded that Cruz was incompetent and found that he could not proceed with sentencing.

A second report concurred with the diagnosis, noted Cruz's ongoing refusal to take anti-psychotic medication recommended by BOP personnel, concluded that without medication Cruz would remain incompetent, and stated that "there is a substantial probability that [his] competency can be restored with a period of forced medication." The prosecution obtained an order authorizing the BOP to medicate Cruz against his will.

On appeal, the issue was whether "the Government, pursuant to the Supreme Court's decision in *Sell v. United States*, 539 U.S. 166, 123 S.Ct. 2174, 156 L.Ed.2d 197 (2003),

can have a sufficiently important interest in forcibly medicating a defendant to restore his mental competency and render him fit to proceed with sentencing.” In affirming the decision of the federal district court, the Third Circuit held that the government *could* have a sufficiently important interest in sentencing a defendant for serious crimes to justify involuntary medication. Relying on the stated concern in *Sell* that “memories may fade or evidence may be lost,” the Third Circuit held the same concern applies with equal force in the sentencing context (the guilt phase was at issue in *Sell*) because it means that it may be “difficult or impossible to *sentence* a defendant who regains competence after years of commitment.” Additionally, while it may be cognizable that some crimes are not “serious” enough to justify forcible medication at the sentencing stage, Cruz’s offense was certainly “serious” enough.

The United States Supreme Court denied certiorari in January 2015.

Sexually Violent Person: No due process violation in delay of over two years (due to prison sentence in unrelated matters) between finding that defendant is a sexually violent person and the start of his confinement based on that finding

***Gilbert v. McCullough*, 776 F.3d 487 (7th Cir. 2015).**

Carl C. Gilbert, Jr. had his parole revoked twice after he violated the conditions of his parole. These violations occurred while a civil commitment petition was pending against him, but because Gilbert was sentenced to prison after his second parole revocation, he served that sentence before being transferred to a Wisconsin Department of Health Services ("DHS") facility as a civilly committed person (a jury having found that he qualified as a sexually violent person). Gilbert argued on habeas review that his commitment was contrary to the Supreme Court's decision in *Foucha v. Louisiana*, 504 U.S. 71 (1992) because the interposition of his prison term caused a delay between his commitment verdict and his entry in DHS care, meaning that there was no "current" determination that he was a sexually violent person when he entered DHS care. After the Supreme Court of Wisconsin rejected Gilbert’s due process argument, both the federal district court for the Eastern District of Wisconsin and the Court of Appeals for the Seventh Circuit expressed concern regarding the delay, but ultimately held that the decision to reject Gilbert’s due process claim did not qualify as “contrary to or an unreasonable application of clearly established United States Supreme Court precedent.”

Although the Seventh Circuit acknowledged that “[w]ere the question presented to us as an initial question of federal constitutional law, we might reach a different result” and that the “two-and-a-half year delay between the order of commitment and Gilbert's entry into DHS care is certainly a concern for us,” they found themselves “constrained...by the narrow scope of habeas review.” In distinguishing *Foucha*, the Seventh Circuit found that, unlike in that case, there was “no suggestion that Gilbert no longer suffers from a mental disorder.” Further, there was no ruling or even intimation that “Gilbert could be committed, or that his commitment could continue, if he no longer had a mental disorder,” which *would* have been a holding contrary to *Foucha*.

Fourth Amendment Liberty Interest During Mental Health Crisis: exigent circumstances exception allows warrantless entry and seizures when officers have reasonable basis to believe person poses imminent danger of harm to self

Sutterfield v. City of Milwaukee, 751 F.3d 542 (7th Cir. 2014).

Krysta Sutterfield sued the City of Milwaukee and several of its police officers after officers forcibly entered her home to effectuate an emergency detention for purposes of a mental health evaluation, opened a locked container, and seized for safekeeping the gun and concealed-carry licenses they found inside. Sutterfield contended that the officers in question violated her rights under the Second, Fourth, and Fourteenth Amendments. On appeal from the federal district court for the Eastern District of Wisconsin, the Seventh Circuit held that the warrantless entry into Sutterfield's home was justified under the exigent circumstances exception to the Fourth Amendment's warrant requirement, as the officers had a reasonable basis to believe that Sutterfield posed an imminent danger of harm to herself. The Seventh Circuit ultimately affirmed the lower court's grant of summary judgment to the defendants on the basis of qualified immunity, even assuming that the search of a closed container for a gun, and the ensuing seizure of that gun, violated Sutterfield's Fourth Amendment rights.

On appeal, only the liability of the individual officers was at issue. Sutterfield argued that the police officers' warrantless entry into her home, the seizure of her person, the search of the locked compact disc case, and the seizure of the revolver and the concealed carry licenses discovered therein all violated her rights under the Fourth and Fourteenth Amendments, and that the seizure of the gun and licenses also violated her rights under the Second Amendment. She further contended that because these rights were clearly established (in her view), the officers did not enjoy qualified immunity from suit. The two primary competing interests at stake in the case were Sutterfield's privacy—specifically the right to be left alone in her home—and the important role police play in safeguarding individuals from dangers posed to themselves and others.

The Seventh Circuit noted that the Milwaukee police had been contacted by Sutterfield's physician with a concern that she might harm herself, and that Wisconsin law set forth an emergency detention procedure to deal with that sort of situation. Pursuant to section 51.15, a statement authorizing Sutterfield's emergency detention was prepared, and police executed that statement when they entered Sutterfield's home and took her into their custody. There was no suggestion that the officers acted for any reason other than to protect Sutterfield from harm. The Seventh Circuit also noted that their task was made more complicated by (1) the lack of information presented by the parties as to alternatives other than emergency detention, and (2) a lack of clarity in Fourth Amendment law as to the appropriate framework for examining warrantless intrusions motivated by purposes other than law-enforcement and evidence-gathering. Ultimately, however, the Seventh Circuit held that warrantless entry into appellant's home could not be sustained on the basis of the community caretaker doctrine, but was justified under the exigent

circumstances exception to the Fourth Amendment's warrant requirement, as the officers had a reasonable basis to believe that appellant posed an imminent danger of harm to herself.

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SENATE BILL NO. _____ HOUSE BILL NO. _____

1 A BILL to amend and reenact §§ 37.2-804.2, 37.2-809, and 37.2-814 of the Code of Virginia, relating to
2 notice of temporary detention and involuntary admission hearings.

3 **Be it enacted by the General Assembly of Virginia:**

4 **1. That §§ 37.2-804.2, 37.2-809, and 37.2-814 of the Code of Virginia are amended and reenacted**
5 **as follows:**

6 **§ 37.2-804.2. Disclosure of records.**

7 Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is
8 currently providing services to a person who is the subject of proceedings pursuant to this chapter shall,
9 upon request, disclose to a magistrate, the court, the person's attorney, the person's guardian ad litem, the
10 examiner identified to perform an examination pursuant to § 37.2-815, the community services board or
11 its designee performing any evaluation, preadmission screening, or monitoring duties pursuant to this
12 chapter, or a law-enforcement officer any information that is necessary and appropriate for the
13 performance of his duties pursuant to this chapter. Any health care provider, as defined in § 32.1-
14 127.1:03, or other provider who has provided or is currently evaluating or providing services to a person
15 who is the subject of proceedings pursuant to this chapter shall disclose information that may be
16 necessary for the treatment of such person to any other health care provider or other provider evaluating
17 or providing services to or monitoring the treatment of the person. Health records disclosed to a law-
18 enforcement officer shall be limited to information necessary to protect the officer, the person, or the
19 public from physical injury or to address the health care needs of the person. Information disclosed to a
20 law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.

21 Any health care provider providing services to a person who is the subject of proceedings under
22 this chapter ~~may~~ shall make a reasonable attempt to notify the person's family member or personal
23 representative, including any agent named in an advance directive executed in accordance with the
24 Health Care Decisions Act (§ 54.1-2981 et seq.), of information that is directly relevant to such
25 individual's involvement with the person's health care, which may include the person's location and

26 general condition, in accordance with subdivision D 34 of § 32.1-127.1:03, unless the provider has
27 actual knowledge that the family member or personal representative is currently prohibited by court
28 order from contacting the person.

29 Any health care provider disclosing records pursuant to this section shall be immune from civil
30 liability for any harm resulting from the disclosure, including any liability under the federal Health
31 Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person
32 or provider disclosing such records intended the harm or acted in bad faith.

33 **§ 37.2-809. Involuntary temporary detention; issuance and execution of order.**

34 A. For the purposes of this section:

35 "Designee of the local community services board" means an examiner designated by the local
36 community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has
37 completed a certification program approved by the Department, (iii) is able to provide an independent
38 examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has
39 no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment
40 interest in the facility detaining or admitting the person under this article, and (vii) except for employees
41 of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

42 "Employee" means an employee of the local community services board who is skilled in the
43 assessment and treatment of mental illness and has completed a certification program approved by the
44 Department.

45 "Investment interest" means the ownership or holding of an equity or debt security, including
46 shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other
47 equity or debt instruments.

48 B. A magistrate shall issue, upon the sworn petition of any responsible person, treating
49 physician, or upon his own motion and only after an evaluation conducted in-person or by means of a
50 two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an
51 employee or a designee of the local community services board to determine whether the person meets
52 the criteria for temporary detention, a temporary detention order if it appears from all evidence readily

53 available, including any recommendation from a physician or clinical psychologist treating the person,
54 that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of
55 mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as
56 evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if
57 any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for
58 his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or
59 incapable of volunteering for hospitalization or treatment. The magistrate shall also consider the
60 recommendations of any treating or examining physician licensed in Virginia if available either verbally
61 or in writing prior to rendering a decision. Any temporary detention order entered pursuant to this
62 section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection
63 shall not preclude any other disclosures as required or permitted by law.

64 C. When considering whether there is probable cause to issue a temporary detention order, the
65 magistrate may, in addition to the petition, consider (i) the recommendations of any treating or
66 examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person,
67 (iii) any past mental health treatment of the person, (iv) any relevant hearsay evidence, (v) any medical
68 records available, (vi) any affidavits submitted, if the witness is unavailable and it so states in the
69 affidavit, and (vii) any other information available that the magistrate considers relevant to the
70 determination of whether probable cause exists to issue a temporary detention order.

71 D. A magistrate may issue a temporary detention order without an emergency custody order
72 proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to
73 subsection B if (i) the person has been personally examined within the previous 72 hours by an
74 employee or a designee of the local community services board or (ii) there is a significant physical,
75 psychological, or medical risk to the person or to others associated with conducting such evaluation.

76 E. An employee or a designee of the local community services board shall determine the facility
77 of temporary detention in accordance with the provisions of § 37.2-809.1 for all individuals detained
78 pursuant to this section. An employee or designee of the local community services board may change
79 the facility of temporary detention and may designate an alternative facility for temporary detention at

80 any point during the period of temporary detention if it is determined that the alternative facility is a
81 more appropriate facility for temporary detention of the individual given the specific security, medical,
82 or behavioral health needs of the person. In cases in which the facility of temporary detention is changed
83 following transfer of custody to an initial facility of temporary custody, transportation of the individual
84 to the alternative facility of temporary detention shall be provided in accordance with the provisions of §
85 37.2-810. The initial facility of temporary detention shall be identified on the preadmission screening
86 report and indicated on the temporary detention order; however, if an employee or designee of the local
87 community services board designates an alternative facility, that employee or designee shall provide
88 written notice forthwith, on a form developed by the Executive Secretary of the Supreme Court of
89 Virginia, to the clerk of the issuing court of the name and address of the alternative facility. Subject to
90 the provisions of § 37.2-809.1, if a facility of temporary detention cannot be identified by the time of the
91 expiration of the period of emergency custody pursuant to § 37.2-808, the individual shall be detained in
92 a state facility for the treatment of individuals with mental illness and such facility shall be indicated on
93 the temporary detention order. Except as provided in § 37.2-811 for inmates requiring hospitalization in
94 accordance with subdivision A 2 of § 19.2-169.6, the person shall not be detained in a jail or other place
95 of confinement for persons charged with criminal offenses and shall remain in the custody of law
96 enforcement until the person is either detained within a secure facility or custody has been accepted by
97 the appropriate personnel designated by either the initial facility of temporary detention identified in the
98 temporary detention order or by the alternative facility of temporary detention designated by the
99 employee or designee of the local community services board pursuant to this subsection. The person
100 detained or in custody pursuant to this section shall be given a written summary of the temporary
101 detention procedures and the statutory protections associated with those procedures.

102 F. Any facility caring for a person placed with it pursuant to a temporary detention order is
103 authorized to provide emergency medical and psychiatric services within its capabilities when the
104 facility determines that the services are in the best interests of the person within its care. The costs
105 incurred as a result of the hearings and by the facility in providing services during the period of
106 temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs

107 reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of
108 Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance
109 Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary
110 detention.

111 G. The employee or the designee of the local community services board who is conducting the
112 evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention
113 order, the insurance status of the person. Where coverage by a third party payor exists, the facility
114 seeking reimbursement under this section shall first seek reimbursement from the third party payor. The
115 Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances
116 covered by the third party payor have been received.

117 H. The duration of temporary detention shall be sufficient to allow for completion of the
118 examination required by § 37.2-815, preparation of the preadmission screening report required by §
119 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid
120 involuntary commitment where possible, but shall not exceed 72 hours prior to a hearing. If the 72-hour
121 period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is
122 lawfully closed, the person may be detained, as herein provided, until the close of business on the next
123 day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The
124 person may be released, pursuant to § 37.2-813, before the 72-hour period herein specified has run.

125 I. If a temporary detention order is not executed within 24 hours of its issuance, or within a
126 shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the
127 office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the
128 jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96
129 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a
130 designee of the local community services board prior to issuing a subsequent order upon the original
131 petition. Any petition for which no temporary detention order or other process in connection therewith is
132 served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be
133 returned to the office of the clerk of the issuing court.

134 J. The Executive Secretary of the Supreme Court of Virginia shall establish and require that a
135 magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose
136 of performing the duties established by this section. Each community services board shall provide to
137 each general district court and magistrate's office within its service area a list of its employees and
138 designees who are available to perform the evaluations required herein.

139 K. For purposes of this section, a health care provider or designee of a local community services
140 board or behavioral health authority shall not be required to encrypt any email containing information or
141 medical records provided to a magistrate unless there is reason to believe that a third party will attempt
142 to intercept the email.

143 L. The employee or designee of the community services board who is conducting the evaluation
144 pursuant to this section shall, if he recommends that the person should not be subject to a temporary
145 detention order, inform the petitioner ~~and~~, an onsite treating physician, and any other person who is
146 required to be given notice of the hearing pursuant to subsection M of his recommendation.

147 M. The petitioner and the person's personal representative, including any agent named in an
148 advance directive executed in accordance with the Health Care Decisions Act (§ 54.1-2981 et seq.), or,
149 if no personal representative exists, the nearest known relative of the person other than the petitioner
150 shall be given adequate notice of the place, date, and time of the hearing. Any person given notice
151 pursuant to this subsection shall be entitled to retain counsel at his own expense, to be present during the
152 hearing, and to testify and present evidence. Any person given notice pursuant to this subsection shall be
153 encouraged but shall not be required to testify at the hearing, and the person whose temporary detention
154 is sought shall not be released solely on the basis of the petitioner's, the personal representative's, or the
155 relative's failure to attend or testify during the hearing.

156 **§ 37.2-814. Commitment hearing for involuntary admission; written explanation; right to**
157 **counsel; rights of petitioner.**

158 A. The commitment hearing for involuntary admission shall be held after a sufficient period of
159 time has passed to allow for completion of the examination required by § 37.2-815, preparation of the
160 preadmission screening report required by § 37.2-816, and initiation of mental health treatment to

161 stabilize the person's psychiatric condition to avoid involuntary commitment where possible, but shall be
162 held within 72 hours of the execution of the temporary detention order as provided for in § 37.2-809;
163 however, if the 72-hour period herein specified terminates on a Saturday, Sunday, legal holiday, or day
164 on which the court is lawfully closed, the person may be detained, as herein provided, until the close of
165 business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is
166 lawfully closed.

167 B. At the commencement of the commitment hearing, the district court judge or special justice
168 shall inform the person whose involuntary admission is being sought of his right to apply for voluntary
169 admission for inpatient treatment as provided for in § 37.2-805 and shall afford the person an
170 opportunity for voluntary admission. The district court judge or special justice shall advise the person
171 whose involuntary admission is being sought that if the person chooses to be voluntarily admitted
172 pursuant to § 37.2-805, such person will be prohibited from possessing, purchasing, or transporting a
173 firearm pursuant to § 18.2-308.1:3. The judge or special justice shall ascertain if the person is then
174 willing and capable of seeking voluntary admission for inpatient treatment. In determining whether a
175 person is capable of consenting to voluntary admission, the judge or special justice may consider
176 evidence regarding the person's past compliance or noncompliance with treatment. If the judge or
177 special justice finds that the person is capable and willingly accepts voluntary admission for inpatient
178 treatment, the judge or special justice shall require him to accept voluntary admission for a minimum
179 period of treatment not to exceed 72 hours. After such minimum period of treatment, the person shall
180 give the facility 48 hours' notice prior to leaving the facility. During this notice period, the person shall
181 not be discharged except as provided in § 37.2-837, 37.2-838, or 37.2-840. The person shall be subject
182 to the transportation provisions as provided in § 37.2-829 and the requirement for preadmission
183 screening by a community services board as provided in § 37.2-805.

184 C. If a person is incapable of accepting or unwilling to accept voluntary admission and treatment,
185 the judge or special justice shall inform the person of his right to a commitment hearing and right to
186 counsel. The judge or special justice shall ascertain if the person whose admission is sought is
187 represented by counsel, and, if he is not represented by counsel, the judge or special justice shall appoint

188 an attorney to represent him. However, if the person requests an opportunity to employ counsel, the
189 judge or special justice shall give him a reasonable opportunity to employ counsel at his own expense.

190 D. A written explanation of the involuntary admission process and the statutory protections
191 associated with the process shall be given to the person, and its contents shall be explained by an
192 attorney prior to the commitment hearing. The written explanation shall describe, at a minimum, the
193 person's rights to (i) retain private counsel or be represented by a court-appointed attorney, (ii) present
194 any defenses including independent evaluation and expert testimony or the testimony of other witnesses,
195 (iii) be present during the hearing and testify, (iv) appeal any order for involuntary admission to the
196 circuit court, and (v) have a jury trial on appeal. The judge or special justice shall ascertain whether the
197 person whose involuntary admission is sought has been given the written explanation required herein.

198 E. To the extent possible, during or before the commitment hearing, the attorney for the person
199 whose involuntary admission is sought shall interview his client, the petitioner, the examiner described
200 in § 37.2-815, the community services board staff, and any other material witnesses. He also shall
201 examine all relevant diagnostic and other reports, present evidence and witnesses, if any, on his client's
202 behalf, and otherwise actively represent his client in the proceedings. A health care provider shall
203 disclose or make available all such reports, treatment information, and records concerning his client to
204 the attorney, upon request. The role of the attorney shall be to represent the wishes of his client, to the
205 extent possible.

206 F. The petitioner and the person's personal representative, including any agent named in an
207 advance directive executed in accordance with the Health Care Decisions Act (§ 54.1-2981 et seq.) or, if
208 no personal representative exists, the nearest known relative of the person other than the petitioner shall
209 be given adequate notice of the place, date, and time of the commitment hearing. ~~The petitioner~~ Any
210 person given notice pursuant to this subsection shall be entitled to retain counsel at his own expense, to
211 be present during the hearing, and to testify and present evidence. ~~The petitioner~~ Any person given
212 notice pursuant to this subsection shall be encouraged but shall not be required to testify at the hearing,
213 and the person whose involuntary admission is sought shall not be released solely on the basis of the
214 petitioner's, the personal representative's, or the relative's failure to attend or testify during the hearing.

215

#

FOR DISCUSSION PURPOSES ONLY

SENATE BILL NO. _____ HOUSE BILL NO. _____

1 A BILL to amend and reenact §§ 37.2-809 and 37.2-817 of the Code of Virginia, relating to temporary
2 detention; involuntary admission; recommendations of relatives.

3 **Be it enacted by the General Assembly of Virginia:**

4 **1. That §§ 37.2-809 and 37.2-817 of the Code of Virginia are amended and reenacted as follows:**

5 **§ 37.2-809. Involuntary temporary detention; issuance and execution of order.**

6 A. For the purposes of this section:

7 "Designee of the local community services board" means an examiner designated by the local
8 community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has
9 completed a certification program approved by the Department, (iii) is able to provide an independent
10 examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has
11 no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment
12 interest in the facility detaining or admitting the person under this article, and (vii) except for employees
13 of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

14 "Employee" means an employee of the local community services board who is skilled in the
15 assessment and treatment of mental illness and has completed a certification program approved by the
16 Department.

17 "Investment interest" means the ownership or holding of an equity or debt security, including
18 shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other
19 equity or debt instruments.

20 B. A magistrate shall issue, upon the sworn petition of any responsible person, treating
21 physician, or upon his own motion and only after an evaluation conducted in-person or by means of a
22 two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an
23 employee or a designee of the local community services board to determine whether the person meets
24 the criteria for temporary detention, a temporary detention order if it appears from all evidence readily
25 available, including any recommendation from a physician or clinical psychologist treating the person,

26 that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of
27 mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as
28 evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if
29 any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for
30 his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or
31 incapable of volunteering for hospitalization or treatment. The magistrate shall also consider, if
32 available, the recommendations of (a) the person's personal representative, including any agent named in
33 an advance directive executed in accordance with the Health Care Decisions Act (§ 54.1-2981 et seq.),
34 or any relative of the person and (b) any treating or examining physician licensed in Virginia-if available
35 either verbally or in writing prior to rendering a decision. Any temporary detention order entered
36 pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This
37 subsection shall not preclude any other disclosures as required or permitted by law.

38 C. When considering whether there is probable cause to issue a temporary detention order, the
39 magistrate may, in addition to the petition, consider (i) the recommendations of any treating or
40 examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person,
41 (iii) any past mental health treatment of the person, (iv) any relevant hearsay evidence, (v) any medical
42 records available, (vi) any affidavits submitted, if the witness is unavailable and it so states in the
43 affidavit, and (vii) any other information available that the magistrate considers relevant to the
44 determination of whether probable cause exists to issue a temporary detention order.

45 D. A magistrate may issue a temporary detention order without an emergency custody order
46 proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to
47 subsection B if (i) the person has been personally examined within the previous 72 hours by an
48 employee or a designee of the local community services board or (ii) there is a significant physical,
49 psychological, or medical risk to the person or to others associated with conducting such evaluation.

50 E. An employee or a designee of the local community services board shall determine the facility
51 of temporary detention in accordance with the provisions of § 37.2-809.1 for all individuals detained
52 pursuant to this section. An employee or designee of the local community services board may change

53 the facility of temporary detention and may designate an alternative facility for temporary detention at
54 any point during the period of temporary detention if it is determined that the alternative facility is a
55 more appropriate facility for temporary detention of the individual given the specific security, medical,
56 or behavioral health needs of the person. In cases in which the facility of temporary detention is changed
57 following transfer of custody to an initial facility of temporary custody, transportation of the individual
58 to the alternative facility of temporary detention shall be provided in accordance with the provisions of §
59 37.2-810. The initial facility of temporary detention shall be identified on the preadmission screening
60 report and indicated on the temporary detention order; however, if an employee or designee of the local
61 community services board designates an alternative facility, that employee or designee shall provide
62 written notice forthwith, on a form developed by the Executive Secretary of the Supreme Court of
63 Virginia, to the clerk of the issuing court of the name and address of the alternative facility. Subject to
64 the provisions of § 37.2-809.1, if a facility of temporary detention cannot be identified by the time of the
65 expiration of the period of emergency custody pursuant to § 37.2-808, the individual shall be detained in
66 a state facility for the treatment of individuals with mental illness and such facility shall be indicated on
67 the temporary detention order. Except as provided in § 37.2-811 for inmates requiring hospitalization in
68 accordance with subdivision A 2 of § 19.2-169.6, the person shall not be detained in a jail or other place
69 of confinement for persons charged with criminal offenses and shall remain in the custody of law
70 enforcement until the person is either detained within a secure facility or custody has been accepted by
71 the appropriate personnel designated by either the initial facility of temporary detention identified in the
72 temporary detention order or by the alternative facility of temporary detention designated by the
73 employee or designee of the local community services board pursuant to this subsection. The person
74 detained or in custody pursuant to this section shall be given a written summary of the temporary
75 detention procedures and the statutory protections associated with those procedures.

76 F. Any facility caring for a person placed with it pursuant to a temporary detention order is
77 authorized to provide emergency medical and psychiatric services within its capabilities when the
78 facility determines that the services are in the best interests of the person within its care. The costs
79 incurred as a result of the hearings and by the facility in providing services during the period of

80 temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs
81 reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of
82 Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance
83 Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary
84 detention.

85 G. The employee or the designee of the local community services board who is conducting the
86 evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention
87 order, the insurance status of the person. Where coverage by a third party payor exists, the facility
88 seeking reimbursement under this section shall first seek reimbursement from the third party payor. The
89 Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances
90 covered by the third party payor have been received.

91 H. The duration of temporary detention shall be sufficient to allow for completion of the
92 examination required by § 37.2-815, preparation of the preadmission screening report required by §
93 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid
94 involuntary commitment where possible, but shall not exceed 72 hours prior to a hearing. If the 72-hour
95 period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is
96 lawfully closed, the person may be detained, as herein provided, until the close of business on the next
97 day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The
98 person may be released, pursuant to § 37.2-813, before the 72-hour period herein specified has run.

99 I. If a temporary detention order is not executed within 24 hours of its issuance, or within a
100 shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the
101 office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the
102 jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96
103 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a
104 designee of the local community services board prior to issuing a subsequent order upon the original
105 petition. Any petition for which no temporary detention order or other process in connection therewith is

106 served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be
107 returned to the office of the clerk of the issuing court.

108 J. The Executive Secretary of the Supreme Court of Virginia shall establish and require that a
109 magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose
110 of performing the duties established by this section. Each community services board shall provide to
111 each general district court and magistrate's office within its service area a list of its employees and
112 designees who are available to perform the evaluations required herein.

113 K. For purposes of this section, a health care provider or designee of a local community services
114 board or behavioral health authority shall not be required to encrypt any email containing information or
115 medical records provided to a magistrate unless there is reason to believe that a third party will attempt
116 to intercept the email.

117 L. The employee or designee of the community services board who is conducting the evaluation
118 pursuant to this section shall, if he recommends that the person should not be subject to a temporary
119 detention order, inform the petitioner and an onsite treating physician of his recommendation.

120 **§ 37.2-817. Involuntary admission and mandatory outpatient treatment orders.**

121 A. The district court judge or special justice shall render a decision on the petition for
122 involuntary admission after the appointed examiner has presented the report required by § 37.2-815, and
123 after the community services board that serves the county or city where the person resides or, if
124 impractical, where the person is located has presented a preadmission screening report with
125 recommendations for that person's placement, care, and treatment pursuant to § 37.2-816. These reports,
126 if not contested, may constitute sufficient evidence upon which the district court judge or special justice
127 may base his decision. The examiner, if not physically present at the hearing, and the treating physician
128 at the facility of temporary detention shall be available whenever possible for questioning during the
129 hearing through a two-way electronic video and audio or telephonic communication system as
130 authorized in § 37.2-804.1.

131 B. Any employee or designee of the local community services board, as defined in § 37.2-809,
132 representing the community services board that prepared the preadmission screening report shall attend

133 the hearing in person or, if physical attendance is not practicable, shall participate in the hearing through
134 a two-way electronic video and audio or telephonic communication system as authorized in § 37.2-
135 804.1. Where a hearing is held outside of the service area of the community services board that prepared
136 the preadmission screening report, and it is not practicable for a representative of the board to attend or
137 participate in the hearing, arrangements shall be made by the board for an employee or designee of the
138 board serving the area in which the hearing is held to attend or participate on behalf of the board that
139 prepared the preadmission screening report. The employee or designee of the local community services
140 board, as defined in § 37.2-809, representing the community services board that prepared the
141 preadmission screening report or attending or participating on behalf of the board that prepared the
142 preadmission screening report shall not be excluded from the hearing pursuant to an order of
143 sequestration of witnesses. The community services board that prepared the preadmission screening
144 report shall remain responsible for the person subject to the hearing and, prior to the hearing, shall send
145 the preadmission screening report through certified mail, personal delivery, facsimile with return receipt
146 acknowledged, or other electronic means to the community services board attending the hearing. Where
147 a community services board attends the hearing on behalf of the community services board that prepared
148 the preadmission screening report, the attending community services board shall inform the community
149 services board that prepared the preadmission screening report of the disposition of the matter upon the
150 conclusion of the hearing. In addition, the attending community services board shall transmit the
151 disposition through certified mail, personal delivery, facsimile with return receipt acknowledged, or
152 other electronic means.

153 At least 12 hours prior to the hearing, the court shall provide to the community services board
154 that prepared the preadmission screening report the time and location of the hearing. If the representative
155 of the community services board will be present by telephonic means, the court shall provide the
156 telephone number to the board.

157 C. After observing the person and considering (i) the recommendations of any treating or
158 examining physician or psychologist licensed in Virginia, if available, (ii) the recommendations of the
159 person's personal representative, including any agent named in an advance directive executed in

160 accordance with the Health Care Decisions Act (§ 54.1-2981 et seq.), or any relative of the person, (iii)
161 any past actions of the person, ~~(iii)~~ (iv) any past mental health treatment of the person, ~~(iv)~~ (v) any
162 examiner's certification, ~~(v)~~ (vi) any health records available, ~~(vi)~~ (vii) the preadmission screening
163 report, and ~~(vii)~~ (viii) any other relevant evidence that may have been admitted, including whether the
164 person recently has been found unrestorably incompetent to stand trial after a hearing held pursuant to
165 subsection E of § 19.2-169.1, if the judge or special justice finds by clear and convincing evidence that
166 (a) the person has a mental illness and there is a substantial likelihood that, as a result of mental illness,
167 the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by
168 recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (2)
169 suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic
170 human needs, and (b) all available less restrictive treatment alternatives to involuntary inpatient
171 treatment, pursuant to subsection D, that would offer an opportunity for the improvement of the person's
172 condition have been investigated and determined to be inappropriate, the judge or special justice shall by
173 written order and specific findings so certify and order that the person be admitted involuntarily to a
174 facility for a period of treatment not to exceed 30 days from the date of the court order. Such involuntary
175 admission shall be to a facility designated by the community services board that serves the county or
176 city in which the person was examined as provided in § 37.2-816. If the community services board does
177 not designate a facility at the commitment hearing, the person shall be involuntarily admitted to a
178 facility designated by the Commissioner. Upon the expiration of an order for involuntary admission, the
179 person shall be released unless he is involuntarily admitted by further petition and order of a court,
180 which shall be for a period not to exceed 180 days from the date of the subsequent court order, or such
181 person makes application for treatment on a voluntary basis as provided for in § 37.2-805 or is ordered
182 to mandatory outpatient treatment pursuant to subsection D. Upon motion of the treating physician, a
183 family member or personal representative of the person, or the community services board serving the
184 county or city where the facility is located, the county or city where the person resides, or the county or
185 city where the person receives treatment, a hearing shall be held prior to the release date of any
186 involuntarily admitted person to determine whether such person should be ordered to mandatory

187 outpatient treatment pursuant to subsection D upon his release if such person, on at least two previous
188 occasions within 36 months preceding the date of the hearing, has been (A) involuntarily admitted
189 pursuant to this section or (B) the subject of a temporary detention order and voluntarily admitted
190 himself in accordance with subsection B of § 37.2-814. A district court judge or special justice shall
191 hold the hearing within 72 hours after receiving the motion for a mandatory outpatient treatment order;
192 however, if the 72-hour period expires on a Saturday, Sunday, or legal holiday, the hearing shall be held
193 by the close of business on the next day that is not a Saturday, Sunday, or legal holiday.

194 C1. In the order for involuntary admission, the judge or special justice may authorize the treating
195 physician to discharge the person to mandatory outpatient treatment under a discharge plan developed
196 pursuant to subsection C2, if the judge or special justice further finds by clear and convincing evidence
197 that (i) the person has a history of lack of compliance with treatment for mental illness that at least twice
198 within the past 36 months has resulted in the person being subject to an order for involuntary admission
199 pursuant to subsection C; (ii) in view of the person's treatment history and current behavior, the person
200 is in need of mandatory outpatient treatment following inpatient treatment in order to prevent a relapse
201 or deterioration that would be likely to result in the person meeting the criteria for involuntary inpatient
202 treatment; (iii) as a result of mental illness, the person is unlikely to voluntarily participate in outpatient
203 treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment
204 following inpatient treatment; and (iv) the person is likely to benefit from mandatory outpatient
205 treatment. The duration of mandatory outpatient treatment shall be determined by the court based on
206 recommendations of the community services board, but shall not exceed 90 days. Upon expiration of the
207 order for mandatory outpatient treatment, the person shall be released unless the order is continued in
208 accordance with § 37.2-817.4.

209 C2. Prior to discharging the person to mandatory outpatient treatment under a discharge plan as
210 authorized pursuant to subsection C1, the treating physician shall determine, based upon his professional
211 judgment, that (i) the person (a) in view of the person's treatment history and current behavior, no longer
212 needs inpatient hospitalization, (b) requires mandatory outpatient treatment at the time of discharge to
213 prevent relapse or deterioration of his condition that would likely result in his meeting the criteria for

214 involuntary inpatient treatment, and (c) has agreed to abide by his discharge plan and has the ability to
215 do so; and (ii) the ordered treatment will be delivered on an outpatient basis by the community services
216 board or designated provider to the person. In no event shall the treating physician discharge a person to
217 mandatory outpatient treatment under a discharge plan as authorized pursuant to subsection C1 if the
218 person meets the criteria for involuntary commitment set forth in subsection C. The discharge plan
219 developed by the treating physician and facility staff in conjunction with the community services board
220 and the person shall serve as and shall contain all the components of the comprehensive mandatory
221 outpatient treatment plan set forth in subsection G, and no initial mandatory outpatient treatment plan set
222 forth in subsection F shall be required. The discharge plan shall be submitted to the court for approval
223 and, upon approval by the court, shall be filed and incorporated into the order entered pursuant to
224 subsection C1. The discharge plan shall be provided to the person by the community services board at
225 the time of the person's discharge from the inpatient facility. The community services board where the
226 person resides upon discharge shall monitor the person's compliance with the discharge plan and report
227 any material noncompliance to the court in accordance with § 37.2-817.1.

228 D. After observing the person and considering (i) the recommendations of any treating or
229 examining physician or psychologist licensed in Virginia, if available, (ii) the recommendations of the
230 person's personal representative, including any agent named in an advance directive executed in
231 accordance with the Health Care Decisions Act (§ 54.1-2981 et seq.), or any relative of the person, (iii)
232 any past actions of the person, ~~(iii)~~ (iv) any past mental health treatment of the person, ~~(iv)~~ (v) any
233 examiner's certification, ~~(v)~~ (vi) any health records available, ~~(vi)~~ (vii) the preadmission screening
234 report, and ~~(vii)~~ (viii) any other relevant evidence that may have been admitted, if the judge or special
235 justice finds by clear and convincing evidence that (a) the person has a mental illness and that there
236 exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1)
237 cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or
238 threatening harm and other relevant information, if any, or (2) suffer serious harm due to his lack of
239 capacity to protect himself from harm or to provide for his basic human needs; (b) less restrictive
240 alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his

241 condition have been investigated and are determined to be appropriate; (c) the person has agreed to
242 abide by his treatment plan and has the ability to do so; and (d) the ordered treatment will be delivered
243 on an outpatient basis by the community services board or designated provider to the person, the judge
244 or special justice shall by written order and specific findings so certify and order that the person be
245 admitted involuntarily to mandatory outpatient treatment. Less restrictive alternatives shall not be
246 determined to be appropriate unless the services are actually available in the community.

247 E. Mandatory outpatient treatment may include day treatment in a hospital, night treatment in a
248 hospital, outpatient involuntary treatment with anti-psychotic medication pursuant to Chapter 11 (§ 37.2-
249 1100 et seq.), or other appropriate course of treatment as may be necessary to meet the needs of the
250 person. Mandatory outpatient treatment shall not include the use of restraints or physical force of any
251 kind in the provision of the medication. The community services board that serves the county or city in
252 which the person resides shall recommend a specific course of treatment and programs for the provision
253 of mandatory outpatient treatment. The duration of mandatory outpatient treatment shall be determined
254 by the court based on recommendations of the community services board, but shall not exceed 90 days.
255 Upon expiration of an order for mandatory outpatient treatment, the person shall be released from the
256 requirements of the order unless the order is continued in accordance with § 37.2-817.4.

257 F. Any order for mandatory outpatient treatment entered pursuant to subsection D shall include
258 an initial mandatory outpatient treatment plan developed by the community services board that
259 completed the preadmission screening report. The plan shall, at a minimum, (i) identify the specific
260 services to be provided, (ii) identify the provider who has agreed to provide each service, (iii) describe
261 the arrangements made for the initial in-person appointment or contact with each service provider, and
262 (iv) include any other relevant information that may be available regarding the mandatory outpatient
263 treatment ordered. The order shall require the community services board to monitor the implementation
264 of the mandatory outpatient treatment plan and report any material noncompliance to the court.

265 G. No later than five days, excluding Saturdays, Sundays, or legal holidays, after an order for
266 mandatory outpatient treatment has been entered pursuant to subsection D, the community services
267 board where the person resides that is responsible for monitoring compliance with the order shall file a

268 comprehensive mandatory outpatient treatment plan. The comprehensive mandatory outpatient treatment
269 plan shall (i) identify the specific type, amount, duration, and frequency of each service to be provided
270 to the person, (ii) identify the provider that has agreed to provide each service included in the plan, (iii)
271 certify that the services are the most appropriate and least restrictive treatment available for the person,
272 (iv) certify that each provider has complied and continues to comply with applicable provisions of the
273 Department's licensing regulations, (v) be developed with the fullest possible involvement and
274 participation of the person and his family, with the person's consent, and reflect his preferences to the
275 greatest extent possible to support his recovery and self-determination, (vi) specify the particular
276 conditions with which the person shall be required to comply, and (vii) describe how the community
277 services board shall monitor the person's compliance with the plan and report any material
278 noncompliance with the plan. The community services board shall submit the comprehensive mandatory
279 outpatient treatment plan to the court for approval. Upon approval by the court, the comprehensive
280 mandatory outpatient treatment plan shall be filed with the court and incorporated into the order of
281 mandatory outpatient treatment. Any subsequent substantive modifications to the plan shall be filed with
282 the court for review and attached to any order for mandatory outpatient treatment.

283 H. If the community services board responsible for developing the comprehensive mandatory
284 outpatient treatment plan determines that the services necessary for the treatment of the person's mental
285 illness are not available or cannot be provided to the person in accordance with the order for mandatory
286 outpatient treatment, it shall notify the court within five business days of the entry of the order for
287 mandatory outpatient treatment. Within two business days of receiving such notice, the judge or special
288 justice, after notice to the person, the person's attorney, and the community services board responsible
289 for developing the comprehensive mandatory outpatient treatment plan shall hold a hearing pursuant to §
290 37.2-817.2.

291 I. Upon entry of any order for mandatory outpatient treatment entered pursuant to subsection D,
292 the clerk of the court shall provide a copy of the order to the person who is the subject of the order, to
293 his attorney, and to the community services board required to monitor compliance with the plan. The
294 community services board shall acknowledge receipt of the order to the clerk of the court on a form

295 established by the Office of the Executive Secretary of the Supreme Court and provided by the court for
296 this purpose within five business days.

297 J. The court may transfer jurisdiction of the case to the district court where the person resides at
298 any time after the entry of the mandatory outpatient treatment order. The community services board
299 responsible for monitoring compliance with the mandatory outpatient treatment plan or discharge plan
300 shall remain responsible for monitoring the person's compliance with the plan until the community
301 services board serving the locality to which jurisdiction of the case has been transferred acknowledges
302 the transfer and receipt of the order to the clerk of the court on a form established by the Office of the
303 Executive Secretary of the Supreme Court and provided by the court for this purpose. The community
304 services board serving the locality to which jurisdiction of the case has been transferred shall
305 acknowledge the transfer and receipt of the order within five business days.

306 K. Any order entered pursuant to this section shall provide for the disclosure of medical records
307 pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or
308 permitted by law.

309 #

SENATE BILL NO. _____ HOUSE BILL NO. _____

1 A BILL to amend and reenact §§ 37.2-809 and 37.2-816 of the Code of Virginia, relating to local
2 community services boards; contents of evaluation or preadmission screening report.

3 **Be it enacted by the General Assembly of Virginia:**

4 **1. That §§ 37.2-809 and 37.2-816 of the Code of Virginia are amended and reenacted as follows:**

5 **§ 37.2-809. Involuntary temporary detention; issuance and execution of order.**

6 A. For the purposes of this section:

7 "Designee of the local community services board" means an examiner designated by the local
8 community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has
9 completed a certification program approved by the Department, (iii) is able to provide an independent
10 examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has
11 no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment
12 interest in the facility detaining or admitting the person under this article, and (vii) except for employees
13 of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

14 "Employee" means an employee of the local community services board who is skilled in the
15 assessment and treatment of mental illness and has completed a certification program approved by the
16 Department.

17 "Investment interest" means the ownership or holding of an equity or debt security, including
18 shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other
19 equity or debt instruments.

20 B. A magistrate shall issue, upon the sworn petition of any responsible person, treating
21 physician, or upon his own motion and only after an evaluation conducted in-person or by means of a
22 two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an
23 employee or a designee of the local community services board to determine whether the person meets
24 the criteria for temporary detention, a temporary detention order if it appears from all evidence readily
25 available, including any recommendation from a physician or clinical psychologist treating the person,

26 that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of
27 mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as
28 evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if
29 any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for
30 his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or
31 incapable of volunteering for hospitalization or treatment. The magistrate shall also consider the
32 recommendations of any treating or examining physician licensed in Virginia if available either verbally
33 or in writing prior to rendering a decision. Any temporary detention order entered pursuant to this
34 section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection
35 shall not preclude any other disclosures as required or permitted by law.

36 C. When considering whether there is probable cause to issue a temporary detention order, the
37 magistrate may, in addition to the petition, consider (i) the recommendations of any treating or
38 examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person,
39 (iii) any past mental health treatment of the person, (iv) any relevant hearsay evidence, (v) any medical
40 records available, (vi) any affidavits submitted, if the witness is unavailable and it so states in the
41 affidavit, and (vii) any other information available that the magistrate considers relevant to the
42 determination of whether probable cause exists to issue a temporary detention order.

43 D. A magistrate may issue a temporary detention order without an emergency custody order
44 proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to
45 subsection B if (i) the person has been personally examined within the previous 72 hours by an
46 employee or a designee of the local community services board or (ii) there is a significant physical,
47 psychological, or medical risk to the person or to others associated with conducting such evaluation.

48 E. An employee or a designee of the local community services board shall determine the facility
49 of temporary detention in accordance with the provisions of § 37.2-809.1 for all individuals detained
50 pursuant to this section. An employee or designee of the local community services board may change
51 the facility of temporary detention and may designate an alternative facility for temporary detention at
52 any point during the period of temporary detention if it is determined that the alternative facility is a

53 more appropriate facility for temporary detention of the individual given the specific security, medical,
54 or behavioral health needs of the person. In cases in which the facility of temporary detention is changed
55 following transfer of custody to an initial facility of temporary custody, transportation of the individual
56 to the alternative facility of temporary detention shall be provided in accordance with the provisions of §
57 37.2-810. The initial facility of temporary detention shall be identified on the preadmission screening
58 report and indicated on the temporary detention order; however, if an employee or designee of the local
59 community services board designates an alternative facility, that employee or designee shall provide
60 written notice forthwith, on a form developed by the Executive Secretary of the Supreme Court of
61 Virginia, to the clerk of the issuing court of the name and address of the alternative facility. Subject to
62 the provisions of § 37.2-809.1, if a facility of temporary detention cannot be identified by the time of the
63 expiration of the period of emergency custody pursuant to § 37.2-808, the individual shall be detained in
64 a state facility for the treatment of individuals with mental illness and such facility shall be indicated on
65 the temporary detention order. Except as provided in § 37.2-811 for inmates requiring hospitalization in
66 accordance with subdivision A 2 of § 19.2-169.6, the person shall not be detained in a jail or other place
67 of confinement for persons charged with criminal offenses and shall remain in the custody of law
68 enforcement until the person is either detained within a secure facility or custody has been accepted by
69 the appropriate personnel designated by either the initial facility of temporary detention identified in the
70 temporary detention order or by the alternative facility of temporary detention designated by the
71 employee or designee of the local community services board pursuant to this subsection. The person
72 detained or in custody pursuant to this section shall be given a written summary of the temporary
73 detention procedures and the statutory protections associated with those procedures.

74 F. Any facility caring for a person placed with it pursuant to a temporary detention order is
75 authorized to provide emergency medical and psychiatric services within its capabilities when the
76 facility determines that the services are in the best interests of the person within its care. The costs
77 incurred as a result of the hearings and by the facility in providing services during the period of
78 temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs
79 reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of

80 Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance
81 Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary
82 detention.

83 G. The employee or the designee of the local community services board who is conducting the
84 evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention
85 order, the insurance status of the person. Where coverage by a third party payor exists, the facility
86 seeking reimbursement under this section shall first seek reimbursement from the third party payor. The
87 Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances
88 covered by the third party payor have been received.

89 H. The duration of temporary detention shall be sufficient to allow for completion of the
90 examination required by § 37.2-815, preparation of the preadmission screening report required by §
91 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid
92 involuntary commitment where possible, but shall not exceed 72 hours prior to a hearing. If the 72-hour
93 period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is
94 lawfully closed, the person may be detained, as herein provided, until the close of business on the next
95 day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The
96 person may be released, pursuant to § 37.2-813, before the 72-hour period herein specified has run.

97 I. If a temporary detention order is not executed within 24 hours of its issuance, or within a
98 shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the
99 office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the
100 jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96
101 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a
102 designee of the local community services board prior to issuing a subsequent order upon the original
103 petition. Any petition for which no temporary detention order or other process in connection therewith is
104 served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be
105 returned to the office of the clerk of the issuing court.

106 J. The Executive Secretary of the Supreme Court of Virginia shall establish and require that a
107 magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose
108 of performing the duties established by this section. Each community services board shall provide to
109 each general district court and magistrate's office within its service area a list of its employees and
110 designees who are available to perform the evaluations required herein.

111 K. For purposes of this section, a health care provider or designee of a local community services
112 board or behavioral health authority shall not be required to encrypt any email containing information or
113 medical records provided to a magistrate unless there is reason to believe that a third party will attempt
114 to intercept the email.

115 L. The employee or designee of the community services board who is conducting the evaluation
116 pursuant to this section shall, if he recommends that the person should not be subject to a temporary
117 detention order, inform the petitioner and an onsite treating physician of his recommendation. If the
118 employee or designee of the local community services board recommends that the person should not be
119 subject to a temporary detention order, the employee or designee of the local community services board
120 shall include in his evaluation, if available, any recommendations of (i) the person's personal
121 representative, including any agent named in an advance directive executed in accordance with the
122 Health Care Decisions Act (§ 54.1-2981 et seq.), or any relative of the person and (ii) any treating or
123 examining physician licensed in Virginia that are contrary to the recommendations of the employee or
124 designee of the local community services board.

125 **§ 37.2-816. Commitment hearing for involuntary admission; preadmission screening**
126 **report.**

127 The district court judge or special justice shall require a preadmission screening report from the
128 community services board that serves the county or city where the person resides or, if impractical,
129 where the person is located. The report shall be admitted as evidence of the facts stated therein and shall
130 state (i) whether the person has a mental illness and whether there exists a substantial likelihood that, as
131 a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or
132 others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant

133 information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or
134 to provide for his basic human needs, (ii) whether the person is in need of involuntary inpatient
135 treatment, (iii) whether there is no less restrictive alternative to inpatient treatment, and (iv) the
136 recommendations for that person's placement, care, and treatment including, where appropriate,
137 recommendations for mandatory outpatient treatment. If the employee or designee of the local
138 community services board recommends that the person is not in need of involuntary treatment, the
139 employee or designee of the local community services board shall include in the report, if available, any
140 recommendations of (a) the person's personal representative, including any agent named in an advance
141 directive executed in accordance with the Health Care Decisions Act (§ 54.1-2981 et seq.), or any
142 relative of the person and (b) any treating or examining physician licensed in Virginia that are contrary
143 to the recommendations of the employee or designee of the local community services board. The board
144 shall provide the preadmission screening report to the court prior to the hearing, and the report shall be
145 admitted into evidence and made part of the record of the case. In the case of a person who has been
146 sentenced and committed to the Department of Corrections and who has been examined by a psychiatrist
147 or clinical psychologist, the judge or special justice may proceed to adjudicate whether the person has
148 mental illness and should be involuntarily admitted without requesting a preadmission screening report
149 from the community services board.

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SENATE BILL NO. _____ HOUSE BILL NO. _____

1 A BILL to amend and reenact §§ 37.2-809 and 37.2-816 of the Code of Virginia, relating to temporary
2 detention and involuntary admission; access to medical records.

3 **Be it enacted by the General Assembly of Virginia:**

4 **1. That §§ 37.2-809 and 37.2-816 of the Code of Virginia are amended and reenacted as follows:**

5 **§ 37.2-809. Involuntary temporary detention; issuance and execution of order.**

6 A. For the purposes of this section:

7 "Designee of the local community services board" means an examiner designated by the local
8 community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has
9 completed a certification program approved by the Department, (iii) is able to provide an independent
10 examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has
11 no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment
12 interest in the facility detaining or admitting the person under this article, and (vii) except for employees
13 of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

14 "Employee" means an employee of the local community services board who is skilled in the
15 assessment and treatment of mental illness and has completed a certification program approved by the
16 Department.

17 "Investment interest" means the ownership or holding of an equity or debt security, including
18 shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other
19 equity or debt instruments.

20 B. A magistrate shall issue, upon the sworn petition of any responsible person, treating
21 physician, or upon his own motion and only after an evaluation conducted in-person or by means of a
22 two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an
23 employee or a designee of the local community services board to determine whether the person meets
24 the criteria for temporary detention, a temporary detention order if it appears from all evidence readily
25 available, including any recommendation from a physician or clinical psychologist treating the person,

26 that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of
27 mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as
28 evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if
29 any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for
30 his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or
31 incapable of volunteering for hospitalization or treatment. The magistrate shall also consider the
32 recommendations of any treating or examining physician licensed in Virginia if available either verbally
33 or in writing prior to rendering a decision. Any temporary detention order entered pursuant to this
34 section shall provide for the disclosure of medical records pursuant to § 37.2-804.2, and the employee or
35 designee of the local community services board who is conducting the evaluation shall request the
36 disclosure of any medical records that are not in the possession of the employee or designee of the local
37 community services board from any health care provider, as defined in § 32.1-127.1:03, who the
38 employee or designee of the local community services board knows has provided or is currently
39 providing services to the person. The employee or designee of the local community services board shall
40 provide any medical records disclosed to him to the magistrate. This subsection shall not preclude any
41 other disclosures as required or permitted by law.

42 C. When considering whether there is probable cause to issue a temporary detention order, the
43 magistrate may, in addition to the petition, consider (i) the recommendations of any treating or
44 examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person,
45 (iii) any past mental health treatment of the person, (iv) any relevant hearsay evidence, (v) any medical
46 records available, (vi) any affidavits submitted, if the witness is unavailable and it so states in the
47 affidavit, and (vii) any other information available that the magistrate considers relevant to the
48 determination of whether probable cause exists to issue a temporary detention order.

49 D. A magistrate may issue a temporary detention order without an emergency custody order
50 proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to
51 subsection B if (i) the person has been personally examined within the previous 72 hours by an

52 employee or a designee of the local community services board or (ii) there is a significant physical,
53 psychological, or medical risk to the person or to others associated with conducting such evaluation.

54 E. An employee or a designee of the local community services board shall determine the facility
55 of temporary detention in accordance with the provisions of § 37.2-809.1 for all individuals detained
56 pursuant to this section. An employee or designee of the local community services board may change
57 the facility of temporary detention and may designate an alternative facility for temporary detention at
58 any point during the period of temporary detention if it is determined that the alternative facility is a
59 more appropriate facility for temporary detention of the individual given the specific security, medical,
60 or behavioral health needs of the person. In cases in which the facility of temporary detention is changed
61 following transfer of custody to an initial facility of temporary custody, transportation of the individual
62 to the alternative facility of temporary detention shall be provided in accordance with the provisions of §
63 37.2-810. The initial facility of temporary detention shall be identified on the preadmission screening
64 report and indicated on the temporary detention order; however, if an employee or designee of the local
65 community services board designates an alternative facility, that employee or designee shall provide
66 written notice forthwith, on a form developed by the Executive Secretary of the Supreme Court of
67 Virginia, to the clerk of the issuing court of the name and address of the alternative facility. Subject to
68 the provisions of § 37.2-809.1, if a facility of temporary detention cannot be identified by the time of the
69 expiration of the period of emergency custody pursuant to § 37.2-808, the individual shall be detained in
70 a state facility for the treatment of individuals with mental illness and such facility shall be indicated on
71 the temporary detention order. Except as provided in § 37.2-811 for inmates requiring hospitalization in
72 accordance with subdivision A 2 of § 19.2-169.6, the person shall not be detained in a jail or other place
73 of confinement for persons charged with criminal offenses and shall remain in the custody of law
74 enforcement until the person is either detained within a secure facility or custody has been accepted by
75 the appropriate personnel designated by either the initial facility of temporary detention identified in the
76 temporary detention order or by the alternative facility of temporary detention designated by the
77 employee or designee of the local community services board pursuant to this subsection. The person

78 detained or in custody pursuant to this section shall be given a written summary of the temporary
79 detention procedures and the statutory protections associated with those procedures.

80 F. Any facility caring for a person placed with it pursuant to a temporary detention order is
81 authorized to provide emergency medical and psychiatric services within its capabilities when the
82 facility determines that the services are in the best interests of the person within its care. The costs
83 incurred as a result of the hearings and by the facility in providing services during the period of
84 temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs
85 reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of
86 Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance
87 Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary
88 detention.

89 G. The employee or the designee of the local community services board who is conducting the
90 evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention
91 order, the insurance status of the person. Where coverage by a third party payor exists, the facility
92 seeking reimbursement under this section shall first seek reimbursement from the third party payor. The
93 Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances
94 covered by the third party payor have been received.

95 H. The duration of temporary detention shall be sufficient to allow for completion of the
96 examination required by § 37.2-815, preparation of the preadmission screening report required by §
97 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid
98 involuntary commitment where possible, but shall not exceed 72 hours prior to a hearing. If the 72-hour
99 period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is
100 lawfully closed, the person may be detained, as herein provided, until the close of business on the next
101 day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The
102 person may be released, pursuant to § 37.2-813, before the 72-hour period herein specified has run.

103 I. If a temporary detention order is not executed within 24 hours of its issuance, or within a
104 shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the

105 office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the
106 jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96
107 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a
108 designee of the local community services board prior to issuing a subsequent order upon the original
109 petition. Any petition for which no temporary detention order or other process in connection therewith is
110 served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be
111 returned to the office of the clerk of the issuing court.

112 J. The Executive Secretary of the Supreme Court of Virginia shall establish and require that a
113 magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose
114 of performing the duties established by this section. Each community services board shall provide to
115 each general district court and magistrate's office within its service area a list of its employees and
116 designees who are available to perform the evaluations required herein.

117 K. For purposes of this section, a health care provider or designee of a local community services
118 board or behavioral health authority shall not be required to encrypt any email containing information or
119 medical records provided to a magistrate unless there is reason to believe that a third party will attempt
120 to intercept the email.

121 L. The employee or designee of the community services board who is conducting the evaluation
122 pursuant to this section shall, if he recommends that the person should not be subject to a temporary
123 detention order, inform the petitioner and an onsite treating physician of his recommendation.

124 **§ 37.2-816. Commitment hearing for involuntary admission; preadmission screening**
125 **report.**

126 The district court judge or special justice shall require a preadmission screening report from the
127 community services board that serves the county or city where the person resides or, if impractical,
128 where the person is located. The report shall be admitted as evidence of the facts stated therein and shall
129 state (i) whether the person has a mental illness and whether there exists a substantial likelihood that, as
130 a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or
131 others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant

132 information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or
133 to provide for his basic human needs, (ii) whether the person is in need of involuntary inpatient
134 treatment, (iii) whether there is no less restrictive alternative to inpatient treatment, and (iv) the
135 recommendations for that person's placement, care, and treatment including, where appropriate,
136 recommendations for mandatory outpatient treatment. In preparing the preadmission screening report,
137 the board shall request the disclosure of any medical records that are not in the possession of the board
138 from any health care provider, as defined in § 32.1-127.1:03, who the board knows has provided or is
139 currently providing services to the person. The board shall include any medical records disclosed to it in
140 the preadmission screening report provided to the court. The board shall provide the preadmission
141 screening report to the court prior to the hearing, and the report shall be admitted into evidence and
142 made part of the record of the case. In the case of a person who has been sentenced and committed to the
143 Department of Corrections and who has been examined by a psychiatrist or clinical psychologist, the
144 judge or special justice may proceed to adjudicate whether the person has mental illness and should be
145 involuntarily admitted without requesting a preadmission screening report from the community services
146 board.

147 #

SENATE BILL NO. _____ HOUSE BILL NO. _____

1 A BILL to amend and reenact § 19.2-169.6 of the Code of Virginia, relating to involuntary psychiatric
2 admission from local correctional facility.

3 **Be it enacted by the General Assembly of Virginia:**

4 **1. That § 19.2-169.6 of the Code of Virginia is amended and reenacted as follows:**

5 **§ 19.2-169.6. Inpatient psychiatric hospital admission from local correctional facility.**

6 A. Any inmate of a local correctional facility who is not subject to the provisions of § 19.2-169.2
7 may be hospitalized for psychiatric treatment at a hospital designated by the Commissioner of
8 Behavioral Health and Developmental Services as appropriate for treatment of persons under criminal
9 charge if:

10 1. The court with jurisdiction over the inmate's case, if it is still pending, on the petition of the
11 person having custody over an inmate or on its own motion, holds a hearing at which the inmate is
12 represented by counsel and finds by clear and convincing evidence that (i) the inmate has a mental
13 illness; (ii) there exists a substantial likelihood that, as a result of a mental illness, the inmate will, in the
14 near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior
15 causing, attempting, or threatening harm and any other relevant information or (b) suffer serious harm
16 due to his lack of capacity to protect himself from harm as evidenced by recent behavior and any other
17 relevant information; and (iii) the inmate requires treatment in a hospital rather than the local
18 correctional facility. Prior to making this determination, the court shall consider the examination
19 conducted in accordance with § 37.2-815 and the preadmission screening report prepared in accordance
20 with § 37.2-816 and conducted in-person or by means of a two-way electronic video and audio
21 communication system as authorized in § 37.2-804.1 by an employee or designee of the local
22 community services board or behavioral health authority who is skilled in the assessment and treatment
23 of mental illness, who is not providing treatment to the inmate, and who has completed a certification
24 program approved by the Department of Behavioral Health and Developmental Services as provided in
25 § 37.2-809. The examiner appointed pursuant to § 37.2-815, if not physically present at the hearing,

26 shall be available whenever possible for questioning during the hearing through a two-way electronic
27 video and audio or telephonic communication system as authorized in § 37.2-804.1. Any employee or
28 designee of the local community services board or behavioral health authority, as defined in § 37.2-809,
29 representing the board or authority that prepared the preadmission screening report shall attend the
30 hearing in person or, if physical attendance is not practicable, shall participate in the hearing through a
31 two-way electronic video and audio communication system as authorized in § 37.2-804.1. When the
32 hearing is held outside the service area of the community services board or behavioral health authority
33 that prepared the preadmission screening report, and it is not practicable for a representative of the board
34 or authority to attend or participate in the hearing, arrangements shall be made by the board or authority
35 for an employee or designee of the board or authority serving the area in which the hearing is held to
36 attend or participate on behalf of the board or authority that prepared the preadmission screening report;
37 or

38 2. Upon petition by the person having custody over an inmate, a magistrate finds probable cause
39 to believe that (i) the inmate has a mental illness; (ii) there exists a substantial likelihood that, as a result
40 of a mental illness, the inmate will, in the near future, (a) cause serious physical harm to himself or
41 others as evidenced by recent behavior causing, attempting, or threatening harm and any other relevant
42 information or (b) suffer serious harm due to his lack of capacity to protect himself from harm as
43 evidenced by recent behavior and any other relevant information; and (iii) the inmate requires treatment
44 in a hospital rather than a local correctional facility, and the magistrate issues a temporary detention
45 order for the inmate. Prior to the filing of the petition, the person having custody shall arrange for an
46 evaluation of the inmate conducted in-person or by means of a two-way electronic video and audio
47 communication system as authorized in § 37.2-804.1 by an employee or designee of the local
48 community services board or behavioral health authority who is skilled in the assessment and treatment
49 of mental illness and who has completed a certification program approved by the Department as
50 provided in § 37.2-809. After considering the evaluation of the employee or designee of the local
51 community services board or behavioral health authority, and any other information presented, and
52 finding that probable cause exists to meet the criteria, the magistrate may issue a temporary detention

53 order in accordance with the applicable procedures specified in §§ 37.2-809 through 37.2-813. The
54 person having custody over the inmate shall notify the court having jurisdiction over the inmate's case, if
55 it is still pending, and the inmate's attorney prior to the detention pursuant to a temporary detention order
56 or as soon thereafter as is reasonable.

57 Upon detention pursuant to this subdivision, a hearing shall be held either before the court
58 having jurisdiction over the inmate's case or before a district court judge or a special justice, as defined
59 in § 37.2-100, in accordance with the provisions of §§ 37.2-815 through 37.2-821, in which case the
60 inmate shall be represented by counsel as specified in § 37.2-814. The hearing shall be held within 72
61 hours of execution of the temporary detention order issued pursuant to this subdivision. If the 72-hour
62 period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the
63 inmate may be detained until the close of business on the next day that is not a Saturday, Sunday, legal
64 holiday, or day on which the court is lawfully closed. Any employee or designee of the local community
65 services board or behavioral health authority, as defined in § 37.2-809, representing the board or
66 authority that prepared the preadmission screening report shall attend the hearing in person or, if
67 physical attendance is not practicable, shall participate in the hearing through a two-way electronic
68 video and audio communication system as authorized in § 37.2-804.1. When the hearing is held outside
69 the service area of the community services board or behavioral health authority that prepared the
70 preadmission screening report, and it is not practicable for a representative of the board or authority to
71 attend or participate in the hearing, arrangements shall be made by the board or authority for an
72 employee or designee of the board or authority serving the area in which the hearing is held to attend or
73 participate on behalf of the board or authority that prepared the preadmission screening report. The
74 judge or special justice conducting the hearing may order the inmate hospitalized if, after considering
75 the examination conducted in accordance with § 37.2-815, the preadmission screening report prepared in
76 accordance with § 37.2-816, and any other available information as specified in subsection C of § 37.2-
77 817, he finds by clear and convincing evidence that (1) the inmate has a mental illness; (2) there exists a
78 substantial likelihood that, as a result of a mental illness, the inmate will, in the near future, (a) cause
79 serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or

80 threatening harm and any other relevant information or (b) suffer serious harm due to his lack of
81 capacity to protect himself from harm as evidenced by recent behavior and any other relevant
82 information; and (3) the inmate requires treatment in a hospital rather than a local correctional facility.
83 The examiner appointed pursuant to § 37.2-815, if not physically present at the hearing, shall be
84 available whenever possible for questioning during the hearing through a two-way electronic video and
85 audio or telephonic communication system as authorized in § 37.2-804.1. The examination and the
86 preadmission screening report shall be admitted into evidence at the hearing.

87 B. In no event shall an inmate have the right to make application for voluntary admission as may
88 be otherwise provided in § 37.2-805 or 37.2-814 or be subject to an order for mandatory outpatient
89 treatment as provided in § 37.2-817.

90 C. If an inmate is hospitalized pursuant to this section and his criminal case is still pending, the
91 court having jurisdiction over the inmate's case may order that the admitting hospital evaluate the
92 inmate's competency to stand trial and his mental state at the time of the offense pursuant to §§ 19.2-
93 169.1 and 19.2-169.5.

94 D. An inmate may not be hospitalized longer than 30 days under subsection A unless the court
95 which has criminal jurisdiction over him or a district court judge or a special justice, as defined in §
96 37.2-100, holds a hearing and orders the inmate's continued hospitalization in accordance with the
97 provisions of subdivision A 2. If the inmate's hospitalization is continued under this subsection by a
98 court other than the court which has jurisdiction over his criminal case, the facility at which the inmate
99 is hospitalized shall notify the court with jurisdiction over his criminal case and the inmate's attorney in
100 the criminal case, if the case is still pending.

101 E. Hospitalization may be extended in accordance with subsection D for periods of 60 days for
102 inmates awaiting trial, but in no event may such hospitalization be continued beyond trial, nor shall such
103 hospitalization act to delay trial, as long as the inmate remains competent to stand trial. Hospitalization
104 may be extended in accordance with subsection D for periods of 180 days for an inmate who has been
105 convicted and not yet sentenced, or for an inmate who has been convicted of a crime and is in the
106 custody of a local correctional facility after sentencing, but in no event may such hospitalization be

107 continued beyond the date upon which his sentence would have expired had he received the maximum
108 sentence for the crime charged. Any inmate who has not completed service of his sentence upon
109 discharge from the hospital shall serve the remainder of his sentence.

110 F. For any inmate who has been convicted and not yet sentenced, or who has been convicted of a
111 crime and is in the custody of a local correctional facility after sentencing, the time the inmate is
112 confined in a hospital for psychiatric treatment shall be deducted from any term for which he may be
113 sentenced to any penal institution, reformatory or elsewhere.

114 G. Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services
115 to an inmate who is the subject of a proceeding under this section, upon request, shall disclose to a
116 magistrate, the court, the inmate's attorney, the inmate's guardian ad litem, the examiner appointed
117 pursuant to § 37.2-815, the community service board or behavioral health authority preparing the
118 preadmission screening pursuant to § 37.2-816, or the sheriff or administrator of the local correctional
119 facility any and all information that is necessary and appropriate to enable each of them to perform his
120 duties under this section. These health care providers and other service providers shall disclose to one
121 another health records and information where necessary to provide care and treatment to the inmate and
122 to monitor that care and treatment. Health records disclosed to a sheriff or administrator of the local
123 correctional facility shall be limited to information necessary to protect the sheriff or administrator of
124 the local correctional facility and his employees, the inmate, or the public from physical injury or to
125 address the health care needs of the inmate. Information disclosed to a law-enforcement officer shall not
126 be used for any other purpose, disclosed to others, or retained.

127 Any health care provider disclosing records pursuant to this section shall be immune from civil
128 liability for any harm resulting from the disclosure, including any liability under the federal Health
129 Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person
130 or provider disclosing such records intended the harm or acted in bad faith.

131 H. Any order entered where an inmate is the subject of proceedings under this section shall
132 provide for the disclosure of medical records pursuant to subsection G. This subsection shall not
133 preclude any other disclosures as required or permitted by law.

