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In This Issue:

I. Rethinking Guardianship and Substitute Decision Making: Supported Decision-Making and the Reform of Virginia Law, Policy, and Practice to Protect Rights and Ensure Choice

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Introduction

In the 2020 General Assembly session, Senate Bill 585 was introduced to amend Virginia's guardianship statute to explicitly recognize "supported decision-making" as a less restrictive alternative to guardianship that must be considered in every guardianship proceeding. The bill also included a "Supported Decision-Making Act" that would become Chapter 12 of Title 37.2 of the Virginia Code, giving legal recognition and validity to supported decision-making agreements entered into by adults with an intellectual or developmental disability and "supporters" (defined in the bill) who assist that adult in making and carrying out decisions regarding the matters specified in the agreement.

As discussed in more detail below, while the General Assembly did not enact SB 585 as submitted, it did add provisions to the Virginia Code that bring greater focus to alternatives to guardianship and require more explicit support for the independence and capacity of the individual even when a guardian is appointed for that individual. The General Assembly also required further study and report on the use of supported decision-making agreements as a less restrictive alternative to guardianship and conservatorship.

While the term "supported decision-making" is new to Virginia law, this concept gives effective expression to our society's long-standing commitment to protecting individual independence and personal autonomy. As we set out below, it is time for supported decision-making to become an explicit part of Virginia statutory law.

The Intersection of Rights and Choice

Consider the intersection of *rights* and *choice.* As Americans, there are certain rights we hold so dear, so basic to our shared ethos and experience, that we rarely think of them unless they are threatened: freedom of speech, religion, and association; to vote; and the inalienable rights that shaped our nation: life, liberty, and the pursuit of happiness.

Next, consider how each of those rights—how, indeed, *all* of our rights—depend on choice. Freedom of speech is choosing what to say and what to keep to ourselves; voting is choosing who will govern us; the rights to life, liberty, and the pursuit of happiness are choosing where, how, and with whom we spend our lives.

Choice, then, makes rights actual rather than theoretical. Therefore, the *right to make choices*—deciding how we will order and carry out our lives and having those rights respected—is our most essential, indispensable right.[1]

Choice, Self-Determination, and Quality of Life

Clinically, the right to make choices is called *self-determination.* People are *self-determined* when they make decisions—the "simple and complex everyday life choices regarding where, how, and with whom they live."[2] By making and implementing decisions, they become and remain "causal agents . . . actors in their lives instead of being acted upon."[3]

Self-determination was first described as a basic human need by Edward Deci in 1975.[4] In the nearly five decades since, study after study has found that people with disabilities who exercise more self-determination—who make more choices—have better lives: they are more likely to be independent, employed, involved in their communities, and better able to recognize and avoid abuse.[5]

Conversely, losing self-determination "can be as harmful as having it is helpful."[6] People, especially people with disabilities, who lose self-determination often "feel helpless, hopeless, and self-critical, and will not behave because [they] can see no use in behaving."[7] Studies show that losing the right or option to make choices can lead to negative psychological impacts including "learned helplessness"[8] and other "self-handicapping" behaviors[9] such as loss of motivation to try new things.[10]

Guardianship and Self-Determination

When people are ordered into *guardianship* (called *conservatorship* or *interdiction* in some states), their legal authority to make some or all decisions is removed by a court and given to a third

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[1] Martinis, J. & Gustin, J. (2017). Supported decision-making as an alternative to overbroad and undue guardianship. *The Advocate, 60*(6), 41-46.

[2] Blanck, P. & Martinis, J. (2015). *"*The right to make choices": The national resource center for supported decision-making. *Inclusion, 3*(1), 24-33, p. 25.

[3] Wehmeyer, M. L., Palmer, S., Agran, M., Mithaug, D., & Martin, J. (2000). Promoting causal agency: The self-determined learning model of instruction. *Exceptional Children, 66*(4), 439-453, p. 440.

[4] Deci, E. (1975). *Intrinsic motivation*. New York, NY: Plenum Press.

[5] *e.g.,* Wehmeyer, M.L., & Schwartz, M, (1997). Self-determination and positive adult outcomes: A follow-up study of youth with mental retardation or learning disabilities. *Exceptional Children, 63(2),* 245-255; Wehmeyer, M. L., & Palmer, S. B. (2003). Adult outcomes for students with cognitive disabilities three-years after high school: The impact of self-determination. *Education & Training in Developmental Disabilities*, *38*(2), 131-144; Khemka, I., Hickson, L., & Reynolds, G. (2005). Evaluation of a decision-making curriculum designed to empower women with mental retardation to resist abuse. *American Journal on Mental Retardation*, *110*(3), 193-204.

[6] Martinis, J. & Blanck, P. (2019). *Supported decision-making: From justice for Jenny to justice for all!* Stafford, Virginia: Something Else Solutions Press., p. 24

[7] Deci, 1975, p. 208

[8] Garber J. & Seligman, M. (Eds.), (1980). *Human helplessness: Theory and applications,* London: Academic Press.

[9] Jones, E., & Berglass, S. (1978). Control of attributions about the self through self-handicapping strategies: The appeal of alcohol and the role of underachievement. *Personality and Social Psychology Bulletin 4*, 200-206.

[10] Peterson C., & Bossio, L. (1989). Learned helplessness. In Curtis, R. (Ed.), *Self-defeating behaviors: Experimental research, clinical impressions and practical limitations* (p. 241). New York, New York: Plenum Press.

party.[11] Historically, governments have appointed guardians for people deemed "by reason of age or disability . . . incapable of making such decisions for themselves."[12]

The roots of modern guardianship may be found in Ancient Rome, where the Justinian Code required *the feebleminded* (as they called people with cognitive disabilities) to have *curators* to make decisions for them.[13] Feudal Great Britain, through the 1324 statute *De Praerogativa Regis*, empowered courts to appoint *committees* to make decisions for *idiots* and *lunatics* (as they called people with disabilities) in the King's name.[14]

The United States followed the British model, giving states "all the powers in this regard which the sovereign possesses in England."[15] Consequently, guardianship is governed by state law, and each state has enacted its own statutes, policies, and procedures.[16] As a general matter, however, people are ordered into guardianship when a state court determines they are "incapacitated" and/or in need of "protection" due to being unable to make some or all life decisions. The court then appoints a third party to make those decisions in place of the person.[17]

The guardianship process has long been viewed, in America and abroad, as "a humanitarian response to the vulnerability of the incompetent,"[18] providing protection to those that "cannot take care of themselves in a manner that society believes is appropriate."[19] As a result, courts, legislators, and policymakers have not historically considered whether and when people with disabilities truly need guardianship or, once imposed, whether they truly "continue[s] to need or benefit" from it.[20]

However, recent research and scholarship have found that *overbroad or undue guardianship*—guardianship imposed on people who can make their own decisions or that take away more rights than are absolutely necessary[21]—may lead to decreased quality of life. Such guardianships reduce or remove self-determination[22] and may establish "expectancies of failure . . . that diminish

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[11] *e.g.,* Blanck & Martinis, 2015.

[12] Winick, B. (1995). The side effects of incompetency labeling and the implications for mental health law. *Psychology, Public Policy and Law, 1*(1), 6-42, p. 27.

[13] Fleming, R., & Robinson, C. (1993). Care of incompetent adults: A brief history of guardianship. *The Arizona Attorney, 30,* 16-42.

[14] O'Sullivan, J. (2002). Role of the attorney for the alleged incapacitated person. *Stetson Law Review, 31,* 687-734; Regan, J. (1972). Protective services for the elderly: Commitment, guardianship and alternatives. *William and Mary Law Journal, 13,* 569-622.

[15] Late Corp. of the Church of Jesus Christ of Latter-Day Saints v. United States, 136 U.S. 1 (1890), p. 57.

[16] *e.g.,* Blanck & Martinis, 2015; Martinis, J., Harris, J., Fox, D., & Blanck, P. (in press). State guardianship laws and supported decision-making in the United States after *Ross and Ross v. Hatch*: Analysis and implications for future research, education, and advocacy. *Journal on Disability Policy Studies*.

[17] Blanck & Martinis, 2015.

[18] Frolik, L. (1998). Guardianship reform: When the best is the enemy of the good. *Stanford Law and Policy Review, 9,* 347-355, p. 350.

[19] Kapp, M. (1999). *Geriatrics and the law: Understanding patient rights and professional responsibilities*. New York, NY: Springer, p. 109.

[20] Wright, J. (2004). Protecting who from what, and why, and how? A proposal for an integrative approach to adult protective proceedings. *Elder Law Journal, 12,* 53-118, p. 60.

[21] Hatch, M.J, Crane, S.A., & Martinis, J. (2015). Unjustified isolation is discrimination: The Olmstead case against overbroad and undue organizational and public guardianship. *Inclusion, 3*(2), 65-74.

[22] Blanck & Martinis, 2015

subsequent [life] performance."[23] Worse, people ordered into overbroad and undue guardianship may suffer a "significant negative impact on their physical and mental health, longevity, ability to function, and reports of subjective wellbeing."[24] Thus, labeling people "incompetent" or "incapacitated" and ordering a person into guardianship may actually increase the behaviors that first led to the guardianship.[25]

Studies suggest that many, if not most, guardianships are overbroad or undue.[26] For example, even though over 60% of state guardianship laws require courts to impose the least restrictive form of guardianship,[27] *full* or *plenary* guardianship (where the guardian is given the authority to make *all* decisions for the person) is ordered in the vast majority of cases.[28] One study found that plenary guardianships were ordered in over 90% of the guardianships it examined.[29] Similarly, a 10-state study found that 87% of the guardianships it reviewed were plenary.[30] These studies demonstrate that, in the words of one scholar, "Courts do not [order limited guardianships] because there is little reason or incentive to do so. It seems that as long as the law permits plenary guardianship, courts will prefer to use it."[31]

The U.S. Congress recognized and elaborated upon the problems of overbroad and undue guardianship in a report entitled *Abuses in Guardianship of the Elderly and Infirm: A National Disgrace*. Congressman Claude Pepper summarized his committee's findings by stating:

> The typical ward has fewer rights than the typical convicted felon. . . By appointing a guardian, the court entrusts to someone else the power to choose where they will live, what medical treatment they will get and, in rare cases, when they will die. It is, in one short sentence, the most punitive civil penalty that can be levied against an American citizen, with the exception, of course, of the death penalty[32]

Nevertheless, there are "deeply embedded tendencies toward protection over autonomy, and courts continue to issue guardianship orders that are not necessary and are overly broad in scope."[33] Indeed, the estimated number of adults under guardianship has tripled since 1995.[34]

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[23] Winnick, 1995, p. 15

[24] Wright, J. (2010). Guardianship for your own good: Improving the well-being of respondents and wards in the USA. International Journal of Law and Psychiatry, 33(5), 350-368, p. 354.

[25] Blanck & Martinis, 2015.

[26] Salzman, L. (2010). Rethinking guardianship (again): Substituted decision making as a violation of the integration mandate of Title II of the Americans with Disabilities Act. University of Colorado Law Review, 81, 157-244.

[27] Martinis, et al., in press.

[28] Frolik, L. (2002). Promoting judicial acceptance and use of limited guardianship. Stetson Law Review, 31, 735.

[29] Teaster, P., Wood, E., Lawrence, S., & Schmidt, W. (2007). Wards of the state: A national study of public guardianship. Stetson Law Review, 37, 193-241.

[30] Lisi, L. B., Burns, A., & Lussenden, K. (1994). National study of guardianship systems: Findings and recommendations. Center for Social Gerontology.

[31] Frolik, 1998, p. 354.

[32] Abuses in guardianship of the elderly and infirm: A national disgrace. A briefing by the chairman of the Subcommittee on Health and Long-term Care of the Select Committee on Aging, 100th Cong. 1 (1987), H.R. Rpt. 100-641 (opening statement of Chairman Claude Pepper, p. 4). Retrieved from http://files.eric.ed.gov/fulltext/ED297241.pdf

[33] Salzman, 2010, p. 178.

[34] Reynolds, S. L. (2002). Guardianship primavera: A first look at factors associated with having a legal guardian using a nationally representative sample of community-dwelling adults. Aging and Mental Health, 6, 109-120;

Supported Decision-Making as an Alternative to Guardianship

The overuse of overbroad and undue guardianship continues even though federal laws such as the Americans with Disabilities Act[35] and Supreme Court precedent such as *Olmstead v. L.C.*[36] mandate equal opportunity and community inclusion for people with disabilities. In addition, studies have found that people with disabilities who do not have guardians are more likely to work, live independently, have their rights respected, date and get married than similarly situated people with guardians.[37]

In the last decade, people with disabilities, families, courts, legislators, and policymakers have searched for an alternative to guardianship that enhances self-determination while ensuring that people with disabilities have the assistance they need to properly and safely make decisions and direct their lives. Supported Decision-Making ("SDM") has emerged and is increasingly being recognized and used as a preferred, legally and legislatively recognized alternative to guardianship.[38]

While there is no "one-size-fits-all" model of SDM, it generally occurs when people choose and work with people they trust, such as friends, family members, and professionals, who help them understand the situations and choices they face, so they may understand, consider, make, and communicate their own decisions.[39] In that way, SDM represents the way most adults make simple and serious life choices "such as whether to get car repairs, sign legal documents and consent to medical procedures: they seek advice, input and information from friends, family or professionals who are knowledgeable about those issues, so they can make their own well-informed choices."[40]

SDM relationships should be individualized to the strengths, preferences, and needs of each person. As such, they may be "of more or less formality and intensity" as needed, from informal support by people who "speak with, rather than for, the individual with a disability"[41] to formally organized and run "micro-board[s]" and "circles of support."[42] However, effective SDM relationships share three common characteristics:

Schmidt, W. C. (1995). Guardianship: Court of last resort for the elderly and disabled. Durham, NC: Carolina Academic Press; Uekert, B. K., & Van Duizend, R. (2011). Adult guardianships: A "best guess" national estimate and the momentum for reform. Future trends in state courts 2011: Special focus on access to justice.

[35] Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. (2006).

[36] Olmstead v. L.C., ex rel. Zimring, 527 U.S. 581 (1999).

[37] Bradley, V., Hiersteiner, D., St. John, J., & Bourne, M. L. (2019). What Do NCI Data Reveal About the Guardianship Status of People with IDD? National Core Indicators Data Brief. Retrieved from https://www.nationalcoreindicators.org/upload/core-indicators/NCI_GuardianshipBrief_April2019_Final.pdf?fbclid=IwAR3H3203x5nI_G6bZ

[38] Blanck & Martinis, 2015; U.S. Administration for Community Living. (2017). Supported decision making program. Retrieved from: **https://www.acl.gov/programs/consumer-control/supported-decision-making-program**

[39] Dinerstein, R. (2012). Implementing legal capacity under article 12 of the UN Convention on the Rights of Persons with Disabilities: The difficult road from guardianship to supported decision making. *Human Rights Brief, 19,* 8-12; Martinis & Blanck, 2019.

[40] Quality Trust for Individuals with Disabilities. (2013). *Supported decision-making: An agenda for action*, p. 2. Retrieved from https://www.c-q-l.org/wp-content/uploads/2019/12/CQL-Supported-Decision-Making-Agenda-For-Action-2015.pdf

[41] Dinerstein, 2012, p. 10

[42] Kohn, N., Blumenthal, J., & Campbell, A. (2013). Supported decision-making: A viable alternative to guardianship? *Penn State Law Review, 117,* 1111-1157, p. 1123.

> (1) they are based on a set of guiding principles that emphasize the person with disability's autonomy, presumption of capacity, and right to make decisions on an equal basis with others;
>
> (2) they recognize that a person's intent can form the basis of a decision-making process that does not entail removal of the individual's decision-making rights; and
>
> (3) they acknowledge that individuals with disabilities will often need assistance in decision-making through such means as interpreter assistance, facilitated communication, assistive technologies and plain language.[43]

Through these SDM relationships:

> an individual with limitations in decision-making abilities can receive support to understand relevant information, issues, and available choices, to focus attention in making decisions, to help weigh options, to ensure that decisions are based on her own preferences, and, if necessary, to interpret and/or communicate her decisions to other parties.[44]

Researchers and scholars have found that many, if not most, people with disabilities would be able to make their own decisions and direct their lives, if given appropriate support through SDM. For example, one scholar stated:

> Just as most individuals residing in institutions would benefit from living and receiving care in a less restrictive community setting, many individuals with guardians could successfully manage their personal and property affairs through the less isolating mechanism of supported decision making."[45]

Research and scholarship also find that SDM is associated with increased self-determination. Thus, people who use SDM as an alternative to guardianship may "reap the benefits from increased life control, independence, employment, and community integration."[46] Consequently, in the last decade, increasing numbers of people with disabilities, family members, professionals, and organizations are endorsing and using SDM as an alternative to guardianship.

The modern SDM movement was catalyzed by the case of Margaret "Jenny" Hatch, a 29 year-old Virginian with Down syndrome.[47] In 2013, Jenny became the first person to win, at trial, the legal right to choose where and how to live using SDM.[48] One year earlier, Jenny had been ordered into

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[43] Dinerstein, 2012, pp. 10-11.
[44] Salzman, L. (2010). Guardianship for persons with mental illness-a legal and appropriate alternative. . *Louis UJ Health L. & Pol'y*, *4*, 279, p. 306.
[45] Salzman, 2011, p. 194.
[46] Blanck & Martinis, 2015, p. 31
[47] Vargas, T. (2013, August 2). Woman with down syndrome prevails over parents in guardianship case. *The Washington Post*. Retrieved from: http://www.washingtonpost.com/local/woman-with-down-syndrome-prevails-over-parents-in-guardianship-case/2013/08/02/4aec4692-fae3-11e2-9bde-7ddaa186b751_story.html
[48] Martinis & Blanck, 2019.

a plenary guardianship even though she had worked at a community-based, competitive job for five years, lived in her own community apartment, and had established close ties to local political figures, a church, and a circle of friends who supported her.[49] Even though Jenny had long chosen where she lived and worked, and what she did in her spare time, her new guardians were authorized "to make decisions regarding visitation of individuals with [Jenny], [her] support, care, health, safety, habilitation, education, therapeutic treatment and . . . residence."[50]

At her trial, Jenny argued that she used SDM to make her own decisions and did not need a guardian to make decisions for her. She presented evidence that her supporters helped her understand, make, communicate, and carry out her life choices. Experts testified on her behalf that using SDM enhanced Jenny's quality of life and was consistent with research, law, and best practices.[51]

After six days of trial and argument, the court ordered Jenny into a one-year, limited guardianship, which expired in August of 2014. The court appointed the people Jenny wanted to live with as her temporary guardians and authorized them only to make medical and safety decisions on her behalf, with Jenny retaining all of her other rights. The court then ordered the guardians to work with Jenny so that she may fully transition "to the support[ed] decision making model" in one year. Furthermore, the court ordered the temporary guardians, when making health and safety decisions during the one-year period, to "assist [Jenny] in making and implementing decisions we have termed 'supported decision making.'"[52]

The Avalanche of Supported Decision-Making

Immediately after her victory, Jenny returned to her home, job, and church and was hailed in the U.S. and internationally as "the rock that starts the avalanche" of SDM.[53] As the inspiration and face of the Jenny Hatch Justice Project, she now works to increase awareness, access to, and use of SDM as an alternative to guardianship.[54]

In the years since, the "avalanche" of SDM has resulted in courts, legislatures, and public and private policy organizations recognizing the import and benefits of SDM and endorsing SDM as an alternative to guardianship. Across the United States, older adults, people with intellectual and developmental disabilities, and people with mental illnesses have successfully argued that they, like Jenny, can make decisions and direct their lives without a guardian if they have the support they need and want. Cases where people have avoided or terminated guardianships because they can use SDM include: *In Re: Tecora Mickel*, DC Probate Case No: 2015 INT 000291; *In re: Tanya Powell*, DC Probate Case No. 2015 INT 529; *In Re: Beck*: Circuit Court, Wayne County, Indiana, Case No: 89CO1-1011-GU-025; *In re: KH*, Case No PR03-00264 (2nd Judicial District Court, County of

[49] Hatch, J. (2015). My story. *Inclusion*, *3*(1), 34-34; Hatch, Crane, & Martinis, 2015
[50] Martinis & Blanck, 2019; Ross and Ross v. Hatch, Case No. CWF-120000-426, Order Appointing Temporary Guardians (Circuit Court of Newport News, 2013). Retrieved from: http://jennyhatchjusticeproject.org/docs/justice_for_jenny_trial/jhjp_trial_order_appointing_temporary_guardians.pdf.
[51] Martinis & Blanck, 2019.
[52] Ross and Ross v. Hatch, Case No. CWF-120000-426, Final Order (Circuit Court of Newport News, 2013). Retrieved from**:** http://jennyhatchjusticeproject.org/docs/justice_for_jenny_trial/jhjp_trial_final_order.pdf
[53] Vargas, 2013.
[54] *e.g.,* www.jennyhatchjusticeproject.org

Washoe, NV, 2017); *In re C.B.* (Superior Court of Vermont, Orleans Unit, 4/11/2017); and *Matter of Eli T.*, 89 N.Y.S.3d 844, 849 (N.Y. Sur. Ct., Kings Cty. 2018).

In addition, 11 states and the District of Columbia have passed laws recognizing SDM as a less-restrictive, preferred alternative to guardianship. In 2015, Texas amended its guardianship laws to recognize the availability and effectiveness of "Supports and Services"— defined as formal and informal resources and assistance that enable people to meet their needs; care for their health; manages their finances; and make personal decisions—as an alternative to guardianship.[55] The law requires courts to find by clear and convincing evidence that a person cannot make decisions using Supports and Services before appointing a guardian.[56] Texas' law also empowers people to enter into Supported Decision-Making agreements that authorize people to provide them with the Supports and Services they need and want.

Since Texas passed its law, Maine, Delaware, Wisconsin, Missouri, Alaska, Nevada, Indiana, North Dakota, Rhode Island, Minnesota, and the District of Columbia have revised their laws to recognize SDM as an alternative to guardianship. In addition, 41 states now have laws requiring courts to consider less restrictive alternatives before imposing a guardianship.[57]

Public and private agencies and organizations also recognize and promote SDM as an alternative to guardianship. In 2014, the Administration for Community Living in the U.S. Department for Health and Human Services described SDM "as an alternative to and an evolution from guardianship" and stressed the importance of people "retain[ing] their own decision-making authorities . . . with the assistance of appropriate services and supports."[58]

In 2017, the American Bar Association adopted a resolution:

> urging state, territorial, and tribal legislatures to (1) amend their guardianship statutes to require that supported decision making be identified and fully considered as a less restrictive alternative, before guardianship is imposed, and (2) require that decision-making supports that would meet the individual's needs be identified and fully considered in proceedings for termination of guardianship and restoration of rights.[59]

The Resolution further urges courts to consider (1) SDM as a less restrictive alternative to conservatorship and (2) decision-making supports that would meet the individual's needs as grounds for termination of a guardianship and restoration of rights.[60]

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[55] *Tex. Est. Code § 1002.031*
[56] *Tex. Est. Code § 1101.101(a)(D) & (E)*
[57] Martinis et al., in press
[58] Administration for Community Living. (2014). Supported decision making (Grant No. HHS-2014-ACL-AIDD-DM-0084), pp. 2, 6. Retrieved from **http://www.grants.gov/web/grants/view-opportunity.html?oppId=256168**
[59] American Bar Association, *ABA Urges Supported Decision Making as a Less Restrictive Alternative to Conservatorship,* Bifocal: The Journal of the American Bar Association Commission on Law and Aging, 38(6) (2017). Retrieved from: **https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_38/issue-6--august-2017-/aba-urges-supported-decision-making-as-less-restrictive-alternat.html**
[60] American Bar Association, 2017.

Finally, the National Guardianship Association, which is made up of and trains guardians across the country, has endorsed SDM as an alternative to conservatorship, stating:

> Alternatives to guardianship, including supported decision making, should always be identified and considered whenever possible prior to the commencement of guardianship proceedings.[61]

Recent Developments in Supported Decision-Making in Virginia

In Virginia, Jenny Hatch's home state, knowledge and use of SDM has grown. The Arc of Northern Virginia and the Burton Blatt Institute at Syracuse University are partnering on an SDM pilot project designed to empower 10 Virginians with disabilities to use SDM and then study the impact on their self-determination and quality of life. Project participants and their parents were provided with information and resources on SDM and encouraged to create individualized SDM plans that reflected their interests, strengths, and needs. The plans took many shapes, from charts and spreadsheets to dictated narratives. After participants had used their plans for some time, they were interviewed, using qualitative and quantitative methodologies to determine how SDM had impacted their self-determination, community integration, quality of life, and whether their attitudes about guardianship had changed. The project is ongoing, with results hopefully released by the end of 2020.[62]

Virginia has also passed legislation to increase knowledge of, access to, and use of SDM. In 2018, Delegate Kaye Kory introduced legislation requiring the Commonwealth to study the potential of SDM for people with intellectual and developmental disabilities, compare Virginia's guardianship policies and procedures to those of other states, and identify times and areas where SDM may be used as an alternative to guardianship.[63]

The Virginia Joint Commission on Health Care conducted the study and reported their results in Fall 2019. The Commission recommended changes to the Virginia Code to (1) permit people with disabilities to use SDM to make decisions related to their services from Department of Behavioral Health and Developmental Services and to make SDM agreements with their supporters that would be recognized under Virginia law; (2) require Guardians *ad litem* to consider and to include in their report to the Court their findings regarding SDM as an alternative in guardianship cases; (3) require the Virginia Department of Education to update its materials to include information on SDM for families with children approaching adulthood who have an intellectual or developmental disability; and (4) make Virginia's guardianship law clearer.[64]

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[61] National Guardianship Association, "Position Statement on Guardianship, Surrogate Decision Making, and Supported Decision Making," (2015), available at: http://www.guardianship.org/documents/NGA_Policy_Statement_052016.pdf

[62] The Arc of Northern Virginia (n.d.). Supported decision-making resource library. Retrieved from: https://thearcofnova.org/programs-services/sdm-resource-library/

[63] VA HJR, 2018 session (2018)

[64] Virginia Joint Commission on Health Care (2019). Supported decision making. Retrieved from: http://jchc.virginia.gov/Supported%20Decision%20Making.pdf

The Joint Commission's recommendations were incorporated into legislative proposals in the Virginia House and Senate.[65] After hearings and reconciliation, the Senate bill passed unanimously and was signed into law and took effect on July 1, 2020.[66]

While the final version of the new law does not give explicit statutory recognition to SDM agreements, as proposed in the original bill, it does expand knowledge, access, and use of SDM in several ways. First, if the respondent to a guardianship petition is between 17.5 and 21 years of age, the Guardian *ad litem* must now review the student's Individualized Education Program (IEP), if one exists, and include the results of the review in reports filed with the court.[67] This requirement will provide a fuller picture of the person's strengths and abilities than is generally shown by psychological testing in guardianship cases.

In addition, the new law requires the Department of Education to provide information on SDM and other alternatives to guardianship, such as Powers of Attorney, at annual IEP meetings.[68] Studies show that schools and educational professionals are the leading referral source for guardianship and that guardianship is often presented to parents as the only option for their children.[69] By requiring schools to provide information on alternatives to guardianship, the new law ensures that parents receive information on the full range of decision-making options for their children.

Furthermore, the new law requires Guardians *ad litem* to consider less-restrictive alternatives to guardianship and recommend them as appropriate.[70] The law also mandates that Courts inform guardians, when appointed, that the person must be actively encouraged to participate in making decisions and act on their own behalf whenever possible.[71]

Finally, the new law requires the Virginia Department of Behavioral Health and Developmental Services to convene a workgroup to study the use of SDM agreements by and for people with disabilities.[72] The workgroup was convened in summer 2020 and is publishing its final recommendations in Fall 2020. The group, comprised of SDM experts and interested parties all over the state, agreed on four core principles as a foundation for their recommendations. First, we should always presume people are capable of making their own decisions. Second, if an individual does need assistance in making decisions, the supports put in place should be the least restrictive option appropriate to meet the need. Third, any supporters or guardians should make decisions and offer support based upon the individual's preferences. Finally, the group recognized that risk and the opportunity (or many opportunities) to make poor decisions are critical for growing good decision-making skills.

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[65] VA HB 1321, 2020 session (2020); VA SB 585, 2020 session (2020)
[66] Va Code, Chapter 855 (2020). Retrieved from: https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP0855
[67] Va Code Ann. § 64.2-2003 (2020)
[68] Va Code Ann. § 22.1-217.2 (2020)
[69] Jameson, J. M., Riesen, T., Polychronis, S., Trader, B., Mizner, S., Martinis, J., & Hoyle, D. (2015). Guardianship and the potential of supported decision making with individuals with disabilities. Research and Practice for Persons with Severe Disabilities, 40, 36-51.
[70] Va Code Ann. § 64.2-2003 (2020)
[71] Va Code Ann. § 642.-2007 (2020).
[72] Va Code Ann. § 64.2-2009 (2020).

From these principles, the group focused on making final recommendations to be published. The first recommendation was to elevate the use of SDM, including defining it in Virginia Code and in related regulations around authorized representatives. The group made it clear this should not result in over-formalizing SDM or defining its use narrowly. Next, the group recommended funding for education and training groups that would likely have the greatest encounters with people using SDM. Lastly, the workgroup recommended supporting data collection and research on the use of SDM and related outcomes.

Supported Decision-Making and People with Mental Health Challenges: Law, Research, and Practice

Traditionally, discussion and practice of SDM has focused on older adults and people with intellectual and developmental disabilities. However, people with mental health challenges can, do, and have been recognized as using SDM as an alternative to guardianship and a way to increase their self-determination, make their own decisions, and direct their lives.

For example, in *In Re Tecora Mickel,* a person with mental illness successfully petitioned the court to terminate her guardianship because she used SDM. Ms. Mickel was under a plenary guardianship and her guardian had no contact with her. Because her right to enter into contracts was removed by the court, she could not sign a lease or an agreement for job training. Therefore, she was unemployed and homeless. Ms. Mickel presented evidence and argued that she did not need a guardian because she had a support system of friends and professionals that was willing to, and did, help her make decisions and direct her life. After a contested hearing, the court terminated her guardianship and authorized her attorney and others to serve as her SDM team.[73]

The Saks Institute for Mental Health Law, Policy and Ethics, at the University of Southern California Gould School of Law, and the Burton Blatt Institute at Syracuse University are implementing an SDM project focused on people with mental illnesses. The project works with people with mental illnesses to identify life areas where they want support, the people they want support from, and the type of support they want. Then, the project assists them in creating and implementing individualized SDM plans. Periodically, project participants are interviewed to help identify successes and challenges, and determine whether life outcomes, such as community integration, have improved. The study findings will help identify best practices and common challenges, and will shape future projects designed to empower people with mental illnesses to use SDM as an alternative to guardianship and a way to increase the self-determination and quality of life.[74]

This use of SDM plans by individuals experiencing mental health challenges is similar to the use of Wellness Recovery Action Plans (WRAPs), first developed in 1997 and now utilized in different ways throughout the United States and other countries. As described on the official WRAP website, the WRAP is a "self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be." Its components include, among other things: a "wellness toolbox" in which a person identifies resources—including friends and

[73] *In Re: Tecora Mickel*, DC Probate Case No: 2015 INT 000291

[74] Schnieders, C. (2019). Supported decision-making and people with psychiatric disabilities: Pioneering research at California's Saks Institute. *Impact 32*(1), 40-41

supporters—that help the person maintain physical and mental wellness; a daily plan for maintaining wellness; identification of stressors that can undermine wellness, as well as signs that a person may be experiencing a crisis; and a crisis plan that enables the person's supporters to know when they need to take action to ensure that the person gets needed care, and that sets out what care the person prefers to address and resolve the crisis.

Although the WRAP is a proven tool for helping people maintain wellness and cope with mental health crisis, the WRAP does not, on its own, have the status of a legal document that must be honored by others. To provide such a document, mental health advocates have pushed since the 1990s for legislation to expand the scope of health care advance directives—legal documents in which people set out their preferences regarding their care and appoint an agent to make decisions for them in the event they become incapacitated (generally associated with "end of life" care)—to specifically address mental health care. In response, 25 states have enacted statutes specifically authorizing "Psychiatric Advance Directives" (PADs). Almost all of the remaining states authorize health care advance directives, which can include at least some provisions for mental health care. While Virginia does not have a specific PAD statute, it specifically authorizes and supports the use of the health care advance directive to include mental health care, including psychiatric hospitalization. (More information about advance directives for mental health care in Virginia can be found at the Virginia Advance Directives website.)

While PADs are increasingly available as wellness tools for individuals with mental health challenges, a distressingly small percentage of individuals with serious mental illness have completed a PAD. There have been a number of initiatives in several states (including Virginia) to address this problem. One groundbreaking project is being carried out by Texas Rio Grande Legal Aid, which works with people with serious mental illness to empower them to create and implement Psychiatric Advance Directives. In these PADs, people with mental illnesses use SDM to identify and share with supporters, professionals, first responders, and others their preferences for treatment, communication, and anything else that will help when they are in crisis. These PADs may identify effective treatments or medication that the person prefers, and ineffective ones to which the person objects, and may also list the people who should be contacted and steps that should be taken when the person is in crisis or needs assistance. Once complete, PADs are then provided to local law enforcement, crisis responders, medical personnel, and others as appropriate so they are aware of the person's preferences. In that way, PADs help people with mental illnesses and professionals interact in a positive way focused on the person's preferences and strengths, "reducing the likelihood that interactions will result in criminal charges or long-term, involuntary hospitalization."[75]

Finally, and most importantly, laws that increase access and opportunities to use SDM are equally applicable to people with mental illnesses. A recent study found that 84% of U.S. states have laws that expressly require courts to consider whether people do or could use less restrictive alternatives before ordering them into guardianship.[76] People with mental illnesses in those states may avail

[75] Hallmark, L., & Martinis, J. (2019). Psychiatric advance directives: The TRLA model in Texas. *Impact 32*(1), 43-44 ,p. 43

[76] Martinis, et al., in press

themselves of these laws, as Tecora Mickel did, and argue that they use SDM and, therefore, do not need a guardian.

For example, Virginia's guardianship law states, in part, "In determining the need for a guardian or conservator and the powers and duties of any guardian or conservator, if needed, consideration shall be given to the following factors . . . the availability of less restrictive alternatives."[77] By the law's express terms, Virginians with mental illnesses may defend themselves against a guardianship petition by presenting evidence and argument that they use a less restrictive alternative such as SDM.

Conclusion: Looking Back, Moving Forward

The journey to equality and inclusion, until the "shameful wall of exclusion finally comes tumbling down,"[78] has been a long and hard one for people with disabilities, and especially people with mental illnesses. Millions of people who, with appropriate support, could lead meaningful and productive lives have, instead, "been . . . prevented from being full and equal parts of their communities. . . They have been physically separated, by institutionalization, socially separated, through the stigma of unfounded beliefs that they are "dangerous" or "unable to take care of themselves," and legally separated, through guardianship."[79] SDM has the potential to provide people with an opportunity to make decisions, direct their lives, and receive support on an equal footing with other members of society. As SDM case and statutory law, policy and practice mature and scale, people with disabilities will have the opportunity to build and exercise self-determination and achieve the research-proven benefits of enhanced life control, leading them ever closer to "the Nation's proper goals regarding people with disabilities" including "equality of opportunity, full participation, independent living, and economic self-sufficiency."[80]

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[77] Va. Code Ann. §64.2-2007(c).
[78] C-SPAN. (1990). User clip: President George H.W. Bush signs Americans with Disabilities Act, 1990. Retrieved from: https://www.c-span.org/video/?c4763579/user-clip-president-george-h-w-bush-signs-american-disabilities-act-1990
[79] Hallmark & Martinis, 2019, p. 43.
[80] Americans with Disabilities Act, 42 U.S.C. §12101(a)(7), (2006).

Board for People with Disabilities, the U.S. Department of Health and Human Services or any other funding agency.

Editor's Note: *The SDM work group formed by the Department of Behavioral Health and Developmental Services, as directed by Senate Bill 585, submitted its written report on October 28, 2020. That report can be found here on Virginia's Legislative Information System (LIS). A summary of Senate Bill 585, and a link to the bill (where you can also review the original version of the bill and its legislative history) is included in the article below regarding the 2020 general session of the Virginia General Assembly.*

II. The 2020 Virginia General Assembly: Summary of Behavioral Health-Related Legislation

A. The General Session:

A number of important bills related to behavioral health issues impacting a broad range of concerns were enacted by the Virginia General Assembly in the 2020 session. The General Assembly also directed the formation of, and reports from, work groups addressing a number of behavioral health related concerns, including the following:

- policies and procedures for obtaining medical temporary detention orders for patients experiencing a health crisis;
- determining who should be qualified to evaluate a person for entry of a temporary detention order (TDO) for temporary psychiatric hospitalization;
- the functioning of the state's acute psychiatric bed registry;
- the process for approving residential psychiatric services for children and adolescents;
- the use of statutory "barrier crimes" to automatically disqualify individuals from serving in positions to treat or care for others;
- practices in correctional facilities to accommodate the needs of inmates with developmental disabilities;
- practices in correctional facilities regarding solitary confinement; and
- the use of "supported decision-making" agreements as a less restrictive alternative to the appointment of a guardian or conservator for incapacitated persons.

While not requiring a work group, the General Assembly did direct the Department of Juvenile Justice (DJJ), in collaboration with the Department of Behavioral Health and Developmental Services (DBHDS), to promulgate regulations governing the housing of youth who are detained in a juvenile correctional facility pursuant to a contract with the federal government and not committed to such juvenile correctional facility by a court of the Commonwealth. Those regulations must address, among other things, standards on the use of force, on assuring necessary and appropriate physical and mental health care, and on assuring DJJ staff access to youth placed there.

Also included in the list of enacted bills below are bills that change both interrogation and sentencing procedures in criminal cases involving juveniles, reflecting the General Assembly's recognition that the differing mental capacities and maturity levels of juveniles need to be considered in both law enforcement encounters with juveniles and in making sentencing decisions regarding juveniles who have committed crimes.

The listing below is extensive, though not exhaustive.

Gun Safety

HB 2 (Plum) - **Firearm transfers; criminal history record information checks; penalty.**

This bill amends §§18.2-308.2:2, 22.1-277.07 and 54.1-4201.2 and adds §18.2-308.2:5. The central reform of the bill is the expansion of background checks for firearms purchases by requiring background checks of prospective purchasers or transferees at firearms shows. Until now, such background checks have been voluntary, and seldom used, a fact that gun safety advocates argued was allowing individuals to purchase firearms despite being prohibited by statute (due to conviction of certain crimes, involuntary commitment to a psychiatric hospital, etc.) from doing so. This bill also *adds* a requirement that a person seeking to purchase a firearm must consent to a records check that includes confirming whether the purchaser was ever psychiatrically hospitalized under a temporary detention order (TDO) pursuant to §37.2-809 and then (at their involuntary commitment hearing) voluntarily admitted themselves to a psychiatric facility. While §18.2-308.1:3 has, since 2008, prohibited individuals with such a history from possessing a firearm, Virginia statutes have not, until now, provided for a records search for such information as a condition of purchasing a firearm. This bill incorporates **HB 355.**

HB 674 (Sullivan) - **Firearms; removal from persons posing substantial risk; penalties.** This bill amends §§ 18.2-308.09, 18.2-308.2:1, 18.2-308.2:2, and 18.2-308.2:3 and adds §§ 18.2-308.1:6, 19.2-152.13 through 19.2-152.17, and 19.2-387.3. It authorizes district courts, circuit courts, and magistrates to enter a 14-day "emergency substantial risk order," on petition by a law enforcement officer or Commonwealth's Attorney, to prohibit a person from purchasing, possessing, or transporting a firearm, and to require that person to surrender all firearms in his possession, upon a finding that there is probable cause to believe that the person "poses a substantial risk of personal injury to himself or others in the near future" by their possession or purchase of firearms. A hearing must be held in the circuit court within 14 days of issuance of the emergency order to determine whether a "substantial risk order" should be issued. If the circuit court finds by "clear and convincing evidence" that the person poses a substantial risk of personal injury to himself or others in the near future by possessing or acquiring a firearm, the court *shall* issue a substantial risk order, which remains in effect for 180 days and can be extended for up to another 180 days following motion, hearing, and additional findings by the court of continued substantial risk of injury to self or others. In any hearing, the judge "shall" consider "any relevant evidence including any recent act of violence, force, or threat as defined in § 19.2-152.7:1 by such person directed toward another person or toward himself." Persons who are subject to a substantial risk order are guilty of a Class 1 misdemeanor if they purchase, possess, or transport a firearm; are disqualified from having a concealed handgun permit; and may not be employed by a licensed firearms dealer. A person subject to such an order also has the right to file a motion to dissolve the order prior to its scheduled expiration. Any similar order entered by a court in another state is now recognized and enforced in Virginia.

As noted in prior issues of DMHL, research has shown that similar laws already in effect in other states for several years have reduced suicides in those states. Suicide by firearm continues to be a significant cause of death in the United States, claiming over 23,000 lives a year and accounting for approximately 60% of all firearms deaths. This bill is identical to **SB 240.**

SB 684 (Mason) - **Involuntary commitment and restoration of firearm rights.** This bill amends § 18.2-308.1:3 to provide that if a person is involuntarily committed to a psychiatric hospital (or to mandatory outpatient treatment) by a special justice or district court judge, the person loses the right to purchase, possess, or transport a firearm, *regardless* of the outcome of any appeal of that ruling that the person may make to the circuit court. The bill also amends § 37.2-821 to provide that, if the circuit court finds in the *de novo* appeal hearing that the appellant no longer meets the criteria for involuntary commitment or mandatory outpatient treatment, the court "shall not dismiss the Commonwealth's petition but shall reverse the order of the district court." The result: a person's sole avenue for restoration of firearms rights after being involuntarily committed in the original commitment hearing is through a petition by the person to the local general district court for restoration of firearms rights as provided for under §18.2-308.1:3. Under that section, the person's firearms rights are restored if the court finds by a preponderance of the evidence "that the person will not likely act in a manner dangerous to public safety and that granting the relief would not be contrary to the public interest."

SB 684 was submitted and enacted in response to the Virginia Supreme Court's holding in *Paugh v. Henrico Area Mental Health and Developmental Services*, 286 Va. 85, 743 S.E.2d 277 (2013). In that case, the court held that, because the appeal hearing was a *de novo* hearing, if the circuit court found that the appellant *no longer* met the criteria for involuntary commitment (often a likely outcome, since the circuit court hearing is held days after the original commitment hearing, and during that time most psychiatrically hospitalized individuals improve and are even discharged), the proper action by the court was dismissal of the petition for involuntary commitment. Dismissing the petition rendered the original commitment order a nullity, and thereby eliminated the prohibition on firearms possession that resulted from that commitment order. SB 684 ensures that the firearms prohibition imposed as a result of the original commitment order remains in effect, regardless of the outcome of any appeal of that order to the circuit court.

Emergency mental health services

HB 362 (Rasoul) - **Capacity determinations; physician assistant.** This bill amends § 54.1-2983.2 by adding physician assistants to the list of health care practitioners who can determine whether a person is incapable of making an informed decision regarding psychiatric hospitalization, and thereby activate that person's advance health care directive in regard to such hospitalization. The bill also provides that a nurse practitioner can also make this determination. (The law previously specified "psychiatric nurse practitioner.") An advance health care directive, under which a health care agent can make health care decisions for a person who has become incapable of making such decisions, normally is activated only after both an attending physician and a second physician or psychologist determine that the person has become incapable of making such decisions. § 54.1-2983.2 allows people to specify in their advance directive that it can be activated in regard to decisions about their psychiatric hospitalization upon the determination by any one of a list of health care practitioners—now including physician assistants—that they have lost the capacity to make an informed decision about such hospitalization. This makes it easier for health care agents

to secure short-term psychiatric hospital admissions (currently a maximum of 10 days) for individuals who are in mental health crisis, and thereby avoid the trauma and stigma of involuntary psychiatric hospitalization. This bill is identical to **SB 544.**

HB 1118 (Bell) - **Involuntary admission; transportation; transfer to local law enforcement.** This bill amends §§ 16.1-340.2, 16.1-345, 37.2-810 and 37.2-829 by providing greater clarity on who has the authority to transport a minor or adult who has been ordered into a psychiatric facility. First, the bill makes clear that a magistrate, after issuing a temporary detention order (TDO) for a person's hospitalization, may change the authorized transportation provider for that person at any time prior to the actual transport of the person. Second, the bill provides that, where a non-law enforcement transportation provider has been authorized to transport a person to the hospital under a TDO or under an order of involuntary commitment, and such a provider becomes unable to complete the transport, the law enforcement agency in the jurisdiction where the transport breaks down "shall" take custody of the person and provide transportation to the proper facility. This bill incorporates **HB 1117** and is identical to **SB 603.**

HB 1452 (Hope) - **Temporary detention for observation and treatment.** This bill amends §§ 37.2-808 and 37.2-1104 to clarify existing provisions of § 37.2-1104 (entitled "Temporary detention in hospital for testing, observation or treatment" and often informally referred to as the "medical TDO" statute) and the relationship of the "medical TDO" to emergency custody orders (ECOs) entered for individuals in mental health crisis. § 37.2-1104 authorizes a licensed physician to ask the local district court (or, if the court is "unavailable," the local magistrate) to enter an order authorizing the detention, observation, and/or treatment of a patient in a local hospital (often the hospital emergency department) for a maximum of 24 hours if (i) there is probable cause to believe that the person is incapable of making an informed decision about care for a "physical or mental condition" due to the person's "mental or physical condition," and (ii) the "medical standard of care" calls for providing the proposed care within the next 24 hours to prevent injury, disability, death, or other harm from this condition. The bill specifies that "mental or physical condition includes intoxication." The bill also amends § 37.2-808 to make clear that, if the person is being held in the hospital by a law enforcement officer under an ECO, the person is released from the officer's custody as soon as a medical TDO is entered for that person. The bill directs the Department of Behavioral Health and Developmental Services to convene a work group to develop standard policies and procedures regarding medical TDOs. This bill is identical to **SB 738**.

This bill appears to be prompted in part by the finding that a significant percentage of individuals taken into custody under an ECO and later involuntarily hospitalized in state psychiatric facilities under a TDO are intoxicated at the time of their ECO and TDO, and that by the time these individuals arrive at state facilities under a TDO (or shortly thereafter) their intoxication resolves and they no longer meet the criteria for continued involuntary hospitalization. As a result, the petitions that sought their psychiatric hospitalization are dismissed at their commitment hearings. Sending such individuals to state hospitals appears to many to be a waste of limited state hospital resources and ultimately unhelpful to these individuals. There is hope that if these individuals can be successfully detained and treated in the hospital emergency department setting under a "medical TDO," a significant number of unnecessary psychiatric hospitalizations can be avoided. Emergency department directors respond that their departments are not designed, equipped or staffed to provide prolonged treatment of such individuals, most of whom do have underlying serious mental illnesses, and that problems in obtaining timely court review and meeting the

courts' evidentiary standards for establishing patients' lack of capacity make it unlikely that these individuals can be successfully managed in the hospital ED setting.

HB 1453 (Hope) - **Acute psychiatric bed registry; information required to be reported.** This bill directs the Department of Behavioral Health and Developmental Services to establish a work group to evaluate the role of, and make recommendations related to, improving the structure and effectiveness of the psychiatric bed registry in collecting and disseminating information about the availability of acute psychiatric beds in the Commonwealth. This directive is the result of widespread reports that the bed registry process is essentially broken and currently cannot be relied upon for "real time" information regarding available psychiatric beds as originally intended. The work group's findings, conclusions, and recommendations are due to the Governor and the Chairmen of the Senate Committee on Education and Health, the House Committee on Health, Welfare and Institutions, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century by November 1, 2020. This bill is identical to **SB 739.**

HB 1482 (Gooditis) - **Involuntary admission or certification of eligibility order; appeals.** This bill amends § 37.2-821 by clarifying provisions governing appeals of orders for involuntary admission to a psychiatric facility or for certification for admission to a training center (due to intellectual/developmental disability). In particular, it provides that in cases in which a person is released from a facility or center while the appeal is still pending, the review of the appeal shall be in accordance with statutory provisions for testing the legality of a detention.

HB 1699 (Aird) - **DBHDS; work group to study expanding the individuals who may conduct evaluations for temporary detention; report.** This bill directs the Commissioner of the Department of Behavioral Health and Developmental Services to establish a work group to (i) review the current process for conducting evaluations of persons who are subject to emergency custody orders to determine whether they meet the criteria for temporary detention, including any challenges or barriers to timely completion of such evaluations and factors giving rise to delays in completion of such evaluations, and (ii) develop a comprehensive plan to expand the individuals who may conduct effective evaluations of persons who are subject to emergency custody orders to determine whether they meet the criteria for temporary detention. The work group's findings and conclusions and proposed plan must be submitted to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions, Senate Committee on Education and Health, and Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2020. This bill is identical to **SB 768.**

SB 903 (Vogel) - **Hospitals; emergency treatment for substance use-related emergencies; services.** This bill amends § 32.1-127 by requiring the Board of Health to establish regulations requiring hospitals with an emergency department to have protocols for treatment of individuals experiencing a substance use-related emergency, with such protocols including the completion of appropriate assessments or screenings to identify medical interventions necessary for the treatment of these individuals in the emergency department. Such protocols "may" also include a process for providing patients who are discharged directly from the emergency department with recommendations for post-discharge follow-up care for any identified substance use disorder, depression, or mental health disorder, as appropriate. Such recommendations may include instructions for distribution of naloxone, referrals to peer recovery specialists and community-based providers of behavioral health services, or referrals for pharmacotherapy for treatment of drug or alcohol dependence or mental health diagnoses.

Treatment services and insurance coverage

HB 42 (Samirah) - **Health care providers; screening of patients for prenatal and postpartum depression; training.** This bill directs the Board of Medicine to annually send out a communication encouraging primary, maternity, obstetrical, and gynecological health care service providers to screen patients for prenatal or postnatal depression or other depression, as clinically appropriate, and to include in the Board's communication information about the factors that may increase susceptibility of certain patients to prenatal or postnatal depression or other depression, including racial and economic disparities.

HB 115 (Hope) - **Programs to address career fatigue and wellness in certain health care providers; civil immunity.** This bill amends §§ 8.01-581.16, 8.01-581.17, and 54.1-2909 by expanding civil immunity for health care professionals to include those serving as members of, or consultants to, entities that address issues related to career fatigue and wellness in health care professionals who are licensed to practice medicine or osteopathic medicine or who are licensed as a physician assistant. The bill also clarifies that a practitioner's participation in a career fatigue or wellness program does not trigger a requirement to report that practitioner to the Department of Health Professions, unless there is evidence indicating a reasonable probability that the practitioner is not competent to continue in practice or is a danger to himself, his patients, or the public. The bill contains an emergency clause.

HB 145 (Simon) - **Public elementary and secondary schools; treatment of transgender students; policies.** This bill adds § 22.1-23.3, which requires the Department of Education to provide to local school boards by December 31, 2020 model policies on the treatment of transgender students in public elementary and secondary schools, addressing common issues regarding transgender students in accordance with evidence-based best practices and include information, guidance, procedures, and standards. The new section lists eight specific issues to be addressed. By the beginning of the 2021-22 school year, each school board must adopt policies that are consistent with (but may be more comprehensive than) the Department's model policies. This bill is identical to **SB 161.**

HB 386 (Hope) - **Department of Health Professions; conversion therapy prohibited.** This bill adds § 54.1-2409.5, which prohibits any health care provider or person who performs counseling as part of his training for any profession licensed by a regulatory board of the Department of Health Professions from engaging in "conversion therapy" (defined in part as "any practice or treatment that seeks to change an individual's sexual orientation or gender identity") with any person under 18 years of age. Such counseling is declared to be unprofessional conduct and is grounds for disciplinary action, and the expenditure of state funds for such counseling is prohibited by the bill. This bill is identical to **SB 245.**

HB 728 (Hope) - **Secretaries of Education and Health and Human Resources; work group; process for approval of residential psychiatric placement and services; report.** This bill directs the Secretaries of Education and Health and Human Resources to establish a work group to study the current process for approval of residential psychiatric services for children and adolescents, with an emphasis on identifying and addressing barriers to timely placement in such services, especially for those who are in acute care settings. The work group must report its findings and recommendations to the Chairmen of the House Committee on Appropriations, the Senate Committee on Finance and Appropriations, and the Joint Subcommittee to Study Mental Health

Services in the Commonwealth in the 21st Century by December 1, 2020. This bill is identical to **SB 734**.

HB 925 (Coyner) - **DMAS; steps to facilitate transition between two programs.** This bill directs the Department of Medical Assistance Services (DMAS) to establish a process and plan to ensure that any person transitioning from Home and Community-Based Services waiver program to a Medicaid Works waiver program is appropriately assessed and supported in regard to the services needed for the person to live and fully participate in his community, and to further ensure that any such person is able to return to his original program if the transition is not successful.

HB 1056 (Adams) - **Commission on Wellness and Opportunity established.** This bill adds chapter 60 to Title 30 of the Virginia Code, with §§ 30-376 through 30-383, to create a 23-member Commission on Wellness and Opportunity in the legislative branch. The commission, which will meet quarterly, is to develop "a comprehensive framework for defining what wellness means for Virginia that is based on the structural and social dimensions of wellness and the interrelationship of all aspects of the environment to individual and public wellness," "identify priorities and actions" for a "comprehensive framework for wellness," "develop policy recommendations" for comprehensively improving the well-being of Virginia citizens, with attention to "wellness deficiencies and inequities" in the state, and submit an annual report. If no funding is appropriated for the commission in any year, it will cease to exist on July 1 of the fiscal year in which funding ended. Otherwise, the commission sunsets on July 1, 2025.

HB 1332 (Kilgore) - **Statewide Telehealth Plan.** This bill adds § 32.1-122.03:1 to require the Board of Health to develop and implement, by January 1, 2021, a Statewide Telehealth Plan as part of the State Health Plan, to promote an integrated approach to the use of telehealth and telemedicine services (defined in the bill). The Plan must include, among other things, provisions for (i) the use of remote patient monitoring services and store-and-forward technologies; (ii) the promotion of the inclusion of telehealth services in hospitals, schools, and state agencies; and (iii) a strategy for the collection of data regarding the use of telehealth services.

HB 1508 (McQuinn) - **Minimum staffing ratio for school counselors.** This bill modifies § 22.1-253.13:2 to require local school boards to employ school counselors in accordance with new specified ratios, effective with the 2020-2021 school year. This bill incorporates **HB 398**.

HB 1722 (Roem) - **Department of Education; guidance and resources; applied behavior analysis services.** This bill requires the Department of Education to develop and publish no later than November 16, 2020, guidance and resources relating to the provision of applied behavior analysis services in public schools for students who are in need of such services.

SB 177 (Hanger) - **Autism Advisory Council; sunset.** This bill amends § 30-329 by extending the sunset provision of the Autism Advisory Council from July 1, 2020, to July 1, 2022.

SB 256 (Ruff) - **Alzheimer's Disease and Related Disorders Commission; sunset.** This bill amends § 51.5-154 by extending the sunset provision of the Alzheimer's Disease and Related Disorders Commission from July 1, 2020, to July 1, 2023. This bill is identical to **HB 310**.

SB 280 (Barker) - **Health insurance; mental health parity; required report.** This bill, which amends § 38.2-3412.1, codifies an existing requirement that the State Corporation Commission's Bureau of Insurance make an annual report regarding claims information for mental health and substance use disorder benefits, and specifies that claim denials, complaints and appeals and network adequacy be included in that report. The report must be publicly accessible and provided

to General Assembly oversight committees. The bill also directs the Joint Legislative Audit and Review Commission (JLARC) to conduct a third-party review of the Bureau's reports and information compiled by the Bureau from 2017 through 2020, and to report its findings and recommendations regarding mental health and substance use disorder benefits parity with medical and surgical benefits and access to mental health and substance use disorder services. The JLARC report shall be provided to the House Committee on Labor and Commerce, the Senate Committee on Commerce and Labor, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century by December 1, 2020.

SB 864 (Pillion) - **Comprehensive harm reduction programs; public health emergency; repeal sunset.** This bill repeals the sunset on the authorization provided in 2017 under § 32.1-45.4 for the Commissioner of Health, upon the declaration of a public health emergency, to establish and operate local or regional comprehensive harm reduction programs aimed at reducing the spread of HIV, viral hepatitis, and other blood-borne diseases in Virginia, as well as reducing the transmission of blood-borne diseases through needlestick injuries to law-enforcement and other emergency personnel and providing information to individuals who inject drugs regarding addiction recovery treatment services. Such programs may provide for the distribution of sterile hypodermic needles and syringes and the disposal of used hypodermic needles and syringes. This bill is identical to **HB 378**.

Authorized use of naloxone to respond to drug overdose

HB 908 (Hayes) - **Naloxone; possession and administration; employee or person acting on behalf of a public place; immunity.** This bill amends §§ 8.01-225 and 54.1-3408. It expands the list of those authorized to administer naloxone to include an employee or other person acting on behalf of a "public place" (defined as "any enclosed area that is used or held out for use by the public, whether owned or operated by a public or private interest") who has completed a training program on the administration of naloxone or other opioid antagonist is authorized to possess and administer naloxone or other opioid antagonist, other than naloxone in an injectable formulation with a hypodermic needle or syringe, in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health. The bill also provides that a person who is not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal may administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. The bill provides immunity from civil liability for a person who, in good faith, administers naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose, unless such act or omission was the result of gross negligence or willful and wanton misconduct. This bill incorporates **HB 650**, **HB 1465**, and **HB 1466**.

HB 1261 (Hodges) - **Athletic trainers; naloxone or other opioid antagonist.** This bill amends § 54.1-3408 to authorize licensed athletic trainers to possess and administer naloxone or other opioid antagonist for overdose reversal pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice.

Patient information confidentiality and information sharing

HB 548 (Delaney) - **Virginia Freedom of Information Act; exclusions; Department of Behavioral Health and Developmental Services; records of active investigations.** This bill amends § 2.2-3705.3 by adding subsection 13, which exempts from mandatory disclosure under the Virginia Freedom of Information Act records of active investigations that are being conducted by the Department of Behavioral Health and Developmental Services.

HB 1328 (Watts) - **Exchange of offender medical and mental health information and records.** This bill amends § 53.1-133.03 by adding subsection E, which requires a health care provider who has provided services within the last two years to a person who is committed to a local or regional correctional facility to disclose to that facility, upon its request, any information necessary to ensure the continuity of care of that committed person. Exceptions to the disclosure requirement regarding substance use treatment information and information not related to the section are acknowledged. The bill also provides protection from civil liability for any health care provider disclosing information under this subsection, absent bad faith or malicious intent.

SB 575 (Dunnavant) - **Prescription Monitoring Program; information disclosed to the Emergency Department Information Exchange; redisclosure.** This bill amends §§ 54.1-2523 and 54.1-2525 to provide for the mutual exchange of information between the Prescription Monitoring Program and the Emergency Department Information Exchange and clarifies that nothing shall prohibit the redisclosure of confidential information from the Prescription Monitoring Program or any data or reports produced by the Prescription Monitoring Program disclosed to the Emergency Department Information Exchange to a prescriber in an electronic report generated by the Emergency Department Information Exchange so long as the electronic report complies with relevant federal law and regulations governing privacy of health information. The bill appears to be identical to HB 648 (Hurst), though this is not indicated in the Legislative Information Service (LIS) description of either bill. This bill is identical to **HB 648**.

Health care professionals

HB 471 (Collins) - **Health professionals; unprofessional conduct; reporting.** This bill amends §§ 54.1-2400.6 and 54.1-2909, which set out the obligations of the chief executive officer and the chief of staff of hospitals and other health care institutions in Virginia, as well as the directors of licensed home health or hospice organizations and home health organizations exempt from licensure and the administrators of licensed assisted living facilities and providers licensed by the Department of Behavioral Health and Developmental Services, to report to the Department of Health Professions any information of which they may become aware in their professional capacity regarding a health care provider's fitness to practice due to mental health or substance use issues or inappropriate behavior. The bill lowers the threshold for making such a report by requiring a report from these individuals when they: (i) have "a reasonable belief" (vs. the former standard of "reasonable probability") that a health care professional is or may be professionally incompetent, (ii) have a reasonable belief that the health care professional "has *or may have* engaged (vs. the former standard of "reasonable probability" that the health care professional "has" engaged) in intentional or negligent conduct that causes or is likely to cause injury to a patient or patients; (iii) have a reasonable belief that the health care professional has *or may have* engaged in unprofessional conduct (vs. the former standard of "reasonable probability" that the health care professional "has" engaged in unprofessional conduct); (iv) have reached this "reasonable belief"

after "review" of available information and, "if necessary," an investigation "or" consultation with the appropriate internal boards or committees authorized to impose disciplinary action (vs. the former standard of reporting only after "investigation and consultation" with such boards or committees). This bill is identical to **SB 540**.

HB 597 (Murphy) - **Group homes; licensure; certain information required.** This bill amends §§ 63.2-1701 and 63.2-1702 and adds § 37.2-405.2 to require every applicant for licensure or renewal of a license to operate a group home at which services for individuals with mental health or substance use disorder are offered to submit to the Department of Behavioral Health and Developmental Services, together with such application, the following: financial information; information about services and staffing; a statement of the applicant's legal name and the names and addresses of any officers, agents, sponsors, partners, shareholders, or members; and information about any similar operations in other states in which the applicant is involved, together with a list of the states in which licenses have been issued for such operations and the dates for which such licenses were issued. The bill also provides that in the case of an application for licensure as a children's residential facility, the application shall contain information regarding any complaints, enforcement actions, or sanctions against a license to operate a children's residential facility held by the applicant in another state, and the Department of Social Services is required to consider any complaints, enforcement actions, or sanctions against the applicant's license to operate a children's residential facility in another state in its determination of whether to grant a license.

HB 1540 (Collins) - **Behavioral health providers; barrier crimes; exceptions.** This bill amends §§ 37.2-314, 37.2-416, and 37.2-506, which set out the "barrier crimes" that disqualify individuals from employment in state mental health facilities and as direct care staff and in other staff positions in mental health and substance use treatment programs operated by community services boards and licensed providers, and which also provide *exceptions* to such disqualifications. The bill adds additional crimes to the list of barrier crimes for which an *exception* is available in the case of employment with an adult substance use or mental health treatment program at community services boards and at private providers of behavioral health services licensed by the Department of Behavioral Health and Developmental Services (DBHDS). The bill also allows DBHDS to hire individuals convicted of various barrier crimes in a position of employment at a state facility if the Department determines that the individual has been rehabilitated successfully and is not a risk to individuals receiving services.

HB 1653 (Wilt) - **Department of Education; data collection; school counselor positions.** This bill requires the Department of Education to collect data from school boards regarding their ability to fill school counselor positions and their preferences for meeting updated school-counselor-to-student ratios with other licensed counseling professionals. The Department of Education must report the results to the Governor, the Secretary of Education, the House Committee on Appropriations, and the Senate Committee on Finance and Appropriations no later than December 1, 2020.

SJ 35 (Edwards) - **Study; barrier crimes and criminal history records checks; report.** This joint resolution establishes a joint subcommittee to study the Commonwealth's requirements related to "barrier crimes" (those crimes listed in different sections of the Virginia Code as automatically disqualifying individuals from certain employment positions) and criminal history records checks. The joint subcommittee is directed to develop recommendations related to (i) whether statutory provisions related to criminal history records checks, barrier crimes, and barrier

crime exceptions should be reorganized and consolidated into a central location in the Code of Virginia; (ii) whether certain crimes should be removed from the list of barrier crimes; (iii) whether barrier crime exceptions and waiver processes should be broadened; (iv) whether the required amount of time that must lapse after conviction of certain barrier crimes should be shortened; and (v) other changes that could be made to criminal history records check and barrier crimes requirements that would improve the organization, effectiveness, and fairness of such provisions. While the joint subcommittee is directed to submit its recommendations by the first day of the 2021 General Assembly session, the joint resolution also provides that implementation of this resolution is subject to approval and certification by the Joint Rules Committee, which may approve or disapprove expenditures for this study, extend or delay the period for the conduct of the study, or authorize additional meetings during the 2020 interim.

SB 619 (Deeds) - **School boards; mental health awareness training.** This bill adds § 22.1-298.6 to mandate that school boards require each teacher, and other relevant personnel as determined by each school board, employed on a full-time basis, to complete a mental health awareness training or similar program at least once. The new statute authorizes local school boards to provide such training through contracts with the Department of Behavioral Health and Developmental Services, a community services board, a behavioral health authority, a nonprofit organization, or other certified trainer or via an online module. This bill is identical to **HB 74**.

SB 760 (Deeds) - **Licensure of psychologists; Psychology Interjurisdictional Compact.** This bill adds § 54.1-3606.2, entitled "Psychology Interjurisdictional Compact," which authorizes Virginia to become a signatory to the Psychology Interjurisdictional Compact. Under the Compact, psychologists licensed to practice in one of the Compact member states are authorized to practice in any Compact member state. The bill has a delayed effective date of January 1, 2021, and directs the Board of Psychology to adopt emergency regulations to implement the provisions of the bill.

SB 880 (Locke) - **Minimum staffing ratio for school counselors.** This bill amends § 22.1-253.13:2 by modifying required ratios of school counselors in elementary, middle and high schools, beginning with the 2020-2021 school year.

SB 1046 (Deeds) - **Clinical social workers; patient records; involuntary detention orders.** This bills amends §§ 8.01-413, 8.01-581.20, 16.1-340.1, 20-124.6, 32.1-127.1:03, 37.2-809, 38.2-608, 53.1-40.2, and 54.1-2969 by adding clinical social workers to physicians and clinical psychologists as the health care providers who can disclose or recommend the withholding of patient records, face a malpractice review panel, and provide recommendations on involuntary temporary detention orders. Interestingly, the amendment to § 53.1-40.2 also authorizes clinical social workers to be an independent examiner in an involuntary commitment hearing for a person who is a prisoner in the Department of Corrections, but clinical social workers are not given similar authority in involuntary commitment proceedings in any other setting.

Criminal justice

HB 35 (Lindsey) - **Juvenile offenders; parole.** This bill amends § 53.1-165.1 to provide that any person who was sentenced to life imprisonment for a single felony or multiple felonies committed while the person was a juvenile and has served at least 20 years of such sentence, and any person who has active sentences that total more than 20 years for a single felony or multiple felonies committed while the person was a juvenile and who has served at least 20 years of such sentences,

shall be eligible for parole. The bill also amends § 53.1-136 to empower the State Parole Board to adopt, subject to the Governor's approval, rules granting parole pursuant to § 53.1-165.1 on the basis of a prisoner's demonstrated maturity and rehabilitation and "the lesser culpability of juvenile offenders." This bill is identical to **SB 103**.

HB 259 (Simon) - **Unrestorably incompetent defendant; competency report.** This bill amends § 19.2-169.1 to provide that in cases where competency evaluators find that a defendant is likely to remain incompetent to stand trial for the foreseeable future due to an ongoing and irreversible medical condition, and prior medical or educational records are available to support that finding, the evaluation report may recommend that the court find the defendant unrestorably incompetent to stand trial and the court may proceed with the disposition of the case. This eliminates the current requirement that the defendant must nevertheless undergo treatment for a period of time to restore his competency before the court can make a finding that the defendant is unrestorably incompetent to stand trial. The bill also amends § 18.2-308.1:3 to provide that a person found to be unrestorably incompetent to stand trial shall be prohibited from purchasing, possessing, or transporting a firearm. This bill is identical to SB 670.

HB 659 (Hope) - **Department of Corrections; workgroup; recommendations to assist people with developmental disabilities.** This bill directs the Department of Corrections to create a workgroup to review current guidelines and develop recommendations that recognize and make accommodations for inmates with developmental disabilities.

HB 744 (Watts) - **Sentencing of juvenile tried as adult.** This bill amends § 16.1-272 by giving circuit court judges, in cases where a juvenile is tried as an adult and convicted of a felony, discretion to depart from any mandatory minimum sentence required by law and suspend any portion of an otherwise applicable sentence. The bill also requires the court, when sentencing a juvenile as an adult, to consider the juvenile's exposure to adverse childhood experiences, early childhood trauma or any child welfare agency, and to consider the differences between juvenile and adult offenders.

HB 746 (Watts) - **Custodial interrogation of a child; parental notification and contact.** This bill adds § 16.1-247.1, which requires that, prior to the custodial interrogation of a child who has been arrested by a law-enforcement officer for a criminal violation, the child's parent, guardian, or legal custodian be notified of the arrest and the child have contact with his parent, guardian, or legal custodian. Such notification and contact may be in person, electronically, by telephone, or by video conference. Prior notification and contact are not required if the parent, guardian, or legal custodian (i) is a codefendant in the alleged offense; (ii) has been arrested for, has been charged with, or is being investigated for a crime against the child; or (iii) cannot reasonably be located or refuses contact with the child; or if the officer conducting the interrogation reasonably believes the information sought is necessary to protect life, limb, or property from an imminent danger and the questions are limited to those "reasonably necessary" to obtain that information.

HB 1231 (Wilt) - **Department of Criminal Justice Services (DCJS); crisis intervention team training.** This bill amends § 9.1-188, which provides for mental health crisis intervention team training for local police departments through DCJS, by adding "brain injury" to the training and including the Department for Aging and Rehabilitative Services and brain injury stakeholders to the list of entities with whom the DCJS is required to consult in developing the training program. This bill is identical to **SB 494**.

HB 1284 (Hope) - **Correctional facilities; use of isolated confinement.** This bill directs the Board of Corrections, in consultation with a stakeholder work group, to conduct a review of the standards and requirements governing, and the application and use of, isolated confinement in local correctional facilities. A report from that review is due by December 1, 2020.

SB 20 (Ebbin) - **Board of Juvenile Justice; Department of Behavioral Health and Developmental Services; regulations governing the housing of youth pursuant to contracts with the federal government.** This bill requires the Board of Juvenile Justice, in collaboration with the Department of Behavioral Health and Developmental Services, to promulgate regulations governing the housing of youth who are detained in a juvenile correctional facility pursuant to a contract with the federal government and not committed to such juvenile correctional facility by a court of the Commonwealth. The bill specifies a number of matters that the regulations must address, including: standards on the use of force; staff training in cognitive behavioral interventions, de-escalations techniques, and other advanced practices; assuring necessary and appropriate physical and mental health care; and inclusion of a requirement in any contract between a juvenile correctional facility and the federal government to house youth that staff of the Department of Juvenile Justice (DJJ) shall have the same level of access to such youth that DJJ staff would ordinarily have regarding any other youth committed to such facility. This bill is a direct response to a pending federal lawsuit and DJJ investigation regarding conditions in a juvenile correctional facility that housed undocumented immigrant children placed there by the Department of Homeland Security under a contract with the facility.

SB 133 (Stuart) - **Deferred disposition in criminal cases.** This bill adds § 19.2-303.6, which authorizes a court, upon a plea of guilt or upon a finding of guilt after trial, to defer sentencing where the court also finds that the accused has autism spectrum disorder or an intellectual disability and there is clear and convincing evidence that the criminal conduct was caused by or had a direct and substantial relationship to the defendant's disorder or disability. Without entering a judgment of guilt, the court can place the accused on probation subject to terms and conditions set by the court. Upon violation of a term or condition, the court may enter an adjudication of guilt; or upon fulfillment of the terms and conditions, the court may discharge the accused and dismiss the proceedings against him without an adjudication of guilt.

SB 667 (Boysko) - **Arrest and prosecution when experiencing or reporting overdoses.** This bill amends § 18.2-251.03, which addresses the arrest and prosecution of individuals experiencing or reporting alcohol or drug overdoses. Previously, this section provided that a person had an affirmative defense to a charge of unlawful purchase, possession or consumption of alcohol, possession of a controlled substance, possession of marijuana, public intoxication, or possession of paraphernalia if the person at that time was in good faith seeking emergency medical help for himself or another person for a drug or alcohol overdose and remained at the scene and identified himself to responding authorities and was arrested based on his seeking medical attention. The amendment goes beyond the "affirmative defense" protection and instead provides that "no individual shall be subject to arrest or prosecution" for such offenses in those circumstances. This protection does not apply if the request for help is made while officers are executing a search warrant or conducting a search or making an arrest. In addition, the bill provides that "no law-enforcement officer acting in good faith shall be found liable for false arrest if it is later determined that the person arrested was immune from prosecution under this section."

SB 683 (Mason) - **Competency to stand trial; outpatient treatment.** This bill amends § 19.2-169.1 by specifying that, when outpatient treatment is recommended and ordered for restoration

of competency, such treatment may occur in a local correctional facility or at a location determined by the appropriate community services board or behavioral health authority.

SB 818 (Morrissey) - **Behavioral health dockets; established.** This bill adds § 18.2-254.3, entitled "Behavioral Health Docket Act," which establishes behavioral health courts as specialized court dockets within the existing structure of Virginia's court system, offering judicial monitoring of intensive treatment and supervision of offenders who have co-occurring behavioral health issues, such as mental illness and substance use, that are found to have contributed to their criminal conduct. The bill establishes a state behavioral health docket advisory committee in the judicial branch, and gives the Supreme Court of Virginia the authority and responsibility for administrative oversight of implementation of the Act. Each jurisdiction or combination of jurisdictions intending to establish or continue such dockets is required to establish a local behavioral health docket advisory committee, which must establish policies and procedures for the operation of the docket. The Office of the Executive Secretary of the Supreme Court of Virginia shall develop a statewide evaluation model to assess the effectiveness of the participating courts, and by December 1 of each year shall submit to the General Assembly a report regarding its evaluations. The Act is modeled on the Drug Treatment Court Act (§ 18.2-254.1).

Guardianship

SB 585 (Dunnavant) - **Guardianship for incapacitated persons.** This bill amends §§ 64.2-2000, 64.2-2003, 64.2-2007, and 64.2-2009, which deal with guardianship and conservatorship proceedings, and adds § 22.1-217.2. When originally introduced in the Senate, the bill also proposed to add the "Supported Decision-Making Act" as Chapter 12 of Title 37.2. That proposed act would have authorized adults with intellectual or developmental disability to enter into a supported decision-making agreement with a "supporter" (defined in the bill) who assists the person in making and carrying out decisions regarding the matters specified in the agreement. The Act notably includes a statement of the following principles to guide the interpretation and administration of the Act: "All adults should be able to live in the manner they wish and to accept or refuse support, assistance, or protection as long as they do not harm others and are capable of making decisions about those matters… All adults should be able to be informed about and, to the best of their ability, participate in the management of their affairs… All adults should receive the most effective yet least restrictive and intrusive form of support, assistance, or protection when they are unable to care for themselves or manage their affairs alone…The values, beliefs, wishes, cultural norms, and traditions that an adult holds should be respected in managing an adult's affairs."

The bill's proposed Supported Decision-Making Act was deleted in its entirety from the bill in the Senate. Other key provisions of the bill were kept in place. The bill as enacted provides that, if the respondent to a guardianship or conservatorship petition is between 17-and-a-half and 21 years of age and has an Individualized Education Plan (IEP), the guardian ad litem appointed to represent the respondent shall review the IEP and include the results of his review in the report required to be submitted to the court. The bill also requires the guardian ad litem to consider whether a less restrictive alternative, including the use of an advance directive or durable power of attorney, is available to provide assistance to the respondent. (The original bill also required the guardian ad litem to consider and report on whether a Supported Decision-Making agreement would be a viable

alternative to appointment of a guardian or conservator. That provision was removed from the bill in the Senate.).

The bill also requires the court, upon appointment of a guardian or conservator, to inform such person of his duties and to advise that the respondent should be encouraged to participate in decisions, act on his own behalf, and develop or maintain the capacity to manage his personal affairs if he retains any decision-making rights. The bill sets out specific language to be included in all orders of appointment of a guardian.

The new § 22.1-217.2 requires the Superintendent of Public Instruction to make available special education "transition materials" (addressing, among other things, how decisions are to be made regarding a student's special education services once that student becomes an adult) for students and parents to use in their annual IEP meetings, which local school systems are expected to utilize. These materials, prepared by the Department of Education, must include information about powers of attorney and guardianship.

Finally, the bill requires the Department of Behavioral Health and Developmental Services to convene a group of stakeholders to study the use of supported decision-making agreements as a less restrictive alternative to the appointment of a guardian or conservator for an incapacitated person. The Department shall report the group's findings and recommendations to the Chairmen of the Senate Committee on the Judiciary and the House Committee on Health, Welfare, and Institutions no later than November 1, 2020.

As introduced, the bill was a recommendation of the Joint Commission on Health Care.

Oversight of DBHDS and CSBs by State Inspector General

HB 1100 (Carr) - **State Inspector General; powers and duties.** This bill amends § 2.2-309 to require the State Inspector General to establish policies and procedures regarding the intake and investigation of complaints of fraud, waste, and abuse by agencies and staff over which it has jurisdiction, and amends § 2.2-309.1 to specify that the State Inspector General has the authority and duty to provide oversight of the Department of Behavioral Health and Developmental Services and community-based providers to identify system-level issues and conditions affecting quality of care and safety and provide recommendations to alleviate such issues and conditions. As introduced, this bill was a recommendation of the Joint Legislative Audit and Review Commission.

B. The Special Session:

Governor Northam called a special session of the General Assembly over the summer to respond to the range of social and economic impacts from the COVID-19 pandemic and to address racial injustices and inequities highlighted by spring and summer protests throughout the country. The special session, which began on August 14 and lasted to early November, tackled a range of budget, policy and action issues. A number of those issues had both direct and indirect impacts on mental health services in Virginia. Much of the mental health budget enacted by the General Assembly in the general session earlier in the year was preserved. In addition, bills were enacted to bring change to mental health crisis intervention services, with an emphasis on both reducing law enforcement involvement in such interventions (assuming a supportive rather than a primary role) and improving law enforcement officer competencies. As noted below, many of the specifics

of such reform will be up to the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Criminal Justice Services (DCJS) to work out collaboratively with interested stakeholders throughout the state.

Other legislation opens up the ability of community services boards and private mental health providers to provide tele-mental health services directly to their clients in their homes and other community settings. This change holds the promise of dramatically extending and expanding treatment and support services to many clients who need such care but are unable or unwilling to come to standard health care settings for treatment.

Legislation authorizing city and county governments to establish civilian oversight bodies to review local law enforcement policies and practices and the conduct of individual officers could have important positive impact on the culture and practice of police in regard to individuals with serious mental illness. Similarly, legislation giving the Attorney General the authority to open investigations and file civil actions against both local and state government agencies that are believed to be depriving persons of "rights, privileges, or immunities secured or protected by the laws of the United States and the Commonwealth" provides the Attorney General with a potentially powerful tool for correcting law enforcement agency practices that result in inappropriate treatment of individuals experiencing serious mental illness, and particularly those encountering the police in the midst of a mental health crisis.

Emergency Mental Health Services

SB 5038 (McPike) - **Comprehensive crisis services; mental health awareness response and community understanding services (Marcus) Alert System.** This bill adds Virginia Code § 37.2-311.1, directing the Department of Behavioral Health and Developmental Services to develop a comprehensive crisis service continuum comprised of a crisis call center, mobile crisis teams, crisis stabilization centers, and a "Marcus" alert system for mental health crisis response. The Department is required to collaborate with stakeholders to develop a plan for the implementation of a Marcus alert system in every locality over a period of years. The bill also adds Virginia Code § 9.1-193 to direct the Department of Criminal Justice Services to develop a plan for law enforcement's role in the Marcus alert system and protocols for law enforcement participation.

This legislation was the result of a protracted process that involved three different bills and extended conference committee negotiations to produce a final single bill. Two identical bills—**SB 5084** and **HB 5043**—would have amended only Title 9.1 of the Code, directing the Department of Criminal Justice Services to establish the Marcus alert system. That system would divert calls regarding individuals in mental health crisis to "community response teams" led by mental health clinicians, with law enforcement support. The bills required that the law enforcement officers on those teams carry only "non-lethal" force when responding to calls, and that those officers not be in uniforms and not be in vehicles that could be identified as law enforcement vehicles. Neither bill attempted to relate this crisis response system to the existing provisions in Title 9.1 establishing Crisis Intervention Teams (Article 13, §§ 9.1-187 through 190), which were also created with the intention of diverting individuals in mental health crisis from the criminal justice system and providing training for law enforcement officers to more effectively manage encounters with individuals in mental health crisis. In addition, the bills did not make reference to, or relate the Marcus alert system to, any of the "mobile crisis team" programs that are already operated by community services boards in many Virginia jurisdictions and are being expanded as part of the

STEP-VA program for behavioral health services established through the Department of Behavioral Health and Developmental Services.

The term "Marcus" alert system in SB 5084 sand HB 5043 was a direct reference to Marcus-David Peters, a young man who was shot and killed by a police officer in a tragic incident that occurred in 2018. Mr. Peters appeared to be in a psychotic state and was unarmed and naked at the time he was shot. Police body camera video footage showed that Mr. Peters—who had already hit three other vehicles with the vehicle he was driving and then crashed his own vehicle—did not respond to the directions of the officer who had pursued him under lights and siren from the site of Mr. Peters' first collision to the scene of his car's crash. Instead of remaining in his car as directed by the officer, Mr. Peters exited his vehicle through the driver's side window and, already naked, ran onto I-95 without regard to traffic. The body camera video shows that Mr. Peters was hit by a vehicle on I-95 and fell to the highway pavement, where he rolled about for several seconds. Upon seeing the officer, who was standing several yards away on the highway on-ramp, holding a taser pointed in Mr. Peters' direction, Mr. Peters advanced toward the officer, threatening to kill him. The officer, after warning Mr. Peters and retreating back several yards toward his vehicle, discharged the taser when Mr. Peters continued to advance toward him. One prong of the taser hit Mr. Peters but had no apparent effect on him. As described in a detailed report by the Richmond City Commonwealth's Attorney, Mr. Peters continued his advance and "lunged" at the officer and, as Mr. Peters "continued to charge in apparent attack," the officer fired "at least twice," hitting Mr. Peters in the forearm and abdomen.

The Commonwealth's Attorney found that the officer's use of force in this incident was justified, but Mr. Peters' family (and others) vehemently disagreed. As part of their response to Mr. Peters' death, they sought reform legislation regarding police encounters with individuals in mental health crisis. In SB 5084 and HB 5043, which were a product in part of the efforts of the Peters family and mental health reform advocates, "Marcus" is an acronym for "Mental Health Awareness Response and Community Understanding Services."

SB 5038, another bill introduced in the special session to address the crisis response system, proposed to amend Article 13 of Title 9.1, regarding Crisis Intervention Teams, by adding § 9.1-187.1. That new section would add to Crisis Intervention Teams the concept of "Crisis Co-Response Teams," defined in the bill as "a group of mental health service providers working with registered peer recovery specialists and law-enforcement officers as a team, with the mental health service providers leading such team, to help stabilize individuals during law-enforcement encounters and crisis situations." The bill did not place the lethal force limitations on law enforcement team members that the Marcus alert bills did, but it shared with those bills the goal of diverting mental health crisis calls to teams led by mental health service providers, so that direct encounters with law enforcement would be reduced and, with that, the use of force and the resort to arrest would be lessened.

Ultimately, all three bills were merged into a new SB 5038. The final bill adds Article 16 to Title 9.1, establishing the Marcus alert system. The "community care team" concept is maintained, but the "mobile crisis team" and "mobile crisis response" are also included as comparable concepts. The goals of the reformed crisis response system are maintained, but there are no specific provisions limiting law enforcement use of force and use of uniformed officers and identifiable police vehicles as there were in the original Marcus alert bills. Notably, the bill adds a provision requiring localities to establish a "voluntary database" available to the 9-1-1 alert system, where adults with mental health-related issues (or the parents or guardians of minors with such issues)

can provide information that can help crisis team members to understand their challenges and respond to them more appropriately in a crisis. The final bill also sets out DCJS responsibilities to establish a plan and standards for law enforcement participation in the Marcus alert system.

Unlike the three original bills, the final bill also amends Title 37.2 of the Virginia Code, adding § 37.2-311.1, in which DBHDS is directed to develop a "comprehensive crisis system," "based on national best practice models and composed of a crisis call center, community care and mobile crisis teams, crisis stabilization centers, and the Marcus alert system." The Department is to work with DCJS and identified stakeholders in the development of that system, taking into account and incorporating, as appropriate, existing crisis response systems and protocols. Emphasis is given to establishing protocols for diverting crisis calls from 9-1-1 dispatch to mobile crisis/community care team dispatch, and for establishing the role of law enforcement as a backup and support to the mobile crisis/community care teams. DBHDS must establish a Marcus alert system in at least one community services board or behavioral health authority in each of the Department's five regions by December 1, 2021, and expand the system each year until it is established in every such agency in the state by July 1, 2026. The final bill is officially designated as the Marcus-David Peters Act.

SB 5014 (Edwards) - **Minimum training standards for law-enforcement officers; crisis intervention team training.** This bill amends Virginia Code § 9.1-102 to give the Department of Criminal Justice Services (DCJS) the power and duty to establish (1) compulsory training standards for law enforcement officers' basic training and re-certification that includes crisis intervention training, and (2) compulsory in-service training for law enforcement officers that addresses: "(i) relevant state and federal laws; (ii) awareness of cultural diversity and the potential for bias-based profiling as defined in § 52-30.1; (iii) de-escalation techniques; (iv) working with individuals with disabilities, mental health needs, or substance use disorders; and (v) the lawful use of force, including the use of deadly force only when necessary to protect the law-enforcement officer or another person…" The bill also amends § 9.1-188 to require DCJS to develop modules of "principles-based training" as part of basic training and re-certification. All officers who are involved in a crisis intervention team (CIT) program must complete a comprehensive advanced training curriculum. Every locality is required to establish or be part of a crisis intervention team program. Notably, this legislation makes no reference to the Marcus alert system or the "community care team" and "crisis co-response team" concepts for crisis response set out in SB 5038. However, as noted above, SB 5038 requires DBHDS and DCJS to develop a comprehensive crisis response system that takes into account existing crisis response programs.

Telehealth Services

HB 5046 (Adams) - **Telemedicine services; originating site.** This bill amends Virginia Code §§ 32.1-325, 38.2-3418.16 and 38.2-4319 by directing the Board of Medical Assistance Services to amend the state plan for medical assistance services so that there is payment for medically necessary health care services provided through telemedicine services, regardless of the "originating site" for the services or whether the patient is accompanied by a health care provider at the time such services are provided. The definition of "originating site" for such "virtual" services is expanded to include any location where the patient is located, including any medical care facility or office of a health care provider, the home of the patient, the patient's place of employment, or any public or private primary or secondary school or postsecondary institution of higher education at which the person to whom services are provided is located. The bill also

requires insurers and health care plan providers to provide coverage for telemedicine services regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. The bill also prohibits insurers and plans from requiring a health care provider to use proprietary technology or applications as a condition of getting reimbursed for telemedicine services. The Department of Medical Assistance Services is required to continue reimbursing health care providers for Medicaid-covered services delivered via audio-only equipment and by telemedicine services until July 1, 2021. (This bill is identical to SB 5080.)

Criminal Justice System

HB 5055 (Herring) - **Law-enforcement civilian oversight bodies**. This bill adds § 9.1-601 to the Virginia Code to authorize any Virginia city or county to establish a law-enforcement civilian oversight body that may (i) receive, investigate, and issue findings on complaints from civilians regarding conduct of law-enforcement officers and civilian employees; (ii) investigate and issue findings on incidents, including the use of force by a law-enforcement officer, death or serious injury to any person held in custody, serious abuse of authority or misconduct, allegedly discriminatory stops, and other incidents regarding the conduct of law-enforcement officers or civilian employees; (iii) make binding disciplinary determinations in cases that involve serious breaches of departmental and professional standards; (iv) investigate policies, practices, and procedures of law-enforcement agencies and make recommendations regarding changes to such policies, practices, and procedures; (v) review all investigations conducted internally by law-enforcement agencies and issue findings regarding the accuracy, completeness, and impartiality of such investigations and the sufficiency of any discipline resulting from such investigations; (vi) request reports of the annual expenditures of law-enforcement agencies and make budgetary recommendations; (vii) make public reports on the activities of the law-enforcement civilian oversight body; and (viii) undertake any other duties as "reasonably necessary" to provide the oversight authorized by the statute. This bill does not authorize oversight of sheriff's departments. The bill provides that a law-enforcement officer who is subject to a binding disciplinary determination may file a grievance requesting a final hearing under the locality's local grievance procedures. The bill, identical to **SB 5035** (Hashmi), would enable civilian oversight bodies to review, among other things, the conduct of officers and the policies, procedures and practices of the local law enforcement agency in regard to officer interaction with individuals in mental health crisis.

HB 5072 (Lopez) - **Law-enforcement misconduct.** This bill adds § 2.2-511.1 to the Virginia Code. It begins by setting out that it is "unlawful for the Commonwealth or any locality, or any agent thereof, or any person acting on behalf of the Commonwealth or any locality, to engage in a pattern or practice of conduct by law-enforcement officers of any agency of the Commonwealth or any locality that deprives persons of rights, privileges, or immunities secured or protected by the laws of the United States and the Commonwealth." It then provides that the Attorney General has the power to file a civil suit to eliminate, or inquire into or seek to conciliate, any such unlawful pattern whenever the Attorney General has reasonable cause to believe that law-enforcement officers of any agency of the Commonwealth or any locality are engaging in a pattern or practice that deprives persons of rights, privileges, or immunities secured or protected by the laws of the United States and the Commonwealth. Any conciliation agreement with a locality to resolve an unlawful pattern and practice may include a court-enforceable deprivation of certain

local funds if the locality fails to abide by the agreement. This bill, identical to **SB 5024**, provides the Virginia Attorney General with authority similar to that granted by Congress to the U.S. Justice Department (DOJ), which DOJ used for several years to bring enforcement actions against, and to develop consent agreements with, a number of local governments and law enforcement agencies throughout the country where the DOJ found an unlawful pattern or practice by law enforcement toward certain residents or groups of residents. In many localities, such actions resulted in significant changes in the way law enforcement agencies interacted with residents experiencing mental illness, reducing incidents of harm and unnecessary arrests and incarceration.

IV. Case Law Developments

A. Federal Circuit Court Decisions

Fair Labor Standards Act; work requirement as part of residential treatment program: Second Circuit rejects the claim by a former patient of Phoenix House that he was entitled to compensation for the daily work he performed as part of his residential substance use treatment program, with the court applying the "primary beneficiary test" used for assessing unpaid internships and finding that, since the plaintiff received "significant benefits" from staying at Phoenix House (as an alternative to incarceration), he was not entitled to compensation under the FLSA for the work he performed at Phoenix House.

Vaughn v. Phoenix House New York, No. 19-517-cv (2020, 2d Cir.)
https://caselaw.findlaw.com/us-2nd-circuit/1908046.html

Background: Mr. Vaughn entered the Phoenix House residential substance abuse treatment program as an alternative to incarceration for criminal charges. After moving from inpatient to outpatient status, he violated program conditions and was returned to the inpatient program. He refused to conduct work duties that were a part of the program, but after being advised that he would be discharged from the program and returned to jail if he did not do so, he began to comply. He was released 9 months later. Vaughn later sued the program, claiming, among other things, that he was required to work 8 hours a day, 6 days a week, without compensation. Vaughn also stated that although he complained to the program that this uncompensated work requirement violated the Fair Labor Standards Act (FLSA), the program failed to alter the working conditions. The trial court dismissed Vaughn's FLSA claim, finding that Vaughn failed to allege sufficient facts in his pleadings to show that he was an employee of Phoenix House under the FLSA. Vaughn appealed.

Holding: The Appeals Court found that under the facts alleged in Mr. Vaughn's complaint, he was not an employee under the FLSA. It affirmed the trial court's dismissal.

Discussion: The court found Vaughn's situation at Phoenix House analogous to that of an unpaid intern, which had been analyzed by the Appeals Court in the case of *Glatt v. Fox Searchlight Pictures, Inc.*, 811 F.3d 528 (2d Cir. 2016). The Court in *Glatt* set out a number of factual inquiries (based on the three part "primary beneficiary test") to make in order to answer the primary question of "whether the intern or the employer is the primary beneficiary of the relationship." In Mr. Vaughn's case, the Court noted in particular that, although Mr. Vaughn was not compensated for

performing the work required by Phoenix House, Mr. Vaughn received significant benefits from staying at the facility: he was permitted to receive rehabilitation treatment there in lieu of a jail sentence, was provided with food, a place to live, therapy, vocational training, and jobs that kept him busy and diverted from drugs. In its summary finding, the Court wrote: "A recipient of in-patient treatment in a court-ordered drug or alcohol rehabilitation program who performs work for, or on behalf of, the program during the course of treatment, as in the circumstances presented here, is not an employee of the program for the purposes of the FLSA."

Americans with Disabilities Act; law enforcement; deliberate indifference: **Third Circuit reverses trial court's dismissal of a claim by deceased's survivor that the local police department violated the ADA by failing to accommodate mentally disabled individuals encountered by the police, with the Court ruling that the plaintiff made sufficient specific claims of prior acts of police abuse and harassment of individuals with mental disabilities, and of the department's failure to adopt a proposed policy governing police interaction with persons with disabilities that would have resulted in a different police response to the incident which led to the deceased's suicide.**

Haberle v. Borough of Nazareth, No. 18-3429 (3d Cir. 2019)
https://law.justia.com/cases/federal/appellate-courts/ca3/18-3429/18-3429-2019-08-29.html

Background: Claims against the Nazareth Police Department and several officers were brought by Timothy Nixon's survivor, Ms. Haberle, after an incident in which Nixon, experiencing a mental health crisis caused by severe depression, told Ms. Haberle he was suicidal, stole a firearm from a friend, and went to a cousin's apartment. Fearing that Mr. Nixon would commit suicide, Ms. Haberle, Nixon's partner, contacted the police. Rather than address the situation as a mental health crisis, Officer Troxell obtained a warrant for Nixon's arrest, rebuffed the suggestions of fellow officers to get the help of crisis negotiators, and went straight to the door of the home where Nixon was located, knocked on the door, and identified himself as a police officer. Nixon immediately went into a bedroom and killed himself with the gun. In her claim, Haberle argued that Nixon's suicide was the foreseeable result of Troxell's behavior, which amounted to an unlawful seizure of Nixon in violation of the 4th Amendment, and a "state-created" danger in violation of the 14th amendment, and that Troxell's conduct was a result of the Department's failure to implement policies and procedures to accommodate disabled individuals in violation of the Americans with Disabilities Act (ADA). The trial court, on motion of the defendants, dismissed all claims. On appeal, the Appeals Court upheld dismissal of the unlawful seizure and state-created danger claims. The Appeals Court further held that Haberle had not stated a claim for damages under the ADA because she had not alleged facts showing inaction by the Borough amounting to "deliberate indifference" by the police. The Appeals Court remanded with the direction that Haberle be given an opportunity to amend her complaint to cure that defect. Haberle did amend her complaint, but the trial court dismissed it. Haberle appealed.

Holding: The Appeals Court found that the plaintiff raised a "plausible" claim that the Nazareth Police Department had been "deliberately indifferent" in failing to enact proposed policies for accommodating individuals encountered by the Department who have mental disabilities, in spite of known issues with those encounters, and remanded the case to the trial court for further proceedings.

Discussion: The trial court's dismissal was based on the court's finding that Haberle had failed to allege "a pattern of Nazareth police mishandling encounters with citizens experiencing mental health crises that result in citizens' suicides." The Appeals Court ruled that Haberle did not need to plead "such specific allegations," and that the amended pleading did meet requirements for going forward in an ADA claim; the alleged facts showed a history of encounters between disabled individuals and the police that resulted in harm to those individuals and also showed that the Department, aware of those encounters and their risks, failed to adopt an offered policy to address them.

Insanity defense; expert opinion: Ninth Circuit reverses trial court's exclusion of expert testimony by a psychologist offered in support of a defendant's insanity defense, finding that the trial court abused its discretion when it found the proffered testimony irrelevant because the psychologist did not opine that the defendant was "unable to appreciate the nature and quality of his acts at the time the crime was committed," when such a conclusion is the province of the jury. The admissibility of the psychologist's expert testimony should instead be focused on whether it would have assisted the jury in drawing its own conclusions as to a fact in issue.

United States v. Ray No. 18-50115 (2020, 9th Cir.)
United States v. Bacon No. 18-50120 (2020, 9th Cir.)
https://law.justia.com/cases/federal/appellate-courts/ca9/18-50115/18-50115-2020-04-28.html

Background: Patrick Bacon and Daniel Ray were charged with felonies for their armed assault on a fellow federal prison inmate. Mr. Bacon gave notice of his intent to plead not guilty by reason of insanity, but the trial court granted the prosecution's motion to exclude the opinion testimony of Mr. Bacon's proffered expert, Dr. Karim, a psychologist. The court summarized Rule 702 of the Federal Rules of Evidence, as well as the *Daubert* standard, for expert evidence, but ultimately focused on relevance and ruled that Dr. Karim's testimony was "not relevant" because it would "not help the trier of fact to understand the evidence or determine the issue of sanity." Dr. Karim opined that "it would be reasonable to conclude with a high degree of medical certainty" that a person in Mr. Bacon's condition "would have had difficulty understanding the nature and quality of his actions at the time of the offense conduct." The court, however, ruled that the threshold for relevance required him to opine whether Mr. Bacon *met* the insanity criteria, i.e., that due to mental illness, Mr. Bacon was unable to understand or appreciate (as opposed to having difficulty understanding and appreciating) the nature and quality of his acts. The exclusion of Dr. Karim's testimony barred Mr. Bacon's insanity defense. Following his conviction at trial, Mr. Bacon appealed.

Holding: The Appeals Court overturned Mr. Bacon's conviction and remanded for a new trial, finding that the trial court abused its discretion in excluding the testimony of Dr. Karim.

Discussion: Citing its prior ruling in *United States v. Christian*, 749 F.3d 806 (9th Cir. 2014), the Appeals Court noted that an expert witness "must not state an opinion about whether the defendant did or did not have a mental state that constitutes an element of the crime charged or of a defense." That is the province of the ultimate fact-finder, in this case the jury. The trial court abused its discretion by requiring Dr. Karim to provide such an opinion. The proper inquiry for the court is

whether the expert testimony "will assist the trier of fact in drawing its own conclusion as to a fact in issue," and in making that inquiry the court should not limit its consideration to the strength of the expert's opinion. Finding that the trial court did not make the proper inquiry regarding Dr. Karim's proffered testimony, the Appeals Court vacated the convictions and remanded Mr. Bacon's case to the trial court.

B. State Court Decisions

Involuntary medication; competence; due process: D.C. Court of Appeals upholds the involuntary medication of defendants who had been ordered to the hospital for treatment to restore their competency to stand trial, finding that the involuntary medication was given to address the defendants' dangerous behavior in the hospital, the hospital's administrative process met constitutional due process standards for such situations, and the hospital did not have to comply with the *Sell* standards for involuntary administration of medication to restore competency as the defendants contended.

In re Johnny Taylor and Brandon Byrd, Appellants, No. 17-CO-174 and No. 18-CO-334 (DC 2020)
https://casetext.com/case/in-re-taylor-9302044

Background: Messrs. Taylor and Byrd were found incompetent to stand trial and committed to Saint Elizabeths Hospital for treatment to restore them to competency. During that commitment, their treating psychiatrists requested hospital permission to medicate them without consent, *not* to render them competent but in order to curb their violent and dangerous behavior. The psychiatrists' request was approved following an internal administrative hearing process that complied with D.C. Code procedures for the involuntary medication of civilly committed mental health patients. Taylor and Byrd objected, claiming that, because they were pretrial detainees hospitalized to restore competency, they were entitled to special judicial findings as dictated by *Sell v. United States* before they could be involuntarily medicated, regardless of the medication's purpose. In the absence of those judicial findings, their involuntary treatment violated both constitutional due process standards and D.C. statutes. Taylor and Byrd filed motions to enjoin the hospital from medicating them against their will, the D.C. Superior Court denied the motions, and both individuals appealed.

Holding: The Appeals Court affirmed the decision of the Superior Court, finding that, when the purpose of involuntary medication is to stop dangerous, illness-driven behavior in the hospital and not to restore the person's competency to stand trial, the authorization to involuntarily administer medication can come from an internal administrative proceeding. Further, the Court found that the hospital's in-house administrative procedures for approving the involuntary administration of medication met both the statutory standards of the applicable D.C. Code and the constitutional due process standards set out by the Supreme Court in *Washington v. Harper.* The motions filed by Taylor and Byrd were denied.

Discussion: The Appeals Court specifically rejected the argument by Messrs. Taylor and Byrd that their status as pretrial detainees entitled them to additional due process protections against involuntary medication even when that medication was sought to eliminate dangerous behavior,

not to restore competency. The Court noted that the *Sell* decision itself "explicitly envisioned" that pretrial detainees could be medicated involuntarily for reasons unrelated to competency to stand trial. It also rejected the appellants' claim that the administrative hearing process to which they were subjected was inadequate because the procedures approved by the Supreme Court in *Harper* applied to convicted criminals already in prison, and not to pretrial detainees. The Appeals Court found that the appellants' dangerous behavior presented the same challenges to institutional safety as those involved in *Harper.* Any impact that the approved medications might have on the appellants' ability to participate in their trials could be addressed and mitigated after the immediate issue of the danger the appellants posed to other hospital patients and staff had been addressed.

Insanity defense: Indiana Supreme Court reverses multiple arson convictions and finds the defendant not guilty by reason of insanity due to evidence of the defendant's long history of "acute" mental illness and the unanimous findings of three court-appointed evaluators, which was sufficient to establish that the defendant was unable to appreciate the wrongfulness of his conduct at the time of his offense, despite "demeanor evidence" presented at trial indicating that the defendant understood his conduct was wrongful and tried to hide it from others.

Payne v. Indiana, Case No. 20S-CR-313 (Indiana 2020)
https://law.justia.com/cases/indiana/supreme-court/2020/20s-cr-313.html

Background: Jesse Payne was charged with multiple counts of arson or attempted arson but was initially found incompetent to stand trial. That incompetency continued for 11 years. When he finally went to trial, he pled not guilty by reason of insanity. Three court-appointed mental health experts unanimously concluded that he suffered from paranoid schizophrenia and delusional disorder and, as a result, he was unable to distinguish right from wrong at the time of his offense. Nonetheless, the jury found Payne "guilty but mentally ill" (GBMI) on all counts. He was sentenced to a total of 90 years in prison. On appeal, the Court of Appeals affirmed, holding that the "demeanor evidence" presented at trial of Payne's "deliberate, pre-meditated conduct" (Payne attempted to conceal his actions at the time of the arsons) was sufficient to support the jury's conclusion that Payne was sane at the time of his offense, despite the expert opinion to the contrary.

Holding: Acknowledging that the trial court's determination that a defendant was not insane at the time of the offense warrants "substantial deference," and that appellate review must consider "only the evidence most favorable to the judgment," the Indiana Supreme Court also noted that "the inferences drawn by the fact-finder from the evidence at trial must be reasonable and logical." The Court found that in this case "the evidence leads only to the conclusion that Payne was insane at the time he committed the offenses." The Court reversed the GBMI conviction to find Payne not guilty by reason of insanity (NGRI) and remanded the case back to the trial court with instructions to hold a hearing for Payne's involuntary psychiatric commitment.

Discussion: The Court cited the following in overturning Mr. Payne's GBMI verdict: (1) the uniform consensus by all three mental health experts that Payne's mental illness (in particular his severe and persistent delusions and hallucinations) rendered him incapable of appreciating the wrongfulness of his acts; and (2) Payne's long and unremitting history of serious mental illness—beginning at age thirteen—and diagnoses of chronic paranoid schizophrenia, polysubstance abuse,

and anti-personality disorder, which resulted in a continuing pattern of hallucinations, delusional episodes, a series of both voluntary and involuntary psychiatric hospitalizations, and treatments with "a veritable cocktail of antipsychotic medications." The Court noted that, even when Payne was restored to competency to stand trial after 11 years of treatment, his "delusional worldview" persisted, so that while he showed no outward psychotic symptoms, "he possessed little if any rational thought," as reflected in his testimony at trial claiming that he was responding to "an elaborate conspiracy involving criminal activity and obstruction of justice by various government officials." These factors together, in the view of the Court, clearly overrode the "demeanor evidence" (i.e., Payne's conducting the arsons at night to avoid detection, his efforts to conceal his acts, etc.) that was introduced at trial to show that he understood the wrongfulness of his actions and was therefore sane and guilty of these crimes, though mentally ill. A lengthy dissent argued that the Court failed to give to the jury the deference to which it was entitled as the fact-finder, and that such deference would have found that the record contained sufficient evidence to support the jury's verdict.

C. Matter of First Impression: Virginia Circuit Court Decision

Competency; due process; extradition: Fairfax Circuit Court rules that in an extradition proceeding where the mental competency of the detainee is placed in issue, the detainee must have sufficient capacity to assist his counsel with the "narrow inquiry" of whether (1) he is the person sought by the demanding jurisdiction and (2) he was present in that jurisdiction at the time of the alleged offense. Based upon the Court's observations of the detainee, a mental capacity evaluation was ordered.

Re: Solomon v. Kincaid, Case No. CL-2020-993 (Va. Cir. 2020)
https://casetext.com/case/solomon-v-kincaid

Background: Mr. Solomon was detained in Virginia on a warrant for arrest, for extradition to New Jersey. He declined to waive extradition in the General District Court, and through his court appointed counsel petitioned the Circuit Court for a Writ of Habeas Corpus, claiming that his mental incompetence was a bar to extradition and seeking adjudication of whether he was entitled to a mental health evaluation to determine his capacity to assist his counsel and understand the extradition proceedings. Solomon's behaviors while in custody were so challenging that the court arranged for his participation in the hearing by videoconference; further, the Court received evidence and argument on both the extradition request and Solomon's capacity instead of holding separate hearings on each issue. The evidence presented was more than sufficient to establish that Solomon was the man sought by New Jersey authorities, and that Solomon offered no meaningful rebuttal to that evidence.

Holding: The court ruled that, if a detainee is found by the court to be "sufficiently irrational" as to make a mental health evaluation necessary, he is entitled to a "limited" mental health evaluation to determine whether he has the capacity to assist his counsel in regard to the "narrow inquiry" of whether (1) he is the person sought by the demanding jurisdiction and (2) he was present in that jurisdiction at the time of the alleged offense. If he lacks capacity, he is entitled to be "sufficiently restored to a level commensurate with the degree of assistance required."

Finding from observation at the hearing that Solomon had "exhibited sufficient irrationality" to warrant the "limited" mental health evaluation described by the court, the court ordered that evaluation. The court directed that, if the evaluation found that Mr. Solomon had sufficient capacity to assist his counsel in the just-completed extradition hearing, then the extradition could proceed, given the un-rebutted evidence already presented that Solomon was the person sought by New Jersey authorities. The court further directed that if Mr. Solomon was found to lack the requisite capacity, he would be ordered restored to "the limited mental competence called for in the context of extradition proceedings," and the Court would then revisit the extradition evidence at a future hearing.

Discussion: The court noted that there was no legal precedent in Virginia to guide the court in the extradition setting. Further, courts in other states had taken widely varying positions. Citing a variety of U.S. Supreme Court decisions and decisions from other states, the court noted that "due process is flexible and should be tailored to fit the nature of the liberty interest at stake," looking both at the nature of the government function involved and at the individual liberty interest involved. The court observed that an individual who is subject to extradition is entitled to representation by counsel, and that such representation is meaningful only if the individual has the capacity to meaningfully assist counsel. However, given the "summary and mandatory" nature of an extradition proceeding, the extent of the individual's capacity is limited to what counsel may raise in the extradition proceedings in comparison to what may be raised in defense against the crime charged. This is because the issues in extradition are limited to whether the person is the individual being sought by the extraditing state and whether that individual was present in the state at the time of the alleged offense. Accordingly, the scope of the competence required for a detainee in an extradition hearing is narrower than that required for a defendant at trial on a criminal charge.

Notably, because Mr. Solomon also had a criminal charge pending against him in the Fairfax County General District Court, had completed a mental capacity evaluation in regard to that matter, and had subsequently expressed his desire to waive extradition, the circuit court ultimately set a hearing to determine whether he had the competence consistent with the guideposts of its current holding and then decide whether it would entertain his waiver.

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