

DEVELOPMENTS IN MENTAL HEALTH LAW

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In Memoriam

Dr. Samuel Hughes Melton, Commissioner of the Virginia Department of Behavioral Health and Developmental Services, died on August 2, 2019 following an automobile accident. His obituary (available [here](#)), and innumerable tributes to him elsewhere, highlight his extraordinary intelligence and energy, his deep compassion and his dedication to public service. This issue cites presentations made by Dr. Melton throughout 2018 as he led his department's in-

tensifying but unfinished effort to transform public mental health services in Virginia. His leadership will be greatly missed.

I. Update on the Work of the SJ 47 Joint Subcommittee

BACKGROUND

The SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century (“Joint Subcommittee”), established by the Virginia General Assembly in 2014 through [Senate Joint Resolution 47](#), has been engaged in studying in depth the structure and operation of Virginia’s public behavioral health care system and recommending needed reforms.

Early on, the Joint Subcommittee members noted that prior efforts to reform the system had, for various reasons, been limited to improvements in mental health crisis services and hospital care. Those efforts did not adequately address ways to help Virginia residents with mental health needs avoid crisis and live more stable and productive lives. The Joint Subcommittee’s commitment to a broader focus for system change has contributed to critically important changes in the shape and direction of Virginia’s public behavioral health care system, including:

- **STEP-VA:** The Joint Subcommittee has supported legislative adoption of and funding for *STEP-VA* (System Transformation Excellence and Performance–Virginia), a system reform proposed by the Department of Behavioral Health and Developmental Services (DBHDS) to expand and strengthen public community-based behavioral health services and reduce the use and disproportionate expense of state psychiatric hospitals.
- **Permanent supportive housing:** The Joint Subcommittee has supported annual increases in funding for *permanent supportive housing* and other creative housing initiatives to enable individuals with severe and persistent mental illness to live with greater stability in their communities and avoid hospitalization.
- **Tele-mental health services:** It has supported funding for the development and expansion of *tele-mental health services* to increase access to quality care for individuals throughout the state, but particularly for those living in rural areas where access to mental health care is often difficult. It has also supported expanded training for doctors in the use of telemedicine and increased reimbursement for services provided via telemedicine.
- **Mental health services in jails and prisons:** It has supported and recommended funding for *mental health screening of inmates in jails and prisons* and for improved care and *discharge planning services* for those inmates with mental health needs who are returning to the community. It has also supported statutory changes to give the Board of Corrections authority to investigate the deaths of inmates in local correctional facilities.

- **Mental health dockets:** It has supported the development of *mental health dockets* in local courts to provide supervision and services for individuals with mental illness so that they may achieve sufficient stability to end the behaviors resulting in their (often repeated) arrests and incarceration (often for petty crimes).
- **Children’s services:** It has supported expanded and improved mental health *services for children*.
- **Crisis response services:** It has supported improvements in mental health *crisis response services* to improve patient outcomes and reduce the demand on state psychiatric hospitals for crisis care. It has also worked to “de-criminalize” crisis intervention, with some of the specific measures including the expansion of the Crisis Intervention Team (CIT) model and the CIT Assessment Centers (CITACs). It has also supported funding for DBHDS-supervised *non-law enforcement transportation* for individuals for whom Temporary Detention Orders (TDOs) are issued for crisis care. (Such individuals, both children and adults, are currently transported, in handcuffs or similar restraints, in law enforcement vehicles.)
- **Information sharing:** It has supported legislation enabling *better information sharing* among providers and law enforcement to improve crisis response, and reforming the statewide Psychiatric Bed Registry to provide a better “real-time” picture of hospital bed availability for placement of individuals in crisis.
- **Family involvement:** It has supported legislation to provide better *notice to, and opportunity for input by, family members* during a crisis intervention.
- **Expanded access to mental health services through Medicaid expansion:** Members of the SJ 47 Joint Subcommittee also supported Virginia’s expansion of Medicaid coverage, which has made mental health services available to thousands of Virginians with mental illness who had been uninsured and often untreated as a result.

Legislative summary available: The specific pieces of legislation and budget amendments advanced by the SJ 47 Joint Subcommittee from 2014 through 2017 and enacted by the General Assembly are described in a document developed by Joint Subcommittee support staff in the Division of Legislative Services (DLS) that is available [here](#) on the DLS website. A summary of the Subcommittee’s meetings and actions from 2014 through 2017 is available [here](#). The DLS website also has a record of each of the Joint Subcommittee’s meetings, including the studies, reports, and other documents presented at those meetings. To review the Joint Subcommittee’s work meeting-by-meeting in detail, go [here](#) on the DLS website.

Ongoing review of system structure reform: As these measures have been implemented, the SJ 47 Joint Subcommittee has continued to study whether changes in the structure and functioning of the public behavioral health care system would enable that system to operate more efficiently and effectively and reduce current disparities across different parts of the state in the nature and quality of available treatment services. The members have continued to monitor implementation of STEP-VA and the coordination of that process with the development by the Department of Medical Assistance Services (DMAS) of the state’s Medicaid managed care program for the provision of behavioral health services. They have also con-

tinued their focus on mental health services for individuals with mental illness who become involved in the criminal justice system, looking in particular at ways to develop appropriate and enforceable standards of mental health care in local correctional facilities.

2018: AREAS OF FOCUS

While the Joint Subcommittee maintained attention on a number of mental health services and issues, it gave particular focus in 2018 to three areas of concern:

- A. Mental Health Services System Structure and Restructuring;
- B. Mental Health Services in the Criminal Justice System; and
- C. The Census Crisis in the State Psychiatric Hospitals.

A. Mental Health Services System Structure and Restructuring

> June 5 meeting

At its June 5 meeting, Work Group 1 received a presentation (which can be found [here](#)) from Ann Bevan, Director of the Division of Developmental Disabilities and Behavioral Health in DMAS. Dr. Bevan noted that Medicaid is the single largest payer for behavioral health services in the Commonwealth and in the country, and that DMAS is moving Medicaid to a managed care model based on several key principles: integration of behavioral healthcare with primary care; services that are “evidence based”; payment to care providers that is based on performance and meaningful patient outcomes (“value based” compensation); and ease of access to services (“no wrong door”). According to Ms. Bevan, DMAS was working with a large stakeholder group and was receiving consulting and research services from the Farley Center to facilitate the implementation of this managed care model throughout 2018 and 2019. Six Managed Care Organizations (MCOs) are already under contract to manage medical and behavioral health services for DMAS.

Daniel Herr, DBHDS’ Deputy Commissioner for Behavioral Health Services, gave a presentation (available [here](#)) providing an overview of the public behavioral health delivery system in Virginia, including the funding arrangements for CSBs and mechanisms for accountability for the funding provided to the CSBs through the state budget. He listed the behavioral health priorities of DBHDS as

1. implementation of STEP-VA;
2. continued development of “same day access” in the CSBs to ensure care for individuals seeking services;
3. implementation of SPQM (Service Process Quality Management, a web-based tool that aids in using data for operations management and outcomes measurement);

4. reduction of the high census in state psychiatric hospitals by increasing community service alternatives, improving discharge of patients ready to return to the community, and strengthening the partnership with private hospitals;
5. financial realignment to move more state general fund dollars to communities for community-based care while increasing community financial responsibility for individuals who are involuntarily hospitalized; and
6. Medicaid expansion implementation (to ensure that newly Medicaid-eligible individuals with mental health treatment needs obtain coverage).

Jennifer Faison, executive director of the VACSB, which represents the state's CSBs, also described the public mental health system from the perspective of the CSBs. She noted in particular that the CSBs are often the community provider of last resort for behavioral health services, providing care for individuals who are uninsured *and* for those who are insured but whose service needs are not covered by their insurance companies. (A DLS summary of Ms. Faison's remarks, as well as those of Daniel Herr and Ann Bevan, is available [here](#).)

➤ **July 16 meeting**

DBHDS Commissioner Melton made a presentation entitled "Behavioral Health System Accountability and Oversight" (available [here](#)). In that presentation, the Commissioner covered some of the same ground as covered by Daniel Herr regarding DBHDS and the CSBs, but he expanded on Mr. Herr's account in two significant ways.

First, Commissioner Melton noted that DBHDS and DMAS were "partnering to implement a system redesign that addresses all Medicaid mental health services regardless of who provides them – *private or public*." This was notable in light of the facts, shown in Dr. Melton's PowerPoint, that almost 90% of Medicaid behavioral health dollars were spent on three community-based services (i.e., mental health skill building, therapeutic day treatment, and intensive in-home services) and that almost 90% of the Medicaid dollars spent on those services went to *private* providers. Dr. Melton stated that the Medicaid managed care design "will incorporate" STEP-VA into the continuum of services, providing "a more seamless healthcare experience starting with early intervention services."

The goal, according to Dr. Melton, was to ensure that individuals receive, across their lifetime, evidence-based, trauma-informed behavioral health services that meet "best practice" standards. Among the measures to achieve this goal will be reforming DBHDS licensing standards and regulations "to produce a system that ensures quality and accountability *whether an individual is served with state general funds or Medicaid by a public or private provider*" (emphasis added).

Second, regarding accountability and DBHDS oversight of the CSBs, the Commissioner noted that the 2019 performance contract between DBHDS and the CSBs includes additional performance requirements, particularly in regard to continuity of care provided to individuals as they move from inpatient to outpatient settings, so that these individuals experience greater stability in their lives. The Commissioner also noted a plan to use the "DLA [Daily Living

Activities] 20” (described in a “[Fact Sheet](#)” published by MTM Services) as a vehicle for measuring CSB success in helping clients maintain health and stability in their lives.

The ILPPP submitted a report (found [here](#)), exploring the variations in funding and services across CSBs. This report was part of the SJ 47 Joint Subcommittee’s ongoing effort to understand and try to address the disparities in the treatment experience of individuals across the different CSBs in the state. Not surprisingly, those CSBs with the greatest variety of services also had the highest levels of local funding to support those services. Notably, the current data available to ILPPP staff to look at services across the state shows only the kinds of services provided, as the system currently lacks information on the quality of services and outcomes experienced by those receiving services.

The July 16 meeting also included a presentation (found [here](#)) by Ray Ratke of the Virginia Network of Private Providers. Mr. Ratke noted that 86% of community-based behavioral health Medicaid dollars go private providers, and that 85% of the cost to deliver those services goes to pay those providers’ employees. Mr. Ratke submitted that the behavioral health care system’s move toward “value based” contracting is a “good thing,” but that the infrastructure to measure and report the outcomes demonstrating value may be too expensive for some private providers to implement. Similarly, while regulations are “necessary and important,” they can also have unintended consequences and cost implications that compromise care instead of supporting desired outcomes. Mr. Ratke emphasized that there must be a viable business model under which the desired services and outcomes can be achieved, and he expressed the desire of the private provider community to be a partner in the process of developing the wellness-focused model of Medicaid Behavioral Health Managed Care.

➤ **August 7 meeting**

At its August 7 meeting, Work Group 1 continued to consider different structural options for Virginia’s behavioral health service systems by hearing three different presentations: an overview of state behavioral systems across the nation, and overviews of Virginia’s public health and social services systems.

A presentation (available [here](#)) by PCG Health, a consulting firm, regarding other state behavioral healthcare systems, identified the following “key structural variables distinguishing state behavioral healthcare systems”:

1. *Proximity to the Governor*: The closer the state mental health agency is to the Governor in the executive branch, the higher the state fund expenditures on mental health care. PCG noted that DBHDS “reports to the governor through a single intermediary, which is typical of other states.”
2. *Location in State Government*: “The way a SMHA [state mental health agency] is organized within the state government influences how much it spends per capita.” “Independent SMHAs within the state government spend more per capita than those under an umbrella agency.” DBHDS is viewed by PCG as “an independent agency.”

3. *State-Based vs. County-Based Organization*: PCG identified “three primary methods of organization and funding of community mental health services by SMHAs”:

- a. State-Operated: The state is the “direct service provider for community services.” It generally relies more on state general funds and less on Medicaid and other insurance sources and tends to have the highest administrative costs and the lowest per capita costs of the three models. There are “consistent standards of service provision and management across the state.” Only 5 states have this model.
- b. Locally-Operated: “County/City is the direct service provider for community services.” “SMHA role in community services [is] limited to funding, oversight, and limited coordination.” This model leverages “local health care dollars” and has more overall funding available. “Many large states rely on [a] county-based system for funding and administrative reasons.”

Generally this model has the highest per capita expenditures overall, and is usually characterized by “internally fragmented standards and service provisions, disparities in health outcomes and access to care in different parts of the state, and less-efficient coordination of care.” This makes a “state-wide transformation” in care “a difficult undertaking.”

“Most of the nation’s largest states feature locally-operated services, including New York, California, Texas, Pennsylvania, and Ohio.” Virginia does so as well.

- c. State-Contracted: “Private organizations are the direct community service provider,” with the SMHA directly funding community providers to deliver services.
4. *Relationship with Medicaid Authority*: “The extent of the relationship between SMHAs and the state’s Medicaid Authority directly affects expenditure.” “States with close organizational relationships between the SMHA and Medicaid authority are usually better equipped to coordinate Medicaid-financed community services with the rest of the system.” PCG noted that Virginia’s DBHDS is separate from DMAS.
5. *Authority over State Hospitals*: DBHDS, like the SMHA in almost all states, operates the state psychiatric hospitals. “There does not appear to be any dominant, or best-practice solution to decide how different stakeholders are to be accountable for hospital admissions and discharges. However, there is general consensus that the state maintains control over admissions, and community providers should have ‘skin in the game’ over discharges.”
6. *Other Service Populations*: “Virginia is one of 10 states that consolidates MH, SUD, and I/DD services under a single agency.”

The PCG consultants also reviewed recent behavioral health system structural reforms undertaken in other states. Significantly, PCG found no dominant trend, as different states have chosen to adopt dramatically different models. Models include:

- *Integration*: for example, Texas “has consolidated most of its safety net agencies under its Health and Human Services Commission to form a super-agency.” (Notably, this reform is in the context of an overall model of county-based mental health service delivery.)
- *Regionalization*: for example, Wisconsin “recently completed a number of pilots to determine whether a regional approach is feasible for its county-based system.”
- *Localization*: for example, California has “returned to its county-based system after years of enhanced state authority.” Its SMHA is “restricted to state hospital administration.”

Work Group 1 also heard presentations on the structure of community-based public health services (found [here](#)) through the Virginia Department of Health and on the structure of public social services (found [here](#)) through the Virginia Department of Social Services. Notably, the presentation on public health services noted that there is a state statutory mandate for cities and counties to establish local agencies to provide community-based services and a state requirement that each locality provide a level of funding to supplement state dollars appropriated to cover the costs of such services (similar to the arrangement for community mental health services). The Public Health Department presentation then set out the following observations:

- “Cities and counties without strong revenue base tend to pay less, but also tend to have greater need.”
- “They cannot ‘match’ additional state resources, despite need.”
- “Cities tend to have more established, better funded public health services.”
- “Is revenue generating capacity of a locality the best approach to funding public health?”
- “Funding formula does not recognize health disparities, or social determinants of health.”

The observations mirror those that have arisen in regard to the funding of the public mental health system.

A document providing a comparison of “state-local governance and collaboration” in the public health system, public mental health system, and social services system was provided to Work Group 1 at its subsequent meeting and is available [here](#).

➤ **September 5 meeting**

In a presentation on “Children’s Community-Based Behavioral Health Services” (available [here](#)), Margaret Nimmo Holland, Executive Director of Voices for Virginia’s Children, noted

that while the General Assembly had recently provided funding for some important children's mental health services, Virginia continued to underfund children's services. She emphasized the importance of such services as key to prevention and early intervention in mental health care, and she identified other key developments that will require the expansion of such care, including:

- the proposed behavioral health transformations in Medicaid managed behavioral health care, which will have a re-designed continuum of services starting at “the beginning of life;”
- the federal Family First Prevention Services Act, which both enables and requires increased mental health services for children at risk of foster care and for children in the foster care system (with the requirement that such services be evidence-based); and
- the increased attention by Virginia to school safety for children, which will bring to the forefront the need for school-based mental health services.

Ms. Nimmo Holland asked a number of questions regarding mental health system capacity into the near-term and long-term, including whether DBHDS and the CSBs were developing STEP-VA services to match the requirements of the Family First Prevention Services Act, and whether there is the infrastructure in place to provide school-based services to children.

DBHDS Deputy Commissioner Mira Signer made a presentation on “Behavioral Health Medicaid Transformation” (found [here](#)) that echoed much of the June 5 presentation by Dr. Bevan on behalf of DMAS. It was significant in its emphasis on the joint effort of DBHDS and DMAS, working with the Farley Center as a consultant, to develop the Medicaid managed care behavioral health care system in a way to ensure that it “aligns with and supports STEP-VA.” A presentation on the “strategic plan” was planned for early in 2019.

A study presented to Work Group 1 by the ILPPP entitled *CSB Structure, Financing, and Governance* (available [here](#)), provided the following key findings:

- “Level of service provided, sources of funding, and particularly level of local financial support, vary widely” across the CSBs, with CSBs in rural areas (and some in less affluent urban areas) having fewer services due largely to having less funding and financial support.
- “Political structure of CSBs strongly affects level of funding and political support,” with the most strongly financially supported CSBs being ‘Administrative Policy Boards’ that are agencies of their local governments - most of which are located in more affluent urban/suburban jurisdictions. They receive not only substantial funding from the local government of which they are a part but also have many administrative services and supports (human resources, IT, office space and maintenance, etc.) provided by other local government departments. In contrast, ‘Operating Boards’ are independent entities serving multiple local jurisdictions and most are located in rural and largely low-income areas. They have substantially less financial support from those jurisdictions and must bear the costs of all of their administrative infrastructure and operations.

- “A substantial portion of ALL local funds invested in mental health services in the Commonwealth is concentrated in 11 Administrative Policy Boards” (e.g., in FY 2017, \$261M out of \$287M total local mental health funding). Those 11 Boards serve 50% of Virginia’s residents.
- “Medicaid funds are playing an increasingly important role in the system.”
- “Operating CSBs face greater challenges than Admin-Policy CSBs, due to a comparatively weaker sense of ‘ownership’ by participating local governments.”
- “Many operating CSBs, especially small rural boards, face substantial fiscal vulnerability” given their limited local financial support, their dependence upon Medicaid reimbursement for services as their primary source of revenue, and the increasing uncertainties (and current delays in reimbursement) in the Medicaid system.
- “As presently administered, the ‘local match’ is an inefficient and outdated device for increasing local mental health funding.” The current 10% match requirement is beyond the capacity of some localities. Limits in local match can also lead to some CSBs being unable to pursue grants for additional services because the grants also require a local match, which the localities cannot afford.
- “CSB Board members vary significantly in level of involvement.”
- “Regional arrangements” involving collaborations among the CSBs in each of the state’s five mental health services regions to implement region-wide services or projects “have been successfully used.” These collaborations have taken different forms in different regions, and have been particularly useful in psychiatric hospital census management and in creating and managing “high-intensity, low-demand services” (e.g., Crisis Services Units) that individual CSBs could not support on their own.
- “DBHDS will likely need additional capacity for oversight,” as the ILPPP found that DBHDS’s current “oversight practices” “are not grounded in robust and systematic data analysis.”
- “DBHDS formula for allocating state general funds to CSBs requires review,” as the current allocation of state funds to CSBs “appears to be based primarily on historical levels, perceived immediate needs, and ongoing support for legislatively targeted programs (e.g., CIT programs, CSUs) and does not explicitly consider such factors as “local cost of living, ability to pay, level of local support, Medicaid penetration, and other demographic factors.”

Given these findings, the ILPPP report suggested three possible policy initiatives:

1. Ask JLARC (the Joint Legislative Audit and Review Commission) “to study the formula currently used by DBHDS to allocate state general funds for mental health services among CSBs” and “assess alternative approaches” for both “allocating” and “leveraging” state general funds to assure adequate access to services in the underserved areas of the Commonwealth.
2. Direct DBHDS (or the Secretary of HHR), in consultation with stakeholders, to study the feasibility and potential advantages and disadvantages of “consolidating the smallest CSBs with larger adjacent CSBs.”
3. Strengthen the capacity of DBHDS “to oversee the delivery of mental health services by CSBs”, and determine how that might best be done.

➤ **November 5 meeting**

At the November 5 meeting, Connie Cochran, Acting DBHDS Deputy Commissioner, submitted a report (available [here](#)), entitled *Building Behavioral Health System Accountability*. The presentation focused on the use of the annual performance contract between DBHDS and each of the 40 CSBs as a mechanism for ensuring proper service delivery and outcomes. She noted in particular the changes made in DBHDS structure to enhance the capacity of DBHDS to ensure accountability from the CSBs and recent changes in the terms of the performance contract to provide for specific services and outcomes from CSBs.

Among the future and even more fundamental changes in the performance contract planned by DBHDS is the move to an “outcome driven” contract based on collected data that measure service outcomes. In particular, the DLA-20 (described earlier and explained [here](#)) will be used to measure individual outcomes. Relatedly, the SPQM will provide a web-based “dashboard” that will pull together the collected data in a form that will allow for meaningful review of agency performance.

Ms. Cochran also pointed to “regional collaboration” as a key component of the system reform process, noting that key services, such as crisis care and residential services, “thrive in a regional delivery model.” She also noted that the regional model adopted by DBHDS for ongoing use is an eight-region variation on the five Health Planning Regions (HPRs) into which the 40 CSBs are currently organized. Two of the existing HPRs - Region II (northern Virginia) and Region IV (central Virginia, surrounding the Richmond metro area) will remain the same, as they are “compact, primarily urban regions,” and two subregions will be established within each of the remaining regions I, III and V.

The System Structure and Finance (SSF) Expert Advisory Panel submitted two reports, one on the method of allocating state general funds to the CSBs and the other on the potential for a regional model for community behavioral health services.

The SSF panel report on state fund allocation (found [here](#)) followed up on a key suggestion from the ILPPP study of the CSB system presented at the September 5 meeting—namely, that JLARC study the current fund allocation model for CSBs and make recommendations

regarding other possible funding models. The report states that the “mechanism for distributing state general fund dollars to CSBs currently tends to operate on a ‘maintenance of effort’ basis from year to year and does not reflect a systematic assessment of local needs,” failing to account for such factors as “population, Medicaid penetration, income, and ability of localities to raise revenue.” Noting the Joint Subcommittee’s commitment to giving Virginia residents the assurance of a baseline of public mental health services available to them anywhere in the Commonwealth, the Advisory Panel recommended that JLARC be asked to examine both the current funding system and alternatives models. At the same time, the Panel cautioned that many CSBs currently face a number of financial stresses, and suggested that any new funding formula “should apply exclusively to new funds... [in order to] avoid disruptive effects on service delivery in the event that longstanding funding allocations were suddenly erased.”

The SSF panel also reviewed the regional collaborations of the CSBs and the potential for a regional model of DBHDS oversight of CSB services. (The report is available [here](#).) The report noted that the primary functions of the current regional collaborations are “to manage funding streams and programs relating to hospital utilization, and to manage services that are high intensity but low incidence and as such can be delivered more efficiently when done in partnership with multiple CSBs.” The regions also provide a venue for collaborative problem solving, which can offer CSBs the flexibility to respond to challenges that may be unique to their part of the state. The report noted that other states, such as Georgia, have more formalized regional organization of their local CSBs, with Georgia’s Department of Behavioral Health and Developmental Disabilities having regional field offices to work with the CSBs in each region. It pointed out that, while such regional organization was a possible model, there was no clear evidence that it would be superior to other options for improving DBHDS oversight of and partnership with the CSBs.

DBHDS Commissioner Melton provided a STEP-VA Implementation Update (available [here](#)) to a meeting of the whole committee on November 5. Dr. Melton noted that the process of fully identifying and defining the services included in each category of the STEP-VA model remains an ongoing process. Notably, the Commissioner placed all of STEP-VA firmly within the Medicaid Behavioral Health Redesign framework, indicating that essential behavioral health services will be categorized, defined, and compensated in the same way under both STEP-VA and Medicaid. This compatibility of the two systems will be vitally important to the CSBs who, as a result of Medicaid expansion in Virginia, increasingly rely on Medicaid reimbursement to pay for the services they provide.

➤ **December 4 meeting**

The “update” provided jointly at the December 4 meeting by DBHDS and DMAS on Medicaid Behavioral Redesign (available [here](#)) confirmed the Commissioner’s November 5 presentation of a full integration of STEP-VA with Medicaid Behavioral Health Managed Care.

The joint presentation stated that “the need identified” in the Medicaid transformation effort “is to establish an array of services that complement the foundational changes that STEP-VA

provides.” The “process” for the development of that array of complementary services “is through the concurrent redesign of the Medicaid behavioral health services to support and sustain STEP-VA.”

The Medicaid behavioral health redesign also envisions alignment with a number of other key health, behavioral health and developmental initiatives, including, for example, the federal Family First Prevention Act (regarding services to children at risk of foster care placement and to those in foster care); Addiction and Recovery Treatment Services (ARTS); Evidence Based Practices implementation by DJJ in regard to juveniles served by DJJ; and the Virginia Mental Health Access Program (VMAP, a VDH program to expand the capacity to provide mental health care for children and adolescents in primary care settings). The “long term vision” is to “shift our system’s need to focus on crisis by investing in prevention and early intervention with mental illness.” The presentation described a redesign process that involves input from and collaboration with a variety of stakeholders, and noted the “strong precedent” in other states for system change “through developing capacity for integrated care in physical health and school settings.” “Formal implementation planning” was set to begin in March of 2019.

➤ **Mental Health System Structure and Finance recommendations to the 2019 General Assembly**

Based upon the recommendations from Work Group 1, the SJ 47 Joint Subcommittee legislative package included the following:

1. ***“Right-sizing” the state hospital system:*** Request that the Department of Behavioral Health and Developmental Services prepare a plan to “right size” the state hospital system, including appropriate capacity and distribution of capacity, and take steps to transition from the current system to the right-sized system.
2. ***Tele-mental health services:***
 - a. Introduce a Budget Amendment allocating \$1.1M General Funds to support the third year of activities related to the Appalachian Tele-mental Health Initiative – Virginia Pilot.
 - b. Introduce Budget language during the 2019 Session to bring forward unspent funds from the previous fiscal years that were allocated to the Appalachian Tele-mental Health Initiative – Virginia Pilot. (Those unspent funds would otherwise revert to the State General Fund at the end of SFY 2019.)
 - c. Reintroduce a Budget Amendment in the 2019 Session to allocate \$671,000 General Funds in the first year, and \$704,550 General Funds in the second year, of the FY 2019- 2020 State Budget, in order to increase psychiatrist rates paid by the Department of Medical Assistance Services.
 - d. Introduce a Budget Amendment in the 2019 Session to allocate State General Funds to increase the Department of Medical Assistance Services telehealth origi-

nating site facility fee to 100% of the Medicare rate, including annual Medicare fee increases.

A report on the fate of those initiatives in the 2019 General Assembly session is available [here](#).

B. Mental Health Services in the Criminal Justice System

➤ June 5 meeting

The support staff for Work Group 2 developed a proposed work plan, with the following major areas of focus:

- “Identifying barriers to CSBs providing services in jails;”
- “Reviewing data on recently approved improvements, including the mental health jail screening tool, forensic discharge planning, and alternative transportation;” and
- “Reviewing the results of the Locality Readiness Assessment conducted by the Criminal Diversion Expert Advisory Panel” regarding localities’ capacity to implement Crisis Intervention Team (CIT) training and programming, including in some instances the establishment of a CIT Assessment Center (CITAC).

The DLS summary of the meeting is available [here](#).

➤ August 7 meeting

Michael Schaefer, Ph.D., Assistant DBHDS Commissioner for Forensic Services, made a presentation on *Mental Health Standards for Virginia’s Local and Regional Jails* (available [here](#)). Dr. Schaefer noted that while the Virginia Board of Corrections (BOC) has medical/behavioral healthcare standards for the 59 jails that it certifies, those standards focus on the jails having policies and procedures in place and do not address the availability and quality of care within the facilities. Dr. Schaefer noted that 76% of the funding for behavioral healthcare services in the jails comes from local funds and only 6% from state general funds.

After several high-profile cases raised concerns about the quality of medical and behavioral healthcare services in the jails, the Joint Commission on Health Care (JCHC) directed a staff study of jail medical and behavioral health services. At the same time, DBHDS formed a work group of stakeholders to develop a set of standards for behavioral health care in the jails.

The DBHDS work group developed 14 standards addressing the following issues: access to care; policies and procedures; communication of patient needs; mental health training for correctional officers; mental health care liaison; medication services; mental health screening; mental health assessment; emergency services; restrictive housing; continuity and coordination of care during incarceration; discharge planning; basic mental health services; and

suicide prevention. Dr. Schaefer reported that “most” of the jails would meet about “half” of these requirements, and that additional funding would be needed to enable all jails to comply with all standards.

Dr. Schaefer addressed the question of whether the CSBs could provide the needed behavioral healthcare services in the jails. He noted that some CSBs are currently providing such services to their community jails, but that a number of factors—including the overlap of jail and CSB service areas, the limitations of some jail budgets, the existing (and in many cases satisfactory) contract arrangements between jails and private health care providers, and both workforce and budget challenges for the CSBs—made a uniform requirement of CSB services problematic. Dr. Schaefer recommended a focus on “what” behavioral healthcare services are provided in the jails, rather than a focus on “who” provides those services. He noted that the DBHDS work group was continuing to coordinate with the JCHC in seeking solutions.

➤ **September 5 meeting**

Tori Raiford, Chief of Restrictive Housing and Serious Mental Illness for the Department of Corrections (DOC), made a presentation (available [here](#)) on the DOC’s “Secure Diversionary Treatment Program for Inmates with SMI.” Members of the Joint Subcommittee had expressed concern about the adverse impacts on inmates with serious mental illness from being placed for extended periods of time in restrictive housing within the correctional facilities. Ms. Raiford outlined the different categories of restrictive housing used by DOC for inmates with both SMI and significant behavioral problems that made it impossible for them to safely remain in the general facility population, and she noted the improved active treatment services now being provided in those restrictive settings to enable inmates to improve rather than deteriorate.

Work Group 2 also received a presentation from Judge Downer of General District Court for the 16th Judicial District of Virginia (Charlottesville/Albemarle County) describing that court’s “therapeutic docket” program. As set out in the program’s application to the Virginia Supreme Court for approval as a “specialty docket” (available [here](#)), the effort to create a therapeutic docket in that district was prompted by a consensus among many stakeholders in the local criminal justice system that, despite the success of such diversion programs as CIT, too many people were being incarcerated for behaviors that appeared to be related to their serious mental illness. Research by the University of Virginia confirmed that 23% of jail inmates met the criteria for serious mental illness (SMI), and that fewer than half of those individuals were successfully linked to mental health services. Of those inmates who were “super utilizers” of jail (those with 4 or more jail intakes over the course of the 18-month study, accounting for 5.6 % of inmates but 21% of intakes), one in three met the screening criteria for SMI.

The additional program documents provided to the Work Group included: the *Therapeutic Docket Manual* (available [here](#)); the *Participant Handbook* (available [here](#)); the *Participant Agreement* (available [here](#)); the *Referral Form* (available [here](#)); and a *Q&A* (available [here](#)).

In discussion afterward, Del. Bell noted “the need for local flexibility in testing various approaches to mental health dockets...” (See a summary of that meeting [here](#).)

➤ *October 1 meeting*

The Criminal Justice Diversion Advisory Panel made a presentation to Work Group 2 (found [here](#)) on the feasibility of requiring that CSBs provide mental health services in all Virginia jails. The presentation reiterated most of the pros and cons of such a requirement that were identified in Dr. Schaefer’s presentation in August. The panel noted in particular the following: several jails had successful behavioral healthcare service contracts with other providers, and these successful programs would be disrupted by a requirement for CSB service delivery; many contract medical providers in the jails provide both general health care and behavioral health care while the CSBs provide only behavioral health care; the CSBs face significant workforce challenges now with the increasing requirements of STEP-VA, and most do not have expertise in care delivery in the correctional setting. The panel submitted that more data was needed on the actual needs and deficits in the jails, and that alternative approaches might include (1) providing funding for in-jail CSB services only in those jurisdictions where the jails have been found to be “lacking in quality care;” and (2) enacting amendments to the Virginia Code to provide for “[mental health standards] and regulatory oversight as well as plan for implementation.”

Stephen Weiss, a Senior Health Policy Analyst for the JCHC, presented a report (available [here](#)) entitled *Quality of Health Care Services in Virginia Jails and Prisons, and Impact of Requiring Community Services Boards to Provide Mental Health Services in Jails – Final Report of 2-year Study*. The report reviews the health care needs of inmates in Virginia’s jails, and looks at particular challenges facing the jails in meeting the increasing care needs of inmates. Those challenges include the increasing number of older adults, many with multiple serious medical problems, as well as the increase of individuals with opioid dependence problems, including pregnant women. Mr. Weiss also identified a continuing increase in the percentage of inmates with mental illness and serious mental illness (SMI). Compounding the challenges posed by the medical and mental health needs of inmates is a significant shortage of medical professionals to work in the correctional setting.

Mr. Weiss noted that it was difficult to establish accepted measures of the quality of care to this population. Mr. Weiss cited current DCJS pilot projects that are attempting to determine best practices for mental health care in the correctional setting, and noted the challenges that those projects are facing in making validated findings, in part because of the difficulty in recruiting an adequate behavioral health workforce for a time-limited project. Mr. Weiss also noted that some jails in Virginia currently have an excellent working relationship with their local CSBs for mental health services, and he highlighted the program in Henrico County as a potential model. Like Dr. Schaefer and the Advisory Panel, he addressed the question of whether CSBs should be required to provide behavioral health services to jail inmates, and noted some of reasons against such a requirement, including the fact that some jails are located a substantial distance from any CSB, and that a number of jails already have relationships with medical and mental health providers that are working well.

Mr. Weiss cited the work of the DBHDS work group addressing mental health services in the jails, and endorsed the 14 standards of care developed by that group. He noted that the “policy options” that JCHC staff were presenting in regard to health care for inmates included: funding for development of electronic health records in all prisons; amending the Code of Virginia by adding in Chapter 53.1-5 to require the BOC to adopt minimum health care standards for local and regional jails; developing a “single statewide” HIPAA-compliant release form to facilitate information sharing to improve treatment; and establishing an inter-agency “Local and Regional Jail and Mental Health and Substance Use Disorder Best Practice Committee” to improve care in jails and prisons.

VCU professor Alison Bowman Balestrieri, Ph.D, reported on her survey of the state’s jails regarding their healthcare delivery services for inmates. (Her report is available [here](#).) She began by noting that the state’s jails constitute a “system” only in the loosest sense, as they are independently operated and have no central databank. There currently is “no baseline of knowledge” regarding healthcare delivery services in the jail. Her work, while limited to being a “self-report” by sheriffs and jail administrators, was intended to provide a “baseline” of knowledge. 71% of the contacted facilities participated in the survey.

Dr. Balestrieri noted that most Virginia jails are substantially overcrowded, increasing the challenges of maintaining their health and safety. She also pointed out the following characteristics of jail inmates—contrasting them with prison inmates—that makes care in the jail setting more challenging for jail administrators:

Jail	Prison
Mostly pretrial detainees or short-term post-conviction inmates	All convicted felons
Dynamic average daily inmate population	Static daily inmate population
High population turnover	Low population turnover
High number of annual admissions	Low number of annual admissions
Short lengths of stay	Long lengths of stay
Uncertainty of length of stay	Certainty of length of stay
Jail admission directly from community	Prison admission from jail
Limited if any medical records	Medical records from jail
Crisis care common	Chronic care common

Dr. Balestrieri noted that the “most pressing challenge” as identified by jail staff was the “increasing rates of inmates with serious mental illness.” Her preliminary recommendations for improving care in the jails included:

1. “Include jails in any and all discussions of community health & healthcare reform.”
2. Provide for better “health information exchange and continuity of care.”
3. Provide “full funding for forensic discharge planning for inmates with serious mental illness.”
4. Downsize jail populations.
5. Require that health insurance coverage continue when a person is incarcerated.
6. Expand the availability of telehealth services in the jails.

➤ **November 5 meeting**

Dr. Schaefer of DBHDS updated Work Group 2 on the progress of criminal justice related mental health initiatives that were funded by the 2018 General Assembly (report available [here](#)). Those initiatives included:

- *Grants to establish CIT training programs and CIT Assessment Centers (CITACs) in 6 unserved rural jurisdictions:* Dr. Schaefer reported that the grant applications submitted indicated that the jurisdictions were not yet prepared for a startup of these initiatives. DBHDS was providing further guidance and assistance to the jurisdictions.
- *Grants to establish mental health forensic discharge planning services in local and regional jails:* Grants were awarded to fund proposals for the Hampton Roads Regional Jail and the Southwest Virginia Regional Jail, with the involvement of the CSBs in each of those regions.
- *Intercept II diversion program in rural regions:* Grants were awarded for programs operated by Northwestern CSB and Mount Rogers CSB, with funding available for a third program.

Dr. Schaefer provided a general overview of the grant-funded mental health dockets in Virginia, including the standards for participation by defendants with mental illness, the general requirements of the programs (all programs in Virginia, for example, are “post-plea” programs), and the current data on outcomes for participants. To date, those who have completed the program have had a lower level of criminal justice involvement, have experienced a significant drop in the need for crisis intervention services, and have shown a significant increase in participation in two particular forms of non-crisis mental health services—case management and psychosocial rehabilitation.

Dr. Schaefer also used the presentation to review the multi-step “Sequential Intercept Model” for providing mental health service intervention and support to individuals with mental illness coming into contact with the criminal justice system. The goal is for each community to eventually have a fully functioning Sequential Intercept Model.

➤ **December 4 meeting**

Work Group 2 received a presentation from the SJ 47 Criminal Diversion Expert Panel (available [here](#)) on the following key issues:

- *Enabling jails to receive information regarding the mental health condition and treatment of jail inmates:* The panel recommended an amendment to Virginia Title 53.1 to mandate and set standards for the exchange of mental health information of jail inmates with mental health conditions, subject to the limits of the federal HIPAA Privacy Rule. The panel noted that there are multiple misconceptions about HIPAA restrictions. As an example, the panel pointed out that HIPAA specifically allows health care providers to share with corrections officials medical and mental health information regarding inmates, when that sharing is needed to care for the inmates and ensure the proper operation and safety of the facility. The panel noted that this issue is part of a larger issue for the state's jails: there is no one set of standards regarding the medical and mental health care of inmates.
- *Authorizing and directing the Board of Corrections to establish a set of standards for behavioral health care in local and regional correctional facilities:* The panel noted that currently local correctional facilities are subject to oversight from 6 different agencies, with no set of substantive regulations regarding the mental health care of inmates developed by any of those agencies. The panel recommended that Virginia Code Section 53.1-68 be amended to both authorize and mandate the Board of Corrections to develop such standards, and for those standards to include information-sharing regarding the mental health condition and care of inmates.

➤ **Criminal Justice System Recommendations to the 2019 General Assembly**

Based upon the recommendations of Work Group 2, the SJ 47 Joint Subcommittee legislative package included the following:

1. ***Mental health dockets:*** A bill (a preliminary draft found [here](#)) that would amend Virginia Code Section 18.2-254.2 by requiring the Office of the Executive Secretary (OES) to annually evaluate the “specialty docket” programs operating in the state and report the results to the General Assembly by December 1 of each year.
2. ***Law enforcement officer training:*** A bill (a preliminary draft found [here](#)) to amend Virginia Code Section 9.1-102 by requiring the Department of Criminal Justice Services (DCJS) to address the following in its training standards and published model policies for law enforcement personnel: “Sensitivity to and awareness of persons experiencing behavioral health or substance abuse crises, including chronic homeless inebriates.”
3. ***Mental health treatment standards and inmate medical information sharing in Virginia jails:*** A bill (a preliminary draft found [here](#)) to amend Virginia Code Sections 53.1-40.10, 53.1-68 and 53.1-133.03 to provide for the sharing of medical and mental health information regarding inmates in local, regional, and state correctional facilities by treatment providers with correctional facility operators for the purposes authorized by

HIPAA. The bill also provides for the Board of Corrections (BOC) to develop and enforce standards for medical and mental health care of inmates.

4. ***BOC policies on inmate mental health information exchange:*** A proposal to ask the BOC to “develop policies to improve the exchange of offender medical information, including electronic exchange of information for telemedicine, telepsychiatry and electronic medical chart access by health care providers and report on the policies and implementation plan and related costs by October 2019.”

A report on the fate of those initiatives in the 2019 General Assembly session is available [here](#).

C. The Census Crisis in the State Psychiatric Hospitals

➤ June 5 meeting

Mental health crisis services and emergency response was initially placed under Work Group 2. At the Work Group’s June 5 meeting, a report (found [here](#)) from ILPPP staff noted that Subcommittee leadership had directed the ILPPP to form a statewide TDO task force to address and make recommendations to alleviate the census crisis in the state psychiatric hospitals. The June 5 report stated that, in addition to a statewide panel, regional panels in each of the state’s Health Planning Regions (including three separate sub-region groups in Region 3) had been formed to address the crisis in their respective regions and make recommendations regarding services that could reduce the demand on the state hospitals.

By the time of the June 5 Joint Subcommittee meeting, meetings of stakeholders had been held in Region 4, while in other regions meetings had been or were being scheduled. Findings and recommendations from the Region 4 meetings were shared with CSB leadership in the other regions, who expressed their general agreement with the Region 4 results. Recommendations included the following points:

1. Collecting key data: There was little data available regarding voluntary admissions to private psychiatric hospitals and regarding the varying operational bed capacities of those hospitals (and both are significant factors in bed availability for TDO patients). At that time, the VHHA was facilitating discussions between private hospitals and ILPPP staff on developing and sharing that data. In addition, there was agreement on the need for a more in-depth understanding of the conditions, characteristics and needs of the individuals in crisis being screened for hospitalization under a TDO. To gain this greater understanding, Region 4 CSBs agreed to an ILPPP proposal to collect key data from the pre-admission screening forms completed by CSB evaluators in Region 4 during a one-month period.
2. Developing non-hospital treatment options for individuals experiencing mental health crisis: Different CSBs and advocacy organizations within Region 4 identified and were evaluating the viability of alternatives to emergency psychiatric hospitalization:

- a. Psychiatric Emergency Centers (PECs), which are 23 hour facilities that could be particularly helpful for individuals whose crises are fueled in part by alcohol or drug use.
 - b. Crisis Triage Centers, with a particular focus on developing capacity to help individuals exhibiting aggressive and challenging behaviors.
 - c. Peer-Operated Respite Centers, where individuals can seek out help early on in an effort to avoid escalation into crisis.
 - d. Expansion or modification of the capacity of existing community facilities, such as CSUs.
3. Reviewing the current statutory requirements regarding ECOs and the 8-hour ECO decision-making period for issuing a TDO: In conjunction with the development of non-hospital emergency treatment options, there might be a need to review the current laws on ECOs and TDOs. The review should assess whether changes could be crafted to allow for a longer ECO period (perhaps up to 24 hours) for individuals who are in one of these alternative facilities, as additional time might change the clinical needs of some individuals (particularly those whose crisis is fueled in part by alcohol or drug use) and result in their crisis being resolved without a TDO.
4. Developing local capacity to serve “special populations” whose treatment needs are outside “standard” mental health treatment interventions: Several groups were identified who present behavioral challenges during crisis and placement challenges when hospitalization is no longer needed. They include: individuals who are also experiencing ID/DD; individuals with a history of aggressive behaviors; individuals with complex medical needs; individuals who are homeless or have unstable housing; individuals with dementia. There was agreement over the need to develop local capacities to provide both community-based care and short-term local inpatient care for individuals with these characteristics.
5. Ensuring continuity of services following hospital discharge to lessen risk of re-hospitalization: In the discussion regarding this need, Henrico County noted that it was developing a program, based on an existing program in New York, to identify “high utilizers” early on in their hospitalization and ensure improved collaboration and discharge planning between the hospital and the CSB so that these individuals would continue to receive contact and services following discharge from the hospital.
6. Identifying the non-emergency care that produces the greatest benefit in preventing mental health crises, and securing DBHDS and Medicaid Managed Care support for that care: Several CSB representatives indicated that the existing service payment structure of Medicaid Managed Care was too restrictive, did not allow for needed innovation in community care, and did not cover the costs of care. They also indicated that DMAS’s decision to have 6 statewide Managed Care Organizations (MCOs) resulted in ever-higher administrative costs on CSBs and private providers alike, limiting the effectiveness and timeliness of care.

7. Public-private collaboration: There was general agreement that reducing the current pressures on the state psychiatric hospitals required a robust and open public-private collaboration, including a clear understanding of the current challenges that the public and private sector partners face, and the “business model” upon which each was acting. For example, both the state hospitals and the private hospitals face the same challenges regarding infrastructure maintenance and modernization, qualified staffing levels, increased regulatory requirements, and increasingly complex patients that impact operational costs and the viability of operating at certain bed capacities. The Region 4 stakeholders’ discussion indicated that there were pressures on private hospitals to reduce their psychiatric bed capacities. For this and other reasons, there needed to be a shared “business plan” on psychiatric bed capacity in the region (and statewide), with the goal being to maximize the system’s capacity to effectively respond to and resolve individuals’ mental health crises in the least restrictive way possible, and as close to those individuals’ homes as possible. A key hope of the CSBs and state hospitals was that this effort would include enhancing the capacity of local private hospitals to manage the special behavioral and medical challenges presented by some individuals in crisis.

➤ September 5 meeting

Work Group 1 received a presentation from Region 3 CSB staff regarding the results of a *Crisis Response and Child Psychiatry* program developed with grant funds from DBHDS to serve the entire region (10 largely rural CSBs covering all of Western Virginia). Their report is available [here](#). The report showed that, with sufficient funding to

1. provide timely psychiatric services to children and adolescents via telemedicine,
2. establish one mobile and two center-based crisis response centers, and
3. operate one residential Crisis Stabilization Unit for the region,

the Region 3 CSBs were able to:

- increase child and adolescent access to mental health services by more than ten-fold and
- significantly *reduce* the number of children TDO’d to the Commonwealth Center for Children and Adolescents (CCCA, the state’s only public psychiatric hospital for children and adolescents) during a period when the admissions to the CCCA were otherwise steadily increasing.

➤ November 5 meeting

Three documents on the TDO crisis were submitted for the Joint Subcommittee’s November 5 meeting: a presentation from the ILPPP entitled *The TDO patient crisis in state hospitals: contributing factors, possible responses and continuing challenges* (updated version availa-

ble [here](#)); an interim report of the Statewide TDO Task Force (updated version available [here](#)); and a report (including specific project proposals) from the regional stakeholder group meetings regarding the TDO crisis (entitled *Mental Health Crisis Emergency Response: Improving Care for People in Crisis in Virginia*, not currently available on the DLS website). The presentation and the Statewide TDO Task Force report included a number of key findings and recommendations, including the following:

1. The number of individuals TDO'd to *state* psychiatric hospitals has continued to go up, despite the fact that the *total* number of TDOs issued statewide has stabilized and, in some jurisdictions, has gone down.
2. During the same period, private psychiatric hospitals have accepted increasing numbers of *voluntary* patients and *decreasing* numbers of TDO patients; further, many private hospitals may have fewer psychiatric beds available than they are licensed to have for a variety of reasons (e.g., insufficient staffing to cover all beds).
3. The possible responses to the resulting rising demand on state hospitals include the following:
 - a. Provide more robust access to outpatient services.
 - b. Develop alternative crisis response services, such as mobile crisis teams, peer respite centers, and psychiatric emergency centers (PECs).
 - c. Give individuals who enter certain alternative crisis response services more time (up to 24 hours) to recover from their crisis before deciding whether they need hospitalization. This would require an extension of the Emergency Custody Order (ECO) period from its current 8-hour limit.
 - d. Make it easier to transfer individuals from hospital EDs to community mental health placements (Crisis Stabilization Units, Intensive Community Residential Treatment, and Assisted Living Facilities).
 - e. Develop community placements for hard-to-discharge individuals (citing a study from Region 2, available [here](#), on the need for a residential facility with high levels of care and supervision for individuals with multiple mental health and medical conditions).
 - f. Develop community service competencies to address the treatment challenges presented by individuals with particularly challenging conditions (e.g., those with ID/DD; those with dementia; those with high levels of aggression or a history of aggression; those with complex medical conditions).

➤ **December 4 meeting**

The TDO Task Force submitted a second interim report to the Joint Subcommittee (found [here](#)), and an updated PowerPoint presentation (found [here](#)), which confirmed the findings of the first report and reviewed the Task Force's consideration of (1) community TDO diversion

projects proposed as a result of the regional stakeholder meetings on the TDO crisis, and (2) possible code changes addressing key concerns regarding mental health crisis response.

In regard to the regional proposals, a document developed by ILPPP staff entitled *The Case for a Psychiatric Emergency Center (PEC) Pilot Project* (found [here](#)) was submitted, describing PEC proposals that emerged from Regions 2, 3 (where there were two separate proposals) and 4. In addition, a document setting out a proposal by Region 3a for a mobile crisis team (available [here](#)) was submitted. Accompanying those submissions was a document developed by the National Association of State Mental Health Program Directors (NASMHPD) entitled *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness* (found [here](#)).

The TDO Task Force report noted that the Task Force deferred on recommending funding for a particular TDO-related project, in part due to a desire to maintain primary focus on fully funding STEP-VA and in part due to a recognition that the standard practice in Virginia has been to recommend services, rather than specific projects, to the General Assembly, with specific programs later being selected (if General Assembly funding is provided) through a grant or RFP process.

Concerning the possible statutory changes that were drafted by ILPPP staff (all of those changes are found together as a single document [here](#) on the DLS website), the Task Force had a specific recommendation regarding one suggested statutory change:

Individuals in crisis who have complex medical conditions - The report noted that state hospitals are required by statute to accept *every* person who is held under an ECO and determined to meet the criteria for hospitalization under a TDO but for whom a private psychiatric bed cannot be found by the end of the 8-hour ECO period. As a result of this requirement, the report stated, the state hospitals were receiving individuals whose medical treatment needs exceeded the capacity of the state hospitals to safely treat and manage. ILPPP staff drafted bills that would allow state hospitals to decline to accept TDO patients at the end of their ECO periods—even if no private hospital has accepted those patients—if the patients’ medical conditions are beyond the capacity of the hospital to treat.

The Task Force recommended that “... a suitable body of experts be appointed to study and make recommendations to the General Assembly by the fall of 2019 on how best to address the treatment needs of individuals in mental health crisis who have complex medical conditions and prevent their admission to state psychiatric hospitals that are not equipped to care for them. The specific goals of the study would be to (i) review all relevant data from the CSBs and state and private hospitals to ascertain the clinical characteristics of these patients and the dimensions and scale of this problem and (ii) develop specific proposals regarding the type(s) and sizes of the facilities that are needed to serve them in crisis situations.”

DLS staff drafted a bill (found [here](#)) that would provide General Assembly direction and authorization for such a study.

In regard to the other proposed statutory changes, Task Force members determined that they were not in a position to make a recommendation without further review by their constituent-

cies. The code changes were included in the report to the Joint Subcommittee for its consideration:

- *Amend VA Code Section 37.2-808(K) to ensure that custody of a person held under an ECO is maintained until the TDO that has been issued in a timely manner is actually served.* This proposal was in response to doubts raised by law enforcement officers over whether they have the authority to continue holding a person under an ECO if the person's 8-hour ECO period has passed but a TDO, though issued, has not yet been *served* on that person.
 - *Amend VA Code Section 37.2-1104 to authorize Magistrates to hear requests for Medical TDOs without requiring that the local court must first be found to be "unavailable."* This proposal was in response to concerns raised by emergency room doctors over delays in obtaining court review of their requests for authorization to hold, observe, and treat patients needing emergency care but unable to provide informed consent to such care. Such delays heighten concerns about potential liability for medical providers when they provide treatment that is necessary but does not have clear authorization (and in some cases may be resisted by the patient). The proposed amendment arguably would improve the timeliness and the quality of care provided to patients in emergencies by allowing doctors to seek medical TDOs from the magistrate, without having to first go to the court and determine that the court is "unavailable."
 - *Amend VA Code Sections 37.2-813, 37.2-838 and 37.2-839 to ensure CSB access to patients and patient information for psychiatric hospital discharge planning.* This proposal was intended to facilitate pre-discharge services for individuals hospitalized under a TDO by directing the sharing of information needed to provide those services. Virginia law already requires discharge planning for individuals who are involuntarily committed to state hospitals, and authorizes exchange of information between state hospitals and local CSBs to develop those discharge plans (see Sections 37.2-837 and 37.2-839). This proposal would provide similar information exchange requirements if a CSB offered pre-discharge planning for a person TDO'd to a *private* hospital. (The ability of CSBs to offer such a service will remain contingent upon CSBs obtaining the funding and staffing needed to do this work.)
- **State Psychiatric Hospital TDO Census Crisis Recommendations to the 2019 General Assembly**

Based upon the recommendations of Work Group 1, the SJ 47 Joint Subcommittee legislative package included the following:

1. ***Individuals in mental health crisis with complex medical needs:*** "Request that the Department of Behavioral Health and Developmental Services facilitate a stakeholder group to study options for addressing the treatment needs of individuals in mental health crisis who have complex medical needs."
2. ***Psychiatric Emergency Centers (PECs):*** "Provide funding for a psychiatric emergency center pilot program."

A report on the fate of those initiatives in the 2019 General Assembly session is available [here](#).

The other specific code amendments noted but not acted upon by the TDO Task Force were deferred for possible consideration by the Joint Subcommittee in 2019.

THE SJ 47 JOINT SUBCOMMITTEE’S CONTINUING OPERATION

The Joint Subcommittee voted to ask that the General Assembly continue the Joint Subcommittee’s operations to December 1, 2021. The General Assembly authorized that continuation by passing SJ 301 (found [here](#)).

II. Behavioral Health Related Legislation Enacted in the 2019 General Assembly Session

[HB 1642](#) (Hope) **Restrictive housing; data collection and reporting, Department of Corrections to submit report.** This bill creates Virginia Code Section 53.1-39.1, which requires the Department of Corrections to submit to the General Assembly and the Governor by October 1 each year a report setting out key data about its inmates, with a focus on the Department’s use of “restrictive housing” and “Shared Allied Management” (SAM) units (for vulnerable populations), and the number of full-time mental health staff in correctional facilities. (Identical **SB 1777**.)

[HB 1729](#) (Landes) **Guidance counselors; changes name to school counselors, staff time.** This bill amends several sections of Title 22.1 to change the name of “guidance counselors” to “school counselors” and to require that each public elementary or secondary school counselor spend at least 80 percent of staff time during normal school hours in the direct counseling of individual students or groups of students.

[HB 1878](#) (Garrett) **Naloxone; possession and administration by regional jail employees.** This bill amends Virginia Code Section 54.1-3408(X) by adding “employees of regional jails” to the list of public employees who may possess and administer naloxone or other opioid antagonists, provided that they have completed a training program.

[HB 1917](#) (Stolle) **Department of Corrections; Director to establish health care continuous quality improvement committee.** This bill creates Virginia Code Section 53.1-17.1, which requires the DOC Director to establish a health care continuous quality improvement committee, consisting of the Director and specified health care professionals employed by the Department. The committee must establish criteria for evaluating the quality of health care services in DOC facilities, monitor the care provided by DOC facilities based on those criteria, develop strategies to improve the quality of care, and publish quarterly reports on a DOC website on its work. As introduced, this bill was a recommendation of the Joint Commission on Health Care. (Identical to **SB 1273**.)

[HB 1918](#) (Stolle) **Corrections, Board of; minimum standards for health care services in local correctional facilities.** This bill amends Virginia Code Section 53.1-5 by adding to the powers and duties of the State Board of Corrections the duty to establish minimum standards for health care services (including medical, dental, pharmaceutical, and behavioral health care) in local, regional, and community correctional facilities, along with procedures to enforce those standards. It provides that this be done with advice and guidance from the Commissioner of Behavioral Health and Developmental Services and the State Health Commissioner. The standards must include a requirement for quarterly “continuous quality improvement” reports from these facilities, which the Board must make available on its website. (Identical to [SB 1598](#).)

[HB 1933](#) (Hope) **Prisoners in local and regional correctional facilities; medical and mental health treatment of those incapable of giving consent.** This bill adds Sections 53.1-133.04 and 53.1-133.05 to the Virginia Code (and amends related portions of Sections 17.1-406, 17.1-410 and 37.2-803), to establish a process for the sheriff or administrator of a local or regional correctional facility to petition a court to authorize medical or mental health treatment for a prisoner in that facility who is incapable of giving informed consent to such treatment. The process parallels the process already available in state correctional facilities through Section [53.1-40.1](#), and requires notice, appointment of counsel, and a hearing held either in the local court or in space provided by the sheriff and approved by the court. The court must authorize the requested treatment if it finds that: the prisoner is incapable, either mentally or physically, of giving informed consent; the prisoner does not have a relevant advanced directive, guardian, or other substitute decision maker; the proposed treatment is in the best interest of the prisoner; and the jail has sufficient medical and nursing resources available to safely administer the treatment and respond to any adverse side effects that might arise from the treatment. Liability protections are provided against claims of treatment without consent for treatment given in accordance with the court order.

[HB 1942](#) (Bell) **Behavioral health services; exchange of medical and mental health information and records regarding inmates in local, regional and state correctional facilities; standards for behavioral health services in local correctional facilities.** This bill amends Virginia Code Sections 53.1-40.10 and 53.1-133.03 to authorize local, regional and state correctional officials to obtain from health care providers medical information regarding facility prisoners when such information is necessary (1) for the provision of health care to the prisoner, (2) to protect the health and safety of the prisoner and others in the facility, or (3) to maintain the security and safety of the facility, and to exchange such information among facility staff as necessary to maintain the security of the facility, its employees or other prisoners. Further, the bill amends Virginia Code Section 53.1-68 to direct the State Board of Corrections to establish minimum standards for behavioral health services in local correctional facilities.

[HB 1970](#) (Kilgore) **Telemedicine services; payment and coverage of services.** This bill amends Virginia Code Sections 32.1-325 and 38.2-3418.16 by requiring insurers, corporations, and health maintenance organizations to cover medically necessary remote patient monitoring services as part of their coverage of telemedicine services to the full extent that these services are available. The bill adds and defines the term “remote patient monitoring services.” The Board of Medical Assistance Services is directed to include in the state plan for medical assistance services a provision for the payment of medical assistance for medi-

cally necessary health care services provided through telemedicine services. (This bill is identical to [SB 1221](#).)

[HB 2017](#) (Peace) **Auxiliary grants; selection of supportive housing.** This bill amends Virginia Code Section 51.5-160 to allow individuals receiving auxiliary grants to select supportive housing without any requirement that such individuals wait until their first or any subsequent annual reassessment to make such a selection. The bill directs the Commissioner for Aging and Rehabilitative Services to (1) promulgate regulations to implement the provisions of the bill within 180 days of its enactment and (2) develop guidance documents for implementation of the provisions of the bill no later than February 1, 2020. The bill sets a ceiling 90 auxiliary grant recipients receiving supportive housing, but provides that this can be increased to 120 if the waiting list for this service maintained by DBHDS equals or exceeds 30 as of October 1, 2020.

[HB 2126](#) (Davis) **Specific requirements established for “step therapy protocols” adopted by health benefit plan providers, to ensure the integrity of the protocols and to enable patients to file appeals to request approval of alternative therapies.** This bill adds Virginia Code Section 38.2-3407.9:05 to require that carriers issuing health benefit plans that include “step therapy protocols” (defined as protocols “setting the sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are covered under a...plan”) must comply with specific requirements (such as development of the protocols by multidisciplinary panels, management of conflicts of interest, adoption based on peer-reviewed research and medical practice, and regular updating). In addition, step therapy protocols must provide the patient and prescribing provider with access to a clear and readily accessible process to request a step therapy exception. The measure establishes conditions for granting an exception, and steps for an appeal from denial of a requested exception. These requirements shall apply to any health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2020.

[HB 2158](#) (Plum) **Naloxone; expanding list of individuals who may dispense.** This bill amends subsection X of Virginia Code Section 54.1-3408 by expanding the list of individuals who may dispense naloxone or other opioid antagonist pursuant to a standing order to include health care providers providing services in hospital emergency departments and emergency medical services personnel, and eliminates certain requirements as set out in the bill. It also amends Subsection Y to modify provisions relating to those acting on behalf of organizations that provide services to persons at risk of opioid overdose or training on the administration of naloxone, and adds requirements for the dispensing of naloxone in an injectable formulation with a hypodermic needle or syringe. The bill also allows a person who dispenses naloxone on behalf of an organization to charge a fee for the dispensing of naloxone, provided that the fee is no greater than the cost to the organization of obtaining the naloxone dispensed.

[HB 2213](#) (Heretick) **Providing medical/mental health information of jail inmates to local probation officers for probation planning and supervision.** This bill amends subsection (3) of Virginia Code Section 54.1-133.03 to allow the sharing of medical and mental health information regarding inmates of local and regional correctional facilities to “local probation officers” for purposes of probation planning, release and supervision. Previously the subsection referenced only “probation and parole officers.”

[HB 2318](#) (McGuire) **Naloxone; possession and administration by school nurses and local health department employees.** This bill amends subsection X of Virginia Code Section 54.1-3408 to add school nurses, local health department employees assigned to a public school under an agreement between the local health department and school board, and other school board employees or individuals contracted by a school board to provide school health services, to the list of individuals who may possess and administer naloxone or other opioid antagonists, provided that they have completed a training program.

[HB 2499](#) (Watts) **Department of Corrections directed to develop policies to improve the exchange of medical and mental health information regarding inmates.** This bill amends Virginia Code Section 53.1-40.10 by adding subsection D, which directs the Department of Corrections to develop policies to improve the exchange of offender medical and mental health information, including policies to improve access to electronic medical records by health care providers and electronic exchange of information for telemedicine and telepsychiatry. A report on the Department's progress is due on October 1, 2019, to the Chairmen of the House Committee on Health, Welfare and Institutions, the Senate Committee on Education and Health, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century.

[HB 2558](#) (Pillion) **Medicaid recipients; treatment involving opioids or opioid replacements; payment.** This bill adds Virginia Code Section 54.1-2910.3:1 to prohibit health care providers licensed by the Board of Medicine from requesting or requiring a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance to pay out-of-pocket costs for treatment involving (1) the prescription of an opioid for the management of pain or (2) the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction. The bill further requires providers who do not accept payment from the Department of Medical Assistance Services (DMAS) to give advance written notice to patients who seek such treatment and who receive medical assistance services through DMAS that: (1) DMAS will pay for such treatment if it meets DMAS's medical necessity criteria and (2) the provider does not participate in the Commonwealth's program of medical assistance and will not accept payment from DMAS for such treatment. Such notice and the patient's acknowledgement of such notice must be documented in the patient's medical record. (This bill is identical to [SB 1167](#).)

[HB 2559](#) (Pillion) **Allowing exceptions to the statutory requirement for electronic transmission of prescriptions for a controlled substance that contains an opioid.** This bill adds subsections C and D to Virginia Code Section 54.1-3408.02 to provide exceptions to the requirement of subsection B that all prescriptions for controlled substances that contain an opioid must be issued as an electronic transmission. Exceptions include prescriptions provided directly to the patient or patient's agent or to a medical facility, and certain hardship circumstances. In addition, the licensing health regulatory board of a prescriber may grant the prescriber a waiver of the electronic prescription requirement for a period not to exceed one year due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber. The bill also amends Section 54.1-3410 to provide that a dispenser who receives a non-electronic prescription is not required to verify whether one of the exceptions applies. The bill further requires the Boards of Medicine, Nursing, Dentistry and Optometry to promulgate regulations to implement the prescriber waivers, and requires the Secretary of

Health and Human Resources to convene a work group to review the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid, and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022.

[HB 2652](#) (Hope) **Regulation of licensed providers; Board of BHDS to require disclosure of certain information about employees.** This “Section 1” bill directs the Board of Behavioral Health and Developmental Services to amend regulations governing licensed providers to require that, whenever a person who (a) is a current or former employee of, or associated with, a licensed provider and (b) holds, or held, a position requiring a criminal background check, applies for employment or for a role with another provider in a position that also requires a criminal background check, and the other provider requests (with the written consent of the applicant) information from the first provider regarding the applicant’s fitness for employment, the provider must provide a statement regarding the character, ability and fitness for employment of the applicant (subject to cited confidentiality requirements).

[HB 2693](#) (Price) **Qualified mental health professionals; regulations for registration.** This bill amends Virginia Code Section 54.1-3500 by creating and defining separate licensed/registered positions of "qualified mental health professional-adult" and "qualified mental health professional-child" as sub-categories of “qualified mental health professional.” This bill also creates the new position of "qualified mental health professional-trainee.” The bill also amends subsection 9 of Virginia Code Section 54.1-3505 to require the Board of Counseling to promulgate regulations for the registration of individuals receiving supervised training to qualify as a qualified mental health professional. (This bill is identical to [SB 1694](#).)

[SB 1231](#) (Ebbin) **Modification of court review procedures for capital murder defendants found to be unrestorably incompetent to stand trial.** This bill amends subsection F of Virginia Code Section 19.2-169.3 by changing the timing of the court review hearings for capital murder defendants determined to be unrestorably incompetent. The previous procedure was to hold review hearings every six months, for an indefinite period. Under the new provisions, review hearings will be held annually for the first 5 years, and biennially thereafter, or at any time that the director of the facility providing restoration services submits a report stating that the defendant has been restored to competency. The bill also specifies that no unrestorably incompetent capital murder defendant shall be released except pursuant to a court order.

[SB 1395](#) (Howell) **Threat of death or bodily injury to a health care provider constitutes a class one misdemeanor.** This bill amends subsection B of Virginia Code Section 18.2-60 by providing that any person who orally makes a threat to kill or to do bodily injury against any health care provider engaged in the performing health care duties in a hospital or in an emergency room on the premises of any clinic or other facility rendering emergency medical care is guilty of a Class 1 misdemeanor. Exception: if the person is on the premises of the hospital or facility emergency room as a result of an emergency custody order, an involuntary temporary detention order, an involuntary hospitalization order, or an emergency custody order for a conditionally released acquittee.

[SB 1436](#) (McClellan) **Hospitals required to develop a written discharge plan, including notice to the appropriate community services board, regarding any child suspected of being an abused or neglected child due to prenatal substance exposure.** This bill amends subsection B Virginia Code 63.2-1509 by requiring that, whenever a hospital health care provider reports suspected child abuse or neglect resulting from prenatal substance exposure, the hospital must then develop a written discharge plan that includes, among other things, appropriate treatment referrals and notice to the community services board of the jurisdiction in which the mother resides for the appointment of a discharge plan manager. (The bill also provides that such reports shall not constitute a *per se* finding of child abuse or neglect.)

[SB 1488](#) (Hanger) **Secretary of Health and Human Resources directed to convene stakeholder work group to examine causes of high census at DBHDS psychiatric hospitals.** This “Section 1” bill directs the Secretary of Health and Human Resources to convene a stakeholder work group to examine the causes of the high census at the Commonwealth's state hospitals for individuals with mental illness, and to specifically address the impact on such census from: (1) the practice of conducting evaluations of individuals who are the subject of an emergency custody order in hospital emergency departments; (2) the treatment needs of individuals with complex medical conditions; (3) the treatment needs of individuals who are under the influence of alcohol or other controlled substances; and (4) the need to ensure that individuals receive treatment in the most appropriate setting to meet their physical and behavioral health care needs. In addition, the bill directs the work group to consider the potential impact on such census from: (1) extending the time frame during which an emergency custody order remains valid; (2) revising security requirements to allow custody of a person who is the subject of an emergency custody order to be transferred from law enforcement to a hospital emergency department; (3) diverting individuals who are the subject of an emergency custody order from hospital emergency departments to other more appropriate locations for medical and psychological evaluations; and (4) preventing unnecessary use of hospital emergency department resources by improving the efficiency of the evaluation process. The work group must address issues affecting both adults and children, and develop recommendations for both long-term and short-term solutions and report them to the Chairmen of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century, the House Committee on Appropriations, the House Committee for Courts of Justice, the Senate Committee on Finance and the Senate Committee for Courts of Justice by November 1, 2019.

[SB 1644](#) (Boysko) **Sharing of health information between community services boards and jails regarding inmates who are or have received mental health services from community services board.** This “Section 1” bill directs the Department of Behavioral Health and Developmental Services (DBHDS) to convene a work group to study the issue of and develop a plan for sharing protected health information of individuals with mental health treatment needs who have been confined to a local or regional jail in the Commonwealth and who have previously received mental health treatment from a community services board or behavioral health authority in the Commonwealth. DBHDS must submit a report by October 1, 2019, to the Governor and the General Assembly on (1) development of the plan, (2) the content of the plan, and (3) the steps necessary to implement the plan, including any statutory or regulatory changes and any necessary appropriations.

[SB 1655](#) (Cosgrove) **Ongoing evaluation of and reports on specialty dockets.** This bill adds Virginia Code Section 18.2-254.2 to require the Office of the Executive Secretary (OES) of the Supreme Court to develop a statewide evaluation model and conduct ongoing evaluations of the effectiveness and efficiency of all local specialty dockets established in accordance with the Rules of Supreme Court of Virginia. Local courts must report to the OES as requested, and the OES must submit a report to the General Assembly by December 1 of each year. (This bill is identical to [HB 2665](#).)

[SB 1685](#) (Dunnavant) **Health insurance credentialing and compensation of mental health professionals and private mental health agencies.** This bill amends Virginia Code Section 38.2-3407.10:1 and adds Section 38.2-3407.10:2 to require health insurers and other carriers that credential the mental health professionals in their provider networks to establish reasonable protocols and procedures for reimbursing a mental health professional for mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending, if that application is approved. (Medicare Advantage plans and Medicaid plans are excluded from such requirement.) The bill also provides that if the credentialing application is not approved, the insured patients who are served while the professional's application was pending cannot be charged for those services. The bill also enables insurers to establish reasonable protocols and procedures for credentialing private mental health agencies, so that any mental health professional employed or engaged by any such agency is deemed credentialed. The bill establishes minimum standards that must be maintained by credentialed private mental health agencies.

[SB 1693](#) (Vogel) **Health insurance coverage for autism spectrum disorder.** This bill amends Virginia Code Section 38.2-3418.17 by requiring health insurers, health care subscription plans, and health maintenance organizations to provide coverage for the diagnosis and treatment of autism spectrum disorder in individuals of *any* age, an expansion of this section's current requirement for coverage only from age 2 through age 10. This expanded coverage applies to insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2020. (This bill is identical to [HB 2577](#).)

[SJ 301](#) (Deeds) **Extension of Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century through December 1, 2021.** This resolution continues the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century for two additional years, through December 1, 2021, with an executive summary of the Joint Subcommittee's findings and recommendations to be submitted annually.

III. Providing Emergency Medical Care without Informed Consent: An Important Decision from a Federal District Court

On May 9, 2019, a memorandum opinion issued by Senior Judge Norman K. Moon of the U.S. District Court for the Western District of Virginia (Charlottesville Division) in the case

of *Jane Doe v. Pamela Sutton-Wallace, et al* (case no. 3:18-CV-00041) provided important legal guidance in regard to the authority to provide emergency medical care—even over objection—to certain individuals in mental health crisis. It made clear that the authority to treat exists in regard to patients who are brought to the hospital emergency room for assessment and medical treatment under an Emergency Custody Order entered under Virginia Code Section 37.2-808 (or under the equivalent emergency custody exercised by law enforcement officers as authorized by Section 37.2-808). However, it left unresolved the extent of the authority to provide medical treatment (particularly over objection) when the individual needs emergency care but is not in custody under the specific authority of a state statute.

Background

On January 11, 2018, Jane Doe attempted suicide through carbon monoxide poisoning in her car. A police officer found her and assumed custody of her under Virginia Code Section 37.2-808(G), which authorizes an officer to assume custody of a person who the officer has probable cause to believe “meets the criteria for emergency custody” under Section 37.2-808. Those criteria, set out in subsection 37.2-808(A), are that the person “(i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.” The purpose of taking such a person into custody is to transport the person to an appropriate facility to obtain an evaluation from a trained evaluator from the local community services board to determine whether the person meets the statutory criteria for involuntary psychiatric hospitalization under a Temporary Detention Order (TDO). Evaluators provide their findings to the local magistrate, the only official authorized by statute to enter a TDO, under Section 37.2-809.

Section 37.2-808 originally empowered only magistrates to authorize taking individuals into custody for a TDO evaluation. Magistrates provide such authorization through entry of an Emergency Custody Order (ECO). The section was later amended to empower law enforcement officers to take individuals into custody based on their own determinations in the community. Such action by an officer, now authorized by Section 37.2-808(G), is sometimes referred to as a “paperless ECO,” though it is more accurate to say that it is emergency custody without an order. Under Section 37.2-808, both a magistrate-issued ECO and emergency custody assumed by independent officer action have an 8-hour limit, within which the magistrate must decide whether or not to issue a TDO.

Section 37.2-808(C) specifically authorizes a law enforcement officer transporting a person under Section 37.2-808 to take that person to a medical facility “as may be necessary to obtain emergency medical evaluation or treatment that shall be conducted immediately in accordance with state and federal law.” Further, Section 37.2-808(I) states: “Nothing herein

shall preclude a law-enforcement officer or alternative transportation provider¹ from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.”

In this case, the officer who assumed emergency custody of Jane Doe had her transported to the University of Virginia (UVA) Medical Center for emergency medical treatment. Ms. Doe was awake and alert at the hospital, and made “strenuous objections” to blood or urine samples being taken as part of her emergency assessment and care. Despite her objections, those samples were taken and emergency treatment was given.

The Claim

As a result of this experience, Ms. Doe filed suit against 13 defendants, including identified doctors and nurses and unknown support staff at the UVA Medical Center. Ms. Doe claimed that she was competent to make decisions about her care while in the UVA Medical Center, and that, despite her objections (which apparently included her active physical resistance), she was given injections of drugs (and was not advised of the potential side effects of those drugs) and was physically restrained by several staff in order for blood and urine samples to be taken from her. Ms. Doe stated in her complaint that she was receiving treatment for a diagnosed “post-traumatic stress disorder,” and that this condition had been “exacerbated” by the actions of the UVA Medical Center staff, and that it was “the practice” of the Center “to force treatment and medications on unwilling but competent patients.”

Ms. Doe claimed that, in treating her over her objection, the UVA Medical Center staff, acting as agents of the state, violated her “protected liberty interest,” guaranteed under the due process clause of the 14th amendment, to refuse unwanted medical treatment, to be free from restraint, and to give informed consent to medical treatment before such treatment is given. (Because UVA is a state university, the UVA Medical Center staff were deemed to be acting “under color of state law” and therefore subject to claims of constitutional rights deprivations.) Ms. Doe also claimed that the Medical Center staff’s actions constituted gross negligence, assault and battery, and false imprisonment under Virginia law.

Motion for Judgment on the Pleadings

Among the 13 defendants, only Dr. Syverud initially filed a “motion for judgment on the pleadings,” asserting that, even if all of Ms. Doe’s factual allegations were accepted as being true, those allegations did not entitle Ms. Doe to a legal judgment against him. Dr. Syverud’s defenses to the claims included: (1) he was entitled to “qualified immunity” with respect to Ms. Doe’s claims of constitutional violation because there was no existing case law giving Dr. Syverud notice that his conduct violated Ms. Doe’s constitutional rights; (2) Ms. Doe’s pleadings failed to establish that Dr. Syverud was acting under the color of state law; (3) Dr. Syverud’s conduct was “legally justified or excused”; (4) Ms. Doe’s state law claims fail to state a claim; and (5) Ms. Doe’s attempted suicide barred her federal and state law claims.

¹ Under Section 37.2-808(C), a magistrate issuing a TDO can designate a local law enforcement agency *or* an “alternative transportation provider” to transport an individual for whom an ECO has been entered to the site for evaluation.

The Court's Decision

The Honorable Norman K. Moon, Senior Judge of the Federal District Court for the Western District of Virginia, granted Dr. Syverud's motion, without prejudice, in a memorandum opinion issued on May 9, 2019.

The claim of constitutional violation

The Court began its opinion by citing Fourth Circuit Court of Appeals decisions explaining the concept of "qualified immunity" as a protection of government officials from claims of constitutional violations "stemming from their discretionary functions," noting that such officials "are not liable for bad guesses in gray areas; they are liable for transgressing bright lines" (citing *Raub v. Campbell*, 785 F.3d 876, 880–81 (4th Cir. 2015)).

The Court set out the two questions that are asked in a "qualified immunity" analysis: (1) whether the plaintiff has established the violation of a constitutional right, and (2) whether that right was clearly established at the time of the alleged violation. It noted that the Court can address the second question first if that will "best facilitate the fair and efficient disposition of each case" (citing *West v. Murphy*, 771 F.3d 209, 213 (4th Cir. 2014)).

The Court wrote that, because Ms. Doe claimed that Dr. Syverud violated her "protected liberty interest in refusing unwanted medical treatment," her right to give informed consent to medical treatment and her right to be free of restraints, "the contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right." *S.P. v. City of Takoma Park, Md.*, 134 F.3d 260, 266 (4th Cir. 1998). For Dr. Syverud to have such an understanding regarding his actions with Ms. Doe, there must be "clearly established authority" that would have put Defendant Syverud "on notice that [his] conduct violated" Plaintiff's rights. *S.P.*, 134 F.3d at 266–67.

The Court then looked at Fourth Circuit Court of Appeals decisions regarding "police seizures in the mental health context," noting the fact-specific analysis used by the Fourth Circuit, and concluding that "if there is sufficient evidence to justify a seizure in the mental health context, that will lend support to Defendant Syverud's argument that he is entitled to qualified immunity."

The Court next looked at "a competent person's constitutionally protected liberty interest in refusing unwanted medical treatment, which stems from an individual's Fourteenth Amendment right to life, liberty, and property." *See Cruzan by Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 278 (1990). Noting that there was "little guidance regarding qualified immunity in this context," the Court emphasized that "the proper inquiry is whether it would be clear to a reasonable official that his actions in treating a suicidal, competent, but unwilling patient brought in under state custody would violate the patient's clearly established rights."

The Court affirmed "that a 'physical intrusion, penetrating beneath the skin, infringes an expectation of privacy that society is prepared to recognize as reasonable.' *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 616 (1989)," but that "the contours" of such a privacy right are "less clear" where (1) "an individual is in state custody, but is not a convicted prisoner," and (2) "medical care is necessary." The Court then cited *Hill v. Nicodemus*, 979

F.2d 987, 991 (4th Cir. 1992), and *Buffington v. Baltimore County, Md.*, 913 F.2d 113 (4th Cir. 1990), where the Court found an *affirmative duty* on government officials to *provide* care to prevent the suicide of individuals in their custody. “Accordingly,” the Court wrote, “if Plaintiff was properly in state custody at the time she was presented to Defendant Syverud, there are few bright lines regarding her rights, providing further support to the conclusion that Defendant Syverud is entitled to qualified immunity. In this case,” the Court continued, “the question of custody is largely dependent on the controlling Virginia statutes...”

The key Virginia statute on which the Court then focused was Section 37.2-808. The Court noted that there was “no dispute” that Ms. Doe’s suicide attempt gave the officer probable cause to believe she met the criteria for emergency custody set out in that section. Further, since Ms. Doe was properly brought to the Medical Center under Section 37.2-808(I), which authorizes “emergency medical treatment or further medical evaluation,” Dr. Syverud’s “belief that he had a right to perform the procedures necessary to treat Plaintiff was reasonable.” “Furthermore,” the Court continued, “insofar as precedent should have informed Defendant Syverud’s actions, it supports his belief that he had a duty to prevent Plaintiff’s suicide. *See Hill* 979 F.2d at 991 (4th Cir. 1992).”

Ms. Doe’s counsel argued that Section 37.2-808 did not provide authority for Medical Center staff to medically treat Ms. Doe against her will, but rather only authorized her mental health evaluation. To medically treat Ms. Doe over her objection, counsel argued, the sole source of authority under Virginia law was a court order obtained under either Section 37.2-1104 (often referred to as the “medical detention order” statute) or Section 37.2-1101 (“judicial authorization for treatment”). The Court dismissed that argument, noting that orders for treatment under those sections can only be obtained if the patient is found by the Court to *lack* the capacity to give informed consent to treatment, while Ms. Doe claimed, and Dr. Syverud stipulated, that Ms. Doe *had* the capacity to give informed consent to treatment throughout her time at the Medical Center.

Finding, in light of the controlling case law and applicable Virginia statutes, that it would not “be clear to a reasonable official” that Dr. Syverud’s conduct was “unlawful in the situation he confronted,” the Court ruled that Dr. Syverud was entitled to qualified immunity in regard to Ms. Doe’s constitutional claims.

The State Law Claims

Noting that there were other defendants in the case against whom Ms. Doe still had federal claims pending, the Court decided to exercise its discretion to exercise “supplemental jurisdiction” over Ms. Doe’s state law claims. The Court then dismissed each of those claims.

False Imprisonment and Assault and Battery

The Court wrote that a finding of “false imprisonment” in Virginia requires proof of “direct restraint of physical liberty...without adequate legal justification”; that a “battery” is “an unwanted touching” that is “neither consented to, excused, nor justified”; and that an “assault” is an act that intends offensive contact with another person or the apprehension of it, and creates in the other a “reasonable apprehension of an imminent battery.” Noting that, under Virginia law (citing *Koffman v. Garnett*, 265 Va. 12, 574 S.E.2d 258, 261 (2003)), a “legal justification for the act being complained of will defeat an assault or battery claim,”

the Court ruled that Dr. Syverud “was justified in providing the emergency medical treatment and/or evaluation as contemplated in § 37.2-808(I). Therefore, his actions were legally justified and Plaintiff cannot sustain her claims of false imprisonment or assault and battery under Virginia law.”

Gross Negligence

The Court observed that Ms. Doe’s “ultimate claim” was that Dr. Syverud “intentionally ordered” the medical procedures to which Ms. Doe objected, “and did so, not with the intent to harm her, but with the willful and wanton disregard for her rights.” “This,” the Court concluded, “does not charge ‘the heedlessness, inattention, or inadvertence which is the hallmark of negligence. Rather, [it] charges the recklessness and conscious characteristic of willful and wanton conduct.’ Elliot, 292 Va. at 582. Accordingly, Plaintiff fails to plead the elements of a right of action sounding in gross negligence.”

Continuing Litigation

Since the May 9 issuance of Judge Moon’s memorandum opinion, the other named defendants have also filed a motion for judgment on the pleadings. Ms. Doe has filed a motion to amend/correct the original complaint, and is in the process of filing a response to the new motion from the other defendants.

Key Unresolved Concerns

Even assuming that Judge Moon’s ruling remains the law of this case at the end of this litigation, his decision leaves key concerns unresolved. The legal protection afforded to Dr. Syverud to provide emergency treatment to an individual who clearly needed emergency medical care in the wake of a suicide attempt, but who adamantly objected such care, was rooted in the fact that the individual at the time was in “state custody” under a statute that clearly provided for the provision of needed emergency medical assessment and care. (Virginia Code Section 37.2-808.) However, hospital emergency department staff regularly see individuals who have attempted suicide, or experienced significant injury or harm of some kind, but who are not in state custody under Section 37.2-808 when they arrive at the emergency department. (They may, for example, have been brought in by concerned family members, or by ambulance.). While the need of those individuals for emergency medical care to prevent further harm, or even death, may be every bit as great as, or greater than, that of Ms. Doe, what legal authority do emergency medical providers have to assess and treat them if they, like Ms. Doe, object to such care? We would submit that Virginia common law and statutory law provide little to no guidance, or protection, in these situations, and that our emergency medical care providers deserve to have guidance and protection so that they can focus on their mission to care for those who need immediate medical care.

IV. Case Law Developments

United States Supreme Court

Death penalty; 8th amendment prohibition on cruel and unusual punishment; competence: Supreme Court vacates death sentence of prisoner who became cognitively impaired *after* he was convicted and sentenced for murder, and remanded sentencing to the trial court, ruling that in order to be competent to receive the death penalty, the prisoner must be able to reach “a ‘rational understanding’ of why the State wants to execute him.”

Madison v. Alabama (No. 17-7505) (2019)

Background: Vernon Madison killed a police officer in 1985, was found guilty of capital murder and sentenced to death. After going to death row, he suffered a series of strokes, and was diagnosed as having vascular dementia with attendant disorientation and confusion, cognitive impairment, and memory loss. After a 2016 stroke he petitioned the Court for a stay of execution, claiming that he had become “incompetent” to be executed because, due to the strokes, he could no longer remember committing the crime. Citing the U.S. Supreme Court’s decisions in *Ford v. Wainwright*, 477 U. S. 399 and *Panetti v. Quarterman*, 551 U. S. 930, he argued that “he no longer understands” the “status of his case” or the “nature of his conviction and sentence.” The Alabama court had found that Madison had “a rational understanding of [the reasons for] his impending execution,” as required by *Ford* and *Panetti*, even if he had no memory of committing his crime; further, it found that Madison’s condition did not implicate *Ford* or *Panetti* because in both those cases the prisoner suffered from psychosis or delusions. Madison first brought a habeas corpus action under the Antiterrorism and Effective Death Penalty Act (AEDPA) of 1996. The U.S. Supreme Court, citing the deference for lower court death penalty decisions required by the AEDPA, declined to overturn the state court decision (thereby overturning the ruling of the 11th Circuit Court). However, when Madison later sought “direct review” of the state court’s decision prior to his execution, the Court determined that it had a broader review authority.

Holding: Justice Kagan, writing for a 5-3 majority that included Chief Justice Roberts (with Justice Kavanaugh not participating), stated that “the sole inquiry for the court remains whether the prisoner can rationally understand the reasons for his death sentence.” Executing a person who does not have such a rational understanding “offends humanity” and makes the retributive function of such punishment meaningless. Justice Kagan wrote that, under the Court’s prior ruling in *Panetti*, “a person lacking memory of his crime may yet rationally understand why the State seeks to execute him; if so, the Eighth Amendment poses no bar to his execution.” However, she continued, contrary to the state’s ruling regarding Madison, nothing in *Panetti* requires that a person’s *lack* of such rational understanding must be rooted in a delusional or psychotic disorder. Accordingly, “a person suffering from dementia may be unable to rationally understand the reasons for his sentence; if so, the Eighth Amendment does not allow his execution.” Because the state court failed to address Madison’s claim of incompetence within this framework, the decision to execute Madison violated the 8th amend-

ment prohibition on cruel and unusual punishment. The Court vacated the state court's decision and directed a new review of Madison's claim.

Discussion: It is notable that there was a vigorous dissent that claimed, first, that Madison did not raise—or even “hint at”—the constitutional claim affirmed by the majority ruling (as Madison had focused his appeal on his inability to remember committing the murder), so that Madison's appeal should have been rejected; second, that the state court's rulings had been broader and more consistent with *Panetti* than the majority ruling indicated. The dissent stated that the majority's action “makes a mockery of our rules.”

Fourth Circuit Court of Appeals

8th amendment cruel and unusual punishment; deliberate indifference: Fourth Circuit affirms District Court ruling that Virginia was subjecting its death row prisoners to cruel and unusual punishment through conditions amounting to solitary confinement, based solely on their status as death row prisoners and not on any prison-related misconduct. Given the known danger of serious psychological and emotional harm from such isolation, the state exhibited deliberate indifference to the risks of damage posed to these inmates.

Porter v. Clarke (No. 18-6257) (4th Cir., 2019)

Background: Three inmates on Virginia's death row in Sussex I state prison sued the state over death row conditions. The district court entered summary judgment in favor of the inmates, finding that the death row inmates' long-term detention in conditions amounting to solitary confinement (for years, they spent between 23 and 24 hours a day “alone, in a small . . . cell” with “no access to congregate religious, educational, or social programming”) created a “substantial risk” of psychological and emotional harm and that the state defendants, knowing or having reason to know the risks posed by these conditions, were “deliberately indifferent” to the dangers posed to the inmates. The district court awarded injunctive and declaratory relief. The state, while implementing a number of modifications to death row conditions in response to the district court's decision, appealed to the Court of Appeals.

Holding: The Fourth Circuit affirmed the district court. It noted the Supreme Court's prior rulings that the 8th amendment “imposes a duty on prison officials to ‘provide humane conditions of confinement’” (*Farmer v. Brennan*, 511 U.S. 825, 832 (1994)) and that any prison conditions alleged to amount to the “cruel and unusual punishment” prohibited by the 8th amendment must be considered on the basis of “the evolving standards of decency that mark the progress of a maturing society.” (*Estelle v. Gamble*, 429 U.S. 97, 102 (1976)). Further, the Court wrote that analysis of any 8th amendment “conditions of confinement claim” involves a two-prong test: (1) the plaintiff must show that the alleged conditions were “objectively, sufficiently serious,” meaning that they must be “extreme,” resulting in “a serious or significant physical or emotional injury” or “a substantial risk of serious harm”; and (2) a plaintiff must show that prison officials showed “deliberate indifference” by prison officials to the objectively serious conditions being challenged (quoting *Farmer*). The Court found that the district court correctly ruled that the prisoners had satisfied both prongs on the basis of uncontested evidence presented to the trial court. The Appeals Court noted that a large

body of research over decades—especially recent research that was done after the Fourth Circuit’s last decision regarding prison conditions—made clear the serious adverse psychological and emotional effects on prisoners subjected to similar conditions. In addition, the Court noted that the Virginia Department of Corrections itself maintained procedures that *barred* the placement of *non*-death row prisoners for more than 30 days in such conditions, which constituted “unrebutted evidence” of the state’s awareness of the harmful effects of such conditions. It also found that the “extensive scholarly literature” on the adverse effects of these conditions “was so obvious that it had to have been known.”

The state attempted to argue that, given the changes made on death row since the district court’s ruling—providing for more human interaction and contact and increasing opportunities for socialization and physical and social activities and contact with family (which the plaintiffs agreed placed the prison in compliance with 8th amendment requirements)—there was no need for the injunctive relief ordered by the trial court. The Court disagreed, finding that the state provided no guarantees that the offending conditions would not be re-instituted.

Discussion: The Appeals Court did find that the district court erred in rejecting a claim by the state that it could have legitimate penological justification for its severe confinement conditions on death row: “a legitimate penological justification can support prolonged detention of an inmate in segregated or solitary confinement, similar to the challenged conditions on Virginia’s death row, even though such conditions create an objective risk of serious emotional and psychological harm.” However, the state defendants “elected not to argue in their briefing to this Court that the district court erred in disregarding their previously asserted penological justifications.” The Court surmised that this may have been “because Plaintiffs presented unrebutted empirical evidence that, as a group, “[d]eath-sentenced inmates do not have disproportionate rates of serious violence when confined under general population security conditions,” or “perhaps” because the prison had not had “any notable security incidents” since instituting more humane confinement standards. In any event, the Court ruled, because the state did not pursue this claim, it was waived.

Sexually dangerous person; civil commitment: The Fourth Circuit rules that the Adam Walsh Child Protection and Safety Act does not require that a defendant be diagnosed with a paraphilic disorder to be civilly committed under that Act.

U.S. v. Charboneau (No. 17-7306) (4th Cir., 2019)

Background: Charboneau had a long history of substance abuse and criminal conduct, with Charboneau being found under the influence of alcohol in virtually every case in which he was arrested, including three separate incidents of violent sexual assault (at least one with a minor). He served years in prison for those assaults, and while on supervised release from federal prison in 2003 following the third assault, he committed his fourth sexual offense, again intoxicated, victimizing his niece. Charboneau served out a state prison sentence for that assault, and returned to federal prison to serve additional time for violating the terms of his release from his prior federal sexual assault conviction. Prior to his discharge from federal prison the government initiated civil commitment proceedings under the Adam Walsh Act, alleging that he was a sexually dangerous person. The Act authorizes the government to file

a civil action, in which the government has the burden to prove by clear and convincing evidence that the individual: (1) has previously "engaged or attempted to engage in sexually violent conduct or child molestation"; (2) currently "suffers from a serious mental illness, abnormality, or disorder"; and as a result of that condition, (3) "would have serious difficulty in refraining from sexually violent conduct or child molestation if released." If the government proves its case, the person can be confined, either by federal authorities or state authorities where the individual was domiciled or tried, and treated until "no longer sexually dangerous." The Act allows the individual to seek review of this civil commitment at any time beginning 180 days after the initial commitment.

At the initial commitment hearing, three government experts found that, while Charboneau did not suffer from a paraphilic disorder (a condition characterized by "recurrent, intense, sexually arousing fantasies, urges, or behaviors that are distressing or disabling and that involve inanimate objects, children or nonconsenting adults, or suffering or humiliation of oneself or the partner with the potential to cause harm" [see Merck Manual, Overview of Paraphilic Conditions, found [here](#)]), he did suffer from alcohol use disorder, which they deemed a serious mental illness, with one expert finding that this was coupled with a mixed personality disorder that included "multiple schizotypal and schizoid characteristics." All three found that Charboneau would have serious difficulty refraining from future sexually violent conduct, with two experts basing that finding solely on Charboneau's alcohol use disorder and a third basing his finding on the combined effect of Charboneau's alcohol use disorder and his "mixed personality disorder." Charboneau's expert agreed that he did not suffer from a paraphilic disorder, but further found that his alcoholism could not be seen as causing his sexual assaults, as Charboneau was often drunk without engaging in sexually inappropriate conduct. As a result, this expert concluded, Charboneau could not be found to have a serious mental illness related to his sexually violent behavior and therefore did not meet the statutory definition of a sexually dangerous person under the Walsh Act.

The trial court found persuasive the evidence presented by the expert who diagnosed Charboneau as suffering from both an alcohol use disorder and personality disorder that resulted in Charboneau having serious difficulty in refraining from sexually violent behavior if released. The Court entered an order of commitment. Charboneau appealed.

Holding: Finding that the Adam Walsh Act does not require a diagnosis of a paraphilic disorder and that the district court's findings were fully supported by the record, the Appeals Court affirmed the trial court's decision. "The plain language of the statute," the Court wrote, "does not require a respondent to be diagnosed with a paraphilic disorder to satisfy the serious mental illness element of the Act. Likewise, no controlling precedent requires such a diagnosis. Congress could have easily added language requiring a paraphilic disorder if that was its intent. But the Act as written does not require any specific mental illness, abnormality or disorder to satisfy the serious mental illness element."

Discussion: In its opinion, the Court agreed that, in the absence of a paraphilic disorder diagnosis, the government has "a steeper climb" to show "the causal link" between the individual's mental illness and his ability to refrain from sexually violent conduct in the future. In Charboneau's case, the trial court set out in detail its finding, based on its careful consideration of the experts' opinions, that Charboneau's mixed personality disorder together with his alcohol use disorder satisfied the serious mental illness element under the Act. Noting that it

was not the Appeals Court's role to "re-weigh the evidence and impose a different result when the district court does not commit legal error and bases its decision on evidence in the record," the Court, finding no legal error, affirmed the trial court's ruling.

Sentencing; mitigation; 6th amendment ineffective assistance of counsel: In a death penalty case, the Fourth Circuit finds that defense counsel's failure to adequately investigate whether defendant suffered from Fetal Alcohol Syndrome constituted ineffective assistance of counsel, and vacated the death sentence imposed and remanded for further proceedings.

Williams v. Stirling No. 18-2 (4th Circuit, 2019)

Background: Williams was convicted by a South Carolina jury of kidnapping, murder and possession of a firearm during commission of a violent crime and was sentenced to death. After his state appeals failed, he petitioned the federal court for a writ of habeas corpus. The federal court granted the petition on only one of his claims: ineffective assistance of counsel due to "trial counsel's failure to investigate potentially mitigating evidence of Fetal Alcohol Syndrome ('FAS')." The state appealed.

Holding: The Court of Appeals affirmed. Williams had never received a diagnosis of FAS during his life, *but* there was evidence of alcohol abuse by Williams' mother during her pregnancy, and evidence that Williams had organic brain damage. While the constitutional standard for effective assistance of counsel "does not require investigation of every conceivable line of mitigating evidence," the Court wrote, it "does impose 'a duty to make reasonable investigations or to make a reasonable decision that makes particular investigations unnecessary.'" A reviewing court "must consider not only the quantum of evidence already known to counsel, but also whether the known evidence would lead a reasonable attorney to investigate further." The failure of counsel to pursue further investigation given the information available about a potentially significant mitigating factor constituted a breach of counsel's duty to Williams and prejudiced Williams in the sentencing phase of the trial. Accordingly, the death sentence was vacated by the Court and sentencing was remanded for further proceedings.

Discussion: The Court noted that defense counsel has the discretion to make a "strategic" decision as to whether to offer a particular mitigation defense at sentencing. In Williams' case, defense counsel did submit mitigation evidence, but did not pursue FAS as a possible mitigating factor. Although the state attempted to argue that this fell within the province of defense counsel's strategic decision-making regarding mitigation, the Appeals Court disagreed, finding that the failure to even investigate FAS left defense counsel without sufficient information to even make a strategic decision about the use of such a defense. The Court's decision was likely aided by defense counsel's open acknowledgement at the district court hearing that he should have pursued an investigation into FAS as a possible mitigating factor, and that in retrospect he was surprised that he did not do this and could not explain why he did not. The Court also cited the American Bar Association Guidelines for the Appointment and Performance of Defense Counsel in Death Penalty Cases that were in effect at the time of Williams' trial. The commentary in those guidelines identified FAS as a potentially mitigating factor that should be investigated by counsel in capital cases.

V. Institute Programs

Please visit the Institute's website at <http://www.ilppp.virginia.edu/OREM/TrainingAndSymposia>

The Institute has started announcing its offerings for the program year September 2019 through June 2020. Additional programs will be announced. Please visit and re-visit the Institute's website to see new and updated announcements. The Institute appreciates support for its programs. Please share this edition of *DMHL* and share announcements of programs that may interest your professional, workplace, and community colleagues.

The Institute of Law, Psychiatry and Public Policy at the University of Virginia is approved by the ***American Psychological Association*** to sponsor continuing education for psychologists. The Institute of Law, Psychiatry and Public Policy at the University of Virginia maintains responsibility for each program and its content.

Programs as jointly provided by the ***Office of Continuing Medical Education of the University of Virginia School of Medicine*** and Institute of Law, Psychiatry, and Public Policy.

Announced programs:

Assessing Risk for Violence in Clinical Practice

September 18 2019, Charlottesville VA: Topics of this one-day program include overview of risk assessment (history, process, ethical considerations), empirically supported risk factors, structured risk assessment instruments, risk communications and report writing. The HCR:20 instrument is presented including an exercise using a case example. Faculty will also discuss proceeding from risk assessment to risk management. This program meets one of the training requirements for clinicians who conduct VA DBHDS Commissioner evaluations for NGRI acquittees.

Complete information at <https://www.ilppp.virginia.edu/OREM/AdultPrograms/Course/135>



Evaluating for Capacity

September 30 2019, Charlottesville VA: Eric Drogin JD, PhD, ABPP on faculty of the Harvard Medical School (Forensic Psychiatry Service, Department of Psychiatry, Beth Israel Deaconess (BIDMC) Medical Center) and Amber Vernon PsyD, with Richmond Behavioral Health Authority will present a one-day program on evaluation of capacity, that will provide a broad overview of decision-making capacity with in-depth discussion focused on applications related to assessment in civil, forensic and community-based mental health settings.

Complete information at <https://www.ilppp.virginia.edu/OREM/AdultPrograms/Course/138>



At the conclusion of the program participants will be able to

- Identify the historical basis for modern competency assessments
- Incorporate legal standards in identifying civil competency thresholds
- Distinguish between modes of assessing past, present, and future substituted judgement
- Conduct assessments of testimonial capacity in civil contexts
- Identify the various domains addressed in guardianship evaluations
- Apply relevant content in a community-based mental health setting to include consent to treatment and implementation of substitute decision-makers
- Make necessary adjustments for specialty populations and emergency treatment
- Emulate best practices for effective data interpretation, report writing, and clinical documentation

Six hours of accredited continuing education are available for psychologists, physicians, and others. The course has been approved for 5.5 credit hours including (0.0) credit hours for Ethics by the ***Mandatory Continuing Legal Education Board, Virginia State Bar***. The course has been approved for 5.5 credit hours by the ***Supreme Court of Virginia, Office of the Executive Secretary***. Award of accredited CE requires proper application and some awards may require a fee for hours claimed. Visit the program's webpage for more details.



Basic Forensic Evaluation: Principles and Practice

October 7-11 2019: This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation with adults. Content includes clinical, legal, ethical, practical and other aspects of forensic mental health evaluation with adults. The format combines lectures, clinical case material, and practice case examples for evaluation of adults. Day five incorporates a report writing exercise.

Complete information at <https://www.ilppp.virginia.edu/OREM/AdultPrograms/Course/134>



Evaluating Individuals Found Not Guilty by Reason of Insanity

December 6 2019: This one-day program addresses assessment of persons who have been found Not Guilty by Reason of Insanity (NGRI) in criminal cases and therefore require forensic evaluation regarding commitment or conditional release. Please note that this program is most relevant for VA DBHDS staff involved in evaluation and supervision of NGRI acquittees. This program meets the training requirements for clinicians who conduct VA DBHDS Commissioner-appointed evaluations of NGRI acquittees.

Complete information at <https://www.ilppp.virginia.edu/OREM/AdultPrograms/Course/136>



Challenging Issues when Evaluating Adjudicative Competency in Juveniles

December 6 2019, Charlottesville VA: Ivan Kruh PhD, Clinical and Forensic Psychologist, will lead a one-day program on challenging issues with juvenile competency evaluation. Juvenile competency evaluations can be understood as an effort to answer five successive questions for the court. Dr Kruh, with two Virginia experts, will be discuss and seek clarity on each of these successive questions and their issues. Strategies for explaining the issues in written reports will also be discussed.

Complete information at <https://www.ilppp.virginia.edu/OREM/JuvenilePrograms/Course/139>

At the conclusion of the program participants will be able to

- Discuss the five questions that constitute a juvenile competency evaluation
- Conceptualize the differences between Factual Understanding and Rational Understanding
- Describe unique ways in which Autism Spectrum Disorder can affect competent functioning
- Identify key contextual domains for considering the fit between the youth's abilities and the demands of the case they are facing
- Outline issues in the controversy within the field of forensic mental health regarding the Ultimate Issue
- Describe what competency remediation services are and factors to analyze when considering if a given youth is likely to benefit from them



Assessing Risk for Violence with Juveniles

January 24 2020, Charlottesville VA: This one-day program trains mental health professionals, juvenile and criminal justice professionals, social and juvenile services agencies, educators, and others to apply current research pertaining to risk assessment with juveniles. Along with theoretical foundations the program includes review of legal parameters, impact of online behavior, and student threats in school settings.

Complete information at <https://www.ilppp.virginia.edu/OREM/JuvenilePrograms/Course/137>



Cultural Competency Issues with Forensic Evaluation

February 24 2020, Charlottesville VA: Barry Rosenfeld PhD, Professor and Chair, Department of Psychology and Adjunct Professor of Law, Fordham University, will present a one-day program on issues related to forensic assessment of individuals from diverse ethnic and linguistic backgrounds. Workshop topics will follow the timeline of a typical evaluation with a review of issues and solutions that can be implemented.

Complete information at <https://www.ilppp.virginia.edu/OREM/AdultPrograms/Course/141>

At the conclusion of the program

- Participants will be able to describe the principles of cultural competence in psychological evaluations
- Participants will identify forms of cultural biases that can impact forensic consultation
- Participants will list steps necessary before evaluating individuals of diverse cultural backgrounds
- Participants will be capable of training and utilizing interpreters in forensic assessment
- Participants will competently interpret assessment and interview data in culturally diverse settings



- Participants will differentiate appropriate and inappropriate psychological tests that can be used with individuals of particular cultural backgrounds.
- Participants will apply ethical standards to their cross-cultural assessment practice

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Juvenile Forensic Evaluation: Principles and Practice

March 16-20 2020, Charlottesville VA: This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation with juveniles. Content includes clinical, legal, ethical, practical and other aspects of forensic evaluation with juveniles. The format combines lectures, clinical case material, and practice case examples for evaluation of juveniles. Day five incorporates a case report writing exercise.

Complete information at <https://www.ilppp.virginia.edu/OREM/JuvenilePrograms/Course/140>

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IN PLANNING: Realizing Opportunity for All Youth, the National Academies new report

Proposed for April 3 2020, Charlottesville VA: ILPPP and colleagues are planning a one-day seminar on the National Academies of Sciences new report, Realizing Opportunity for All Youth - <https://www.nap.edu/catalog/25388/the-promise-of-adolescence-realizing-opportunity-for-all-youth>.

Please return to the website <https://www.ilppp.virginia.edu/OREM/JuvenilePrograms/Course/144> to find updated information as plans for this special program are developed.

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Assessing Individuals Charged with Sexual Crimes

April 29-30, 2020, Charlottesville VA: This two-day program focuses on the assessment and evaluation of individuals charged with sexual crimes in Virginia. The program provides legal background relevant to assessment involving sexual offenses, overview of paraphilias and base rates of re-offending, and discussion of a well-researched sexual offender risk assessment instrument. This program may meet needs of providers for renewal of SOTP certification in Virginia.

Complete information at <https://www.ilppp.virginia.edu/OREM/SexOffenderPrograms/Course/142>

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Conducting Mental Health Evaluations for Capital Sentencing Proceedings

May 4-5 2020: This two-day program prepares experienced forensic mental health professionals to meet the demands of a capital sentencing case, in which the accused faces the possibility of the death penalty. Attorneys and others are welcome. The agenda includes statutory guidelines for conducting these evaluations, the nature of the mitigation inquiry, the increased relevance of intellectual disabilities, the process of consulting with both the defense and the prosecution, and ethics in forensic practice.

Complete information at <https://www.ilppp.virginia.edu/OREM/AdultPrograms/Course/143>

Questions about ILPPP programs or about *DMHL*?: please contact els2e@virginia.edu

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

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