DEVELOPMENTS IN MENTAL HEALTH LAW

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

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I. Update

SJ 47 Joint Subcommittee Update: A Vision for Public Mental Health Services in Virginia Takes Shape

At the October 26, 2016 meeting of the SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century, the Subcommittee's Work Groups and members appeared to move closer to adopting a shared vision of a future statewide system of mental health services, while acknowledging the significant obstacles to realizing that vision. The Joint Subcommittee's Work Groups also recommended more immediate action on reforms within the current system to help to move it toward that future vision. The Division of Legislative Services (DLS) report on the October 26 meeting can be found here, and a more detailed description of each Work Group's activities and decisions from the summer of 2016 to the October 2016 meeting follows the summary below.

The Vision for the Public Mental Health Services System

Adoption of the STEP-VA (System Transformation, Excellence and Performance in Virginia) program model

Senator Hanger, the chair of the System Structure and Finance Work Group (Work Group #1), noted the Work Group's endorsement of the Department of Behavioral Health and Developmental Services' (DBHDS) STEP-VA plan for the Commonwealth's public mental health system. That plan is built upon the concept of providing access across the state to 10 "core" services that would ensure access to needed services for all individuals with mental illness. Those services are: (1) same day access to mental health screening and timely access to assessment, diagnostic, and treatment services; (2) outpatient primary care screening and monitoring services; (3) crisis services; (4) person-centered mental health service treatment planning services; (5) outpatient mental health and substance abuse services; (6) targeted mental health case management; (7) psychiatric rehabilitation services; (8) peer support and family support services; (9) mental health services for members of the armed forces and veterans; and (10) care coordination services.

Funding priority for "same day access" and outpatient primary care

Work Group #1 also endorsed the DBHDS proposal that full funding for these "core" services be implemented over a period of years, with such funding being sought first for the statewide implementation of two services: (1) same day access to mental health screening and timely access to assessment, diagnostic, and treatment services (estimated cost: $1.5 million in FY 2017, $12.3 million in FY 2018, and $17.3 million annually thereafter); and (2) outpatient primary care screening and monitoring services (estimated cost: $3.72 million in FY 2019 and $7.44 million annually thereafter).

Availability of Psychiatric Emergency Services (PES) units to persons in crisis

Delegate Garrett, chair of Work Group #3 (Mental Health Crisis Response and Emergency Services) described to the Joint Subcommittee the Work Group's endorsement of PES units, which, he explained, are an alternative to hospital emergency departments, and to psychiatric hospitalization, in providing treatment for individuals experiencing mental health crisis. Delegate Garrett noted that such units may reduce the costs associated with psychiatric boarding, but that the Work Group and its Advisory Panel are still attempting to determine the costs associated with psychiatric boarding in the Commonwealth and the potential cost benefits that may result from the establishment of psychiatric emergency services units.

Adoption of a model for criminal justice diversion

Delegate Bell, the chair of the Work Group #2 (Criminal Justice Diversion), reported that in 2017 the work group will focus on specific models for diverting persons with mental illness from the criminal justice system.

Permanent Supportive Housing
Senator Howell, chair of Work Group #4 (Housing), reported that an estimated 5,000 individuals in Virginia are in need of permanent supportive housing. Permanent supportive housing is a support for persons with serious mental illness that has been proven to be effective in both enabling people to stabilize their lives and reducing the costs of providing services to these individuals (who, without the housing and related services, experience more frequent hospitalizations, criminal justice system involvement, and crises requiring higher cost care). Full implementation of permanent supportive housing in Virginia would, according to Senator Howell, cost $100 million.

Enabling ongoing review and reform
Senator Deeds and other Joint Subcommittee members discussed a key dilemma: that prior studies of the state's mental health system had seldom resulted in more than piecemeal reforms, focused primarily on Virginia's mental health emergency response system. Meaningful change would require substantive improvements to the community-based care available throughout the state, and a state body that could continue the Joint Subcommittee's work after the expiration of its four-year charge. Senator Deeds expressed his preference that the Joint Commission on Health Care (JCHC) be given sufficient resources to continue this work on an ongoing basis.

Specific reform proposals for 2017

The Work Group chairs set out the following specific reform proposals:

Telemental Health
From Work Group #1: Request the Joint Commission on Health Care (JCHC) to review the work group report on telemental health services (described later in this article) and develop recommendations for increasing the use of telemental health services.

From Work Group #3: Amend Virginia's laws to facilitate the use of telemental health services, and in particular the prescribing of medications via telemental health, to the extent allowable under federal law. (More details on the specific proposed amendments to the Virginia Code are set out later in this article.)

Information sharing
From Work Group #1: Amend Va. Code § 37.2-818 to allow DBHDS access to records relating to involuntary commitments to enable DBHDS to maintain statistical archives and conduct research on the consequences and characteristics of those proceedings.

State psychiatric hospital utilization
From Work Group #1: Reduce and stabilize the current census at the state psychiatric hospitals through multiple strategies, including (1) implement census reduction initiatives adopted by DBHDS and the CSBs (described more below); (2) develop budget requests to support needed initiatives; (3) study the "statutory, policy, financing, and administrative elements of the current mental health system" that are not "aligned" with the vision of system reform; (4) direct DBHDS and DMAS to study the potential use of

the Involuntary Mental Commitment Fund for both involuntary and voluntary temporary detention.

Alternative (non-law enforcement) transportation services for people in mental health crisis

From Work Group #3: Require DBHDS and other relevant stakeholders to develop a model for the use of alternative transportation providers, including the criteria for the certification of such providers and the costs and benefits associated with the implementation of the model.

Mental Health Services in the Criminal Justice System

From Work Group #2:

Provide authority to an appropriate entity, possibly the Virginia Board of Corrections (BOC), to investigate in-custody deaths in jails.

Require the use of a standardized instrument upon intake of persons into jails to screen for mental illness.

Require DBHDS to develop a plan for the provision of discharge planning services for persons with mental illness being released from jail that ensures that each jail in the Commonwealth has access to such services. The plan shall include an estimate of the cost of providing discharge planning services as well as an estimate of any cost savings that may result from the provision of such services.

Permanent Supportive Housing

From Work Group #4:

Provide $10 million in new funding for permanent supportive housing targeted to address frequent users of high-cost systems (e.g., state psychiatric hospitals and jails).

Amend the Virginia Housing Trust Fund to require that 20 percent of the Fund be used for (1) supportive services and predevelopment assistance for permanent supportive housing for the homeless and (2) temporary rental assistance.

Require the Department of Housing and Community Development, in consultation with other agencies and stakeholders, to develop and implement strategies for housing individuals with serious mental illness.

Require the Department of Medical Assistance Services (DMAS), in consultation with other agencies and stakeholders, to research and recommend strategies for financing permanent supportive housing through Medicaid reimbursement.

The Journey to the Recommendations and Actions at the October 26, 2016 Meeting

As reported in the July 2016 issue of *DMHL*, the four Work Groups that brought their reports and recommendation to the full Joint Subcommittee membership on October 26 had been formed in the spring of 2016, with assistance provided to the Work Groups by

Expert Advisory Panels assembled by the Institute of Law, Psychiatry and Public Policy. The activities of the Work Groups and their Panels, including the presentations and materials that they considered (and which are posted on the Division of Legislative Services [DLS] website), are summarized below:

Work Group #1 – System Structure and Finance

June 23, 2016 meeting: Consensus on key system problems and future system structure

Highlighted system problems

As reported in the July 2016 issue of *DMHL*, the SJ 47 Joint Subcommittee identified three major problems with Virginia's current public mental health services system:

(1) lack of a consistent array of services across the Commonwealth;
(2) need for uniform measures of performance and outcomes; and
(3) lack of accountability for performance and for achieving desired outcomes.

Recommended system structure

After reviewing the three major state models for community-based public mental health service systems in the U.S., Work Group #1 recommended the following at the June 23 meeting of the Joint Subcommittee:

1. That Virginia retain the current system structure, which is "largely" state funded (with some urban and suburban local governments providing substantial additional funds for services) and operated by local government agencies (the Community Services Boards) that both provide services directly and contract with private/non-profit entities for services, with the state operating the main public psychiatric hospitals; *but*
2. That the state substantially modify the current system by providing for "greater state direction and control"; *and*
3. That local entities be made "more accountable for their performance to the state and to the populations they serve."

Work Group #1's chair, Sen. Hanger, emphasized the goal of having the same behavioral healthcare services available "everywhere" in the Commonwealth, and cited the services set out in the "Certified Community Behavioral Health Clinic" model – identified by Interim DBHDS Commissioner Barber in his April 23, 2016 presentation to the Joint Subcommittee as being the model that DBHDS had embraced in its STEP-VA reform initiative – as providing a "focus" for Work Group #1's ongoing work.

August 22, 2016 meeting: System challenges and visions, and the need for reliable data

System Challenges identified by the Advisory Panel

As set out in the DLS summary of the Work Group #1's August 22 meeting (and in a memorandum from Professor Bonnie), Work Group #1's Advisory Panel identified four key system challenges that were a focus of the Panel's work:

1. Closing gaps in service capacity and access – The Panel planned to work with DBHDS to develop a cost estimate for implementing statewide the service array set out in the STEP-VA plan (based on the CCBHC model) over the course of a decade.

2. Creating necessary data capacity – The panel found that "the necessary data infrastructure does not yet exist and many of the necessary data elements are not yet available," and it planned to work with DBHDS to "build the necessary data capability to support the transformed system of care."

3. Solving cross-system challenges – Finding that the poor outcomes for people with serious mental illness often result from "gaps and misalignments in services across systems" – for example, providing safe transport for persons in crisis and appropriately diverting people with mental illness from involvement with the criminal justice system – the Panel will look at communities that have developed innovative solutions.

4. Coordinating publicly funded mental health services – The Panel submitted that lining up Medicaid funding with state and local government general funds for public mental health care is a key challenge for making the services system financially sustainable.

5. Linking community services board funding to state hospital use – Since July of 2014, when state psychiatric hospitals became the guaranteed placement of "last resort" for persons in mental health crisis, admissions to state hospitals under Temporary Detention Orders (TDOs) have increased 164%. Because the state alone absorbs the costs of this dramatically increasing admissions rate, the Panel is exploring how best to incentivize local CSBs to find better ways than hospitalization to resolve such crises.

DBHDS and the model for needed services

At Work Group #1's August 22 meeting, Daniel Herr, JD, Assistant DBHDS Commissioner for Behavioral Healthcare Services, made a presentation on the needed set of services in the state's behavioral healthcare system. The model of services Mr. Herr presented was an integration of the standards developed under the CCBHC model and those developed by the DBHDS Transformation Initiative. Mr. Herr noted in particular the problems in the current system with varying access to services, variation in available services across jurisdictions, and the over-reliance on more costly crisis services and institutional care. A key component of the proposed new system of care is "same day access" to "screening, assessment and diagnosis, including risk assessment," which promises to reduce crisis care and enable people to enter into care when they recognize a need for care.

DBHDS and data system challenges and recommendations

A DBHDS presentation on data collection noted the growing demand from multiple government, insurance, and grant-funding sources for data that meaningfully captures the effectiveness of behavioral health care services, and the current absence of a robust statewide system for gathering and sharing such data. The presentation recommended the development of a single electronic health records system for all of the state's CSBs, and the state's engagement with a consulting firm to help set the standards for development of a system that can collect, maintain and communicate meaningful outcome data. It was noted, however, that a lot of the needed technologies and standards are "emerging" technologies, so it is not easy to find the right people to do this important work.

The financial burden on localities in funding behavioral healthcare services

One reason for the Advisory Panel's recommendation to maintain the current public behavioral healthcare services structure has been the active participation by many local governments in funding services provided by the local CSBs and other providers. Work Group #1 received at its August 22 meeting a presentation on the challenging fiscal realities limiting local government participation in such services, along with "selected examples" of programs receiving local government financial support that have a behavioral healthcare component, and the specific experience of Roanoke County in funding such services.

October 26, 2016 meeting: A vision for how the system should look and specific interim reform proposals

As set out in more detail in the DLS summary of the Work Group #1 meeting on October 26, the Work Group developed the following major proposals:

Adoption of the STEP-VA (System Transformation, Excellence and Performance in Virginia)

The Work Group received two key documents for its deliberations on October 26. First, a report from Professor Bonnie, entitled "Interim Report on Core Services", began with a review of the various mental health system reform studies in Virginia over the prior 45 years, noting that each had identified the same deficiencies in Virginia's mental health services system – (1) the fragmented nature of the system (and in particular the lack of coordination between state and local systems) that allowed too many people to "fall through the cracks," (2) the high variability among the state's CSBs in the types, quantity and quality of services available (with financial and resource deficits in rural areas being particularly acute) and the disproportionate amount of funding going to hospital-based care, leaving community-based care underfunded and underdeveloped, and (3) the lack of clear accountability and oversight.

The Panel's report went on to note that the past reform studies had resulted in only piecemeal changes in different parts of an inadequate system (for example, funding additional crisis teams and "drop-in" centers, and reforming certain aspects of the ECO/TDO process), and that the remaining inadequacies had contributed to the "overwhelming" number of individuals with behavioral health needs who are now in

correctional facilities. Virginia's opioid epidemic has made the consequences of these service system inadequacies even more dire.

The Panel submitted that Virginia needs a "road map" for "comprehensive" reform that "provides a clear vision of the behavioral health system we are seeking" *and* "identifies a sequence of specific steps designed to achieve that vision."

The Panel set out three broad criteria that a reformed system must meet:

1. It must "provide a consistent array of services and supports" throughout the state.
2. Those services must be of "high quality" and "based on evidence of what works."
3. The system must be "aligned" with current reforms in overall health care, "including integration of primary and behavioral healthcare, data-driven decision making, and outcome-based care."

The Panel reported that it supported the STEP-VA plan developed by DBHDS and the CSBs as providing the "needed vision" for comprehensive reform. STEP-VA builds on the "9+1" services model for Certified Community Behavioral Health Clinics (CCBHC) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) under a grant program offered to the states.

The Panel report noted that DBHDS has provided a "potential timeline" for funding STEP-VA in stages, over time. The draft of the DBHDS plan, entitled "Preliminary Report on Services", lists and describes the core services that should be available to every person in Virginia who needs them, and provides an estimate of the cost of enabling Virginia's service system to provide these services. (These cost estimates are based on the self-assessment done by the eight CSBs that participated in the CCBHC grant project). Acknowledging that the financial resources do not exist to implement this system immediately, the report recommends a focus first on two services: "same day access to screening/timely access to assessment, diagnostic, and treatment services and referrals;" and "outpatient primary screening and monitoring services."

As the Panel notes in its report, starting with "same day access" places emphasis on the "front door" of the system to increase the engagement of individuals by responding immediately when they report that they need services. The current weeks-long waiting process in many CSBs (a few have actually implemented "same day access" already) results too frequently in people being unable to follow through with services, or experiencing crisis while waiting for an initial appointment and needing more intensive services. Seeing these individuals quickly will also need to be followed with promptly matching them with the services that they are found to need. The potential "payoff" is that early engagement will result in better treatment outcomes, fewer crises, and fewer incidents that result in coercive involvement with the criminal justice and social services systems. The second listed priority – primary care screening – recognizes that behavioral health cannot be separated from general health, and that addressing individuals' general health conditions significantly impacts the success of their behavioral healthcare.

The Advisory Panel report noted that realizing this vision in the step-by-step process proposed would require two key commitments:

1. *Funding* - There would need to be a commitment to tapping "all available funding sources": Medicaid (current and "expanded"), federal block grants, state and local funds, Comprehensive Services Act (CSA) funds, and others, and to producing efficiencies in various ways.
2. *Accountability* – "Virginia must establish a cross-cutting accountability structure" to monitor implementation and respond to issues that arise.

The DBHDS preliminary report added another key need: information technology and infrastructure upgrades to support implementation of the new system. The estimated cost of these upgrades is just over $20 million.

Specific Reform Initiatives

Hospital Bed Utilization:

The Panel's proposal on state hospital utilization noted that, after reform legislation in 2014 made the state psychiatric hospitals the guaranteed placement of "last resort" (for individuals in custody under ECOs who meet TDO criteria), the census at those hospitals dramatically increased, and remains above 95%, with some facilities exceeding 100%—well above levels where patient and staff safety start to decline. (Best practices set a hospital census limit of 85%.) Virginia already has a higher ratio of state hospital beds per population than the national average (17.3 per 100,000 vs. 15 per 100,000). Improving local services to reduce the need for hospitalizations is a challenge for local programs, as Virginia's state hospitals split the state behavioral healthcare budget with local services at a 50/50 rate, while nationally the split is 23% to state hospitals and 75% to local services.

A key fact noted by the Advisory Panel is that the state assumes all of the costs of caring for a person in a state psychiatric hospital; there are no financial costs to a locality when a person is sent to a state facility. A question for the Panel was whether a financing structure that created incentives for localities to prevent state hospitalizations would help to reduce the current hospitalization rate. The Panel looked at the practices of a number of different states. They noted that, as is "well understood", having the same "entity" responsible and accountable for both clinical outcomes and financial expenditures results in the most efficient delivery of the most effective care. Short of having a "single entity" approach, the Panel found a "variety of mechanisms" (cited in the proposal) in different states that "can create sufficient incentives for community providers to effectively manage state hospital utilization."

The Panel then went on to note that, in May, DBHDS started "an ongoing dialogue" with the state's CSBs and state hospitals on strategies to reduce and stabilize the utilization rate for those hospitals, including improved communication, training, transportation, discharge planning, and enhanced participation and cooperation by private psychiatric hospitals. DBHDS at that time had also identified just over 8.5 million dollars for "capacity-building" to improve locally based crisis services and enhance local capacity to care for hospital patients ready for discharge. (A DBHDS power point presentation sets

out the extent of the hospital utilization problem and the various strategies being adopted with different CSBs to reduce the hospital census.) While "applauding" this initiative, the Panel noted its limited funding and scope, and the still un-addressed "structural incentives" that now exist for *increased* hospitalization: the "last resort" laws; the "free care" provided by state hospitals; the "discretion granted" to local private hospitals to refuse admissions; and the bias toward involuntary (vs. voluntary) care.

The Panel made the following recommendations regarding hospital utilization:

1. That DBHDS and the CSBs implement the census reduction initiative and report on the results to the SJ 47 Joint Subcommittee.

2. That DBHDS and the CSBs develop budget request(s) for FY 2018 to support the initiatives needed to keep state hospital utilization at or below 90% capacity.

3. That study continue of the elements of the current behavioral health system that are not aligned with strategic and operational objectives, or that create impediments to efficient and effective care, and recommend solutions to the Subcommittee by October 30, 2017, including the use of financial risks and incentives to achieve performance objectives.

4. That DBHDS and the Department of Medical Assistance Services (DMAS) study: (a) the potential use of the Involuntary Mental Commitment Fund (IMCF) for *both* voluntary inpatient treatment and involuntary temporary detention, to create an incentive to reduce the use of involuntary treatment statewide; (b) possible transfer of the IMCF fund from DMAS to DBHDS; and (c) other strategies for improving the use of these funds.

Telemental Health:

The Advisory Panel noted that research and practice in Virginia and in other states has established that a variety of mental health services can be provided through telecommunication—from expert consultation with healthcare providers to conducting diagnostic and treatment sessions with patients to remotely monitoring a patient's health and behavior—thereby making services available to individuals (particularly those living in the rural areas of the state) who otherwise would be unable to reach those services. Thus, telemental health is "not only a viable but an essential tool for bridging the existing care gap." However, "despite its demonstrated utility," it has not been widely adopted in Virginia. A Telemental Health work group was formed to look at the current barriers to wider use of telemental health services and to recommend actions to overcome those barriers. Its report identified and addressed five types of barriers: provider barriers, workforce barriers, financial barriers, patient/client barriers, and policy barriers. It listed 30 policy and practice options for overcoming these barriers, and made 12 specific recommendations for immediate consideration. For most of those, the work group recommended, and the Panel concurred (in a document entitled "Expanding Use of Telemental Health Services in the Commonwealth"), that the Joint Commission on Health Care is the most appropriate body for further reviewing and developing

implementation strategies for those recommendations, and reporting its findings and recommendations to the Joint Subcommittee in 2017.

Data Sharing Challenges

The Panel noted that key data for evaluating the mental health emergency response system includes information from involuntary commitment hearings. Because Virginia law has no provision for enabling the Supreme Court of Virginia to share with DBHDS the confidential data from commitment hearings, the Panel proposed an amendment to Virginia Code § 37.2-818 to require district courts to provide this information to DBHDS upon request.

Work Group #2 – Criminal Justice Diversion

June 23, 2016 meeting: Selecting priorities for criminal justice diversion

As reported in the July 2016 issue of *DMHL*, by June of 2016 Work Group #2's interests had coalesced around the following matters: (1) how persons with mental illness are diverted from the criminal justice system in other states, including the stage or stages in the criminal justice process at which diversion occurs, and the crimes that are eligible for diversion; (2) mental health courts, with a focus on showing how such courts actually improve outcomes for the individuals who participate in them, how best to ensure uniform "best practices" in their operation across the state (if implemented), and an explanation of why defendants choose to participate in these courts when they require defendants to comply with so many conditions, including additional services, supervision and review hearings; (3) consideration of codifying or otherwise formalizing the creation of Mental Health/Criminal Justice Stakeholder groups in the Commonwealth; and (4) how best to standardize mental health screening for inmates, ensure access to needed psychiatric medications for those in jail, and provide effective discharge planning to link inmates with mental illness to community services upon release.

In meetings in June and July, the Advisory Panel discussed issues and established working groups regarding: mental health courts (and in particular legislators' concerns about costs, efficacy, and the public perception of different, and therefore unequal, treatment of individuals in these courts); treatment in jails of persons with serious mental illness; creation of Mental Health/Criminal Justice Stakeholder groups; and mental health discharge planning for persons with serious mental illness being released from jail.

August 22, 2016 meeting: Looking at mental health courts, diversion services, and investigations into mental health treatment in jails

Mental Health Courts

Work Group #2 heard a presentation from the Hon. Jacqueline Talevi, Chief Judge of the General District Court for the 23rd Judicial District (Roanoke and Salem), regarding the "therapeutic court" established there for persons with serious mental illness. That program, with screening of willing participants, intensive treatment and support services, supervision and review, a 12-month time frame, and reduction of sentence or sentencing

to "time served" for those completing the program, is similar to other programs elsewhere in Virginia. However, as shown by the Virginia Mental Health Docket Matrix developed by Jana Braswell of DBHDS (and a member of the Advisory Panel), there are notable differences among the seven dockets that are compared in the matrix. There is only one circuit court – the Norfolk Circuit Court – identified as having a mental health docket.

Diversion and Community Services

Michelle Albert, LPC, CSOTP, the Jail Diversion Therapist Supervisor for the Alexandria CSB, provided a power point presentation on Alexandria CORE (Collaboration for Recovery and Re-Entry). The CORE program is an interagency collaboration that operates under the Alexandria Community Criminal Justice Board (CCJB) and the Board's Jail Diversion Subcommittee. The program utilizes the 5-stage sequential intercept model, and identifies individuals in those different stages of criminal justice system involvement who have serious mental illness and appear to be amenable to services to help them stabilize and avoid re-arrest and incarceration. Most of the program participants enter the program as part of the jail pre-discharge planning process (Stage 4: Re-entry) or while under community probation supervision (Stage 5: Community Corrections/Community Support). Among the remarkable accomplishments of the program staff working with these individuals is their securing key benefits – insurance coverage, SSI or SSDI benefits, supportive housing – that significantly improve and stabilize clients' living conditions. In a study of program efficacy, it was found that, in the year following their discharge from jail, CORE clients experienced an 82% reduction in their total days of incarceration, and 78% of them were not re-incarcerated at all.

In-custody jail death investigations

The Work Group also heard a presentation from Colonel Bobby D. Russell, Superintendent of the Western Virginia Regional Jail and President of the Virginia Association of Regional Jails, on the investigation of deaths of inmates in jail custody. According to Colonel Russell, whenever there is such a death, the jail contacts: (1) either the local law enforcement or the State Police, for an independent investigation; (2) the Office of the Medical Examiner (since an autopsy is performed for any such death); and (3) the Board of Corrections (BOC), which is responsible for jail oversight and conducts jail inspections through the Department of Corrections. In any death the regional jail also conducts its own internal investigation concurrently with the law-enforcement agency investigation. Colonel Russell saw the BOC as the most appropriate body for assessing jail performance, given its statutory duty and authority in regard to jail operations and its familiarity with those operations. He did not see the Office of the State Inspector General (OSIG) as "set up" to investigate local and regional jails and other agencies, and he was not surprised at the OSIG's report that, in its investigation of the death of Jamycheal Mitchell at the Hampton Roads Regional Jail, the OSIG was unable to gain access to the jail for purposes of investigating Mr. Mitchell's death.

A summary of the Work Group's August 22 meeting, which is posted on the DLS website, can be found here.

October 26, 2016 meeting: Setting criminal justice diversion priorities

As set out in more detail in the DLS summary of the Work Group's meeting on October 26, Work Group #2 developed the following major proposals:

Authorizing an appropriate independent entity to investigate treatment of inmates at jail facilities

The Work Group heard from employees of the Office of the State Inspector General (OSIG) who had acted as "whistleblowers" in claiming that, in its investigation into the 2015 death of Jamychael Mitchell at the Hampton Roads Regional Jail, the OSIG, among other things, (1) failed to use its authority to investigate the role of the jail and its medical services provider in Mr. Mitchell's death, (2) had undisclosed and compromising conflicts of interest due to OSIG staff relationships with leadership in DBHDS, (3) had been aware, prior to Mr. Mitchell's death, of information on serious patient and staff safety issues and staff workload problems at Eastern State Hospital that had been actively suppressed. In a statement submitted to the Work Group, the whistleblowers questioned whether, given the cited problems, the OSIG could be entrusted with the responsibility to conduct independent investigations of the mental health treatment of inmates in local and regional jails. They noted that the Attorney General's request to the U.S. Department of Justice to conduct an investigation into Mr. Mitchell's death indicated the serious loss of confidence in the efficacy of the OSIG, and they asked for action by the General Assembly to ensure that jail inmates with mental health needs receive the care they need. The whistleblowers responded to a number of questions from Work Group members.

In the follow-up discussion, there was consensus that an "appropriate entity" must be given clear authority to conduct investigations into "in-custody deaths" in jails, and while much of the discussion centered on the possibility of giving the Board of Corrections this authority, no consensus was reached.

Requiring the use of a standardized instrument at intake to identify persons coming into jail who have mental illness needing treatment

DBHDS Commissioner Barber made a PowerPoint presentation to the Work Group on mental health screening in local and regional jails, showing that there are validated screening tests (75% accuracy) that can be used by trained jail staff to identify inmates who have mental health conditions requiring treatment. The Commissioner noted that, while Virginia has long encouraged jails to use a screening instrument, many jails still do not use one, and the jails using screening instruments are using different ones. He recommended that the General Assembly support/mandate the use of standardized mental health screening processes in local and regional jails, noting that the requirement for such screening can be incorporated into state regulations or included in budget language. Commissioner Barber recommended that, rather than mandate a particular screening instrument, the General Assembly give the DBHDS Commissioner, or the Board of Corrections, the authority to name the tool to be used.

The Work Group's Advisory Panel also recommended that jails be required to use a standardized mental health screening instrument, as set out in a presentation to the Work

Group by the Panel's chair, Leslie Weisman, LCSW. The Work Group voted to adopt and put forward that recommendation.

Developing a plan for mental health discharge planning services for persons with mental illness being released from jail

In her presentation to the Work Group regarding recommendations from the Panel, Ms. Weisman reported that jail discharge planning was deemed by the Panel members to be of paramount importance, and that every jail should have access to a jail discharge planner. She noted that community services boards (CSBs) currently perform this service for individuals being discharged from state hospitals, and submitted the Panel's recommendation that DBHDS develop a plan to ensure that discharge planning occurs at every jail.

The Work Group adopted a proposal that DBHDS develop a plan for the provision of discharge planning services for persons being released from jail that ensures that each jail in the Commonwealth has access to such services. The plan must include an estimate of the cost of providing discharge planning services, as well as an estimate of any cost savings that may result from the provision of such services.

Other criminal justice diversion services remaining under study

As reflected in Ms. Weisman's report to the Work Group on October 26, and in the summaries of the Panel's meetings on September 15 and October 11, the following matters remain under study.

Mental Health Dockets:

As reported by Ms. Weisman at the Panel's September and October meetings, the Virginia Supreme Court formed a Behavioral Health Docket Advisory Committee, chaired by Judge Talevi, to establish standards that must be met by any court that wants to establish a behavioral health docket. Ms. Weisman also noted to the Panel members that Work Group #2 members wanted more information on why defendants agree to participate in these dockets when they demand so much compliance with various services and what the source of satisfaction is for defendants who complete the special docket program. The Panel members made plans to conduct research on these questions in 2017, including interviews with participants in current Virginia programs.

(*Note*: In an action taken on November 14, 2016 and effective January 16, 2017, the Virginia Supreme Court adopted and promulgated a new Rule 1:25, "Specialty Dockets," establishing a set of standards and procedures that any district or circuit court must follow if it wishes to establish one or more "specialty dockets," which are defined as "specialized court dockets within the existing structure of Virginia's circuit and district court system offering judicial monitoring of intensive treatment, supervision, and remediation integral to case disposition." Rule 1:25 recognizes three types of "specialty dockets" – drug treatment courts, veterans dockets, and behavioral/mental health dockets – with behavioral/mental health dockets described as dockets that "offer defendants with diagnosed behavioral or mental health disorders judicially supervised, community-based treatment plans, which a team of court staff and mental health professionals design and

implement." A district or circuit court wishing to establish one of these specialty dockets – or to *continue* an existing one – must petition the Supreme Court for authorization, and in that petition it must "demonstrate sufficient local support for the establishment of this specialty docket, as well as adequate planning for its establishment and continuation."
The new rule empowers the Chief Justice to establish, by order, a Specialty Docket Advisory Committee and appoint its members, and to *also* establish and select the members of the advisory committees for each of the approved types of specialty dockets. (The rule declares the State Drug Treatment Court Advisory Committee, established under Va. Code Section18.2-254.1, as constituting the Drug Treatment Court Docket Advisory Committee under this rule.)

The new Rule 1:25 is on the Virginia Supreme Court website, and is linked here.

Standardized Mental Health Treatment in Jails:

The Panel noted in its discussions the recommendation of the DBHDS "Justice-Involved Transformation Team" that there be standardized mental health treatment in jails, and in her presentation to the Work Group, Ms. Weisman submitted the need for "minimum standards" for mental health treatment in jails. This issue was not taken up by the Work Group at the October 26 meeting.

Criminal Justice Stakeholder Groups:

In the meetings of both the Panel and the Work Group, Ms. Weisman has argued for the importance of local stakeholder groups in monitoring any changes in services provided to persons with mental illness. While no consensus on this has developed, the Panel is developing a survey to send out to CSBs to determine what similar stakeholder groups are already operating.

Work Group #3 – Mental Health Crisis Response and Emergency Services

June 23, 2016 meeting: Selecting mental health emergency service priorities, and reviewing alternative transportation models for persons in mental health crisis

As reported in the July 2016 issue of *DMHL*, the Advisory Panel report to the Work Group identified four main subject areas in need of immediate attention: (1) the development of regional psychiatric emergency services (PES) units to improve crisis outcomes and reduce both "psychiatric boarding" in hospital Emergency Departments and psychiatric hospitalizations; (2) the use of telepsychiatry in the crisis context to increase access to psychiatric treatment in mental health crises; (3) the use of a medical or other alternative model of transportation for individuals in crisis in place of the current law-enforcement model, to reduce trauma for individuals and families while maintaining safety and to use law enforcement services more effectively; and (4) the identification of a core service model of treatment services for those in crisis. The Work Group reviewed the Panel recommendations at its June 23 meeting, and also received a presentation from DBHDS on the alternative transportation pilot project in the region served by the Mt. Rogers Community Services Board, and a presentation from the Virginia Sheriffs Association on the impact of required law enforcement transportation on local sheriffs

departments and the Association's support for the Mt. Rogers project and similar alternative models.

August 22, 2016 meeting: Confirming the importance of telemental health services

At its August 22 meeting (described in more detail in the DLS summary found here on the DLS website), the Work Group received (1) a presentation from the University of Virginia on its telepsychiatry program and the demonstrated effectiveness of telepsychiatry, particularly in reaching individuals in seriously under-served rural jurisdictions; (2) a presentation from Centra Health on its use of telepsychiatry in its outpatient mental health programs, with important observations on the need for such technology in the face of the current serious shortage of psychiatrists, particularly for children and adolescents; and (3) a presentation from the Virginia Association of Health Plans and Virginia Premier Health, Inc., regarding the value of telepsychiatry in various settings – particularly in the treatment of children and elderly nursing home residents – and the challenges posed by uneven insurance coverage for such services.

October 26, 2016 meeting: Recommending reform action

The Advisory Panel submitted a report to the Work Group in preparation for its October 26 meeting setting out recommendations regarding the key reform measures, including:
On transportation: supporting the continuation and possible expansion of the Mt. Rogers pilot (if certain cost issues could be controlled), initiation of a similar pilot in an urban community and continued research into other models and possible funding mechanisms.
On telemental health: support for the recommendations from two separate telemental health groups: (1) the recommendations from Sen. Dunnavant's "stakeholders group" on enabling the prescribing of Schedule II-V drugs via telemental health services; (2) overcoming the multiple barriers to expanded use of telemental health services through the initiatives recommended by the telemental health group established jointly by the Work Group #1 and Work Group #3 Advisory Panels. (As noted above, Work Group #1 and its Advisory Panel specifically recommended referral of the telemental health group's recommendations to the Joint Commission on Health Care for further study and action.)
On Psychiatric Emergency Services (PES) units: support for continued study of potential models from other states, and possible future pilot sites developed from existing CIT Assessment Centers.
On Core Emergency Services: support for the STEP-VA initiative in identifying and defining the set of "core" services needed to establish an effective community-based mental health services system. (This has since become a key part of the work of Work Group #1.)

At the October 26 meeting itself (as set out in more detail in the DLS summary found here), the Work Group considered the following:

Support for alternative transportation

Del. Garrett, the Work Group chair, discussed the Mt. Rogers project, which, with over 300 alternative transports without any incident, has helped to establish that non-law enforcement crisis transport can be provided safely. However, he noted, costs and other considerations preclude continuing that particular project. Based on his discussions with various stakeholders, Del. Garrett suggested, and the Work Group members supported, a possible Section 1 bill for the 2017 session, directing DBHDS and DCJS, with full stakeholder participation, to develop a comprehensive model for alternative transport of persons in mental health crisis. A report and proposed model would be due to the Joint Subcommittee by October 1, 2017.

Support for code and regulatory changes to enable medication prescription through telepsychiatry

W. Scott Johnson, Esq., who coordinated the stakeholders group established by Sen. Dunnavant to address statutory and regulatory restrictions on medication prescription via telepsychiatry, spoke to the Work Group (with Sen. Dunnavant attending and sitting with the Work Group members). As set out in more detail in Mr. Johnson's letter to Del. Garrett and Sen. Dunnavant (and in the DLS summary), under federal law Schedule II-V controlled substances cannot be prescribed by a physician via telemedicine unless the patient (1) is in a hospital or clinic that is registered with the Drug Enforcement Administration (DEA) as a permitted drug-dispensing site or (2) is in the presence of a DEA registered practitioner (a physician or "mid-level provider"). Mr. Johnson reported that, as part of the stakeholders group initiative, DBHDS and the Board of Pharmacy have been working together on a process to enable local CSBs to obtain state controlled substance registrations through the Board of Pharmacy that would enable the CSBs to obtain a DEA registration and thereby have active telepsychiatry, including medication prescriptions via telepsychiatry, at the CSB sites. The Board of Pharmacy noted that legislation is required to clearly authorize the issuance of controlled substance registrations to the CSBs. A proposed amendment to Virginia Code Section 54.1-3423 to provide such authorization was attached to Mr. Johnson's letter.

Mr. Johnson also reported that Section 54.1-3303 of the Virginia Code is the primary statute that sets out "what constitutes a valid prescription," and that the statute includes language addressing the prescribing of Schedule VI drugs via telemedicine. Noting that an "action item" for both the stakeholders group and the SJ 47 Work Group #3 was to ensure that state laws on telemedicine are not more restrictive than federal laws, the group's recommendation is to amend Section 54.1-3303 to clarify that a practitioner's compliance with federal law constitutes compliance with state law. A proposed clarifying amendment to Section 54.1-3303 was attached to Mr. Johnson's letter.

Delegate Garrett and Senator Dunnavant expressed their support for these proposed changes to facilitate telepsychiatry, and they described telepsychiatry as an innovative and needed way to connect health care providers to underserved populations in both rural and urban areas across the Commonwealth.

Improving Response to Mental Health and Drug Use Emergencies through Emergency Department Care Coordination

Representatives of the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, and the Commonwealth Strategy Group made a PowerPoint presentation on the "Care Coordination and Improvement Initiative" that arose out of language in the General Assembly's 2016 budget mandating the Department of Medical Assistance Services (DMAS) to convene a work group to improve emergency department (ED) care. As the presentation emphasized, ED staffs face a highly fragmented health care system with poor communication and little information sharing among its various parts. This seriously compromises the ability of ED staff to effectively serve patients and refer them to community based follow-up services that prevent returns to the ED.

The work group found that other states, including Washington and Oregon, have successfully implemented a system of "real-time electronic communication among providers and across systems" that enables ED staff to better assess, treat and refer patients. This has resulted in improved care coordination and cost savings.

The care coordination model focuses particularly on "super utilizers": individuals who repeatedly use the ED but could be better served with coordinated outpatient care. Timely information sharing among providers improves treatment in the ED and enables continuity of care for these individuals instead of repeated crises and ED visits. Washington experienced a 9.9% drop in emergency room visits by the Medicaid population after the incorporation of this model, with roughly $34 million in savings and a 27% reduction in opioid deaths.

A governance model is being developed for Virginia, which will identify the ongoing key stakeholder leadership and form a sustainable funding model, with the system to be running by July 1, 2017. An RFP process will be used to select a vendor to integrate the electronic information systems of the involved entities.

Work Group #4 – Housing

June 23, 2016 meeting: Confirming the evidence that "Permanent Supportive Housing" dramatically improves the lives of persons with serious mental illness and lowers the costs of care

As reported in the July 2016 issue of *DMHL*, Senator Howell, the chair of Work Group #4, noted at the June 23 meeting of the SJ 47 Joint Subcommittee that "permanent supportive housing" is a "universally accepted 'best practice'" in effectively reducing homelessness among persons with serious mental illness." Its effectiveness in both stabilizing the lives of persons with serious mental illness and dramatically reducing the costs of service to them (through reductions in ER visits, involuntary commitments and criminal justice system involvement encounters) has been demonstrated in Virginia's own programs (as shown here). The Work Group's Advisory Panel submitted a number of tentative recommendations for securing additional permanent supportive housing services.

August 22, 2016 meeting: Permanent supportive housing as a necessary service for compliance with Americans with Disabilities Act (ADA) under the *Olmstead* decision

At the August 22 meeting, the Work Group considered the need for a more robust permanent supportive housing program for individuals with serious mental illness in order to comply with the standards of the ADA. In a PowerPoint presentation to the Work Group, Ms. Martha Kinsley noted that, in its 1999 decision in the *Olmstead* case, the U.S. Supreme Court held that under the ADA "states have an affirmative obligation to ensure that individuals with disabilities live in the least restrictive, most integrated settings possible." Ms. Kinsley is the "Olmstead Independent Reviewer" for implementation of the settlement agreement between the U.S. Department of Justice and the State of North Carolina, under which the state has agreed to establish a program of permanent supportive housing, including specified related supportive employment and other services, to enable individuals with serious mental illness to live in "the least restrictive, most integrated settings possible." Ms. Kinsley pointed out that settings that are deemed "segregated" include adult/personal care homes, nursing homes, and segregated day programs, which are placements typical of those made in Virginia for many persons with serious mental illness.

October 26, 2016 meeting: An agenda for expanded permanent supportive housing

At its October 26 meeting, the Work Group accepted and presented to the SJ 47 Joint Subcommittee the following recommendations from its Advisory Panel (set out in more detail here):

1. Seek General Assembly funding for the operation of additional permanent supportive housing units, with a focus on frequent users of "high-cost systems" (e.g., psychiatric hospitals and jails).
2. Amend Virginia law to increase to 20% the percentage of funding from the Virginia Housing Trust Fund designated for (a) supportive services and assistance for permanent supportive housing and other long-term housing options for the homeless, and (b) temporary rental assistance (not to exceed one year).
3. Include in the General Assembly's charge to the Department of Housing and Community Development (DHCD) a requirement that it develop and implement, with participation by multiple agencies and stakeholders, strategies for housing individuals with serious mental illness.
4. Include budget language that requires DMAS to research and recommend, with participation by multiple agencies and stakeholders, strategies for the financing of supportive housing services through Medicaid reimbursement.

The last meeting of the SJ 47 Joint Subcommittee for 2016 is currently set for December 6. It is expected that action will be taken on a number of the proposals from the Work Groups.

II. ILPPP Data Corner

National Mental Health Services Survey: Virginia Summary

Ashleigh Allen, Tom Ko, VP Nagraj

Introduction

Access to mental health services (MHS) remains a significant problem in the United States.[1] Even as more Americans gain insurance coverage, actual access to care can vary greatly depending on regional characteristics such as degree of development, population density, or other socioeconomic factors.[2] Variance in provider acceptance of different insurances or payment methods can also seriously limit access to MHS.[3] The recent increase in psychiatric civil commitment in Virginia[4] has raised concerns about access to different mental health services within the state. In this report, we use data from a national survey to give an overview of MHS in Virginia.

Data Source

The 2010 National Mental Health Services Survey (N-MHSS) was conducted by the United States Department of Health and Human Services in order to gather data on all mental health treatment facilities within the United States. The survey was conducted via mail questionnaire, telephone interview, and web-based survey. The data that N-MHSS collects uniquely encompasses state-level and national data for both public and private facilities. Such an expansive data set provides a useful overview of information such as the types of mental health treatment facilities, types of services offered, infrastructure, and client demographics. Presented below is a brief overview of some characteristics of mental health treatment facilities within Virginia.[5]

Inclusion and Exclusion Criteria

The N-MHSS does not collect data from facilities that provide treatment only to incarcerated persons, DoD facilities, and individual/small group facilities not licensed or certified as part of a mental health center or clinic.[6] For our sub-analysis of N-MHSS data, we limited our queries to Virginia facilities, and excluded facilities of the "multi-setting facilities" type due to extremely limited sample size.

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[1] http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500423

[2] Cummings et al. 2013 http://www.ncbi.nlm.nih.gov/pubmed/23965816.

[3] http://archpsyc.jamanetwork.com/article.aspx?articleid=1785174

[4] https://www.washingtonpost.com/local/social-issues/civil-psychiatric-commitments-rose-in-virginia-in-possible-deeds-effect/2015/07/02/fbe7b2d2-210c-11e5-aeb9-a411a84c9d55_story.html

[5] United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. National Mental Health Services Survey (N-MHSS), 2010. ICPSR34945-v3. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2015-11-23. http://doi.org/10.3886/ICPSR34945.v3

[6] http://www.samhsa.gov/data/sites/default/files/NMHSS2010_Web/NMHSS2010_Web/NMHSS2010_Web.pdf

Abbreviation	Definition	Abbreviation	Definition
AssertComm	Assertive Community Treatment	MHHousing	Housing Services
ClientFees	Client/Patient Fees	MHLegal	Legal Advocacy Services
CMHG	Community Mental Health Block Grants	OP	Outpatient (or day treatment/partial hospitalization) Setting
CSBG	Community Service Block Grants	OthOrg	Other National/State/Local Organization
DHHS	US Department of Human and Health Services	PvrtIns	Private Insurance
DPH	State Department of Health	RC	Residential Setting
HospLic	Hospital Licensing Authority	SA	State Substance Abuse Agency
IllnessMgmt	Illness Management and Recovery	SMHA	State Mental Health Agency
IP	Hospital Inpatient Setting	StateEduc	State Education Agency Funds
JC	Joint Commission	StateJuv	State Corrections or Juvenile Justice Agency Funds
LocalGov	Local Government Funds	StateWelfare	State Welfare or Child or Family Services Agency Funds
MHConsumer	Consumer-Run Services	SuppEmploy	Supported Employment
MHEmgcy	Psychiatric Emergency Walk-In Services	SuppHousing	Supported Housing

Results

Facility Type

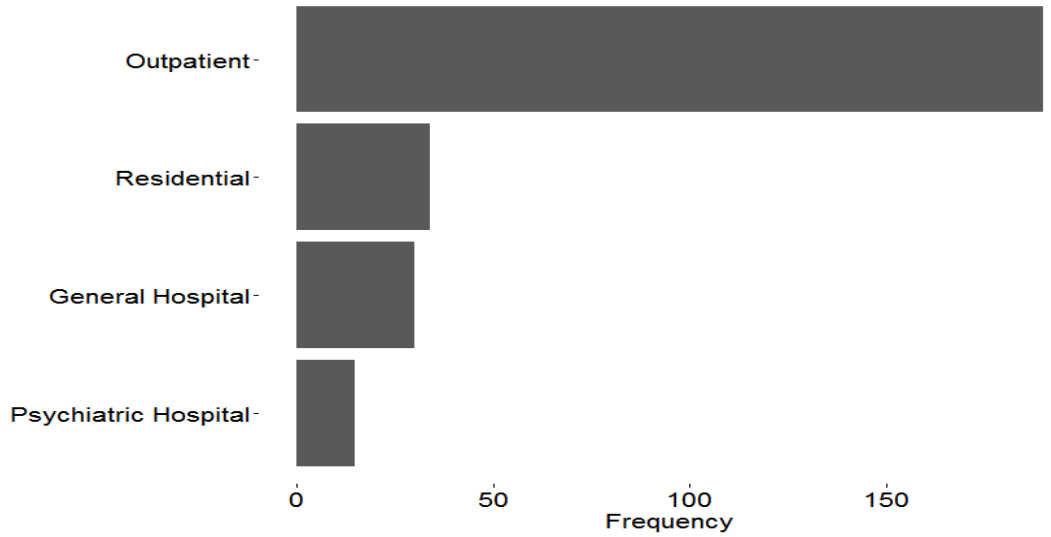

Fig. 1 Outpatient facilities comprise a major portion (70.6%) of Virginia MHS facilities.

Facility Ownership Status

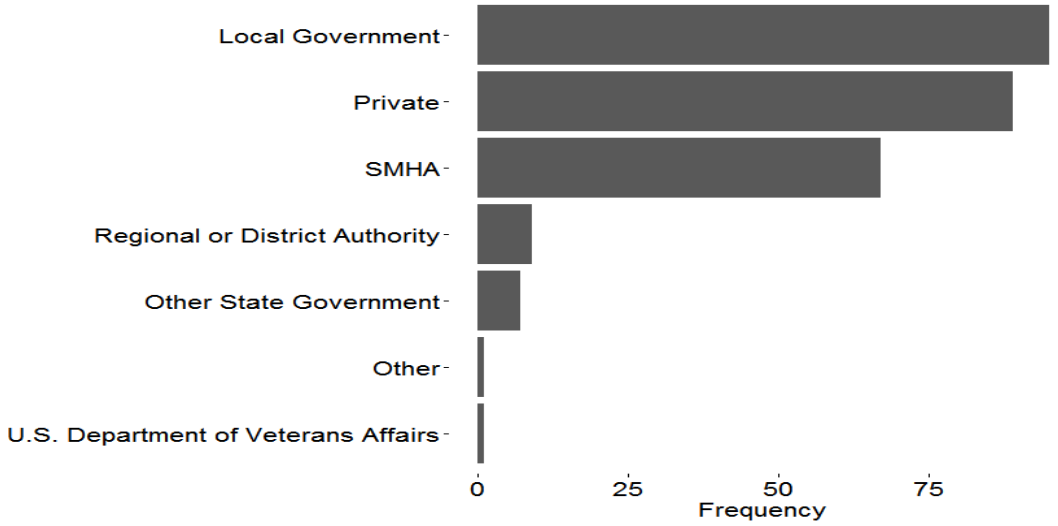

Fig. 2 MHS facilities in Virginia are mostly owned by local government (35%), private institutions (33%) and State Mental Health Agencies (25%).

Crisis Team

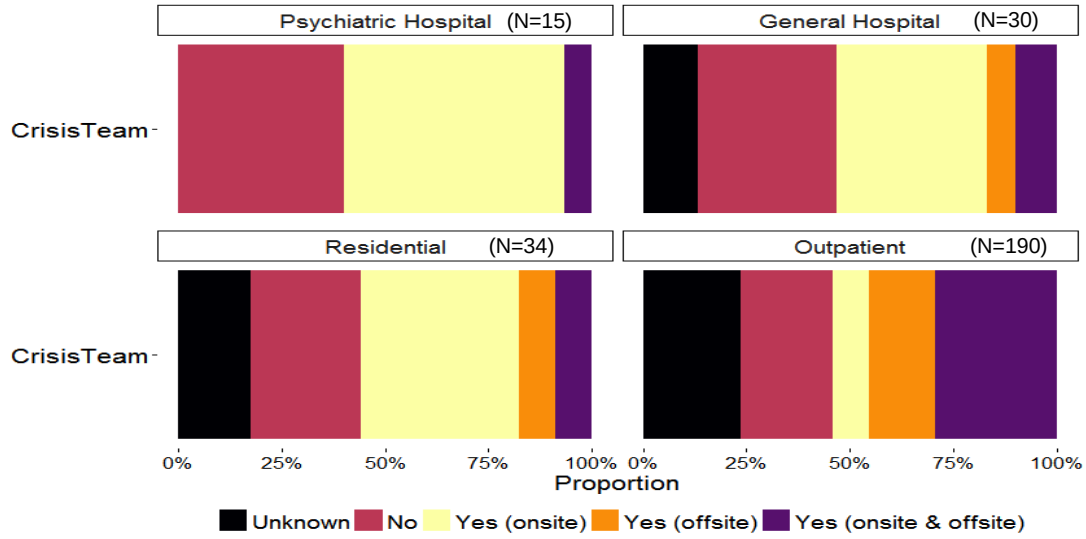

*Fig.3 Responses by MHS facilities to the N-MHSS survey item regarding the presence of a crisis team, broken down by facility type. The percentages of responses are derived from **within** each facility type.*

Over 50% of each facility type reported having a crisis team (onsite, offsite, or both). Outpatient facilities reported the smallest proportion of onsite-only crisis teams (8.95%) and the largest proportion of both onsite and offsite crisis teams (29.47%). The other three facility types reported the opposite trend, each having a fairly large proportion of onsite-only crisis teams (>36.67%) and a small proportion of both onsite and offsite crisis teams (<10%). None of the psychiatric hospitals in the survey reported having offsite-only crisis teams.

Licensing

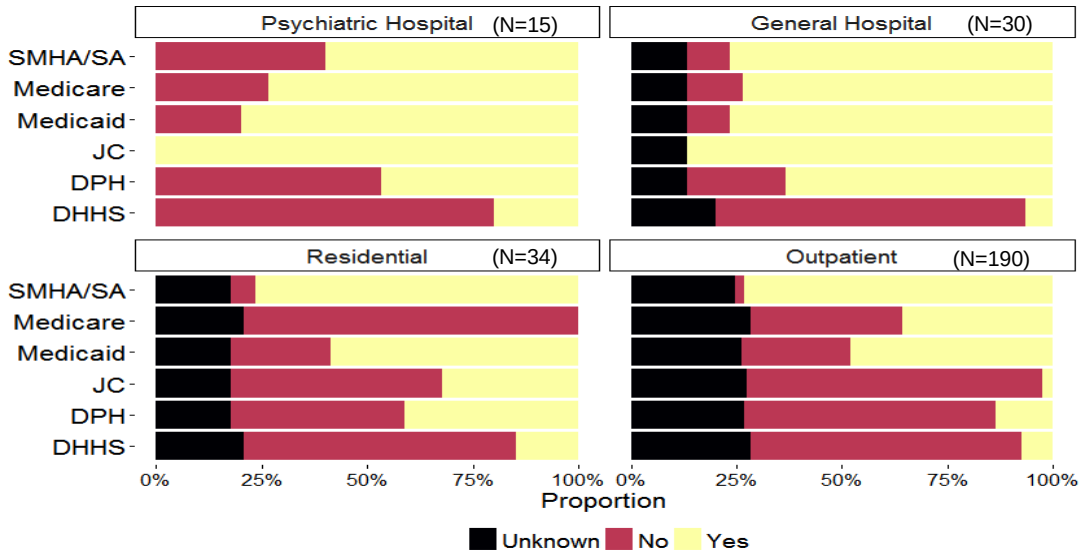

*Fig.4 Entities that MHS facilities report to be licensed by, broken down by facility type. The percentages of responses are derived from **within** each facility type.*

Very few of any of the facility types were licensed by the US DHHS. Every psychiatric hospital in the survey reported licensing from the Joint Commission. A large portion of all facility types were licensed by state mental health/substance abuse agencies.

Setting

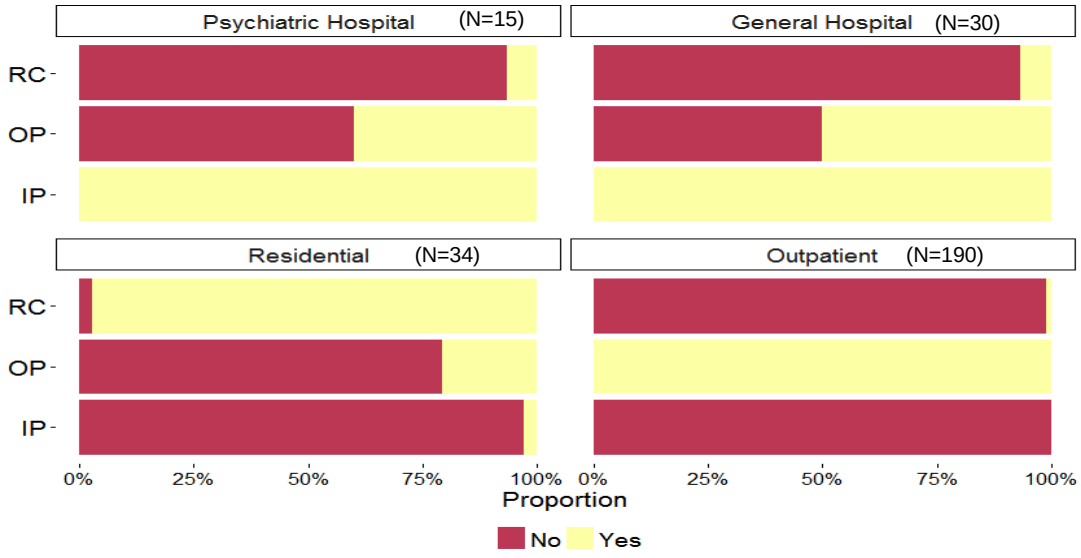

*Fig.5 Settings in which MHS facilities offer mental health treatment, broken down by facility type. The percentages of responses are derived from **within** each facility type.*

All psychiatric hospitals and general hospitals offered inpatient services, whereas almost all residential and outpatient facilities did not offer inpatient services. General hospitals and psychiatric hospitals were both split approximately evenly on outpatient services.

Ages Admitted

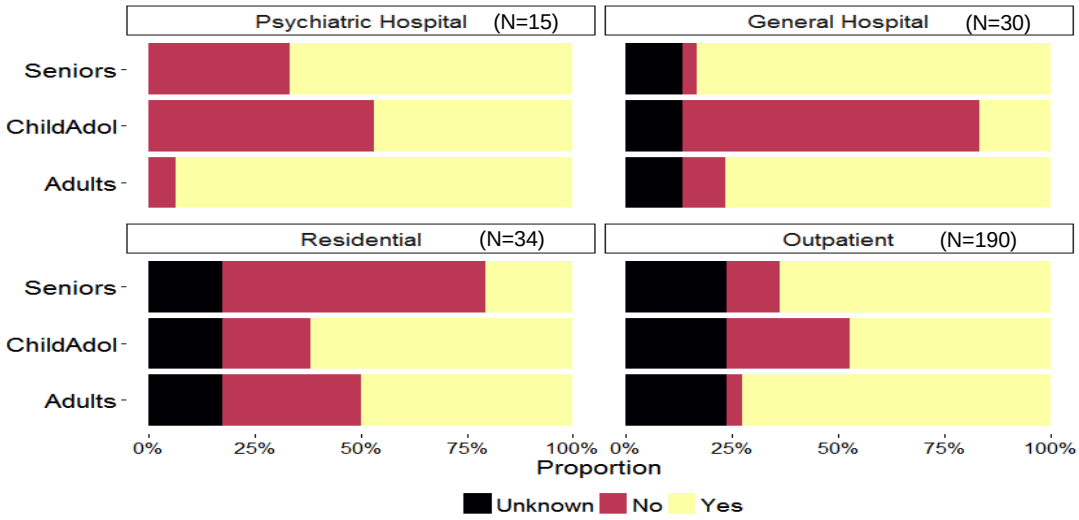

*Fig.6 Age groups admitted by MHS facilities, broken down by facility type. The percentages of responses are derived from **within** each facility type.*

Notably, there was great variance in responses among different types of facilities. Over 50% of psychiatric hospitals, psychiatric units within general hospitals, and outpatient facilities admitted seniors. Only 20.6% of residential facilities admitted seniors. Only 16.7% of general hospitals admitted children/adolescents, whereas over 50% of each of the other facility types admitted children/adolescents.

Services Offered

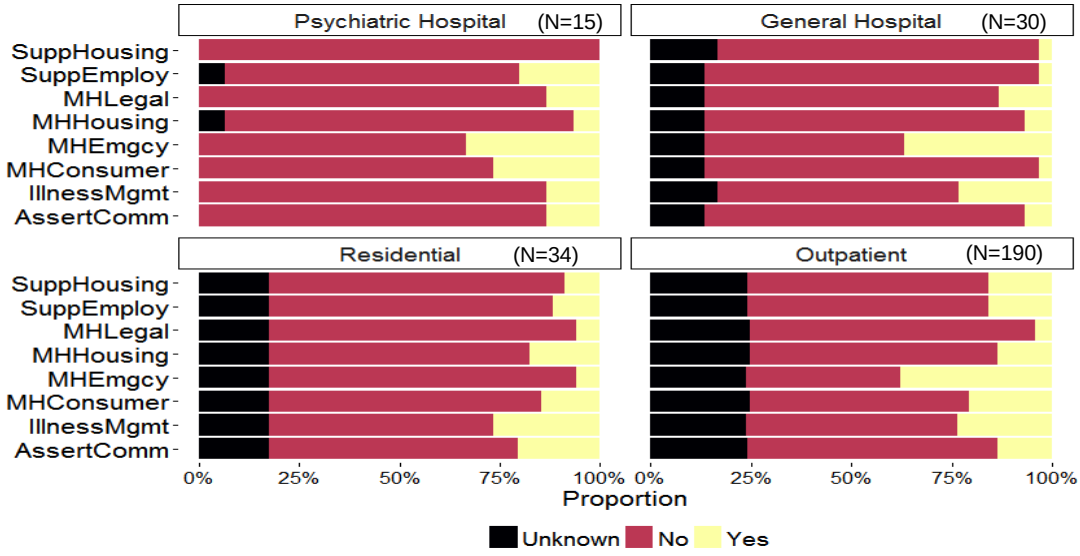

*Fig.7 Types of services offered by MHS facilities, broken down by facility type. The percentages of responses are derived from **within** each facility type.*

The majority of each type of Virginia MHS facility did not provide specialized support services, such as employment support, housing support, and legal support. The most common type of support service was walk-in mental health emergency services.

Funding Sources

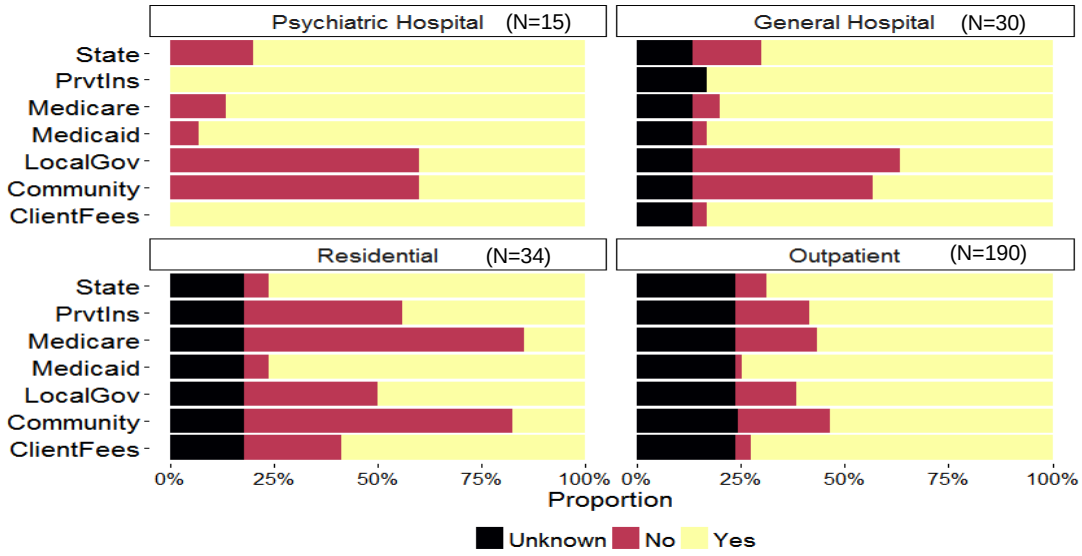

*Fig.8 Sources of funding for MHS facilities in Virginia, broken down by facility type. The percentages of responses are derived from **within** each facility type.*

Medicaid was a significant contributor of funding (>75%) for each type of MHS facility. Medicare was also a common source of funding for all facility types barring residential. Other sources of funding that were prevalent across all facilities included state funding and private insurance. A large number of outpatient facilities received funding from all of the sources listed above (at least 53.68% for any form of funding). Local government and community funds were the least common types of funding across facility type.

Discussion

It is evident from the N-MHSS (2010) that the notion of disparity of mental health services across the state of Virginia is not unfounded. Though psychiatric hospitals, general hospitals, residential facilities, and outpatient facilities all can serve varying purposes, there is a considerable amount of variance among facility types concerning sources of funding, licensure, services offered, and other characteristics.

Importantly, only a small proportion of each facility type offered mental health support services such as employment support, housing support, or legal support. This is an important finding because past research on Virginia's mental health system has shown that access to these services could help improve care to individuals experiencing psychiatric emergencies.[7] In fact, for many people experiencing a psychiatric emergency

[7] http://www.ilppp.virginia.edu/PublicationsAndPolicy/DownloadPDF/65

who are ultimately involuntarily committed, access to one of these support services could have prevented their commitment.[8]

Note that the data for this brief analysis are from 2010, and the landscape of mental health services offered by facilities in Virginia has likely changed some in the elapsed years. For example, crisis intervention teams and telepsychiatry services have likely experienced significant growth since 2010. At this time, N-MHSS public use data sets are only available through 2010, though ILPPP staff are attempting to secure more recent data. Staff also plan to compare Virginia N-MHSS data against other states' N-MHSS data.

III. Case Law Developments

Federal Circuit Court Decisions

Probation Supervision of Sex Offenders and Delegation of Judicial Authority: Fifth Circuit rules District Court's probation requirement that the offender comply with "unspecified lifestyle restrictions" imposed by the offender's therapist during supervised release constitutes an unauthorized delegation of judicial authority and the oral sentencing pronouncement controls when in conflict with the written record.

United States v. Morin, No. 15-50197, 2016 U.S. App. LEXIS 14549 (5th Cir. Aug. 8, 2016).

Background: Robert Morin pleaded guilty to failing to register as a sex offender as required by the Sex Offender Registration and Notification Act (SORNA). The district court sentenced Morin to 33 months of imprisonment and five years of supervised release. Morin challenged two conditions of his supervised release. He contended that the district court impermissibly delegated judicial authority by directing that Morin comply with unspecified "lifestyle restrictions" that might be imposed by a therapist throughout the term of his supervised release. He contended that the breadth of this requirement permitted a therapist, not the court, "to decide the nature and extent of the punishment imposed." Morin additionally argued that the written requirement that he abstain from the use of alcohol during his term of supervised release was not included in the district court's oral pronouncement of the sentence, making it invalid.

Holding: The Fifth Circuit agreed and vacated the two challenged conditions.

Notable Point:

Scope of conditions of supervised release: The Fifth Circuit emphasized that only courts have the authority to impose conditions of supervised release beyond the mandatory restrictions. The court agreed that the manner and means of therapy

[8] http://www.ncbi.nlm.nih.gov/pubmed/23475404

during treatment may be devised by therapists. Therapists and other non-judicial actors could forward to the court recommendations for new conditions.

Medical Care and Substantive Due Process Violations in Correctional Facilities: Seventh Circuit rules that a plaintiff may submit into evidence a DOJ report showing "systemic flaws" in the jail's medical care of inmates under the hearsay exception for "factual findings from legally authorized investigations."
[Editor's note: While the substandard care addressed in this case did not involve mental health care, the court's ruling has important implications for litigation involving mental health care in public facilities.]

Daniel v. Cook Cnty., No. 15-2832, 2016 U.S. App. LEXIS 14886 (7th Cir. Aug. 12, 2016).

Background: Alex Daniel was a pretrial detainee when he suffered multiple fractures in his wrist after falling during a basketball game. Daniel was initially treated by an on-duty general practitioner with an elastic bandage and a sling and after a delay was eventually treated by an orthopedic specialist. Daniel was placed in a long arm cast, which was replaced by a short arm cast three weeks later. The orthopedic specialist instructed Daniel to return in another three weeks to have the short arm cast removed; however, Daniel's cast was not removed until ten weeks later. During this delay, Daniel filed multiple grievances with the jail staff seeking treatment for his wrist. Daniel was examined by another orthopedist who concluded that Daniel suffered from "residual and permanent stiffness of his left hand and wrist," more likely than not caused by the long immobilization in the short arm cast. Daniel filed suit and offered as evidence a report from the DOJ detailing systemic health care problems at the jail. The district court granted summary judgment for defendant Cook County ruling that the DOJ report was inadmissible hearsay.

Holding: The Seventh Circuit ruled that the DOJ report met the requirements for a presumption of admissibility in civil cases for "factual findings from a legally authorized investigation" under the Federal Rules of Evidence. The court reversed the grant of summary judgment and remanded for further proceedings.

Mental Health Treatment Regulation and First Amendment Claims of Patients: Ninth Circuit upholds California statute prohibiting state-licensed mental health providers from engaging in sexual orientation change efforts (SOCE) with minor patients, rejecting claims under the Free Exercise and Establishment clauses of the First Amendment.

Welch v. Brown, No. 15-16598, 2016 U.S. App. LEXIS 17867 (9th Cir. Oct. 3, 2016).

Background: California SB 1172 went into effect prohibiting mental health providers from engaging in SOCE with patients under 18 years of age. Plaintiffs provided counseling and other services involving SOCE and appealed the denial of a motion for a preliminary injunction to prevent the enforcement of California SB 1172. Plaintiffs

claimed that SB 1172 violated the Free Exercise and Establishment Clauses by excessively entangling the state with religion and advancing or inhibiting a religion. Plaintiffs also claimed that SB1172 violated a substantive due process right to privacy in seeking a particular type of treatment.

Holding: On appeal, the Ninth Circuit affirmed the district court's judgment upholding the California statute. The court held that plaintiffs' claims failed because the scope of the law regulated conduct only within the confines of the counselor-client relationship and the prohibition against sexual orientation change efforts applied without regard to the nature of the minor's motivation for seeking treatment. The court also ruled that substantive due process rights did not extend to the choice of type of treatment or provider.

Notable Point:

Confines of the counselor-client relationship: The court specifically held that SB 1172 does not apply to clergy or pastoral counselors "as long as they do not hold themselves out as operating pursuant to their license."

Individuals with Disabilities Education Act (IDEA) and Mental Health Services: Ninth Circuit rules that a student was eligible for special education services based on prior psychiatric hospitalizations and suicide attempts even though those incidents occurred outside the school environment, and directs that an individualized education plan be developed for the student despite findings that the student was performing well at school.

L.J. v. Pittsburg Unified Sch. Dist., No. 14-16139, 2016 U.S. App. LEXIS 16201 (9th Cir. Sep. 1, 2016).

Background: L.J. was a primary school student exhibiting behavioral problems in grades two through five. L.J.'s mother repeatedly requested that the school district find L.J. eligible for special education under the IDEA, but the requests were denied. Through mediation, the school district agreed to transfer L.J. to another school, provide one-on-one counseling through a paraeducator, and provide an assessment by a school psychologist. Despite the services provided, L.J. continued to act out violently and made two suicide attempts resulting in his confinement to a psychiatric hospital, which caused him to miss six school days. L.J.'s mother filed a request for a due process hearing claiming the school district failed to provide a Free Appropriate Public Education (FAPE) by denying L.J special education services and that the district failed to make requested records relating to L.J.'s counseling available. An administrative law judge ruled that L.J. did not have any qualifying disabilities and even if he had such qualifying disabilities, L.J. was not eligible for special education services because his academic performance was satisfactory when he was able to attend school. On appeal, the district court ruled that L.J. had qualifying disabilities, but did not need special education services because of his satisfactory academic performance.

Holding: The Ninth Circuit reversed and held that the student was eligible for special education services. The court ruled that the student exhibited a need for services because his improved performance was due to his receipt of special education services, and that the student's psychiatric hospitalizations and suicide attempts were relevant to his eligibility for specialized instruction even though they occurred outside the school environment. The court also held that the school district committed procedural violations of the IDEA by failing to disclose school records and failing to conduct a health assessment.

Notable Point:

Qualifications for special education services: The court explained that a student with qualifying disabilities is nonetheless ineligible for special education services if support provided through general education services is sufficient to address the needs of the student. The Ninth Circuit ruled that the lower courts mischaracterized the specialized services L.J. was receiving as falling under general education services.

ADA Non-discrimination Requirement for "Public Accommodations": Tenth Circuit adopts a definition of "public accommodations" under the ADA that results in a commercial plasma donation center being prohibited from refusing to do business with a person with schizophrenia who seeks to donate plasma.

Levorsen v. Octapharma Plasma, Inc., 828 F.3d 1227 (10th Cir. 2016).

Background: Brent Levorsen had various psychiatric disorders including borderline schizophrenia. For years, Levorsen donated plasma in exchange for money in an effort to supplement his limited income. In May 2013, he attempted to do so at a Salt Lake City branch of Octapharma Plasma, Inc., but an employee at that location became aware that Levorsen had borderline schizophrenia. The employee informed Levorsen that he was ineligible to donate plasma out of a fear of him lashing out during the donation process, possibly injuring himself or others. Levorsen then obtained a note from his psychiatrists clearing him to donate, but Octapharma maintained its refusal to allow Levorsen to donate. Levorsen then brought suit claiming discrimination under the ADA. The district court granted Octapharma's motion to dismiss for failure to state a claim based on a determination that plasma donation centers do not fit the definition of a service establishment under the ADA.

Holding: The Tenth Circuit reversed the district court's finding and held that plasma donation centers fit the definition of service establishments under the ADA. The court reasoned that the "ordinary meaning" of service establishment was not tied to the purchase of services from the establishment; rather, an establishment that provides a service, which could include accepting and paying for donations of plasma, is the essence of the term and what the ADA sought to cover. The court remanded the case for further proceedings consistent with that determination.

State Court Decisions

<u>Burden of Proof for Involuntary Commitment</u>: Alaska Supreme Court rules that for involuntary commitment based upon the person's inability to care for self in the community, the petitioner has the burden to prove that, even with the services and supports that are available in the community, the person is too disabled to care for self and that commitment is the least restrictive alternative.

In re Hospitalization of Mark V., 375 P.3d 51 (Alaska 2016).

Background: Anchorage police took Mark V. into custody and transported him to an emergency psychiatric facility after he was found nude in public claiming to be the King of England. The treatment facility petitioned the superior court for an *ex parte* order authorizing Mark's hospitalization at Alaska Psychiatric Institute based on a determination that he was "gravely disabled" as a result of paranoid schizophrenia. The superior court granted the petition and ordered an evaluation period of 72 hours. During that initial evaluation period, Mark's treating psychiatrist filed a petition seeking to extend Mark's commitment for an additional 30 days. The superior court approved the 30-day commitment order based on testimony by Mark's psychiatrist that Mark's inappropriate behavior would continue if he were released before his manic symptoms improved.

Holding: The Alaska Supreme Court held that a 30-day commitment petition must allege less restrictive alternatives have been considered and petitioners must prove by clear and convincing evidence at a hearing that there are no less restrictive alternatives. The court found that this burden was met during the hearing and affirmed the decision of the superior court granting the 30-day commitment.

Notable Point:

No less restrictive alternative: The court explained that it is a constitutional prerequisite for involuntary commitment to prove that no less restrictive alternatives exist.

<u>Intellectual Disability and Death Penalty</u>: On remand from the U.S. Supreme Court decision in *Hall v. Florida*, Florida Supreme Court finds that Hall meets the clinical, statutory, and constitutional requirements to establish that Hall's intellectual disability precludes his being executed for the murders he committed.

Hall v. State, 41 Fla. L. Weekly 372 (2016).

Background: Freddie Lee Hall was convicted of murder in 1978 and his conviction and sentence were upheld by the Florida Supreme Court in 1981. After numerous appeals, Hall's case received cert to the U.S. Supreme Court on a claim that Florida's requirement that an inmate show an IQ test score of 70 or below before presenting any additional evidence of intellectual disability violated the Eighth Amendment. The U.S. Supreme Court agreed and remanded the case for a determination of Hall's intellectual disability.

Holding: The Florida Supreme Court found that despite Hall's IQ test scores above 70, he met the clinical definition of intellectually disabled based on evidence of organic brain damage, mental illness, and records indicating low intellectual ability. The court reversed the order of the circuit court denying post-conviction relief, vacated Hall's death sentence, and imposed a life sentence.

Notable Point:

Age of onset for intellectual disability: The court reiterated that Florida statute requires only that intellectual disability be demonstrated to have manifested prior to age 18, not that it be diagnosed prior to age 18.

<u>Imposition of Probation Conditions Requiring Sex Offender Treatment</u>: Florida Supreme Court rules that probation condition requirement that defendant attend sex offender therapy was invalid because it did not bear a "reasonable relation" to rehabilitation where defendant was charged with lewd and lascivious molestation but convicted of misdemeanor battery.

Villanueva v. State, 41 Fla. L. Weekly 319 (2016).

Background: Villanueva was charged with one count of lewd and lascivious molestation of a child older than 12 but less than 16 years old. The victim was Villanueva's daughter, who testified that Villanueva touched her breast and buttocks on three separate occasions. The jury acquitted Villanueva of lewd and lascivious molestation, but found him guilty of a lesser included offense of misdemeanor battery. The trial judge sentenced Villanueva to 90 days in jail followed by one year of probation. A special condition of the probation was a requirement that Villanueva participate in sex offender therapy pursuant to a Florida statute. That statute set probation standards including sex offender treatment for certain enumerated offenses, which included the charge of lewd and lascivious molestation, but not misdemeanor battery. Villanueva appealed, raising the issue of whether sex offender therapy was restricted by statute to only the enumerated offenses and whether the imposition the condition in this case comports with probation standards announced by the Florida Supreme Court in *Biller*. The district court upheld the sex offender treatment imposed by the trial court.

Holding: The Florida Supreme Court ruled that sex offender treatment was not limited to certain enumerated offenses, overruling a lower court decision in *Arias v. State*, 65 So. 3d 104 (Fla. Dist. Ct. App. 2011). The court also ruled that the imposition of sex offender treatment in the present case was invalid under *Biller*, because the condition did not rationally relate to future criminality.

Notable Point:

Rational relation to future criminality: The court explained that Villanueva's conviction of the lesser included offense of misdemeanor battery indicated that the touching was not committed in a lewd and lascivious manner; therefore, he should

not be a candidate for sex offender treatment. The court also relied on the fact that Villanueva did not have any prior convictions.

<u>Provider Liability and Duty of Care in Outpatient Mental Health Setting</u>: In medical malpractice suit against psychiatrist for suicide of patient, Supreme Court of Florida rules that while there is no provider duty to prevent suicide in the outpatient setting, there is still a duty of care owed to the patient and the case presented a genuine issue of material fact as to whether that duty was breached.

Chirillo v. Granicz, 41 Fla. L. Weekly 345 (2016).

Background: Robert Granicz filed a medical malpractice case against his deceased wife's primary care physician, Dr. Joseph Chirillo, alleging he breached his duty of care in treating her, which resulted in her suicide. The decedent had a history of depression and began seeing Dr. Chirillo, who changed her medication from Prozac to Effexor. Following that change the decendant called Dr. Chirillo's office and told his medical assistant that she had stopped taking the Effexor because of side effects and that she had not felt right for the past few months. This information was given to Dr. Chirillo, who changed the decedent's prescription to Lexapro. Dr. Chirillo's office called the decedent and told her to pick up her new prescription, but did not request that she schedule an appointment with Dr. Chirillo. The decedent picked up her prescription later that same day, but Granicz found her body hanging in their garage the next day. Dr. Chirillo filed a motion for summary judgment claiming that he owed no duty to prevent a patient's unforeseeable suicide while the patient was not in his control. The trial court granted the motion, but the Second District reversed on appeal.

Holding: The Supreme Court of Florida affirmed the decision of the Second District and held that the plaintiff showed a genuine issue of material fact regarding the proximate cause of his wife's suicide. The court remanded the case for trial.

Notable Point:

First District Case: The Florida Supreme Court explicitly disapproved the analysis regarding duty used by the First District in *Lawlor v. Orlando*, 795 So. 2d 147 (Fla. Dist. Ct. App. 2001).

<u>Provider Liability and Duty to Warn Third Parties in the "Zone of Danger" of Potential Harm by Patient</u>: Vermont Supreme Court replaces its May 6, 2016 opinion with an amended opinion, which still finds the existence of a duty of mental health care providers to warn a patient's caregivers of dangers posed by a patient if those caregivers are actively involved in the patient's treatment plan and are within the "zone of danger" posed by the patient's violent propensities.

Kuligoski v. Brattleboro Retreat, No. 14-396, 2016 Vt. LEXIS 106 (Sep. 16, 2016).

Background: E.R. was involuntarily committed to state mental health facilities and was diagnosed with a schizophreniform disorder before being transferred to Battleboro

Retreat. After being discharged from the retreat to the home of his parents, who were his ongoing caregivers, and while undergoing outpatient treatment with Northeast Kingdom Human Services (NKHS), E.R. assaulted his father, Michael Kuligoski. Plaintiffs filed suit against Battleboro Retreat and NKHS for failure to warn of E.R.'s danger to others, failure to train E.R.'s parents in handling E.R., failure to treat, improper release, and negligent undertaking. The superior court granted the defendants' motions to dismiss for failure to state a claim and plaintiffs appealed.

Holding: The Vermont Supreme Court reversed the rulings of the superior court relating to the failure to warn and failure to train claims. However, the court explained that the duty to warn included elements of the failure to train claim and held that there was no independent cause of action for a failure to train. The court also held that a provider has no duty to convey information in violation of HIPAA.

Notable Points:

Duty to warn: The court explained that the duty to warn is narrow and **"**applies only when a caregiver is actively engaging with the patient's provider in connection with the patient's care or the patient's treatment plan (or in this case discharge plan), the provider substantially relies on that caregiver's ongoing participation, and the caregiver is himself or herself within the zone of danger of the patient's violent propensities."

§ 43 of the Restatement Third of Tort Law: The court rejected the view that there is a duty to third parties based on the undertaking of another.

Judicial Order Authorizing Involuntary Administration of Medication in Hospital Setting: **Vermont Supreme Court reverses lower court order authorizing medication over objection of involuntarily committed patient because the lower court failed to make specific findings on whether patient's written statement of objection to medication, made prior to hospitalization, was a competent refusal that had to be honored under Vermont law**.

In re I.G., 2016 VT 95

Background: I.G. was hospitalized at the Vermont Psychiatric Care Hospital (VPCH) pursuant to a court order stemming from an arrest for assaulting his girlfriend. I.G. was previously hospitalized at VPCH and was diagnosed with schizophrenia. When he was discharged from VPCH after the previous hospitalization, he started living at a residence for people with mental illness. While there, I.G. signed a document purported to be an advance directive stating that he did not want any psychiatric medication. Following I.G.'s current hospitalization, VCPH filed an application to involuntarily medicate I.G. After a hearing, the trial court ordered I.G.'s involuntary medication for 90 days. I.G. appealed.

Holding: The Vermont Supreme Court ruled that the trial court did not adequately address the issue of whether the purported advance directive was a competent written expression or preference regarding medication according to Vermont statute. The court reversed and remanded for a determination of I.G.'s competency at the time of signing the advance directive.

Notable Point:

Advance directive: The Vermont Supreme Court reversed the decision of the trial court even though the advance directive at issue in this case did not meet the statutory requirements of an advance directive because it was not signed by two witnesses.

Employment Discrimination in Mental Health Facilities: Washington Supreme Court rules that psychiatric hospital cannot modify staff assignments to accommodate racial prejudices of patient, even when patient threatens violence if staff members of a particular race are assigned to him.

Blackburn v. Dep't of Soc. & Health Servs., 375 P.3d 1076 (Wash. 2016).

Background: Plaintiffs were employees of a psychiatric hospital and challenged alleged discriminatory staffing practices. Employees were generally assigned a particular home ward, but could be reassigned based on a "pull list." The pull list was meant to ensure that employees were reassigned to other wards on an equal basis. M.P., a particularly violent patient, threatened an African-American staff member, which resulted in a decision not to assign any African-American staff to that patient's ward to ensure staff safety. The following day, a nurse directed that a white staff person be assigned to M.P.'s ward, which would have been a deviation from the pull list assignment system. The plaintiff employees sued claiming employment discrimination and disparate treatment. The trial court dismissed the claims, concluding the adverse employment action was not severe enough to be actionable and the overriding factor was safety. The plaintiffs appealed.

Holding: The Washington Supreme Court ruled that there were no valid legal justifications for the race-based determinations in the staffing directive. The court reversed the decision of the trial court on this claim and remanded for a determination of damages.

Notable Point:

Bona fide occupational qualification (BFOQ): The court found it doubtful that a BFOQ defense could apply in this case, but ruled that it had been waived by the defense at trial.

IV. Institute Programs

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

The Institute continues to announce new offerings for the program year August 2016 through June 2017. Please visit and re-visit the Institute's website to see new and updated announcements. The Institute appreciates your interest and support for its programs. Please feel free to share this edition of *DMHL* and to share announcements of programs that may interest your professional, workplace, and community colleagues. Thank you.

Announced programs:

Assessing Risk for Violence with Juveniles

January 27 2017, Charlottesville VA: This one-day program trains mental health professionals, juvenile and criminal justice professionals, social and juvenile services agencies, educators, and others to apply current research pertaining to risk assessment with juveniles. Along with theoretical foundations the program includes review of legal parameters, impact of online behavior, and student threats.

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

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

Juvenile Forensic Evaluation: Principles and Practice

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

Evaluation Update: Applying Forensic Skills with Juveniles

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

Assessing Individuals Charged with Sexual Crimes

April 26-27 2017, Charlottesville VA: This two-day program focuses on the assessment and evaluation of individuals charged with sexual crimes, sexual offenders including 19.2-300 pre-sentencing evaluations, and 37.2-904 assessment of sexually violent predators. The program provides discussion of legal background relevant to assessment involving sexual offenses, paraphilias, base rates of re-offending, and well-researched sexual offender risk assessment instruments. This program may meet needs of providers for renewal of SOTP certification in Virginia.

In planning:

A day-long seminar on the topic 'Cognitive Bias in Forensic Psychology' with Tess Neal PhD, Arizona State University. A date in early May 2017 is being planned. Please return to the ILPPP website to find complete information when available.

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

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The Editor may be contacted at *jeogal@gmail.com*

Editor
John E. Oliver, J.D.
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Managing Editor
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