

Overview of Program Reforms Required for Medicaid Expansion in Virginia

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Phase One Requirements

- Implementation of the Medicare-Medicaid (“dual-eligible”) pilot program
- Enhanced program integrity and fraud prevention efforts
- Inclusion of foster care children in managed care
- Implementation of a new eligibility and enrollment system
- Improved access to Veterans services through the creation of the Veterans Benefit Enhancement Program
- Tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services

Phase Two Requirements

- Provide services and benefits that are the types that are provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care with the exception of non-traditional behavioral health and substance use disorder services
- Place reasonable limitations on “non-essential benefits” such as non-emergency transportation
- Require patient responsibility including reasonable cost-sharing and patient participation in wellness activities
- This reformed service delivery model is mandatory, to the extent allowed, and should, at a minimum, include:
 - Limited high-performing provider networks and medical/health homes
 - Financial incentives for high quality outcomes and alternative payment methods
 - Improvements to encounter data submission, reporting, and oversight
 - Standardization of administrative and other processes for providers
 - Support of the health information exchange
- Administrative simplification of the Medicaid program through any necessary waiver(s) and/or State Plan changes to provide maximum flexibility and expedited ability to develop and implement pilot programs to test models that:
 - Leverage innovations and variations in regional delivery systems
 - Encourage innovations that improve quality of services and yield cost savings to the Commonwealth
 - Link payment and reimbursement to quality and cost containment outcomes

Phase Three Requirements

- The state is required to seek delivery system reforms that
 - Focus on “cost-effective, managed and coordinated delivery systems”
 - Move all remaining Medicaid populations and services, including long-term care (LTC) and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems
- A report shall be provided to the 2014 General Assembly regarding the progress of designing and implementing such reforms.

Other Components

- Virginia's 2013 Appropriations Act includes language instructing DMAS to disenroll and eliminate coverage for the expanded population if the state's required match exceeds 10 percent of the program costs
- A reserve fund was created to collect savings attributable to expanded coverage
 - DMAS estimates that the state will save \$1.32 billion between 2014-2022 due to
 - Reduced general fund payments to hospitals for uncompensated care, resulting from the decreased number of uninsured Virginians (\$637 million)
 - The use of federal Medicaid dollars for
 - The Department of Corrections' inmate hospital costs (\$290 million)
 - Some CSB services (\$292 million) and temporary detention orders and other programs (\$104 million)

DEVELOPMENTS IN MENTAL HEALTH LAW

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Mental Health Related Provisions of the Patient Protection and Affordable Care Act and the Potential Impact of Medicaid Expansion in Virginia

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President Lyndon Johnson once commented that the process of implementing the Medicare program represented “the largest managerial effort the nation had undertaken since the Normandy invasion.”¹ Almost half a century later, with the passage of the Patient Protection and Affordable Care Act (Affordable Care Act), the United States has embarked on an even larger task: to reform the fiscal viability, accessibility and quality of the American health care system. The Affordable Care Act is comprised of a broad range of provisions including health insurance market reforms; the creation of new health insurance marketplaces (exchanges); coverage mandates and incentives; changes to Medicare, Medicaid and the Children’s Health Insurance Program (CHIP); improvements to quality of care and system performance and programs to address workforce shortages.

Almost all of the provisions impact behavioral health care either directly or indirectly by, for example, awarding grants for mental illness research, incentivizing the movement toward coordinated and comprehensive person-centered care, and providing greater access to insurance coverage and health care services. Given that approximately 34 percent of Virginia’s uninsured population is believed to have mental health or substance use needs, whether or not these individuals will be able to obtain insurance either through the exchange or the expansion of the state’s Medicaid program will have significant implications for the future of behavioral health care in Virginia.² This year the budget passed by the General Assembly and approved by Governor McDonnell allows expansion to occur only if a commission of legislators agrees that a series of reforms to the Medicaid system have been accomplished.

Provisions of the Affordable Care Act Related To Behavioral Health Care³

- Insurers no longer will be allowed to deny coverage or charge a higher premium due to pre-existing conditions, including mental illnesses such as schizophrenia, bipolar disorder and major depression.
- Health insurance enrollees no longer can have annual or lifetime dollar limits placed on their coverage or have their coverage arbitrarily rescinded.
- Children are allowed to stay on their parent’s plan until their 26th birthday, even if they are married. Over 66,000 young adults are now covered in Virginia as a result of this provision.
- Prior authorization is no longer required for emergency care.⁴
- All health insurance plans, both within and outside of the health insurance exchanges, must comply with the Domenici-Wellstone Mental Health Parity Act of 2008.
- Mental health and substance abuse treatments must be included among the essential health benefits (EHBs) for all individual and small group plans within and outside of the health insurance exchange.⁵

¹ Longest, Beaufort B. 2010. *Health Policy Making in the United States (5th Ed.)*. Chicago, IL/Health Administration Press, p.103.

² Population estimate provided by the Virginia Association of Community Services Boards.

³ Additional information about these, and other, provisions of the Affordable Care Act can be found at <http://kff.org/health-reform/> and <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

⁴ Some exceptions apply.

⁵ Virginia has chosen to let the federal government run the exchange for the state. The largest small group plan in Virginia, Anthem Blue Cross Blue Shield’s KeyCare PPO (along with CHIP and the Federal Employees Dental and

- Prescription drug coverage, including medications for mental health disorders, also must be included among the essential health benefits for all individual and small group plans within and outside of the health insurance exchange. However, the final regulations for essential health benefits prescription drug coverage recently released by the Department of Health and Human Services (HHS) does not require that plans adopt the Medicare Part D program's mandated coverage of substantially all medications in six protected classes. Instead, plans must cover at least the greater of a) one drug in every category and class or b) the same number of drugs in each category and class as the benchmark plan.^{6 7}
- Beginning January 2014, smoking cessation drugs, barbiturates, and benzodiazepines will be removed from Medicaid's excludable drug list.
- The Medicare Part D coverage gap ("the doughnut hole") for prescription medications has been reduced by providing a \$250 rebate in 2010 and a 50% discount on brand-name drugs in 2011. The coverage gap will be completely closed in 2020 by reducing coinsurance to 25% for all spending between the deductible and the catastrophic limit for both brand name and generic drugs. As of this year, Virginians have saved \$84 million by the reduction in the Medicare Part D doughnut hole.
- Preventive care, including depression and alcohol misuse screenings, will be provided without patient cost-sharing obligations.
- Loan repayment programs are funded for pediatric subspecialists including providers of child and adolescent mental and behavioral health services who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population.
- The Mental and Behavioral Health Education and Training Grants program provides funding to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Norfolk State University is one of 24 schools to receive the grant and has been awarded \$458,277.
- The Melanie Blocker Stokes Post-Partum Depression Act provides education for mothers, support services to women experiencing post-partum depression and to their families, and funding for research on the causes, diagnoses, and treatment of post-partum depression.
- In Virginia, the Centers for Medicare and Medicaid Services (CMS) is working with a VCU consortium of medical practices on a Medicare Independence at Home demonstration program to provide chronically ill or high-need Medicare beneficiaries with primary care services in their home. The teams of participating health professionals may share in savings resulting from preventable hospitalizations and readmissions, reductions in cost of care, and improvement in health outcomes, efficiency, and patient satisfaction.

Vision Plan for supplemental pediatric dental and vision benefits, respectively) was chosen as the benchmark for determining the essential health benefits package.

⁶ The final rule adopts essential health benefit standards for plan years 2014-2015 only. After 2015, HHS may reconsider its requirements for EHBs and will offer additional guidance in the future.

⁷ Academy of Managed Care Pharmacy. February 21, 2013 News Release. *HHS Finalizes Rule for Prescription Drug Benefit Design Under Essential Health Benefits to Implement Affordable Care Act Provisions and Clarifies Preventive Coverage for Certain OTC Items.*

- Grant funding has been provided for co-locating primary and specialty care in community-based mental health settings. The Norfolk Community Services Board (CSB) received \$2 million to integrate primary care. The CSB's Medical Services Unit will be expanded to include primary care to serve 225 individuals per year in one setting, using the person-centered healthcare home model.⁸
- Virginia has received \$72 million for Community Health Centers to prepare for the expected doubling of the number of patients seen in the next 5 years.
- Finally, the Affordable Care Act includes provider incentives for adopting service delivery models (such as medical homes and accountable care organizations) that replace the fee-for-service system with quality outcomes-based coordinated and comprehensive person-centered care.

Access to Affordable Health Insurance

In order for individuals with behavioral health care needs to benefit from the majority of the Affordable Care Act's components mentioned above, they must first have access to affordable health insurance. Currently over one million Virginians, fourteen percent of the state's population, are uninsured. Sixty percent have incomes at or below 200% of the Federal Poverty Level (FPL), and many with mental health and/or substance use needs are now being served by CSBs or are receiving care through the use of emergency departments.⁹ While Virginia has an extensive network of healthcare safety net providers, it only has capacity to treat approximately 30% of the uninsured.¹⁰

However, over 500,000 uninsured Virginians could obtain health insurance as a result of the Affordable Care Act. This population includes working parents, uninsured veterans, children who age out of Medicaid, the disabled who must wait two years for Medicare coverage, and other low income adults. Approximately 400,000 adults will qualify for Medicaid if the program is expanded to include all qualified persons with incomes up to 138% of FPL (e.g. about \$15,400 per year for an individual and \$32,000 per year for a family of four).¹¹ One hundred thousand individuals (adults and children) are expected to obtain coverage through the exchange in which premium tax credits and cost-sharing subsidies are available for individuals and families with incomes up to 400% of FPL, and 71,000 currently eligible but uninsured children are expected to

⁸ APA Advocacy Rush Notes, Health Reform Special Report. 2010.

⁹ Kaiser Family Foundation. *State Health Facts* (www.statehealthfacts.org). Mary Ann Bergeron, Virginia Association of Community Services Boards, Presentation on Health Care Reform: Impact and Benefits for Virginia and Citizens with Behavioral Health and Developmental Needs.

¹⁰ Jill Hanken, Virginia Poverty Law Center, Presentation on The Affordable Care Act: What's Next for Virginia? (December 2012).

¹¹ In Virginia, over 834,000 people have health coverage through Medicaid/FAMIS. The program covers mostly seniors in nursing homes, people with disabilities, pregnant women, children, and working families. The current eligibility levels in Virginia are less than 30% of FPL for working parents; 80% of FPL for the aged, blind, or disabled; up to 200% of FPL for children and pregnant women during their pregnancy (through Medicaid or FAMIS). Childless adults are not eligible.

enroll in FAMIS or Medicaid. The rest will remain uninsured, highlighting the continuing need for community health centers and other safety net providers in Virginia.¹²

The Question of Medicaid Expansion in Virginia

In June of 2012, the U.S. Supreme Court ruled that the federal government could not force states to expand their Medicaid programs by withholding federal funds from the existing Medicaid programs. With the expansion decision now left to each state, at the close of Virginia's 2013 General Assembly Session, Governor McDonnell, the House of Delegates and the Senate reached an agreement that if the state is to expand its Medicaid program in 2014, a series of reforms must first be accomplished. Whether reforms meet the criteria established in the budget (HB 1500) will be determined by a bi-cameral Medicaid Innovation and Reform Commission (Commission) consisting of five Senators and five Delegates, and the Secretary of Health and Human Resources and the Secretary of Finance as ex-officio members. The House members are Lacey E. Putney (I-Bedford), House Appropriations Committee Chair, and his appointees: Steve Landes (R-Augusta), Jimmie Massie (R-Henrico), Beverly Sherwood (R-Frederick), John O'Bannon (R-Henrico) and Johnny Joannou (D-Portsmouth). The Senate members are Walter A. Stosch (R-Henrico), Senate Finance Committee Chair, and his appointees: Emmett W. Hanger, Jr. (R-Augusta), John Watkins (R-Powhatan), Janet D. Howell (D-Reston), and L. Louise Lucas (D-Portsmouth). A majority of Commission members from each chamber is required to determine if Medicaid will be expanded based on their assessment of whether the reforms specified in the budget amendment have been achieved. The Commission is scheduled to meet every other month, beginning in June of this year.

During the General Assembly Session, some legislators questioned the constitutionality of empowering a sub-group of legislators with the ability to determine whether Virginia expands its Medicaid program without allowing the full Assembly to vote on the issue either during a special session or during next year's session. At the request of Delegate Robert Marshall, Attorney General Ken Cuccinelli issued an opinion that the Assembly could not delegate budget authority to a special committee.¹³ Budget negotiators from the House and Senate addressed the problem by introducing a revised amendment that appropriates the federal funding for expansion in 2014 once the Commission determines that the required reforms are complete. In so doing, the appropriation was approved by the Assembly, not the Commission, returning oversight and authority to the legislature as a whole.¹⁴

Required Medicaid Reforms:¹⁵

¹² The almost 500,000 individuals who will remain uninsured include U.S. citizens who either choose not to be covered or are exempt from the mandate, low income legal immigrants who are ineligible for Virginia's Medicaid program and cannot afford exchange products, and undocumented immigrants.

¹³ The Opinion is available on the Attorney General's website at:
<http://www.oag.state.va.us/Opinions%20and%20Legal%20Resources/OPINIONS/2013opns/13-013%20Marshall.pdf>.

¹⁴ Michael Martz, Richmond Times-Dispatch: Reforms at 'Front End' of Medicaid Expansion (Feb. 24, 2013).

¹⁵ Budget language for the reforms can be found in Item 307, Number 20c of the 2012-2014 Appropriations Act (HB 1500). Additional sources for this section: 1) Jill Hanken, e Virginia Poverty Law Center, and Michael Cassidy, The Commonwealth Institute, Presentation to the Children's Health Insurance Program Advisory Council on

The program reforms, outlined in Virginia’s 2012-2014 Appropriations Act, which must be achieved in order for Medicaid expansion to be approved by the Commission are organized into three phases.

Phase One Requirements:

- Implementation of the Medicare-Medicaid (“dual-eligible”) pilot program
- Enhanced program integrity and fraud prevention efforts
- Inclusion of foster care children in managed care
- Implementation of a new eligibility and enrollment system
- Improved access to Veterans services through the creation of the Veterans Benefit Enhancement Program
- Tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services

Phase Two Requirements:

- Provision of services and benefits that are the types that are provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care with the exception of non-traditional behavioral health and substance use disorder services
- Placement of reasonable limitations on “non-essential benefits” such as non-emergency transportation
- Requiring patient responsibility including reasonable cost-sharing and patient participation in wellness activities
- This reformed service delivery model is mandatory, to the extent allowed, and should, at a minimum, include:
 - Limited high-performing provider networks and medical/health homes
 - Financial incentives for high quality outcomes and alternative payment methods
 - Improvements to encounter data submission, reporting, and oversight
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 - Support of the health information exchange
- Administrative simplification of the Medicaid program through any necessary waiver(s) and/or State Plan changes to provide maximum flexibility and expedited ability to develop and implement pilot programs to test models that:
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 - Encourage innovations that improve quality of services and yield cost savings to the Commonwealth
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Phase Three Requirements:

Medicaid Expansion in Virginia: A Path Forward (with Some Speed Bumps)(March 1, 2013); 2) Communication with Virginia’s Department of Medical Assistance Services. March-May, 2013.

- The state is required to seek delivery system reforms that
 - Focus on “cost-effective, managed and coordinated delivery systems”
 - Move all remaining Medicaid populations and services, including long-term care (LTC) and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems
- A report shall be provided to the 2014 General Assembly regarding the progress of designing and implementing such reforms.

All of the reforms specified in Phase One are currently underway and are the least likely to delay expansion. While the Medicare/Medicaid dual eligibility demonstration project is a large and difficult program to implement, it is progressing and interaction between the Department of Medical Assistance Services (DMAS) and CMS is positive. Importantly, the project includes an option for individuals with serious mental illness (SMI) within the dual-eligible population to choose a behavioral health organization, such as a Community Services Board, as a health home. This will enable the utilization of targeted case management in overall care coordination, and ultimately provide greater “flexibility in paying for needed and effective services, including peer services, to support individuals with SMI in their communities.”¹⁶

Also, DMAS is currently moving foster care children into the managed care system, and the process is on track for completion in the Richmond and Tidewater regions by July 1, 2013, and statewide in October of next year. The Veterans Benefit Enhancement Program is in development; and DMAS has been focusing efforts in the area of community behavioral health, working on regulations to better specify the qualifications needed for providers to assure that mental health services are administered appropriately.

The reforms in Phase Two apply to all Medicaid populations, except dual eligibles and individuals in long-term care, and are intended to bring substantial changes to Virginia’s current Medicaid benefits structure, requiring it to be more like a commercial health insurance plan. However, given that non-traditional behavioral health and substance use disorder services (e.g. community mental health services) typically are not covered in commercial insurance products, the language does specify that these services should continue to be included in the Medicaid health plan. According to DMAS staff, moving to a commercial health insurance plan model with limitations on non-essential benefits and increased cost-sharing obligations for patients appears to be possible under current federal regulations. However, the budget language does not specify the degree to which benefits must be limited and cost-sharing increased. Until specific metrics are determined by the Commission members, DMAS officials cannot say whether further approval from CMS will be needed. Simplification of how Virginia administers the Medicaid program, including consolidation of waiver programs for community based services, and the development of delivery and payment reform pilot programs likely will require further negotiations with CMS before they can be approved.

Lastly, Phase Three requires DMAS to seek innovative ways to deliver more cost-effective, managed and coordinated care to all Medicaid participants. The use of the word

¹⁶ Mary Ann Bergeron, Virginia Association of Community Services Boards, Update on Community Support Boards and Managed Care in Virginia, The National Association of County Behavioral Health and Developmental Disability Directors Newsletter (September 2012), p. 2.

“seek” suggests that the Commission will recognize that broad system reforms take years to fully implement and, therefore, will only require that progress is being made in order for Medicaid expansion to occur.

Other Components of the Medicaid Reform Requirements:

In order to address concerns that the promised federal medical assistance percentages specified in the Affordable Care Act may be reduced through federal law or regulation in the future, leaving Virginia to pay a greater share of the costs for Medicaid expansion, Virginia’s 2013 Appropriations Act includes language instructing DMAS to disenroll and eliminate coverage for the expanded population if the state’s required match exceeds 10 percent of the program costs.¹⁷ In addition, a reserve fund was created to collect savings attributable to expanded coverage. DMAS estimates that the state will save \$1.32 billion between 2014-2022 due to reduced general fund payments to hospitals for uncompensated care, resulting from the decreased number of uninsured Virginians (\$637 million), and the use of federal Medicaid dollars for the Department of Corrections’ inmate hospital costs (\$290 million), some CSB services (\$292 million) and temporary detention orders and other programs (\$104 million).¹⁸ Currently all of these programs are funded by state and/or local dollars. If expansion occurs, the federal government will pay 100 percent of the cost for three years, and 90 percent thereafter. The savings realized by the state will be used to support reforms outlined in Phase Two and to be used after 2020 when Virginia will pay 10 percent of the Medicaid expansion costs.

Conclusion

The Patient Protection and Affordable Care Act is the most extensive healthcare reform legislation since the passage of Medicare and Medicaid, and it is not surprising that the law, two years after its passage, remains highly controversial. The debates over the law’s provisions, like Medicaid expansion, highlight the ideological diversity of Americans and the challenge of reforming a massive health care system that needs to be fixed. However, there does appear to be general agreement that many of the law’s provisions, if implemented fully, accurately, and efficiently, can improve how behavioral health care is accessed and provided in our society. Medical homes, Accountable Care Organizations, and other models of integrated care link physical and mental health services; and they emphasize payment based on the quality, rather than the quantity, of the services provided. As a result, these system-wide models of change hold significant promise for many individuals with mental health needs and substance use disorders who have experienced the challenge of finding care in a fragmented service system.

However, given that approximately 34% of Virginia’s uninsured population has some type of behavioral health care need, the expansion of the state’s Medicaid program is seen as a necessity by many health care professionals in order for health care reform to be fully realized in Virginia. During the 2013 General Assembly Session, state lawmakers came to an agreement that efforts to reform the state’s Medicaid program must first be in place before expansion can

¹⁷ The Affordable Care Act includes the provision that states that choose to expand their Medicaid program will receive 100% federal funding for years 2014-2016, phasing down to a 90% federal match after 2020.

¹⁸ Go to The Commonwealth Institute’s website (www.thecommonwealthinstitute.org) for a more detailed analysis of DMAS estimates of the expected state savings from Medicaid expansion and the Affordable Care Act overall.

occur. Many of these reforms already are being implemented and should not pose a problem for expansion, while others likely will require further approval from CMS. At this point, it would be inaccurate to claim that Medicaid expansion in Virginia definitely will occur; but it is clear that Virginia's Medicaid program is being reformed, hopefully resulting in more efficient, effective, and comprehensive care for individuals with behavioral health care needs.

2013 Virginia General Assembly Update

Magistrates Required to Consider Alternative Transportation Order; Use for TDOs Restricted

Little legislation to change the substantive law related to mental health was introduced in the 2013 General Assembly Session. The most consequential was Senator Charles Carrico's Senate Bill 920¹⁹ that will require, effective July 1, 2013, a magistrate to consider ordering an alternative transportation provider, in lieu of law enforcement, to transport a person with mental illness under an emergency custody order ("ECO") or temporary detention order ("TDO") whenever the magistrate is advised that a willing and appropriate alternative person, facility or agency is available and the transportation can be provided safely. As originally introduced, the bill *required* a magistrate to order alternative transportation if an appropriate transportation provider was available and willing to provide transportation and could do so safely. As finally enacted, the magistrate is not *required*, however, to order such transportation, but only to *consider* it.

Under current law, an alternative transportation order ("ATO") may only be issued for a person subject to an ECO under Virginia Code § 37.2-808 when probable cause exists that the person meets the second prong of the commitment criteria, namely that "the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs." The legislation now also makes it absolutely clear that an ECO may not be issued when probable cause exists that the person meets the first prong of the criteria, that is, when a person is a danger to self or others. Parallel language has also been inserted in the TDO statute, § 37.2-810, prohibiting issuance of an ATO if the person meets the first dangerousness prong of the commitment criteria. Law enforcement must therefore provide transportation whenever the person meets the dangerousness criteria for both ECOs and TDOs, effective July 1, 2013.

The alternative transportation provisions were originally enacted in 2009 upon the recommendation of the Commonwealth of Virginia's Commission on Mental Health Law Reform. A key complaint leading to the establishment of the Commission, and forcefully presented by members of the Senior Lawyers Conference of the Virginia State Bar, was that elderly people in nursing homes in need of psychiatric care were being forced to be transported to psychiatric facilities by uniformed law enforcement officers in patrol cars and in restraints,

¹⁹ The full text of SB 920 is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+ful+CHAP0371+pdf>.

often resulting in increased trauma and bad outcomes.²⁰ In 2009, at least 27 other states permitted transport by someone other than law enforcement, including family, friends, mental health professionals, ambulances and public and private transportation companies, although most, as does Virginia, continue to rely upon law enforcement for a majority of their transports. The goals of the legislation were two fold:

- 1) decriminalizing transportation and reduce stigma through lessening Virginia's over-reliance on law-enforcement agencies and the use of restraints in transporting individuals in the civil commitment process, while at the same time ensuring the safety of the person, the transporter and the public, and
- (2) promoting the recovery of the individual by enabling the provision of voluntary services in the least restrictive manner and setting.²¹

When the alternative transportation provisions were first enacted in 2009, the limitation on issuance of ATOs only for persons under an ECO who met the second prong of the criteria was inserted as a compromise to assuage worries by some that public safety would be compromised. It was thought by some that the ECO stage was too early in the commitment process to determine whether alternative transportation could be provided safely because the person's condition and dangerousness had not as yet been assessed. It was then agreed, however, that the ATO should at least be available for individuals meeting either prong at the TDO stage because mental health professionals would have had the opportunity to assess the person's risk and stabilize their condition. This will no longer be possible.

Most ATOs are issued for individuals under a TDO, rather than an ECO, because an assessment of the person's condition will have been done and their condition may have stabilized somewhat. The additional time prior to the issuance of a TDO may also permit an alternative transportation provider to be identified. But for individuals who, for example, may have attempted suicide and are still dangerous to themselves, but whose dangerousness is under the immediate control of emergency medical personnel or others, law enforcement custody and transportation will still be required even though it could safely be accomplished by ambulance or other transportation provider.

Law enforcement agencies have long complained of the burden placed on them in transporting persons under ECO, TDO and commitment orders, and the burden has become worse in recent years with the decline in the availability of TDO beds and hospitals' refusal to admit a person without "medical clearance." During Fiscal Year 2011, 6,362 ECOs and 20,420 TDOs were issued according to the Supreme Court of Virginia's eMagistrate System.²² The burden becomes especially heavy for town police who often may have only one or two officers on duty, if any at all. The town may therefore be deprived of police protection during the period of time required waiting for a medical assessment, identification of a TDO bed, and then

²⁰ Commonwealth of Virginia, Commission on Mental Health Law Reform, Progress Report on Mental Health Law Reform, December 2008, available at:

http://www.courts.state.va.us/programs/cmh/2008_1222_progress_report.pdf.

²¹ *Id.* at 36, and 2008 Transportation Work Group Report available at:

http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_1216_wg_transportation_rpt.pdf.

²² Commission on Mental Health Law Reform, Operation of the Civil Commitment Process in FY 2011, available at: http://www.courts.state.va.us/programs/cmh/reports/2011_statistical_report_of_commitment_hearings.pdf.

transporting a person long distances for hospitalization. While most law enforcement agencies acknowledge the public safety necessity of providing such custody and transportation, disputes between individual agencies have resulted in the convoluted instructions to magistrates about which agency to order to provide transportation found in §§§ 37.2-808, 37.2-810 and § 37.2-829, including the formula on how to compute the so-called “50-mile rule” found in § 37.2-810. Subsection C of § 37.2-810 does, however, permit law enforcement agencies to enter into mutual aid agreements to facilitate execution of TDOs, which could resolve some of these disputes.

Senator Carrico became especially concerned this past year about the burden on law enforcement upon the issuance of an Attorney General Opinion to the County Attorney for Wise County in October 2011.²³ The Opinion advises that the primary law enforcement agency which the magistrate must order to take custody of an individual and provide transportation under Virginia Code §§ 37.2-808 and 37.2-810 is the town police department in towns that have established a police department. Otherwise the sheriff of the surrounding county is required to provide the transportation.

As a practical matter, the legislation may have little effect. Since its enactment, alternative transportation is being used in every area of the Commonwealth, but to a very limited extent.²⁴ By requiring magistrates to consider the issue when presented to them, it may draw more attention to the possibilities of its use, which would be a positive outcome. The cumbersome custody transfer provisions, plus the new restrictions on persons who may avail themselves of the ATO provisions, do not encourage its use. Primarily, however, alternative transportation services have not been developed due to a lack of funding, and will not be until a dependable funding stream can be established. The Department of Medical Assistance Services, for example, has not yet developed a system for payment although such services are required under the State Medical Assistance Plan. As long as law enforcement is required to provide transportation at no charge, a reliable funding mechanism may never be developed.

CSB Where Person Resides or Receives Treatment May File Motion for Mandatory Outpatient Treatment

House Bill 1423²⁵ introduced by Delegate John O’Bannon will permit, effective July 1, 2013, the CSB where the person resides or receives treatment to file a motion for that person’s mandatory outpatient treatment (“MOT”) upon discharge. Currently only the community services board (“CSB”) where a person has been either voluntarily or involuntarily hospitalized, can do so. Logically, the CSB where the person resides would be the CSB providing treatment and with the most knowledge about the person’s treatment needs. This bill will clarify the provisions enacted last year that subjects for the first time a person to involuntary MOT for up to 90 days who first voluntarily accepts treatment under Virginia Code § 37.2-805, as well as a person completing a period of inpatient hospitalization under § 37.2-817.C. In addition to the

²³ 2011 Op. Va. Att’y Gen. ___. The opinion is available at:

<http://www.oag.state.va.us/Opinions%20and%20Legal%20Resources/Opinions/2011opns/11-123-Mullins.pdf>.

²⁴ For information on the use of alternative transportation, see the study completed by Amy Askew and published in Volume 30, Issue 1, March 2011, issue of *Developments in Mental Health Law* available at:

<http://ilppp.virginia.edu/PublicationsAndPolicy/Index>.

²⁵ The full text of HB 1423 is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+ful+CHAP0179+pdf>.

CSB, others that may file such a “motion” include the treating physician, a family member or personal representative of the person.²⁶ Although it is unclear procedurally how a “motion” could be filed with no petition or active case pending in court, any person could in any event have been the subject of a petition for MOT under § 37.2-817.D since its enactment in 2008.

As a practical matter, MOT has seldom been used in Virginia for a number of reasons. The criteria for ordering MOT is the same as the commitment criteria for inpatient hospitalization and thus too high. Resources for the delivery of community services are also not sufficiently available to meet the needs of individuals with mental illness. Further, Virginia’s 48-hour maximum detention period is too short a timeframe in which to develop the required treatment plan, although this should not be a problem following a period of inpatient hospitalization. Finally, the process is overly complicated and too burdensome to implement for both the courts and the CSBs.²⁷ The Prince William County CSB has made the most effective use of MOT through its policy of conducting a follow-up prescreening for an individual who is the subject of a petition for civil commitment just prior to the hearing. By that time, the person’s condition has had more of an opportunity to stabilize and community resources to meet the person’s needs may be identified. The most practical use of MOT is its use by the Valley CSB following a person’s period of inpatient hospitalization embodied in this and the 2012 legislation.

TDO Extension to 72 Hours Fails

The Commission on Mental Health Law Reform has advocated since 2007²⁸ extension of the 48-hour time frame required under Virginia law for conducting a commitment hearing following the issuance of a temporary detention order under Virginia Code § 37.2-809. Virginia’s 48-hour time frame is one of the shortest in the country. Three other states allow a hearing within 30 days but most states require a hearing within 4 to 8 days of the person’s detention, with the mid-range being 7 to 10 days. Expanding the TDO timeframe before a commitment hearing is held would decrease the need for involuntary hospitalizations by providing more time for individuals to be treated and stabilized, permitting a safe discharge plan to be developed, and either negating the need for hospitalization altogether or increasing the likelihood of voluntary admission. It would also give examiners time to conduct a more thorough evaluation, as required in § 37.2-815, to guide the court’s decision if a commitment hearing is necessary. Data from Virginia, Colorado, Massachusetts and Pennsylvania on lengths of stay contained in a report prepared by Sarah E. Barclay for the Commission on this issue indicated that the two-day temporary detention period is not adequate for a thorough assessment

²⁶ For an analysis of Delegate David Albo’s House Bill 476, see *Developments in Mental Health Law*, Vol. 31, Issue 3, April 2012 available at: <http://ilppp.virginia.edu/PublicationsAndPolicy/Index>.

²⁷ Askew, Amy Liao, Use of Mandatory Outpatient Treatment in Virginia – A Preliminary Report on the First Two Years, University of Virginia School of Medicine, Department of Public Health Services, January 2011 at: http://www.courts.state.va.us/programs/cmh/reports/2011_01_mot_report.pdf. An excerpt of the study is also available in *Developments in Mental Health Law*, Vol. 30, Issue 2, March 2011 at: <http://ilppp.virginia.edu/PublicationsAndPolicy/Index>.

²⁸ See the Commonwealth of Virginia, Commission on Mental Health Law Reform, Progress Report on Mental Health Law Reform, December 2008 available at: http://www.courts.state.va.us/programs/cmh/reports/2008_1222_progress_report.pdf.

in some cases. Further, 30% of commitment hearings in Virginia occur in less than 24 hours,²⁹ which almost always results in involuntary commitment.

Legislation has been introduced each year since 2009, but has failed due to the uncertainty of its fiscal impact. Delegate Joseph Yost and Senator George Barker introduced legislation again this year extending the TDO time period to 72 hours through House Bill 1680 and Senate Bill 996,³⁰ respectively. Senator Barker's bill included an effective date of January 1, 2014, rather than July 1, 2013, and contained a clause subjecting its enactment to sufficient appropriations to cover its cost. Nonetheless, Senator Barker's bill died in the House Appropriations Committee due to its potential fiscal impact.³¹

A Study on the Use of Longer Periods of Temporary Detention to Reduce Mental Commitments was presented to the Virginia General Assembly's Joint Commission on Health Care on June 28, 2012 and found that longer periods of temporary detention lead to a reduction in involuntary civil commitments.³² Although Virginia law requires hearings to be held within 48 hours of execution of a TDO, that time period may be extended to 72 or 96 hours if the detention falls on a weekend or long holiday weekend. This extension provided a natural variation in TDO length based on local practice and the occurrence of weekends and holidays upon which the Study could rely to correlate longer detention stays with shorter stays.³³ The data revealed that longer periods of temporary detention were correlated with an increased probability of dismissal of a civil commitment petition rather than further psychiatric hospitalization. Unfortunately, the Study also found that there would be a slight increase in the number of inpatient TDO days paid from the Involuntary Commitment Fund. That increase should be offset by a reduction in the number of post-commitment hospital days paid for by Medicaid. Nonetheless, due to the inability to adequately project the cost of extending the TDO time period especially in this still fiscally constrained economic environment, the General Assembly declined to take this action at this time. This issue has been presented to the Mental Health Workgroup of the Governor's Task Force on School and Campus Safety,³⁴ however, and its recommendations due June 30, 2013 bear watching.

²⁹ Sarah E. Barclay, Increasing the Temporary Detention Period Prior to a Civil Commitment Hearing, Implications and Recommendations for the Commonwealth of Virginia Commission on Mental Health Law Reform, April 2008, available at: http://www.courts.state.va.us/programs/cmh/reports/2008_04_tdo_period_barclay_report.pdf.

³⁰ The full text of SB 996 is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+ful+SB996E+pdf>.

³¹ See the Fiscal Impact Statement attached to the bill at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+oth+SB996FE122+PDF>.

³² The presentation to the Joint Commission on Health Care is available on the Commission's website at: http://services.dlas.virginia.gov/User_db/frmView.aspx?ViewId=2991.

³³ Wanchek, Tanya Nicole, Ph.D., J.D., Bonnie, Richard J. LL.B. Use of Longer Periods of Temporary Detention to Reduce Mental Health Commitments, *Psychiatric Services*, Vol. 63, No. 7, July 2012. An abstract of the article is available at:

<http://ps.psychiatryonline.org/Article.aspx?ArticleID=1151384>.

³⁴ James M. Martinez, Jr., Presentation to the Mental Health Workgroup of the Governor's Task Force on School and Campus Safety, March 28, 2013 available at: <http://www.dbhds.virginia.gov/documents/Overview%20MOT-%20TDO%20Extension%20201.03.28.pdf>.

College Mental Health Study Recommendations Pass

University, CSB and Psychiatric Facility Memoranda of Understanding

The Virginia College Mental Health Study that measured student access to mental health services four years after the Virginia Tech tragedy,³⁵ was published in 2011 and identified significant information gaps among college and university officials, community services boards (CSBs), and psychiatric hospitals during the emergency custody, temporary detention and commitment evaluation processes. The Study was conducted by the College Mental Health Task Force, established in conjunction with the Joint Commission on Health Care and the Commonwealth of Virginia Commission on Mental Health Law Reform. It also found that colleges and universities often have significant mental health and behavioral information that would aid state officials involved in commitment proceedings. It further found that residential colleges are the “homes” to which many discharged students return after hospitalization. Colleges and universities should therefore be notified and involved in these proceedings to ensure community safety and appropriate continuity of care when a discharged student returns to campus.

Based on these findings, the task force recommended each college and university establish a written memorandum of understanding with its respective CSB to ensure both parties have the same understanding of the scope and terms of their relationship and with local psychiatric hospitals to assure inclusion of colleges, where appropriate, in the post-discharge planning of student patients, whether admitted voluntarily or involuntarily. CSBs should also establish a reliable system for notifying in a timely fashion a designated contact person at each Virginia college or university whenever one of its students is the subject of commitment proceedings and for assuring exchange of information among the college, providers and the legal system.

House Bill 1609,³⁶ introduced by Delegate Timothy Hugo, and Senate Bill 1342, introduced by Senator Chap Petersen, will now require each public four-year college or university to establish memoranda of understanding with its local CSB and with local hospitals and other local mental health facilities to expand the scope of services available to students seeking treatment. The memoranda must designate a contact person to be notified whenever a student is involuntarily committed, or when a student is discharged from a mental health facility and consents to such notification. It must also provide for the inclusion of the college or university in post-discharge planning whenever a student who has been committed intends to return to campus to the extent allowable under federal privacy laws.

Community College Referral Policy

The Task Force further found that a significant number of community college students do not have access to off-campus mental health services because they are more likely than students in four-year colleges to be uninsured or under-insured and because most CSBs lack the capacity

³⁵ The Full Study may be accessed on the Joint Commission on Health Care website at: http://services.dlas.virginia.gov/User_db/frmView.aspx?ViewId=2742.

³⁶ The full text of HB 1609 is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+ful+CHAP0735+pdf>.

to provide timely counseling and psychiatric assistance. The task force members believed that capacity to prevent and respond successfully to mental health crises depends on timely access to clinically trained professionals who are able to screen and refer troubled students.

The task force therefore recommended that “the Commonwealth embark on a sequential plan, as resources permit, to assure that every community college has the capacity to provide brief screening and referral services for students who appear in need of mental health intervention; to maintain fully staffed threat assessment teams; to conduct risk assessment screenings in cases that may pose a risk of harm to campus safety; and to coordinate with CSBs, law enforcement agencies and families to carry out emergency interventions and other types of crisis response when necessary.”³⁷

As a result, Delegate Scott Surovell and Senator George Barker introduced House Bill 2322³⁸ and Senate Bill 1078, respectively, requiring the State Board for Community Colleges to develop a mental health referral policy requiring each community college to designate at least one individual at each college to serve as a point of contact with the local CSB emergency services system clinician or other qualified mental health services provider. The contact could then facilitate the screening and referral of students who may have emergency or urgent mental health needs, and assist the college in developing policies and training to address the needs of students exhibiting suicidal tendencies and in carrying out its duties related to the implementation of threat assessment teams.

Governor’s Task Force Budget Recommendations Adopted

Following the massacre of 20 first-graders and 6 adults at Sandy Hook Elementary School in Newtown, Connecticut in December, Governor Bob McDonnell issued Executive Order 56 establishing a multidisciplinary task force to review school and campus safety in Virginia and to make both short term recommendations that might be enacted during the 2013 General Assembly Session and prepare long term solutions. The Governor also established a separate Mental Health Workgroup chaired by Attorney General Ken Cuccinelli and Secretary of Health and Human Resources Dr. Bill Hazel. The Mental Health Workgroup is evaluating Virginia’s mental health system to recommend improvements for identification, intervention, and treatment of behavioral and mental disabilities with a focus on ways to prevent acts of violence.³⁹

Three specific budget recommendations originating from the Mental Health Workgroup were successful, as well as several other recommendations that were jointly considered by the Mental Health, Public Safety and Education Workgroups:

Suicide Prevention:

³⁷ An Executive Summary of the College Mental Health Study prepared by Professor Richard J. Bonnie was published in *Developments in Mental Health Law*, Volume 31, Issue 1, December 2011 and is available at: <http://ilppp.virginia.edu/PublicationsAndPolicy/Index>.

³⁸ The full text of HB 2322 is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+ful+CHAP0606+pdf>.

³⁹ The minutes, presentations and handouts from the Mental Health Workgroup’s meetings are available on the Department of Behavioral Health and Developmental Services’ (“DBHDS”) website at: <http://www.dbhds.virginia.gov/SchoolSafetyTF-MHWorkgroup.htm>.

The General Assembly appropriated \$500,000 for the development of a comprehensive statewide suicide prevention program. Presentations to the Workgroup revealed that suicide is a major public health problem. It is the 11th leading cause of death nationwide and suicide attempts account for hundreds of thousands of emergency room visits and hospital admissions each year. Virginia's suicide rate is now the highest in 13 years. Not only is suicide an individual tragedy, but many of the perpetrators of mass violence are suicidal with most of these events ending in the suicide of the perpetrator.⁴⁰

Suicide is also preventable with knowledge about evidence-based practices increasing dramatically in the past ten years. House Bill 1500, Item 314 N, directs the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS), in collaboration with the Departments of Health, Education, Veterans Services, Aging and Rehabilitative Services, and other partners to develop and implement a statewide program of public education, evidence-based training, health and behavioral health provider capacity-building, and related suicide prevention strategies. Virginia's cross-agency suicide prevention program, currently entirely federally funded, will form the basis of this new suicide prevention strategy.

Mental Health First Aid Training

Prior to a mass shooting event, the Workgroup learned that many perpetrators show warning signs related to their behavior. Some of this violence may be preventable if persons are alert to signs and symptoms of mental illness or risks of suicide and other violence. Mental Health First Aid is a 12-hour training course designed to give members of the public skills on how to recognize and respond to those experiencing mental or emotional distress. Based on training developed in Australia, participants in mental health training programs in Missouri and Maryland have demonstrated greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved coordination with health professionals, and decreased stigmatizing attitudes about seeking help.⁴¹

The General Assembly appropriated \$600,000 to provide mental health first aid training and certification to assist in recognizing and responding to mental or emotional distress. House Bill 1500, Item 315 AA, requires the funding to be used to cover the cost of personnel dedicated to this training activity, training and certification, and manuals and certification for all those receiving the training. Participants will include school personnel, clergy, health professionals, community agency staff, military and veteran service organizations, and other first responders.

Children's Psychiatry and Crisis Response Services

The General Assembly appropriated an additional \$1.85 Million to the original appropriation of \$1.75 Million, for a total of \$3.65 Million, for the second year of the biennium

⁴⁰Proposals for the Governor's Taskforce on School and Campus Safety Mental Health Workgroup at 4-6, available at: <http://www.dbhds.virginia.gov/documents/130124Proposals.pdf>. See, also Virginia Department of Health's website on suicide prevention at: <http://www.vdh.virginia.gov/ofhs/prevention/preventsuicideva/index.htm>.

⁴¹*Id.* at 9-11, available at: <http://www.dbhds.virginia.gov/documents/130124Proposals.pdf>. See, also Mental Health First Aid USA's website at: http://www.mentalhealthfirstaid.org/cs/program_overview/.

to expand child psychiatry and children's crisis response services for children with mental health and behavioral disorders. Wait periods for children to receive psychiatric services are currently eight weeks or more, leaving many children with pressing mental health needs and without timely access to mental health care and medications. Many individuals are therefore turned away in crisis situations when they most need help.⁴² This funding will begin to address this situation.

House Bill 1500, Item 315 W, directs that these funds be divided among the health planning regions based on the current availability of services and be used to hire or contract with child psychiatrists to provide direct clinical services, including crisis response services. Child psychiatrists must also provide training to and consultation with other children's health care providers in the health planning region, such as general practitioners, pediatricians, nurse practitioners, and community service board staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities.

Drop-Off Centers

At the Mental Health Workgroup's recommendation, the General Assembly appropriated an additional \$900,000 beyond the \$600,000 appropriated last Session for the second year of the biennium to expand from five to eight the number of drop-off centers around the Commonwealth.⁴³ Popular with law-enforcement agencies, these centers provide an alternative to incarceration for people with serious mental illness. When police officers take custody of an individual in their community for petty offenses, but believe their behavior is the product of a mental illness, they may take these individuals to a "no refusal" drop-off center to obtain an evaluation as to their mental condition. This then frees up patrol officers to return to their duties instead of tying them up for many hours waiting for an evaluation and identification of a detention bed. Where this service is not available, police officers often arrest a person with mental illness for a petty crime, rather than waste their valuable time in the mental health process. House Bill 1500, Item 315 X, requires that priority for new funding be given to programs that have implemented Crisis Intervention Teams pursuant to Virginia Code §§ 9.1-102 and 9.1-187 and have undergone planning to implement drop-off centers.

Threat Assessment Teams and Immunity from Liability

Although recommendations from the Public Safety Workgroup, the Mental Health Workgroup also considered the development of Threat Assessment Teams⁴⁴ and the provision of civil immunity for anyone who reports in good faith information that an individual poses a

⁴² *Id.* at 7-8, available at: <http://www.dbhds.virginia.gov/documents/130124Proposals.pdf>.

⁴³ *Id.* at 14-17, available at: <http://www.dbhds.virginia.gov/documents/130124Proposals.pdf>.
<http://www.dbhds.virginia.gov/documents/ThreatAssessment%20in%20Higher%20Ed%202013.03.28.pdf>.

⁴⁴ Presentation on Virginia Law on Threat Assessment in Public Institutions of Higher Education to the Mental Health Workgroup of the Governor's Task Force on School and Campus Safety by Kay Heidbreder, Virginia Tech University General Counsel and Special Assistant Attorney General, March 28, 2013, available at: <http://www.dbhds.virginia.gov/documents/ThreatAssessment%20in%20Higher%20Ed%202013.03.28.pdf>.

credible danger of serious bodily injury or death to one or more students, school personnel or others on school property.⁴⁵

House Bill 2344,⁴⁶ introduced by Delegate Mark Cole, requires each school board to establish a violence prevention committee and threat assessment teams similar to those required for Virginia's public institutions of higher education. The Center for School Safety within the Department of Education must provide training and a model policy to local school districts. The local threat assessment teams are required to (i) provide guidance to students, faculty, and staff regarding recognition of threatening or aberrant behavior that may represent a threat to the community; (ii) identify members of the school community to whom threatening behavior should be reported; and (iii) implement the policies adopted by the school board. Included in the legislation are referrals to local community services boards.

Senate Bill 1376,⁴⁷ introduced by Senator Stephen Martin, extends civil immunity, effective July 1, 2013, to any person who, in good faith and without malice, reports, investigates, or causes an investigation to be made into the activities of any person relating to bomb threats or other explosives, alcohol or drug use at a school or institution of higher education, or in connection with a school or institutional activity, or information that any person poses a credible danger of serious bodily injury or death to any other person on school property. Currently only school personnel are immune from such liability.

The Final Report of the Governor's Task Force on School and Campus Safety is due June 30, 2013.

Recently Decided Cases

Virginia Court of Appeals Finds No Right to Jury Trial on Involuntary Medication Petition; Appeal Moot on Sufficiency of Evidence Issue

The Virginia Court of Appeals found no right to trial by jury on a hospital psychiatrist's petition under Virginia Code § 37.2-1101 to involuntarily medicate an individual found not guilty by reason of insanity. The Court of Appeals also held that the appellant's claim that forced medication violated his basic beliefs was moot because the circuit court's 180-day order expired shortly before the Court heard his appeal. The Court, however, found the issue of his right to a jury trial was not moot because it was "subject to repetition, yet evading review." The Court then proceeded to decide this issue on the merits finding no right to trial by jury under the United States and Virginia Constitutions or Virginia statutory law. *William Scott Ingram v. Commonwealth*, 2013 Va. App. LEXIS 131 (April 23, 2013), slip opinion at: <http://www.courts.state.va.us/opinions/opncavwp/1385123.pdf>.

⁴⁵ Minutes of the Mental Health Workgroup, January 24, 2013 available at: <http://www.dbhds.virginia.gov/documents/130124Minutes.pdf>.

⁴⁶ House Bill 2344 as enacted by the General Assembly is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+ful+CHAP0710+pdf>.

⁴⁷ Senate Bill 1376 as enacted by the General Assembly is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?131+ful+CHAP0665+pdf>.

Ingram was found not guilty of malicious wounding by reason of insanity (“NGRI”) in the Martinsville Circuit Court in 1995 and has been periodically recommitted in accordance with Virginia law to various state psychiatric facilities, most recently Southern Virginia Mental Health Institute in Danville. Ingram has been diagnosed with various psychiatric conditions, including bipolar type schizoaffective disorder, narcissistic and antisocial personality disorder, and poly-substance dependence. When his father no longer agreed to serve as his son’s authorized representative for the purpose of making treatment decisions on his behalf, his psychiatrist first petitioned the Danville General District Court in 2009 for an order to involuntarily treat him with anti-psychotic medication pursuant to Virginia Code § 37.2-1101, which the court granted. Ingram appealed to the circuit court arguing in a *de novo* hearing that, among other things, the evidence was insufficient as a matter of law because the order violated his religious beliefs. On further appeal, the Court of Appeals dismissed the case as moot because the 180-day order had expired before the appeal was heard. *Ingram v. Commonwealth*, 2010 Va. App. LEXIS 254 (June 22, 2010)(unpublished), *slip opn.* at: <http://www.courts.state.va.us/opinions/opncavwp/2436093.pdf>.

In 2012, Ingram’s psychiatrist again petitioned for involuntary court-ordered treatment. The general district court granted the petition and Ingram appealed to the circuit court demanding a trial by jury. Ingram also argued that the involuntary medication violated his religious beliefs or basic values. Unlike the previous appeal in which Ingram testified that medication violated his long-standing religious beliefs, he now states that he plays in a rock band, which is “sort of like a religion to [him].” The circuit court denied the request for a jury, conducted a *de novo* evidentiary hearing, and granted the petition. That 180-day order again expired before the appeal was heard. Under Virginia law, § 37.2-1102(3), an order authorizing treatment with anti-psychotic medication cannot exceed 180 days.

The Commonwealth moved to dismiss the appeal on the grounds of mootness. Relying on *Chafin v. Chafin*, 133 S.Ct. 1017, 1018 (2013), the Court of Appeals stated that a case becomes moot when the issue presented is no longer live, or “when the dispute is no longer embedded in actual controversy about the plaintiffs’ particular legal rights.” *Already; LLC v. Nike, Inc.*, 133 S.Ct. 721, 726 (2013). Courts do not issue advisory opinions and will review such cases in very limited circumstances and only when the underlying controversy is capable of repetition, yet evading review. *Va. State Police v. Elliott*, 48 Va. App. 551, 554, 633 S.E.2d 203, 204 (2006). Such review should occur rarely and only in cases that are “short-lived by nature,” *Daily Press, Inc. v. Commonwealth*, 285 Va. 447, 452, __S.E.2d__ (2013), and then only when the party seeking review can demonstrate that he will be subjected to the same illegal conduct.

In this case, the Court of Appeals found that Ingram’s claim that involuntary medication violated his personal beliefs and basic values was fact-based and challenged the sufficiency of the evidence. His claim in this case differed from the factual basis of his previous claim. Because the Court had no confidence that the fact pattern would remain the same, it declined to find that the claim met the capable of repetition, yet evading review doctrine.

On the right to jury trial issue, however, the Court found that Ingram, having been found NGRI nearly twenty years earlier, would likely be the subject of future treatment petitions, each

of which could raise the same jury issue, but never be decided. The Court found that this claim presents a question of law unaffected by the facts underlying any given petition. Because the jury trial issue presents an exceptional situation that is capable of repetition, yet evading review, the Court proceeded to decide the issue.

On the merits, the Court of Appeals noted that neither the United States nor Virginia Constitutions afford the right to trial by jury. Although the Fourteenth Amendment guarantees the right to due process before deprivation of a liberty interest, here the right to avoid unwarranted medication, it does not include the right to trial by jury. Relying on *Washington v. Harper*, 494 U.S. 210, 228 (1990), the Court found that a proceeding to order involuntary medication does not even require a judicial decision maker. The Court also found that although the Sixth Amendment guarantees a jury trial in all criminal prosecutions that could result in imprisonment for longer than six months, this proceeding is not criminal, but civil, and could not result in any incarceration. Further, although the Seventh Amendment also guarantees a right to trial by jury in suits at common law where more than \$20 is in dispute, this right has never been applied to state court proceedings.

Under the Virginia Constitution, the Court found that the right to a jury trial applies only to proceedings for which the right to a jury trial existed when the Constitution was adopted. In this case, the statutory scheme was enacted well after the adoption of the Constitution and bears none of the indicia of a traditional common law proceeding. It does not attempt to affect the property rights of a patient or place him in the indeterminate custody of the state. “Instead, Code § 37.2-1101 represents a uniquely modern application of the *parens patriae* duty of the state to protect those ‘incapable of making an informed decision’ by attempting to ameliorate their illnesses in a manner consistent with the needs of society balanced with the deeply held religious or basic values of the individual.” *Ingram v. Commonwealth*, slip opn. at 9.

Finally, Ingram argues that Virginia Code § 8.01-336(D) affords him the right to trial by jury because his claim that the treatment is contrary to his religious beliefs and basic values which constitutes a plea in equity. Subsection D provides: “In any action in which a plea has been filed to an equitable claim, and the allegations of such plea are denied by the plaintiff, either party may have the issue tried by jury.” The Court reasons that this claim is not a plea in equity because such a plea is a discrete form of defensive pleading that does not address the merits of a case. Instead this plea raises a single set of facts that would be an absolute defense to a claim, such as the statute of limitations, *res judicata*, a release, or infancy. In this case, Ingram bears the burden of proving that the treatment is contrary to his religious beliefs or basic values. If he proves this, the burden then shifts to the Commonwealth to prove that the treatment is “necessary to prevent death or a serious irreversible condition.” The Court of Appeals held that this situation is different from the traditional plea in equity raising “a single state of facts or circumstances” and therefore the circuit court was not required to empanel a jury to decide the issue.

Pending Virginia Commitment Cases

Virginia’s appellate courts have decided very few cases related to the civil commitment or involuntary treatment processes because of the short duration of its commitment and treatment

orders, 30 days for an initial commitment and 180 days for a recommitment, and 180 days for orders authorizing treatment with antipsychotic medication. The lower courts in the Commonwealth therefore have very little guidance in implementation of these statutes. Surprisingly, the Virginia Supreme Court granted petitions for appeal from two recent commitments in Henrico County and heard oral argument on April 18, 2013.

In the first case, Michael Paugh argues that the circuit court should review the special justice's decision to commit rather than considering that the circuit court hearing is a trial *de novo* as provided in § 37.2-821; whether the entirety of the Virginia Preadmission Screening Report, including hearsay, should be admitted into evidence, rather than only the facts therein, as provided in Virginia Code § 37.2-816; and whether Paugh met the criteria for involuntary commitment at the time of the circuit court hearing *de novo*. *Paugh v. Henrico Area Mental Health and Developmental Services*, Record No. 121562.

In the second case, Charles Wood also argues whether the circuit court should decide whether he met the criteria for commitment on the date of the initial hearing rather than the date of the *de novo* trial in circuit court and whether the court erred in admitting the Preadmission Screening Report in full, including the hearsay contained in the report. The Justices expressed reservations during oral argument about whether the two cases are moot, precluding decision. Decisions in the two cases should be issued during the Court's June Term unless they are sooner dismissed as moot.

Fourth Circuit Holds Competency to Stand Trial Standard Sufficient to Permit Borderline Competent Defendant to Represent Self

The Fourth Circuit Court of Appeals has determined that once a borderline competent defendant meets the standard for competence to stand trial, the court need not inquire further as to whether the defendant is competent to represent himself. *United States v. Bernard*, 708 F.3d 583 (4th Cir. 2013). The Fourth Circuit held that the Supreme Court in *Indiana v. Edwards*, 554 U.S. 164 (2008) only *permits* a court to force counsel on a criminal defendant who is borderline competent, but does not *require* it to do so. Instead the Fourth Circuit found that this case more closely resembles *Godinez v. Moran*, 509 U.S. 389 (1993), that held that “ the competence that is required of a defendant seeking to waive his right to counsel is the competence to waive the right, not the competence to represent himself.” *Id.* at 399.

In this case, Michael Defante Bernard was charged in North Carolina with possessing and conspiracy to possess marijuana with intent to distribute and possession of a firearm in furtherance of a drug trafficking offense. Bernard had a long history of mental illness, suffering from severe depression, chronic schizophrenia and paranoia. He had been physically and emotionally abused as a child, attempted suicide at least three times and had been involuntarily committed on at least four separate occasions. He also had a history of failure to take his medications. Bernard also abused cocaine and marijuana to cope with his mental illness.

Concerns were raised about Bernard's competency to stand trial and the district court ordered an evaluation. A government psychologist recommended that he be found incompetent to stand trial due to his schizophrenia, paranoid delusions, and disorganized thought processes.

The court thereupon found Bernard incompetent to stand trial and ordered him treated for restoration to competency. Less than six months later, another government psychologist recommended that Bernard be found competent to stand trial because the antipsychotic, antidepressant, and anti-anxiety medications rendered him able to understand the proceedings against him and to assist his counsel.

At his second competency hearing, the trial court found Bernard competent to stand trial. His counsel then moved to withdraw as counsel based upon Bernard's request to represent himself, and to appoint him as stand-by counsel. Defense counsel represented to the court that it *must* find the defendant competent to waive counsel, if it also found him competent to stand trial, ostensibly but incorrectly referencing *Godinez v. Moran*. The trial court expressed strong misgivings about allowing the defendant to represent himself, but after engaging in colloquy with Bernard, determined he could go forward. The court further elaborated that it would monitor his competence as the trial progressed. During trial, Bernard made opening and closing statements, testified on his own behalf and re-opened his case to question a law enforcement officer whom he had declined to cross-examine during the government's case-in-chief. He did not, however, make any objections during the government's case, question any of the government's witnesses, or call any witnesses on his own behalf. The jury deliberated 12 minutes and found him guilty on all charges. At the scheduled sentencing hearing, Bernard's mental condition had seriously deteriorated and he was again fully represented by his stand-by attorney. At the final sentencing hearing held several months later after his further restoration to competency, the court sentenced him to 15 years in prison.

On appeal, Bernard argued that the trial court erred when it allowed him to exercise his right to self-representation at trial saying it abused its discretion in failing to apply the more rigorous standard following *Edwards* that required him to be represented by counsel. Bernard further contended that his trial counsel was ineffective by representing to the court that his competence to waive counsel was governed by the same standard as his competence to stand trial.

The Fourth Circuit applied the "plain error" standard in reviewing the appeal, not an abuse of discretion standard. The plain error standard requires that when a defendant fails to make a contemporaneous objection to an assignment of error at trial, the error must be plain on its face, affect his substantial rights and adversely affect the outcome of the proceedings. The Fourth Circuit reiterated that a defendant has a Sixth Amendment right to self-representation under *Faretta v. California*, 422 U.S. 806, 819, 821 (1975). It stated that in *Godinez*, the Supreme Court held that the competence of a defendant to stand trial is the same as the competence to waive the right to counsel. The Court went on to write that *Edwards* did not change that right. In *Godinez*, the trial court found the defendant competent to stand trial and permitted him to waive counsel and represent himself. By contrast, the trial court in *Edwards* found him competent to stand trial but refused to allow him to represent himself. The Fourth Circuit determined that the Supreme Court's had held in *Edwards* that the Constitution permits the government to limit a defendant's right of self-representation on the ground that the defendant lacks the mental capacity to conduct his trial defense unless represented. A different standard than the competency to stand trial standard *may*, but *is not required*, to be used when the defendant asserts his right of self-representation. Because the trial court in this case was

permitted, but not required, to apply a higher standard to assess Bernard's competency to represent himself and did not, there was no plain error.

The dissent agreed with the distinction the majority drew between *Godinez* and *Edwards*, but found that the record reflected that the trial court did not believe it had *any* discretion to consider a higher standard than competency to stand trial and therefore did not do so. Its belief that it had no discretion, and therefore did not exercise any, was itself an abuse of discretion warranting a remand.

Ninth Circuit Finds Federal Juvenile Delinquency Act, Not Adult Act, Controls When Juvenile Committed to Determine Competency to Stand Trial

The Ninth Circuit Court of Appeals has held that a juvenile charged with murder under the Federal Juvenile Delinquency Act whose competency to stand trial is in doubt must be committed under the juvenile provisions of 18 U.S.C. § 5037(e) and not the provisions related generally to all commitments under 18 U.S.C. § 4241(d). *United States v. LKAV, Juvenile Male*, 2013 U.S. App. LEXIS 6573 (9th Cir. April 2, 2013).

Tribal authorities with the Tohono O'odham nation charged 17-year old LKAV with murder in May 2009. He was found incompetent and remained in tribal custody but without being sent to a treatment facility for restoration to competency. In November 2011, the United States filed its own charge against LKAV as an alleged juvenile delinquent under the Federal Juvenile Delinquency Act. The United States then obtained a writ of habeas corpus to remove him from tribal custody and moved to commit him for a psychiatric evaluation pursuant to the provision pertaining in general to all federal criminal cases under 18 U.S.C. § 4241(d). The presiding magistrate judge granted LKAV's request for a local evaluation in Phoenix, Arizona.

After an extensive evaluation, the examining psychologist determined LKAV was incompetent to stand trial. LKAV then moved to proceed with commitment under the juvenile act. The United States maintained that LKAV should be committed to an adult facility under § 4241(d). The magistrate judge granted the United States' motion and committed LKAV to the custody of the Attorney General for hospitalization for a period not to exceed four months to determine whether he could be restored to competency. LKAV filed a timely appeal, but in the interim was transported to the Federal Medical Center in Butner, North Carolina. FMC-Butner completed its competency evaluation in January 2013 and advised the court that with an additional period of hospitalization and treatment, LKAV could be restored to competency. It requested an additional 120-day extension of the commitment order, which the district court granted. LKAV appealed.

The Ninth Circuit heard LKAV's appeal under the collateral order doctrine finding that the commitment order conclusively determines LKAV's rights as to his pre-adjudication commitment; his commitment is a completely separate issue from the ultimate issue of his delinquency; and delay until a final decision of his delinquency on the merits would render the commitment order effectively unreviewable.

The Ninth Circuit then reviewed the language of the respective statutes and determined that the plain language of § 5037(e) is clear that it applies to the commitment and evaluation of alleged juvenile delinquents:

If the court desires more detailed information concerning an alleged or adjudicated delinquent, it may commit him...to the custody of the Attorney General for observation and study by an appropriate agency. Such observation and study shall be conducted on an outpatient basis, unless the court determines that inpatient observation and study are necessary to obtain the desired information. *In the case of an alleged juvenile delinquent, inpatient study may be ordered only with the consent of the juvenile and his attorney.* The agency shall make a complete study of the alleged or adjudicated delinquent to ascertain his personal traits, his capabilities, his background, any previous delinquency or criminal experience, *any mental or physical defect*, and any other relevant factors. The Attorney General shall submit to the court and the attorneys for the juvenile and the Government the results of the study within *thirty days* after the commitment of the juvenile, unless the court grants additional time. (Emphasis added.)

By contrast, the commitment scheme generally applicable to all defendants contained in § 4241(d) requires mandatory commitment for determination of the defendant's potential for restoration to competency. The United States had argued that § 5037(e) does not mention competency and therefore the mandatory competency evaluation and commitment procedures in § 4241(d), which are more explicit and comprehensive and apply to all federal criminal proceedings applies.

The Court found that because § 5037(e) expressly provides for commitment, study, and observation of alleged juvenile delinquents, and specifically references a study of any mental or physical defect, it controls over conflicting provisions in § 4241(d) that apply to federal criminal defendants generally. The Court pointed out, however, that the United States could have sought to have LKAV transferred for trial as an adult and therefore all of the provisions in § 4241(d) would have applied, but for some reason chose not to do so. The Court recognized that because LKAV has now turned 21 and is no longer a juvenile, his further treatment and custody may cause the United States some incidental inconvenience because he cannot be housed with other juveniles or adults. Nonetheless the Court held that the purpose of Federal Juvenile Delinquency Act is to provide for the preferential and protective care and treatment of juvenile delinquents who are significantly different from adult offenders, and its provisions must therefore control.

Eighth Circuit Upholds Dismissal of Civil Suit Alleging Violation of the Constitution and ADA for Interrogation of Suspect with Intellectual Disabilities

The Eighth Circuit Court of Appeals has upheld the district court's grant of summary judgment dismissing a civil case filed on behalf of a 30-year old man with intellectual disabilities against the City of Waverly, Iowa, and the investigating officer, finding no violation of his constitutional rights, § 504 of the Rehabilitation Act, 29 U.S.C. § 794, and Title II of the

Americans with Disabilities Act, 42 U.S.C. § 12132, as a result of his interrogation and subsequent charges of sexual assault. *Folkerts v. City of Waverly*, Iowa, 707 F.3d 975, (8th Cir. 2013), *rehearing denied* 2013 U.S. App. LEXIS 7279 (8th Cir. April 10, 2013).

The plaintiffs Melvin and Idella Folkerts are the legal guardians of their adult son Travis Folkerts who has an IQ of 50. In May 2008, Travis lived alone in a supervised apartment when a neighbor reported that Travis had engaged in inappropriate conduct with her minor son. A patrol officer who knew Travis had a disability spoke with the complainant and then contacted Troy Schneider, an investigator with the police department and now a defendant in this case. The patrol officer then spoke with Travis who was alone and read him his Miranda rights, asking Travis if he understood them. Travis indicated he did and then provided the officer with the phone number of his caseworker upon request.

The next day Schneider went to Travis' apartment where he was alone and read him his Miranda rights and more fully explained them so he could better understand them. Schneider believed Travis understood them. He then took Travis to the police station where he continued the interrogation in a conference room that Schneider believed was less intimidating than the regular, smaller interrogation room. He also asked Travis non-leading open-ended questions because he thought it would be easy to get him to say something he did not do if he was asked leading, direct questions.

At Travis' request, Schneider called Travis' mother who spoke with Travis by phone. Travis told her he was nervous. Schneider told Mrs. Folkerts she could come down to the police station if she wanted, but she said she thought Travis would be less nervous if she did not. Schneider continued the interrogation and Travis incriminated himself. Afterwards Schneider drove Travis to his parents' home and explained the situation to them. Schneider then arranged to have Travis booked using friendlier booking procedures. After consulting with the county attorney, Schneider filed a complaint charging Travis with the misdemeanor of lascivious conduct. An Iowa court found Travis incompetent to stand trial and dismissed the charges.

The Folkerts then filed a civil lawsuit against the City of Waverly and the investigator Troy Schneider under 42 U.S.C. § 1983, alleging violation of their son's and ward's substantive constitutional rights in the interrogation process, and violations of § 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act for disparate treatment and failure to make reasonable accommodations. To establish a substantive due process violation, the Court stated that the Folkerts must demonstrate that a fundamental right has been violated and that the officer's conduct shocks the conscience. To support their allegations the Folkerts recited Schneider's 1) failure to accommodate Travis' disability during the interrogation; 2) inadequate investigation; 3) investigation as retaliation against Travis' relatives; and 4) filing of a defective charge.

The Court found that Schneider's behavior did not shock the conscience. He altered his questioning style, more fully explained Travis' Miranda rights, and interviewed Travis in a less intimidating room. He also called Travis' mother and invited her to the police station. The Court also found that the adequacy of the investigation also did not shock the conscience. In order to do so, the Court stated the officer must 1) attempt to coerce or threaten the suspect; 2)

purposefully ignore evidence of the suspect's innocence; or 3) systematically pressure to implicate the suspect despite contrary evidence. Further, the patrol officer here had interviewed the alleged victim, his mother and visited the scene. The Court therefore found that Schneider's failure to do so himself does not establish an intentional or reckless failure to investigate.

The evidence also revealed that during an investigation the previous year of a burglary of a business owned by Travis' cousin's wife, Schneider was alleged to have been rude to Travis' cousin and not to have pursued a lead. No evidence was submitted, however, that Schneider retaliated against the family members by investigating Travis. Lastly the charge filed required a showing that the accused be "in a position of authority" over the victim. There was no Iowa case law interpreting this element of the offense before Schneider filed the charge and he sought the advice of the county attorney before doing so. Although following an attorney's advice does not automatically provide an officer with qualified immunity, the Court found it demonstrates the reasonableness of the action. In this case, Schneider's behavior does not shock the conscience.

The Folkerts also alleged that the city's culture of indifference to people with disabilities demonstrated its deliberate indifference to Travis' needs. The Court stated that a pattern of similar constitutional violations by trained employees, or a specific instance accompanied by a showing of lack of training to handle recurring situations, is necessary to establish deliberate indifference on the part of the city. The Court found that the plaintiffs here, however, failed to allege even a single violation of rights.

To establish a prima facie § 504 violation, a qualified individual with a disability must be denied the benefit of a program or activity of a public entity receiving federal funds. For a prima facie ADA violation, a qualified individual with a disability must be excluded from participation or denied the benefits of a public entity's services, programs, or activities. Here, the interrogation was covered by the ADA. The Court found, however, that no reasonable jury could conclude that the defendants failed to make reasonable accommodation for Travis' disability. Schneider altered his questioning style, more fully explained his Miranda rights, interviewed Travis in a less threatening room, drove Travis to the Folkerts' home and explained the situation to them, and arranged an alternative and friendlier booking procedure. Most importantly, the Court stated Schneider called Travis' mother and reasonably concluded that her comment that her presence might make Travis more nervous meant that she was not coming to the police station and was not requesting additional or alternative accommodations for her son. The Eighth Circuit therefore upheld the district court's granting of the defendants' motion for summary judgment and dismissal of the case.

Mississippi Supreme Court Finds Failure to Appoint PTSD Expert Denies Due Process

The Mississippi Supreme Court has held that the trial court's refusal of funds for the defendant to hire a post-traumatic stress disorder ("PTSD") expert was an abuse of discretion and denied the defendant his right to a fair trial. *Evans v. Mississippi*, 2013 Miss. LEXIS 31 (Miss. January 31, 2013). In so doing, the Supreme Court reversed the decisions of both the Court of Appeals and the trial court and remanded the case for a new trial.

In April 2007, Dante Lamar Evans, then age 14, was arrested for the murder of his father. In a videotaped police statement, Dante stated that he and his mother had been abused by his father, that his father had threatened to kill his mother on several occasions, that he had witnessed his father holding his mother underwater in the bath tub, and that his father tried to hit his mother with a car. He also stated that his father had lashed out against him, and at one point injured his eye. Dante was hospitalized with depression in 2001 and was diagnosed with PTSD.

In 2006, Dante moved with his mother to North Carolina, but after he began spending time with a gang and using drugs, she sent him to live with his father in Biloxi. In February 2007, Dante moved in with his father in a FEMA trailer, but after several weeks told the school guidance counselor that he had been thinking of killing his father. The counselor then called another counselor and he told them both that his father was beating him. The next morning the counselor called in the school social worker who told Dante that a parent has the right to discipline a child as long as they do not leave bruises. Dante explained that his father did not leave bruises, but did push and punch him in the chest and forbade him from contacting his mother. The social worker suggested Dante write his mother, but when he attempted to do so during class, the letter was confiscated. The school notified Dante's father and scheduled a meeting with him. The father acknowledged that he was strict with his son but that they had a good relationship. Dante's mother then called his father during the meeting and the father gave the phone to his son. The next day Dante came to school with a bruise next to his eye. Dante said his father had pushed him against the trailer. The Department of Social Services then investigated but found no reason to intervene. A few weeks later, Dante's father was found dead from a gunshot wound. Dante told police he took his father's handgun from a locked tool box two nights before the shooting and had practiced using it. At first it would not fire, indicating to him that he should not do this. He told police that he had no experience with guns.

In April 2008, the defense hired a psychologist to conduct a psychological examination of Dante to determine if he was competent to stand trial and his mental state at the time of the offense. The psychologist reported that Dante was competent but that he had been diagnosed previously with PTSD and was currently exhibiting symptoms of PTSD, including fear and a sense of helplessness, agitated behavior, outbursts of anger, difficulty concentrating, and intrusive memories of past abuse. The psychologist stated that she was not an expert in PTSD and recommended that another expert in PTSD be appointed to assist Dante in his defense of imperfect self-defense.

Dante's counsel then moved the court to appoint a PTSD expert to assist in the preparations for trial and to testify, and requested no more than \$3000 to hire this expert. The trial court denied the motion stating that Dante, the examining psychologist, and other witnesses could testify to his abusive family history. At trial, Dante's counsel requested a jury instruction on his theory of imperfect self-defense. The court refused to give this instruction on the grounds that Dante had failed to present enough evidence to support the theory. In March 2009, the jury convicted Dante of murder and sentenced him to a mandatory life term.

On appeal, six of the judges of the Court of Appeals affirmed the conviction holding that the trial court properly denied the funds to hire an expert because the expert testimony was intended to support the theory of imperfect self-defense which was not supported by the

evidence. Three judges dissented finding that a PTSD expert was necessary because such testimony was necessary to support this defense.

The Mississippi Supreme Court reversed finding that the denial of expert assistance in this case was in fact prejudicial to the assurance of a fair trial. The Court found each case must be decided on a case-by-case basis but that it would be an abuse of discretion to deny funds for an expert if a defendant had provided concrete reasons showing a substantial need for such assistance. The Court found that in this case Dante had met his burden of proof. The expert appointed to assess his competence to stand trial found him competent but indicated he had previously been diagnosed with PTSD and was currently exhibiting its symptoms. She stated she was not an expert in PTSD and therefore could not assist in the preparation of his defense, and specifically that PTSD affected his state of mind at the time of the offense. Although she could recognize the symptoms, she had stated that she did not have the expertise to explain to a jury PTSD's effects on a person's mental state.

Relying on *Ake v. Oklahoma*, 470 U.S. 68, 80-81 (1985), the Mississippi Supreme Court found that to support his theory of imperfect self-defense, Dante was required to show that he acted without malice and under a bona fide belief that his actions were necessary to avoid death or bodily harm. The Court explained that a defendant under *Ake* does not have a constitutional right to an expert of his own choosing, but based on the facts of this case, Dante had demonstrated that an expert in PTSD was needed to prepare an adequate defense. The Court determined that lay witnesses could not testify as to the symptoms and characteristics of PTSD and provide a medical diagnosis. An expert could also explain to the jury how a child's mind could be affected when suffering from PTSD, and the lack of such information deprived Dante of a fair trial. Denying him the funds to hire such an expert was therefore an abuse of discretion and violated his due process right to a fair trial. The Supreme Court then reversed the decisions of both the Court of Appeals and the trial court, and remanded the case for a new trial.

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