

Legal and Ethical Challenges in Mental Health Law: A Primer for Virginia Lawyers

by Molly A. Huffman



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Lawyers regularly encounter the mental health law system in their practice. Sometimes it's through a client who is suffering from a mental health illness, and sometimes the illness results in a crime or a family misfortune. Sometimes lawyers are involved through representing health care providers. Even those whose practices focus on education, privacy, constitutional law, and administrative law can become involved in the system.

Prior to 2008, Virginia's mental health laws had not been materially reformed in nearly thirty years. However, since then Virginia legislators have made significant changes in laws pertaining to mental health. Even with changes, legal and ethical challenges remain for those practicing in this area.

The Commission on Mental Health Law Reform was appointed by then Chief Justice of the Supreme Court of Virginia Leroy Rountree Hassell Sr. in October 2006 and was directed to conduct a comprehensive examination of Virginia's mental health laws and services. Then, on April 16, 2007, thirty-two people were shot and killed at Virginia Tech by a student who had previously shown signs of mental illness on several occasions. In the aftermath, Virginia pledged to expeditiously improve its mental health system. In April 2008, one year after the Virginia Tech shootings, twenty-six new mental health laws were signed into law in Virginia. The result was a broadening of Virginia's commitment laws and a \$42 million increase in community health services funding over two years. A portion of that funding was taken away in 2009 because of Virginia's budget crisis, but a lasting result was increased attention on Virginia's limited options for community-based mental health care.¹ This article addresses only a few of the most notable recent mental health law changes, but there have been

and continue to be many legal updates and ethical challenges in this arena.

ECO and TDO Commitment Criteria

One of the major changes in the year after the Virginia Tech tragedy was in the standard required to commit someone as an in-patient for mental health treatment against his will pursuant to an Emergency Custody Order (ECO) or Temporary Detention Order (TDO). Before 2008, the standard required clear and convincing evidence that "the person present[ed] an imminent danger to himself or others as a result of mental illness or ha[d] been proven to be so seriously mentally ill as to be substantially unable to care for himself." The high "imminent danger" standard was abandoned, and the current law provides for a lower standard of "substantial likelihood" that the person will cause serious physical harm to himself or others, or that he will suffer serious harm because of his lack of capacity to protect himself from harm or to provide for his basic human needs.²

In addition to the change in commitment criteria from "imminent danger" to "substantial likelihood," the language "unable to care for himself" was changed to "suffer serious harm due to lack of capacity."³ Also, magistrates now "shall" issue ECOs and TDOs if these criteria are met, rather than the previous "may" issue. Finally, the

time a person may be detained under an ECO was extended from four hours to six hours, if there is a finding by the magistrate that good cause exists for the extension. These changes have been in effect for some time now, but ensuring that we in the legal community understand the standard is important for all of us whose practices involve commitment and mental health issues. A commitment hearing takes place prior to the end of the 48 hour TDO.⁴ During the commitment hearing, the magistrate may consider the following evidentiary considerations: recommendations of any treating physician or psychologist licensed in Virginia, the independent examiner's certification, past actions of the person, past mental health treatment, any health records that may be available, the preadmission screening report, and any other relevant evidence admitted. Commitment pursuant to this hearing shall not exceed 30 days, and any subsequent orders are not to exceed 180 days.⁵ Often, patients who are committed are not committed for the full thirty days.

Admission to In-Patient Psych Facility Pursuant to a Patient's Advance Directive

In 2009, for the first time, the law governing advance directives in Virginia was changed to permit inclusion of a provision allowing the person's agent to consent to the person's admission to a facility for no more than ten calendar days if the person has a mental illness, is unable to make his own decisions, is in need of treatment, and the advance directive specifically includes this provision allowing in-patient treatment by the agent over the patient's objection.⁶ A determination of incapacity must be made by two physicians or a physician and a clinical psychologist, one of whom may not be involved in the patient's care. Advising clients of this mental health appointment option when they are completing their advance directives and remembering to ask for the most updated copy of an individual's advance directive when in a crisis situation can be very important for lawyers.

Mental Illness in the Homeless Population and Treatment by Hospitals

One of the larger legal and ethical problems in the mental health arena may become the treatment of the homeless. The homeless population across the country—and within Virginia—has a high rate of mental illness. They often suffer from psychiatric problems and substance abuse, and without health insurance, turn to hospital emergency rooms for care. Discharge of homeless patients

from hospitals after treatment is a hot area for prosecution, and there have recently been some large recoveries against hospitals. The bottom line is that hospitals are being treated as the safety net for the homeless, and are forced to keep these patients until they find placement in homeless shelters, mental health facilities (which is very difficult), nursing facilities (which is even more difficult), or another approved location. The idea that a hospital is responsible for a homeless patient after discharge, simply because the homeless patient presented to that hospital for treatment, will place significant financial burdens on hospitals. Without adequately planning for discharge of their homeless, poor, mentally ill patients, hospitals face a large amount of exposure. Returning these patients to the streets from where they came carries a heavy risk. Virginia has not passed legislation on this issue, but other states, such as California, have. These anti-dumping bills require hospitals to find placement for homeless patients rather than send them back to the streets, but as seen in Virginia, sufficient placements do not always exist.⁷

“Streeting,” Need for Placement Beds, and EMTALA

Similarly, the term “streeting” has already become well known in Virginia. “Streeting” is a term which refers to a patient who apparently meets the criteria for a TDO, but is released from custody because an available psychiatric bed cannot be found, or because the patient is subject to an ECO which expires before a TDO can be obtained.⁸ The term “streeting” has received recent attention in Virginia because of Eastern

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State Hospital's downsizing in 2010, and the Office of Inspector General for Behavioral Health and Developmental Services' (OIG's) recent focus on the term in its reports. Based on reports from community services boards (CSBs), the OIG estimated that 200 individuals were “streeted” in Virginia in 2010. This means that these 200

people were evaluated by skilled clinicians and determined to be a danger to themselves or to others, but they could not get access to a secure environment for temporary detention and further evaluation.⁹ Several trends may be responsible for the “streeting” phenomenon. Private psychiatric beds have significantly decreased in number over the past two decades because of a conscious effort to “deinstitutionalize” mental health care, shifting away from hospitals and moving towards community-based, outpatient care.¹⁰ In addition, budget constraints have caused the loss of many in-patient services and beds.

Health care providers routinely face problems with access to beds for in-patient treatment. According to a recent report by the Treatment Advocacy Center, Virginia has a serious shortage of public psychiatric beds for patients who need immediate crisis care.¹¹ (Their figures show that Virginia has 22.2 public beds per 100,000 population.) Furthermore, the number of private psychiatric beds has continued to decrease across the commonwealth. From 1991 to 2005, Virginia lost 793 psychiatric beds.¹² At Eastern State Hospital in Williamsburg, the number of psychiatric beds has dropped 40 percent since 2003. In 2010, forty Hampton Roads residents were denied care at Eastern State because no beds were available.¹³ At times, patients who need care are not committed because a bed cannot be found for them. In an effort to ameliorate this problem, the Joint Commission has indicated interest in creating a statewide bed registry to expedite the process of locating a private psychiatric facility to admit a patient in need of and meeting the criteria of a TDO.¹⁴

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When there is a lack of beds, hospitals are challenged. On one hand, without a court order, hospitals cannot hold these patients against their will in the emergency department. Thus, if a TDO is not in place at the expiration of the ECO or a bed cannot be found, the patient may leave the emergency department, even though he is still in need of critical psychiatric care. This poses many ethical and legal problems for hospitals. On the other hand, The Emergency Medical Treatment

and Active Labor Act (EMTALA) requires the hospital to screen and stabilize the emergency medical condition (or transfer) for all patients presenting to the emergency department. Thus, the hospital needs to be able to screen and stabilize the patient and provide care to stabilize him under their EMTALA obligations, but if that patient wishes to leave the hospital, he cannot be stopped absent a court order.

In the End, Where is Virginia on Mental Health?

In 2006, the National Alliance on Mental Illness (NAMI) gave Virginia a D grade on mental health. The next round of grading took place in 2009, and Virginia received a C, largely because of the intense scrutiny that followed the 2007 tragedy at Virginia Tech. In comparison, NAMI gave the entire United States a D grade on mental health in both 2006 and 2009.¹⁵ This suggests that Virginia is slightly above the national average, but is far from perfect. In 2010, NAMI estimated that of Virginia’s 7.8 million residents, close to 262,000 adults live with serious mental illness, and about 82,000 children live with serious mental health conditions.¹⁶

In sum, there has been much change in mental health laws in Virginia since 2008, but as events such as the tragedy at Virginia Tech and the recent tragedy in Tucson, Arizona, on January 11, 2011, remind us, change is still needed. These events continue to shape discussions across the country about mental health reform, behavioral health medicine, and sadly, the growing need and importance of these services in our societies. With these events and their resulting changes come a myriad of legal and ethical issues for all of us practicing law in the commonwealth — no matter what our specialty.

Endnotes:

- 1 NAMI State Advocacy 2010, *State Statistics: Virginia*. Available at <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93525&FusePreview=Yes/>.
- 2 Va. Code §§37.2-808 and 809.
- 3 Va. Code §37.2-808(A) Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and

- other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. Any emergency custody order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or permitted by law.
- 4 Va. Code § 37.2-809 and Va. Code § 37.2-814.
 5 Va. Code § 37.2-817. Involuntary admission and mandatory outpatient treatment orders.
 6 Va. Code § 37.2-805.1(A).
 7 Ca. Health & Safety Code § 1262.5.
 8 Simpson, Elizabeth, *The Virginian-Pilot*, June 6, 2011, “In hours of need, some mentally ill find closed doors”. Available at <http://hamptonroads.com/2011/06/hours-need-some-mentally-ill-find-closed-doors-0>.
 9 Office of the Inspector General for Behavioral Health and Developmental Services, *Update on “Streeting” in the Commonwealth*, at 1. Sept. 2011. Available at http://sfc.virginia.gov/pdf/Public%20Safety/2011%20Interim%20Mtg/090811_No2c_Inspector_General_Report.pdf
 10 Simpson, *supra* note V.
 11 Torry, E. Fuller, et al., *The Shortage of Public Hospital Beds for Mentally Ill Patients, A Report of the Treatment Advocacy Center*. Available at http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_public_hospital_beds.pdf
 12 Report of the Joint Legislative Audit and Review Commission to the Governor and General Assembly of Virginia. *Availability and Cost of Licensed Psychiatric Services in Virginia* at ii. Senate Document No. 19, 2007. Available at <http://jlarc.state.va.us/Reports/Rpt365.pdf>.
 13 Simpson, Elizabeth, *The Virginian-Pilot*, June 6, 2011. Available at <http://hamptonroads.com/2011/06/hours-need-some-mentally-ill-find-closed-doors-0>.
 14 *Office of the Inspector General for Behavioral Health and Developmental Services, Update on “Streeting” in the Commonwealth*, at 1. Sept. 2011. Available at http://sfc.virginia.gov/pdf/Public%20Safety/2011%20Interim%20Mtg/090811_No2c_Inspector_General_Report.pdf
 15 In 2009, no states received an A, six states received a B, eighteen states received a C, twenty-one states received a D, and six states received an F. NAMI State Advocacy 2010, *State Statistics: Virginia*. Available at http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75354.
 16 NAMI State Advocacy 2010, *State Statistics: Virginia*. Available at <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93525&FusePreview=Yes/>.

Virginia Offers Advance Health Care Directive Registry

The Commonwealth of Virginia is offering a statewide Advance Health Care Directive Registry. The registry, available to all legal Virginia residents, stores documents that detail and protect health care wishes in the event people are unable to speak for themselves. These documents include medical power of attorney, do-not-resuscitate orders, and other health care wishes.

“This public-private partnership between the Virginia Department of Health, UNIVAL Inc., and Microsoft Corporation provides an important service to all Virginians,” said William Hazel Jr., secretary of Health and Human Resources. The registry is free for users.

Without advanced planning, health care decisions are often left to

family members when loved ones become incapacitated and unable to speak for themselves. The registry relieves loved ones of that burden and ensures that those loved ones, as well as health care providers, know a person’s wishes and who they want making medical decisions for them. Through the registry, residents can also make known their wishes regarding organ donation.

Using the registry is easy. Users enter basic information, create an account and select a personal identification number (PIN) and password. Each Virginian who signs up for the registry receives an identification card containing their personal registry information so health care providers can access their information if necessary. They may also share their PIN

with friends, family, and health care providers, allowing them access to their information.

The registry will be interoperable with the statewide Health Information Exchange. The exchange is a secure, confidential, electronic system where a patient’s records will be accessible to other health care providers throughout the nation if a patient chooses to participate. As the statewide exchange becomes operational, the registry will be a value-added service.

To sign up for the health care registry, visit <https://www.virginiaregistry.org>. People without access to a computer can still be part of the registry by calling **800-224-0791**.